[Report of the Medical Officer of Health for Hounslow].

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The Health Services of Hounslow 1966

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London Borough of Hounslow
Annual Report 1966

of the Medical Officer of Health and Principal School Medical Officer

Robert L Lindon MRCS LRCP DPH DCH

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Councillor Mrs M T Roebuck
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Staff of the Department of Health at 31st December 1966

Medical Officers

Staffing establishment
15

Medical Officer of Health and
Principal School Medical Officer
R L Lindon MRCS LRCP DPH DCH

Deputy Medical Officer of Health and
Deputy Principal School Medical Officer
Megan E Wilkinson MB ChB DPH

Principal Medical Officers
P A Bennett MB ChB
Elizabeth N Christie MB ChB DPH
Dulcie G Gooding MB BS MRCS LRCP DPH

Assistant Principal Medical Officer
Betty P Westworth MB ChB DObst RCOG

Senior Assistant Medical Officer
A R Broadbent MRCS LRCP DPH DIH

Assistant Medical Officers
Miss P J A Bell MB BS MRCS LRCP DCH
G T J Cook MB ChB
Miss M Foxworthy MB BCh BAO
Mrs A J V Lawson MB BS DObst RCOG
Mrs R Prothero MD LRCP LRCS DCH
Mrs J R Richards MB ChB

Consultants

In conjunction with the Regional Hospital Boards

Audiology Unit
L Fisch MD DLO

Cerebral Palsy Unit
A D Barlow MA MB BChir MRCP DCH

Child Guidance Clinic
W P K Calwell MB BS DPM

Ophthalmic Clinics
C J L Blair MRCS LRCP
Miss H B Casey MB BCh DOMS

Orthopaedic Clinics
J A Cholmeley MB BS FRCS
E A Devenish MS FRCS

Mental Health Service C F Herridge MA MB BCh DPM	In conjunction with the Regional Hospital Boards
Chest Clinic R Heller MD	
Pathologist E Nassau MD	**Staffing establishment**
Dental Officers and Orthodontists	12
Chief Dental Officer D H Norman BDS LDS RCS	
Senior Dental Officer Miss N Leaver BDS LDS	
Orthodontist S Levy BDS	
Dental Officers Miss F H Bowie BDS LDS Mrs B Fox BDS LDS Miss M A Robinson LDS RCS	
Senior Psychologist for special units and special schools Miss M C Tyson BA BSc (Econ) PhD	1
Social Work Organiser and Advisor on Health Education E Heimler AAPSW	1
Physiotherapists	5
Superintendent Physiotherapist Mrs J Biddle MCSP SRP	
Speech Therapists	5
Senior Speech Therapist Miss E G Richnell LCST LRAM	
Health Visitors and School Nurses	37
Superintendent Health Visitor Miss E L Donovan SRN SCM HV	
Deputy Superintendent Health Visitor Vacant	

	Staffing Establishment
Student Health Visitors	3
Tuberculosis Health Visitors	5
Home Nurses	34
Domiciliary Midwives	16
Non-Medical Supervisor of Midwives and Superintendent Home Nurse Miss V Murphy SRN SCM HV RMPA	
Deputy Non-Medical Supervisor of Midwives and Deputy Superintendent Home Nurse Miss M A Taylor SRN SCM MTD	
Public Health Inspectors	24
Chief Public Health Inspector K J Smith FAPHI MRSH	
Deputy Chief Public Health Inspector F V Bell MRSH MAPHI	
Public Analysts	In conjunction with the Greater London Council
W B Chapman BSc FRIC E H W J Burden BSc FRIC	
Veterinary Inspector	
J A Morris MRCVS	
Pupil Public Health Inspectors	4
Rodent Officer	1
Rodent Operators/ General Duties Assistants	8
Mortuary Attendant	1
Psychiatric Social Workers	2
Mental Health Social Workers	11
Chief Mental Welfare Officer W N Carey SRN RMN	
Deputy Chief Mental Welfare Officer A H Duff Dip SS	

Junior Training Schools and Special Care Units

Staffing Establishment

Hanworth	
Supervisor	1
Mrs F R Williams NAMH	
Assistant Supervisors	6
Trainee Supervisor	1
General Duties Assistants	4
Coach Guide	1
Cook	1
Cleaner	1
Stoker	1
Isleworth	
Supervisor	1
Miss G M Chapman	
Assistant Supervisors	7
Trainee Supervisor	1
General Duties Assistants	3
Coach Guide	1
Cook	1
Cleaner	1

Adult Training Centres

Acton Lodge	
Manager	1
J R Simpson	
Deputy Manager	1
Senior Instructors	2
Instructors	9
Cooks	2
Domestic Assistant	1
Coach Guides	2
Brentford Adult Training Centre	
Supervisor Instructor	1
B F Pitt	
Instructors	3

Supply Staff for Schools and Centres

Senior Physiotherapist	1
Supervisor	1
Trainee Supervisor	1

	Staffing establishment
Hostel for the Mentally Ill	
Warden T V Jones DSC	1
Assistant Warden	1
Housekeeper	1
Cooks	2
Domestic Assistants	2
Day Nurseries	
Matrons	3
Deputy Matrons	3
Wardens	3
Nursery Nurses	15
Nursery Students	14
Cooks	3
Domestic Assistants	7
Hounslow Chest Clinic	
Almoner	In conjunction with the North West Metropolitan Regional Hospital Board
Clerk	
Medical Auxiliaries, etc	
Psychotherapist	1
Dental Auxiliaries	2
Dental Surgery Assistants	16
Audiometricians	3
Chiropodists	3
Orthoptist	1
Occupational Therapist	1
Vision Screen Operator	1
Welfare Assistants	2
Welfare Officer	1
Clinic Attendants	5
Home Helps	160
Organiser Miss D Claxton	1
Assistant Organisers	4
Caretakers and Cleaners	11
Administrative and Clerical	79
Chief Administrative Officer H L Law ARSH MRIPHH	
Deputy Chief Administrative Officer J W Dean FSS	

Figures are equivalent full-time to the nearest whole number

To the Mayor · Alderman and Councillors of the London Borough of Hounslow

I have the honour to present the second Annual Report on the health of the people living in the London Borough of Hounslow. My report includes a survey of the health services provided by the borough, with special emphasis on new developments achieved during the year as well as those planned for the future.

With the unanimous support of the Health Committee and the full Council the Department of Health has had an active and fruitful second year. From Chiswick in the east to Feltham in the far west of the new London Borough of Hounslow many worthwhile improvements, new projects and new policies have been inaugurated in the health field and are already gathering momentum. I shall mention only a few of these achievements, but for reference I have included a summary of the ten year programme for health services in the body of the report.

In Heston
The Borough's first Health Centre
During the year the first health centre was completed in Heston. This was also the first health centre to be opened within the catchment area of the Middlesex Executive Council which covers about the same area as that of the old County of Middlesex. This is an achievement by the London Borough of Hounslow in only its second year of office as, between the inception of the National Health Service in 1948 and the year 1964, the rate of opening of health centres for the whole country was just over one per year. In fact the first purpose-built health centre to be opened in a fully established urban area, such as we have here in Hounslow, was in 1964 in the West Riding of Yorkshire.

In Heston
The Second Day Centre for the Elderly Confused
Plans for the provision of only the second day centre for the elderly confused in the area of the old County of Middlesex were approved by the Ministry of Health and the building is due for completion in December 1967.

In Heston
A major extention to the Audiology Unit
Plans for a major extention to the purpose-built audiology unit were approved by the Department of Education and Science and the Ministry of Health. The extensions are due for completion by the middle of 1967 and will improve the already excellent and internationally known facilities for the assessment of hearing loss in infants and children.

In Isleworth
The Hostel for the Mentally Disordered
This hostel was completed and the first patients were admitted.

In Isleworth
The first Special Multipurpose Gymnasium to be incorporated in a new Adult Training Centre
Plans were agreed by the Ministry of Health for the rehousing of Acton Lodge Adult Training Centre in a new purpose-built centre on the same site. This project is due to commence in 1967 and will be the first in the country to have a specially designed multipurpose gymnasium.

In Hounslow
The Medical Unit for the Assessment and Care of Handicapped Children
The new and unique medical unit for the assessment and care of spastic and other handicapped children was completed and her Royal Highness, The Princess Margaret, Countess of Snowdon, has graciously accepted the invitation by the Borough Council to open this unit in March 1967. This new building replaces the old adapted one which has housed the unit since 1957, but has now become too small and outdated.

In Feltham
The Borough's second Health Centre
The building of the second health centre in the London Borough of Hounslow is now very near completion and will be opened in 1967.

In Feltham
The Junior Training School and Special Care Unit
The construction of the 114 place junior training school and special care unit is ahead of schedule, and completion is expected towards the end of 1967. A weekly boarding unit for twelve children is also being built within the same curtilage.

In Feltham
Plans for the second and third Hostels for the Care of the Mentally Disordered
Plans are progressing favourably for the building of two additional hostels for the care of the mentally disordered in the borough.

In Brentford
The Borough's third Health Centre
The existing clinic is in the process of being adapted as a health centre for a group of six doctors who have requested health centre accommodation. When the centre is completed in 1967 the London Borough of Hounslow will have three completed health centres at the rate of one health centre for each year of its existence, a rate equal to that achieved by the country as a whole in the eighteen years preceding the year 1964.

In Chiswick
Improved temporary accommodation for Health and Dental Clinics
The health and dental clinics will be moved early in 1967 into improved though less spacious temporary accommodation in the town hall so as to clear the site for the provision of modern health centre facilities so clearly needed in this area.

In Hounslow
Administrative Centre for Health and Social Service Departments serving whole Borough
I wrote in some detail in my last annual report about the proposal for a comprehensive central co-ordinating health, welfare and children's centre situated adjacent to Hounslow Hospital at 92 Bath Road. Considerable progress had been made and the plans were approved in principle by the appropriate Ministries. The borough architects are now working on the detailed drawings and costings. Building is due to commence in February 1968. This exciting project with its twelve consulting suites for family doctors may well show new ways of increasing communication not only between the three parts of the National Health Service but also between them and the social services of the Welfare and Children's Departments to the mutual benefit of all concerned.

New buildings are, however, only part of the story. New services such as cervical cytology have commenced in existing buildings, and others such as chiropody have been significantly expanded. It is becoming increasingly difficult to accommodate the additional staff necessitated by the new services being developed.

In 1965 it was my endeavour to make my first preface and annual report for the new borough as comprehensive as possible in order to provide a vade mecum of information and a base line from which to move forward. I therefore reported on the work of members of staff of the many disciplines in the department and also on the variety of health facilities which the council, through the department of health, provides for the citizens of the borough. This year every effort has been made to reduce repetition to a minimum, although some is inevitable in a report which statutorily must be presented annually. I shall, therefore, not make the customary comments on the vital statistics which are fully shown elsewhere, except to again comment on the continued rise in illegitimate births, the percentage per live births this year being 9.7 compared with 8.7 last year and this year's national figures of 7.9. Heart disease continued to be the leading cause of death in the borough as indeed it is for the country as a whole. It accounts for 740 (33%) as compared with 739 last year.

Lung cancer accounted for 145 of the 468 deaths from cancer in the borough during the year. Lung cancer as I said last year is an eminently preventable disease and the advice in regard to the dangers of smoking to both lungs and heart and indeed other organs can only be further emphasized. A distressing degree of complacency, however, continues in the minds of the general public, young and old alike, to these dangers in this country particularly, and as interest lately has turned towards the Common Market perhaps a comparison of death rates and life expectancies on an international basis with other European countries will help to show that there is need for far more to be done in this field of prevention despite our National Health Service.

I shall quote only total death rates and life expectancy rates because for obvious reasons international comparisons of these rates are not

open to the same criticisms as are similar comparisons between death rates from particular diseases where diagnostic interpretations may vary between one country and another.

The following tables and extracts are taken from a stimulating paper given by Dr R Logan, Director of the Medical Care and Research Unit at Manchester University—

Health Hazards in Middle Age

'Although the leading causes of death hold the same rank across all developed countries, the middle aged die at different rates from the same diseases in each country and these add up to considerable differences in risk of death. Middle aged men in Sweden die at almost half the rate of those in Scotland. Britain is far from the top in the world league of a score of developed countries and, in the European competition, is nearer to the bottom. Neither do the chances improve for those who reach retirement. Indeed, by the time men and women have passed their prime of life, their chances of survival from 65 to 85 for men in Norway are double those in England, and the gap has not narrowed in recent years, and France is improving in its lead on us. Amongst women, the Norwegians again have the brightest prospects of survival, but the differences internationally are less for women than men, and indeed the English woman is catching up with brighter prospects of her overseas sisters. However, this enhancement of her survival makes her even more likely to be a widow as her English husband is marking time. Indeed, it is men in late middle age who are the only male group to mark time in risk of dying, whilst their women folk continue to improve so that the gap has widened and for the past decade men aged 55–64 have been dying at twice the rate of their female peers. The reasons for this, of course, lie in the nature of the killing diseases with the men succumbing to ischaemic heart diseases and lung cancer at over five times the rate of women and from road accidents, suicides and other violent deaths at twice the female rate, whilst bronchitis is essentially a working man's killer (and his personal air pollution from cigarette smoking is the common and dominant factor in this self destruction, from coronary catastrophy, lung cancer and bronchitis, at least)'. *(1)*

Death rates per 1000 in middle age in 1963

Males	*45–49*	*50–54*	*55–59*	*60–64*
Sweden	4.0	6.2	10.9	18.8
Holland	4.4	7.5	12.8	20.6
Italy	5.8	9.3	15.5	25.0
England and Wales	5.4	9.5	17.1	28.8
Scotland	7.2	11.9	21.0	34.0

Females	*45–49*	*50–54*	*55–59*	*60–64*
Sweden	2.9	4.1	6.7	10.7
Holland	2.7	4.1	6.2	10.5
Italy	3.4	5.1	7.8	12.8
England and Wales	3.6	5.3	8.3	13.7
Scotland	4.4	6.6	10.3	17.4

Retirement—Chance of surviving from 65 to 85 per 1000

	Males		*Females*	
	1950	*1962*	*1950*	*1962*
Norway	263	262	300	321
Holland	231	235	255	286
Sweden	204	216	233	287
France	136	170	242	302
England and Wales	132	139	235	284

Bronchitis, well known as the English disease accounts for part of these differences in that it kills seven in every hundred of us even in middle age ie between the ages of 45 and 65 at a time of great responsibilities to work and family alike. It is also interesting that a glance at the last table clearly shows that there would be few widows in this country if Englishmen and Welshmen had the same survival rates as their near neighbours the Norwegian men just across the North Sea. What tragedies and unhappiness this would prevent to say nothing of the economic loss caused to individuals, to families and to the country as a whole!

Nobody, however, questions the durability of our individual constitutions nor the standards of

our hospital and medical services in relation to those other countries of Europe. But from the preventive point of view these figures demonstrate in no uncertain terms that certain aspects of our environment must militate against us as a nation. Is it the atmosphere we breathe, polluted as it is by our particular brands of cigarette smoke, our domestic coal fires, our industrial concentrations and processes and our vehicle exhausts, or other pollutants? Is it the food and fluids we eat and imbibe including the excess of refined and whitened sugars or unsuitable animal fats? Is it our excess of weight or lack of exercise or a combination of these and other factors? In what ways do we differ from our more long-lived European cousins who do not even have the benefits of a comprehensive National Health Service?

The above figures clearly point to the fact that it is preventive measures rather than curative that are all important if our healthy survival is to be brought in line with others. One of the most important of these measures is undoubtedly the attainment of clean air and in Hounslow the public health inspectorate is sparing no effort to achieve this aim. Of equal importance in the achievement of healthy living standards is the reasonable but rigorous application of the requirements of the Housing Acts, the Food and Drugs Acts, the Public Health Act, The Offices, Shops and Railway Premises Act and many others too numerous to mention here. A full account on environmental health is given by Mr K J Smith, chief public health inspector, later in this report. Early detection of disease, though of secondary importance to primary prevention, is nevertheless the next step along the road to overall improvement. In this context I discussed the question of the provision of screening techniques by both the local health authority and the general practitioner at some length in my preface last year. There are however in all forms of human endeavour certain limits beyond which it becomes questionable whether the effort is justified by the results, the law of diminishing returns. Also no community has unlimited resources and therefore many difficult decisions regarding the relative priorities of a variety of services are frequently demanded. This law particularly applies to preventive medicine and for this reason it is our duty to review our services at regular intervals to ensure that they continue to be relevant to the needs of the community.

Our National Health Service will however be truly comprehensive only when it blends curative and preventive medicine so as to attain optimum health throughout life. Perhaps the following functional divisions may illustrate more clearly what I tentatively suggest is necessary to form such a comprehensive service—

1. A General Practice and Community Health Service embracing all aspects of family and individual health in the home with special emphasis on infant and child health and development in conjunction with a risk/observation register and also on health in retirement.
2. An Occupational Community Health Service embracing school health, student health and health at work or in other words health in one's occupation whatever one's age.
3. A Hospital Service embracing acute and severe medical and surgical illness needing hospital-based diagnostic and/or therapeutic care in order to return the patient as quickly as possible to the care of the community health services with as complete restoration of health as is practicable.

My brief here is on community health as illustrated by 1 and 2 above, and I will now consider 2 first mainly in relation to the Borough's service. Between the ages of 5 and 65 the greater part of one's waking hours is spent at work and the rest mainly at home, in contrast fortunately for the majority of us, only a minute fraction of our useful life is spent within a hospital. Needless to say care in hospital at such a time is of vital import to us as individuals but the future here seems beset with increasingly expensive treatment procedures and frightening ethical problems occasioned by organ transplantation and the possibility of prolonging life by artificial means after death would normally have supervened often in an individual who would no longer be able to live a separate existence. In these circumstances cold surgery such as the repair of hernias would appear after the first forty-eight hours to be more a problem

for the family doctor and local health authority nursing service than for continued expensive hospital care.

To get back to community care. Firstly the school health service covers the years 5–15 and beyond if necessary. In Hounslow it follows the usual pattern of four routine medical inspections, but the question of selective examinations is under active consideration though our departmental medical officers appear to prefer the former well tried method of case finding.

In this context the advantage for the handicapped child of locally based medical assessment units appears now to have been widely realised and the problems of how, where and when to set up such units are now actively exercising the minds of doctors and others at many levels in this country and in the committees of the World Health Organisation. In Hounslow two such local authority assessment units have flourished for over ten years and have attracted a stream of visitors from all parts of the world.

The teams at the purpose-built medical assessment unit for all types of paediatric handicapping conditions at Martindale and at the purpose-built audiology unit at Heston are truly multi-disciplinary. Here are shown the great benefits which can accrue from the combination in one team of hospital consultants, local authority medical and paramedical staff and the teaching staff of the immediately adjacent special schools and satellite special classes.

Here assessment of every function from infancy onwards can be carried out without causing apprehension to the child. Vital follow-up is continuous as the child attends school daily. Wheelchairs, calipers, plasters, hearing aids, physiotherapy, speech therapy, orthoptic exercises and a host of other therapies can be obtained without stepping outside the schools with its attendant loss of vital time and energy for both child and parent. Physiotherapy and hydrotherapy are viewed by these children in much the same way as physical education and games are viewed by ordinary children. To these children in a school setting the speech therapists, orthoptists and nurses are people no different from their class teachers or teachers of the hard of hearing. There is every advantage for such local assessment units to be attached where possible to large comprehensive special schools within the community rather than to district hospitals. Continuous observation and close liaison with the teachers, psychologists and other school staff is inevitably so much better in school surroundings and the atmosphere of a hospital is also avoided. After all such children rarely need pathological, radiological or other investigation at a moment's notice and if they do require such an investigation as an EEG it can usually be arranged at leisure with the same consultant paediatrician who attends the hospital and the medical assessment unit—in fact he himself usually refers the child to his own unit at the hospital.

The advantage of the combination of pre-school out-patient diagnostic and therapeutic facilities within the medical services for the school child at these units was further augmented in 1961 by the setting up of a risk/observation register aimed at earlier detection. (2 and 3) In 1965 a closer integration was achieved with the consultant obstetricians at the local district hospitals and this has resulted in the formation of a programme on the subject for the borough's computer. The first part of the programme is now almost complete after considerable early difficulties due to the complexity of the subject.

Student Health Service and Occupational Staff Health Service

As an extension to the school health service the borough has formed a student health service for students attending its Polytechnics and Colleges of Further Education.

In this context the Department of Health has been fortunate in the appointment of Dr A R Broadbent, senior medical officer, who is qualified and experienced in occupational health. Reports on the London Borough of Hounslow's new student health service and on its proposed occupational staff health service are to be found in the body of the report but it is pleasing to have these new policies confirmed at a later date by the following extracts from papers read by doctors at the Health Congress in Eastbourne—

'Almost all occupational activities provide health hazards of some kind which vary only in degree or complexity. The suitability of these many

persons whether young or ageing, whether fit or disabled, should in medical terms be the concern of a doctor trained in occupational medicine. A wonderful opportunity is available to demonstrate boldness and imagination by creating an occupational health service embracing everyone from the age of five years until retirement and even beyond. In my submission there is little distinction between a school and a student health service; there is no validity in providing a health service to university students and yet refusing it to even greater numbers attending Colleges of Advanced Technology or Education'. *(4)*
'University health services, developed in British Universities largely during the last two decades, are now an accepted feature of university life. During the next two decades "L'explosion Scolaire" will continue unabated and full-time students are expected to reach a total of over half-a-million, almost a quarter in part-time education. Perhaps the most urgent need at present is to extend medical services along the lines already well established in universities to the large number of young men and women in Institutions of Higher Education for whom, as yet, little is done'. *(5)*

In Hounslow several students have already made known their gratitude for this new service.

General Practice and Community Health Service
Present trends of thought suggest that a population of 250,000 is the most suitable size for coverage by a single urban borough local health authority and by a single district hospital with some 2,000 beds for acute, maternity, geriatric, mental illness and mental sub-normal cases if all such beds were provided within one hospital. If this were the case provision could theoretically be illustrated as follows—

a. A single district hospital with approximately 2,000 beds for	250,000
b. A single local health authority for the practice of the medical officer of health/principal school medical officer being	250,000
c. A single general practitioner practice being	2,500

Each hospital/local health authority catchment area would thus have about one hundred family doctors practising within its boundaries and if health centre practice were favoured this would require the local health authority to provide, on present day formulae, some ten to twelve health centres only one of which could be adjacent to the local hospital. This particular centre could of course be made larger, but this might be at the expense of the patients in terms of travelling time due to the greater distances involved between home and centre. The siting and size of the centres would also relate to the location and sizes of the pockets of population and the shopping centres. In this context the future provision of health centres in the London Borough of Hounslow is envisaged as follows—

a. Feltham		
	(Approx population	50,000) 3 health centres
b. Heston & Isleworth		
	(Approx population	108,000) 6 health centres
c. Brentford & Chiswick		
	(Approx population	50,000) 3 health centres

At the time of writing one is complete in each of the three areas listed above and two more are at the working drawing stage in Heston and Isleworth.

Although the population of Hounslow is a little short of a quarter-of-a-million, from a practical point of view it has been found to be ideal for the provision of all the local health authority services on a personal basis (in liaison with other social service departments) except perhaps in relation to the proper provision for the assessment, care and education of handicapped children.

The practice of each medical officer of health/principal school medical officer in a local health authority serving a population of approximately 250,000 would include for instance—

a. School children		
	(5–15 years of age)	Approx 40,000
b. Pre-school children		
	(0– 5 years of age)	Approx 20,000
c. Physically handicapped children requiring day special schooling	Approx	35

A day school for the physically handicapped in contrast to classes attached to normal schools requires at least one hundred pupils to be a viable unit, and the attainment of this number as can be seen from the above figures, would require the combined catchment area of at least four boroughs making a total population of about 1,000,000 persons. Similarly a local authority medical assessment unit for the care of these children and out-patients attending the unit and the hearing clinic with an associated school for the deaf would require also a catchment area with a population in the region of 1,000,000.

The provision for the assessment, care and education of such categories of handicapped children in the London Borough of Hounslow accords with the above figures in that its two special schools with associated assessment units actually serve three adjacent boroughs on a regional basis which combined with Hounslow form a population of some 925,000 and as has already been said, has in existence a team of specialists supplied by the Regional Hospital Board, the local education authority and the local health authority in accordance with the recent World Health Organisation recommendations.

Whereas a medical officer of health/principal school medical officer in an urban area with a local health authority practice of 250,000 population would have on his list about forty children sufficiently handicapped to attend a school for the physically handicapped and a medical officer of health/principal school medical officer with a regional unit practice of 1,000,000 would have one-hundred-and-sixty such children on his list, a single-handed family doctor on the same proportional basis would be likely to have on average less than one such child in his practice of 2,500. In order to gain any knowledge of, or insight into the complex series of paediatric diseases that cause handicapping in childhood it is necessary to see many such cases in order to learn by comparisons of cases over a period of time. Specialised doctors in local health authorities and local education authorities are therefore ideally placed to carry out such essential work and to do research for the benefit of the children.

The medical officer of health/principal school medical officer practice of approximately 40,000 school children and 20,000 pre-school children also enables his specialist departmental medical officers and their ancillary teams of audio-metricians, nurses, orthoptists, etc to be ideally placed to carry out overall sweep and specialised screening tests in regard to the early detection of visual, perceptual and hearing difficulties and other paediatric handicapping conditions. Joint medical records for children and complete co-operation between family doctors and local health authority doctors especially in health centres with the help of computers may herald a great advance in our service for children.

There is likely to be a shortage of doctors for a decade or more and many local authority departmental medical officers are highly skilled in developmental paediatrics and allied specialties. A high proportion of these excellent doctors are women who may have reached high places in other fields of medicine if they had not had family or other commitments.

Although in the future some functions now carried out by such doctors may more properly be carried out by interested family doctors, the specialist local authority doctor for the reasons already stated will always be required for the time consuming and complex tasks in child development screening for the detection, diagnosis, assessment and care of the handicapped children and for recommending appropriate schooling and carrying on adequate follow up.

Some degree of integration of these doctors into family doctor group practices especially in health centre practice within the field of community medicine would seem the obvious answer to many crucial and long standing problems and the family doctors with whom I have discussed this suggestion in the last two years have all been very sympathetic and agreeable to the idea. Unless some way of integration is found the skill and the considerable training these doctors have acquired are likely to be wasted at a time of doctor shortage and the vast body of knowledge and specialised techniques built up since the turn of the century in child development and school health could be thrown aside and neglected just at a time when computer

programming may render them invaluable.

The child is father to the man and therefore a good paediatric, student health, occupational health and family health service should ensure at a later stage a healthier mind and body in retirement and in old age. Nevertheless the care of the old needs much further thought. With the compilation of age/sex registers, greater administrative support and the aid of health visitors and social workers the general practitioners will know the vulnerable groups such as the elderly on their lists and be in an improved position to prevent or ameliorate many of their difficulties and ailments. There is still, however, much to be said for the consultative clinic especially orientated for the elderly where their particular problems can be discussed in a leisurely fashion befitting the dignity of their age. In Hounslow the health committee and the council have agreed in principle to the proposed setting up of such clinics in close consultation and liaison with the local practitioners, local medical committee, local consultant geriatricians and the Regional Hospital Board. Later in the main report Mr D M Fleet, the borough's chief welfare officer, gives an account of the rapidly extending services his department is now able to provide for the elderly and the adult handicapped. A comprehensive report on the borough service for the mentally ill is to be found in my 1965 annual report.

It is my feeling, therefore, that ultimately specialisation within group practices in health centres will be as inevitable as specialisation has become within hospital practice. The previous discussion has shown that it may well be preferable for some doctors within the group such as those dealing with handicapped school children, in general, students, epidemiology and possibly geriatrics to remain on a salaried basis as is at present the case for local health authority and hospital doctors; but it would appear to many that it remains essential for family doctors as a whole to retain their present basis of payment as independent contractors both to ensure their choice of patient and the patient's choice of doctor.

Health Centre Practice

Over 50% of the family doctors in the borough have indicated their wish to practise in health centres and the health committee with the full support of the Council have responded by giving considerable priority to the building of these centres as indicated in the Department of Health's ten year programme.

So in Hounslow one may now envisage the setting up of multi-disciplinary teams in health centres in much the same way as such teams have already become an accepted feature of hospital and local health authority work. During this transitional phase we feel sure that the remaining doctors who wish to continue to work in their existing well established practices will ensure continuity and balance in the provision of medical care in concert with their colleagues in health centres. These doctors may be assured that the local health authority for its part will continue to give equal support and help to all doctors regardless of whether they work in health centres or not.

In relation to doctors with average lists of 2,500 the suggested relative sizes of the practices of the appropriate local authority paramedical and ancillary staff are given below. From these figures the total establishment in present circumstances may be formulated for such field staff in a local authority of 250,000 people. Such an ideal establishment is not however easily attainable.

Field staff	*Ratio of staff to population*	*Establishment*
Health visitors	1: 5,000 (500 children under 5)	50
Home nurses	1: 6,000 (district and surgery)	40
Midwives	1:14,000 (55 cases per year)	18
Social workers	1:20,000 (Medico-social and mental health)	12
Home helps	1:1,000	250

The above field staff would work in and from health centres in close and harmonious

relationship with groups of family doctors and be linked as disciplines by the medical officer of health within his health area.

Based on the above figures a model team in each average sized health centre or large group practice serving for example a population of 20,000 persons would be—

Doctors	8
Health visitors	4
Home nurses	3
Midwives	1–2
Social worker	1
Home helps	20
Clerical staff	6

In addition to the above team local authorities also employ many other professional staff who would work from time to time in close liaison with the family doctors especially if they were all under the same roof! For instance I have already discussed at some length the possible relationship that could be developed with the departmental medical officers; other staff would include dental surgeons, orthodontists, psychologists, child care and family case workers, physiotherapists, speech therapists, orthoptists, audiometricians, peripatetic teachers and those in the social work field. Also for many years local authorities have had the invaluable assistance of hospital specialists seconded by the Regional Hospital Board for sessional work within clinics and health centres. Such specialists in Hounslow include on a regular basis a paediatrician, psychiatrists, orthopaedic surgeons, otologists, ophthalmologists and several others on an occasional basis.

Some doctors have informed me that they are apprehensive about losing some degree of their special doctor/patient relationship in a health centre organised in this way. I feel sure the answer is that those doctors, who are aware of the extreme importance of such a relationship in general practice, will always attain it successfully wherever they work.

Further it can undoubtedly be said that expert help whether administrative, social or nursing, according to circumstances, may relieve the doctor of many tasks and allow him to concentrate on the work for which he has been trained and has made his chosen vocation.

Certainly I have found that case conferences held by such a multi-disciplinary team never fail to enrich and broaden the vision of those participating and yet allow each individual the opportunity to specialise according to his or her interest.

Finally, to this whole health team one could apply what has been said recently in relation to doctors 'wherever a doctor practices, courtesy, kindness and gentleness forms an essential part of the art of medicine'. This must not be forgotten in an age of computers, age/sex registers and sophisticated techniques.

Appreciation

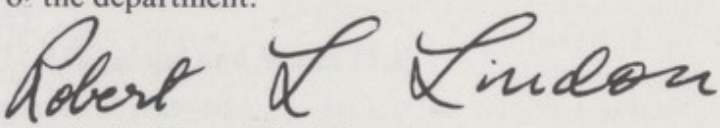
I would like once again to thank the family doctors and hospital staff for their help and co-operation on numerous occasions during the year.

I would also wish to thank the members of voluntary associations who have contributed so much to the success of the services.

My thanks are also due to all the members of the staff of the Department of Health for their loyal support and conscientious attention to duty throughout the year. I would like to thank all who have contributed to the compilation of this report and in particular Mrs Marilyn Sturgeon who once again has helped with the design and general layout.

I wish to thank the chief and senior officers of the other departments for their ready help during the year.

I also wish to express my appreciation to the chairman and members of the Health Committee and Public Health (Special Powers) Sub Committee, the chairman and members of the Education Committee and Special Services Sub Committee for their continued understanding and considerable support which have once again been a source of inspiration to myself and all members of the department.



Medical Officer of Health and
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Summary of general and vital statistics relating to the London Borough of Hounslow

Statistics for the area

Area (including inland water)	14,469 acres
Population—1961 census	208,893
Population—Registrar General's estimate mid-1966	207,320
Persons per acre	14.3
Number of habitable premises (1st April 1966)	64,894
Number of new houses erected during the year	905
Rateable value (June 1966)	£16,030,966
Product of a penny rate (estimated 1966/67)	£64,750

Vital Statistics

Live births	
Number	3,519
Crude rate per 1,000 population	17.0
Adjusted rate per 1,000 population	16.5 (England and Wales 17.7)
Illegitimate live births	
Number	340
Per cent of total live births	9.7 (England and Wales 7.9)
Stillbirths	
Number	40
Rate per 1,000 live and still births	11.2 (England and Wales 15.4)
Total live and still births	3,559
Infant mortality (deaths under 1 year)	69
Total infant deaths per 1,000 total live births	19.6 (England and Wales 19.0)
Legitimate infant deaths per 1,000 legitimate live births	19.2
Illegitimate infant deaths per 1,000 illegitimate live births	23.5
Neonatal mortality (deaths under four weeks)	
Number	49
Rate per 1,000 total live births	13.9 (England and Wales 12.9)
Early Neonatal mortality (deaths under one week)	
Number	42
Rate per 1,000 total live births	11.9 (England and Wales 11.1)
Perinatal mortality (still births and deaths under one week combined)	
Number	82
Rate per 1,000 total live and still births	23.0 (England and Wales 26.3)

Maternal mortality (including abortion)	
Number	1
Rate per 1,000 total live and still births	0.28 (England and Wales 0.26)
Deaths (total—all ages)	
Number	2,230
Crude rate per 1,000 population	10.8
Adjusted rate per 1,000 population	11.2 (England and Wales 11.7)
Deaths caused by	
Cancer (all forms)	
Number	468
Rate per million population	2,257 (England and Wales 2,250)
Heart Disease	
Number	740
Rate per million population	3,569 (England and Wales 3,783)

All rates for England and Wales are provisional

Annual Report of the Medical Officer of Health for the year 1966

Vital Statistics

Area and Population
The London Borough of Hounslow has an area of 14,469 acres and an estimated population of 207,320 which is a reduction of 1,573 compared with the 1961 census.

Live Births
The number of live births occurring during 1966 was 3,519 (1816 male and 1703 female) which gives a live birth rate of 17 per 1,000 population.

Apart from other causes the rate will vary according to the age and sex distribution of the population and to allow a valid comparison with other areas the Registrar General provides an area comparability factor. When this is applied the rate becomes 16.5 compared with a provisional rate of 17.7 for the whole of England and Wales. The local and national live birth rates show decreases of 0.1 and 0.4 respectively compared with those for the previous year.

Almost one in ten live births were illegitimate.

Stillbirths
Forty stillbirths occurred during the year compared with 51 during 1965. Three were registered as illegitimate. The stillbirth rate was 11.2 compared with 15.4 for the country as a whole.

Deaths
During the year 2,230 borough residents died, more than one half from cancer or heart disease. The crude death rate of 10.8 when adjusted by the area comparability factor was 11.2 compared with an estimated rate of 11.7 for England and Wales. The rate for Hounslow increased by 0.5 over that for 1965. Sixty seven per cent of all deaths were of persons aged 65 years or over.

Infant Mortality
There were 69 deaths of children under one year of age compared with 55 during 1965. Eight of these were illegitimate. The infant mortality rate was 19.6 compared with 19 for England and Wales.

Although the Hounslow rate shows a comparatively large increase compared with that of 15.5 for the previous year it is not significantly higher for that of the whole country. Nevertheless although the increase is deplored it will undoubtedly act as a stimulus and a reminder of the need for eternal vigilance in this field.

The causes of death and the ages at which they occurred are shown in Table 2 and it will be noticed that 62 per cent of all infant deaths occurred before the end of their first week of life.

Maternal Mortality
One death was due to causes associated with pregnancy which gave a maternal mortality rate of 0.29 per 1,000 total live and still births compared with 0.25 for England and Wales.

Infectious Diseases

International certificates of vaccination and inoculation against smallpox, yellow fever and cholera
Applications for authentication dealt with by the medical officer of health numbered 12,415 compared with 3,387 for 1965 and constituted a substantial item of work.

The number of corrected notifications of infectious diseases received during the year compared with 1965 are summarised below—

Disease	*1966*	*1965*
Typhoid and para-typhoid fever	1	1
Scarlet fever	120	106
Erysipelas	4	16
Puerperal pyrexia	53	101
Meningococcal infection	3	2
Acute pneumonia	18	17
Dysentery	79	9
Measles	893	1,653
Whooping cough	37	32
Food poisoning	1	24
Tuberculosis—		
pulmonary	64	70
non-pulmonary	19	11

The table on page 100 gives the number of cases notified under age groups.

Smallpox
There were 33 referrals for supervision of possible smallpox contacts who had arrived in this country from locally infected or declared endemic smallpox areas and who were reported to be proceeding to addresses in the borough. All these were visited and kept under surveillance for the required period.

During the outbreaks of variola minor in Pontypool and the West Midlands a circular was sent to family doctors asking them to notify me of any doubtful or suspicious cases of chickenpox. As a result several joint consultations were held in the patients' homes but all the cases were diagnosed as chickenpox.

Whooping Cough
There were 37 cases notified compared with 32 in 1965. Seven of these cases were under the age of one year and three of these were aged 10 weeks, 2 months and 5 months respectively.

Vaccination records show that nine of the twenty-eight notified cases under the age of six years had been immunised in infancy. It has been suggested that the current whooping cough vaccines might now be less effective than in former years.

Measles
Measles was less prevalent than in 1965 but 893 cases were notified, a higher incidence than would be expected in a 'non-epidemic' year.

The Minister's approval to offer measles vaccination under Section 26 of the National Health Service Act, 1946, was not sought pending the results of the long-term follow up of the children who participated in the Medical Research Council's investigation of measles vaccines trial.

Dysentery
There were 79 cases compared with 9 cases in 1965. The increase is partly accounted for by an outbreak affecting 53 children and staff at a day nursery.

Food poisoning
Although 66 cases of suspected food poisoning were notified, after full investigation only one case was confirmed, the causative organism being salmonella heidelberg. Three other salmonella infections (not food-borne) were also identified.

Of the 62 remaining cases notified (18 sporadic and 44 cases in 15 families) all laboratory investigations proved negative.

Leprosy
The Public Health (Leprosy) Regulations, 1966 came into operation on 1st March 1966 and revoked the Public Health (Leprosy) Regulations 1951. The new regulations provide that, instead of being sent direct to the Chief Medical Officer of the Ministry of Health, notifications of leprosy are to be sent to the local Medical Officer of Health who sends copies to the Ministry's Chief Medical Officer.

Leptospirosis (Weil's Disease)
Notes in the form of a small booklet have been issued to sewermen and others who may be exposed to this infection. The booklet gives advice on the preventive measures to be taken by workers exposed to this occupational hazard and on the importance of seeking early medical attention if the worker is infected or shows any of the signs or symptoms of leptospirosis.

Rodenticides
A wash-hand unit was fitted in the van used by the rodent operatives and sewermen to enable these workers to wash their hands after laying rat bait poison in the sewers.

Medical Arrangements for Long Stay Immigrants
Long-stay immigrants are asked to give their destination addresses at ports of arrival and these are forwarded to the medical officer of health. All the addresses situated in the borough are visited by public health inspectors who advise the immigrants on how to use the national health service. If the immigrant is accompanied by a child the address is visited by a health visitor.

Destination addresses in this borough were given by 290 immigrants but in 115 cases it was found that the immigrants had not arrived at the address given.

One immigrant was found to be suffering from pulmonary tuberculosis.

Fever Hospital
The borough is served by the South Middlesex Hospital but on occasions accommodation in other fever hospitals may be used. During the year 157 patients from the borough were admitted as suffering from or suspected to be suffering from infectious disease. Close contact is maintained between the hospital and the department of health so that any necessary action can be taken without delay.

Disinfection
Where necessary, disinfection of rooms is carried out by the department. During the year 18 rooms were disinfected and three sets of bedding were destroyed. Five lots of clothing were disinfected before being sent abroad.

Venereal Disease
The nearest hospitals with venereal disease clinics are West Middlesex, Central Middlesex, Hillingdon and West London Hospitals. Attached to most venereal disease clinics is a social worker who gives assistance with the social problems arising from these diseases and most clinics also make efforts to trace and secure treatment for contacts. Throughout the country the incidence of venereal disease is on the increase which is as much a social as a medical problem.

Vaccination and Immunisation · Section 26

Poliomyelitis
During the year 3,859 children under the age of 16 years completed the course of treatment necessary for protection. A further 2,563 children were given 'boost' doses.

Diphtheria, Whooping Cough and Tetanus
Protection against these diseases can be given by injection only and the antigens can be given singly or in combination. The poliomyelitis antigen can also be added so that by a course of three injections protection against these four diseases can be given. The general practice is to use a triple antigen and to use oral vaccine for poliomyelitis. In certain cases, on clinical grounds, it may be advisable to omit whooping cough protection. The number of children under the age of 16 years who completed primary courses or were given re-inforcing injections during the year was as under—

	Primary course	*Reinforcing injections*
Diphtheria	3,149	3,735
Whooping Cough	2,610	1,359
Tetanus	3,769	3,608
Poliomyelitis	3,859	2,563
Smallpox	2,386	257

Protection against tetanus is now being offered to pupils in secondary schools as it was not in general use when they were babies.

Smallpox
Despite the success with which recent outbreaks of smallpox in this country have been controlled the Ministry of Health recommends that children should be vaccinated against smallpox before they reach the age of three years. During the year primary vaccination was done in 2,386 children under the age of 16 years and 257 were re-vaccinated. No complications occurred in relation to these vaccinations.

Tuberculosis
Since 1957 protection against tuberculosis has been offered to secondary school pupils. The BCG vaccine is also used by the Chest Clinics for the protection of child contacts.

The usual practice is to do a skin test first and to give BCG vaccine to those who do not react to the test. School children showing a positive reaction are referred to the Chest Clinic for a chest X-ray as a positive reaction may be due to previous contact with tuberculosis. The numbers tested and vaccinated during the year are shown below—

Contacts at chest clinic	
Number skin tested	245
Number found positive	56
Number found negative	189
Number vaccinated	119

School children and students

Number skin tested	1,779
Number found positive	536
Number found negative	1,153
Number vaccinated	1,153

General

Protection against smallpox, diphtheria, whooping cough, tetanus and poliomyelitis can be obtained at local authority clinics or given by general medical practitioners. A fee is paid to general practitioners for notification to the Medical Officer of Health of vaccinations or immunisations carried out by them in respect of children up to the age of 16. The local authority does not provide vaccination against yellow fever, cholera, typhoid or paratyphoid fevers and persons desiring such protection should consult their own doctors.

Yellow fever vaccination is carried out at the following centres—

Hospital for Tropical Diseases 4 St Pancras Way London NW1 Tel: Euston 4411 Ext 137

Medical Department Unilever House Blackfriars EC4 Tel: Fleet Street 7474 Ext 2841

53 Great Cumberland Place W1 Tel: Ambassador 6456

Patients are seen by appointment only. No charge is made.

Cholera, enteric fever and typhus vaccination is available at the Hospital for Tropical Diseases 4 St Pancras Way NW1 Tel: Euston 4411 Ext 137 by appointment only.

Anthrax vaccine is available from the Central Public Health Laboratory Colindale Avenue NW9 Tel: Colindale 7041.

Services provided for the London Borough of Hounslow by other Authorities

North West Metropolitan Regional Hospital Board 40 Eastbourne Terrace W2

South West Middlesex Group Hospital Management Committee West Middlesex Hospital Isleworth

The following are the main hospitals—	*Cases Admitted*	*Approximate No of available staffed beds*
West Middlesex Hospital Twickenham Road Isleworth Tel: 01-560 2121	Mainly acute	855
Chiswick Maternity Hospital Netheravon Road W4 Tel: 01-994 1124	Maternity only	51
Brentford Hospital Boston Manor Road Brentford Tel: 01-560 6959	Acute	33
South Middlesex Hospital Mogden Lane Isleworth Tel: 01-892 2841	Mainly acute including isolation	155

continued

Staines Group Hospital Management Committee *Ashford Hospital Ashford Middlesex*		
Ashford Hospital Ashford Middlesex Tel: 01-695 3271	Mainly acute	421
Hounslow Hospital Staines Road Hounslow Tel: 01-570 4448	Acute	75
Hounslow Chest Clinic 28 Bell Road Hounslow 01-570 6217	–	–
Ashford Chest Clinic Ashford Hospital Tel: 01-695 3271	–	–
Hospitals for the Mentally Sub-Normal		
Leavesden Hospital Abbots Langley Watford Tel: 01-477 2222 (North West Metropolitan Regional Hospital Board)		2,227
Psychiatric Hospitals		
Springfield Hospital Beechcroft Road Upper Tooting SW17 Tel: BALham 1212 (South West Metropolitan Regional Hospital Board)		1,797
St Bernard's Hospital Southall Middlesex Tel: 01-574 5381 (North West Metropolitan Regional Hospital Board)		2,492
Smallpox Hospital		
Joyce Green Hospital Dartford Kent (Long Reach Hospital) Tel: 01-32 23231 (Admission to this hospital should be arranged through the Medical Officer of Health Tel: 01-570 6231)		

Middlesex Executive Council
This body is responsible for the provision under the National Health Service Act of the general practitioner, dental (other than Local Health Authority provision for expectant and nursing mothers, young children and school children) pharmaceutical and supplementary ophthalmic services. The headquarters of the Council are at North West House 119 Marylebone Road NW1 Tel: 01-723 1277.

Ambulance Service
The Borough is included in the area of the Greater London Council Ambulance Service. Provision is made for the conveyance of sick, accident and emergency cases. Tel: 01-204 0251.

Health Centres

The borough council is in favour of integrating the local health authority services with the general practitioner service by the provision of health centres.

Groups of family doctors throughout the borough showed an increasing interest in schemes for working from combined centres with the local health authority. During the year the department continued to have discussions with the Middlesex Executive Council, the Local Medical Committee, the Ministry of Health and general medical practitioners.

The end of the year saw one health centre completed and one nearing completion. Approval was also received to the adaptation of a large clinic to provide a health centre to accommodate six general practitioners in addition to the local health authority services.

Schedules of accommodation and briefs were prepared in respect of two other health centres after consultation with the Ministry of Health and it is hoped that these projects will start in the 1967/68 financial year.

Heston Health Centre Vicarage Farm Road
This centre which was completed in September 1966 is in use for local health authority and school health services. Negotiations on rental and contracts were proceeding with the Middlesex Executive Council and the two family doctors who wish to work from the centre.

Spring Road Health Centre Feltham
This centre which is in the course of erection should be completed early in 1967. Three consulting rooms and three examination rooms will be available to family doctors on a shared accommodation basis. Preliminary negotiations with doctors who wish to work from the centre are proceeding.

Brentford Health Centre
Work on the adaptation of the Brentford Clinic to provide shared accommodation for six general practitioners who have inadequate premises or will be displaced by redevelopment schemes will commence in 1967.

Hounslow Health Centre 92 Bath Road
An outline of the services to be provided from this proposed comprehensive health, welfare and children's centre was given in my previous report. Schedules of accommodation and briefs were prepared in respect of phases I and II of this project. The Ministry of Health approved sketch plans for phase I enabling the borough architect to proceed with working drawings.

The accommodation to be provided in phase I comprises a general practitioner unit from which thirteen doctors wish to practise full-time and a further six part-time, and a child psychiatric unit. This building will be linked to the existing local health authority clinic and the dental and school clinics and to the health department's main administrative offices.

Phase II will provide accommodation for mental health services including a day centre for the mentally ill who are capable of recovery and return to normal living, also flats for two midwives and a caretaker.

Subject to a satisfactory conclusion in regard to contracts and rentals it is hoped that building work on this project will start early in 1968.

Phase III which will accommodate the children's and welfare departments and communal accommodation including dining rooms, a conference room and a library is included in the programme for the 1969/70 financial year.

South Hounslow Health Centre
A group of three doctors has indicated an

interest in practising from a health centre planned on a site in south Hounslow. A schedule of accommodation and a brief have been prepared and the borough architect will shortly be submitting a plan for this project. Subject to the Ministry of Health's approval it is hoped to include this project in the 1967/68 financial year.

In the Ten Year Development Programme the following projects are planned—

Extensions to the existing clinics at Bedfont, Hanworth and Cardinal Road Feltham to provide accommodation for general practitioners.

The provision of health centres at Cranford, Chiswick, Old Isleworth, Osterley, South Chiswick and Hounslow Heath.

The provision of mini-clinics/health centres at Heston Farm and Mogden Lane are also under consideration.

Co-ordination and co-operation of health department services with the hospital and family doctor services

There is increasingly better co-operation between the department of health and family doctors.

Liaison and attachment schemes of health visiting, midwifery and nursing staff with the general practitioner service are under consideration. Schemes which are already in operation are mentioned elsewhere in the report. Frequent discussions took place with groups of family doctors who were interested in working from health centres. With the provision of these centres it will be possible to provide a domiciliary team co-ordinated by the family doctor. This will greatly facilitate the working of the general practitioner and local health authority services for the benefit of the community.

Close co-operation continues between the department and the staff of the hospitals in the area.

Midwifery · Section 23

The general arrangements for the domiciliary care of maternity cases remain the same as for 1965, Heston, Isleworth and Feltham districts being covered by the council's midwives, Brentford and Chiswick cases undertaken by Queen Charlotte's Hospital midwives and planned forty-eight hour discharges in Brentford and Chiswick being attended by a midwife operating on our behalf from the London Borough of Ealing. Six hundred and nineteen domiciliary confinements were attended by the council's midwives during the year compared with 637 during 1965 but the small reduction was more than compensated by the 694 early hospital discharge cases compared with 550 in the previous year. Midwives employed by Queen Charlotte's hospital attended ninety-two domiciliary confinements and also the eighty-six patients discharged from that hospital after forty-eight hours and before the tenth day of the puerperium.

A full establishment of midwives was maintained throughout the year. Fourteen pupil midwives came on to the district for training. Of these nine were from Hillingdon hospital and five from West Middlesex hospital training schools.

Two midwives and Miss Taylor, deputy non medical supervisor of midwives attended compulsory refresher courses conducted by the Central Midwives Board.

Co-operation with Family Doctors

The majority of the midwives attended ante-natal clinics provided by family doctors at their own surgeries and liaison in this field continues to be very good and will facilitate the implementation of attachment schemes when these are eventually put into operation.

Emergency Obstetric Units

Units are situated at Hillingdon and West Middlesex Hospitals. Their services were required on three occasions during 1966.

Analgesic Apparatus

Four Entonox analgesic machines were purchased during 1966. This is considered to be the safest type of analgesia for midwifery purposes as the mixture of gas is 50% nitrous oxide and 50% oxygen. The machines proved very useful to patients with maternal or foetal distress.

Maternity Medical Services Co-operation Card

The main purpose of this card is to ensure that each member of the obstetric team is aware of the

attention given to patients by other members. It is now becoming more widely used between hospital and local authority clinics, also between the general practitioners and midwives on domiciliary work.

Maternity Services Liaison Committee
The committee meets approximately every three months, and consists of members representing the Regional Hospital Board, the South-West Middlesex Hospital Management Committee, the Tottenham Group Hospital Management Committee, Hammersmith Hospital, Queen Charlotte's Hospital, West Middlesex Hospital, Bearsted Hospital, the London Boroughs of Hounslow, Ealing, Hammersmith and Richmond-upon-Thames, the Middlesex Executive Committee, the Middlesex Local Medical Committee, and the Local Medical Committee for the County of London.

The Maternity Liaison Committee met twice during the year when such matters as the various forms for use in connection with planned 48 hour discharges and the maternity register and child observation records were considered, as well as the usual review of catchment areas for the maternity units within the south-west Middlesex group.

Health Visiting · Section 24

The most important part of the health visitor's work lies in the homes of the families which she visits, as it is there that she develops the close personal relationships on which her success depends both as a health teacher and family adviser. It is after she has come to be known and trusted that members of families will send for her in time of need. Other opportunities for health visitors to discuss subjects relevant to health are afforded at ante and post natal, child welfare and mothercraft and relaxation clinic sessions and at various talks and demonstrations she is able to give. Meantime trained nurses relieve health visitors of most of the routine work in schools and clinics to enable the latter to have the maximum time available for the special advisory work for which they have been trained.

Staff
At the end of the year the staff consisted of the superintendent health visitor and the full-time equivalent of 17.8 health visitors and nine clinic nurses. The deputy superintendent had obtained a superintendent's post towards the end of the year and the vacancy she left was being advertised.

Training
During the year one health visitor attended a field worker's instruction course at Chiswick Polytechnic, one attended a refresher course and one a study conference. The superintendent health visitor also attended three conferences, one of a day's duration and the other two of three days' duration.

Students
The borough sponsored four trainee health visitors whose training commenced in September. The shortage of health visitors continues to impose severe restrictions on any expansion of the work but plans for liaison between health visitors and groups of family doctors are included in our forward planning to be put into effect as soon as possible. Meantime much informal liaison with family doctors, hospitals, the staff of Children's, Education and Welfare Departments, as well as with many voluntary bodies, is already an established practice in the borough.

Home Nursing · Section 25

The administration of the home nursing service continued in the same way as for 1965 though much thought was given to the possibility of attachment of home nurses to family doctors where group practice is carried on. On request one nurse in the Feltham area now attends at surgery for two hours on one morning each week. It has been found that the nurse is not always occupied for the full two hours and is able to leave as soon as the necessary treatment has been given. Visits made during 1966 totalled 91,371 to 2,414 patients. Of these 1,530 were aged 65 years or over, many of whom are in the 80–90 years age group and are feeble and slow if at all mobile and tend to take up much of the nurse's time. Incontinence pads are being used more and more

and are now supplied to subnormal cases together with protective undergarments through the home nursing service.

Laundry Service
Incontinent patients who are infirm or where washing facilities are poor and payment of laundry charges cannot be afforded, are provided with a free laundry service under Section 84 of the Public Health Act, 1936. One local laundry has continued the service for these patients and during the year forty cases were assisted in this way after certificates had been issued as required by the act. Sheets were also loaned free of charge to a few necessitous cases.

Staff
A full establishment of home nurses was maintained and many enquiries received for employment.

One home nurse attended a refresher course and Miss Taylor, deputy superintendent of home nurses attended a civil defence course. Two nurses completed district nurse training courses and one other commenced a course of training. Students from the Middlesex Hospital, Hounslow Hospital, West Middlesex Hospital and Chiswick Polytechnic pre nursing courses all accompanied home nurses on nursing rounds as part of their practical training.

The Marie Curie day and night nursing service proved very useful and was much appreciated by seventeen patients and their relatives. Recruitment to this service improved during the latter months of the year.

Home Help Service · Section 29

In reviewing the activities of the home help service for the past year the most significant feature has been the recruitment drive. Some forty additional home helps have been engaged during the year and owing to the large number of applicants for this work it is possible to be increasingly selective. On 31st December the equivalent of 145 whole-time staff were employed.

Two thousand and six homes were served by home helps during the year, an increase of 325, totalling 281,307 hours. The type of case to which service was given is as follows—

Aged (65 years and over)	1,515
Chronic sick and tuberculous	148
Maternity	171
Mentally disordered	17
Others	155
Total	2,006

Maternity
During the year the number of cases of home confinement in receipt of home help service increased by thirty.

Care of the Aged
The growth of the service continues and as will be seen from the statistics given the number of homes provided with help increased during the year by 325. We are singularly fortunate in that the helpers and staff readily respond to the urgent and sometimes onerous calls made upon them.

As the capabilities of the elderly diminish and they become housebound the service has been able to meet the changing needs more easily due to the number of staff recruited during the year.

Neighbourly Help
Whilst neighbourly helps are difficult to recruit there were six operating in the borough at the end of the year.

Evening and Night Service
There was an expansion of the evening service where help is provided between the hours of 5 pm and 7 pm for the elderly and chronic sick who live alone, and also for families where the mother is ill or in hospital and there are young children who require a meal and to be put to bed. Such help was provided in seventeen households.

Where necessary, help is also provided on Saturdays, Sundays and bank holidays. Weekend help was provided in thirty-one households.

Night help was provided on a limited scale for seriously ill persons without relatives or friends to assist them.

No charge is made for home help provided to persons in receipt of supplementary benefit from the Ministry of Social Security or those suffering from toxaemia of pregnancy.

Prevention of illness · care and after-care Section 28

Tuberculosis
Tuberculosis prevention, care and after-care services for patients living at home are provided at the Hounslow and Ashford Chest Clinics.

During 1966 there were 64 notifications of pulmonary tuberculosis and 19 notifications of non-pulmonary tuberculosis, compared with 70 and 11 notifications respectively in 1965.

The total number of cases on the register at the end of the year was 2,720. Table 13 shows an analysis of cases notified in 1966. There were 13 deaths from tuberculosis in 1966.

Recuperative Holiday Homes
During the year the borough council accepted responsibility under Section 28 of the National Health Service Act 1946 for the maintenance of fifty-four persons in recuperative holiday homes. Thirty-five were admitted to such homes and nineteen were cancelled or withdrawn.

Loan of Nursing Equipment
The British Red Cross Society continues to operate a scheme for the loan of nursing equipment on behalf of the council. Charges for this service are nominal but in certain circumstances are abated or waived. Monies received from loan charges enable replacement items of equipment to be obtained.

Chiropody Service
The demand for this service continued to increase throughout 1966 and although great difficulty was experienced in recruiting and retaining the services of a sufficient number of chiropodists, at the end of the year twenty-three weekly sessions were being held in local authority clinics compared with eighteen during the earlier months. A total of 1,019 clinic sessions were held at which 1,385 patients made 7,066 attendances for treatment as follows—

Chiropody Service

Category of patient	*First Attendances*		*Re-attendances*	*Total attendances*
	New cases	*Old cases*		
Elderly persons	425	949	5,657	7,031
Physically handicapped	2	1	19	22
Expectant & nursing mothers	3	1	–	4
School children	3	–	5	8
Others	1	–	–	1
Totals	434	951	5,681	7,066

One additional chiropodist was appointed to undertake domiciliary chiropody treatment. Thus, four chiropodists were engaged on carrying out the domiciliary treatment of aged and infirm patients who were unable to attend the clinics. The following are the details of domiciliary visits carried out during the year under the council's directly-provided service—

Category of patient	*First visits*		*Subsequent visits*	*Total visits*
	New cases	*Old cases*		
Elderly persons	266	321	2,344	2,931
Physically handicapped	8	17	135	160
Totals	274	338	2,479	3,091

The arrangements whereby some patients in the Brentford and Chiswick areas are referred to a privately practising chiropodist continued during 1966 and forty-four patients made 165 attendances for treatment for which payment was made to the chiropodist by the council.

In addition to the foregoing treatments undertaken by the council's directly-provided service, the arrangements were continued with the Heston and Isleworth Old People's Welfare Committee whereby chiropodists treated elderly patients in their own homes or at clinics provided by that organisation.

The council continued to pay the organisation an agreed quarterly grant of £425 which was based on the existing case loading. The following figures show the extent of the service provided by the Heston and Isleworth Old People's Welfare Committee during the year—

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201 domiciliary patients received a total of 1,206 home visits.

243 patients made a total of 1,384 attendances at specially arranged sessions. The slight decrease in these figures compared with the corresponding figures for 1965 was due to the prolonged illness during 1966 of one chiropodist engaged on this work.

The co-operation between this voluntary organisation and the department of health is now well established and this relationship was maintained throughout the year.

Problem Families

Special efforts continue to be made to assist families, often for long periods, where mothering and fathering is inadequate and home life is generally far below the accepted minimum often due to poor management or irresponsible behaviour on the part of weak or unstable parents. Sharing in this work are members of the Children's Department and voluntary agencies such as the NSPCC. Two members of the medical staff and one social worker from the Royal Hospital for Sick Children also lent much help with one particular family during the year, supplementing our knowledge of two children suffering from chronic illness.

Health Education

A health education sub-committee was set up towards the end of the year to discuss health education in general, to explore the possibilities of extending health education in schools and to investigate the means by which adult health education in the borough could be expanded. The sub-committee consists of four members of the health department staff an assistant education officer and the senior lecturer for health education at one of the borough's further education colleges.

Talks accompanied by films and discussion groups were held at all our infant welfare and ante-natal clinics and at mothercraft sessions. Mental and physical development of the child formed an important part of these discussions.

The medical officer for the student health service gave a course of lectures to students at the two polytechnic colleges on a wide variety of health matters including local authority community health services, venereal diseases, alcohol and drugs. He also participated in conjunction with members of the college staff in an induction course for overseas students. Talks were given on the medical services available to students, diet, clothing, and study in relation to the British way of life.

A medical officer and a health visitor gave a series of lectures on first aid to staff and students attached to the St John Ambulance Brigade.

A series of talks on drugs supplemented by the film 'Hooked' was given to youth club members on request.

Lectures on health subjects including cervical cytology and family planning were given by medical officers and health visitors to several adult groups and mothers' clubs.

Home Safety

Mr Jones, home safety officer, reports as follows—

'Attention is drawn to the fact that in 1965 in Great Britain 8,384 people died as a result of accidents in and around the home. This is an overall improvement in the figures for the second year in succession, and compared with 1964 the death total decreased by 176 (or 2.1 per cent).

Home accident fatalities constituted over thirty-nine per cent of all accidental deaths in 1965 and accounted for 1.4 per cent of deaths due

to all causes. The Home Safety Committee is constantly attacking the problem by way of propaganda, talks and suggested legislation in the attempt to reduce this shocking casualty figure. Of particular note is the fact that during 1966 the borough council approved the installation of appropriate fireguards to all existing aged persons' dwellings.

Falls account for more accidental deaths in and around the home than all other causes collectively. Fatalities due to falls in Great Britain in 1965 numbered 4,451 ie fifty-three per cent of the overall total. About half of the deaths are caused by falls on one level, ie tripping, slipping and stumbling, and about a quarter are due to falls from one level to another eg down stairs, from ladders, etc. Eighty-nine per cent of the fatalities were to people aged 65 years and over.

The second main cause of accidental death in the home is poisoning—the death toll in 1965 was 1,696 ie twenty per cent of the total. Fatalities due to household gas numbered 948 constituting fifty-six per cent of the deaths due to poisoning, most of the victims being elderly people. There were seventy-three deaths due to other gases, and deaths caused by solid and liquid substances numbered 675.

As in 1964, suffocation and choking constituted the third major cause of accidental deaths in the home in 1965. There were 889 fatalities due to this cause ie nearly eleven per cent of the total. In this category of accidents about seven out of ten of the victims choke over food and a quarter suffocate in pillow and bedclothes. Over seventy per cent of the deaths due to suffocation and choking were to children under five years of age in 1965.

The fourth main cause of home accident fatalities in 1965 was burns and scalds. The toll was 869, ie over ten per cent of the overall total. In this general category about nine out of ten of the deaths are due to fire and explosion of combustible materials, ie burns by clothing catching alight, by falling into the fire, conflagration, etc. The remaining fatalities are caused by hot substances, corrosive liquids and steam. Frequent victims of accidental burns and scalds are elderly people and very young children.

Deaths due to other miscellaneous causes in Great Britain totalled 479. Of these, seventy-five were due to drowning and about sixty were caused by electrocution. Deaths due to lack of care of infants numbered forty-seven and excessive cold caused forty-three fatalities. There were about twenty-five deaths caused by blows from falling objects, and deaths due to firearms numbered twenty-three.'

The Hounslow Project and its implication for Health Education in general

The Hounslow Project is an operational research in the field of prevention, particularly that of social and emotional breakdown.

Included in my last report was a description of the survey being conducted by Mr E Heimler, AAPSW, who is the social work organiser and advisor on health education and is assisted by Miss Julia Dighton, psychiatric case worker.

The pilot survey to ascertain community attitudes to the social services provided by the borough has now been completed and the work has attracted the attention of the Ministry of Health who have informally indicated their willingness to consider granting financial assistance but the position has not yet been reached when a final decision can be made.

The survey clearly indicates that the possibility of breakdown is increased during periods of change in human life. These changes may be due to a number of reasons, such as unemployment, the death of a family member, change of occupation and/or environment, physical or mental illness, school leaving, choosing work or occupation, marriage, pregnancy, the birth of a subnormal or sick child, the menopause and finally, retirement. There are, of course, other phases of life when significant changes also occur.

If the nature of such changes is fully understood, both by those whose responsibility it is to assist people under stress and also by the individuals themselves, then the danger of breakdown can be prevented in a large number of instances.

The project workers have ascertained that there is a relationship between human satisfactions on one hand, and normal social functioning on the other, and they have found that when the

satisfaction rate of people falls below a certain point this seems to correspond to the onset of social or emotional breakdown. It is also significant that when frustrations override satisfactions in the five main areas of life (work, finance, family relationship, friendship and the more personal area), there is then danger, both with young and old, of finding unsatisfactory compensations.

Such compensations may be any of the following—promiscuous sexual behaviour, drug addiction, smoking, alcoholism, crime, delinquency, etc. It is now thought likely that by assessing people's satisfactions and frustrations at an early stage such unhealthy patterns can be prevented from developing. Satisfied people, whether young or old, do not need abnormal stimuli.

The implications of this research for health education are only too obvious. They can be enumerated as follows—

1. Teachers, health visitors, social workers and general practitioners can be trained to identify, on a scientific basis, people's satisfactions and frustrations at an early stage either before breakdown occurs or resorting to unhealthy stimuli.
2. Through group discussions (small groups of eight to ten people), people can be taught the need for self-fulfilment in the five main areas of their lives. Such group discussions could be used to instruct on the consequences of heavy drinking, drug addiction, smoking and other forms of abnormal satisfactions which undermine health.
3. Through the use of a screening device which ascertains people's problems in the community, and by using the community's resources such as social clubs, educational facilities, etc, people can be helped to function more effectively in society and thus avoid the danger of breakdown.
4. Methods and techniques can be developed to help individuals and their families to realise and utilise their potentials more fully; such techniques can be shared with social workers, clergy, health visitors and others.
5. The possible recognition, through scientific methodology, of abnormal patterns may lead to the early identification of stress conditions which may contribute to blood pressure, gastric conditions, coronary thrombosis, etc.

Through this work we are now beginning to discover new methods of health education and we hope in time to be able to develop more effective ways of influencing people's attitudes to health problems.

We are also now beginning to explore the relationship between institutional life, such as in hospitals, Homes and hostels and it's effect upon people's satisfaction whilst within such settings, and thus we may be able to make recommendations as to the necessary changes which might enable an individual in such a setting to gain the maximum satisfaction and benefit from his stay.

Cervical Cytology

The memorandum on population screening for carcinoma of the cervix was received in October 1966 with circular 18/66 which conveyed the Minister of Health's approval under Section 28 of the National Health Service Act 1946 to all local health authorities to make arrangements for obtaining cervical smears for cytological investigation by hospital laboratories. Approval had already been given in March 1966 to this council for the institution of these arrangements.

The department has co-operated closely with Ashford and West Middlesex Hospitals and with the family doctors in the development of this service.

The scheme was put into operation at the end of August when the hospitals could accept only 30 smears a week from this department. We were therefore able to start only on a limited scale and publicity was avoided as the demand might otherwise cause a breakdown in the service. A letter was sent to all family doctors in the borough explaining the position. They were informed of the times of the clinics and were offered the service for their patients. Women could also apply direct to the clinic for an appointment. The smears were taken at the close of ante-natal sessions as this was economical in terms of clinic staff.

Although the Ministry of Health's directive is that women of age 35 and over should have a smear every five years, women over the age of 25 who presented themselves were accepted.

In this borough cervical cytology is part of a

more thorough examination. Our medical officers examine the vagina and all the pelvic organs and also the breasts. The blood pressure is taken and the urine is tested. Instructions are also given in personal hygiene as this is an important factor in the prevention of cervical carcinoma.

If any abnormality is found in the smear the patient is referred to her family doctor and a copy of the pathologist's report is also sent to him. The doctor in turn refers the patient to a gynaecologist for further investigation. Each patient is informed by letter of a negative result.

As is to be expected gynaecological defects come to light at these clinics and the medical officers report anything of significance to the patient's family doctor.

Cervical smears are also taken at the Family Planning Clinics.

The following statistics relate to women examined at the council's clinics during 1966—

Smears taken	192
Positive smears (see note below)	1
Negative smears	191
Referred to general practitioner with gynaecological defects	11
Referred to general practitioner for other reasons	5

Further investigation, including cone biopsy. Pathologist could not detect any evidence of a carcinoma in situ.

Care of Mothers and Young Children · Section 22

Ante-natal Clinics

The trend of decreasing attendance in both ante-natal and post-natal care has continued at medical officer clinics as the pattern of ante-natal care and post-natal care by the mother's general practitioner becomes more firmly established. This year there were 333 medical officer sessions the attendances at which totalled 1,745. One hundred and seventeen sessions with a midwife only in attendance were held, the attendances at which totalled 789. Many mothers, however, attend the clinics for mothercraft and relaxation and the number of total attendances, 2,186, is not far short of the 2,390 attendances made last year. Only 112 mothers took advantage of our facilities for post-natal examinations. The practice of undertaking ante-natal care in the middle months of pregnancy has continued for patients booked at hospitals but referred back to us after their initial visit to hospital.

Child Welfare Clinics

During the year 1,420 sessions were held at which 8,713 children made a total of 56,580 attendances, representing a fall of 4,360 attendances. General practitioners are increasingly undertaking child care and management and there seems to be a steady increase in mothers of young children going out to work. Both these factors no doubt have contributed to the decrease in clinic attendances.

Welfare Foods

National welfare foods and approved proprietary preparations are stocked at child welfare centres for sale, or if the need is proved, for free issue. During the year £11,980 was received for the sale of proprietary preparations.

The quantities of national welfare foods issued were—

National dried milk (tins)	12,203
Orange juice (bottles)	58,195
Vitamin tablets (packets)	3,245
Cod liver oil (bottles)	2,974

Notification of Congenital Defects Apparent at Birth

Since 1st January 1964 it has been a statutory requirement that all congenital malformations apparent at birth be notified to the Medical Officer of Health at the same time as the notification of birth. The names of children so notified are included in the department's observation register as children at risk and particulars are also sent each month to the Ministry of Health

The following is a list of defects notified during 1966—

Central Nervous System	
Anencephalus	1
Hydrocephalus	3
Microcephalus	1
Spina bifida	6
Eye, ear	
Accessory auricle	1
Defects of ear NOS	1
Alimentary system	
Cleft lip	6
Cleft palate	5
Rectal and anal atresia	3
Heart and great vessels	
Other defects of heart and great vessels	1
Congenital heart disease NOS	6
Respiratory system	
Defects of respiratory system NOS	2
Uro-genital system	
Other defects of kidney and ureter	1
Hypospadias	3
Other defects of male genitalia	3
Defects of uro-genital system NOS	1
Limbs	
Polydactyly	5
Dislocation of hip	1
Talipes	23
Other defects of hand	2
Other defects of pelvic girdle and lower limb	2
Defects of lower limb NOS	1
Other skeletal	
Defects of skull and face	1
Spinal curvature	1
Other systems	
Defects of muscles	2
Other defects of skin (including ichthyosis congenita)	4
Exomphalos	1
Other malformations	
Mongolism	5
Multiple malformations NOS	1

NOS—Not otherwise specified

For our own purposes, the only children we follow up are those whose defect is likely to be a handicap to them in their future progress.

As the notifications are made within the first 48 hours of birth, often before a doctor has examined the baby, it is possible that a considerable number of congenital defects are not notified by this method, notably such conditions as pyloric stenosis, fibrocystic disease, various congenital heart defects and various renal defects. We therefore still rely upon the hospital paediatricians for their co-operation with regard to notifying these defects.

Observation Register

I am grateful to Dr D G Gooding for the following preliminary report—

'In the summer of 1965 a scheme was developed in liaison with the consultant obstetricians and paediatricians at the West Middlesex Hospital and Chiswick Maternity Hospital whereby the department of health was given access to hospital obstetric records.

The hospitals state on their birth notification form whether or not they consider that any child born may need further observation due to pre, peri or post natal hazard, and therefore is at greater risk than normal of developing a handicap.

Between June 1965 and the end of December 1966 a total of 1666 children were notified as being in need of further observation. It is interesting that only about 898 of these cases were actually followed up at local infant welfare clinics.

Of these 898 cases, 191 failed one or more of the last tests taken. It is not possible to give a scientific analysis of these results but on reviewing the cases individually it was felt that probably about 83 out of the 191 cases were showing signs either of physical or mental retardation to some significant degree. A further 11 children were showing signs of developmental retardation but were already known to be suffering from a specific handicap which could account for this.

Amongst these 191 children were a total of 51 children with a wide variety of defects ranging from minor congenital and orthopaedic disorders to more severe handicaps. A total of 37 of these 51 children were under the care either of hospitals or our own medical units, including the audiology unit and the medical advisory unit attached to Martindale School. Once again the range of handicap varied from minor to fairly severe handicaps such as deafness, cerebral palsy etc.

Of the 768 cases which were closed or were not followed up almost half (402) moved out of the borough before any follow-up could be undertaken. A small percentage (43 children) did not attend as they were attending hospital or their general practitioner and the remainder were non-attenders at clinics. Twenty-eight children died within the first year of birth, 34 cases were closed during the year as progressing with normal development and at the end of the year there were 898 children remaining on the register for further observation.

It is too early to comment upon the effectiveness of this type of observation register. It is felt that a fairly high proportion of children with handicaps are being kept under observation and that early knowledge of their defects will enable both the Health and Education Departments to provide appropriate help when necessary. It is hoped that by continuing the register for a few more years the early detection of educational subnormality will become possible. On the other hand, a high proportion of children have not been seen and our interest has now been stimulated to follow up some of the non-attenders with the help of the health visitors. There is also, of course, a fairly high proportion of children who develop a handicap due to an unknown cause and we rely upon our liaison with hospitals, general practitioners, the help of clinic doctors and the health visitors to refer these children for further observation and full assessment if in their opinion it is required.'

Children notified 'At risk' up to 31.12.66	1,666
Open cases	
Children on register at end December 1966 and who attended at least once	898
Children who failed one or more of last test taken	191
Failures thought to be significant	83
Failures associated with known handicaps	11
Failures thought probably not to be of significance	97
Cases closed or not followed up	768
Moved away	402
Died	28
Closed, normal development	34
Non-attenders, reason not stated	202
Non-attenders, mother did not wish to attend	59
Non-attenders, attending GP or hospitals	43

Phenylketonuria

Health visitors carry out phenistix tests for phenylketonuria on as many young babies as possible at the ages of three and six weeks. No positive reactions were obtained.

Care of the Unsupported Mother and her Child

The work of caring for unsupported mothers by making arrangements for their welfare during pregnancy, their place of confinement and eventually their return to life in the community, and also satisfactory care for their babies, has continued under the medical social worker whose office is in Ealing but who undertakes this work for Ealing, Hillingdon and Hounslow. During the year the borough accepted financial responsibility for eighteen mothers placed in St Agnes Home, Chiswick, maintained by the Hammersmith Deanery Association for Moral Welfare Work and for fifty-five mothers placed in homes outside the borough. These mothers are required to pay a standard charge towards their care subject to assessment on the council's scale of charges.

The local branch of the Moral Diocesan Society, Welcare, also plays an important part in caring for some of our unsupported mothers.

Day Nurseries

There are three day nurseries in the borough, Danesbury Road, Feltham (40 places), Portsdown House, Brentford (32 places) and Nantly House, Hounslow (54 places), all of which are approved by the Ministry of Health for the training of student nursery nurses. This means a high standard is maintained. The children of mothers who have to go to work, because for various reasons they are without the support of a husband continue to represent the bulk of admissions but places are also provided for children whose mothers are ill or whose home environment is detrimental to health and development. In addition, children with handicaps are admitted for reasons related to social experience and supervised training, as well as the affording of some relief to over-burdened mothers. Thus the local authority day nurseries play an important role in preventing children from being taken into care and in the prevention of the break-up of the family. From time to time it is inevitable that cases of infectious diseases occur in these susceptible young children and when a case occurs no new admissions are allowed until a period of quarantine has elapsed and one is sure a new child will not be exposed to infection from contacts of the original case already in the nursery who may be incubating the disease. This year saw a fair share of infections in all of our day nurseries with an inevitable fall in the total number of attendances compared to last year in both Portsdown House and Nantly House Day Nurseries.

The attendances made by children were as under—

Feltham Day Nursery	9,029
Portsdown House Day Nursery	6,195
Nantly House Day Nursery	11,386

During 1966 a nursery nurse attended a two week's nursery nurses refresher course at Chiswick Polytechnic. All the students in training passed their final examinations entitling them to NNEB certificate.

The nurseries themselves provide a means for students of Chiswick Polytechnic who are being prepared for one or other type of social work to observe the kind of care and organised activity that children receive in day nurseries and to develop their own powers of observation. The demand for this kind of experience is increasing. It is gratifying to report that both course tutors and individual students have written in to thank us for the facilities afforded and for the insight they have gained into the needs of young children.

Nurseries and Child Minders Regulation Act

The following were registered at the end of the year—

Private Day Nurseries	10 with accommodation for 267 children
Child Minders	15 approved for the care of 153 children

The number of places thus provided greatly exceeds the number of places provided in the borough's nurseries.

There is little doubt that there is growing widespread outside employment of mothers of small children as well as an increased awareness amongst young mothers that the three-to-five year olds need opportunities to extend their environment beyond their home, especially when space and opportunities for play are limited. The day nursery and nursery school provision does not meet the demand for the care of the 'under fives' and this leaves the field open for private individuals to try to fill the gaps. Those who run the 'private sector' often need much support, advice and encouragement to fit them for the task they have undertaken. Two evening courses are provided annually at Chiswick Polytechnic on the health, educational and psychological needs of the under fives, with special reference to children in nursery groups. Much encouragement is given to those in charge of small children who have not had previous appropriate training, to attend such a course and when this is not possible a visit of observation to one of our day nurseries is advocated and the reading of a very useful paperback.

Unregistered Child Minders

Women undertaking the daily care of not more than two children are not subject to formal supervision, but health visitors try to keep some watch on children placed with such unregistered child minders. To encourage unregistered child minders to accept some degree of supervision and to bring the children to the child welfare clinic once a month, the council, subject to the minder and the child's mother accepting and abiding by the scheme, will pay the minder one shilling a day for each child minded. So far this scheme has not been popular, and at the end of the year only one unregistered child minder was participating.

Family Planning

In February 1966 Ministry of Health Circular 5/66 was received in which the minister asked all local health authorities to review their arrangements for providing a family planning service and urging them to improve and develop their local services to the fullest extent within existing powers. As the law now stands local health authorities are empowered to provide family planning advice and treatment only for women for whom pregnancy would be detrimental to health. The private members' bill which was presented to Parliament on 14th June would enable local health authorities to make arrangements for the provision of advice and treatment in connection with contraception for any women who seek it without regard to marital status and to give treatment on social as well as on medical grounds free of charge to those who cannot afford to pay for treatment.

Family planning clinics are organised and held within the borough by the Family Planning Association in local authority clinics. At the beginning of the year eight weekly sessions were being held by the Family Planning Association at five clinics and no charge was made for the use of the clinics. By the end of the year the number of sessions held had been increased to twelve.

The council accepts financial responsibility for charges made by the Family Planning Association in respect of patients referred to them by the council's medical officers where it was considered that pregnancy would be detrimental to health.

The times and places of family planning sessions are publicised throughout the council's clinics and our medical officers, health visitors, midwives and home nurses make this information known in their daily work with families.

There is very close co-operation between this department and the local branch of the Family Planning Association and I am a co-opted member of the executive council of the Family Planning Association.

Dental Care

The following report on the priority dental service has been submitted by the chief dental officer, Mr D H Norman LDS RCS BDS—

'The borough dental service has continued to meet the demand for dental care for expectant and nursing mothers and pre-school children. The demand for treatment was less than if all who actually needed care had asked for it. While efforts were continually made to stimulate demand particularly from parents of pre-school children staffing difficulties made it unrealistic to launch a large scale campaign. Unfortunately all the signs are that this undesirable state of affairs will continue at least for the next few years.'

Report of the Principal School Medical Officer for the year 1966

Organisation
This is the second annual report on the School Health Service provided since 1st April 1965, by the London Borough of Hounslow. The arrangement whereby the school health service was closely integrated with the other health services administered by the Department of Health has continued. Joint use is made of medical, dental, nursing and other staff as well as of clinic premises.

Co-operation
It is important that there is an exchange of information between hospital, general practitioner and school medical staff.

On the whole, local hospitals send reports to the school medical officers on children who have been in-patients; others tend not to do so automatically but will send reports on request.

Before any child is referred for specialist or hospital treatment it is the practice, except in emergencies, to ask the family doctor whether he is in agreement, or whether he wishes to treat or refer the child himself.

School Health Service

School Population

At the end of the year the maintained school population was as shown below—

Nursery Schools and Classes	204
Primary Schools	16,750
Secondary Modern Schools	7,169
Grammar Schools	3,927
Special Schools	547
Total	28,597

Periodic Medical Inspection

Under the provisions of the Education Act it is the duty of a local education authority to provide, at appropriate intervals, for the medical inspection of pupils in attendance at any school provided by them. The authority may require the parent of any pupil, in attendance at such school, to submit the pupil for medical inspection in accordance with the arrangements made for such inspection. Although the Act thus places a legal obligation on the parent to submit the child for examination, no pressure is put on the parents unless there is reason to suspect that the pupil may need special education or may suffer from a defect which might interfere with educational progress. The parent is under no obligation to accept for the child any medical treatment offered by the authority and some parents use the facilities provided under the National Health Service Act.

A minimum of three medical inspections during school life is recommended but a local education authority may arrange others. The usual minimum is as follows—

Entrants	—on admission to school for the first time
Intermediates	—during last year in primary or first year in secondary school
Leavers	—during last year at school

An additional medical inspection at seven to eight years is carried out in the Borough and efforts are made to examine pupils in nursery classes each term. At the examination of 'intermediates' colour vision is tested, as colour blindness may have a bearing on the pupil's secondary education and selection of a career.

Parents are notified of these periodic medical inspections and invited to attend. The proportion of parents attending varies from school to school but is generally highest at the 'entrants' examination. These examinations should be conducted in school to facilitate consideration by parent, teacher and medical officer of any problem concerning the health, education or social adjustment of the pupil but because of pressure of accommodation the inspections for some schools have to be carried out in the nearest clinic.

When a periodic medical inspection is arranged the head teacher is asked to submit the names of any other pupils in whose case special medical inspection is thought to be advisable. Also pupils requiring follow-up from previous medical inspections can be seen and thus the visit of the medical officer to the school is used to cover a wider field than a selected age group. If the best

results are to be obtained from these visits to school there should be close collaboration and consultation between medical officer and head teacher.

At the 'leavers' examination Form Y9 is completed for each pupil and forwarded to the Youth Employment Officer. This form indicates if there are any health reasons for avoiding certain types of occupation.

The number of pupils submitted to periodic medical inspection during the year was 8,704 and the results are shown in Table 1a. The physical condition of 132 (1.5%) was considered to be unsatisfactory. The concept of unsatisfactory physical conditions varies with the examining doctors but the important point is that efforts are made to bring the pupil to a satisfactory physical state.

Special Examinations and Re-examinations

Any parent, head teacher, school nurse, speech therapist, physiotherapist or audiometrician, etc may request the medical examination of a pupil and these special examinations are usually carried out at clinics. Regular sessions are held at these clinics when a medical officer is in attendance to see school children, and where necessary special sessions are arranged.

The examinations carried out during the year were as follows—

	Special Examinations	*Re-examinations*
School medical inspection sessions	169	–
Routine clinic sessions	2,393	2,890
Employment of school children	561	–
Children being taken into care	56	–
Freedom from infection	930	–
Pupils at special schools	115	475
Referred by audiometricians	396	–
Attending hearing clinic	–	1,036
Possibly requiring special education	231	–
Total	4,851	4,401

The number of referrals by audiometricians for special examinations increased from 239 during 1965 to 396 this year, an increase of nearly two thirds. This reflects an increasingly effective screening service for the detection of hearing loss rather than any actual increase in the incidence of such defects in the child population in the catchment area.

The defects found at periodic and special medical inspections are shown in Table 2.

Uncleanliness and Verminous Conditions

School nurses make examinations of children in regard to cleanliness of person and clothing and the presence of lice or their eggs (nits). At one time all pupils were examined at least once each term but as uncleanliness of person or clothing is now rare, flea or body lice infestation almost unknown, and the incidence of head lice greatly reduced, such regular examinations are not now held. The nurse now visits schools to carry out these examinations at the request of the head teacher or where there are grounds for suspecting the presence of infestation. During the year the school nurses carried out 14,063 examinations and found lice or their eggs in the hair of 148 individual pupils. Today there is no excuse for such infestation and the infested pupils are now usually members of a hard core of families on whom neither threats nor persuasion seem to have any effect. In most cases the parents deal with the matter as soon as their attention is drawn to it, but 85 formal notices requiring the parent to cleanse the child had to be issued and in 4 cases, where the parent had failed to respond to the formal notice, a cleansing order had to be issued for the pupil to be dealt with by the school nurses.

Medical Treatment

Certain treatment facilities continue to be provided under arrangements made by the local education authority and parents may use these or seek treatment otherwise under the National Health Service. The following notes refer to the treatment facilities provided as part of the school health service. School clinics are listed later in the report.

Minor ailment clinics
These are staffed by nurses and are held at clinic premises each morning. Here are treated slight injuries, skin infections and minor defects of eye or ear. The number of attendances is falling and most sessions now take no more than 30 minutes.

School consultation clinics
These are staffed by a medical officer and regular sessions are held at the various clinic premises. Parents are free to take their children for advice on any condition and pupils may be referred by head teachers, school nurses, etc and these sessions also provide facilities for the follow-up of conditions found at periodic and special inspections. Where active treatment is required, the pupils are referred to their own doctor or specialist clinics and most of the work done by the medical officer is advisory, educational or supportive.

Ophthalmic clinics
Dr H B Casey MB BCh DOMS, ophthalmologist, reports on the work of the ophthalmic clinics—

'The borough's ophthalmic clinics have been running satisfactorily and have been well attended.

The vision of entrants to school is tested during their first year when the hereditary defects of myopia, hypermetropia and astigmatism are detected. It is necessary to test the near as well as the distant vision as high hypermetropes will pass a distance vision test but will fail a near vision test. Most of these refractive errors can be corrected either with spectacles or by occlusion plus orthoptics, thus enabling the child to function better with his or her education and general progress. Children in the 11 to 16 year age group develop axial myopia and often parents and teachers are unaware of these visual changes.

The early treatment of strabismus cannot be over emphasized and children with squints or suspicious squints should be referred to the ophthalmic clinic at an early age as treatment should be started from the age of one year. Binocular vision has to be established early in life and with the co-operation of medical officers, health visitors and parents errors can be corrected and the 'lazy' eye or amblyopia ex anopsia should be a rarity.

Martindale School for the Physically Handicapped is visited once a month and the children have regular eye examinations.

Children are referred to the ophthalmic clinics mostly with refractive errors, squints, blepharitis and conjunctivitis. One child presented herself with bilateral papilloedema which was confirmed as a cranio-pharyngioma. She received operative treatment and is making satisfactory progress.'

Orthopaedic clinics
These clinics are staffed jointly by the Regional Hospital Board who provide the orthopaedic surgeons and the local authority who employ the physiotherapists. Two clinics are held in the borough, one at Brentford Health Centre where Mr J A Cholmeley attends fortnightly and the other at Hounslow Health Centre where Mr F Godsalve Ward attends monthly. Mr Cholmeley is associated with the Royal National Orthopaedic Hospital and Mr Ward with Ashford and Hounslow Hospitals. The attendance of Mr Ward at Hounslow Health Centre began this year, the clinic previously having been under the direction of Mr Maudsley from Heatherwood Hospital. The new arrangement with Mr Ward at Hounslow is proving a particularly happy one because of his connection with Hounslow Hospital which with its X-ray and other facilities, is separated from the Health Centre by only a short public footpath. An easy and fruitful partnership has rapidly been established between the hospital and the local authority in this field.

Although 980 children are on the orthopaedic clinic registers, only 291 needed to see a surgeon during the year. 330 children required treatment by physiotherapists at council clinics. In addition to attendances made at the Brentford and Hounslow clinics a physiotherapist attends the Busch House School four times weekly to provide treatment for children suffering from asthma, bronchitis and other conditions requiring physiotherapy.

Speech therapy clinics
1966 has been eventful in the development of the speech therapy service. At the medical advisory unit at Martindale School for physically handicapped children two fully equipped speech

Speech therapy—
Medical Advisory Unit, Martindale School for physically handicapped pupils.

therapy rooms have been provided and one room at the new Heston clinic. Similar facilities were also planned for the new clinics under construction and for future extensions to existing buildings. These purpose equipped rooms are particularly necessary in view of the increasing number of pre-school children who are being referred for treatment.

In November, a speech therapy clinic was started at the Hanworth junior training school for two sessions weekly. The session previously held at Cranford Infants school was discontinued when the new Heston clinic was opened. The Cranford children now go to Heston clinic.

The number of children treated throughout the year was 555. Of these 221 were new cases. The number discharged was 180.

Types of speech defects	*No of cases receiving treatment—*		
	At Junior Training Schools	*At clinics*	*Total*
Stammering	–	50	50
Clutter or non-fluency	4	6	10
Non-communicating	2	5	7
Retarded language development	11	49	60
Dyslalia associated with deafness	1	14	15
Dyslalia not associated with deafness	4	201	205
Cleft or shortened palate	2	7	9
Dysphonia	1	7	8
Cerebral Palsy	3	–	3
Sigmatism	2	102	104
Other defects	–	3	3
Total	30	444	474

A further 81 children treated in schools are not included in this analysis.

Asthma and allergy clinic

I am grateful to Dr Prothero MD DCH Departmental Medical Officer for submitting the following report on the work of the allergy clinic during 1966.

'There are some 100 children on the roll and of these ten are under the age of five years. The sex distribution is fairly typical: 34% girls and 66% boys.

Supervision following the initial diagnostic interview varies according to the severity of the asthma. Whereas some children attend only for the diagnostic consultation others may attend monthly or even more frequently whilst others may be seen only once yearly to check progress.

Much value is laid on the primary interview when a comprehensive history is taken to elucidate the likely 'trigger' factor in the child's asthma.

Skin tests using Bencard's Allergy Products are done routinely but are not necessarily conclusive as even in the same child different factors might be operative at different times.

Since De Bono's Whistle has become available, easy assessment of lung-function has become possible in a clinic setting. The peak expiratory flow rate (PEFR) is regularly measured and progress assessed clinically and on ventilatory capacity: many children appear to have 'out-grown' their asthma but may be left with significant impairment of lung-function.

Treatment facilities in a local authority clinic are necessarily restricted to antispasmodics, antihistamines, desensitisation, breathing exercises and instructions to parents in regular tipping if pulmonary congestion occurs. Much emphasis is laid on the psychological management of this psychosomatic illness in order to relieve the considerable intrafamilial tensions which accompany the recurrence of airway obstruction in an asthmatic child.

Should steroid treatment be considered necessary the child is referred, with the concurrence of the family doctor, to an appropriate hospital department. There are at present five severely ill children in attendance who are receiving this treatment. Steroid dependence with its associated growth impairment is now avoided by giving short courses of predisolone or intramuscular ACTH.

It was considered that preseasonal hyposensitisation against grass-pollen was indicated in six children: four were subject to severe pollenasthma, two to severe pollenosis.

Alavac (Alum precipitated extracts) was tried in one patient with excellent success and is probably treatment of choice as it involves a significantly lower number of injections (7–8), compared with the standard aqueous pollenvaccines, which were given to the other 5 children (18 injections). Three children did very well during the summer, one moderately and one child had his treatment interrupted as he was selected for six weeks' convalescence in Switzerland aided by a voluntary scheme operating in the Borough.

Three children during 1966 were referred to a day open air school owing to the severity of their asthma and considerable loss of schooling. All these children were of primary school age where placement away from home might have been added traumatic experience.

Much emphasis is attached to adequate counselling of school leavers as the prognosis and possibly life expectancy might well depend on suitable employment. The importance of an optimum education is emphasised to both the children and their parents, as loss of schooling can superimpose the disadvantages of a poor education onto a young person whose clinical condition already might restrict his choice of a suitable occupation.'

Hearing clinic

The work at the clinic continued to expand during the year and plans were approved for an extension to the present unit.

The staff continued to work as members of a medical/educational team. In addition to the routine work in the clinic, the schools and the children's homes, other activities such as the organisation of parents' meetings have continued.

A three day course for training local authority medical officers was held in October and representatives from many of the Greater London boroughs came to see something of the work of the clinic and to learn about the methods used for the detection of hearing loss in young children, and the assessment of hearing loss in deaf children.

The number of new cases seen at the clinic during the year was 316. This is an increase on the previous year and the cases tend to be more complex. Medical officers are now becoming more aware of the problems of children with speech defects, or children who are backward with their speech development and nearly all these cases are now referred for screening for hearing loss. Similarly all children with any other type of handicap are now seen routinely. Eighty one children at the Isleworth Junior Training School were screened during the year for a hearing loss. Nineteen children were found to have a hearing loss not requiring consultant opinion and a further sixteen children were referred to Dr Fisch either for a hearing loss or because they could not be tested at the training school. Of these, six were found to have a significant hearing loss and three were issued with hearing aids. 544 cases were re-examined at the clinic during the year either by Dr Fisch, the consultant, or the principal medical officer.

Routine audiometry was undertaken in schools as in previous years and children who failed sweep tests were re-tested at the local clinic and then referred to the school medical officer if this was thought necessary.

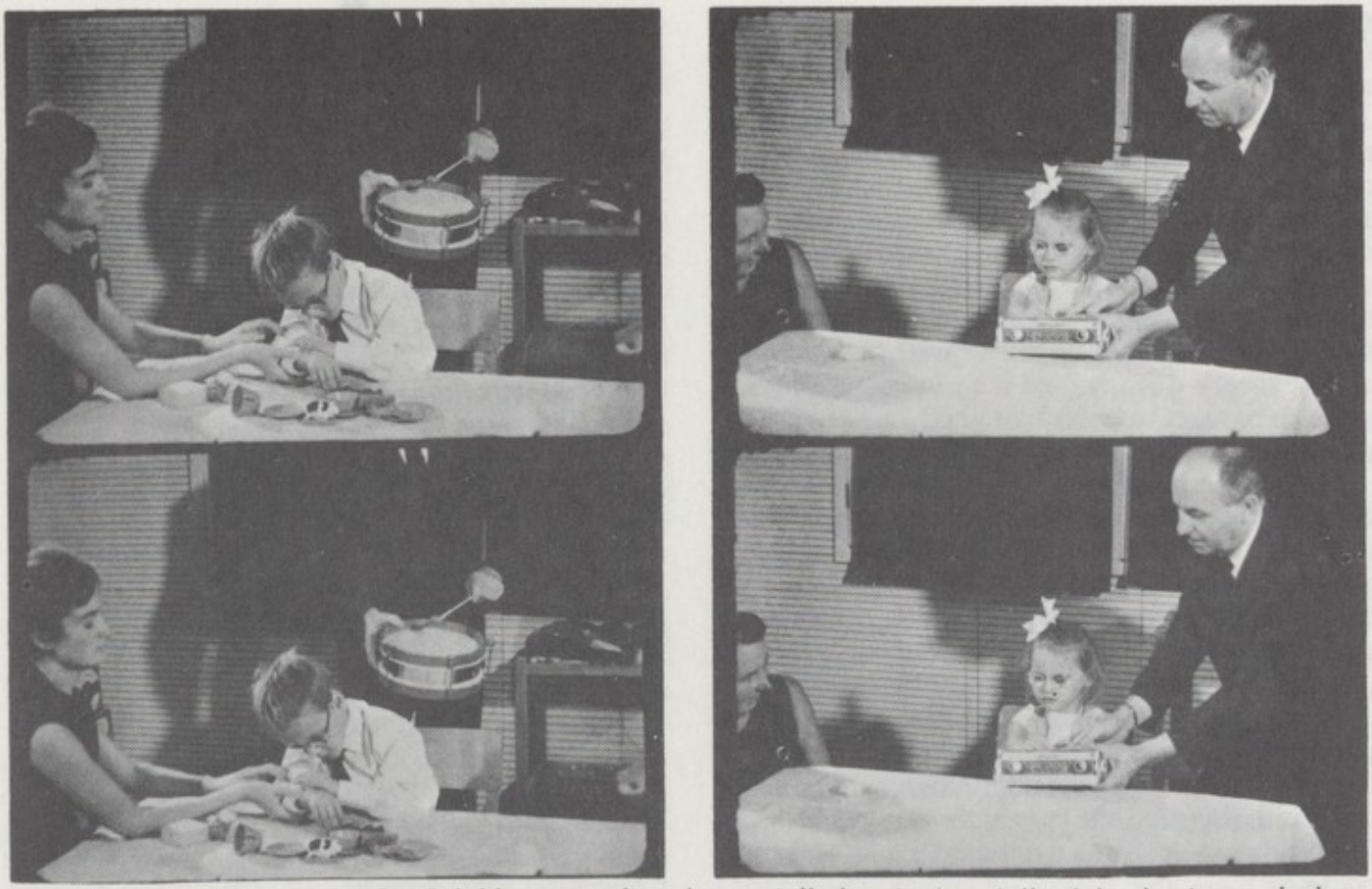
The number of tests made during the year were—

Age	*1st test in school*	*Re-test at clinic*	*Total*	*Re-test failures*
5 to 7 years	2,405	457	2,862	137
8 to 11 years	2,245	161	2,406	41
Total	4,650	618	5,268	178

Children were also seen in clinics as follows for special audiometry after referral by medical officers, speech therapists, general practitioners and from the school psychological service.

Age	*1st test*	*Re-test*	*Total*	*Failures*
Under 5 years	90	4	94	29
5–7 years	349	64	413	131
8–11 years	242	40	282	68
12 years and over	115	9	124	45
Total	796	117	913	273

The work with hearing aids has expanded and during the year audiometricians took 358



Clips from the film being made of children attending the partially hearing/partially sighted unit attached to Heston School for the Deaf.

impressions for earmoulds for use with hearing aids. Initial difficulties of supply of National Health Service Medresco hearing aids were overcome and the clinic now works in close liaison with the West Middlesex Hospital. Sixty eight Medresco aids were issued to children for the first time and 312 Medresco aids were replaced or exchanged. Commercial aids are now superior in performance to Medresco aids for certain types of hearing loss and an increasing number of commercial aids are being issued on trial to children. Subsequently 46 of these aids were bought by the various local education authorities for their children. The small post-aural aids are also improving in design and efficiency and are now suitable for a proportion of children with partial hearing losses.

The clinic received visitors from all over the world, including many from the United States of America and Europe. The total, including visiting students from medical schools, colleges of speech therapy and student teachers of the deaf was 362. All the students attended for teaching and usually observed a clinic. The viewing room is much used for this purpose.

Medical Advisory Unit

The extensions to the Medical Advisory Unit were completed in the summer of 1966 and are now in full use. The unit formerly comprised one large physiotherapy room, a hydrotherapy pool with changing accommodation, a small room for use by medical and neurological staff and a speech therapy room in the school itself. The new building has added a physiotherapy hall which is divisible into two rooms by means of a folding partition together with a store/projection room and shower, a medical room with a one-way viewing window, enabling children in the physiotherapy hall to be observed for teaching

purposes and also two speech therapy rooms. The former speech therapy room has reverted to school use.

Most of the handicaps in children who will need special education are now detected early, due largely to the use of the observation register and the compulsory notification of congenital defects. This has led to an expansion of the work with pre-school children. The six monthly visits to the unit for medical assessment by the doctor, the weekly or fortnightly visits for physiotherapy and/or speech therapy, and the general advice given to parents have been of great value to the pre-school child.

Group meetings for parents of pre-school children have also been initiated with a gratifying response. The first meeting was held in an afternoon when parents were able to meet other handicapped children and their brothers and sisters. This was followed by two evening meetings, one where methods of training spastic children were discussed and the other where the physiotherapists, speech therapists and nursing sister spoke about their work with the pre-school child and discussed the role of the parents. Practical aids were also demonstrated on this occasion.

The work of the four physiotherapists at the unit was augmented by a student physiotherapist from West Middlesex Hospital. Each half term one student therapist received six weeks' training at the unit and both the students and the staff of the unit have found the arrangement valuable. In the early part of the year the physiotherapists were able to start training the children in school sports, field events and archery. In the Summer they organised the first school sports day and subsequently entered some of the children for the British Sports for the Disabled at Stoke Mandeville Hospital. This proved a very successful venture and a number of first and second prizes were collected.

During the year half the children at the school were receiving speech therapy. About one third of these children had severe speech defects caused by cerebral palsy, mainly spastic and athetoid dysarthia and dysphasia. Other speech defects treated included dysphasia, dyslalia, delayed speech and language development and stammering. The new purpose-built rooms made treatment more enjoyable for both child and therapist.

Surgeons have been operating on children born with spina bifida and meningomyelocoele for some years now and the number of referrals for this handicap to the Medical Advisory Unit and in turn for admission to Martindale School, has increased. The number of cerebral palsied children seen at the unit also increased, whilst incidence of other types of handicap remained approximately the same.

The following table shows the type of handicap dealt with at the unit during the year—

	Martindale School Pupils	*Outpatients*
Cerebral palsy	61	19
Spina bifida with paraplegia	9	11
Brain tumours	3	–
Meningitis and encephalitis	2	–
Poliomyelitis	7	–
Muscular dystrophies	12	–
Haemophilia and allied conditions	9	–
Congenital heart disease	8	–
Other physical handicaps	7	5

Child Guidance Clinic

I am grateful to Dr P Calwell MB BS DPM for submitting the following information—

'This year showed a considerable number of changes in the clinic. Dr Levinson who had been medical director from January 1962 resigned in April 1966. During the four years he was medical director there was a steady increase in the number of cases referred to the clinic, and this trend continues.

Dr Levinson, before he left, put forward recommendations for an increase in staff, and a number of these were approved by the appropriate committees during the year.

I succeeded Dr Levinson first as locum and subsequently as medical director. Miss J W Robertson, psychiatric social worker, joined the clinic staff on a full-time basis, replacing Mrs Westland. We were also sorry to lose Miss Haynes who had been with us longer than

any other member of the clinic staff, and had given most valuable service.

Mrs Henry was appointed as part-time psychotherapist and this appointment was most welcome as there is an acute shortage of psychotherapists and a great demand for their services. Not more than twenty children could receive once weekly psychotherapy. This meant in fact that in many cases the emphasis had to be on the difficulties within the families which were dealt with by the psychiatric social workers.

The liaison with other agencies which Dr Levinson started with the probation officers was continued by closer co-operation with the Children's Department, and the introduction of seminars for school medical officers and health visitors.

Mrs Lees took part in the persistent non-attenders working party.

The analysis of referrals below shows that the majority of children are still referred from the school situation and a very small percentage indeed by the general practitioners. It is unfortunate that contact with the general practitioners tends to be very slight.

Source of referrals

Educational psychologist or school	86
School Medical officers	61
Parents	24
General practitioners	13
Other clinics, transfers etc	13
Children's Department	11
Probation Officers	8
Others	4
Total	220
Failed first appointments, or appointments refused or not now required	44
Waiting December 1966 for first appointment	33

The psychiatrist is responsible for the selection of children who require special educational treatment for maladjustment and for the general supervision of such children in attendance at Busch House School.

New cases seen by the psychiatrist

Behaviour	36
Stealing	15
Fears, withdrawn, depression, tics, nightmares, etc	15
School refusal	11
Enuresis	8
Truancy	7
Poor progress, deterioration of work, backwardness	6
Autism	2
'Care and protection'	2
Total	102
Recommendations—	
Treatment	19
Busch House (day school)	16
Residential schooling	12

The analysis of cases seen in 1966 shows that the largest group are behaviour problems, but as always in child psychiatry there is the problem of a great deal of overlap in symptomatlogy. It will be seen that only 19 cases were recommended for treatment, and 16 for day maladjusted school. These figures should be treated with great reserve as it was felt unrealistic to make recommendations for treatment or for maladjusted schools where places were not available or likely to be so.

Intensive work in child guidance clinics can only be carried on where there is a large staff. As only four psychiatric sessions were available throughout the year, very few children could be seen more than once or twice by the psychiatrist and this inevitably makes it difficult to serve a role in prevention as well as treatment.

The primary task of a child guidance clinic has never been made clear. The more successful a clinic becomes in dealing with cases the more referrals occur, which in time tends to lead to considerable delays in treatment and dilution of the services offered.

The Regional Hospital Board has been requested to second more psychiatric sessions and the borough council is being asked to approve the direct appointment of a psychiatrist for two sessions a week.'

I am grateful to Dr Tyson BA BSc (Econ) PhD for submitting the following report—

'Work has continued during 1966 on the lines laid down and developed in 1965, when the position of senior educational psychologist for special schools and special units was first created. There has been much interest in educational fields in this appointment, the first of its kind in the country, and it is possible that some authorities may follow suit in the future, where special educational provision is as geographically close and yet comprehensive as it is in Hounslow.

In the special schools, the work of diagnosis and assessment for purposes of educational guidance and occasionally placement has continued, as also has the development of pilot research projects: this has included the further development at Martindale School (in collaboration with members of the University of Surrey) of electronic equipment to help children with visuo-motor difficulties, and a tentative exploration (with a principal lecturer in movement from a college of education) of assessment of personality difficulties in deaf children by means of movement observation.

Numerous talks and lectures were given, some within the Borough of Hounslow to teachers or parent-teacher groups, and some elsewhere including lectures at an ILEA one-day conference on the neurologically handicapped child, at a meeting of the Society of Teachers of the Deaf, at the University of London Institute of Education, at the annual meeting of head teachers and wardens of Shaftesbury Society schools, and at the Spastics Society college at Wallingford, Berkshire. The senior psychologist also participated in a brains trust held at the Nuffield Speech and Hearing Centre in Gray's Inn Road.

A few days in the summer term were devoted to acting as external examiner of teaching practice for the two-year course for teachers of mentally handicapped children conducted at Chiswick Polytechnic. This provided a valuable opportunity not only to observe the most up-to-date approach to the education of severely sub-normal children, but also (by courtesy of the supervisors) to see many junior training schools administered by other authorities'.

Publication by member of the staff

Body Image and Draw-a-Man Test on Cerebral Palsy

A paper by Dr M L J Abercrombie Bartlett, School of Architecture, University College Hospital and Dr M C Tyson Senior Educational Psychologist for the borough was published in 'Developmental Medicine and Child Neurology' on 1st February 1966.

The authors, both of whom were formerly at the Paediatric Research Unit, Guy's Hospital, give an account of their observations made in administering the Goodenough 'Draw-a-Man' test to estimate the mental ages of cerebral palsied children. They summarise their findings as follows—

'The mental ages of 24 cerebral palsied children as estimated by the Goodenough Draw-a-Man test were similar to those estimated from copying simple figures. It is concluded that performance on the Draw-a-Man test does not give evidence of 'body-image' disorder but of a difficulty of drawing generally.

Drawings of a man by normal children often show peculiarities which might be regarded as signs of physical impairment. It should not be concluded that cerebral palsied children represent specific physical impairments in their drawings unless they consistently show these more frequently than do normal children of the same Goodenough mental age.'

The tests were made in the course of other research at Martindale School for the Physically Handicapped.

School Psychological Service

I am grateful to Mr B R Barnett MA for submitting the following report—

'There continues to be a close liaison and co-operation between educational psychologists and the school medical services. The case conference method of dealing with children's problems has perhaps been utilised less than one would have hoped but this seems to be the result of staff changes on both sides as well as the intense pressure of work.

A working party on persistent non-attendance was formed at the request of the Education Committee and convened by the Chief Education Officer. It consists of the senior representatives

of the social services and the senior psychologist acts as chairman. I would like to express my thanks for the continuing co-operation of the medical department who are represented on the working party by Dr Wilkinson and Mr Sanger. The work has involved frequent attendance at meetings and a large amount of routine work involved in tracing and co-ordinating the medical records of 100 absentee children. The end product has been extremely useful to the working party. The medical department's resources have also been made available for the copying of graphs and articles of interest, help for which I have been most grateful.

The request for an appointment of a social worker to the School Psychological Service was first made in 1965. This has now been approved and an appointment is shortly to be made. The appointment will be made through the medical department and the social worker seconded to work attached to the School Psychological Service. The social worker will be concerned mainly with casework of parents of children showing severe learning problems and having individual remedial treatment or placed in a remedial centre or special class. Once again I wish to express my thanks to the Principal School Medical Officer for his help and encouragement in achieving this important appointment.'

The number of referrals to the School Psychological Service during 1966 was—

Behaviour problems	59
Learning difficulties	182
Others	70
Total	311

Handicapped Pupils

The Education Act places on local education authorities the duties of ascertaining which pupils in their area are handicapped and of providing special educational treatment for such pupils. The several categories of pupils requiring special educational treatment are defined in the Handicapped Pupils and Special School Regulations as follows—

Blind	Epileptic
Partially sighted	Maladjusted
Deaf	Physically handicapped
Partially hearing	Suffering from speech defects
Educationally sub-normal	Delicate

For the purposes of these regulations, ascertainment applies from the age of two years. A blind or deaf child must be educated at a special school unless the Minister approves otherwise.

Special educational treatment for other handicaps may be provided in an ordinary school with the stipulation that the special educational treatment must be appropriate to the disability.

The number of ascertained handicapped pupils and the arrangements made for their special educational treatment are shown in the table overleaf—

Handicapped Pupils requiring education at Special Schools approved under Section 9 (5) of the Education Act 1944 or Boarded in Boarding Homes

During the calendar year ended 31*st December* 1966		*Blind*	*Partially sighted*
A. Number of handicapped children who were newly assessed as needing special educational treatment at special schools or in boarding homes		1	–
B. Number of children newly placed in special schools (other than hospital special schools) or boarding homes			
a. Of those included at A above		1	–
b. Of those assessed prior to Jan 1966		1	–
c. Total newly placed B(a) and (b)		2	–
C. On 19th January 1967			
a. Children requiring places in special schools other than hospital special schools	day	–	–
	boarding	–	–
b. Children included at C(a) who had not reached the age of 5 were awaiting	day	–	–
	boarding	–	–
c. Children included at C(a) who had reached the age of 5 but whose parents had refused consent to their admission to a special school, were awaiting	day	–	–
	boarding	–	–
d. Children included at C(a) who had been awaiting admission to special schools for more than one year	day	–	–
	boarding	–	–
D. On 19th January 1967 the following number of children from the Authority's area—			
a. Were on the registers of—			
Maintained special schools (other than hospital special schools and special units and classes not forming part of a special school) regardless by what authority they are maintained	day	–	12
	boarding	–	–
Non-maintained special schools (other than hospital special schools and special units and classes not forming part of a special school) wherever situated	day	–	–
	boarding	5	–
Independent schools under arrangements made by the authority		–	–
b. Were boarded in homes and not already included in D(a)		–	–
Total D		5	12
Number of children who are awaiting places or who are receiving special education in special schools or who are boarded in homes—Total of sections C(a) and D		5	12
E. On 19th January 1967—			
The following number of handicapped pupils (irrespective of the area to which they belong) were being educated under arrangements made by the authority in accordance with Section 56 of the Education Act 1944			
a. In hospitals		–	–
b. In other groups (eg units for spastics, convalescent homes etc)		–	–
c. At home		–	–

Deaf	*Partially hearing*	*Physically Handicapped*	*Delicate*	*Maladjusted*	*Educationally sub-normal*	*Epileptic*	*Speech defects*	*Total*
1	4	6	19	15	39	–	–	85
1	2	3	11	9	16	–	–	43
2	1	3	2	9	16	–	–	34
3	3	6	13	18	32	–	–	77
–	2	3	5	3	27	–	–	40
1	–	–	2	3	–	–	–	6
–	1	3	–	–	1	–	–	5
1	–	–	–	–	–	–	–	1
–	–	–	–	–	1	–	–	1
–	–	–	–	–	–	–	–	–
–	1	2	–	–	3	–	–	6
–	–	–	–	1	–	–	–	1
14	15	31	29	44	130	–	–	275
–	–	1	21	8	15	–	–	45
–	–	–	–	–	–	–	–	–
3	1	2	1	7	4	1	1	25
–	–	1	–	16	2	–	–	19
–	–	–	–	–	–	–	–	–
17	16	35	51	75	151	1	1	364
18	18	38	58	81	178	1	1	410
–	–	–	–	–	–	–	–	–
–	–	–	–	–	–	–	–	–
–	–	1	–	–	1	–	–	2

During the calendar year ended 31st December 1966—

Number of children who were the subject of new decisions recorded under Section 57 of the Education Act 1944	Nil
Number of reviews carried out under the provisions of Section 57A of the Education Act 1944	Nil
Number of decisions cancelled under Section 57A(2) of the Education Act 1944	Nil

Some handicapped children suffer from more than one disability, eg physically handicapped and partially hearing, epileptic and educationally sub-normal, but are classified in the table under the major handicap.

The following special schools for handicapped pupils are maintained by the Education Committee. Although these schools are attended principally by children who live in the Borough, children from other areas are admitted by arrangement with their local education authorities.

Busch House School (Isleworth)
This school was opened in 1938 as a day open air school for 140 delicate pupils. In 1964 it was adapted to take delicate children and children suffering from minor degrees of maladjustment and the total accommodation reduced from 140 to 100.

A medical officer visits the school weekly to supervise the delicate children and deal with any minor ailments, to maintain close liaison with the head teacher in regard to pupils in the school and to make recommendations for admission or discharge.

The psychiatrist from the Child Guidance Clinic spends one session weekly at the school and the services of the educational psychologists and psychiatric social workers are available.

At the end of the year there were 48 delicate and 52 maladjusted pupils in attendance. The majority of the delicate children require daily treatment and a physiotherapist attends every morning.

Martindale School (Hounslow)
This is a day school for physically handicapped children with accommodation for 110 pupils.

Furniture and apparatus capable of being adapted to the needs of the pupils is in use and facilities are available for hydrotherapy, physiotherapy and speech therapy. The majority of the pupils suffer from cerebral palsy and many are dependent on wheel chairs for locomotion. Close co-operation between the teaching and medical staff is necessary to secure a reasonable balance between the educational and treatment needs of the child and to make the best of his physical and intellectual potentials. Many of these children have learning difficulties and here the services of the senior educational psychologist are particularly useful.

Heston School for the Deaf (Heston)
This day school, with its associated classes for the partially hearing in Townfield and Harlington Secondary Schools, Springwell Infant, Springwell Junior, Norwood Green Infant and Norwood Green Junior Schools provides accommodation for 130 deaf and partially hearing pupils. The medical officer to the Hearing Clinic gives general medical supervision of these pupils and there is full discussion of hearing and learning difficulties between the clinic and teaching staff.

Marjory Kinnon School (Bedfont)
The Old School, Bedfont, was renamed The Marjory Kinnon School in October as a tribute to its first headmistress who retired this year.

This day school for educationally sub-normal pupils has accommodation for 160 children and at the end of the year had 105 boys and 55 girls. Weekly visits are made by a medical officer to provide general medical supervision and for consultation on specific problems as they arise among the pupils, of whom a proportion suffer from some physical disability. Leavers' conferences with the Head Teacher and Youth Employment Officer are held twice yearly and the medical officer of the Mental Health Department is consulted where it is thought that some follow-up and guidance after leaving school may be necessary. The school maintains contact with the Kitson Youth Club for Handicapped persons

which is run by a former pupil of the school.

The waiting list for this school has increased enormously since the boundary changes of the Greater London Area took place, and now plans are going ahead for the provision of more classrooms to accommodate a further twenty children.

Special Education for Retarded Children and the Marjory Kinnon School

by Betty P Westworth MB ChB(St A) DObst RCOG
Part of the dissertation submitted for The University of London Academic Postgraduate Diploma in Public Health 1967

The Old School, Bedfont
(Renamed The Marjory Kinnon School in 1966)
'This school began in 1953 at the old village school in Bedfont, Middlesex. A modern primary school had been built next to it and the local children between five and eleven years enjoyed the new facilities it offered. Rather than demolish the old buildings it was decided to use them for backward children then living in the south-west Middlesex area. Before this the only special education provided had been one class in a primary school at Spelthorne. On January 7th, the teacher of that class was appointed deputy head of the Old School and moved with her eighteen pupils to Bedfont. The head mistress appointed was Mrs Marjory Kinnon who had already had twenty-one years of teaching experience and the majority of this had been with mentally handicapped and slow learning children. Within ten months of opening the school she increased her staff to seven teachers and had one hundred children on the school roll. The numbers grew to 140 children in 1957 and following the erection of a timber annexe in 1963 the total roll increased to its present number of 160. There are twelve teachers in addition to the head and the age range of children is from five to sixteen years. Five of the teachers have additional qualifications for teaching handicapped children and their average length of teaching experience is over twenty years.

I was appointed medical officer to the school in 1961 when the local health authority was Middlesex Area 10, and received a warm welcome from all the staff on my arrival. I was soon accepted as a member of the team and during my weekly visits developed a close understanding with staff and pupils alike. To begin with I am sure that I learned far more from my visits than they learned from me but because of their help a very pleasant equilibrium was soon established. My contacts with the children's parents also developed and during our discussions the same question kept re-appearing, 'Why is it my child, doctor, who is handicapped?' I did not know the answer so decided the least I could do was to try and find out—so my survey began.

I grouped the children according to age and sex and also according to home address (Table 1). This latter division became more important when Middlesex county council gave way to the Greater London council for the old Area 10 was divided into three segments. The Feltham/Bedfont area joined the London Borough of Hounslow, the Twickenham area joined Richmond, and the remaining Staines/Ashford/Sunbury area was absorbed by North Surrey. Prior to these changes in 1965 the Old School had always received educationally subnormal children over eleven years of age from a junior ESN school at Hampton but although this was now under the jurisdiction of Richmond the transfers did continue. This fact, however, will explain the greater number of senior boys and girls in the school.

My next aim was to divide the children into the five social classes (as used in the Registrar General's statistical publications), according to the present occupation of their father, or mother if father was not known, eg illegitimate children. In this way it is shown that this school would appear to have a more representative cross-section of the population than is found in some ESN schools in poorer urban areas, but I could not find statistics for comparison. (Table 2)

In addition to noting the many and varied additional handicaps that the children had, I also separated those children who had experienced some hazard that might place them more at risk to any handicap. The difficulties experienced here were at times acute for the majority of information available about their mothers'

pregnancy, delivery, and the pupils' early childhood was retrospective in nature. Mothers' memories can be extremely inaccurate and this was proved so when facts that they had given me independently were checked with available health visitor or hospital records made at the time of the event. A family history was also carefully examined but frequently the only details obtained were again from the child's parents and any feeling of guilt or shame would naturally lead to repression of the truth.

Of the 151 children whose histories were known, ninety-seven were reported to have had delay in their developmental milestones, that is, they were not walking unaided or saying recognisable words by eighteen months.

Of the remaining fifty-four children whose milestones were said not to be delayed the distribution in social class was as follows—

Class I	0
Class II	3
Class III	19
Class IV	13
Class V	19

Left handed children ie those who write with their left hand

The number of these children in the school was thirty-three in 1964 when the survey was started but in January 1967 was only thirty. Of these twenty were boys and ten girls. This is the normal ratio that one gets because it is known that there are more left handed boys, and more boys who have reading difficulties.

Table 1

Numbers on School Roll, January 1967

Under 8 years	8
9–11 years	40
12–14 years	63
15–16 years	47
Total	158

Home Address	*Boys*	*Girls*
Hounslow	53	20
Richmond	17	9
North Surrey	33	22
Ealing children in care	–	2
Brent children in care	1	1
Total	104	54

Table 2

Social Class	*No of children*	*Expected No of children*
I	3	3
II	11	15
III	57	57
IV	39	21
V	41	12
Not known (ie children in care)	7	–
Total	158	108

The expected rate was calculated from the proportional numbers given in the Registrar General's statistical publications, and shows the increased numbers of children belonging to Social Classes IV and V.

Table 3

Additional Handicaps

Epilepsy	4 (plus 11 with history of convulsions)
Cerebral Palsy	5
Down's Syndrome	2
Phenylketonuria	1
Hypothyroid	5
Hydrocephalic	2
Microcephalic	2

Other congenital abnormalities	9
Dystrophia Myotonica	1
Defective vision (no glasses)	6
Defective vision (with glasses)	22
Defective hearing (no aid)	27
Defective hearing (with aid)	3
Receiving speech therapy	35
Receiving treatment at Child Guidance Clinic	14

Table 4
Routine audiometry figures for children tested in the London Borough of Hounslow during 1966

	No tested	*No failed*	*Percentage failed*
Normal Schools	4,650	178	3.8%
Marjory Kinnon School	44	7	16%
Junior Training Centre	81	25	31%

Table 5

*Children who experienced hazards, placing them 'at risk' (*These hazards include conditions listed below)*

Social classes	I	II	III	IV	V
Children 'at risk'	3	6	21	14	7

This may be compared with the distribution of children in the school into social classes (Table 2) ie

Social classes	I	II	III	IV	V
Children 'at risk'	3	11	57	39	41

*

Cerebral Palsy	Meningitis
Hydrocephalus	Asphyxia at Birth
Microcephalus	Prematurity
Hypothyroidism	Twins
Down's Syndrome	Forceps Delivery
Phenylketonuria	Breech Delivery
Hypercalcaemia	Caesarian Section
Convulsions	

It will be seen that a higher proportion of the children in the upper social classes experienced hazards either ante-natally or in their early years.

The Problems of a Day ESN School

The motto of the school is 'I can if I will' and this is a symbol of the aims for every child to follow. The staff always try to give the children encouragement and confidence to attempt things which may at first seem beyond their capabilities. The system of motivation aims to help the children to achieve social adequacy and to believe in themselves, and at the same time perhaps attain a reasonable and serviceable basic educational level to the limit of their ability. This is done by setting the children a series of goals which are attainable without too great difficulty so that they may experience the satisfaction of success. It may be considered as a form of 'programming'.

The home background of the children is very important for the attitude of the parents to the school will greatly influence the child. It is vital in a special school that parents should contribute towards the motivation of their child and encourage him to develop good work habits. It was not difficult to establish a thriving parent/teacher association, but at Bedfont the scope has been widened to form a 'Friends of the School Association'. This now includes parents of past and present pupils and others interested in mentally handicapped children, and provides an informal background for discussion on many topics. The relationship between the staff and some parents can, however, be difficult, especially

where the parents themselves are inadequate. Frequently they are those who have large families and experience considerable economic difficulties in their efforts for survival. To them, the concern of their child's education is at the bottom of the list of priorities unless he should get into trouble with the law, and then they may be quick to blame his lack of schooling as the cause. In contrast there are other parents who appear to provide every material need for their son or daughter, but still will make no effort to help them or understand their difficulties. Such rejection by the parents can severely hinder any efforts made by the school.

The teaching staff of any special school require the support and advice of visiting 'experts'. In an ESN school the most important member of the ancillary team is the educational psychologist for she is the one who diagnoses the specific disabilities that affect the children and is best qualified to suggest practical help, for example where there are perceptual problems or crossed lateralities. The medical officer in addition to closely supervising the general health of the children, can explain to the staff the manifestations and symptoms of any chronic conditions such as 'phenylpyruvic oligophrenia' or 'dystrophia myotonica' to mention just two dreadful-sounding syndromes! The doctor should also keep in constant touch with other 'specialists' who have an interest in the children. In addition to hospital specialists these include the speech therapist, physiotherapist, audiometrician, peripatetic teachers, dentist and others who visit the school to help the pupils. Liaison between school and home is also instigated by the medical officer who generally knows personally the health visitors who visit the homes and can get first-hand information from them about any particular problems that arise. In some schools one social worker specially appointed for this work can cover the duties carried out by individual health visitors and all the educational welfare workers and so avoid duplication of work and replace it with a unified approach. Also she can cover the work at present done by children's officers and probation officers, help to ensure co-operation, and so increase efficiency and economy.

The welfare assistant or school nurse also holds a very important position within the school and is generally a trained nurse. She is the one who is urgently summoned when an epileptic has a fit, and it is she who is in charge of all the drugs administered to the children during school hours. Unlike her opposite number in ordinary schools she is not occupied solely with grazed knees and tummy-aches, but has to supervise any special diets needed for the children and see that they do receive them. She maintains close liaison with the local school nurse and helps with routine medical inspections, vision testing and dental visits. She also needs to make time available for close scrutiny of the children in various situations such as physical activity, to notice any particular difficulties. A quick screening for plantar warts is often carried out by her at the swimming baths, and any cases excluded for treatment.

Mention was made previously of the difficulties that can arise in a special school for children with multiple handicaps. For this reason it is necessary to have frequent contacts between staff of the various units for exchange of ideas. Meetings of the children, however, are not practical, and when it comes to games and sport it would be unfair to ask them to compete with children attending normal schools. For this reason it is very difficult to arrange competitions or matches, for other ESN schools are always sited a long distance away. As a result the school as a community suffers from some isolation, but attempts to overcome this are made by arranging frequent visits to places or items of interest. A recent experiment has been tried with competitions arranged with C and D streams of local schools and the results appear promising. The younger children also go to the zoo or agricultural shows and the older ones to London and visit places of employment like laundries, bakeries or small manufacturing firms. The outings all help to widen their horizons and increase their experience in the outside world.

During the final two years at school the visits form part of a pre-vocational scheme where the pupils are introduced to new experiences similar to those they will meet after leaving. Specific aspects of working life such as time-keeping, work cards, factory rules, are discussed and the functions of employment exchanges in relation

to changing jobs and attending for interviews are explained. Leisure activities, relationships with the opposite sex, and personal budgeting are also important items on which these children need help and guidance. It is important that the visits to factories and other similar places should provide a true picture for the children so that they may for themselves experience the noise and dirt, and the constant activities in which they might later become a part. If there is already there an ex-pupil from the school it will help the children to identify themselves more closely with the situation.

Delinquency is always a very real problem at an ESN school for in addition to those who come from deprived homes where moral standards are lacking and ignorance prevails, many of these children are easily led by children brighter than themselves. They are unaware of the advantages that people take of them and are too slow to excuse themselves out of suspicious circumstances. The head teacher needs the closest co-operation from the probation officers and together they can often help the child and his family before matters get out of hand. The spheres of action of an ESN school cannot be limited by the school gates.

The Products of an ESN School

The Mental Health Act of 1959 introduced one important change in procedure for dealing with ESN children. Ever since education of feeble-minded children became compulsory in 1914 it had been the duty of all education authorities to notify the mental deficiency authority of all children leaving special schools at sixteen who would need further care and supervision. This statutory supervision was abolished by the act in 1959 and local authorities no longer have a duty to notify leavers from special schools. The children themselves, however, have not changed and most of them can benefit enormously from some form of after-care during this very critical stage of transition from school to work. The child is moving 'from a society which has been geared to his individual needs, and in which he has been taught and guided by trained personnel, into one which probably expects standards of achievement without regard to his individual capacities. His connection with adults who understood him and whom he could respect and lean upon will be broken and new associations made. He will be parted from a group composed of individuals with somewhat similar inadequacies and feelings to his own and will now have to meet, in an extremely different setting, the demands of a more mixed group. These demands may increase his feelings of inadequacy, loneliness and frustration, and make apparent to others his general immaturity.' (1)

The attitude of the child's parents is extremely important and will influence him greatly. With the poorer families if the wage is good then the job is good, whether or not the child is suitably placed. At the other extreme the parents may be most fearful of exposing their child to the rigours of the adult world, having over-protected him since birth. Their attitude that there is no real need for him to work may mean that they have no confidence in the child's abilities and this certainly spoils any chances of success. It is understandable that they do not wish the child to be exploited or ridiculed but how proud the child becomes when he arrives home after earning his first wage packet, proving his ability to compete with the world.

Choice of employment is always very vital when a child leaves an ESN school. Many months before the break is made, the youth employment officer (YEO) visits the school to interview the child and see specimens of work accomplished. Following this it is then most satisfactory to have a case conference with all the interested parties participating. The psychologist and medical officer will submit their reports and the head teacher will complete the portrait of the child. The possibilities and limitations are then discussed with the parents who in turn make suggestions of the type of work they feel would suit their situation. Perhaps the most important consideration is to choose a place where the chances of the child succeeding are very high. They can always proceed for promotion but failure is a tremendous setback and leads to loss of motivation. The capabilities of the child must be matched with a sympathetic employer who has the patience to wait longer than usual for the child to learn his job and become competent within his limited field. The YEO is most knowledge-

able about these employers and keeps in close touch with them.

The type of work chosen will, of course, depend upon the facilities available locally, but laundry work and packing is generally popular with the girls and for the boys labouring and cleaning with car firms, delivery work, gardening, and warehouse work all come within their scope. For those who are felt not yet ready for employment a further year at school may be recommended, or else advantage taken of sheltered workshops or assessment centres provided by the Mental Health department. These facilities, however, tend to be used as a last resort, for every effort is made first to get some occupation however simple for the child. This is essential if he is finally to achieve full integration with the community and not remain for the rest of his life segregated from the 'normal'.

It has been suggested (2) that the practice of specialist youth employment officers for handicapped school leavers be extended and their services be made available to other youth employment officers, in an advisory capacity. This would result in the extension and development of the existing training facilities, but in rural areas this might be economically impracticable. As soon as a special school is established in an area the youth employment officers know what will be asked of them and when the relevant information concerning the child is supplied to them they are very conscientious in their duty.

Very few leavers from ESN schools should be totally illiterate and at Bedfont the average reading age is between eight and nine years. They can also generally deal with the practical money problems up to one pound, but there are exceptions to both groups. These may be children who were admitted in their teens, or who have been very poor attenders, but a proportion of them do have specific learning difficulties. At sixteen they are not, however, incapable of further learning, and evening courses are arranged for them at a local school alongside other types of evening classes. These small groups are taken by teachers from the Old School and so there is no break in continuity for the pupils, and surprising improvements are achieved when reading and money matters assume greater practical importance in their working lives.

There is always a small proportion of children who are 'in care' with the children's department and these always have problems that are peculiar to themselves. Their early history is generally either very vague or quite absent and their lack of roots often leads to additional behaviour problems. Wherever possible the children's home will be unchanged when the child starts employment so that too many changes do not occur simultaneously. This always has fewer problems with girls than boys for they more easily fit in with the house mother and her female staff who help with the younger children. Hostels provided for ESN leavers may be many miles away from the school so if the child is moved he is put into a completely new environment with new faces and the new situation of work, and with no contact with people or places familiar to him. It is really hardly surprising then that delinquent tendencies emerge after such changes.

It is so often found that an adolescent with quite limited ability but with a stable and sympathetic home environment will succeed and remain in a single job and eventually become self-supporting. A relatively less dull boy with a poor deprived home, however, may pass through innumerable situations, eventually becoming work-shy and turning delinquent. Once an ESN child gets into court the chances of him going into residential care—ie an MD hospital, are very high and naturally the chances of a child already in a hostel are even greater. The dice then are really loaded against him.

Birmingham was the pioneer of after-care for the ESN child, for their committee has been in existence since 1901. All leavers are placed under either voluntary or statutory supervision and this is effected by an after-care officer and social workers until the age of twenty-one is reached. After this any cases still requiring support are handed on to the mental health committee and its officers. These arrangements were initiated because it was realised that the most difficult years for the school leaver were those immediately after leaving school. Although no such committee exists at Bedfont there has been long established a youth club for the school where informal supervision can occur. It is situated about two miles

away but is conveniently sited for evening public transport. Children are allowed to join after fifteen years but it often takes some months before they summon enough courage to attend. The club meets weekly and although some of the teaching staff attend, outsiders are not excluded. Members are allowed to bring a friend and the usual types of club recreation are organised. The present leader is a twenty-one year old ex-pupil of the school and he is proving an excellent worker, interested in all aspects of the club. There is no upper age limit so it does provide some form of link with school after the child has left. Here he knows all the faces and when informal advice is needed there is no extra effort required to get it. An annual reunion or party is also arranged and past pupils look forward to contact with old friends, some arriving with husbands or wives and even their children!

The ultimate success comes to these individuals when they achieve steady employment in a suitable situation and so become adequate personalities able to compete with others in everyday life. They learn to take on the responsibilities of marrying and having children, although for this some of them will require some degree of support throughout life. It is so important to prepare the children before they leave school so that they know how and where they can get help if they need it. The girls meet health visitors and go to welfare clinics so that they can understand the reasons for their functions. They also discuss how they can turn to such personalities as their own G.P. or their local cleric if they need advice, and also they meet and are given the address and telephone number of their own mental health officer who will be with them in the years ahead. He generally visits the child's home and introduces himself to the parents before the child leaves school so that reasonable continuity of care can be maintained.

The Future Outlook

A number of comparative studies on special education have been carried out in efforts to assess the benefits to the handicapped child, but no general conclusions have yet been reached. The apparent increase in numbers of ESN children is indicated by the fairly constant figure of those awaiting placement in spite of the increase in the number of available places. One possible cause for this rise may be the current demands made by our present educational system, for as our society becomes more complex and technological, so the dividing line between normality and sub-normality will be drawn higher and higher.

The first region towards which efforts need to be made then, is within our normal educational system so that it can contain and help those children who experience learning problems in their early school years. Only by increasing the scope of remedial classes can these children be helped and of course this demands an immediate increase in the number of teachers within the infant and junior schools. Surely the resources of the many ex-teacher/mothers could be tapped for such part-time specialised tuition. Again, with the advent of comprehensive schooling for senior children, would this not be the opportunity to widen the scope of the schools for the border line ESN and 'dull-normal' children? Special classes for ESN children have existed in normal schools in Scotland for many years now. The wide range of subjects within the comprehensive schools should make it possible for less severely handicapped children to receive the special instruction and treatment which they need within that setting. Certainly the facilities for practical subjects such as metal work and housecraft are most likely to be available in the large comprehensive schools. It is likely that in the future more and more handicapped children will be contained within the normal school system rather than in special schools.

The more severely handicapped children, however, will still need to be separated into special units so that they can derive the most possible benefit from their education. It may well be though, that in the near future the severely sub-normal children will be admitted into the educational system, so abolishing the previous dichotomous system that has little merit. For all children to be looked after, taught or trained by one department is not unreasonable. Why should qualified teachers be excluded from training centres or schools? And why should they not be inspected by visiting ministry officials?

To unify this system would surely increase the flexibility of its functions and lead to greater mobility within its boundaries.

With the rise in numbers of multiply-handicapped children, there will be increased demands for suitable provisions for them, and this in turn will call for modification of the various categories of special schools. Following the Rubella epidemic of 1962, more deaf-blind units have come into being to contain and help these children, born afflicted as a result of their mothers' ante-natal infection. More help is needed though, for such as the partially-sighted children with speech defects, and for the delicate ones who have specific learning problems. The comprehensive special school may well be the formula for the future'.

References

1. Tansley and Gulliford, The Education of Slow Learning Children, London. Routledge and Kegan Paul, 1960.
2. Report of the Working Party for the British Council for Rehabilitation of the Disabled, The Handicapped School Leaver, 1963.

Townhill Park (Southampton)

This residential school for educationally sub-normal girls has accommodation for 55 pupils. A school medical officer visits the school twice a year for a general inspection of kitchens, dormitories, etc, to discuss medical problems with the Matron and general progress of pupils with the Head Teacher.

Aftercare of handicapped pupils

Case conferences are called by the head teachers of the special schools and the Principal School Medical Officer concerned to discuss the special problems which arise when handicapped children reach school leaving age. The Youth Employment Officer and representatives of the Welfare Department attend, and, where appropriate, those representing voluntary organisations such as the Spastic Society and Fellowship for Poliomyelitis are also invited. Arrangements are fully discussed with the parents and where assistance from the Ministry of Labour's scheme for disabled persons is required this is arranged by the Youth Employment Officer.

Martindale School is fortunate in having a further education unit which is attended largely by its pupils who could not be satisfactorily placed on reaching the age of 16.

There remain always some children who are so severely handicapped that no employment is possible, and for these particularly the Welfare Department is able to provide help.

Education otherwise than at school

Consideration is given to providing home tuition to handicapped children awaiting admission to special schools, children having a long convalescence following acute illness, and others who for some specific reason may not be able to attend ordinary schools. Two children were provided with home tuition during the year.

No hospital special schools are provided at hospitals within the Borough but arrangements are made for children to have tuition in the wards at West Middlesex Hospital.

Children excluded from school as unsuitable

No formal decisions were recorded under Section 57 of the Education Act, 1944, excluding children as unsuitable for education in school, nor were any reviews conducted under the provisions of Section 57A or any decisions cancelled under Section 57A(2).

Four children, however, were found unsuitable to attend either ordinary or special schools and these were dealt with informally. Similarly one child dealt with informally was re-admitted to a special school.

Medical and dental inspection and treatment of children excluded from school as unsuitable

The medical and dental facilities are available to the severely sub-normal children attending the two junior training schools in the same way as for those attending ordinary schools. A physiotherapist attends each school about once a week to give treatment to those children in the special care units who additionally have severe physical handicaps, principally cerebral palsy. A speech therapist attends Isleworth Junior Training School once a week to treat a few selected cases and to instruct the staff in the

constant use of speech therapy techniques. It was also possible during the year to arrange for a speech therapist to attend Hanworth Junior Training School.

Day Nursery
In some cases physically and mentally handicapped children of pre-school age can benefit from the training and sheltered atmosphere and the companionship provided by a day nursery. Where recommendations are made for such admission for children over the age of two years, the cost is borne by the Education Committee under Section 56 of the Education Act 1944. Fifteen such children were admitted to day nurseries during the year.

School Meals and Milk

The provision of meals and milk in schools is now firmly established. The milk supplied is pasteurised and is given free. A charge is made for school meals.

A check on one day in September showed that of 26,741 pupils present in school 21,502 (80%) had milk and 18,565 (69%) had dinners. There are 46 school kitchens and children are provided with dinners by a container service at 25 dining centres.

The number of non-maintained schools taking milk was 13 and 77% of the pupils participated. Further education establishments were not included in the check on this occasion.

Recuperative Holidays

During the year the borough council accepted responsibility under Section 48 of the Education Act 1944 for the maintenance of thirty-four children in recuperative holiday homes. Twenty-five were admitted to such homes and nine were cancelled or withdrawn.

First Aid in Schools

First aid material is held at all schools and is limited to simple dressings.

Infectious Diseases

The following numbers of cases of infectious disease are known to have occurred among school children during the year—

Scarlet fever	67
Measles	294
Whooping cough	10
Pneumonia	2
Food poisoning	1
Tuberculosis	3
Chickenpox	687
Mumps	819
German measles	88
Post-infectious encephalitis	4
Meningococcal infection	1
Malaria	1

There were no cases of diphtheria or poliomyelitis. When pulmonary tuberculosis is found in a pupil or teacher the Chest Physician is consulted and where considered advisable, investigations of school contacts are undertaken. School children between their thirteenth and fourteenth birthdays, are offered a test for susceptibility to tuberculosis and BCG vaccination. During the year 1,132 children received BCG vaccination.

Health Education in Schools

There was an increased demand from head teachers for special talks from health department staff.

Talks, followed by discussions, were given to children attending senior schools on the following subjects—diet, rest, exercise, body hygiene, family and human relations including sex, venereal disease, smoking, drugs, alcohol and the medical services available to young people at work.

The question of drug taking was discussed with the chief education officer and the consultant psychiatrist at the Child Guidance Clinic. As far as we are aware, there are no cases of drug taking by school children or students in this borough. Undue publicity has therefore not been given to this subject as it was considered that propaganda might stimulate curiosity and tempt young people to experiment with drugs.

Incidence of persistent non-attendance at secondary schools in the borough

A working party consisting of the children's officer, the deputy medical officer of health, the chief educational welfare officer, a senior educational psychologist, the senior probation officers and a psychiatric social worker at the child guidance clinic was set up to study the incidence of persistent non-attendance at secondary schools in the borough. Twenty schools participated and each head teacher answered a detailed questionnaire orally and sent in a list of persistent non-attenders in the autumn term of 1966, on an agreed criterion of under 80% attendance.

The working party was still examining material at the end of the year but the frequent discussions at the meetings of the working party and with head teachers had already borne fruit in a greater degree of understanding of the problems involved.

Student Health Service

Following preliminary discussions with the staff of the Education Department last year, a health service for students and staff at Chiswick and Isleworth Polytechnics came into operation during the Summer term of 1966. This is in step with a mainly post-war development whereby all universities in Great Britain established such services, having received an impetus from the general realisation of the number of psychiatric difficulties and suicides occuring in some colleges.

It has been found that approximately 5% of all students have psychological disorders which cause serious distress and prolonged handicap. A further ten to twenty per cent have minor, but in practice important, disorders which are often transient but may need skilled help if interference with effective study is to be lessened.

Overseas students coming to this country have additional problems such as difficulties of communication, personal finance, lodgings, nutrition, clothing in relation to the climate, and differences in life and customs. Stress arising from factors such as these may give rise to psychological illness requiring early detection and treatment.

The approximate student population of Chiswick Polytechnic is 3,600 of which 600 are full time and 3,000 part time, and of the 2,500 students at Isleworth 500 are full time and 2,000 part time.

About one tenth of those at Chiswick and one third at Isleworth are from overseas.

Dr Broadbent, a senior assistant medical officer who is particularly interested and well qualified for this work, is responsible for the administrative and clinical work of the service, and attends each of the two colleges once every week during term. As the service has become known so the demand on it has increased and it is already evident that as soon as additional accommodation becomes available it will be necessary to support the medical officer and the two welfare officers and student tutors by recruiting a nursing sister and secretarial help. Such a team has already been accepted by students and staff and it is important that the activities and stresses of students are fully understood so that by early diagnosis psychological and social illness will be prevented.

So far this service is in its infancy, but when accommodation and staff become available it is envisaged that early in each academic year the college medical officer, as part of the induction procedure, would describe the student health service and give general advice to first year students on such matters as diet, rest, care of the eyes, posture, exercise and relaxation.

Students will complete a medical history form and be medically examined on a selective basis in time for any necessary investigations to be made not later than during their second term. Where illness is discovered students would be advised to consult a family doctor near to their home or lodgings with whom they could register.

All students would be advised to undergo a mass radiography chest x-ray and also an ophthalmic examination.

Students will have access to the college medical officer normally by appointment but this will be dispensed with where urgent problems arise. The medical officer will deal with the majority of the students' psychological problems but in any cases of special difficulty the services of the consultant psychiatrist, psychotherapists and educational psychologists are available.

Students are encouraged to be vaccinated or

immunised against the usual infectious diseases either at the college or by their family doctor.

Confidential medical records are maintained by the college medical officer and non-medical records will be kept by the welfare officer who will discuss students' problems freely with the medical officer at special case conferences.

A confidential register is also kept of students who are handicapped for example by diabetes, epilepsy and asthma and these are seen periodically to assess their progress and to give advice on health and welfare matters. It is estimated that four per cent of students attending polytechnics are physically handicapped.

Talks and lectures will be given to students, staff and parents by members of the health and welfare team on subjects peculiar to student life. Group discussions among the team, teaching staff and students are popular and will be extended when facilities become available.

It is envisaged that all health and welfare facilities will be made available also to academic and non-academic staff at the colleges.

The college medical officer is a member of the Safety Committee who appoint and train members of the teaching staff as safety officers who are able to give first aid to the injured.

The college medical officer gives advice to the polytechnic authorities on the working environment and also on safety in workshops and laboratories including radiological and toxic hazards which may arise. He advises also on food hygiene and control of communicable diseases.

The cost to the taxpayer of maintaining a student at a polytechnic is estimated at more than £500 per annum. Student waste due mainly to inadequate academic ability, social, family and mental health problems, is as high as fifty per cent in some colleges of further education so that if the student health service can prevent the loss of three or four students a year, the cost of the service is more than justified.

'Mankind is now in one of its rare moods of shifting its outlook.'

Report of the Principal School Dental Officer for the year 1966

The borough dental services continued to be handicapped by a shortage of suitably qualified dental officers, a difficulty which was faced by almost all other local authorities, and which had probably been exacerbated by the national wage policy which has caused the discrepancy between earnings of general dental practitioners, and the local authority dental officers to further increase.

Towards the end of the year the London Borough of Hounslow decided to improve the career structure of its dental service by creating a post for an additional senior dental officer, and an entirely new post of deputy chief dental officer. Authority was also given to release suitably qualified members of staff to attend a dental hospital for one session weekly, and it was hoped that these improvements in career structure coupled with a generous commencing salary, and accelerated increments might attract more newly qualified dental surgeons to the borough's service.

However, the newly qualified young dental surgeon leaves his dental school with high ideals. He is taught that his individual patient matters above all else, and that regular dental inspections should be received by his patients every four or six months. This poses a problem for the administrators of a dental service which is unable to fully meet its obligations. Clearly the aim must be to carry out a school dental inspection of every child at least annually. With insufficient staff this aim will most probably be achieved by providing full treatment for children seen following routine inspections carried out in strict rotation and restricting emergency treatment solely to the relief of pain.

A policy of treatment based upon 'The greatest good for the greatest number' is quite out of step with the teaching in our dental schools, consequently the younger dental surgeon feels that its pursuance is equivalent to lowering his professional standards. If it was known with certainty that such a stringent policy would need to be pursued for a limited period only, there would be little difficulty, but the school dental service has been inadequately staffed for more than half a century, and realists would find it difficult to predict any end to this malaise in the future.

At the present time therefore every effort is made to arrange regular six monthly dental examinations when this is requested by parents, otherwise our regular patients would receive a lower standard of dental care than if they had elected to receive their dental treatment in the general dental service. This must inevitably be reflected by a somewhat smaller number of routine school dental inspections than might otherwise be the case.

A high acceptance rate for treatment reflects the standard of the service but this in turn reduces the frequency at which schools can be inspected. This difficult problem is under continuous revue and it is pleasing to note that rather more children were inspected at school during 1966 than in the previous year.

The Borough Council endorsed fluoridation of drinking water at the March Council meeting.

A dental officer from the Department of Education and Science visited the borough on the 6th and 7th June and following his inspection a report was received from his department. This commented upon the subject of routine school dental inspections which has been discussed above. The borough dental service was found to be of a generally high standard.

During April the borough dental service received a visit from the president and secretary of the Federal German Dental Association who came to study the role of the dental auxiliary in the provision of dental care for children.

The future of the school dental service must cause concern to all responsible for its efficiency, but in the prevailing circumstances the London Borough of Hounslow took all possible steps to see that its service was maintained at as high a standard as possible.

Table 1 Medical inspection of pupils attending maintained primary and secondary schools (including nursery and special schools)

a. Periodic Medical Inspections

Age groups inspected (by year of birth)	*No. of pupils who have received a full medical examination*	*Physical condition of pupils inspected*	
		Satisfactory	*Unsatisfactory*
1962 and later	405	397	8
1961	1,672	1,656	16
1960	1,041	1,032	9
1959	496	488	8
1958	816	806	10
1957	460	442	18
1956	77	70	7
1955	881	880	1
1954	833	818	15
1953	244	234	10
1952	551	536	15
1951 and earlier	1,228	1,213	15
Total	8,704	8,572	132

b. Special Inspections

Number of Special Inspections	4,851
Number of Re-inspections	4,401
Total	9,252

Pupils found to require treatment (excluding dental diseases and infestation with vermin)

For defective vision (excluding squint)	*For any other condition*	*Total individual pupils*
3	52	51
48	168	197
46	90	131
15	30	41
52	79	122
47	52	78
11	12	17
43	77	115
73	108	157
50	66	88
47	71	98
137	116	236
572	921	1,331

Table 2 Defects found by Periodic and Special Medical Inspections

Defect or Disease		*Number of defects found at*			
		Periodic medical inspections		*Special inspections*	
		Requiring treatment	*Requiring to be kept under observation*	*Requiring treatment*	*Requiring to be kept under observation*
Skin		222	268	370	56
Eyes	a. Vision	572	767	200	190
	b. Squint	79	86	7	9
	c. Other	21	69	24	14
Ears	a. Hearing	83	306	56	197
	b. Otitis Media	23	115	11	7
	c. Other	49	112	37	23
Nose and Throat		71	421	30	100
Speech		57	143	24	28
Lymphatic Glands		3	78	–	9
Heart		9	167	6	32
Lungs		39	227	7	56
Developmental	a. Hernia	5	22	1	11
	b. Other	32	271	8	73
Orthopaedic	a. Posture	9	143	–	14
	b. Feet	90	298	39	94
	c. Other	47	174	22	40
Nervous system	a. Epilepsy	11	30	1	9
	b. Other	12	56	6	29
Psychological	a. Development	9	80	14	26
	b. Stability	28	349	28	188
Abdomen		7	62	1	13
Other		27	251	67	182

Table 3 Treatment known to have been provided by the Council, at Hospitals etc

Condition	*No. of cases known to have been dealt with*
Eye Diseases, Defective Vision and Squint	
External and other excluding errors of refraction and squint	161
Errors of refraction (including squint)	1,860
Total	2,021
Number of pupils for whom spectacles were prescribed	687
Diseases and Defects of Ear, Nose and Throat	
Received operative treatment	
a. for diseases of the ear	–
b. for adenoids and chronic tonsillitis	–
c. for other nose and throat conditions	–
Received other forms of treatment	168
Total	168
Number of pupils known to have been provided with hearing aids	
a. in 1966	16
b. in previous years	48
Orthopaedic and Postural Defects	
a. pupils treated at clinics and out-patient departments	980
b. pupils treated at schools for postural defects	200
Total	1,180
Diseases of the Skin (excluding uncleanliness)	
Ringworm	1
Scabies	3
Impetigo	6
Other skin diseases	577
Total	587
Child Guidance Clinic	
Pupils treated	458
Speech Therapy	
Pupils treated	555
Other treatment given	
a. pupils with minor ailments	250
b. pupils who received convalescent treatment under School Health Service arrangements	25
c. pupils who received BCG vaccination	1,153
d. allergy clinic	95
Total	1,523

Table 4 Infestation with Vermin

Total number of pupils examined in schools by nurses or other authorised persons	14,063
Total number of individual pupils found to be infested	148
Number of individual pupils in respect of whom cleansing notices were issued (Section 54(2) Education Act 1944)	85
Number of individual pupils in respect of whom cleansing orders were issued (Section 54(3) Education Act 1944)	4

Table 5 Dental Inspection and Treatment

	Number of Pupils			
	Age 5–9	*Age 10–14*	*Age 15 & over*	*Total*
Inspections				
First inspection at school				9,258
First inspection at clinic				3,520
No. of first inspections requiring treatment				7,335
No. of first inspections offered treatment				7,323
Pupils re-inspected at clinic				1,204
No. of re-inspections requiring treatment				873
Attendances and treatment				
First visit	2,436	2,498	450	5,384
Subsequent visits	5,603	7,079	1,523	14,205
Total visits	8,039	9,577	1,973	19,589
Additional courses of treatment commenced	378	280	73	731
Fillings in permanent teeth	2,659	7,302	1,734	11,695
Fillings in deciduous teeth	6,058	506	–	6,564
Permanent teeth filled	1,942	5,028	1,165	8,135
Deciduous teeth filled	3,977	336	–	4,313
Permanent teeth extracted	121	742	134	997
Deciduous teeth extracted	2,481	821	–	3,302
General anaesthetics	1,037	473	42	1,552
Emergencies	417	258	50	725
Number of pupils X-rayed				918
Prophylaxis				2,323
Teeth otherwise conserved				66
Number of teeth root filled				71
Inlays				7
Crowns				62
Courses of treatment completed				3,582
Anaesthetics				
General anaesthetics administered by dental officers				2

continued

Table 5 Dental Inspection and Treatment *continued*

	Number of Pupils			
	Age 5–9	*Age 10–14*	*Age 15 & over*	*Total*
Orthodontics				
Cases remaining from previous year				543
New cases commenced during year				145
Cases completed during year				75
Cases discontinued during year				72
No. of removable appliances fitted				258
No. of fixed appliances fitted				15
Pupils referred to hospital consultant				3
Prosthetics				
Pupils supplied with full upper or full lower dentures (first time)	–	2	1	3
Pupils supplied with other dentures (first time)	3	10	2	15
No. of dentures supplied	3	12	3	18
Sessions				
Sessions devoted to treatment				2,962
Sessions devoted to inspection				104
Sessions devoted to Dental Health Education				93

Staff Health Service (Occupational Health)

It is anticipated that a comprehensive health service for the council's staff will be introduced during the coming year.

The council employs approximately 7,000 people engaged in more than one hundred different occupations, who produce many health and welfare problems and a staff health service will play an important role in enabling staff to work at their optimum efficiency.

The present scheme ensures that all newly appointed staff complete a medical history form and are medically examined on a selective basis. Certain staff including those whose duties will bring them into close and regular contact with the general public, particularly mothers and children or who are engaged in the preparation or serving of food, must produce evidence of a satisfactory chest x-ray taken within the past twelve months. Home nurses, midwives, day nursery staff and house parents in children's residential homes are required to have a chest x-ray annually.

Existing staff are medically examined for purposes of admission to the superannuation and sick pay schemes and for continuing fitness for employment after prolonged sick absence or when beyond the normal age of retirement.

Student teachers and those teachers who are about to be appointed to their first teaching post are also medically examined.

Medical examinations of other local authority staff have been carried out on a reciprocal basis as in previous years.

During the year the following examinations and assessments were made—

Medically assessed:		
with medical examination	136	(73)
without medical examination	1,503	(1,346)
Left before completion of medical assessment	100	(71)
Medical examination of existing staff for purpose of admission to the superannuation scheme, sickness pay scheme or continued fitness for employment	64	(80)
Medical examination for first teaching appointments	106	(60)
Medical examination of other local authority staff	9	(11)
Medical examinations carried out by other local authorities	14	(–)
Medical examination of student teachers	172	(175)

Figures in brackets relate to 1965

When the comprehensive service is established it is proposed to extend the scope of the present scheme by the addition of special pre-symptomatic diagnostic tests for staff who are offered appointments between 45 and 55 years of age. At the request of the head of department advice would be given on the health suitability of personnel and hazards and stresses in certain occupations. Disabled workers and those at special risks such as sewer-men and rodent operators would also be medically supervised. At their request employees will receive a check up and be given medical advice especially those returning to work following severe illness.

The treatment of staff suffering from accidents and sudden illness at work would be extended to include the treatment of minor ailments and this would be done in co-operation with general medical practitioners and hospital authorities.

The advisory service to chief officers on means of achieving a healthy working environment will be extended and additional talks will be given to young entrants on health and welfare topics and interested staff instructed in first aid.

Dr A R Broadbent was appointed senior assistant medical officer in September of this year and is particularly well qualified by training and experience to carry out this work. It is envisaged that he will be immediately responsible for the organisation and clinical work of the staff health service and also for that of the student health service which is described in this report under the section dealing with the Report of the Principal School Medical Officer.

Mental Health

Mental Subnormality

Owing to the shortage of mental health social workers the improvement envisaged in the services for these patients and their relatives has not materialised.

More frequent medical counselling of parents is slowly being achieved by additional clinic sessions and it is felt that this is of some benefit to the parents. The numbers on the register have not greatly changed—373 at the end of 1965 and 370 at the end of 1966. The number of severely subnormal children on the waiting list for permanent hospital care is 15 and remains the same as that for the end of 1965. Although several vacancies have already been provided by Leavesden Hospital new cases have been added to the hospital waiting list. The care of these very severely handicapped children in the community places a great strain upon community services, but more particularly of course, upon the families concerned.

It should also be emphasized that the hospital waiting list is artificially low because the only hospital available is Leavesden which is so far removed from the borough as to be impracticable for frequent visiting. Parents tend therefore, only to ask for hospital care for children when the family is near to breaking point. I would like to reiterate the need for a small hospital unit within the community it serves. It is encouraging to learn that at least one regional hospital board, Wessex is thinking along these lines. My overtures to the North West Regional Hospital Board to consider providing such a unit or to enter into a con-joint scheme with this authority have so far been rejected on financial grounds.

One particular problem is that of transporting the patients to and from the special care units each day. At present they are carried in large coaches that are hired on contract from various firms. This often means long and tedious journeys for these very severely handicapped children without any special facility for their care whilst in transit.

Because of the size of the coaches it is often not practicable to pick these patients up at their homes. A larger number of 'minibuses' might prove satisfactory, primarily by being able to pick the patients up at home and by reducing the length of the time the children are in transit.

The liaison with the two local parents' associations is continuing and the relationship proves of value to both sides.

Junior Training Schools and Special Care Units
Isleworth Junior Training School Bridge Road Isleworth

There has been no material change concerning this school since my last report and it continues to run smoothly and efficiently. Unfortunately the supervisor will be retiring in December 1967 and she will prove difficult to replace.

In view of the number of children with physical handicaps, it is considered that an increase in the number of physiotherapy sessions should be sought and further speech therapy sessions are also considered desirable. All the children at the school have recently been screened for hearing defects and it is hoped to make 'screening' a routine procedure both for hearing and vision.

Hanworth Junior Training School Bear Road Hanworth

The additional electrical heating which was provided has proved of great benefit to the children, who having poor circulations, require more than an average standard of heating. Teaching in this school continues to be progressive and of a high standard and the supervisor is encouraging groups of parents to come to the school to observe the teaching and training methods. Thus it is hoped the children will be helped by parents employing the same methods at home and that the parents will learn to drop the attitudes of over-protection that are so common.

During the year swimming was started as an additional activity and a group of suitable children are taken by assistant supervisors to the local swimming baths for instruction.

Fortunately this school is soon to be replaced by larger purpose-built premises and both children and staff will benefit by the greatly improved facilities.

During the course of the year a speech therapist has become available to the school for one session a week.

Colombo House 1 Ferry Road Teddington

The arrangement mentioned in my last report whereby this authority provided a teacher for a class at Colombo House has continued. The class will be absorbed into the new school at Hanworth.

Adult Training Centres

Acton Lodge Adult Training Centre London Road Brentford

There has been no major change in policy at Acton Lodge but with the replacement of the old building, which it is hoped will be completed in 1968, a greater range of activity will be possible. During 1966 the trainees started the internal redecoration of the new building and the part so far completed has shown a very high standard of craftsmanship for which both staff and trainees are congratulated.

As forecast in my last report a part-time teacher started in June 1966 to give lessons to trainees from both Acton Lodge and Brentford Adult Training Centres. She has had no previous experience in this particular field but has made great strides, particularly in social training. She has been helped in her selection of trainees and of teaching materials by the Senior Educational Psychologist for Special Services.

The 'club nights' continue once every fortnight and I am indebted to various voluntary organizations that help to provide entertainments for the trainees on these very successful social occasions. I should like to express my gratitude to the staff who voluntarily give their time and support at the end of a long day.

Brentford Adult Training Centre Commerce Road Brentford

This centre continues to operate successfully within a factory. There has been a slight increase in the number of trainees attending and two have become employees of this particular factory.

Visitors to Junior Training Schools and Adult Training Centres

There has continued to be a number of visitors from members of a large range of disciplines to all the establishments and a number of students has been seconded to the schools for varying periods mainly from Chiswick Polytechnic.

Holiday Camps for the Mentally Subnormal Adults

The department organized two parties to St Mary's Bay Holiday Centre, Romney Marsh, one consisting of 94 women and the other of 99 men all of whom attend training centres within Middlesex.

Children

Three children were sent on a holiday organized by the Borough of Hillingdon at Park Place School, Henley and several other children attended the camp organized by the National Society for Handicapped Children at Sunbury Court.

All of these projects were very successful and I am indebted to the staff, to the voluntary organizations that enabled young people to help in a voluntary capacity in the running of the camps and to various branches of the Society for Mentally Handicapped Children in Middlesex who contributed a total of £85 for extras and entertainment.

Short Term Care

During 1966 arrangements were made for 33 severely subnormal patients, mostly children, to have a total of 36 periods of short term care varying between two and eight weeks. Seventeen of these were awaiting permanent admission to hospital but short term care became necessary either because of crises at home or to give the families some respite from the constant care of difficult patients.

Of the 36 periods of short term care arranged, 34 were accommodated in National Health Service Hospitals, mainly Leavesden Hospital, 1 in Pirates Spring Holiday Home run by the National Society for Mentally Handicapped Children and 1 was placed in a private home.

Mental Illness

This has been a year of considerable change, giving rise to an improved service to patients, family doctors and of the facilities for mental health social work.

At the beginning of the year, there was a complete reorganization at Springfield the catchment hospital which serves the greater portion of the borough's population and also four other London boroughs. The internal arrangements have now been altered to enable virtually, each of the boroughs to have their own section within the hospital with its own medical team headed by a consultant psychiatrist. Dr Herridge was appointed to the hospital as the consultant responsible for the Hounslow area.

In June 1966 Dr Herridge was also appointed for two sessions each week as consultant psychia-

trist to the borough. One session has been devoted either to a tutorial or to a case conference for the mental health social workers, and the second is an evening session for the residents at Wood Lane Hostel.

A mental health social worker is attending the hospital for case conferences one day each week when patients, who are normally borough residents, are discussed. On his return he informs his colleagues of current events affecting their particular patients, so enabling them to be conversant with their progress. It is hoped that when the establishment of social workers is full that officers will be able to visit their own cases in hospital.

As a direct result of these changes and of the increased use of the domiciliary services, there has been a greater reciprocal understanding of the problems affecting both the hospital staff and the mental health social worker.

It has not yet been possible to develop the same degree of liaison with St Bernard's Hospital, but as its catchment area relates only to a small part of this borough, and owing to the shortage of mental health social workers throughout the year it has been considered advisable to concentrate our efforts on the principal catchment hospital. It is unfortunate that this Borough is not served by one hospital for mentally ill patients.

A psychiatric clinic commenced at Hounslow Hospital in October. This has proved of great help and in the initial stages reduced the waiting time for new appointments, but inevitably demand outpaced supply to the extent that there is now a three week's wait before a new patient can be seen by a psychiatrist. Arrangements have been made for a mental health social worker to see beforehand all new patients, with the agreement of the family doctor, to obtain a social history for the psychiatrist, thereby saving his time and enabling him to obtain a first hand account of the home circumstances of the patient. A mental health social worker is also in attendance at the clinic to assist the psychiatrist and to help with patients' social problems.

The hostel at 24 Wood Lane Isleworth, has proved extremely valuable in the rehabilitation programme of many types of psychiatric illness, and though still in its experimental stage, it has shown that there is a need for this type of accommodation both for long term and for short term patients. There is also a need for a degree of flexibility to admit psychiatric patients who require urgent accommodation for social reasons and who would otherwise have no alternative but to be admitted to hospital.

A report by the warden on the first year's management of the hostel is included later in the report.

The Industrial Therapy Organization (Thames) Ltd, has again proved helpful and clearly shows a need for services to be provided for rehabilitation, and has helped considerably those patients who for some reason or other need sheltered conditions and help in acclimatizing to work routines and normal social activities. It has also demonstrated the need for a programme of long term training to enable patients to obtain industrial experience under more sheltered and less demanding conditions than those offered by the Ministry of Labour's industrial rehabilitation units. The need is for a training programme which would accommodate patients who can work only for short, variable hours and which is flexible enough to consider those who are under sedation and find it difficult to get to work at an early hour and to maintain a reasonable output. This need will partly be met by the proposed sheltered workshop.

The staff situation has been variable. One mental health social worker left for promotion to another London borough, and one is to take up an appointment in his home country and there has been considerable difficulty in finding qualified or experienced replacements. Two senior mental health social workers have been seconded to full time Younghusband courses so that for much of the year the service has suffered from a shortage of staff and has delayed the development of the social work that is envisaged for the future.

In the London area the high cost tends to prohibit the more junior staff purchasing their own housing and the council has allocated four housing units for mental health social workers as it is clearly much more satisfactory for these officers to live within or near to the area they serve.

Future Projects

Children's Services

The building of the new junior training school, Main Street Hanworth, was started during the year and it is hoped that it will be ready for occupation in January 1968.

A weekly boarding unit planned on the same site at Hanworth, should also be ready for occupation during 1968.

A site has been allocated in Heston for the proposed full-time residential home.

Adult Services

The plans for replacing the old building at Acton Lodge are complete and it is hoped that the project will be started during 1967.

Owing to planning consent difficulties, the proposal to site the day centre for the elderly mentally confused at St Peter's Road, St Margarets, was abandoned. It is now proposed to convert a former clinic at Heston for this purpose.

It is anticipated that next year a start will be made in building a 25 place hostel for the mentally disordered at The Orchard Staines Road Bedfont.

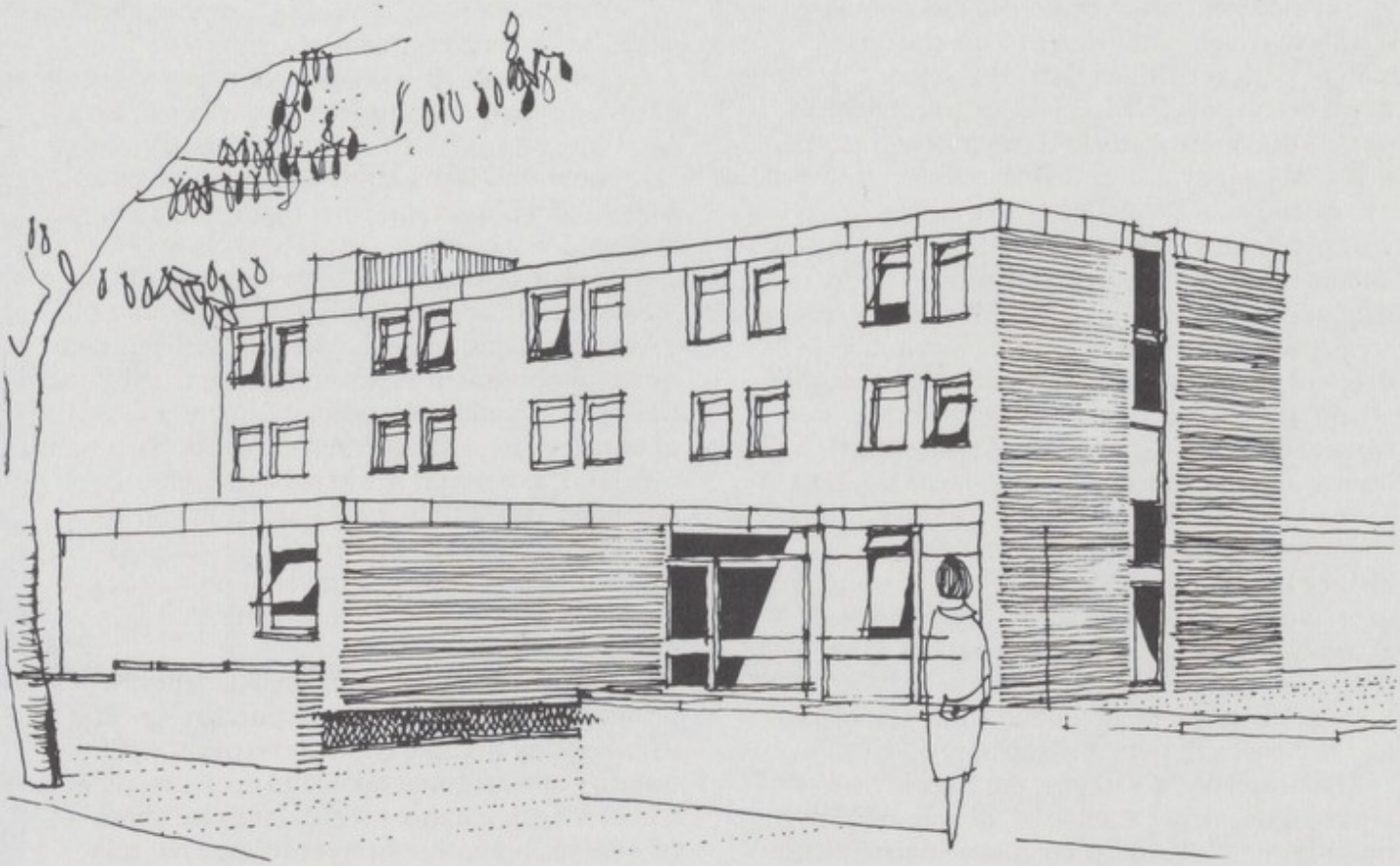
The plans are complete for a day centre for mentally ill patients on the Bath Road site and this is included in the second phase of the extension of the Health Centre.

A site has not yet been chosen for a sheltered workshop which it is now proposed should be provided in conjunction with the Welfare Department for both the mentally and physically handicapped.

Owing to shortage of mental health social workers it has not yet been possible to start a club for mentally ill patients.

24 Wood Lane Isleworth

The following report has been submitted by Mr T V Jones DSC, resident warden of the hostel—



Wood Lane Hostel, Isleworth

'The hostel was opened in March 1966 to accommodate up to 30 women and men who are recovering from mental illness and require supportive care in an understanding, sympathetic and permissive environment in order to acquire a measure of self assurance and stability to enable them within a reasonable time to resume a normal life.

Forty-two residents have been admitted during the first year. Of this number, nine were admitted from other hostels, eighteen from hospitals and fifteen from their homes.

Of these forty-two, twenty are still in residence, two are deceased, eight were discharged as being unsuitable, five have suffered relapses and were returned to hospital, two left of their own accord after brief periods of residence, one returned home after being given temporary residence in the hostel and four have returned to normal community life.

The following local authorities have been responsible for the financial support of residents—

Hounslow	32
Ealing	2
Richmond	1
Kensington & Chelsea	3
Westminster	1
Harrow	1
Brent	1
County of Berkshire	1

Applicants who are recommended and who wish to be admitted to the hostel are interviewed and selected by a panel consisting of the consultant psychiatrist, principal medical officer, chief mental welfare officer and the warden.

All applicants have suffered either mental illness or emotional disturbances due to environment pressures, which they have found excessive. In the early days of the hostel several borderline sub-normal patients were admitted but all have now left. Two, possibly three, residents appear to require more support than a short-stay hostel can provide and long stay supportive accommodation will be sought for them. One patient with psychopathic tendencies who was subject to hysterical outbursts and suicidal gestures has recently been readmitted to the hostel following an intensive course of group therapy at the Henderson Hospital, and is now improving.

Others, who previously experienced great difficulty in mixing with others and holding down jobs are now regularly employed. Despite the effects of the selective employment tax, every resident is working. Several residents have benefitted by their training at Industrial Therapy Organisation (Thames) Ltd, but none is there at present. Two residents have improved following out-patient treatment at the West Middlesex Hospital.

Due to the small number and widely differing ages of the residents it is difficult to organise social activities but they are given every encouragement to lead a normal life by getting out as much as possible and by inviting their friends to the hostel. Swimming and skating parties have been successfully organised.

Each resident is on the list of a family doctor and the majority tend to register with one in particular. In addition the consultant psychiatrist visits the hostel once a week to keep a careful watch on the patients' progress.

Support is also given by the mental health social workers, particularly by the deputy chief mental welfare officer.

A complete change of resident staff occurred during the year. Soon after the hostel opened both the warden and housekeeper resigned and three months later it also became necessary to replace the assistant warden who resigned on being appointed trainee mental health social worker with the borough.

Little change has occurred among the domestic staff who have made a valuable contribution to the life of the hostel.

There was some doubt in the district when a mental rehabilitation hostel was initially discussed. However, after 'one year's service', 24 Wood Lane has quietly and successfully merged into the local domestic scene. There have been no untoward visible occurrences. We have been accepted, and some good has been accomplished.'

I am grateful to Dr Colin Herridge, consultant psychiatrist for the following report—

Report on Hospital Psychiatric Service

'Accepting the regrettable fact that Springfield

Hospital, which deals with the majority of psychiatric admissions from the Borough of Hounslow, is about 12 miles away and not easy to reach by public transport, our emphasis in treatment of nervous illness is swinging more and more to the community. Every effort is made to treat people on an out-patient and day patient basis, to discharge those who have to be admitted, as rapidly as possible to continue their treatment at home and, despite the distance factor, to build up an even closer liaison with the local authority services.

In addition to the existing out-patient and day hospital facilities at the West Middlesex Hospital, a new clinic, attended by two doctors has opened weekly at Hounslow Hospital. It is a great success and unfortunately has already built up a formidable waiting list. The informal atmosphere, and the presence of a local authority mental health social worker to cope with domestic and other similar worries in a way that only a local person can, is its greatest asset.

At Springfield, all admissions from the borough are now cared for by 'The Hounslow Firm', which consists of a consultant, a medical assistant and two registrars. As these are the people who also conduct the out-patient clinics at the West Middlesex Hospital and a considerable volume of home visiting, much greater continuity of care is possible. Furthermore, the firm's weekly full ward round is always attended by a local authority social worker, so that full co-operation is maintained. It has to be admitted, however, that the ever increasing clinical load puts a tremendous strain on the firm, and more medical staff are an urgent need, if the standard of service is to be even maintained, let alone improved. At least one more out-patient clinic is a necessity, further medical cover is required at 24 Wood Lane, where final rehabilitation of discharged patients is carried out, and a further day centre is needed. The present staff cannot hope to cope with these necessary additions.

Finally, it must be noted with great pleasure that the 'stigma' of psychiatric illness appears to be dying an increasingly rapid death, and in the borough it is noticeable how much more ready people are to ask for help early. Much credit must go to the mental health division of the health department for this; their officers have totally lost the image of the 'DAO' and are now regarded as social workers and friends by an increasing number. The hospital service, by moving more and more into the community, will be hard pressed to do justice to this new and encouraging trend.'

Environmental Health

The following is submitted by Mr K J Smith FAPHI MRSH, Chief Public Health Inspector—

'The annual report for 1965 contained a good deal of descriptive material designed to show the effects upon the department of local government reorganisation and the creation of the new borough.

By the beginning of 1966 many difficulties had been overcome and this report is intended to show, in many cases in a more condensed tabular form, the results of a full year's work of the reorganised department together with certain specific information requested by the Minister in Circular 1/67.

Water supply

The greater part of the supply is provided by the Metropolitan Water Board and the remainder by the South West Suburban Water Company and is satisfactory in quantity and quality. The water is derived from the river Thames and no new sources were instituted during the year.

Sampling and quality control at the supplier's works and laboratories are on a daily basis, and 3,287 samples were taken for bacteriological examination and 296 for chemical analysis, with satisfactory results. There are no premises in the borough where water other than from the piped supply is used for drinking.

The water is not plumbo-solvent. Fluoride is not added, and the natural content averages 0.20 milligrammes per litre.

One complaint about alleged unpleasant odours and taste in tap water was investigated. The fault was found to lie in the taps, and their replacement together with some modifications to the pipe runs serving them effectively remedied the trouble.

Wood Lane Hostel— bedroom

Swimming baths and pools
I am indebted to the General Baths Manager for the following data—

Swimming bath	*Annual attendance*	*Maximum on any one day*
Brentford	85,909	559
Chiswick (Open Air) (Summer only)	60,625	2,677
Feltham	335,007	2,272
Heston	204,778	1,145
Hounslow	191,070	295
Isleworth	177,229	976
Slipper Baths		
Chiswick	31,684	–
Brentford	11,178	–
Hounslow	23,670	–
Isleworth	16,218	–

Liaison is maintained between the department and the baths manager in ensuring the purity of the bath waters.

Sewerage and Sewage Disposal
With the exception of a small and diminishing number of premises on the outskirts of the borough which are drained to cesspools or have pail closets, the area is served by the West Middlesex Scheme controlled by the Greater London Council whose Mogden purification works are situated in the borough. Offensive smells in the neighbourhood of the works which prompted numerous complaints from residents in 1964 and 1965 were not repeated in 1966. An improvement scheme costing £154,000 is in progress.

1,938 inspections were made during the year of choked or defective sewers and drains, and 32 tests applied, in connection with 656 complaints received. 100 statutory notices were served under Section 24 of the Public Health Act, 1936, 101 public sewers repaired and 524 cleansed.

Common Lodging Houses
There are no common lodging houses in the borough.

Services under the Food and Drugs Act 1955
There are no egg pasteurisation plants, poultry processing establishments, slaughterhouses or knackers yards in the borough.

Milk supplies—Brucella Abortus
There are no milk producers in the borough, but raw milk is received at one pasteurising dairy.

29 samples from individual churns were taken during the year and examined by the Consultant Pathologist at Harefield Hospital. 4 positive samples were found and the results forthwith transmitted to the authorities in the producing areas.

Milk composition
20 samples were taken for analysis. Of these 7 formal samples of raw milk from one farm outside the borough were found to contain between two and sixteen per cent extraneous water. The farmer was prosecuted and fined £20 and ordered to pay £10 10 0d costs.

Complaints about allegedly dirty milk bottles continue to be received, though of the eight received during the year only two were substantiated upon investigation. In these two cases official warnings were authorised by the Health Committee and the bottler's attention drawn to the circumstances in the remaining six.

Ice-cream
66 samples were taken for bacteriological examination, with the following results—

	Mobile traders				*Fixed premises*			
Grade	*I*	*II*	*III*	*IV*	*I*	*II*	*III*	*IV*
Soft ice-cream			1		3	5		
Prepacked ice-cream	3	1		1	37	4	2	2
Ice lollies								
Total	3	1	1	1	47	9	2	2

Steps were taken to investigate the circumstances connected with the unsatisfactory samples, and repeat samples proved satisfactory.

Other foods and drugs
The scheme for routine sampling set up in 1965

was fully operational by the end of that year, and the following table sets out the commodities sampled and the results of analysis in 1966.

The selection of foods and drugs for sampling is based on suggestions made by the public analyst in addition to local knowledge, and is designed to cover the widest possible variety without wasteful duplication. The figures also include specimens sent to the public analyst in connection with the investigation of complaints or suspected irregularity.

Alcoholic beverages	21
Arrowroot	2
Baking Powder	3
Biscuits	2
Bread	14
Bread and butter	3
Beverages non-alcoholic	2
Cake	13
Cake decorations	9
Cake mixes	5
Canned fish	6
Canned fruit	32
Canned meat	17
Canned puddings	2
Canned soups	2
Canned poultry	1
Canned vegetables	14
Cereals	27
Cheese	9
Chocolate preparations	7
Cocoa	3
Coffee mixtures	4
Colourings	4
Condensed milk	4
Cream	5
Custard powder	6
Cornflour	2
Dried fruit	19
Dried herbs	10
Dried vegetables	2
Drugs, various	135
Fats	23
Fish preparations	6
Fish paste	4
Flour	8
Flavourings	3
Fruit preparations	10
Foreign body	1
Gelatine	4
Gravy	1
Honey	5
Ice-cream	10
Jelly	1
Meals	5
Meat paste	7
Meat pies	9
Meat preparations	27
Milk	20
Milk powder	7
Nuts	3
Oils	12
Potatoes	3
Preserves	33
Puddings	4
Sausages	33
Salad cream and spread	6
Salt	3
Slimming preparations	8
Sauces	4
Soft drinks	19
Soups	3
Spices	20
Spirits	16
Suet	1
Sugar	3
Sugar confectionery	38
Tea	6
Treacle	2
Vinegar	8
Vegetables	1
Yogurt	7
Total	769

The borough council is co-operating in the national investigation into pesticides in foods, and six additional samples of various foodstuffs were procured and sent to the public analyst for this purpose.

Irregularities were disclosed in 74 of the 769 samples submitted, relating to soundness, composition, or labelling.

Reference has been made elsewhere to legal proceedings in connection with seven samples of adulterated milk.

One retailer was prosecuted for selling mixed cereal baby food heavily contaminated with

mould, and fined £10 plus 10 guineas costs.

Official warnings were authorised by the Health Committee in connection with a piece of apple found in a loaf of bread and a piece of rubber in a bottle of milk.

Of the remaining adverse reports, some related to minor infringements while others indicated opportunities to secure modifications of formulations, amendment of labels, or the exhibiting of prescribed notices. A considerable volume of correspondence and much discussion has resulted, and manufacturers and retailers alike have been co-operative in introducing amendments to their recipes or labels. 1,231 visits to premises were made during the year, excluding routine visits to food premises for other purposes recorded elsewhere.

In addition action has been taken under Sections 2 and 8 of the Act in respect of foodstuffs not submitted to the Public Analyst.

At retail premises 16,133 lbs, 5,660 tins, 404 jars and 775 packets of unsound foodstuffs were voluntarily surrendered and destroyed, together with 11,060 packets of defrosted frozen food as a result of breakdown of refrigerators.

Legal proceedings were instituted in the following cases—

	Fines	*Costs*
Unsound bacon	£20	£5 5 0
Mouldy bread	£10	£5 5 0
Unsound ham	£25	£10 10 0
Medical dressing in loaf	£50	–
Cigarette end in bun	£10	£10 10 0
Unsound pork sausages	£25	£6 6 0
Unsound steak and kidney pie	£20	£2 2 0
Unsound meat pie	£15	£5 5 0
Moths in semolina	£10	£2 2 0

Official warnings were authorised by the Health Committee in respect of string in a loaf, glass in jam, ants in table salt, and insect in bread roll.

Food Hygiene (General) Regulations 1960

There are in the borough the following premises to which the Regulations apply—

Bakehouses	22
Butchers	127
Cafes, canteens, clubs	493
Fish shops	47
Greengrocers	149
Groceries and provisions	286
Hotels, public houses and off-licences	198
Food manufacturers and packers	30
Flour confectionery	47
Sugar confectionery	270

No certificates of exemption from the requirement to provide sinks and washbasins under Regulations 16 and 19 respectively have been granted.

4,419 routine inspections were made during the year, and while great advances have been made in recent years in the construction and equipment of food premises the need for continuous surveillance is demonstrated by the fact that 1,329 contraventions of the Regulations were found and dealt with. These related mainly to faulty day-to-day maintenance and techniques.

Legal proceedings were instituted against one food handler for smoking in contravention of Regulation 9. A fine of £20 was imposed together with £6 6 0d costs.

Housing

544 new permanent dwellings were erected by the borough council, and 23 dwelling units created by conversions.

281 dwellings were erected by private enterprise and 80 by housing associations, and 31 additional units provided by private conversions.

The action taken by this department in respect of insanitary or unfit dwellings during the year is summarised below—

Inspections

a. Total inspected for housing defects under Public Health and Housing Acts	820
b. Number inspected and recorded under Housing Regulations—included in (a)	70
c. Number unfit and capable of being rendered fit at reasonable expense	26
d. Number unfit and not capable of being rendered fit at reasonable expense	61
e. Number not included in (c) or (d) in which defects were found	533

Remedy of defects without formal notices	
Dwellings rendered fit in consequence of informal action	220
Action under statutory powers	
a. Section 9 Housing Act 1957	
Dwellings in respect of which notices served	2
Dwellings rendered fit by owners	–
Dwellings rendered fit by local authority	–
b. Public Health Acts	
Dwellings in respect of which notices served	63
Dwellings in which defects remedied by owners	40
Dwellings in which defects remedied by local authority	8
c. Sections 16, 17, 24, 27 and 28 Housing Act 1957	
Undertakings to render fit accepted	3
Undertakings not to use accepted	2
Dwellings rendered fit in consequence of undertakings	–
Dwellings demolished which were subject to undertakings not to use, or to Closing Orders	2
Closing Orders made in breach of undertakings to repair	–
Demolition Orders made in breach of unfit to repair	–
Demolition Orders made	3
Dwellings demolished in pursuance of Demolition Orders	5
Closing Orders made in lieu of Demolition Orders	5
Closing Orders revoked and Demolition Orders substituted	–
Demolition Orders revoked, dwellings having been rendered fit	–
Closing Orders determined, dwellings having been rendered fit	2
d. Section 18 and 27 Housing Act 1957	
Closing Orders made in respect of parts of buildings	3
Closing Orders made in respect of underground rooms	–
Closing Orders determined in respect of parts of buildings rendered fit	–
e. Section 43 Housing Act 1957	
Clearance Areas	
Dwellings subject to confirmed Clearance Orders	–
Dwellings subject to confirmed Compulsory Purchase Orders	35
Dwellings purchased by agreement	–
Dwellings demolished	8
Housing Act 1957—Overcrowding	
a. Number of dwellings overcrowded at the end of the year	57
Number of families dwelling therein	109
Number of persons dwelling therein	448
b. Number of new cases of overcrowding reported during the year	63
c. Number of cases of overcrowding relieved	38
Number of persons concerned in such cases	317
d. Particulars of any case in which dwelling-houses have again become overcrowded after the Local Authority have taken steps for the abatement of overcrowding	–
Other matters	
Dwellings programmed for inspection and demolished voluntarily	5
Dwellings demolished after issue of certificate of unfitness	–
Section 90 Housing Act 1957—Notices served	24
—Remedied	7
Section 15 Housing Act 1961—Notices served	9
Section 16 Housing Act 1961—Notices served	2
Section 19 Housing Act 1964—Notices served	1

The foregoing table is in a prescribed form and does not adequately reflect the mass of work involved. 4,910 inspections and re-inspections, 826 of them at houses in multiple occupation, often outside normal hours, were necessary, and voluminous paper work is inescapable.

Legal proceedings against the owner of one house for contravening Section 90 of the Housing Act 1957 resulted in a fine of £10 and £5 5 0d costs, and further proceedings six months later for failure to abate the overcrowding resulted in a further fine of £15 and £5 5 0d costs. The house

continued

was subsequently vacated.

Thirty-seven other cases of overcrowding were abated without legal proceedings.

During the year representations under Section 19 of the Housing Act 1964 were received from the tenants of five dwellings.

3 preliminary notices and 1 immediate improvement notice were served, 2 undertakings were accepted from the owners, and by the end of the year one dwelling was improved to the full standard.

Under the Rent Act 1957 one application for a certificate of disrepair was received and granted, and two undertakings by landlords under paragraph 5 of the 1st schedule to the Act were submitted.

The Director of Housing is kept informed of adverse housing conditions and assistance is given in assessing applications for rehousing where priority on medical grounds is claimed.

Similarly a great deal of time is spent in inspecting houses subject to mortgage loans by the council where overcrowding in breach of a condition of mortgage is suspected, and in assisting the Valuation & Estates Officer to decide whether a dwelling in respect of which a repairs loan or improvement grant has been applied for will satisfy the requirements of Section 43 of the Housing (Financial Provisions) Act 1958. 377 dwellings were so inspected, of which 192 were found to require some repair.

Moveable dwellings

Invasions by groups of itinerant van-dwellers continue to afflict residents in parts of the borough. 1,977 inspections were made during the year in an effort to relieve residents of intimidation by some of the van dwellers and of the nuisances associated with their unauthorised occupation of land. Few of these people display any desire to settle down for longer than suits their purpose or to learn to behave as responsible citizens. The protection of the amenities of the borough and indeed the protection of persons from physical injury by the van dwellers and their dogs demands nothing less than the sternest measures available. To this end 50 summonses and 9 warrants for arrest of van-dwellers were issued during the year.

Fifteen convictions were obtained, fines totalling £54 12 0d were imposed and costs amounting to £21 awarded. In only two cases were summonses dismissed. The large number of cases in which convictions were not recorded arose from the disappearance without trace of the caravan dwellers after summonses were served.

While much has been done in recent years to regulate and improve caravan sites occupied by law-abiding citizens, and most local authorities would be prepared to attempt to integrate into the community some of the less enlightened van dwellers who might respond, the fact remains that there is an element among the travelling-trader type of van-dwellers who completely disregard all laws and acceptable moral standards. Their livelihood depends largely upon supplies of discarded materials, mainly scrap metal, and mobility is essential when supplies in any one area are temporarily exhausted. The separation of finer metals from other unmarketable material by breaking-up or burning are not processes which could be introduced or tolerated in or near a built-up area since inevitably nuisances from noise and smoke are added to those arising from the absence of elementary sanitary facilities. The van-dwellers are not prepared to conduct their businesses on separate sites out of sight from their caravans. They prefer to move on rather than dispose of valueless material, leaving someone else to clear up the mess they leave behind. Much of the material, though extremely unsightly, is inert and cannot be said to be a nuisance from the strictly public health point of view.

In the interests of their resident population local authorities in built-up and fringe areas have no alternative, in the absence of national control of this particular type of van-dweller, but to exercise every power available to them to prevent or discontinue the unauthorised occupation of land in their areas.

Clean Air

The council continues to co-operate with Warren Spring Laboratory by maintaining 8 sets of smoke and sulphur dioxide measuring apparatus and by forwarding to the laboratory monthly returns showing the highest, lowest and average daily readings.

23 Smoke Control Orders were in operation

in December 1966 affecting 31,665 dwellings and covering 7,563 acres.

3 further Orders affecting 4,986 dwellings and covering 865 acres were awaiting the Minister's confirmation.

Visits to premises by public health inspectors and technical assistants for survey purposes numbered 4,593, and in the implementation of Orders, 6,448.

In the general execution of the Act outside smoke control areas 2,124 inspections were made and 823 smoke observations taken, 633 of them in connection with industrial installations—14 notices were served under Section 30 of the Act.

Emissions of smoke sufficiently heavy to constitute infringements of the Act are rare, but during the year legal proceedings were instituted against one persistent offender and resulted in a fine of £5 on each of two summonses, with £3 3 0d costs.

Under Section 3 of the Act 40 notifications and 5 applications for prior approval were received. All the latter were approved, 3 without modification and 2 after modification.

Plans of 20 new chimneys were examined under Section 10 of the Act. In fifteen cases modifications were required, and all were subsequently approved subject to those modifications.

Factories Act 1961

The annual return submitted to the Minister of Labour in the prescribed form appears as Table 27.

Compliance with the requirements of the Act and relevant Regulations was secured by informal action save in one case where legal proceedings for a contravention of Section 7 were commenced but subsequently withdrawn on satisfactory completion of works to remedy the fault.

182 inspections of outworkers' premises were made in addition to the inspections of factories recorded in the return.

Offices, Shops and Railway Premises Act 1963

The annual return submitted to the Minister of Labour in the prescribed form appears as Table 26.

The number of premises shown in column 4 of Table A of the return as having received a general inspection during the year is accurate having regard to the definition of a 'general inspection' laid down in Circular LA5 but is rather misleading. Of the 2,958 total visits, over one thousand were of a comprehensive character but were not so recorded as to qualify for inclusion in column 4.

Steady progress continues to be made with inspections and general operation of the Act despite some set-backs due to staff sickness.

The following is an analysis of contraventions found and dealt with during the year—

Section 4—Cleanliness	68
Section 5—Overcrowding	6
Section 6—Temperature	101
Section 7—Ventilation	14
Section 8—Lighting	38
Section 9—Sanitary conveniences	103
Section 10—Washing facilities	92
Section 11—Drinking water	5
Section 12—Clothing accommodation	33
Section 13—Seating facilities	4
Section 14—Seats (sedentary workers)	1
Section 16—Floors, passages, stairs	91
Section 17—Machinery	25
Section 24—First aid boxes	62
Section 50—Abstracts not exhibited	66

1,150 contraventions were remedied during the year. This figure of course includes some upon which action was begun in the previous year. It was not found necessary to resort to legal proceedings. All notifications of accidents are closely examined and the majority investigated on site, whether or not there appears to have been a breach of any provision of the Act, and the opportunity is taken to secure amendment of equipment or techniques so as to prevent a recurrence. 74 accidents were reported, all non fatal, during the year. Advice was offered in fifteen cases and two warnings were given.

The following is an analysis of the causes of reported accidents—

	Offices	*Shops*	*Ware-houses*	*Catering Establishments*
Machinery	–	2	5	–
Transport	1	2	2	–
Falls of persons	5	15	4	5
Collisions	1	–	–	1
Handling goods	2	14	–	–
Falling objects	–	3	–	–
Electricity	1	–	–	–
Hand tools	–	2	2	–
Miscellaneous	6	–	–	1

Consultations have taken place with officers of the Ministry of Labour on two potential hazards which have come to light, namely the use in trade premises of small slicing machines intended and designed for the domestic market, and the increasing popularity of the frameless glass door as an architectural feature in modern office blocks and shops. In some conditions of light the latter are almost invisible and a person in a hurry does not always see a low-level knob or cross-bar. No serious accidents have so far been reported, but it is suggested that the incorporation in the design of some visible feature at average eye-level would be a wise precaution.

Prevention of Damage by Pests Act
The annual return submitted to the Minister of Agriculture, Fisheries and Food appears as Table 25.

The figures show a gratifying increase in activity following reorganisation of the section and by the end of the year a scheme set up in collaboration with the Borough Engineer and Surveyor for the provision of labour and equipment to treat the sewers in the older part of the borough was nearing completion. Operations are expected to commence early in 1967.

Pet Animals Act 1951
Twelve premises are licensed and 42 inspections were made during the year.

Riding Establishments Act 1964
Two annual licences were issued during the year, in one case after the execution of substantial improvements to the premises to bring them into conformity with the requirements of the Act. Sixteen inspections were made, including four by the veterinary surgeon retained by the council for the purpose.

Animal Boarding Establishments Act 1963
One annual licence was issued after the execution of works to bring the premises into conformity with the requirements of the Act.

Diseases of Animals Act 1950
Thirty-five inspections were made under the Act and relevant Regulations.

Miscellaneous
A total of 1,204 general complaints was received during the year. Not all of these related to matters with which the department could deal and a surprisingly large amount of time is spent by the inspectors and clerical staff in assisting complainants and directing them to the authorities empowered to help them. Complaints, anonymous or otherwise, are never ignored. As a result of 2,257 inspections nuisances were found at 1,377 premises and remedied at 1,108 during the year after 273 verbal and 1,225 written notices. One nuisance was remedied by the local authority in default of an owner and legal proceedings in one case for failure to comply with a notice served under Section 93 of the Public Health Act 1936 resulted in a fine of £5 and the award of £2 2 0d costs.

The following summarises the activities of the inspectors in connection with matters not specifically covered elsewhere.

Infectious disease investigations	596
Food poisoning investigations	60
Advice to long term immigrants	297
Rodent control in association with the Rodent Officer	182
Mosquito control	11
Agricultural premises	14
Schools	65
Noise nuisance observations	387
Licensed premises	11
Hairdressers and barbers	53

Canal boats	2
Piggeries	21
Public conveniences	15
Swimming baths	15
Accumulations of refuse on vacant land	708
Verminous premises	198
Interviews	657
Unclassified (service of statutory notices and similar purposes)	2,776
Land charge searches	4,760

The inspectors are supported by the staff of disinfectors/drain testers in connection with duties not requiring technical qualification, and the following summarises the latter visits.

Infectious diseases (collection of specimens)	1,322
Vermin and pest treatments	644
Drain testing	875
Collection of old peoples laundry	1,135
Disposal of condemned food	265
Other visits (mainly departmental communications)	12,341

Disinfestation treatments

Bugs and fleas (rooms)	70
Wasps nests	138
Cockroaches (premises)	9
Ants (premises)	18
Other insects (premises)	22
Pigeons destroyed at 11 sites	473

Rehousing on medical grounds

During the year 247 applications for rehousing on medical grounds were received from the Director of Housing. All these applications were supported by medical certificates and were assessed after visits had been paid by either the health visitor or public health inspector.

Public Health Act 1936

Nursing Homes

The local health authority became responsible for the registration and supervision of nursing homes in accordance with regulations made under part VI of the Public Health Act 1936.

Section I of the Nursing Homes Act 1963 made provision governing the conduct of nursing homes with respect to the standard of accommodation, staff and the care provided for patients, and limitations on the number of patients maintained in each home.

At the end of the year three nursing homes were registered to which principal medical officers made periodic visits of inspection.

Survey of Childhood Cancers

The survey which was commenced some years ago under the direction of Dr Alice Stewart, reader in social medicine, Oxford University, involves the follow up histories of children who have died from cancer or leukaemia during 1965 together with those of a control group. The parents of two children in the borough were interviewed during the year for the purpose of completing questionnaires.

The Diploma of Public Health assisted Training Scheme

The scheme whereby medical officers may be seconded to a Diploma of Public Health course and granted leave of absence on full pay and payment of course and examination fees has undoubtedly encouraged suitable young doctors to work in the public health field.

A medical officer was first seconded to a course this year and it is anticipated that another will be nominated to attend a course during 1967.

Establishments for Massage or Special Treatment

During the year nine establishments were licensed by the council for the following purposes—

Massage and electrical treatment	1
Chiropody	6
Chiropody and electrical treatment	2

Each establishment was inspected by a Medical Officer on one occasion during 1966.

Mortuary Service

The borough council maintains a public mortuary in the Feltham area of the borough and only bodies from the urban districts of Staines, Sunbury-on-Thames, Chertsey and Egham, and since the closing of Richmond mortuary some bodies from the London Borough of Richmond-on-Thames, are sent there by the coroner. A nominal charge is made for the use of this mortuary to the councils of the above-mentioned districts.

The coroner has directed that deceased persons who were resident within the London Borough of Hounslow and require to be removed to a public mortuary shall be sent to the Hampton mortuary maintained by the London Borough of Richmond-on-Thames. The council pays a nominal charge for the use of this mortuary.

Burials

Under Section 50 of the National Assistance Act 1948 it is the duty of the council to arrange the burial of any person who has died in the district where it appears that there are no suitable arrangements for the disposal of the body. During 1966 six burials were arranged in accordance with this section.

The Welfare Services in Hounslow

I am grateful to Mr D M Fleet, the Borough's Chief Welfare Officer, for the following report—

'Once again I welcome the opportunity to add brief notes to this report to give some account of the further development of welfare services in the borough during 1966.

The Elderly

No new residential homes became available during the year with the result that the waiting list for such accommodation increased by 47. It is however of some significance that during the year 238 applications for residential care were investigated and at some stage names added to the waiting list. Even more significant, 58 names were deleted either because the applicant was admitted to hospital or death supervened. 133 persons were admitted to permanent care and within the existing 7 homes provision was made for 76 persons to be admitted for what is loosely termed 'short stay care'. By this latter means, elderly or handicapped people were given care to enable relatives to have holidays or in some cases a short relief from their daily burden, and in this way permanent admissions were sometimes avoided.

The policy of providing day care in the homes was developed more extensively but true day centres for the elderly are still awaited. Day clubs however, provide a valuable meeting place for the elderly and towards the end of 1966 the borough council in partnership with voluntary organisations opened a day centre in Feltham and provided a daily meals service six days a week.

The holiday scheme continued to flourish, 157 old people were provided directly with holidays and many others assisted by the making of grants.

The housing committee programme to increase the units of sheltered accommodation throughout the borough will have a greater impact in succeeding years as new schemes are completed. It is believed that this type of accommodation with warden services will eventually lessen the demand for permanent care in residential homes although it may create a demand for increased domiciliary services.

The Blind and Partially Sighted

Whilst there was no significant change in the number of persons on the registers, the welfare needs of the blind and partially sighted tended to increase because of the advancing age of the persons concerned. The social activities were continued and extended in parts of the borough and 30 blind persons were assisted in the provision of holidays.

The Physically Handicapped

The two work centres continued to function successfully but the need to increase these facilities became apparent. It was mentioned last year that the number of persons on the register of physically handicapped had increased to 703 but there were indications that this in no way represented the potential total. In fact, the total

registered at the end of 1966 was 1,006. The actual number of new registrations was considerably higher than the difference between these two figures and it is probably in this field that the greatest volume of work was undertaken by the department. The total number of aids in issue exceed one thousand. Holidays were arranged for 110 persons, almost 100 per cent increase on the number provided in 1965.

The Deaf and Hard of Hearing
The services of a qualified senior welfare officer able to deal with the many problems of people who are deaf or hard of hearing became available during the year and his first task was to prepare an accurate register of the sufferers from this affliction.

Homeless Families
During the year one of the two hostels formerly used to provide temporary accommodation was closed. The welfare committee decided to improve the standard in the remaining hostel and the borough council towards the end of the year were recommended to adopt a completely new policy by assistance to families in distress. The results of that policy will be apparent in future reports.

Meals on Wheels
During the year the average number of meals supplied weekly increased by 80 but the welfare committee were very conscious of the fact that it was not immediately possible to overcome supply difficulties and that delivery was restricted to five days per week.

Transport
The overall needs of the department in providing facilities for blind and handicapped persons to attend classes and social functions, together with the daily requirements to transport elderly people to and from day care and also the growth of the meals service justified the acquisition of additional vehicles. Even so, demand by all handicapped groups in the community far exceed the total availability of suitable transport and it was thus still necessary to call upon volunteers from time to time and to utilise hired transport.

Voluntary Effort
1966 was a year of sustained voluntary effort and one cannot speak too highly of the tremendous part played by societies, committees, organisations, and individuals in the total welfare effort in in the community.

Conclusion
1966 ended with a better prospect in view—a new home, another day centre, a possible work centre, additional transport, and a holiday home. Much remained to be provided but a real start had been made to meet some of the needs apparent at the end of 1965.

The sentiments expressed last year on co-ordination of effort may be re-echoed. Staffs in all the facets of social services provided by the London Borough of Hounslow know they are part of a council team, know that each supports the other and realise that only in this way can the total need be satisfied.'

Co-ordination of Social Services

Co-ordination between the Children's, Health, Housing and Welfare departments continued successfully throughout the year and there was a good relationship with the many voluntary organisations working in the borough.

General policy matters affecting the social services were discussed at the Chairmen and Officers' Co-ordinating Committee and there has been a co-ordinated approach to matters which affect the various departments.

The findings and recommendations of the Seebohm Committee are awaited with interest.

Present and Future Building Projects

Project	*Probable Year of Completion*
Extension to Medical Advisory and Cerebral Palsy Unit, Martindale School Hounslow	1966/67
Heston Health Centre Vicarage Farm Road Heston	1966/67
Feltham Health Centre Spring Road Feltham	1967/68
Hanworth Junior Training School Main Street Hanworth	1967/68
Adaptation of Brentford Clinic Albany Road Brentford to provide a health centre	1967/68
Extension to Feltham Clinic Cardinal Road Feltham	1967/68
Extension to Hanworth Clinic Grove Crescent Hanworth	1967/68
Extension to Audiology Unit Heston School for the Deaf	1967/68
Chiswick Town Hall—alteration for use as clinic and offices	1967/68
Weekly Boarding Unit Main Street Hanworth	1968/69
Day Centre for Elderly Mentally Confused New Heston Road Heston (adaptation of clinic premises)	1968/69
Extension to Acton Lodge Adult Training Centre London Road Brentford	1968/69
Extension to Isleworth Junior Training School Bridge Road Isleworth	1968/69
Hounslow Health Centre—extension to existing Local Health Authority Clinic and Administrative Offices 92 Bath Road Hounslow	
Phase 1—Family doctor and child psychiatric units	1969/70
Phase 2—Mental Health Services, including a day centre for the mentally ill, flats for midwives and caretaker, and stores	1970/71
Phase 3—Children and Welfare Departments, communal dining and conference rooms and library	1972/78
Hostel for Mentally Disordered Staines Road Bedfont	1969/70
Long Stay Home for Mentally Sub-Normal Children New Heston Road Heston	1969/70
Chiswick Health Centre	1970/71
Cranford Health Centre Meadowbank Cranford	1970/71
South Hounslow Health Centre Hounslow Avenue Hounslow	1970/71
Chiswick Day Nursery and flats	1970/71
Hounslow Day Nursery and flats Lampton Road Hounslow (re-building)	1970/71
Hounslow Sheltered Workshop—Joint Welfare/Health Project	1970/71
Brentford Day Nursery and flats	1971/72
Extension to Heston Health Centre	1971/72
Extension to South Hounslow Health Centre	1971/72
Hounslow Heath Health Centre	1972/78
Old Isleworth Health Centre	1972/78
Osterley Health Centre	1972/78
South Chiswick Health Centre	1972/78
Heston Farm Area—Mini Clinic/Health Centre	1972/78
Mogden Lane Area—Mini Clinic/Health Centre	1972/78
Bedfont Day Nursery	1972/78

continued

Project	*Probable Year of Completion*
Heston Day Nursery and flats	1972/78
Isleworth Day Centre and flats	1972/78
Day Centre for Elderly Mentally Confused	1972/78
Extension to Bedfont Clinic Imperial Road Bedfont to provide a health centre	1972/78
Extension to Feltham Clinic Cardinal Road Feltham to provide a health centre	1972/78
Extension to Hanworth Clinic Grove Crescent Hanworth to provide a health centre	1972/78

Statistical Tables

Table 1 Causes of death at different periods of life for 1966

Cause of death	*Total all ages*		*Age group Under 4 weeks*		*4 weeks & under 1 year*		*1-4*		*5-14*		*15-24*		*25-34*		*35-44*		*45-54*		*55-64*		*65-74*		*75 and over*	
	M	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*
Tuberculosis, respiratory	7	5	–	–	–	–	–	–	–	–	–	–	–	–	1	1	1	–	2	1	3	–	–	3
Tuberculosis, other	–	1	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	1
Syphilitic disease	1	2	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	1	1	–	1
Diphtheria	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Whooping cough	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Meningococcal infections	2	–	–	–	1	–	1	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Acute poliomyelitis	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Measles	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Other infective and parasitic diseases	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Malignant neoplasm, stomach	24	24	–	–	–	–	–	–	–	–	–	–	–	–	1	–	–	6	9	2	6	6	8	10
Malignant neoplasm, lung, bronchus	117	28	–	–	–	–	–	–	–	–	1	–	1	–	1	–	10	2	50	12	37	9	17	5
Malignant neoplasm, breast	–	35	–	–	–	–	–	–	–	–	–	–	–	–	–	3	–	7	–	6	–	7	–	12
Malignant neoplasm, uterus	–	14	–	–	–	–	–	–	–	–	–	–	–	–	–	1	–	4	–	2	–	4	–	3
Other malignant and lymphatic neoplasms	101	110	–	–	–	–	–	–	1	–	–	–	2	1	1	5	20	17	20	27	26	29	31	31
Leukaemia, aleukaemia	9	6	–	–	–	–	–	1	–	–	1	–	2	–	–	–	1	1	3	2	1	1	1	1
Diabetes	7	16	–	–	–	–	–	–	–	–	–	–	–	–	–	–	2	1	–	3	1	3	4	9
Vascular lesions of nervous system	119	150	–	–	–	–	–	1	–	–	–	–	1	–	3	–	4	1	19	12	35	43	57	93
Coronary disease, angina	292	157	–	–	–	–	–	–	–	–	–	–	–	1	8	1	31	2	84	22	106	53	63	78
Hypertension with heart disease	10	19	–	–	–	–	–	–	–	–	–	–	–	–	–	–	2	–	2	–	6	5	–	14
Other heart disease	101	161	–	–	–	–	–	–	–	1	1	1	–	1	2	2	3	1	11	9	2	31	62	115
Other circulatory disease	55	64	–	–	–	–	–	–	–	–	–	–	–	1	1	2	3	1	14	10	20	15	17	35
Influenza	4	2	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	1	–	1	1	2	1
Pneumonia	51	84	2	2	5	5	1	–	–	–	–	1	1	–	–	3	1	–	2	5	11	12	28	56
Bronchitis	101	35	1	–	–	2	1	–	–	–	–	–	–	–	–	–	3	1	29	2	30	10	37	20
Other diseases of respiratory system	15	4	–	–	–	–	–	–	–	–	–	–	–	–	1	–	1	1	3	–	7	1	3	2
Ulcer of stomach and duodenum	8	2	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	1	5	–	3	1
Gastritis, enteritis and diarrhoea	3	6	–	–	1	–	1	–	–	–	–	–	–	–	1	–	–	–	–	2	–	1	–	3
Nephritis and nephrosis	3	7	–	–	–	–	–	–	–	–	–	1	–	–	–	–	–	2	2	1	1	1	–	2
Hyperplasia of prostate	6	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	1	–	–	–	1	–	4	–
Pregnancy, childbirth, abortion	–	1	–	–	–	–	–	–	–	–	–	1	–	–	–	–	–	–	–	–	–	–	–	–
Congenital malformations	10	12	5	8	2	–	1	–	–	2	–	–	–	1	–	–	–	1	2	–	–	–	–	–
Other defined and ill-defined diseases	78	79	19	11	3	1	3	2	–	2	4	1	1	2	1	3	7	5	8	9	15	19	17	24
Motor vehicle accidents	21	10	–	–	–	–	–	–	1	–	8	2	–	–	3	–	3	–	2	1	2	3	2	4
All other accidents	14	15	–	1	–	–	–	2	1	–	3	–	1	–	–	–	1	3	2	2	2	–	4	7
Suicide	14	7	–	–	–	–	–	–	–	–	1	–	4	1	2	–	1	3	3	–	1	1	2	2
Homicide and operations of war	–	1	–	–	–	–	–	–	–	–	–	–	–	1	–	–	–	–	–	–	–	–	–	–
Total all causes	1173	1057	27	22	12	8	8	6	3	5	19	7	13	9	26	21	95	59	268	131	340	256	362	533

Table 2 Infant deaths according to age and cause 1966

Cause of death	*Age in Days under 1*	*1*	*2*	*3*	*4*	*5*	*6*
Meningococcal infections	–	–	–	–	–	–	–
Pneumonia	–	–	–	1	–	–	–
Complications of pregnancy, childbirth and puerperium	2	–	–	–	–	–	–
Congenital malformations	5	2	1	1	–	–	–
Birth injuries, post-natal asphyxia and atelectasis	13	1	3	–	–	–	–
Infections of the newborn	–	–	1	–	–	–	–
Other diseases peculiar to early infancy and immaturity unqualified	8	1	2	–	1	–	1
All other diseases	–	–	–	–	–	–	–
Total	28	4	7	2	1	–	1

Table 3 Corrected notifications of infectious diseases 1966

Disease	*Total*	*Age in years Under 1*	*1*	*2*	*3*
Smallpox	–	–	–	–	–
Typhoid fever	–	–	–	–	–
Paratyphoid	1	–	–	–	–
Scarlet fever	120	–	3	12	12
Diphtheria	–	–	–	–	–
Erysipelas	4	–	–	–	–
Puerperal Pyrexia	53	–	–	–	–
Ophthalmia neonatorum	–	–	–	–	–
Acute encephalitis	5	–	–	–	–
Acute poliomyelitis	–	–	–	–	–
Meningococcal infection	3	2	–	–	–
Pneumonia	18	2	–	1	–
Malaria	2	–	–	–	–
Dysentery	79	6	3	7	16
Measles	893	46	99	151	139
Whooping cough	37	7	6	4	4
Food poisoning	1	–	–	–	–
Tuberculosis					
pulmonary	64	–	–	–	–
non pulmonary	19	–	–	–	–

Age in Days			*Age in Months*											
7-13	*14-20*	*21-28*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*11*	*Total*
–	–	–	–	–	–	1	–	–	–	–	–	–	–	1
–	–	–	2	2	–	1	–	1	1	–	–	–	–	8
–	–	–							–	–	–	–	–	2
2	2	1	1	–	–	–	1	–	–	–	–	–	–	16
–	1	–	–	–	–	–	–	–	–	–	–	–	–	18
–	–	–	1	1	5	1	–	–	–	–	–	–	–	9
–	–	–	–	–	–	–	–	–	–	–	–	–	–	13
–	–	1	–	–	–	–	1	–	–	–	–	–	–	2
2	3	2	4	3	5	3	2	1	1	–	–	–	–	69

Age in years									
4	*5-9*	*10-14*	*15-19*	*20-34*	*35-44*	*45-64*	*65 and over*	*Age unknown*	*Cases admitted to hospital*
–	–	–	–	–	–	–	–	–	–
–	–	–	–	–	–	–	–	–	–
–	–	–	1	–	–	–	–	–	1
20	62	5	3	2	1	–	–	–	10
–	–	–	–	–	–	–	–	–	–
–	–	–	–	–	1	2	1	–	3
–	–	–	10	38	5	–	–	–	53
–	–	–	–	–	–	–	–	–	–
1	4	–	–	–	–	–	–	–	5
–	–	–	–	–	–	–	–	–	–
–	1	–	–	–	–	–	–	–	3
–	2	–	–	1	2	7	2	1	7
–	1	–	–	–	1	–	–	–	2
8	7	1	5	17	4	2	–	3	9
152	292	2	1	4	1	1	–	5	27
4	9	1	1	1	–	–	–	–	11
–	1	–	–	–	–	–	–	–	–
–	1	2	6	17	18	15	5	–	20
–	–	–	1	11	5	1	1	–	6

Table 4 Venereal disease patients treated at West Middlesex Hospital

Persons dealt with for the first time and found to be suffering from:	
Syphilis	17
Gonorrhoea	213
Other conditions	934
Total	1164

The figures include patients who do not normally reside in the borough and exclude borough residents attending other hospitals for similar treatment for the first time.

Table 5 Ophthalmia Neonatorum

Total number of cases notified during the year	–
Number of cases in which—	
Vision lost	–
Vision impaired	–
Treatment continuing at end of year	–

Table 6 Vaccination and immunisation

Completed primary courses—number of persons under age 16

Type of vaccine	*Year of birth*					*Others under age 16*	*Total*
	1966	*1965*	*1964*	*1963*	*1959-62*		
Quadruple DTPP	5	47	5	–	2	–	59
Triple DTP	1087	1285	99	27	44	7	2549
Diphtheria/Whooping Cough	–	–	1	1	–	–	2
Diphtheria/Tetanus	105	136	32	30	142	85	530
Diphtheria	–	3	2	–	–	4	9
Whooping cough	–	–	–	–	–	–	–
Tetanus	–	–	1	2	23	605	631
Salk	3	22	5	4	2	1	37
Sabin	987	1996	254	100	296	130	3763
Lines 1+2+3+4+5 (Diphtheria)	1197	1471	139	58	188	96	3149
Lines 1+2+3+6 (Whooping cough)	1092	1332	105	28	46	7	2610
Lines 1+2+4+7 (Tetanus)	1197	1468	137	59	211	697	3769
Lines 1+8+9 (Poliomyelitis)	995	2065	264	104	300	131	3859

Reinforcing doses—number of persons under age 16

Type of vaccine	*1966*	*1965*	*1964*	*1963*	*1959/62*	*Others under age 16*	*Total*
Quadruple DTPP	–	3	6	2	4	–	15
Triple DTP	–	478	631	55	156	23	1343
Diphtheria/Whooping cough	–	–	–	–	–	–	–
Diphtheria/Tetanus	–	104	81	21	1752	203	2161
Diphtheria	–	8	1	2	37	168	216
Whooping cough	–	–	1	–	–	–	1
Tetanus	–	–	1	–	44	44	89
Salk	–	18	9	4	11	1	43
Sabin	–	65	46	16	2153	225	2505
Lines 1+2+3+4+5 (Diphtheria)	–	593	719	80	1949	394	3735
Lines 1+2+3+6 (Whooping cough)	–	481	638	57	160	23	1359
Lines 1+2+4+7 (Tetanus)	–	585	719	78	1956	270	3608
Lines 1+8+9 (Poliomyelitis)	–	86	61	22	2168	226	2563

Table 7 Smallpox vaccination persons aged under 16

Age at date of vaccination	*Number of persons vaccinated or revaccinated during 1966*	
	Number vaccinated	*Number revaccinated*
0–2 months	71	–
3–5 months	35	–
6–8 months	34	–
9–11 months	46	–
12–23 months	1767	–
2–4 years	280	27
5–15 years	153	230
Total	2386	257

Table 8 Midwives who notified their intention to practise within the London Borough of Hounslow during the year 1966

Domiciliary	
Employed by Borough Council	17
Employed by Queen Charlotte's Hospital	10
In private practice	1
Institutional	
Hospitals	149
Nursing Homes	–
Total	177

Table 9 Deliveries attended by domiciliary midwives during 1966

By Midwives employed by Borough Council	619
By Midwives employed by Queen Charlotte's Hospital	92
Total	711
Number of cases delivered in hospitals and other institutions but discharged and attended by domiciliary midwives before the 10th day—	
Borough Council Midwives	694
Queen Charlotte's Hospital Midwives	86
Midwife employed by London Borough of Ealing specifically for 48 hour planned discharges (Brentford and Chiswick area)	29
Total	809

Table 10 Health Visiting

Number of visits paid by Health Visitors during 1966	*First visits*	*Total visits*
Expectant mothers	1261	1974
Children born in 1966	3645	10566
Children born in 1965	3887	11499
Children born in 1961–64	8795	23257
Other classes	1139	2661
All classes	18727	49957

This table does not include

a. Visits made by Tuberculosis Health Visitors

b. Visits to families by Health Visitor/School Nurses whilst acting solely in their capacity as School Nurses

Table 11 Home Nursing

Patients attended by Home Nurses during 1966	
a. number of cases	2414
b. number of visits	91371
Patients included in (a) above who were 65 or over at the time of the first visit	
Number of cases	1530
Children included in (a) above who were under 5 at the time of the first visit	
Number of cases	13
Number of visits included in (b) above of over one hour duration	3649

Table 12 Home Help

Number of cases in which home help was provided during 1966	
Aged 65 or over at time of first visit during year	1515
Aged under 65 at time of first visit during year—	
Chronic sick and tuberculous	148
Mentally disordered	17
Maternity	171
Others	155
Total	2006

Table 13 New cases of Tuberculosis notified formally or otherwise to the Medical Officer of Health and Deaths ascribed to Tuberculosis during 1966

Age in years	*New cases*				*Deaths*			
	Pulmonary		*Non-pulmonary*		*Pulmonary*		*Non-pulmonary*	
	M	*F*	*M*	*F*	*M*	*F*	*M*	*F*
Under 1	–	–	–	–	–	–	–	–
1	–	–	–	–	–	–	–	–
5	1	–	–	–	–	–	–	–
10	2	–	–	–	–	–	–	–
15	4	2	–	2	–	–	–	–
20	4	4	2	4	–	–	–	–
25	12	6	1	5	–	–	–	–
35	12	12	2	3	1	1	–	–
45	3	4	–	–	1	–	–	–
55	7	2	1	–	2	1	–	–
65 and over	6	1	1	–	3	3	–	1
Age unknown	–	–	–	–	–	–	–	–
All ages	51	31	7	14	7	5	–	1

Table 14 Tuberculosis
Summary of the work of chest clinics

Persons examined for the first time	4903
Persons found to be tuberculous	102
New contacts seen for the first time during the year	882
New contacts found to be tuberculous	5
Cases on register at 31st December 1966	942
Home visits made by Tuberculosis Health Visitors during 1966	1916

Table 15 Ante-natal and post-natal clinics

Number of Clinics provided at end of 1966	7
Number of sessions held by Medical Officers	333
by Midwives	117
Total	450
Number of women who attended in 1966	
Ante-natal	583
Post-natal	112
Total number of attendances made by women shown above	
Ante-natal	2534
Post-natal	115

Table 16 Ante-natal mothercraft and relaxation classes

Number of women who attended during 1966	
Institutionally booked	343
Domiciliary booked	60
Total	403
Total number of attendances during 1966	2186

Table 17 Care of premature infants

Number of premature babies born alive to mothers normally resident in the Borough, but excluding babies born in maternity homes or hospitals in the National Health Service

Born at home or in a private nursing home	Born at home or in a private nursing home and nursed entirely at home, or in a private nursing home		
	number born	died during first 24 hours	survived to end of 28 days
15	15	–	15

Table 18 Child welfare centres

Number of centres in use at end of 1966*	11
Number of Child Welfare Sessions held by	
Medical officers	1315
Health visitors	54
Hospital medical staff	51
Total	1420
Number of children who attended during the year and who were born in	
1966	3220
1965	2892
1961–1964	2601
Total	8713
Number of attendances made by children shown above	56580

* The number of centres includes one mobile unit fully staffed by the Council, and a clinic held at Queen Charlotte's Hospital at which the Council provides a health visitor only.

Table 19 Day nurseries provided by the Borough Council as at 31st December 1966

Number	3
Number of approved places	126
Number of children on register at end of year	
Age under 2 years	39
Age 2–5 years	100
Average daily attendance during the year*	
Age under 2 years	27
Age 2–5 years	78

* These are arithmetical averages which reflect absences due to infectious and other illness, and also the postponement of new admissions during outbreaks of infectious illness.

Table 20 Mother and Baby Homes

Provided by Voluntary Organisations with which the Borough Council made arrangements under Section 22 of the National Health Service Act 1946

Name and address of Home	*Number of beds*	
	Total	*Cots*
St Agnes 53 Barrowgate Road Chiswick W4 (Hammersmith Deanery Association for Moral Welfare)	16	4

In addition the Council accepted financial responsibility for 55 cases which were sent to homes outside the Borough.

Table 21 Priority Dental Service
Expectant and nursing mothers and pre-school children

Number of cases	*Number of persons examined during the year*
Expectant and nursing mothers	104
Children aged under 5 and not eligible for school dental service	658

Dental treatment provided	*Scalings and/or stain removal*	*Fillings*	*Teeth filled*	*Crowns and inlays*
Expectant and nursing mothers	65	275	170	1
Children aged under 5 and not eligible for school dental service	137	1274	910	–

Admissions		*Average length of stay in weeks*		
Total number of women admitted	*Number of admissions for which the Council accepted financial responsibility*	*Ante-natal*	*Post-natal*	*Shelter*
92	18	6	4	2

Number of persons who commenced treatment during the year	*Number of courses of treatment completed during the year*
95	64
468	427

Teeth extracted	*General anaesthetics*	*Dentures provided*		*Radiographs*
		Full upper or lower	*Partial upper or lower*	
93	21	6	11	29
513	235	–	–	4

Table 22 Mentally disordered patients under the care of the Borough at 31st December 1966

		Mentally ill					*Sub-normal and severely sub-normal*				
		Under age 16		*Aged 16 and over*		*Total*	*Under age 16*		*Aged 16 and over*		*Total*
		M	*F*	*M*	*F*		*M*	*F*	*M*	*F*	
1	Number of patients under care at 31st December 1966	–	1	83	137	221	63	58	118	131	370
2	Attending training centre	–	–	10	5	15	54	45	40	50	189
3	Awaiting entry to training centre	–	–	–	–	–	4	3	2	1	10
4	Receiving home training	–	–	–	–	–	–	–	–	–	–
5	Awaiting home training	–	–	–	–	–	–	–	–	–	–
6	Resident in LA home/hostel	–	–	4	4	8	–	–	1	–	1
7	Awaiting residence in LA home/ hostel	–	–	–	–	–	–	–	3	–	3
8	Resident at LA expense in other homes/hostels	–	–	4	11	15	1	7	4	8	20
9	Resident at LA expense by boarding out in private households	–	–	–	–	–	1	1	–	3	5
10	Attending day hospitals	–	–	3	8	11	–	–	–	–	–
11	Receiving home visits and not included in lines 2–10										
	a. suitable to attend a training centre	–	–	–	–	–	1	4	9	15	29
	b. others	–	1	62	111	174	4	1	66	58	129
12	Number of children not included in item 2 above because they do not come within the categories covered	–	–	–	–	–	–	–	–	–	–
13	Number of persons included in item 6 above who reside in accommodation provided under the National Assistance Act, 1948	–	–	–	–	–	–	–	–	–	–
14	Number of patients on waiting list for admission to hospital at 31.12.66										
	a. In urgent need of hospital care	–	–	–	–	–	7	7	–	3	17
	b. Not in urgent need of hospital care	–	–	–	–	–	1	–	–	1	2
15	Number of admissions for temporary residential care (eg to relieve the family) during 1966										
	To NHS Hospitals	–	–	–	–	–	12	13	3	6	34
	Elsewhere	–	–	–	–	–	1	1	–	–	2
16	Admissions to guardianship during the year	–	–	–	–	–	–	–	–	–	–
17	Total number under guardianship at end of year	–	–	–	–	–	–	–	–	–	–

Table 23 Number of patients referred during year ended 31st December 1966

	Mentally ill					*Sub-normal and severely sub-normal*				
Referred by	*Under age 16*		*Aged 16 and over*		*Total*	*Under age 16*		*Aged 16 and over*		*Total*
	M	*F*	*M*	*F*		*M*	*F*	*M*	*F*	
General Practitioners	–	1	163	279	443	–	–	–	–	–
Hospitals, on discharge from inpatient treatment	–	–	81	118	199	–	–	–	–	–
Hospitals, after or during outpatient or day treatment	–	–	21	25	46	–	–	1	–	1
Local education authorities	–	1	–	1	2	6	5	9	8	28
Police and courts	–	–	19	11	30	–	–	1	–	1
Other sources	–	–	71	110	181	4	1	4	2	11
Total	–	2	355	544	901	10	6	15	10	41

Table 24 Work of mental health social workers during 1966

	Mental illness	*Mental subnormality*
Visits made	2683	1186
Office interviews	287	87
Compulsory admissions to psychiatric hospitals	156	–
Informal admissions to psychiatric hospitals	115	24

Table 25 Ministry of Agriculture, Fisheries and Food · Prevention of Damage by Pests Act 1949 · Report for 12 months ended 31st December 1966

	Type of property	
Properties other than sewers	*Non-Agricultural*	*Agricultural*
Number of properties in district	74811	9
Total number of properties (including nearby premises) inspected following notification	2502	3
Number infested by Rats	1736	4
Mice	306	1
Total number of properties inspected for rats and/or mice for reasons other than notification	2950	9
Number infested by Rats	2894	1
Mice	91	–
Sewers		
Were any sewers infested by rats during the year?	Yes	

Table 26 Offices, Shops and Railway Premises Act, 1963 · Annual Report for 1966

Section 60 of the above Act requires a local authority as soon as practicable after the 31st December each year and not later than the end of March following, to make to the Minister of Labour a report on their proceedings under this Act containing particulars as prescribed in an order made by the Minister.
These prescribed particulars, as set out below, were forwarded to the Minister of Labour on the 6th March 1967.

Table A. Registrations and General Inspections

Class of Premises	*Number of premises registered during the year*	*Number of premises registered at end of year*	*Number of registered premises receiving a general inspection during the year*
Offices	62	590	48
Retail Shops	52	1142	107
Wholesale shops, warehouses	8	121	4
Catering establishments open to the public, canteens	15	169	6
Fuel storage depots	–	–	–
Totals	137	2022	165

Table B. Number of visits of all kinds by Inspectors to registered premises 2958

Table C. Analysis of persons employed in registered premises by workplace

Class of Workplace	*Number of persons employed*
Offices	15885
Retail shops	6468
Wholesale departments, warehouses	1809
Catering establishments open to the public	1297
Canteens	990
Fuel storage depots	4
Total	26453
Total males	13231
Total females	13222

Table D. Exemptions One exemption granted under Part IV—washing facilities

Table E. Prosecutions None

The exemption mentioned in Table D Part IV, relates only to the provision of hot water to an existing wash basin and is limited to one year.

Table 27 Factories Act 1961 Part I of the Act

Inspections for purposes of provisions as to health made by Public Health Inspectors

Premises	*Number on Register*	*Inspections*	*Number of Written notices*	*Occupiers prosecuted*
a. Factories in which Sections 1, 2, 3, 4 and 6 are to be enforced by Local Authorities	103	29	2	–
b. Factories not included in (a) in which Section 7 is enforced by the Local Authority	876	1152	16	–
c. Other premises in which Section 7 is enforced by the Local Authority (excluding outworkers' premises)	13	30	1	–
Total	992	1211	19	–

Cases in which defects were found

	Number of cases in which defects were found				*Number of cases in which prosecutions were instituted*
	Found	*Remedied*	*Referred To HM Inspector*	*Referred By HM Inspector*	
Want of cleanliness (S1)	–	–	–	–	–
Overcrowding (S2)	–	–	–	–	–
Unreasonable temperature (S3)	1	2	–	–	–
Inadequate ventilation (S4)	–	1	–	–	–
Ineffective drainage of floors (S6)	–	–	–	–	–
Sanitary conveniences (S7)					
a. insufficient	–	3	–	–	–
b. unsuitable or defective	33	54	–	2	–
c. not separate for sexes	–	–	–	–	–
Other offences against the Act (not including offences relating to outwork)	1	–	–	–	–
Total	35	60	–	2	–

Table 27 continued

Outwork—Part VIII of the Act

Nature of Work	*Section 133*			*Section 134*		
	No of Outworkers in August list required by Section 133(1)c	*No of cases of default in sending lists to the Council*	*No of prosecutions for failure to supply lists*	*No of instances of work in unwholesome premises*	*Notices served*	*Prosecutions*
Wearing apparel. Making etc cleaning and washing	1	–	–	–	–	–
Lace, lace curtains and nets	7	–	–	–	–	–

Table 28 Meteorology

Extract from records supplied by the Chief Engineer, Mogden Sewage Works

Week ending 1966	*Barometer*		*Temperature (C°)*		*Days with rainfall*	*Total rainfall (inches)*
	Highest	*Lowest*	*Max*	*Min*		
Jan 1st	29·70	29·01	12·0	—6·5	4	0·77
8th	30·26	29·04	8·5	—1·0	2	trace
15th	30·38	29·74	5·0	—5·5	2	trace
22nd	29·93	29·01	4·0	—6·5	6	0·20
29th	29·82	29·33	12·5	3·0	6	0·42
Feb 5th	29·96	29·57	12·5	3·0	6	0·65
12th	29·70	29·05	13·5	0·0	7	0·95
19th	29·86	29·02	13·0	0·0	3	0·37
26th	29·65	28·74	12·0	2·0	7	1·11
Mar 5th	30·23	29·61	13·0	2·0	5	0·14
12th	30·21	29·70	13·0	0·5	4	0·05
19th	30·68	30·14	13·0	—2·5	–	–
26th	30·58	28·96	14·0	0·0	4	0·19
Apr 2nd	30·10	28·95	14·0	1·0	4	0·19
9th	30·00	29·17	17·0	3·0	6	0·80
16th	29·77	29·25	16·0	0·0	6	0·80
23rd	30·13	29·25	15·5	1·0	7	1·69
30th	30·46	29·53	21·0	4·0	3	0·20
May 7th	30·22	29·36	26·0	6·0	4	0·64
14th	30·31	29·35	19·0	4·5	4	0·70
21st	30·31	29·60	23·0	6·0	3	0·30
28th	30·29	29·55	19·0	4·0	3	0·37
June 4th	30·28	29·60	25·0	6·0	–	–
11th	29·96	29·60	27·0	10·5	3	0·60
18th	29·96	29·70	27·0	9·5	4	0·13
25th	30·10	29·40	22·0	10·5	7	1·84
July 2nd	30·14	29·77	25·0	9·5	2	0·02
9th	30·07	29·67	26·5	12·0	5	0·56
16th	29·94	29·61	22·5	9·5	5	0·35
23rd	30·07	29·65	25·5	8·0	4	0·56
30th	30·00	29·50	20·5	8·5	7	1·20
Aug 6th	29·83	29·41	20·0	7·0	7	1·23
13th	30·00	29·53	23·0	10·0	4	0·19
20th	30·40	28·50	28·0	8·0	–	–
27th	30·10	29·76	23·5	6·5	3	0·03

Table 28 continued

Week ending 1966	*Barometer*		*Temperature (C°)*		*Days with rainfall*	*Total rainfall (inches)*
	Highest	*Lowest*	*Max*	*Min*		
Sep 3rd	29·85	29·43	23·0	11·5	5	1·92
10th	30·08	29·53	23·0	9·0	2	0·22
17th	30·34	29·59	23·0	5·0	5	0·31
24th	30·29	30·06	22·0	8·0	–	–
Oct 1st	30·08	29·22	19·5	7·5	3	0·67
8th	29·86	29·00	19·0	9·0	5	0·92
15th	29·97	29·34	18·0	4·5	5	1·72
22nd	29·90	29·04	18·0	6·0	5	1·18
29th	30·26	29·60	12·0	3·5	3	6·04
Nov 5th	30·28	28·80	12·0	0·5	4	0·52
12th	30·22	29·26	16·0	0·0	3	0·05
19th	30·09	29·52	11·0	8·5	5	0·40
26th	30·16	29·87	10·0	—1·0	6	0·04
Dec 3rd	30·03	28·37	11·0	0·0	7	0·81
10th	30·18	29·14	12·0	—0·5	7	0·93
17th	30·18	28·79	11·5	0·5	6	0·34
24th	30·17	29·51	12·5	—1·0	6	0·43
31st	30·18	29·40	12·5	—4·0	4	0·72

Table 29 Wind direction

Summary of daily records for 53 weeks

N	23 days	SSW	15 days
NNE	10 days	SW	35 days
NE	9 days	WSW	40 days
ENE	6 days	W	23 days
E	12 days	WNW	19 days
ESE	9 days	NW	10 days
SE	3 days	NNW	9 days
SSE	1 day	Calm	129 days
S	9 days	No record	9 days

List of clinics held in the Borough at 31st December 1966

Except for infant welfare and minor ailments attendance at all clinics is by appointment

Clinic	*Infant welfare*	*Ante-natal*	*Immunisation*	*Chiropody*	*Dental*	*School*	*Minor ailments*
Bedfont	Mon pm Wed pm Fri pm	Tue pm (alt) Fri am (relaxation)		Thur pm	Mon to Fri am/pm	Thur am	Mon to Fri am
Brentford	Wed pm Thur pm	Tue pm (alt)	Mon pm Fri pm	Tue am Wed pm Fri am	Wed am/pm Thur am/pm Fri am/pm	Thur am	Mon to Fri am
Chiswick	Tue pm Wed pm Thur pm Fri pm	Thur am Tue am (relaxation)	Mon pm Tue pm Thur pm	Mon am/pm Tue pm Wed am/pm Thur am/pm Fri pm	Mon to Fri am/pm	Mon am	Mon to Fri am
Cranford	Fri pm						
Feltham	Mon pm Tue pm (HV only) Wed pm	Thur pm (relaxation & Mother- craft)	Tue pm	Mon am	Mon to Fri am/pm	Wed am Fri am	Mon to Fri am
Hanworth	Tue pm Wed pm Fri pm	Thur pm Mon pm (relaxation)		Tue pm	Tue am/pm Thur am/pm	Mon am	Mon to Fri am
Heston	Mon pm Tue pm Wed pm	Thur pm & relaxation Wed pm (Midwives)	Fri pm	Wed pm Thur am		Tue am	Mon to Fri am
Hounslow	Tue pm Wed pm Thur pm Fri pm	Tue am Thur pm Tue am (relaxation) Wed pm (Midwives)	Mon pm Wed am	Mon pm Tue am Fri am	Mon to Fri am/pm	Wed am Fri am	Mon to Fri am
Isleworth	Mon pm Wed pm	Tue pm Thur pm (Midwives)	Thur pm	Tue am Fri am/pm	Mon am/pm Tue am/pm Thur am/pm	Mon am	Mon to Fri am
Child Guidance							
Hearing							
Medical Advisory Unit							

Ophthalmic & orthoptic	*Ortho-paedic*	*Physio-therapy*	*Speech Therapy*	*Allergy*	*Mental Health Counselling*	*Child Psychiatry*	*Otology*	*Cerebral Palsy*
			Mon am/pm					
Mon am (alternate)	Mon pm 1st & 3rd		Mon am/pm Tue pm Fri am/pm		Tue pm 2nd & 4th			
Mon am (alternate)			Tue am/pm Thur am/pm		Thur pm 1st			
Thur am (Orthoptist)			Thur pm Mon am/pm Wed am					
Mon am (Orthoptist) Tue am Wed pm	Tue pm 4th	Tue pm Thur pm Fri pm	Tue am/pm Wed am/pm Thur am/pm Fri pm	Fri pm	Tue pm 1st			
Mon pm (alternate)		Mon am Tue am Thur am Fri am	Wed pm Fri am/pm					
						Wed am/pm Thur am/pm Fri pm	Mon am Tue am/pm	Mon pm
Mon am (occasional)		Mon to Fri am/pm	Mon to Fri am/pm					

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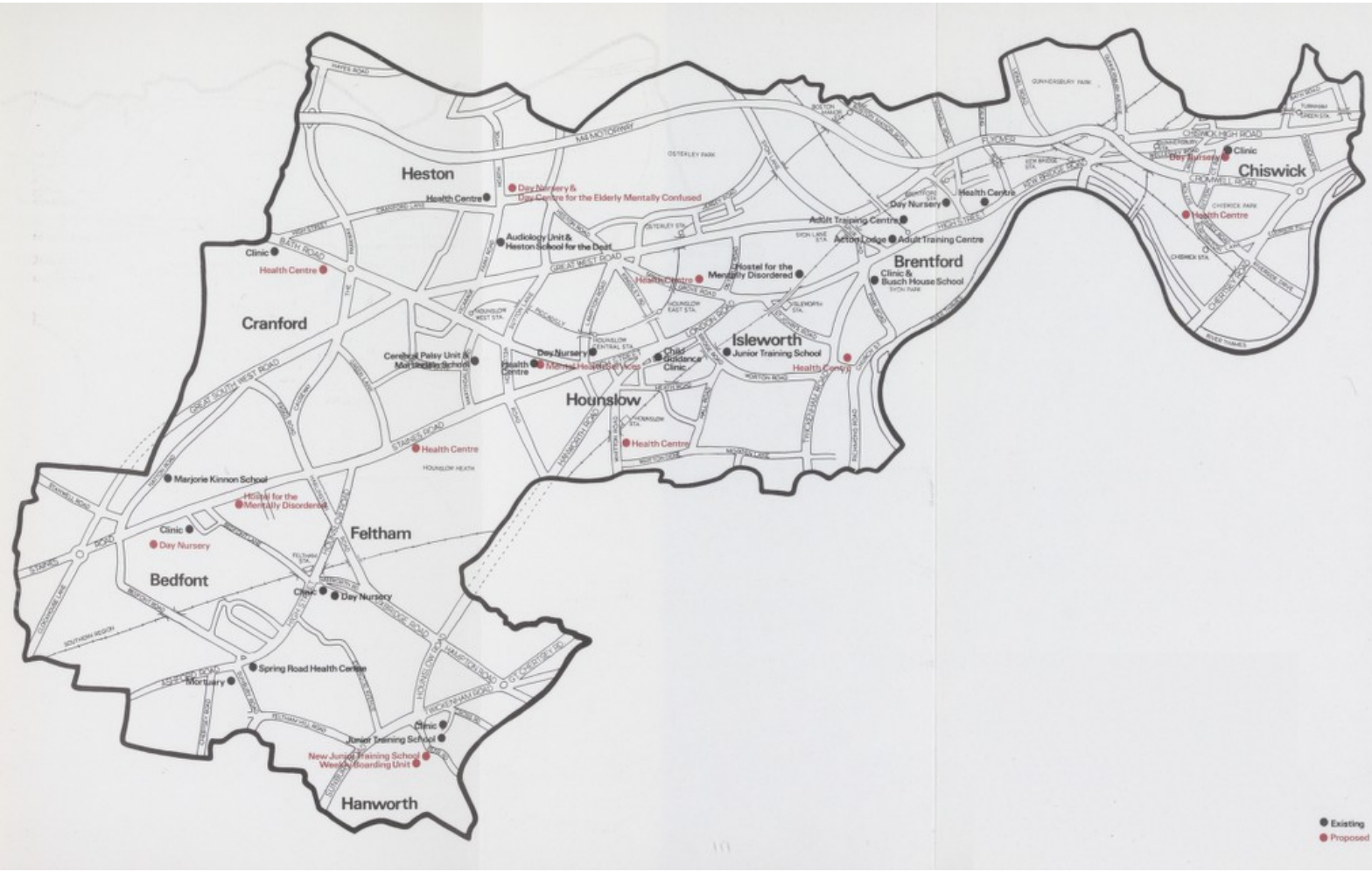
Heston
Day Nursery &
Day Centre for the Elderly Mentally Confused
Health Centre
Clinic
Health Centre
Audiology Unit &
Heston School for the Deaf
Cranford
Cerebral Palsy Unit &
Martindale School
Day Nursery
Health Centre
Hounslow
Health Centre
Health Centre
Marjorie Kinnon School
Hostel for the Mentally Disordered
Clinic
Day Nursery
Feltham
Bedfont
Clinic
Day Nursery
Spring Road Health Centre
Mortuary
Clinic
Junior Training School
New Junior Training School
Weekly Boarding Unit
Hanworth
Health Centre
Day Nursery
Adult Training Centre
Acton Lodge
Adult Training Centre
Brentford
Clinic &
Busch House School
Hostel for the
Mentally Disordered
Health Centre
Isleworth
Junior Training School
Child
Guidance
Clinic
Health Centre
Day Nursery
Clinic
Health Centre
Chiswick
Existing
Proposed