

[Report 1972] / Medical Officer of Health, Brackley Borough.

Contributors

Brackley (England). Borough Council.

Publication/Creation

1972

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I

**BRACKLEY
BOROUGH COUNCIL**

ANNUAL REPORT

OF THE

**MEDICAL OFFICER
OF HEALTH**

JOAN M. ST. V. DAWKINS
M.B., B.S., F.F.C.M., D.P.H., D.C.H.

1972





Tel: Brackley 2441/2

To the Mayor, Aldermen and Councillors,
of the Borough of Brackley.

Mr. Mayor, Aldermen and Councillors,

BRACKLEY BOROUGH COUNCIL

I have the honour to present the Annual Report of the Medical Officer of Health incorporated in the Public Health Act 1936.

The report is presented once again in six sections, each dealing with an aspect of control of environmental health of the area.

The vital statistics for the year show that there was an increase in population of 140 according to the Registrar General's mid-year estimate of 5,100. There were 40 deaths, a decrease of 17 on last year's figure. This gives a standardised rate of 7.2 compared with the national figure of 12.5. Female deaths exceeded male deaths by 1. The number of live births was 109, an increase of 10 on last year's figure. The crude rate of 21.5 compared with 14.8 for England and Wales. Illegitimate births were 3, 2 less than in 1971. There was one death under the age of one year.

ANNUAL REPORT

The first section (A) dealing with the natural and social conditions indicates that the town remains virtually unchanged, although an industrial estate has been established on the south side of the Buckingham Road, at present comprising 26 factories. In this section statistics of births and deaths are given, and consideration made of the causes of warps and preventable morbidity and death. While the annual report relates to local environmental health it would be a mistake to assume that the personal health of individuals living in the town is not a matter of concern. A study on coronary arterial disease, a study on road accidents and details of a RCGP report on home accidents.

MEDICAL OFFICER OF HEALTH

The second section (B) deals with social services, both statutory and voluntary, which are provided in the town. Services given, particularly to the elderly, on a voluntary basis make a valuable contribution to the community life, and gratitude to those who give so unstintingly of their time and help is expressed.

The third section (C) deals with sanitary circumstances giving a description of water supplies, sewerage, refuse collection and disposal, rodent control and other health questions. The extension scheme at the sewage disposal works commenced and it is anticipated that this will be completed by early 1973. Future environmental health control, after reorganisation of services, is also considered.

1972

JOAN M. ST.V. DAWKINS

M.B., B.S., F.F.C.M., D.P.H., D.C.H.

The fourth section (D) is concerned with council housing, improvement grants and other matters. In 1972 30 houses and flats were completed by the Council. 46 dwellings were built by private enterprise.

The fifth section (E) deals with food hygiene and poultry meat was once again the major food inspection function in the town. Changes due to technical advances in the food industry, while greatly improving variety and keeping quality, do not lessen, but rather increase the need for vigilance in food control. Innovations in manufacture, storage and cooking, together with increasing mobility of the population (including travel abroad and the importation of infected animals) remains with the actual food handlers, and the rapid turnover of employment, together with these other factors require supervision from both employer and inspector. Finally consumers, themselves on the alert, should refuse to accept



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Public Health Department,
Municipal Offices,
Market Place,
BRACKLEY.

Tel: Brackley 2441/2

To the Mayor, Aldermen and Councillors,
of the Borough of Brackley.

Mr. Mayor, Aldermen and Councillors,

I have the honour to present the Annual Report of the Medical Officer of Health incorporating that of the Public Health Inspector.

The report is presented once again in six sections, each dealing with an aspect of control of environmental health of the area.

The vital statistics for the year show that there was an increase in population of 140 according to the Registrar General's mid-year estimate of 5,100. There were 40 deaths, a decrease of 17 on last year's figure. This gives a standardised rate of 7.2 compared with the national figure of 12.1. Female deaths exceeded male deaths by 6. The total number of live births was 109, an increase of 4 on last year and giving a standardised rate of 18.0 compared with 14.8 for England and Wales. Illegitimate births were 4, 2 less than in 1971. There was one death under the age of one year.

The first section (A) dealing with the natural and social conditions indicates that the town remains virtually unchanged, although an industrial estate has been established on the south side of the Buckingham Road, at present comprising 26 factories. In this section statistics of births and deaths are given, and consideration made of the causes of early and preventable morbidity and death. While the annual report relates to local environmental health it would be incomplete without some reference to the personal health of individuals living in the area. The section includes comments on cancer, arterial disease, a study on road accidents and details of a ROSPA report on home accidents.

The second section (B) outlines health and social services, both statutory and voluntary, which are provided in the town. Services given, particularly to the elderly, on a voluntary basis make a valuable contribution to the community life, and gratitude to those who give so unstintingly of this constant help is expressed.

The third section (C) deals with sanitary circumstances giving a description of water supplies, sewerage, refuse collection and disposal, rodent control and other health functions. The extension scheme at the sewage disposal works commenced and it is anticipated that this will be completed by early 1974. Future environmental health control, after reorganisation of services, is also considered.

The fourth section (D) is concerned with council housing, improvement grants and other matters. In 1972 66 houses and flats were completed by the Council. 46 dwellings were built by private enterprise.

The fifth section (E) deals with food hygiene and poultry meat was once again the major food inspection function in the town. Changes due to technical advances in the food industry, while greatly improving variety and keeping quality, do not lessen, but rather increase the need for vigilance in food control. Innovations in manufacture, storage and cooking, together with increasing mobility of the population (including travel abroad and the importation of infections), remains with the actual food handlers, and the rapid turnover of employment, together with these other factors require supervision from both employer and inspector. Finally consumers, themselves on the alert, should refuse to accept

Public Health Department,
Municipal Office,
Municipal Palace,
BRASILIA.

10th January 1972

To the Mayor, Aldermen and Councilors,
of the Borough of Brasilia.

Mr. Mayor, Aldermen and Councilors,

I have the honor to present the Annual Report of the Health Officer
of Health Inspecting Unit of the Public Health Department.

The report is presented once again in six sections, each dealing with an
aspect of control of environmental health of the area.

The first section for the year shows that there was an increase in
population of 140 according to the Registrar General's mid-year estimate of
1971. There were 40 deaths, a decrease of 17 on last year's figure. This
gives a standardized rate of 7.5 compared with the national figure of 12.4.
Female deaths exceeded male deaths by 6. The total number of live births was
101, an increase of 4 on last year and giving a standardized rate of 18.0
compared with 14.8 for England and Wales. Infant mortality was 4.5 less
than in 1970. There was one death under the age of one year.

The first section (A) dealing with the natural and social conditions
indicates that the town remains virtually unchanged, although an industrial
estate has been established on the north side of the Buchanan Road at
present comprising 25 factories. In this section attention is drawn to
deaths and deaths, and particularly to the deaths of early and preventable
mortality and death. While the annual report refers to local environmental
health it would be inappropriate without some reference to the personal health of
individuals living in the area. The section includes comments on cancer,
arterial diseases, a study on road accidents and deaths of a child's report
on how accidents.

The second section (B) outlines health and social services, both statutory
and voluntary, which are provided in the town. Services given, particularly
to the elderly, on a voluntary basis make a valuable contribution to the
community life, and gratitude to those who give so willingly of their own
help is expressed.

The third section (C) deals with sanitary arrangements giving a description
of water supplies, sewerage, refuse collection and disposal, refuse control and
other health functions. The extension scheme at the sewage treatment works
commenced and it is anticipated that this will be completed by early 1974. From
environmental health control, after investigation of services, is also
considered.

The fourth section (D) is concerned with council housing, improvement grants
and other matters. In 1971 66 houses and flats were completed by the Council.
45 dwellings were built by private enterprise.

The fifth section (E) deals with food hygiene and public health and
includes the major food inspection function in the town. Changes due to technical
advances in the food industry, while greatly improving variety and keeping
quality, do not lessen the need for vigilance in food control.
Innovations in packaging, storage and ageing, together with increasing use of
of packaging (including travel agents and the preparation of take-aways),
together with the rapid turnover of equipment, and the rapid turnover of equipment,
together with these other factors require supervision from both engineer and
inspector. Finally comments, themselves on the staff, should refer to safety

unsatisfactory practices.

The sixth section (F) deals with control of infectious and other diseases in the town and it is pleasing to report that there were no cases of dysentery or food poisoning notified and only one of infective hepatitis. Two people died from pneumonia and one from bronchitis. There were 2 cases of measles compared with 76 in 1971. Measles vaccination increased considerably in the country. It is to be hoped that from henceforward with the availability of vaccine and the use of the computer, that a higher percentage of children will be vaccinated. While at present the incidence of infectious illness remains satisfactorily low, should succeeding generations of parents fail to respond to the need for immunisation, recrudescence could occur. It remains vitally important therefore for children to be immunised for diphtheria, poliomyelitis, whooping cough, tetanus and now measles, tuberculosis vaccination following later in the early teens. Rubella (German Measles) vaccination is also available to all girls between the ages of eleven and fourteen.

The year was notable for the proposed legislation for the reorganisation of Local Government, the National Health Service, and the Water Authorities, which are timed to coincide in April 1974. The office of Medical Officer of Health will cease, and instead those at present practicing in the public health field will join the National Health Service as part of the new discipline of community medicine. Local authorities will no longer employ doctors, but medical advice will be obtained from community physicians. As the envisaged changes are of historic importance I have attached to this report an appendix which outlines the future role of the community physician and gives some detail of the structure of the reorganised National Health Service, considering also some of the perspective of the changes in health legislation during the century of the practice of public health.

While this report will be my last to this council, and the penultimate one on the health of the town (which will be presented to the enlarged District Council in 1974) I considered it appropriate to present this detailed account of the changes, and at the same time to express the hope, that with adequate collaboration arrangements the future medical advice which will be available to local authorities will be both sought and given as freely and with the same accessibility between doctor, officers and councils of local authorities as when the Medical Officer of Health held office as a statutory appointment.

On a personal note I had the honour to hold office as Chairman of the Northampton division of the British Medical Association; was appointed Chairman of the Oxford Region of Public Health Medical Officers for the fifth year, and represented that Region, again for the fifth year on the Public Health Committee of the British Medical Association. I was also again appointed to the Whitley Council Staff Side.

I wish to express my thanks to Mr. Drabble, the Public Health Inspector, for his diligent work throughout the year, and for his assistance in the compilation of this report, to the officers and members of the Council for their interest and encouragement and to the County Medical Officer of Health for his ready cooperation at all times.

I remain, your obedient Servant,

JOAN M. ST. V. DAWKINS

Medical Officer of Health

The sixth section (5) deals with control of infectious and other diseases in the town and it is pleasing to report that there were no cases of dysentery or food poisoning notified and only one of infectious hepatitis. Two people died from pneumonia and one from bronchitis. There were 5 cases of measles compared with 76 in 1971. Measles vaccination increased considerably in the country. It is to be hoped that from hereonward with the availability of vaccine and the use of the computer, that a higher percentage of children will be vaccinated. While at present the incidence of infectious diseases remains satisfactorily low, should increasing numbers of parents fail to respond to the need for immunization, resurgence could occur. It remains vitally important therefore for children to be immunized for diphtheria, poliomyelitis, whooping cough, tetanus and now measles, tuberculosis, vaccination following later in the early years. Rubella (German Measles) vaccination is also available to all girls between the ages of eleven and fourteen.

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While this report will be my last to this Council, and the Committee one to the health of the town (which will be presented to the enlarged District Council in 1974) I considered it appropriate to present this detailed account of the changes, and at the same time to express the hope, that with adequate collaborative arrangements the future medical advice which will be available to local authorities will be both sought and given as freely and with the same accessibility between doctor, officials and Council as local authorities as when the Medical Officer of Health held office as a statutory appointment.

On a personal note I had the honour to hold office as Chairman of the Northampton Division of the British Medical Association, was appointed Chairman of the Oxford Region of Public Health Medical Officers for the 1973 year, and represented that Region, again for the 1973 year on the Public Health Committee of the British Medical Association. I was also again appointed to the Whitley Council Staff Side.

I wish to express my thanks to Mr. Imbrie, the Public Health Inspector, for his diligent work throughout the year, and for his assistance in the completion of this report, to the officers and members of the Council for their interest and encouragement and to the County Medical Officer of Health for his ready cooperation at all times.

I remain, your obedient servant,

John H. St. V. DAWKINS

Medical Officer of Health

BOROUGH OF BRACKLEY

Public Health and Works Committee, December, 1972

<u>Chairman:</u>	Alderman N.W.F. Howard
<u>Vice Chairman:</u>	Councillor D. Margieson
<u>Aldermen:</u>	B.P.C. Sheppard D.J. Newman E. Whitley
<u>Councillors:</u>	K. Davies J.N. Hutchinson R.D. Hutchings (retired during year) G.I. Phipps P.R.J. Quinn Miss M.K. Ritchie (retired during year) J.R. Williams (Mayor) J.F. Yates Mrs. R.M. Haverly M.J. Held (elected during year) M.A.R. Skermer (elected during year)

Public Health Officers

Joan M. St. V. Dawkins M.B., B.S., F.F.C.M., D.P.H., D.C.H.

Medical Officer of Health, Division 1, Northamptonshire.

(Boroughs of Brackley and Daventry; Urban District of Wellingborough; Rural Districts of Brackley, Brixworth, Daventry, Northampton, Towcester and Wellingborough.)

Senior Assistant County Medical Officer of Health.

Secretary: Mrs. Erica Stevenson.

Office: Divisional Health Office,
7 Cheyne Walk,
Northampton NN1 5PT. Tel: Northampton 34833

Public Health Inspector:

S.C. Drabble, M.A.P.H.I., A.I.A.S., M.Soc.D.Tech.

MEMBERS OF BRANCH

Public Health and Water Committee, December, 1972

Chairman:

Alfred W. W. Howard

Vice Chairman:

Donald R. Harrison

Advisors:

B. C. Shepard

D. J. Brown

E. Whitley

Consultants:

E. Davies

J. W. Harrison

A. D. Harrison (retired during year)

G. I. Higgs

P. H. J. Jones

Miss M. K. Mitchell (retired during year)

J. R. Williams (Rural)

J. R. Yates

Mr. R. M. Bennett

M. J. Reid (retired during year)

M. A. R. Bennett (retired during year)

Public Health Officers

John M. St. V. Lewis M.B., B.S., F.R.C.S., D.F.P.S., D.S.E.

National Officer of Health, District 1, Northamptonshire.

(Branches of Health and Housing; Urban Districts)

at Northampton: Rural Districts of Northampton.

Health Officer, Northampton, Town and

Northampton.

Health Officer, County Medical Officer of Health.

Secretary: Mrs. Eric Stevenson.

Office: Divisional Health Office,

7 Church Walk,

Northampton NN1 2ET. Tel: Northampton 34577

Public Health Inspector

S. C. Davies, M.A., B.S., A.I.A.S., M.S.D.P. Tech.

CAUSES OF DEATH AT DIFFERENT PERIODS OF LIFE DURING THE YEAR 1972

Cause of Death	Sex	All Ages	Under 4 Weeks	4 weeks & under 1. year	Age in Years						
					1-	5-	15-	25-	35-	45-	55- 65- 75 +
Malignant neoplasm, intestine	M F	1 -	- -	- -	- -	- -	- -	- -	- -	- -	1 -
Malignant neoplasm, larynx	M F	1 -	- -	- -	- -	- -	- -	- -	- -	1 -	- -
Malignant neoplasm, lung, bronchus	M F	3 1	- -	- -	- -	- -	- -	- -	- -	1 2	1 -
Malignant neoplasm, uterus	F	1	-	-	-	-	-	-	-	1	-
Malignant neoplasm, prostate	M	2	-	-	-	-	-	-	-	1	1
Leukaemia	M F	- 1	- -	- -	- -	- -	- -	- -	- -	- -	- 1
Other malignant neoplasms	M F	- 1	- -	- -	- -	- -	- -	- -	- -	1 -	- -
Anaemias	M F	- 1	- -	- -	- -	- -	- -	- -	- -	- -	- 1
Hypertensive disease	M F	- 1	- -	- -	- -	- -	- -	- -	- -	- -	- 1
Ischaemic heart disease	M F	4 6	- -	- -	- -	- -	- -	- -	- -	1 2	1 5
Other forms of heart disease	M F	1 3	- -	- -	- -	- -	- -	- -	- -	- -	1 3
Cerebrovascular disease	M F	1 2	- -	- -	- -	- -	- -	- -	- -	1 1	- 1
Other diseases of circulatory system	M F	1 -	- -	- -	- -	- -	- -	- -	- -	- -	- -
Pneumonia	M F	1 1	- -	- -	- -	- -	- -	- -	- -	- -	1 1
Bronchitis and emphysema	M F	1 -	- -	- -	- -	- -	- -	- -	- -	- -	1 -
Other diseases of respiratory system	M F	1 -	- -	- -	- -	- -	- -	- -	- -	1 -	- -
Intestinal obstruction and hernia	M F	1 -	- -	- -	- -	- -	- -	- -	- -	- -	- 1
Other diseases of digestive system	M F	- 1	- -	- -	- -	- -	- -	- -	- -	- -	- 1
Congenital anomalies	M F	- 1	- 1	- -	- -	- -	- -	- -	- -	- -	- -

Cause of Death	Sex	All Ages	Under 4 Weeks	4 weeks & under 1 year	Age in Years									
					1-	5-	15-	25-	35-	45-	55-	65-	75 +	
Symptoms and ill defined conditions	M	-	-	-	-	-	-	-	-	-	-	-	-	
	F	1	-	-	-	-	-	-	-	-	-	-	1	
All other accidents	M	-	-	-	-	-	-	-	-	-	-	-	-	
	F	1	-	-	-	-	-	-	-	-	-	-	1	
Total all causes	M	17	-	-	-	-	-	-	1	4	8	4		
	F	23	1	-	-	-	-	-	2	3	3	14		

SECTION A

NATURAL AND SOCIAL CONDITIONS

Summary of Vital Statistics, 1972

Area of the Borough (Acres)	1,685
Population (Estimated mid-year 1972)	5,100
Number of inhabited houses (end of 1972)	1,751
Rateable value of the Borough	£176,007
Sum represented by a penny rate	£1,735

AREA

There was no change in the area of the administrative Borough during the year, which remains at 1,685 acres.

POPULATION

The resident mid-year home population as estimated by the Registrar General was 5,100 and the vital statistics are based on this figure. The estimated population is 140 more than that for the year 1971. The natural increase in population, that is, the increase of births over deaths is 69.

LIVE BIRTHS

The number of live births was 109 compared with 105 in 1971. The rate per thousand population was 21.4. Applying the Registrar General's Area Comparability Factor for births (.84) to this figure the Standardised Birth Rate obtained for the area is 18.0 compared with 14.8 for England and Wales.

STILLBIRTHS

There were no stillbirths during 1972.

ILLEGITIMATE BIRTHS

The number of illegitimate births in the area was 4, 2 males and 2 females. Shown as a proportion of the total number of live births this represents 4 per cent.

MATERNAL MORTALITY

No death was recorded.

INFANT MORTALITY

One infant died before reaching its first birthday, two less than in 1971. The rate per thousand live births was 9 compared with 17 for England and Wales.

NEONATAL MORTALITY

There was one death under four weeks, giving a rate per thousand live births of 9, compared with 12 for England and Wales.

EARLY NEONATAL MORTALITY

There were no deaths under one week.

NATURAL AND SOCIAL CONDITIONS

Summary of Vital Statistics, 1975

Area of the Borough (Acres)	1,682
Population (Estimated mid-year 1975)	2,100
Number of inhabited houses (end of 1975)	1,151
Estimated value of the Borough	£176,007
Rate represented by a penny rate	£1,132

Notes

There was no change in the area of the administrative Borough during the year, which remains at 1,682 acres.

POPULATION

The resident mid-year home population as estimated by the Registrar General was 2,100 and the vital statistics are based on this figure. The estimated population is 140 more than that for the year 1971. The natural increase in population, that is, the increase of births over deaths is 62.

BIRTHS

The number of live births was 109 compared with 105 in 1971. The rate per thousand population was 51.4. Applying the Registrar General's Area Comparability Factor for births (1.04) to this figure the Standardized Birth Rate obtained for the area is 53.0 compared with 44.8 for England and Wales.

DEATHS

There were no stillbirths during 1975.

ILLUSTRATIVE FIGURES

The number of illegitimate births in the area was 4, 2 males and 2 females shown as a proportion of the total number of live births this represents 4 per cent.

NATURAL MORTALITY

No death was recorded.

INFANT MORTALITY

One infant died before reaching its first birthday, two years in 1971. The rate per thousand live births was 9 compared with 17 for England and Wales.

PERINATAL MORTALITY

There was one death under four weeks, giving a rate per thousand live births of 9, compared with 12 for England and Wales.

EARLY PERINATAL MORTALITY

There were no deaths under one week.

The following table gives the birth-rate, death-rate and infant mortality rate for the Borough, the administrative County of Northamptonshire and England and Wales for the past five years:-

Year	Birth-rate			Death-rate			Infant mortality rate		
	Brackley Borough	Northampton-shire	England & Wales	Brackley Borough	Northampton-shire	England & Wales	Brackley Borough	Northampton-shire	England & Wales
1968	16.03	18.80	16.90	8.50	10.90	11.90	14.00	19.00	18.00
1969	18.20	18.10	16.30	8.40	10.90	11.90	32.00	16.07	18.00
1970	17.40	17.70	16.00	7.10	10.70	11.70	10.00	18.05	18.00
1971	21.20	18.50	16.00	11.50	10.10	11.60	29.00	18.00	18.00
1972	21.40	17.00	14.80	7.80	10.20	12.10	9.00	16.60	17.00

DEATHS

The total number of deaths assigned to the Borough for the year was 40, 17 less than in 1971. The crude death rate based on the mid-year population was 7.8 compared with 11.5 for last year. In order to compare the mortality in the Borough with the mortality for England and Wales it is necessary to make a correction to allow for the difference in age and sex distribution of the two populations. This is done by applying to the crude death rate of the Borough an Area Comparability Factor which has been estimated by the Registrar General as .92 for the Borough, giving a Standardised Death Rate of 7.2 compared with 12.1 for England and Wales.

Once again diseases of the heart and circulation constitute almost one half of the total deaths, taking this year 19 persons, with cancer and respiratory infection being the other two main causes.

EARLY AND PREVENTABLE DEATH AND MORBIDITY

DEATHS FROM CANCER

Lung Cancer and Cigarette Smoking

It is probable that cigarette smoking is the greatest contemporary health problem. 50,000 deaths a year can be attributed to the habit. It is responsible for 9 out of 10 deaths from lung cancer (of which there were in 1972 31,649, 25,754 males, 5,895 females), 3 out of 4 deaths from chronic bronchitis and 1 out of 4 deaths from coronary artery disease. It is estimated that twenty times more work days are lost through sickness from smoking than on industrial disputes.

The following table gives the birth-rate, death-rate and infant mortality rate for the Borough, the administrative County of Hampshire and England and Wales for the past five years:-

Year	Birth-rate			Death-rate			Infant mortality rate		
	per 1,000 live births	per 1,000 population	per 1,000 live births	per 1,000 live births	per 1,000 population	per 1,000 live births	per 1,000 live births	per 1,000 population	per 1,000 live births
1928	16.80	16.80	16.80	11.90	11.90	11.90	14.00	14.00	14.00
1929	16.80	16.80	16.80	11.90	11.90	11.90	14.00	14.00	14.00
1930	16.80	16.80	16.80	11.90	11.90	11.90	14.00	14.00	14.00
1931	16.80	16.80	16.80	11.90	11.90	11.90	14.00	14.00	14.00
1932	16.80	16.80	16.80	11.90	11.90	11.90	14.00	14.00	14.00

DEATHS

The total number of deaths registered in the Borough for the year was 40, 17 less than in 1931. The crude death rate based on the mid-year population was 7.8 compared with 11.5 for last year. In order to compare the mortality in the Borough with the mortality for England and Wales it is necessary to make a correction to allow for the difference in age and sex distribution of the two populations. This is done by applying to the crude death rate of the Borough an Area Coefficient factor which has been estimated by the Registrar General as .95 for the Borough, giving a Standardised Death Rate of 7.5 compared with 11.1 for England and Wales.

Once again however of the heart and circulation remains almost one half of the total deaths, taking this year 19 persons, with cancer and respiratory infection being the other two main causes.

EARLY AND PREVENTABLE DEATH AND MORBIDITY

DEATHS FROM CANCER

John Gower and Elizabeth Jackson

It is probable that cigarette smoking is the greatest contemporary health problem. 30,000 deaths a year can be attributed to the habit. It is responsible for 7 out of 10 deaths from lung cancer (of which there were in 1930 37,648, 25,732 males, 2,892 females), 3 out of 4 deaths from chronic bronchitis and 1 out of 4 deaths from coronary artery disease. It is estimated that twenty times more work days are lost through sickness from smoking than on industrial disputes.

The adverse effects on health of smoking unfortunately only become manifest after many years, and are therefore not obviously connected with the habit. Also in many countries as the economic benefits from taxing tobacco products are large, governments have hesitated to change legislation, and it is not practicable to impose regulations on an unwilling population. However it is imperative to take action that will discourage young people from starting to smoke, and may promote reduction or abstinence in smokers. This includes keeping people constantly and fully informed about the health consequences of smoking and pressing for the curtailing of all forms of sales promotion that encourage the use of tobacco.

It has been suggested in a published report* that the most important approaches to combat the health hazards of smoking are as follows:-

1. The education of youth not to take up smoking.
(In this respect all those adults who are associated with and have influence over young people should by the force of their own example discourage them from starting to smoke. These include parents, teachers, youth leaders, sportsmen, actors, pop stars and others whom young people admire and may emulate.)
2. The exerting of the influence of health workers.
(The medical profession have recognised the hazard, and now only a quarter of British male doctors smoke. Their death rate from lung cancer is now only 2/5th of the national rate.)
3. Group approaches to the control of cigarette smoking by adults.
4. Mass approaches to the control of cigarette smoking.
5. Reducing the effectiveness of the advertising and promotion of cigarettes.
6. Less hazardous smoking.

Other Cancers

The causes of cancer, apart from cancer of the lung, remain still to be ascertained. However some progress is being made, and different methods of controlling the cancerous diseases have greatly increased in effectiveness in recent years. Research is providing information which will help in prevention, in early detection and treatment. New techniques for detection including mammography and xerography, cytology and immunodiagnosis are being used and further improved, while chemotherapy with carcinostatic drugs and hormones and perhaps immunotherapy in the future, may all prove to be new and effective chemo-therapeutic agents. At present early detection and new and more effective treatment have restored numerous patients to lives of good quality for many years.

*Smoking and Health by Professor C.M. Fletcher & Dr. D. Horn. WHO Publication.

The adverse effects on health of smoking are obviously connected with health after many years, and are therefore not obviously connected with the habit. Also in many countries the economic benefits from taxing tobacco products are large. Governments have hesitated to change legislation and it is not practicable to impose regulations on an unwilling population. However it is imperative to take action that will discourage young people from starting to smoke, and may provide reduction or abstinence to smokers. This includes keeping people constantly and fully informed about the health consequences of smoking and pressing for the curbing of all forms of sales promotion that encourage the use of tobacco.

It has been suggested in a published report that the most important approach to curbing the health hazards of smoking are as follows:-

1. The education of youth not to take up smoking.
(In this respect all those adults who are associated with and have influence over young people should be the force of their own example. This includes parents, teachers, youth leaders, sportsmen, actors, pop stars and others whom young people admire and may emulate.)
2. The curbing of the influence of health workers.
(The medical profession have recognised the hazard, and now only a quarter of British male doctors smoke. Their death rate from lung cancer is now only 1/25th of the national rate.)
3. Group approaches to the control of cigarette smoking by adults.
4. Mass approaches to the control of cigarette smoking.
5. Reducing the effectiveness of the advertising and promotion of cigarettes.
6. Less hazardous smoking.

Other Cancer

The causes of cancer, apart from cancer of the lung, remain still to be ascertained. However some progress is being made, and different methods of controlling the cancerous diseases have greatly increased in effectiveness in recent years. Research is providing information which will help in prevention in early detection and treatment. New techniques for detection including mammography and ultrasonography, cytology and immunological tests are being used and further improved. While chemotherapy with cytotoxic drugs and hormones and perhaps immunotherapy in the future, may all prove to be new and effective cancer therapies in the future, it is present early detection and new and more effective treatments have provided cancer patients to lives of good quality for many years.

ARTERIAL DISEASE

The incidence of early degenerative arterial disease, particularly in men, has become the epidemic of civilisation, and presents with cancer, the major challenge to medicine today. The condition is manifest in either strokes or coronary thrombosis, and strikes men in their prime and at the time of their greatest contribution to society. The causes are multiple, and, as stated, cigarette smoking is probably a factor. As well as being part of the process of ageing hereditary factors are involved in some. Women are less affected until after the menopause, indicating a hormonal protection. The only clear evidence is that the incidence is lower in those who take regular physical exercise and who are not obese. This salient feature needs emphasis, as it is easy in a modern industrialised society with the majority occupied in sedentary occupations, the widespread use of motor transport and television, for many to become physically inactive. It is wise to establish a way of life soon after leaving school in which there is regular participation in physical exercise which can be suitably modified to the passing years. This combined with some moderation in the consumption of food, may help to prevent the early onset of arterial disease.

ACCIDENTS

Road Accidents

Definitions

A road accident is one involving personal injury, occurring on the public highway (including footpaths) in which a vehicle is concerned.

Killed means the person died at the time of injury or within 30 days of the accident and because of it.

The various degrees of injury to a person depend upon the extent of the injury requiring hospital in-patient treatment and may be:-

- (i) Serious - such as fractures, internal injuries, severe shock, etc.
- (ii) Slight - sprains, cuts and bruises.

Vehicles involved in accidents are those whose drivers or passengers are injured and vehicles which contribute to the accident, including horses being ridden at the time of the accident. Vehicles which collide after the initial impact are not included unless they aggravate the degree or amount of injury. Vehicles are classified according to their structural type:-

- (i) Pedal Cycles - include children riding toy cycles and first riders of tandems (they make the decisions).

ARTERIAL DISEASE

The incidence of early degenerative arterial disease, particularly in men, has become the epidemic of civilization, and presents with cancer, the major challenge to medicine today. The condition is manifest in either atherosclerosis or coronary thrombosis, and strikes men in their prime and at the time of their greatest contribution to society. The causes are multiple, and, as stated, cigarette smoking is probably a factor. As well as being part of the picture of aging, hereditary factors are involved in some. Women are less affected until after the menopause, indicating a hormonal protection. The only clear evidence is that the incidence is lower in those who take regular physical exercise and who are not obese. This evidence is not as strong as it is in a modern industrialized society, with the majority occupied in sedentary occupations, the widespread use of motor transport and television, for many so-called physically inactive. It is also to be noted that a way of life soon after leaving school in which there is regular participation in physical exercise which can be suitably modified to the passing years. This combined with some moderation in the consumption of food may help to prevent the early onset of arterial disease.

ACCIDENTS

Road Accidents

Definition

A road accident is one involving personal injury, occurring on the public highway (including footpaths) in which a vehicle is concerned.

Killed means the person died at the time of injury or within 30 days of the accident and because of it.

The various degrees of injury to a person depend upon the extent of the injury requiring hospital in-patient treatment and may be:-

(1) Minor - such as fractures, internal injuries, severe shock, etc.

(2) Major - serious, only and fractures.

Vehicles involved in accidents are those whose drivers or passengers are injured and vehicles which contribute to the accident, including horses being ridden at the time of the accident. Vehicles which collide with the injured person are not included unless they aggravate the degree or extent of injury. Vehicles are classified according to their structural type:-

(1) Motor Vehicle - includes motor vehicles, mopeds and light trucks of various types (but not the tractor).

- (ii) Mopeds - two-wheeled motor vehicles of not more than 50 c.c. and equipped with pedals.
- (iii) Motor scooters - two wheels with a platform for feet, open frame and wheels smaller than the conventional motor cycle.
- (iv) Motor cycles - again with two wheels and includes side-car/combinations attached.
- (v) Cars, taxis (including minibus), goods vehicles, public service vehicles and electric milk floats.

Incidence

In 1972 359,792 persons were killed or injured on Britain's roads, an increase of 2% on 1971. Broken down this shows:-

7,779 killed - 1% more than in 1971
 91,342 seriously injured - no significant change
 260,671 slightly injured - 3% more than in 1971

Motor traffic was estimated as 5% higher than in 1971 (measured in terms of vehicle mileage).

The number of accidents is related to the amount of traffic. The doubling of road casualties over the past 20 years is related to the fact that during this time road traffic has TREBLED. When considered in respect of population the trend has been far less happy as road deaths have increased by 57% while population increase was 10%. The individual risk has now increased from 150-1 to 100-1. Recent years have shown a growing proportion of casualties in the younger age groups:-

1:190 of 15-19 years killed each year
 1:790 of 40-49 " " " "
 1:725 of 60-69 " " " "

The incidence in the younger age groups therefore constitutes 33 $\frac{1}{3}$ % of car driver casualties and 45% were riders or passengers of motor vehicles. The 40-49 age group were occupants, drivers and passengers, in cars ($\frac{2}{3}$ of total), and 60-69 were (four-wheel occupants) mostly as passengers in cars/buses.

Road Accidents involving Pedestrians

Pedestrians - including children (under 15 years) and adults - are children riding small cycles, people pushing bicycles or prams or other vehicles such as road sweepers, those leading or herding animals, occupants of invalid chairs or prams, and those who alight from vehicles and are subsequently injured or killed. The figures of accidents to children cause particular concern. One pedestrian in ten killed or seriously injured is aged four or less (for the first eighteen months of life they do not form part of the pedestrian population) indicating that nearly half the casualties are children.

The 60-69 group (elderly) suffer more than double the 40-49 years group. Compared with Western Europe, Britain has the highest pedestrian casualty rate, but for fatalities the figure is nearer the average. This factor is due to a great extent to the large number of pedestrians and the heavy traffic of built-up areas.

(11) Motorcycles - two-wheeled motor vehicles of not more than 20 c.c. and equipped with pedals.

(12) Motor scooters - two wheels with a platform for feet, open frame and wheels smaller than the conventional motor cycle.

(13) Motor cycles - again with two wheels and includes side-car combination
Attached.

(14) Trams, trolleys (including minibuses), goods vehicles, public service vehicles and electric milk floats.

Incidents

In 1975 759,720 persons were killed or injured on Britain's roads, an increase of 25 on 1974. Broken down this shows:-

1,779 killed - 15 more than in 1974
91,342 seriously injured - no significant change
260,871 slightly injured - 25 more than in 1974

Motor traffic was estimated as 2% higher than in 1974 (measured in terms of vehicle mileage).

The number of accidents is related to the amount of traffic. The number of road casualties over the past 20 years is related to the fact that during this time road traffic has tripled. When considered in terms of population the trend has been for less injury as road deaths have increased by 50% while population increase was 10%. The individual risk has now increased from 1:200 to 1:100. Recent years have shown a growing proportion of casualties in the younger age groups:-

1:100 of 15-19 years killed each year
1:150 of 20-29
1:250 of 30-39
1:350 of 40-49

The incidence in the younger age groups therefore constitutes 25% of car driver casualties and 45% were riders or passengers of motor vehicles. The 40-49 age group were occupiers, drivers and passengers. In 1974 1/3 of total, and 40-49 were (four-wheel occupants) nearly as passengers in cars.

Road Accidents Involving Pedestrians

Pedestrians - including children (under 15 years) and adults - are killed or injured when crossing roads or when on footpaths or pavements. The figures of accidents to children cause particular concern. One pedestrian in ten killed or seriously injured is aged four or less (for the first eleven months of life they are not part of the pedestrian population) indicating that nearly half the casualties are children.

The 40-49 group (elderly) suffer more than double the 15-19 years group. Compared with Western Europe, Britain has the highest pedestrian casualty rate, but for fatalities the figure is nearer the average. This factor is due to a great extent to the large number of pedestrians and the heavy traffic of built-up areas.

Causes of Road Accidents

1. Drinking alcohol to the extent of blurring judgement.
2. Not fastening seat belts when available.
3. Delaying repairs to vehicles and not performing routine checks on tyres, lights and brakes.
4. Driving too fast for road conditions - surface, lighting, type of area (30 mph), ice on roads, flooding, and in the summer polished road surfaces and skidding.
5. Leaving off lights well into the lighting-up time (half-an-hour after sunset and half-an-hour before sunrise). The accident rate is higher during the hours of darkness.
6. Getting impatient or starting a journey in a "bad temper".
7. Certain manoeuvres cause or contribute to accidents - e.g. turning right (particularly pedal cyclists - cause of 17% of these accidents). Indicating the opposite direction to that intended to take; brake or acceleration failure; badly parked and unlit vehicles; dog or other animal in the path of the vehicle; automatic level crossings; a disobeyed junction control - a junction being any place at which two or more highways meet at whatever angle, including a roundabout and parts of such highways within 20 yards of the junction.

Action taken to improve Accident Rate

- 1934 - Road Traffic Act, introduced driving tests, 30 mph speed limit and pedestrian crossings.
- 1952 - There was a further reduction in accidents following the introduction of zebra stripes on crossings.
- 1964 - Seat belts for the front seats of motor cars were introduced and to encourage greater use all new cars registered after 1st April 1973 are required to have the latest design of seat belts available which can be fitted and fastened single handed.
- 1967 - Road Safety Acts, drinking and driving clauses stated for the first time that a person driving a motor vehicle would be guilty of an offence if he was shown to have a blood alcohol content above a prescribed level, that chosen being 80 mgm alcohol per 100 ml. blood. There was an immediate and remarkable drop in the accident rate following this legislation and the Act was continuing to have a marked affect at the end of 1972.
- 1971 - The Department put forward proposals to make the wearing of safety helmets for motor cyclists compulsory (this is now law) and has been shown to represent the biggest life saver.

The roads are constantly under surveillance and better road surfaces are being investigated. A 70 mph limit is in operation on motorways and depending on the road and the area through which it runs there are speed limits of 30, 40 and 50 mph in operation. In cases of accidents, fog or other hazardous conditions provision has been made for alterations in the speed limit.

Pedestrian bridges across very busy roads are being built. The radio and television are now used to give relevant information regarding roads and road users.

Causes of Road Accidents

1. Retaining alcohol to the extent of blurring judgement.

2. Not fastening seat belts when available.

3. Delaying repairs to vehicles and not performing routine checks on tyres, lights and brakes.

4. Driving too fast for road conditions - surface, lighting, type of area (30 mph), ice on roads, flooding, and in the summer polished road surfaces are slippery.

5. Leaving off lights well into the lighting-up time (half-an-hour after sunset half-an-hour before sunrise). The accident rate is higher during the hours of darkness.

6. Getting impatient or starting a journey in a "bad temper".

7. Captain manoeuvres cause or contribute to accidents - e.g. turning right (partially) pedal cyclists - cause 61% of these accidents. Indication of the opposite direction to that intended is fatal; signs or manoeuvres (badly parked and noisy vehicles; dog or other animal in the path of the vehicle; automatic level crossings; a disabled junction control - a restriction being any place at which two or more highways meet at whatever an including a roundabout and parts of such highways within 50 yards of the junction.

Action taken to improve accident rate

1954 - Road Traffic Act introduced driving tests, 30 mph speed limit and pedestrian crossings.

1955 - There was a further reduction in accidents following the introduction of white stripes on crossings.

1964 - Road Belts for the front seats of motor cars were introduced and in 1965 the Government was all new cars registered after 1st April 1965 were required to have the latest design of seat belts available which can be fitted and fastened single handed.

1967 - Road Safety Act. Braking and driving classes were for the first time that a person driving a motor vehicle would be guilty of an offence if he was found to have a blood alcohol content above a prescribed level. That chosen being 80 mg alcohol per 100 ml blood. There was an immediate and noticeable drop in the accident rate following this legislation and it has been estimated to have a marked effect at the end of 1970.

1971 - The Government put forward proposals to make the wearing of safety belts for motor cyclists compulsory (this is now law) and has been shown to represent the biggest life saver.

The roads are constantly under surveillance and better road surfaces are being investigated. A 70 mph limit is in operation on motorways and depending on the road and the area through which it runs there are speed limits of 30, 40 and 50 mph in operation. In cases of accidents, fog or other hazardous conditions provision has been made for alterations in the speed limit.

Lightweight bridges across very busy roads are being built. The radio and television are now used to give relevant information regarding roads and road works.

The police in conjunction with parents, education departments and organisations such as the boy scout movement, are teaching road safety. Child cyclists are encouraged to take proficiency tests.

Motor vehicle standards are improving and research is continuous. Recently, because of the number of bad tyres on vehicles, the police have been carrying out spot checks and individuals can be fined if the tread of a tyre is below the stated requirement. Every vehicle of three years and over must have an annual test by a Certified garage and a statement issued indicating the vehicle is road worthy.

The Cost of Accidents

These are immeasurable in terms of pain, grief and suffering. Apart from this they represent a quantifiable loss to the community in economic terms which includes loss of output, cost of medical treatment, the time taken by police and courts, and the damage to property - this was estimated for a fatal accident at £13,000.

Total Cost

Medical treatment, ambulance and funeral	-	£17 million
Police and administration	-	£28 million
Damage to vehicles and other property	-	£198 million
Lost output	-	<u>£103 million</u>
		<u>£346 million</u>

On average road accidents result in an economic loss of approaching £1 million per day, plus the human suffering involved which in money terms is unquantifiable.

Home Accidents

During 1971 there were 6,245 accidental deaths in and around the home, 237 (or 3.7 per cent) fewer than in the previous year. Further analysis shows that the number of people who died in private homes fell by 117, and the number in residential institutions by 120.

Summary

Cause of Death	Private Homes	Residential Institutions	Total Deaths
Poisoning	760	11	771
Falls	2,824	1,034	3,858
Burns and scalds	656	33	689
Suffocation and choking	483	78	561
Others	334	32	366
Total	5,057	1,188	6,245

Every year more people die from falls than from all other accidents in the home, and as many as 62 per cent of the 6,245 fatalities in 1971 resulted from falls. Poisoning accounted for a further 12 per cent of the deaths, burns and scalds for 11 per cent and suffocation and choking for 9 per cent. The remaining deaths were due to miscellaneous causes.

The police is co-operation with parents, education departments and organizations such as the boy scout movement, are teaching road safety. Cyclists are encouraged to take proficiency tests.

Motor vehicle standards are improving and research is continuing. Because of the number of bad types on vehicles, the police have been carrying out spot checks and individuals can be fined if the type is below the stated requirement. Every vehicle of three years and over must have an annual test by a Certified Garage and a statement issued indicating the vehicle is road worthy.

The Cost of Accidents

There are innumerable in terms of pain, grief and suffering. This they represent a quantifiable loss to the community in economic terms which includes loss of output, cost of medical treatment, the loss taken by police and courts, and the damage to property - this was estimated for a fatal accident at £12,000.

Total Cost

Medical treatment, ambulance and funeral	£1.7 million
Police and administration	£38 million
Damage to vehicles and other property	£1.98 million
Lost output	£10.5 million
	<u>£14.6 million</u>

On average road accidents result in an economic loss of approximately £1 million per day, plus the human suffering involved which is many times as quantifiable.

Home Accidents

During 1971 there were 6,145 accidental deaths in and around the home, 237 (or 3.9 per cent) fewer than in the previous year. Further analysis shows that the number of people who died in private homes fell by 11% and the number in residential institutions by 15%.

Summary

Causes of Death	Private Homes	Residential Institutions	Total Deaths
Falls	760	11	771
Poisoning	2,624	1,024	3,648
Burns and scalds	622	33	655
Drowning and choking	483	18	501
Others	334	32	366
Total	5,023	1,198	6,221

Every year more people die from falls than from all other accidents in the home, and as many as 52 per cent of the 2,625 fatalities in 1971 resulted from falls. Poisoning accounted for a further 12 per cent of the deaths, burns and scalds for 11 per cent and drowning and choking for 8 per cent. The remaining deaths were due to miscellaneous causes.

Cause, Age-group and Sex

Cause of Death	Age-group					Sex		Total Deaths
	0-4	5-14	15-44	45-64	65 +	Male	Female	
Poisoning	24	15	205	262	265	339	432	771
Falls	55	16	94	262	3,431	1,061	2,797	3,858
Burns and scalds	103	38	49	109	390	285	404	689
Suffocation and choking	301	18	77	82	83	333	228	561
Others	74	16	65	67	144	185	181	366
Total	557	103	490	782	4,313	2,203	4,042	6,245
Death Rate*	14.2	1.3	2.6	6.6	67.4	9.3	16.1	12.8

*Deaths per 100,000 population

Elderly people are especially prone to domestic accidents and this is reflected in the statistics - over two thirds of the victims were aged 65 and over. Children under five years old accounted for a further 9 per cent of the total.

An alternative analysis of the data indicates that 65 per cent of the victims in 1971 were female.

Falls

Cause of Death	Age-group					Sex		Total Deaths
	0-4	5-14	15-44	45-64	65 +	Male	Female	
Falls on stairs	10	5	45	118	497	276	399	675
Fall from ladders	-	-	4	18	22	37	7	44
Falls from buildings	12	4	22	14	46	55	43	98
Other falls from one level to another	23	5	8	17	274	95	232	327
Falls on same level	-	-	4	12	352	72	296	368
Other and unspecified falls	10	2	11	83	2,240	526	1,820	2,346
Total	55	16	94	262	3,431	1,061	2,797	3,858

Accidental falls caused 3,858 deaths in the home during 1971. This is three more than in the previous year, but 34 fewer than in 1969 and 87 fewer than in 1968.

Women accounted for 76 per cent of the deaths among the over 65's, but less than half the deaths in the remaining age-groups.

Poisoning

A total of 771 people died from accidental poisoning during 1971. This is 48 fewer than in 1970, 55 fewer than in 1969 and 107 fewer than in 1968.

A total of 169 people were accidentally poisoned by ordinary domestic gas in 1971, compared with 407 in 1969. The main reason for this improvement is the gradual

Cause of Death	Age-group						Sex		Total Deaths
	0-4	5-14	15-44	45-64	65+		Male	Female	
Poisoning	24	15	202	262	252		279	422	701
Falls	22	16	94	262	2,421		1,021	2,191	3,212
Barren and accidents	103	24	49	109	290		288	404	692
Difficulties and	201	18	77	82	82		222	228	450
Choking									
Other	74	16	62	67	144		182	181	363
Total	327	102	490	782	4,212		2,202	4,012	6,214
Death Rate*	14.2	1.2	2.6	6.6	67.4		9.2	16.1	12.6

*Deaths per 100,000 population

Mostly people are especially prone to domestic accidents and this is reflected in the statistics - over two thirds of the victims were aged 65 and over. Children under five years old accounted for a further 9 per cent of the total.

An alternative analysis of the data indicates that 62 per cent of the victims in 1971 were female.

Falls

Cause of Death	Age-group						Sex		Total Deaths
	0-4	5-14	15-44	45-64	65+		Male	Female	
Falls on stairs	10	2	42	118	497		270	299	569
Falls from ladders	-	-	4	18	22		17	7	24
Falls from buildings	12	4	22	14	46		29	42	71
Other falls from one level to another	22	2	8	17	274		22	222	244
Falls on roadways	-	-	4	12	222		12	206	218
Other and unspecified	10	2	11	62	2,240		222	1,880	2,102
Total	32	16	94	242	2,421		1,021	2,191	3,212

Accidental falls caused 2,828 deaths in the home during 1971. This is three more than in the previous year, but 24 fewer than in 1969 and 87 fewer than in 1968.

Women accounted for 75 per cent of the deaths among the over 65's, but less than half the deaths in the remaining age-groups.

Poisoning

A total of 771 people died from accidental poisoning during 1971. This is 48 fewer than in 1970, 22 fewer than in 1969 and 107 fewer than in 1968.

A total of 152 people were accidentally poisoned by ordinary domestic gas in 1971. The main reason for this improvement in the statistics compared with 407 in 1969.

introduction of natural gas which is non-toxic.

Cause of Death	Age-group					Sex		Total Deaths
	0-4	5-14	15-44	45-64	65 +	Male	Female	
Barbiturates	-	-	78	148	104	123	207	330
Analgesics and antipyretics	4	1	16	8	2	14	17	31
Other sedatives	-	-	15	12	8	11	24	35
Nervous system and psychotherapeutic drugs	5	2	20	9	3	19	20	39
Other and unspecified drugs	4	2	12	13	6	18	19	37
Alcohol	-	-	9	15	5	16	13	29
Other solids and liquids	5	-	4	3	3	10	5	15
Total solids and liquids	18	5	154	208	131	211	305	516
Piped gas	1	6	30	34	98	79	90	169
Motor vehicle exhaust gas	-	-	9	7	1	17	-	17
Other carbon monoxide gases	4	3	12	10	32	29	32	61
Other gases and vapours	1	1	-	3	3	3	5	8
Total gases and vapours	6	10	51	54	134	128	127	255
Total	24	15	205	262	265	339	432	771

Burns and Scalds

Cause of Death	Age-group					Sex		Total Deaths
	0-4	5-14	15-44	45-64	65 +	Male	Female	
Ignition of clothing	4	7	5	18	108	38	104	142
Burns from controlled fire	3	1	1	9	65	31	48	79
Conflagration	79	28	30	49	111	144	153	297
Other and unspecified burns	7	-	11	28	73	55	64	119
Total fire and flames	93	36	47	104	357	268	369	637
Hot substance, corrosive liquid and steam	10	2	2	5	33	17	35	52
Total	103	38	49	109	390	285	404	689

There were 689 deaths from accidental burns and scalds during 1971, 111 fewer than in 1970, 76 fewer than in 1969 and 92 fewer than in 1968.

At least 77 of 637 deaths from fire and flames were caused by matches and cigarettes, etc.

Cause of Death	Age-Group						Sex		Total Deaths
	0-4	5-14	15-44	45-64	65+		Male	Female	
Heart disease	-	-	78	148	104		127	207	330
Stroke	4	1	16	8	2		14	17	31
Other cardiovascular	-	-	12	12	8		11	24	35
Respiratory system and	2	2	20	9	2		19	20	39
Other and unspecified	4	2	12	12	6		18	19	37
Alcohol	-	-	9	12	2		16	13	29
Other causes and injuries	2	-	4	2	2		10	2	12
Total deaths and injuries	18	2	134	208	131		211	302	513
Poisoning	1	6	20	24	80		29	90	119
Motor vehicle exhaust gas	-	-	2	7	1		17	-	17
Other carbon monoxide	4	2	12	10	22		28	26	54
Other causes and injuries	1	1	-	2	2		2	2	4
Total causes and injuries	6	10	34	43	105		76	118	194
Total	24	12	202	251	236		287	420	717

Deaths and Injuries

Cause of Death	Age-Group						Sex		Total Deaths
	0-4	5-14	15-44	45-64	65+		Male	Female	
Infection of circulatory	4	7	2	18	108		28	104	132
Brain from circulatory	2	1	1	8	62		21	48	69
Other	19	28	20	49	171		144	123	267
Other and unspecified	7	-	11	28	22		32	64	96
Total five and seven	32	36	42	103	363		225	249	474
Hot water, steam, and	16	2	2	2	17		17	22	39
Total	48	38	44	105	380		242	271	513

There were 513 deaths from circulatory system and injuries during 1971. 171 fewer than in 1970, 76 fewer than in 1969 and 22 fewer than in 1968.

At least 77 of 513 deaths from five and seven were caused by infection and other causes.

Suffocation and Choking

Cause of Death	Age-group					Sex		Total Deaths
	0-4	5-14	15-44	45-64	65 +	Male	Female	
Inhalation and ingestion of food	170	4	43	58	71	193	153	346
Inhalation and ingestion of other objects	12	1	2	6	7	15	13	28
Suffocation in bed or cradle	92	-	3	3	1	57	42	99
Other and unspecified suffocation	27	13	29	15	4	68	20	88
Total	301	18	77	82	83	333	228	561

A total of 561 people died from accidental suffocation and choking in 1971. This compares with 635 deaths in 1970, 651 deaths in 1969 and 649 in 1968.

Nearly a third of 561 deaths were caused by young children under five years of age choking over their food.

Other Causes

Cause of Death	Age-group					Sex		Total Deaths
	0-4	5-14	15-44	45-64	65 +	Male	Female	
Drowning and submersion*	33	2	14	12	24	46	39	85
Electric current+	7	5	31	15	12	47	23	70
Excessive cold	-	-	1	4	33	13	25	38
Hunger, thirst, exposure and neglect	13	-	1	9	23	16	30	46
Struck by falling object	5	2	4	3	5	12	7	19
Striking against or struck by object	4	2	3	3	7	10	9	19
Cutting or piercing instruments	2	1	-	8	4	10	5	15
Other and unspecified	10	4	11	13	36	31	43	74
Total	74	16	65	67	144	185	181	366

*A total of 529 people were accidentally drowned in England and Wales during 1971. Although only 85 of these accidents occurred at home, the majority of the remaining deaths were associated with everyday leisure activities.

+Excludes burns by heat from electrical appliances.

The remaining 366 accidental deaths which occurred in and around the home during 1971 were attributed to other miscellaneous causes.

'Open Verdict' Deaths

In addition to the 6,245 fatal accidents, 475 people died in or around the home, but it was impossible to determine whether death was accidental or purposely inflicted. Such cases are classified as 'open verdict' deaths.

Other causes

Cause of Death	Age-group					Sex		Total Deaths
	0-4	5-14	15-44	45-64	65+	Male	Female	
Infestation and ingestion of food	170	4	43	58	71	193	173	366
Infestation and ingestion of other objects	15	1	3	6	7	13	13	26
Infestation in bed or cradle	92	-	2	2	1	27	45	93
Other and unspecified	27	12	29	12	4	68	20	88
Total	204	16	77	82	83	291	251	541

A total of 541 people died from accidental suffocation and choking in 1971. This compares with 632 deaths in 1970, 651 deaths in 1969 and 643 in 1968.

Nearly a third of 541 deaths were caused by young children under five years of age choking over their food.

Other causes

Cause of Death	Age-group					Sex		Total Deaths
	0-4	5-14	15-44	45-64	65+	Male	Female	
Drowning and submersion*	32	2	14	18	24	46	39	85
Electric currents	7	2	21	12	12	43	23	70
Infective cold	-	-	1	4	23	13	28	38
Hunger, thirst, exposure and neglect	12	-	1	9	23	16	20	46
Struck by falling object	2	2	4	2	2	12	7	19
Striking against or struck by object	4	2	3	2	7	10	9	19
Cutting or slashing	2	1	-	8	4	10	2	12
Intoxication	10	4	11	12	26	31	43	74
Other and unspecified	14	16	62	67	144	169	181	350

*A total of 829 people were accidentally drowned in England and Wales during 1971. Although only 85 of these accidents occurred at home, the majority of the deaths were associated with country leisure activities.

*Excludes burns by heat from electrical appliances.

The remaining 366 potential deaths which occurred in and around the home during 1971 were attributed to other miscellaneous causes.

'Open verdict' deaths

In addition to the 5,345 fatal accidents, 472 people died in or around the home, but it was impossible to determine whether death was accidental or purposeful. Such cases are classified as 'open verdict' deaths.

As many as 358 of the 475 deaths were attributed to poisoning by various solids and liquids, and a further 28 deaths to gas poisoning. Twenty-five people died by drowning, and twenty-one people by hanging, strangulation or suffocation.

GENERAL PROVISIONS OF HEALTH AND SOCIAL SERVICES

Laboratory Facilities

The Public Health Laboratory Service operating at both Northampton and Oxford, was available for the diagnosis and analysis of specimens relative to infectious disease and also for the examination of samples of milk, ice-cream, water and others, and was free of cost to the authority. A helpful and efficient service is provided and we thank the laboratory staff at both Northampton General Hospital and the Radcliffe Infirmary, Oxford for their constant cooperation.

Hospital Services

The hospitals available to residents of the Borough are, The Burley General Hospital, Burleigh; Northampton General Hospital and the Radcliffe Infirmary, Oxford. The Cottage Hospital situated in the Borough, which has a small number of beds, is available for certain cases.

Cases of infectious disease requiring hospital treatment are removed to the Isolation Hospitals at Northampton and Oxford.

Ambulance Service

The County Council provides ambulance services for the removal to Hospital of all general, medical, surgical and infectious cases. An ambulance station is situated in the Borough and the service is available at all times.

Nursing in the Home, Midwives and Health Visitor Services

These services are provided directly by the County Council who have a health visitor's office established in the Borough. There is also a 'Home Help Service' provided by the Social Services Department of the County Council, which affords considerable benefit to the community both for domiciliary nursing cases and in the care of old people, who can remain comfortably in their homes and who, without this help, would be in institutions.

Child Welfare Clinic

The Child Welfare Clinic continued to operate during the year and sessions were held on the second Thursday of every month at the Health Clinic, St. Peter's Road. Special Clinics for school children organised by the County Council continued to operate during the year.

Welfare of the Aged - National Assistance Act, 1948, and Section 49, National Assistance (Amendment) Act, 1951.

Under this section the Council is responsible for the removal to suitable premises of persons needing care and attention. No action was taken under this Act, this year.

Services for Old People

The following provide services for old people:-

- (a) General Practitioner Service.
- (b) Hospital and Specialist Services.

As many as 250 of the 475 deaths were attributed to poisoning by various poisons, and 150 deaths to gas poisoning. Twenty-five people died by drowning, and twenty-one people by hanging, strangulation or suffocation.

SECTION B

GENERAL PROVISION OF HEALTH AND SOCIAL SERVICES

Laboratory Facilities

The Public Health Laboratory Service operating at both Northampton and Oxford, was available for the diagnosis and analysis of specimens relative to infectious disease and also for the examination of samples of milk, ice-cream, water and others, and was free of cost to the authority. A helpful and efficient service is provided and we thank the laboratory staff at both Northampton General Hospital and the Radcliffe Infirmary, Oxford for their constant cooperation.

Hospital Services

The hospitals available to residents of the Borough are, the Horton General Hospital, Banbury; Northampton General Hospital and the Radcliffe Infirmary, Oxford. The Cottage Hospital situated in the Borough, which has a small number of beds, is available for certain cases.

Cases of infectious disease requiring hospital treatment are removed to the Isolation Hospitals at Northampton and Oxford.

Ambulance Service

The County Council provide ambulance services for the removal to hospital of all general, medical, surgical and infectious cases. An ambulance station is situated in the Borough and the service is available at all times.

Nursing in the Home, Midwives and Health Visitor Service

These services are provided directly by the County Council who have a health visitor's office established in the Borough. There is also a 'Home Help Service' provided by the Social Services Department of the County Council, which affords considerable benefit to the community both for domiciliary maternity cases and in the care of old people, who can remain comfortably in their homes and who, without this help, would be in Institutions.

Child Welfare Clinic

The Child Welfare Clinic continued to operate during the year and sessions were held on the second Thursday of every month at the Health Clinic, St. Peter's Road. Dental Clinics for school children organised by the County Council continued to operate during the year.

Welfare of the Aged - National Assistance Act, 1948, and Section 47, National Assistance (Amendment) Act, 1951.

Under this section the Council is responsible for the removal to suitable premises of persons needing care and attention. No action was necessary under this Act, this year.

Services for Old People

The following provide services for old people:-

- (a) General Practitioner Service.
- (b) Hospital and Specialist Services.

SECTION 2

GENERAL PROVISIONS OF HEALTH AND SOCIAL SERVICES

Laboratory Facilities

The Public Health Laboratory Service operating at both Northampton and Oxford, was available for the diagnosis and analysis of specimens relative to infectious diseases and also for the examination of samples of milk, ice-cream, water and others, and was free of cost to the authority. A helpful and efficient service is provided and we thank the laboratory staff at both Northampton General Hospital and the Radcliffe Infirmary, Oxford for their constant cooperation.

Hospital Services

The hospitals available to residents of the Borough are, the Horton General Hospital, Banbury; Northampton General Hospital and the Radcliffe Infirmary, Oxford. The Cottage Hospital situated in the Borough, which has a small number of beds, is available for certain cases.

Cases of infectious diseases requiring hospital treatment are removed to the Infectious Hospitals at Northampton and Oxford.

Accident Services

The County Council provide ambulance services for the removal to hospital of all general, medical, surgical and infectious cases. An ambulance station is situated in the Borough and the service is available at all times.

Nursing in the Home, Midwives and Health Visitor Services

These services are provided directly by the County Council who have a health visitor's office established in the Borough. There is also a 'Home Help Service' provided by the Social Services Department of the County Council, which affords considerable benefits to the community both for domestic and nursing cases and in the care of old people. The car remain comfortably in their homes and who, without this help, would be in hospital.

Child Welfare Clinics

The Child Welfare Clinics continued to operate during the year and sessions were held on the second Thursday of every month at the Health Clinic, St. Peter's Road. Dental Clinics for school children organised by the County Council continued to operate during the year.

Welfare of the Aged - National Assistance Act, 1948, and Section 47, National Assistance (Amendment) Act, 1952.

Under this section the Council is responsible for the removal to suitable premises of persons requiring care and attention. No action was necessary under this Act, this year.

Services for Old People

The following provide services for old people:-

- (a) General Practitioner Service.
- (b) Hospital and Specialist Services.

2. The County Council

(a) The Health Department

1. District Nurses
2. Health Visitors
3. Chiropody Services
4. Certain home equipment

(b) The Social Services Department

From the 1st April 1971 the Social Services Department was established in accordance with the requirements of the Local Authority Social Services Act, 1970. In Northamptonshire the department was formed by the amalgamation of the former Childrens' and Welfare Departments, together with several functions which were previously the responsibility of the Health Department, including certain child health functions, care of the handicapped, and Mental Health and Home Help sections.

The following services are now provided for the elderly by this department:-

1. Home Help Service.
2. Residential Accommodation.
3. Holidays for the elderly.
4. Special services for blind, deaf, and home fittings where necessary.

3. Department of Health and Social Security

Financial help where necessary.

4. The District Council

Homes for the aged, flats and in some cases flatlets with Warden supervision.

There are two warden supervised dwellings (25 units and 24 units) as well as 10 bungalows and 20 flats, provided for the elderly.

5. Voluntary Organisations

These are many and services vary in different areas. The Darby and Joan Club which has been established many years in the Borough, meets every Wednesday afternoon in the Town Hall. It is very well attended and popular.

2. The County Council

(a) The Health Department

1. District Nurses
2. Health Visitors
3. Childbirth Services
4. Certain home equipment

(b) The Social Services Department

From the 1st April 1971 the Social Services Department was established in accordance with the requirements of the Local Authority Social Services Act, 1970. In Northamptonshire the department was formed by the amalgamation of the former Children's and Welfare Departments, together with several functions which were previously the responsibility of the Health Department, including certain child health functions, care of the handicapped, and Mental Health and Home Help sections.

The following services are now provided for the elderly by this department:-

1. Home Help Service
2. Residential Accommodation
3. Holidays for the elderly
4. Special services for blind, deaf, and home fittings where necessary

3. Department of Health and Social Security

Financial help where necessary.

4. The Probation Council

Beds for the aged, flats and in some cases flats with garden apartments.

There are two wards supervised buildings (25 units and 34 units) as well as 10 cottages and 20 flats, provided for the elderly.

5. Voluntary Organisations

There are many and services vary in different areas. The Daff and Lion Club which has been established many years in the town, meets every Wednesday afternoon in the Town Hall. It is very well attended and popular.

SECTION C

SANITARY CIRCUMSTANCES OF THE DISTRICT

Water is supplied to the Borough by the Buckinghamshire Water Board. Treatment consists of storage, sedimentation, chlorination and rapid sand gravity filtration. The water is non-plumbo solvent, and fluoride is not added; there is a natural fluoride content of approximately .2 parts per million.

The sources of this supply are varied and for the major portion of the Borough are based on supplies which include deep bores and wells in the lower greensand and chalk, and river water supplies from the Great Ouse. The waterworks plant incorporates electronic and television devices to ensure a constant flow to all areas, and to keep a check on waste.

Generally the supply from the Board was satisfactory in quality and quantity. Twenty-nine samples were taken and submitted to the Public Health Laboratory for examination; the reports indicate that bacteriologically they were satisfactory.

At times one of the problems of the supply is a brown discoloured water, due to a build up of algae in the storage reservoirs, a phenomenon which has become more apparent in recent years than heretofore, and probably due to changing agricultural techniques in the area, whereby certain chemicals infiltrate into the land drains and watercourses.

The total number of properties connected to the mains is 1,761 and only 31 persons within the Borough are not supplied with a mains water supply.

Sewerage - Disposal Works

The Extension Scheme reported on last year has started, and total expenditure will be at least half a million pounds. The works are not expected to be completed before early 1974 when the imposition of VAT on Pumps and other equipment is likely to result in some major cost increases.

Up to the present samples subject to Royal Commission standard tests have maintained a high standard, this is due to careful management. Many more samples are now taken than hitherto in order to assess the degree of possible river pollution during major alterations.

Both the City Engineer's Department at Oxford and the Borough Engineer's Department at Northampton are thanked for providing Brackley with sample analysis facilities to a more sophisticated and detailed extent than a simple B.O.D. test.

As river water is taken for recycling for drinking purposes by the Water Board at a point some distance below Brackley, there is a further need for maintaining sewage effluent to a high standard.

During the year it has been agreed by the Council that they will accept the sewage from the two outlying villages of Hinton in Northamptonshire and Turweston in Buckinghamshire.

An interesting feature of modern progression will occur in both these instances in that the sewage from each village will go to a pumping/comminutor station where it will be macerated and delivered to the Brackley sewers by means of a small bore plastic pipe - in one instance only two inches in diameter. This transfer of sewage from one area to another by means of cheap continuous plastic piping, easily laid, and of much smaller diameter than a normal sewer

SANITARY CIRCUMSTANCES OF THE DISTRICT

Water is supplied to the Borough by the Buckinghamshire Water Board. Treatment consists of storage, sedimentation, chlorination and rapid sand gravity filtration. The water is non-phosphoric sodium, and fluoride is not added; there is a natural fluoride content of approximately 1.2 parts per million.

The sources of this supply are varied and for the major portion of the Borough are based on supplies which include deep bore and wells in the lower green sand chalk, and river water supplies from the Great Ouse. The waterworks plant incorporates electric and television devices to ensure a constant flow to all areas, and to keep a check on wastes.

Generally the supply from the Board was satisfactory in quality and quantity. Twenty-nine samples were taken and submitted to the Public Health Laboratory for examination; the reports indicate that bacteriologically they were satisfactory.

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The total number of properties connected to the mains is 1,761 and only 31 persons within the Borough are not supplied with a mains water supply.

Sanitary - Domestic Works

The Waterworks Board reported on last year had started, and total expenditure will be at least half a million pounds. The works are not expected to be completed before early 1970 when the installation of VRT on pumps and other equipment is likely to result in some major improvements.

Up to the present samples submitted to Royal Commission standards tests have maintained a high standard, this is due to careful management. Many more samples are now taken than hitherto in order to assess the degree of possible river pollution during major alterations.

Both the City Engineer's Department at Oxford and the Borough Engineer's Department at Northampton are thanked for providing facilities with sample analysis facilities to a more sophisticated and detailed extent than a single R.O.D. can.

As river water is taken for recycling for drinking purposes by the Water Board at a point some distance below Brackley, there is a further need for maintaining sewage effluent to a high standard.

During the year it has been agreed by the Council that they will accept the sewage from the two existing villages of Bletchley in Northamptonshire and Trowbridge in Wiltshire.

An interesting feature of modern sewerage is that the sewage from each village will go to a pumping station where it will be metered and delivered to the Brackley sewer by means of a small bore plastic pipe - 15 inch diameter only two inches in diameter. This transfer of sewage into the sewer is another by means of cheap continuous plastic piping, easily laid, and of much smaller diameter than a normal sewer.

will obviate the need for small village works, which do not merit a full-time attendant, and too far from a labour pool to be economically and efficiently managed.

This opens up a nationwide possibility of large central sewage disposal schemes serving a sufficient population to require full technological, laboratory and research facilities together with a well qualified management staff.

Public Cleansing

House refuse collection is carried out weekly with the householder putting it out ready for removal. Special arrangements are however made in respect of the old, the handicapped and the infirm. The Borough disposal tip has been closed and the Council now share a modern disposal plant situated at Farthinghoe, with the Rural District Council.

Smoke Abatement

One factory on the Industrial Estate has been an offender but it is promised that an afterburner plus water-spray-particle-depositor-plant will be installed which should abate the nuisance. The only other smoke problem was abated when a local laundry firm installed a modern solid fuel boiler incorporating mechanical stoking, and forced draught, following intimation of atmospheric pollution.

Borough Swimming Pool

The pool had to be closed on one occasion due to vandal interference with the filtration pump, and once when some unknown chemical was found to have been placed in the pool, and discoloured the water.

The general purity as indicated by the sampling has been satisfactory. It is anticipated that the new covered Public swimming baths will be completed by late 1973.

School Swimming Pools

One of the schools has now installed a satisfactory filtration/chlorination unit and ceased to use a polluted water supply as a part-source. Samples taken indicate satisfactory operation. There is no trouble with any other school pools in the Borough.

Caravan Sites

There are no licensed sites in the Borough.

There has been trouble this year due to an influx of caravans occupied by a cohesive group connected with road and public works schemes in the area. A total of 37 squatters' vans suddenly appeared on the now disused lower railway goods yard at Brackley. British Rail stated they had not given authority for use as a van site, and showed some cooperation with the Council in an endeavour to move them. However, they were still there at the end of the year, but had moved on by February 1973.

The moving of individuals presents ethical problems to those officials forced to carry out such action and it is to be hoped that the Caravan Sites Act will be fully implemented in the near future.

will obviate the need for small village works, which do not merit a full-time attendant, and too far from a labour pool to be economically and efficiently managed.

This opens up a nationwide possibility of large central sewage disposal schemes serving a sufficient population to require full technological, laboratory and research facilities together with a well qualified management staff.

Public Cleansing

House refuse collection is carried out weekly with the householders putting it out ready for removal. Special arrangements are however made in respect of the old, the handicapped and the infirm. The Borough Council has been closed and the Council now share a modern disposal plant situated at Parkington, with the Rural District Council.

Public Amusement

The factory on the Industrial Estate has been an offender but it is pointed out that an effort must be made to ensure that the water supply is not polluted which should be the aim. The only other water problem was noted when a local laundry firm installed a modern solid fuel boiler incorporating mechanical stoking, and forced draught, following installation of atmospheric pollution.

Public Swimming Pool

The pool was to be closed on one occasion due to vandalism interference with the filtration pump, and once when some unknown chemical was found to have been placed in the pool, and discoloured the water.

The general purity as indicated by the sampling has been satisfactory. It is anticipated that the new covered public swimming bath will be completed by late 1977.

School Swimming Pools

One of the schools has now installed a satisfactory filtration/clarification unit and ceased to use a polluted water supply as a part of its. Samples taken indicate satisfactory operation. There is no trouble with any other school pools in the Borough.

Caravan Sites

There are no licensed sites in the Borough.

There has been trouble this year due to an influx of caravans occupied by a collective group connected with road and public works men in the area. A total of 17 caravans were suddenly appeared on the new diamond round. The caravans were at Brackley. British Rail stated they had not given authority for use as a van site, and stated some cooperation with the Council in an endeavour to move them. However, they were still there at the end of the year, but had moved on by February 1977.

The moving of individuals presents special problems to those officials forced to carry out such action and it is hoped that the Caravan Sites Act will be fully implemented in the near future.

Rodent Control

Building activity in Brackley has created a rodent problem. The extension to the sewers for the new housing estates has resulted in multiple entry of rats into the pipes from over the county border. Where the drainage system is faulty, as it has been shown to be on the older council housing estates, the rats get into the houses and cavity walls. This situation occurred at a time when the work of a long-service rodent operator ceased on retirement, and a new operator, only recently trained, was appointed.

A comprehensive attack on the sewerage system, and permanent ring baiting of troublesome areas has reduced the incidence of complaints, and the rat population. No problem of warfarin resistance has occurred.

Mr. Harry Evans, the Mace Bearer and part-time Rodent Operator, who has given valuable service for many years, retired this year.

Noise Abatement Act, 1960

There is no problem in Brackley.

However the siting of a new private housing estates opposite factories on the Industrial Estate has led to some difficult problems. A sleepless householder is unlikely to accept that the noise created by 24 hour factory operation is an unavoidable one and therefore in compliance with the Act.

The Industrial Estate and its factories are developing apace and as this faces, and is in close proximity to new residential estates, it can be foreseen as a possible future noise problem.

Offices, Shops and Railway Premises Act

The standard maintained by Brackley food shops is generally satisfactory. There have been some storage problems in connection with food, both as regards buildings unsatisfactorily protected against vermin and other contamination, and in separating chemical products such as disinfectants, fertilisers, soaps and detergents from foods capable of absorbing taints. Under the Offices section of the work it has been necessary to improve winter heating standards, clothes drying facilities, and in certain offices attached to new factories, the intervening ventilated space necessary between work rooms and the conveniences.

During the year one hotel kitchen was reconstructed, and new additional conveniences with washing facilities provided. This has benefited both patrons and staff.

Radio Activity

One additional radio-active licence was granted in Brackley during the year making two altogether. Unfortunately, in respect of the latest, two of the new devices were removed by children but regained by the police before they could be broken, which could have released a radio active gas, and if occurring inside a room could have been capable of physical damage to a human being. However, no harm resulted in this instance and the devices are no longer in use.

Robert Control

Building activity in Brooklyn has created a rodent problem. The extension to the sewers for the new housing estate has resulted in multiple entry of rats into the pipes from over the county border. Where the drainage system is faulty, as it has been shown to be on the other side of the county border, the rats get into the houses and cavity walls. This cannot be housing estate, the rats get into the houses and cavity walls. This situation occurred at a time when the work of a long-service rodent operator ceased on retirement, and a new operator, only recently trained, was appointed.

A comprehensive attack on the sewerage system, and permanent ringing of the sewerage system, has reduced the incidence of complaints, and the rat population. No problem of vermin infestation has occurred.

Mr. Harry Evans, the Home Officer and part-time Robert Operator, who has given valuable service for many years, retired this year.

Noise Abatement Act, 1960

There is no problem in Brooklyn.

However, the siting of a new private housing estate opposite factories on the Industrial Estate has led to some difficult problems. A complaint has been made to the Council that the noise created by the new factory operation is an unavoidable one and therefore in compliance with the Act.

The Industrial Estate and its factories are developing space and as this takes place, and in close proximity to new residential estates, it can be foreseen as a possible future noise problem.

Odour, Noise and Safety Problems Act

The standards maintained by Brooklyn Food shops is generally satisfactory. There have been some odour problems in connection with food, both as regards buildings unsatisfactorily protected against vermin and other contamination, and in respect of chemical products such as disinfectants, fertilisers, manure and dangerous foodstuffs capable of absorbing odours. Under the Odour and Dangerous Foodstuffs Act, it has been necessary to improve winter heating standards, restrict drying facilities, and in certain cases to restrict the use of the intervening restricted space necessary between work rooms and the containers.

During the year one hotel kitchen was reconstructed, and new additional conveniences with washing facilities provided. This has benefited both patients and staff.

Radio Activity

One additional radio-active licence was granted in Brooklyn during the year making two altogether. Unfortunately, in respect of the latest two of the new devices were removed by children but regained by the police before they could be broken, which could have released a radio active gas, and it occurred inside a room could have been capable of physical damage to a human being. However, no harm resulted in this instance and the devices are no longer in use.

FACTORIES ACT 1961

PREScribed PARTICULARS ON THE ADMINISTRATION OF
THE FACTORIES ACT, 1961, FOR THE YEAR 1972

PART 1 OF THE ACT

1. INSPECTIONS FOR PURPOSES OF PROVISIONS AS TO HEALTH
(including inspections made by Public Health Inspectors)

Premises	No. on Register	Number of		
		Inspections	Written Notices	Occupiers prosecuted
(i) Factories in which Sections 1, 2, 3, 4 and 6 are to be enforced by Local Authorities	7	9	-	-
(ii) Factories not included in (i) in which Section 7 is enforced by the Local Authority	18	38	-	-
(iii) Other premises in which Section 7 is enforced by the Local Authority (excluding out-workers' premises)	-	-	-	-
Total:	25	47	-	-

PACIFIC ACT 1961

EXEMPTED PREMISES ON THE REGISTRATION OF
THE PACIFIC ACT, 1961, FOR THE YEAR 1962

PART I OF THE ACT

EXEMPTIONS FOR PREMISES ON REGISTERED AS TO BE
(including inspections made by Public Health Inspectors)

Premises	No. on Register	Number of		
		Inspection Station	Written Notice	Occupants Presented
(1) Premises in which Sections 1, 2, 3, 4 and 5 are to be enforced by local authorities	7	2	-	-
(2) Premises not included in (1) in which Section 7 is enforced by the local authority	16	20	-	-
(3) Other premises in which Section 7 is enforced by the local authority (ex- cluding out- standing premises)	-	-	-	-
Total:	23	42	-	-

This Act placed a general prohibition on the depositing of poisons and other dangerous substances in any place, and laid the duty of those who deposit such substances on the authority prior to their depositing them.

CASES IN WHICH DEFECTS WERE FOUND

Particulars	No. of cases in which defects were found				No. of cases in which prosecutions were instituted
	Found	Remedied	Referred		
			to H.M. Inspec.	by H.M. Inspec.	
Want of Cleanliness (S.1)	1	1	-	-	-
Overcrowding (S.2)	-	-	-	-	-
Unreasonable Temperature (S.3.)	-	-	-	-	-
Inadequate ventilation (S.4)	-	-	-	-	-
Ineffective drainage of floors (S.6)	-	-	-	-	-
Sanitary conveniences (S.7)					
(a) Insufficient	-	-	-	-	-
(b) Unsuitable or defective	-	-	-	-	-
(c) Not separate for sexes	-	-	-	-	-
Other offences against the Act (not including offences relating to Outwork)	3	1	-	-	-
Total:	4	2	-	-	-

often from products innocently introduced for man's convenience, will be a major function. In rural areas, more production methods in farming are creating further problems, particularly of soil and pollution and will ultimately require a system of national standards of control.

CASES IN WHICH DEFECTS WERE FOUND

Particulars	Found	Referred to H.M. Inspector	Referred to H.M. Inspector	No. of cases in which defects were found	No. of cases in which defects were found
Want of Cleanliness (2.1)	1	-	-	-	-
Overcrowding (2.2)	-	-	-	-	-
Unsanitary (2.3)	-	-	-	-	-
Inadequate ventilation (2.4)	-	-	-	-	-
Ineffective drainage of floors (2.5)	-	-	-	-	-
Rat and vermin (2.6)	-	-	-	-	-
(a) Inefficient	-	-	-	-	-
(b) Unstable or defective	-	-	-	-	-
(c) Not separate for cases	-	-	-	-	-
Other offences against the Act (not including the offences relating to Outlets)	2	-	-	-	-
Total:	4	2	-	-	-

The Deposit of Poisonous Waste Act, 1972

This Act placed a general prohibition on the depositing of poisonous and other dangerous waste, made it a civil liability to do so, and laid the duty of those wishing to deposit to notify the responsible authorities prior to removal or deposition. Operators of commercial tips had also responsibility for notification and duties of local authorities were outlined in relation to enforcement of the Act.

FUTURE PROBLEMS IN ENVIRONMENTAL HEALTH

While the foregoing is a report on the year 1972, at this historic time it is relevant to consider some of the problems which will face the reorganised department of environmental health in 1974.

The disposal of refuse, and the overall control of sewage works will become the responsibility of County Councils and Water Authorities respectively. District Councils will retain their responsibility for sewerage, and collection of refuse. The need for cooperation between the authorities will be paramount. Likewise while the personal health services will be part of the National Health Service, environmental health together with the control of infectious diseases remains a District Council duty.

Successful environmental control can, however, never be achieved without consideration of the personal cooperation of the individuals living in the community. This is evident in its most pressing form in the need for population control. Unless achieved within the remaining years of the century the task of those endeavouring to maintain environmental health will be overwhelming. Already the environment is threatened by congestion of roads and countryside, noise, pollution of air, land, waterways and sea, housing shortages and the need for more services in many fields. The effect of this on the mental health of the people can be inferred by the increase in crime, delinquency, drug taking, alcoholism and child cruelty. The reorganised health services will have the responsibility of providing contraceptive services and plans to expand are already afoot. However in the acceptance by the population of these measures an enlightened health education service will have a vital part to play.

Other aspects of health education will be shared by both authorities, Local Government accepting the need to provide instruction, particularly in safety at home, at work and on the road, and in food hygiene.

It is vital that the secure basis already achieved in the sanitary field is maintained, and the need for the prevention of further pollution, often from products innocently introduced for man's convenience, will be a major function. In rural areas, mass production methods in farming are creating further problems, particularly of smell and pollution and will ultimately require a system of national standards of control.

This Act places a general prohibition on the depositing of poisonous and other dangerous waste, made it a civil liability to do so, and laid the duty of those wishing to deposit to notify the responsible authority prior to removal or deposition. Operators of commercial sites had also responsibility for notification and duties of local authorities were outlined in relation to enforcement of the Act.

FUTURE PROSPECTS IN ENVIRONMENTAL HEALTH

While the foregoing is a report on the year 1972, at this historic time it is relevant to consider some of the problems which will face the environmental department of environmental health in 1974.

The disposal of refuse, and the overall control of sewage works will become the responsibility of County Councils and Water Authorities respectively. District Councils will retain their responsibility for sewerage, and collection of refuse. The need for cooperation between the authorities will be paramount. While the personal health services will be part of the National Health Service, environmental health together with the control of infectious diseases remains a District Council duty.

Successful environmental control can, however, never be achieved without co-operation of the personal cooperation of the individuals living in the community. This is evident in the most pressing form in the need for population control. Unless achieved within the remaining years of the century the task of those endeavouring to maintain environmental health will be overwhelming. Already the environment is threatened by congestion of roads and countryside, noise, pollution of air, land, waterways and sea, housing shortages and the need for more services in many fields. The effect of this on the mental health of the people can be inferred by the increase in crime, delinquency, drug taking, alcoholism and child cruelty. The environmental health services will have the responsibility of providing contraceptive services and plans to extend are already afoot. However in the meantime by the population of these measures an enlightened health education service will have a vital part to play.

Other aspects of health education will be shared by both authorities. Local Government accepting the need to provide instruction, particularly in safety at home, at work and on the road, and in food hygiene.

It is vital that the sector health already achieved in the country. This is maintained, and the need for the prevention of further pollution, after two decades' incessantly introduced for man's convenience, will be a major function. In rural areas, more production methods in farming are creating further problems, particularly of smell and pollution and will ultimately require a system of national standards of control.

SECTION D

HOUSING

Scheme 59 totalling 66 council houses and flats has been completed.

Standard Improvement Grants amounting to £2,614 were paid in connection with the Housing Act, 1969.

Private contractors have been erecting houses, and 46 new dwellings were completed during the year.

There are in the Borough a total of 442 council houses, including fifty for senior citizens. One council house has been adapted for a paraplegic.

Housing Standards

During the year two houses were the subject of action under the Housing Act, 1957 and no Undertaking accepted. Two Closing Orders have been implemented.

Senior Citizen Accommodation

There are fifty units of accommodation available, including self-contained flats, within a block of flats, for married couples or single persons, with communal facilities available and a Warden on call if required. Single rooms are also provided, with communal facilities and more actual care given by the Warden and welfare staff.

Also in the Borough, but operated by the County Council, is an Old Peoples' Home where independent living conditions are not provided, but those incapable of looking after themselves are cared for.

During the year there has not been a serious recurrence of foot and mouth. The contamination of carcasses has, in most cases, been due to sanitation or poor condition arising from either a pathogenic condition, accident or starvation. This latter factor may arise from a variety of causes. As an example, on one occasion this year, some 470 carcasses were examined where gross sanitation and absence of fat surrounding the internal organs appeared to be due solely to lack of adequate feeding with no possibility of evidence of infection. The history of this batch was a compulsory sale from a bankrupt poultry farmer who, on getting into financial difficulties, had not fed the birds properly for a considerable period, and they had no food after the compulsory sale until collection some days later. In other cases the stock has not been actually starved, but were ill fed, and in one instance a professor ceased to feed after a contractor agreed to purchase, again some days involved.

SECTION D

HOUSING

Some 25 cottages in council houses and flats have been completed.
Standard Improvement Grants amounting to £2,614 were paid in connection
with the Housing Act, 1957.

Private contractors have been erecting houses, and 46 new dwellings
were completed during the year.

There are in the Borough a total of 443 council houses, including
fifty for senior citizens. One council house has been adapted for a
physically handicapped person.

Housing Standards

During the year two houses were the subject of action under the
Housing Act, 1957 and no Undertaking accepted. Two Closing Orders have
been implemented.

Senior Citizens Accommodation

There are fifty units of accommodation available, including self-
contained flats, within a block of flats, for married couples or single
persons, with communal facilities available and a Warden on call if
required. Single rooms are also provided, with communal facilities
and more extensive care given by the Warden and welfare staff.

Also in the Borough, but operated by the County Council, is an
Old Peoples' Home where independent living conditions are not provided,
but those incapable of looking after themselves are cared for.

SECTION E

INSPECTION AND SUPERVISION OF FOOD

The production and distribution of food has undergone major changes in the last quarter of the century. Technical advances, which have resulted in the manufacture of an increasing variety of food, with an improved keeping quality, quick transport, pure water, carefully controlled milk supply, and food hygiene legislation have all contributed to the raising of standards. However, many of the innovations have generated further problems of control and the increasing mobility of a rising population have added to, rather than lessened, the need for food hygiene supervision.

Many more premises are now vending food, some for immediate consumption. The almost universal use of refrigerator cabinets, while greatly improving hygiene, nevertheless requires careful stock rotation. There is an increase in the purchase of already cooked food for home consumption. The majority of the working population, including schoolchildren, take their midday meal at a canteen or cafe. Travel at home and abroad is general, the latter sometimes resulting in the importation of intestinal infections, not endemic in the local population, which in food handlers can cause grave concern. The rapid changes in personnel in the food industry need supervision and education from employers and inspectors.

Poultry Processing

The main food problem of Brackley is the existing poultry processing factory with a throughput at present of about 4,000,000 birds per annum. The new poultry factory now nearing completion will deal with freshly killed birds, both eviscerated and New York dressed and mildly chilled carcasses, but will not commence until next year. It is laid out for about a half million annual throughput. The design of this new factory envisages "Open Plan" techniques whereby the washing, de-feathering, stunning, bleeding, evisceration, packaging and despatch arrangements are in one continuous room. It is possible that the carrying out of all processes in a single room might involve hygienic problems.

During the year there has not been a serious recurrence of fowl pest and, the condemnation of carcasses has, in most cases, been due to emaciation or poor condition arising from either a pathogenic condition, accident or starvation. This latter factor may arise from a variety of causes. As an example, on one occasion this year, some 450 carcasses were examined where gross emaciation and absence of fat surrounding the internal organs appeared to be due solely to lack of adequate feeding with no morbidity or evidence of infection. The history of this batch was a compulsory sale from a bankrupt poultry farmer who, on getting into financial difficulties, had not fed the birds properly for a considerable period, and they had no food after the compulsory sale until collection some days later. In other cases the stock had not been actually starved, but were ill fed, and in one instance a producer ceased to feed after a contractor agreed to purchase, again some days involved.

INSPECTION AND SUPERVISION OF FOOD

The production and distribution of food has undergone major changes in the last quarter of the century. Technical advances, which have resulted in the manufacture of an increasing variety of food, with improved keeping quality, quick transport, pure water, carefully controlled milk supply, and food hygiene legislation have all contributed to the raising of standards. However, many of the innovations have generated further problems of control and the increasing mobility of a rising population have added to, rather than lessened, the need for food hygiene supervision.

Many new premises are now vending food, some for immediate consumption. The almost universal use of refrigerator cabinets, while greatly improving hygiene, nevertheless requires careful stock rotation. There is an increase in the purchase of already cooked food for home consumption. The majority of the working population, including schoolchildren, take their midday meal at a canteen or cafe. Travel at home and abroad is general. The latter sometimes resulting in the importation of intestinal infections. Not only in the local population, which is food handlers can cause grave concern. The rapid changes in personnel in the food industry need supervision and education from engineers and inspectors.

Factory Inspection

The main food problem of Hampshire is the existing poultry processing factory with a throughput at present of about 4,000,000 birds per annum. The new poultry factory now nearing completion will deal with freshly killed birds, both vaccinated and New York dressed and mildly chilled carcasses, but will not commence until next year. It is laid out for about a half million annual throughput. The design of this new factory envisages "open plan" techniques whereby the washing, de-feathering, eviscerating, chilling, evisceration, packaging and dispatch arrangements are in one continuous room. It is possible that the carrying out of all processes in a single room might involve hygiene problems.

During the year there has not been a serious recurrence of foot and mouth, the condemnation of carcasses has, in most cases, been due to contamination or poor condition arising from either a pathogenic condition, or infection or contamination. This latter factor may arise from a variety of causes. As an example, on one occasion this year, some 450 carcasses were examined where gross emaciation and absence of fat surrounding the internal organs appeared to be due solely to lack of adequate feeding with no morbidity or evidence of infection. The history of this batch was a compulsory sale from a Hampshire poultry farmer who, on falling into financial difficulties, had not fed the birds properly for a considerable period, and they had no food after the compulsory sale until collection some days later. In other cases the stock had not been actually starved, but were ill fed, and in one instance a producer seemed to feed after a consultant agreed to purchase, again some days later.

With a total of four million birds per annum, and only one inspector available for some of the time, clearly without the help and cooperation of the factory proprietors it would be difficult to check efficiently the soundness of poultry to be sold to the public. However the utmost cooperation is received from the present Brackley factory, and they have recently appointed their own Hygiene Officer who is of great assistance to your inspector.

When European Economic Community rules are applicable in 1974 and 1976 individual carcasses will require to be inspected. This will be a mammoth task in Brackley (when two factories will be operative), facing the proposed new South Northamptonshire District Council, unless the Government veterinary service ultimately takes over supervision.

Other Food Matters

There is an increasing problem in the sale of unsound food from the shops in Brackley mainly the grocery trade.

The deep freezing and refrigeration of food appears to be the main problem at food shops and the fault is not in all cases due to the shop-keeper. Where a deep frozen chicken or turkey is purchased the housewife will occasionally permit it to de-freeze whilst still in the plastic pack, and this may lead to moisture accumulation and eventual commencement of decomposition of the carcass in the home. This may result in a complaint of putrefaction to the Health Department office. An explanation of the true cause of the putrefaction is not always well received.

There is a continuing prevalence of food displayed for sale after the coding date has expired. It is understood that all supermarket managers are instructed to inspect their stock shelves each morning; if they did do so foods with an outdated code would surely be detected; the housewife also should look for the final coding date.

Foods Condemned and/or Surrendered During the Year are as follows:-

	Tons	Cwts.	Qtrs.	Lbs.
Poultry Meat	24	3	1	9
Fresh Meat at retail outlet	-	-	-	22
Other foods	-	9	2	12

Foreign Bodies

There were five instances of metal objects found in food, one case of a stone in canned food, and two instances of contamination occurring from proximity to chemicals. There was one instance of metallic contamination of a food prepared in Brackley but received as a complaint from the Glasgow food inspector.

Food and Drugs Act, 1955

The provisions of the Act relating to the nature of substance of food supplied to the public, are operated by Mr. F.J. Evans, Chief Inspector Weights and Measures Department of the County Council, to whom I am indebted for the following information relating to the work carried out by his Department in the Borough during the twelve months ending 31st March, 1973.

With a total of four million birds per annum, and only one inspector available for some of the time, clearly without the help and cooperation of the factory proprietors it would be difficult to check efficiently the thousands of poultry to be sold to the public. However, the utmost co-operation is received from the present Brooklyn factory, and they have recently appointed their own Hygiene Officer who is of great assistance to your inspector.

When European Economic Community rules are applicable in 1973 and 1974 individual countries will require to be inspected. This will be a massive task in Brooklyn (when two factories will be operative). Facing the proposed new South Hampshire's District Council, unless the Government veterinary services ultimately takes over supervision.

Other Food Factors

There is an increasing problem in the sale of uncooked food from the shops in Brooklyn mainly the grocery trade.

The deep freezing and refrigeration of food appears to be the main problem at food shops and the limit is not in all cases due to the shopkeeper. Where a shopkeeper wishes or wishes to purchase the products will occasionally provide it to be frozen whilst still in the plastic pack, and this may lead to water accumulation and eventual contamination of the contents of the package in the home. This may result in a complaint of contamination to the Health Department Office. An explanation of the true cause of the contamination is not always well received.

There is a continuing prevalence of food displayed for sale after the expiry date has expired. It is understood that all supermarket managers are instructed to inspect their stock regularly. If they did so as soon as an expiry date would surely be detected. The housewife also should look for the final expiry date.

Food Display and/or Contamination During the Year are as follows:-

Type of Food	No. of Complaints	No. of Inspections	No. of Offences	No. of Prosecutions
Poultry Meat	2	1	2	2
French Meat at retail outlet	2	1	1	1
Other foods	12	2	2	2

Further Factors

There were five instances of retail outlets found in food, two cases of a shop to remove food, and two instances of contamination occurring from poultry to chickens. There was one instance of retail contamination of a food prepared in Brooklyn but received as a complaint from the Glasgow food inspector.

Food and Food Act, 1922

The provisions of the Act relating to the nature of substance of food supplied to the public, are operated by Mr. F. J. Evans, Chief Inspector, Health and Consumer Department of the County Council, to whom I am indebted for the following information relating to the work carried out by his Department in the Borough during the twelve months ending 31st March, 1973.

SECTION 2

PREVALENCE OF

Samples taken in Brackley Borough in
the 12 months ending 31st March, 1973

Milk	11
Meat products	5
Cream	1
Cheese	1
Yoghurt	2
Beer	1
Butter	1
Soft drinks	2
Ice cream	1
Condiments	1
	<hr/>
TOTAL	26

Remarks

It is pleasing to be able to report that all the samples which were taken in the Borough during the year were found to be satisfactory.

Weights and Measures Act, 1963

Of the 2,072 articles which were checked for weight or measure during the period under review, only 14 were found to be deficient. The errors were of a minor nature and call for no particular comment.

Since 1968 notification of the diseases listed below is no longer required:-

Acute infectious pneumonia	Erysipelas
Acute primary pneumonia	Haemorrhagic sepsis
Acute rheumatism	Scarlet fever

Responsibility for notifying a case of infectious disease rests exclusively on the medical practitioner attending the patient unless he believes that another practitioner has already notified the case.

During the year 4 cases of infectious disease were notified, a decrease of 79 on last year's figure.

MEASLES

The incidence of measles notification decreased. There were 3 cases as compared with 76 in 1971. While measles is no longer a major cause of morbidity in Britain, it is an unpleasant illness and for some adult life without having contracted it. In addition in the five years preceding 1968 there were 167 deaths. An infection of such universality may result in complications, including neurological sequelae and respiratory, eye and ear infections, and during an epidemic year as many as 8,000 hospital admissions may occur.

Samples taken in Brooklyn Borough in
the 12 months ending 31st March, 1957

11	Milk
2	Meat products
1	Cream
1	Cheese
2	Yoghurt
1	Eggs
1	Butter
2	Soft drinks
1	Ice cream
1	Confectionery

TOTAL 26

Summary

It is pleasing to be able to report that all the samples which were taken in the Borough during the year were found to be satisfactory.

Defects and Remedies Act, 1957

Of the 2,072 articles which were checked for weight or measure during the period under review, only 14 were found to be deficient. The errors were of a minor nature and call for no particular comment.

SECTION F

PREVALENCE OF, AND CONTROL OVER INFECTIOUS AND OTHER DISEASES

Health Services and Public Health Act, 1968 Public Health (Infectious Diseases) Regulations Notification of food poisoning and infectious diseases

All provisions governing the notification of infectious disease and food poisoning are in Sections 47 to 49 of the Health Services and Public Health Act, 1968 and the Public Health (Infectious Diseases) Regulations, 1968.

The infectious diseases to be notified to the medical officer of health are:-

Acute encephalitis	Ophthalmia neonatorum
Acute meningitis	Paratyphoid fever
Acute poliomyelitis	Plague
Anthrax	Relapsing fever
Cholera	Scarlet fever
Diphtheria	Smallpox
Dysentery	Tetanus
(amoebic and bacillary)	Tuberculosis
Infective jaundice	Typhoid fever
Leprosy	Typhus
Leptospirosis	Whooping cough
Malaria	Yellow fever
Measles	

Since 1968 notification of the diseases listed below is no longer required:-

Acute influenzal pneumonia	Erysipelas
Acute primary pneumonia	Membranous croup
Acute rheumatism	Puerperal pyrexia

Responsibility for notifying a case or suspected case of food poisoning or infectious disease rests exclusively on the medical practitioner attending the patient unless he believes that another practitioner has already notified the case.

During the year 4 cases of infectious disease were notified, a decrease of 79 on last year's figure.

MEASLES

The incidence of measles notification decreased. There were 2 cases as compared with 76 in 1971. While measles is no longer a major cause of morbidity in Britain, it is an unpleasant illness and few reach adult life without having contracted it. In addition in the five years preceding 1968 there were 467 deaths. An infection of such universality may result in complications, including neurological sequelae and respiratory, eye and aural infections, and during an epidemic year as many as 8,000 hospital admissions may occur.

PREVALENCE OF, AND CONTROL OVER, INFECTIOUS AND OTHER DISEASES

Health Services and Public Health Act, 1968
Public Health (Infectious Diseases) Regulations
Notification of Food Poisoning and Infectious Diseases

All provisions governing the notification of infectious diseases and food poisoning are in Sections 47 to 49 of the Health Services and Public Health Act, 1968 and the Public Health (Infectious Diseases) Regulations, 1968.

The infectious diseases to be notified to the medical officer of health are:-

Acute encephalitis	Cholera
Acute meningitis	Diphtheria
Acute poliomyelitis	Epidemic typhus
Scarlet fever	(measles and mumps)
Shigellosis	Infective hepatitis
Tuberculosis	Leptospirosis
Typhoid fever	Malaria
Typhus	Measles
Whooping cough	
Yellow fever	

Since 1968 notification of the diseases listed below is no longer required:-

Acute infectious pneumonia	Erysipelas
Acute primary pneumonia	Hemorrhagic fever
Acute rheumatism	Scarlet fever

Responsibility for notifying a case or suspected case of food poisoning or infectious disease rests exclusively on the medical practitioner attending the patient unless he believes that another practitioner has already notified the case.

During the year 4 cases of infectious diseases were notified, a decrease of 75 on last year's figure.

MEASLES

The incidence of measles notification decreased. There were 5 cases as compared with 16 in 1971. While measles is no longer a major cause of mortality in Britain, it is an unpleasant illness and few reach adult life without having contracted it. In addition in the five years preceding 1968 there were 457 deaths. An infection of such universality may result in complications, including neurological sequelae and respiratory, eye and renal infections, and during an epidemic year as many as 8,000 hospital admissions may occur.

The regular biennial cycle of epidemics of measles failed to occur in the 1968-69 winter and again in the winter of 1969-70 there was no national epidemic, due probably to the programme of immunisation which began in 1968. The suspension in March 1969 of a certain batch of vaccine led to a shortage and the rate of immunisation has been less than sufficient to prevent the number of susceptible children increasing with the new births each year. It was evident by the middle of 1970 that the incidence of measles would be high as notifications markedly increased and continued throughout the year. By mid-1970 sufficient supplies of vaccine were available and vaccination was resumed, however during late 1970 and throughout 1971 there was a significant rise of measles notifications nationally and a campaign, initiated by the Chief Medical Officer of the Department of Health, to promote further measles vaccination was successful, and there was a considerable increase in the numbers of children vaccinated. During 1972 the figures continued to rise and in the county, 5,752 children were vaccinated between the ages of 1 and 7 years. 72% of children born between 1st January 1963 and December 1971 were vaccinated.

It is to be hoped that a sufficient number of susceptibles will now be vaccinated and that 1971 will be the last year when a high incidence of measles is recorded.

RUBELLA

Rubella vaccination became available in November 1970 and this was offered to all girls in their 14th year of life (aged 13). Following the increased availability of the vaccines this age limit has now been lowered to include 11 and 12 year old girls.

Vaccination is also offered to female teachers of child bearing age because of the likelihood of their coming into contact with the infection in school. In the county 279 took up the offer, but only 31 had negative haemagglutination inhibition titres, who were vaccinated. Female members of the health department staff were offered similar facilities and 18 of 47 needed protection.

WHOOPING COUGH (Pertussis)

No cases were notified. This is another condition which is becoming largely more benign, but in some cases can be distressing, and in infancy a serious illness. Protection to this disease is often by triple vaccination, together with tetanus and diphtheria.

The County Council are participating in a survey on the efficacy of pertussis vaccination with the Public Health Laboratory Service. Details of notifications together with (where possible) the vaccinal state of the child are provided. The surveillance will include an analysis of the attack rate in vaccinated and unvaccinated children in areas with computer facilities.

SCARLET FEVER

There were no cases notified. Its principle interest is that it gives a rough indication of the amount of streptococcal infection in the community.

POLIOMYELITIS

Once again there has been no case notified, and this freedom can be ascribed to immunisation as the decline in incidence has occurred concurrently with vaccination. The oral Sabin vaccine is now used which gives a longer lasting immunity than the Salk or injected variety. A drink of syrup or a lump of sugar

The regular biennial cycle of epidemics of measles failed to occur in the 1950-55 winter and again in the winter of 1959-60 there was no national epidemic. Due primarily to the program of immunization which began in 1955, the suspension in March 1960 of a certain batch of vaccine led to a shortage and the rate of immunization has been less than sufficient to prevent the number of susceptible children increasing with the new births each year. It was evident by the middle of 1960 that the incidence of measles would be high as notifications markedly increased and continued throughout the year. By mid-1970 sufficient supplies of vaccine were available and vaccination was resumed, however during late 1970 and throughout 1971 there was a significant rise of measles notifications nationally and a consequent, initiated by the Chief Medical Officer of the Department of Health, to promote further measles vaccination was unsuccessful, and there was a considerable increase in the numbers of children vaccinated. During 1972 the figures continued to rise and in the county 3,752 children were vaccinated between the ages of 1 and 7 years 15% of children born between 1st January 1965 and December 1971 were vaccinated. It is to be hoped that a sufficient number of susceptibles will now be vaccinated and that 1971 will be the last year when a high incidence of measles is recorded.

MEASLES

Measles vaccination became available in November 1970 and this was offered to all girls in their 14th year of life (aged 13). Following the increased availability of the vaccine this age limit has now been lowered to include 11 and 12 year old girls.

Vaccination is also offered to female teachers of child bearing age because of the likelihood of their coming into contact with the infection in school. In the county 379 took up the offer, but only 51 had negative haemagglutinated inhibition titres, who were vaccinated. Female members of the health department staff were offered similar facilities and 18 of 41 needed protection.

WHOOPING COUGH (Pertussis)

No cases were notified. This is another condition which is becoming largely more benign, but in some cases can be disastrous, and in infancy a serious illness. Protection to this disease is often by triple vaccination together with tetanus and diphtheria.

The County Council are participating in a survey on the efficacy of pertussis vaccination with the Public Health Laboratory Service. Details of notifications together with (where possible) the vaccination status of the child are provided. The surveillance will include an analysis of the attack rate in vaccinated and unvaccinated children in areas with computer facilities.

SCARLET FEVER

There were no cases notified. Its principal interest is that it gives a rough indication of the amount of streptococcal infection in the community.

POLIOVIRUS

Once again there has been no case notified, and this freedom can be ascribed to immunisation as the disease in childhood has occurred concurrently with vaccination. The oral Babin vaccine is now used which gives a longer immunity than the Babin or injected variety. A brisk or rapid group of 100 of

is also much more acceptable to the young patients than the previous needle prick.

INFECTIVE JAUNDICE

Acute infective hepatitis is a disease caused by a virus which attacks the liver and causes jaundice. It is mainly an infection of young people, of faecal-oral spread, and with an incubation period of 15 to 50 days. The incriminative routes of infection are from food handlers, water, and children to their mothers. The virus is present in faeces 16 days before jaundice and up to 8 days after.

Serum hepatitis, which is another form of infective hepatitis, has a longer incubation period of from 50 to 160 days and affects mainly adults and can be spread by blood transfusion and inefficiently sterilized equipment used by doctors, dentists, nurses, drug addicts and in the various tattooing processes. The clinical groups of these two types of hepatitis are indistinguishable. There is no specific treatment and a jaundiced adult would be away from work from six weeks to two months, and might not feel really fit for a year. Quarantine measures are of little value and patients can be treated at home or in hospital, provided adequate hand-washing techniques are practised with current disinfection of excreta. Serum hepatitis can be virtually abolished if disposable equipment were generally introduced. In this County disposable equipment is used by the County Health Department for all procedures involving immunisation. Gamma Globulin is of value for the protection of close contacts and pregnant women during epidemics.

There was one case notified in the town this year.

TUBERCULOSIS

There was one case of respiratory tuberculosis notified during the year.

SMALLPOX

It has recently been recommended by the Department of Health and Social Security that vaccination against smallpox need no longer be carried out as a routine procedure in early childhood as the risk of exposure to infection is far less likely than at any previous time since the disease was first recorded in this country.

It is however emphasised that all travellers to and from areas of the world where smallpox is endemic, or countries where eradication programmes are in progress, and health service staff who come into contact with patients, should be offered vaccination and re-vaccination.

DIPHTHERIA

There have been no cases of diphtheria in Northamptonshire since 1956. There is therefore, with each successive year of freedom from infection, a diminishing recollection of the dangers of this illness. Mothers without knowledge of the disease feel a false security and may not have their children immunised. That this is a dangerous situation cannot be too strongly stressed, as it is only by keeping up the numbers of children immunised that the disease can be kept in check. It is the duty of all parents to have their children immunised, and if they fail to do so, they neglect their welfare.

is also much more acceptable to the young patients than the previous needle
policy.

INFECTIVE JAVANICA

Acute infectious hepatitis is a disease caused by a virus which attacks
the liver and causes jaundice. It is mainly an infection of young people,
of blood-borne spread, and with an incubation period of 15 to 30 days. The
incubative period of infection is from food handlers, water, and children
in their mothers. The virus is present in faeces 10 days before jaundice and
up to 3 days after.

Jaundice hepatitis, which is another form of infectious hepatitis, has a
longer incubation period of from 30 to 100 days and affects mainly adults
and can be spread by blood transfusion and insecticide spraying.
equipment used by doctors, dentists, nurses, drug addicts and in the various
infectious diseases. The clinical groups of these two types of hepatitis
are indistinguishable. There is no specific treatment and a jaundiced adult
would be away from work for six weeks to two months, and might not feel
fully fit for a year. Quarantine measures are of little value and patients
can be treated at home or in hospital, provided adequate nursing facilities
are provided with current disinfection of excreta. Jaundice hepatitis can be
virtually excluded if disposable equipment were generally introduced. In
this County disposable equipment is used by the County Health Department for all
procedures involving infection. Jaundice hepatitis is of value for the protection
of close contacts and pregnant women during epidemics.

There was one case notified in the town this year.

TUBERCULOSIS

There was one case of respiratory tuberculosis notified during the year.

SHALLOT

It has recently been recommended by the Department of Health and Social
Security that vaccination against smallpox need no longer be carried out as
a routine measure in early childhood as the risk of exposure to infection
is far less likely than at any previous time since the disease was first
recorded in this country.

It is however suggested that all travellers to and from areas of the
world where smallpox is endemic, or countries where eradication programmes
are in progress, and health service staff who come into contact with patients,
should be given vaccination and re-vaccination.

DIPTHERIA

There have been no cases of diphtheria in Northamptonshire since 1955.
There is therefore, with each successive year of freedom from infection,
a diminishing recognition of the danger of this disease. Doctors without
knowledge of the disease feel a false security and may not have their
children vaccinated. This is a dangerous situation cannot be too
strongly stressed, as it is only by keeping up the numbers of children
vaccinated that the disease can be kept in check. It is the duty of all
parents to have their children immunised, and if they fail to do so, they
neglect their welfare.

SONNE DYSENTERY

There were no cases notified as compared with four in 1971.

FOOD POISONING

The condition is usually caused by one of the Salmonella organisms, the commonest being the Typhimurium strain or Paratyphoid A or B. The Staphylococcus gaining an entry to food from an infected spot or boil on the hands, arm or face of a food handler may also cause a severe form of food poisoning. Occasionally food may be chemically contaminated. Typhoid fever is a rare condition, but like the other Salmonellae may gain entry into food by faulty hygiene of food handlers. The sources of infection can be numerous, uncooked contaminated (often imported) meat or poultry being today some of the commonest. Travel abroad resulting in the importation of infections is another source and can cause problems of hygiene in food handlers.

There were no cases of food poisoning reported during the year.

RESPIRATORY INFECTIONS AND INFLUENZA

Two deaths were recorded this year from pneumonia, one from bronchitis and one from influenza. Other respiratory infections are now seldom a cause of death, except as a terminal event, but remain a considerable cause of ill-health. These are still the highest cause of loss of working hours, and bronchitis nasal catarrh and sinus infections result in much disability.

FOOD HANDLING

There were no cases notified as compared with four in 1977.

FOOD POISONING

The condition is usually caused by one of the *Salmonella* organisms, the commonest being the *Typhimurium* strain or *Paratyphoid A* or *B*. The organism gains an entry to food from an infected spot or hole on the hands, rim or base of a food handler may also cause a severe form of food poisoning. Occasionally food may be chemically contaminated. Typhoid fever is a rare condition, but like the other *Salmonellas* may gain entry into food by faulty hygiene of food handlers. The sources of infection can be numerous, uncooked meat (often imported) meat or poultry being today some of the commonest sources. Travel abroad resulting in the importation of infection is another source and can cause problems of hygiene in food handlers.

There were no cases of food poisoning reported during the year.

RESPIRATORY INFECTIONS AND INFLUENZA

The deaths were recorded this year from pneumonia, and two from influenza. Other respiratory infections are now seldom a cause of death, except as a terminal event, but remain a considerable cause of ill-health. There are still the highest causes of loss of working hours, and from these causes and some infections result in such disability.

The Role of the Community in the
Development of Public Health

Community medicine is that function of medicine which concerns itself with populations, rather than with single individuals. A community is all the people living within a defined geographical area whether at home, at school, at work, or in hospital. There has been some semantic misinterpretation implying that community was separate from hospital.

SUMMARY OF PUBLIC HEALTH INSPECTOR'S
VISITS TO PREMISES

House inspections:

(a) Existing stock	39
(b) New houses (Habitation certification)	63

Inspection of bakehouses	9
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Inspection of Food Premises:

(a) Market Stalls	141
(b) Food vans - all types	8
(c) Fried Fish Shops	4
(d) Food Shops - all varieties	110
(e) Restaurants, canteens, refreshment dispenser cabinets, etc.	27

Inspections under Offices, Shops and Railway premises Act (other than food shops)	81
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Drainage Tests

(a) Old properties	4
(b) New properties	118
(c) Investigations other than tests	6

Visits as to Vermin

(a) Insect infestation	3
(b) Mice	22
(c) Rats	34

Visits concerning suspected food poisoning, dysentery, etc.	7
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REPORT OF PUBLIC HEALTH INSPECTOR'S
VISITS TO PREMISES

Before inspection:

- (a) Existing stock
(b) Raw material (habitation certificate)

Inspection of premises:

Inspection of food premises:

- (a) Market stalls
(b) Food vans - all types
(c) Food shops
(d) Food shops - all varieties
(e) Restaurants, canteens, refreshment
dispensary, etc.

Inspection of other premises, shops and railways
premises (not other than food shops)

Business tests

- (a) Old premises
(b) New premises
(c) Investigations other than tests

Visits as to various

- (a) Food inspection
(b) Milk
(c) Water

Visits concerning suspected food poisoning,
dysentery, etc.

The Role of the Community Physician in the
Reorganised National Health Service

Community medicine is that function of medicine which concerns itself with populations, rather than with single individuals. A community is all the people living within a defined geographical area whether at home, in school, at work, or in hospital. There has been some semantic misinterpretation implying that community was separate from hospital.

In the introduction to the Standing Orders of the Faculty of Community Medicine, Royal College of Physicians (1972) the specialty is defined as "that branch of Medicine which deals with populations or groups rather than with individual patients. In the context of a national system of medical care, it, therefore, comprises those doctors who try to measure accurately the needs of the population both sick and well. It requires to bring to this study special knowledge of the principles of epidemiology, of the organisation and evaluation of medical care systems, of the medical aspects of the administration of health services, and of the techniques of health education and rehabilitation which are comprised within the field of social and preventive medicine. Community Medicine thus brings together within the one discipline those who are presently engaged in the practice of public health, in the administration of the health services whether in hospital, local authority, or central government, in relevant research, and those responsible for undergraduate and postgraduate education in the University departments of social medicine."

The reorganised National Health Service, including the new discipline of community medicine, will end the century of practice of public health as a responsibility of local government authorities.* The era was one of major progress in eliminating the gross environmental abuses to human health, and developing the personal preventive services in school health, maternal and child health. The National Health Service Act, 1948, with its deliberate tripartite structure, excluded these services allowing them to remain the responsibility of the local authorities. This decision was a compromise and permitted central government to concentrate on developing therapeutic services, particularly the building up of hospital provisions, which were already crumbling and in some areas non-existent. The achievement of this latter objective has been notable. After twenty years the sharp edges of the tripartite system were becoming blurred, and the need for reorganisation was increasingly evident. These changes, many of which evolved as a result of initiative from the public health service, are now recognised and given impetus by legislation. As in 1948, the 1974 reorganisation will result in a similar (and deliberate) amalgam of compromise and concessions. While the personal health services will cease to be the responsibility of the local authorities, school and environmental health will remain with them, and arrangements will be necessary to maintain cooperation with the social services which retain many functions complementary to health.

Reorganisation of health services are timed to coincide with and relate geographically to the boundaries of local government.

*(The Local Government Board was created in 1871; in 1874 the office of medical officer of health was created, and the first D.P.H. examination was held in Cambridge in 1875.)

The Role of the Community Physician in the
Reorganized National Health Service

Community medicine is that function of medicine which concerns itself with populations, rather than with single individuals. A community is all the people living within a defined geographical area whether at home, in school, at work, or in hospital. There has been some scientific misinterpretation in the past that community was separate from hospital.

In the introduction to the Standing Orders of the Faculty of Community Medicine, Royal College of Physicians (1942) the specialty is defined as "that branch of medicine which deals with populations or groups rather than with individual patients. In the context of a national system of medical care, it, therefore, concerns those doctors who try to measure accurately the needs of the population both sick and well. It requires to bring to this study special knowledge of the principles of epidemiology, of the organization and evaluation of medical care systems, of the medical aspects of the rehabilitation of health services, and of the techniques of health education and rehabilitation which are concerned with the field of social and preventive medicine. Community medicine thus brings together within the one discipline those who are presently engaged in the promotion of public health, in the administration of the health services whether in hospital, local authority, or central government, in relevant research, and those responsible for undergraduate and postgraduate education in the University departments of social medicine."

The reorganized National Health Service, including the new discipline of community medicine, will end the century of practice of public health as a responsibility of local government authorities. The era was one of major progress in eliminating the gross environmental causes of human health, and developing the personal preventive services in school health, maternal and child health. The National Health Service Act, 1948, with its deliberate legislative structure, excluded those services which then remained the responsibility of the local authorities. This decision was a consequence and permitted central government to concentrate on developing the specific services particularly the building up of hospital provisions, which were already existing and in some cases non-existent. The achievement of this latter objective has been notable. After twenty years the health service of the country has been better planned, and the need for reorganization was increasingly evident. These changes, many of which evolved as a result of initiative from the public health services, are now recognized and given impetus by legislation. As in 1948, the 1974 reorganization will result in a similar (and deliberate) transfer of responsibility and concentration. While the personal health services will continue to be the responsibility of the local authorities, school and environmental health will remain with them, and arrangements will be necessary to maintain cooperation with the central services which retain very important complementary to health.

Reorganization of health services are likely to coincide with and relate geographically to the boundaries of local government.

* (The Local Government Board was created in 1911; in 1914 the Office of Medical Officer of Health was created, and the first N.H.S. reorganization was held in Cambridge in 1917.)

The 1974 Reorganisation Structure

Central government will maintain overall control with strengthened regional divisions at the Department of Health and Social Security. Finance will be centrally determined, and priorities, national standards, and objectives will be decided and resources allocated (unlike local government who first consider needs) to regions, which will largely follow, geographically, the present 14 Regional Hospital Boards. Within the regions there will be 90 Area Health Authorities co-terminus with the county and metropolitan councils of the reorganised local government. General practitioners will retain their independent status, executive councils being replaced by family practitioner committees (a part of the area structure). Central control is envisaged as tight, and regions "will coordinate activity and monitor performances at area to ensure that national and regional objectives are achieved."

While the structure of the reorganised health services is not considered in detail it is useful to sketch the broad framework in which community physicians will function. Each Regional Health Authority will have a Chairman (nominated by the Secretary of State) and a committee selected for their managerial skills. At officer level, the regional team of officers will consist of a medical officer, nurse, administrator and treasurer, each with their staffs. The regional authority will be responsible for the general planning of all health services, allocation of finance at region and area, and for a number of specialist services including neuro, plastic and thoracic surgery, radiotherapy and blood transfusion, together with undergraduate teaching.

There will be 90 Area Health Authorities, each having a Chairman (nominated by the Secretary of State) and fourteen members. Areas will contain from one to five (or more) district general hospitals within their boundaries and have overall responsibility for providing all health services for the population. As stated the area will relate geographically to the boundary of the reorganised local authority. Exact co-terminosity cannot always be achieved and there will be overlap areas the servicing of which is a necessary part of forward planning. The area will also be responsible for the setting up of Community Health Councils, which will serve the constituent districts and who will represent the consumer use of the National Health Service.

The area medical officer will be a member of the area team of officers, consisting of nurse, administrator and treasurer, and will have a staff of community physicians responsible for various administrative and preventive medical functions.

At both region and area Joint Liaison Committees have been established for the purpose of coordinating the preparatory work required prior to reorganisation, and with the responsibility of collating information, defining districts and making preliminary assessment of matters requiring decision by the shadow authorities.

General Activities of the Community Physician

Community physicians will function within these administrative units, the regional and area medical officer with their individual teams of community medicine specialists, while at district (the real operational level) there will be a district community physician, who will also be a member of a district team of officers, which will include clinicians from general practice and hospitals.

Central Government will maintain overall control with strengthened regional divisions at the Department of Health and Social Security. Plans will be centrally determined, and priorities, national standards, and objectives will be decided and resources allocated (within local government) who have a number of needs) to regions, which will largely follow, geographically, the present in Regional Hospital Boards. Within the regions there will be 30 Area Health Authorities co-terminous with the county and metropolitan counties of the reorganised local government. General practitioners will retain their independent status, executive councils being replaced by family practitioners' committees (a part of the area structure). Central control is envisaged as tight, and regions will coordinate activity and monitor performance of area to ensure that national and regional objectives are achieved.

While the structure of the reorganised health services is not considered in detail it is useful to sketch the broad framework in which community physicians will function. Each Regional Health Authority will have a Chairman (nominated by the Secretary of State) and a committee selected for their managerial duties. At officer level, the regional team of officers will consist of a medical officer, nurse, administrator and treasurer, each with specific duties. The regional authority will be responsible for the general planning of all health services, allocation of resources at region and area, and for a number of specialised services including cancer, plastic and thoracic surgery, radiology, placed throughout, together with undergraduate teaching.

There will be 30 Area Health Authorities, each having a Chairman (nominated by the Secretary of State) and fourteen members. Areas will contain from one to five (or more) district general hospitals within their boundaries and have overall responsibility for providing all health services for the population. As stated the area will relate geographically to the boundary of the reorganised local authority. Exact co-terminosity cannot always be achieved and there will be overlap across the boundary of which is a necessary part of forward planning. The area will also be responsible for the setting up of Community Health Councils which will serve the constituent districts and who will represent the consumer view of the National Health Service.

The area medical officer will be a member of the Area Team of Officers, consisting of nurse, administrator and treasurer, and will have a staff of community physicians responsible for various administrative and professional medical functions.

At both region and area level Liaison Committees have been established for the purpose of coordinating the proprietary work required prior to reorganisation and with the responsibility of collecting information, defining districts and setting priority assessment of services relating decisions by the Area authorities.

General Activities of the Community Physicians

Community physicians will function within three administrative units, the regional and area medical officer with their individual teams of community medicine specialists, while at district (the real operational level) there will be a district community physician, who will also be a member of a district team of officers, which will include administrative general practice and hospital.

At all levels community physicians will be responsible for a wide spectrum of activities which will include planning, particularly at area and regional level; the measurement and evaluation of health programmes; the development of information systems which will include record linkage, the use of statistics, computers, morbidity and mortality indices. Planning will require rational coordination between hospital and community and here assessment of priorities will be vital. In the field of preventive medicine, child health (including the school health service), health education, identification of vulnerable groups, screening, and a grasp of the effects of advances in medical knowledge will all have a part, and will need skills to anticipate and deploy resources to achieve success.

Community physicians will be members of teams. This function will require new skills and success will depend on being able to convince colleagues, by the careful building up of information systems based on data, of population needs, the evaluation of existing services and the assessment of options, to accept policies and achieve agreement, then setting out successfully to implement those policies. The term 'accountability upwards and delegation downwards' if it is to work successfully will require full understanding and cooperation between officers at all levels.

The Community Physician at District Level

It is at this level that advice on environmental health to the local authorities will be required, and either the district community physician, or more likely, a designated specialist in community medicine, will act as the 'proper officer' to advise district councils on environmental health.

The health service district will be that area served by the district general hospital, involving populations varying in size from 150,000 to 300,000. Services cannot be organised on a strict geographical basis as choice of specialist will remain the prerogative of the general practitioners. Patient flows may vary with specialty. The defined boundaries enjoyed by local authorities will not therefore be applicable for health services and flexible overlap arrangements will be required.

The basic unit of the reorganised health service is the district in which primary care (services supplied by family practitioners, either working in group practices, or in health centres, will be supported by the secondary specialist services based in the district general hospital. The community physician at this level will have many functions; as a member of the district medical team (the only team on which clinicians will serve); as coordinator of health care teams for children, the elderly, maternity, mental and mentally handicapped services, together with any other ad hoc team locally organised. He may also act as adviser to the local district councils on environmental health. He will be required to provide information and advice on all aspects of health needs and on the best deployment of resources to meet those needs.

The district will be the optimum level at which to plan and provide a substantially comprehensive service, in which the community physician will have a vital role in organising operational policies and developing district plans.

Collaboration with Local Authorities

Collaboration Committees are to be established which will include members from both local authorities and the National Health Service, with the responsibility to initiate and maintain the strongest links between the two services. Medical advice will be provided by community physicians and their staffs. Thus a major

At all levels community physicians will be responsible for a wide spectrum of activities which will include planning, particularly at area and regional levels; the measurement and evaluation of health programmes; the development of information systems which will include record linkage, the use of statistics, computers, morbidity and mortality indices. Planning will require rational coordination between hospital and community and have assessment of priorities will be vital. In the field of preventive medicine, child health (including the school health service), health education, identification of vulnerable groups, screening, and a grasp of the effects of advances in medical knowledge will all have a part, and will need skills to anticipate and deploy resources to achieve success.

Community physicians will be members of teams. This function will require new skills and success will depend on being able to convince colleagues, by the careful building up of information systems based on data, of population needs, the evaluation of existing services and the assessment of options, to accept policies and achieve agreement, then working out successfully to implement those policies. The team's accountability to the community and to the government will be a major responsibility. It is to work successfully will require full understanding and cooperation between all levels.

The Community Physician at District Level

It is at this level that advice on environmental health to the local authorities will be required, and either the district community physician, or more likely, a designated specialist in community medicine, will act as the 'expert witness' to advise district councils on environmental health.

The health service district will be that area served by the district general hospital, involving populations varying in size from 150,000 to 300,000. Services cannot be organized on a strict geographical basis as choice of specialist will remain the prerogative of the general practitioners. Patient flows may vary with specialty. The district hospital is served by local authorities will not therefore be applicable for health services and flexible service arrangements will be required.

The health care of the organized health service in the district in which primary care services supplied by family practitioners, either working in groups or in health centres, will be supported by the secondary services. The community physician at this level will have many functions: as a member of the district medical team (the only team on which all specialists will serve); as coordinator of health care teams for children, the elderly, maternity, mental and socially handicapped patients; together with any other ad hoc teams locally organized. He may also act as adviser to the local district council on environmental health. He will be required to provide information and advice on all aspects of health needs and on the best deployment of resources to meet those needs.

The district will be the optimum level at which to plan and provide a substantially comprehensive service, in which the community physician will have a vital role in organizing specialist policies and developing district plans.

Cooperation with Local Authorities

Cooperation Committees are to be established which will include members from both local authorities and the district health service, with the responsibility to initiate and maintain the strongest links between the two services. Medical advice will be provided by community physicians and their staffs. Thus a major

function of the community physician will be in his role as link between the local authorities and reorganised National Health Service. His success in maintaining the relationship with them will be a major factor in sustaining domiciliary services. The social services departments will retain their responsibility for the home help services, for mental health, the elderly, care of children, the handicapped and other services. The need for the strongest of ties in cooperation in planning for all these needs requires no emphasis.

School and environmental health services, including the control of infectious disease (requiring special arrangements with district councils) should continue at their present satisfactory standards. The time honoured office of medical officer of health will cease, together with the many statutory functions, and while those already employed in the public health service are acquainted both with local authority staffing and structure and have established a relationship with its officers, unless a strong and workable system of collaboration is initiated and maintained from the outset, there could be a deterioration when doctors lacking any local authority experience take their place as community physicians.

Training for Reorganisation

Immediately preceding reorganisation short courses in medical administration and integration of medical care have been set up by the Department of Health and Social Security for those already employed in administration of health services. The former, as recommended by the Working Party on Medical Administrators, 1970 (Hunter Committee) are for doctors, while the latter include all those disciplines involved in health care.

Conclusions

The reorganisation of the National Health Service will mark another era in health care in the United Kingdom. The introduction of planning cycles using broad guidelines against known constraints should result in a greater sense of direction of health care planning and cohesion of all services. The opportunity will be given, for the first time, for members of the medical profession to identify what they believe to be the real health needs of the population and how they may best be met from the limited resources (money, manpower, material) available. The community physician as a member of the team at all levels will have an essential role to play. Initially his objective should be to concentrate on subjects which call for his particular expertise maintaining his present preventive activities together with the efficient collaboration with local authorities. His knowledge of statistics, epidemiology, the organisational aspects of medical care and the development of medical information systems can all provide vital components in the successful operation of the reorganised National Health Service.

function of the community physician will be in his role as link between the local authorities and the organized National Health Service. His success in maintaining the relationship with them will be a major factor in maintaining community health. The local services departments will retain their responsibility for the home help services, for mental health, the elderly, care of children, the handicapped and other services. The need for the strongest of links in cooperation in planning for all these needs requires no emphasis.

School and environmental health services, including the control of infectious diseases (requiring special arrangements with district councils) should continue at their present satisfactory standards. The time has come when of medical officers of health will cease, together with the many statutory functions, and while those already engaged in the public health service are maintained with local authority staffs and structures and have established a relationship with the officers, whose a strong and workable system of collaboration is initiated and maintained from the outset, there could be a deterioration when such lacking any local authority experience take their place as community physicians.

Training for Generalists

Immediately preceding registration about 1960, in medical administration and integration of medical care have been set up by the Department of Health and Social Security for those already engaged in administration of health services. The former, as recommended by the Working Party on Medical Administration, 1959 (Hester Committee) are for doctors, while the latter include all those disciplines involved in health care.

Conclusions

The reorganization of the National Health Service will mean another era in health care in the United Kingdom. The introduction of planning system using broad guidelines against known constraints should result in a greater sense of direction of health care planning and cohesion of all services. The opportunity will be given, for the first time, for members of the medical profession to identify what they believe to be the real health needs of the population and how they can best be met from the limited resources (money, manpower, materials) available. The community physician as a member of the team at all levels will have an essential role to play. Initially his objective should be to concentrate on subjects which call for his particular expertise while his present preventive activities together with the efficient collaboration with local authorities. His knowledge of statistics, epidemiology, the organization aspects of medical care and the development of medical information systems can provide vital components in the successful operation of the reorganized National Health Service.

THE NEW STATUTORY BODIES

RESPONSIBLE FOR NHS ADMINISTRATION

<u>Title</u>	<u>Main Functions</u>	<u>Method of Appointment</u>	<u>Accountability</u>
1. Regional Health Authorities (RHAs)	<ul style="list-style-type: none"> a. Regional planning and policies; b. Allocation of resources between AHAs; c. Monitoring of performance of AHAs; d. Executive and operational functions which need to be undertaken on a wider basis than area (inc. responsibility for major capital works, metropolitan county ambulance services; computer services); e. Employment of medical consultants and senior registrars except in "teaching areas" (see 3 below) 	<p>Chairman: by Secretary of State</p> <p>Members: by Secretary of State after consultation with l.a's, universities, health professions, TUC, voluntary organisations, other interested bodies</p>	Secretary of State
2. Area Health Authorities (AHAs)	<ul style="list-style-type: none"> a. Area planning policies; b. Operation of all services (except for those referred to at 1d.) c. Collaboration with local authorities d. Employment of staff for those purposes (except for those at 1e.) e. Arrangements with family practitioners 	<p>Chairman: by Secretary of State</p> <p>Members (usual pattern): Local authority(ies) (statutory minimum)</p> <p>1 by RHA on nomination of university</p> <p>9 by RHA after consultation with professions and interested organisations (including federations of workers or organisations)</p>	RHA (except for 2e, for which accountability is to the Secretary of State)

<u>Title</u>	<u>Main Functions</u>	<u>Method of Appointment</u>	<u>Accountability</u>
3. Area Health Authorities (Teaching) (AHA(T)s)	a. As for other AHAs b. Provision for university of substantial clinical teaching facilities c. Employment of consultants and senior registrars	As for other AHAs but with 1 or 2 additional members appointed on the nomination of universities and with additional appointments of members with teaching hospital experience	As for other AHAs
4. Family Practitioner Committees (FPCs)	Administration of arrangements for family practitioner services	Chairman appointed by and from among members 11 members appointed by AHA (at least 1 to be a member of the AHA) 4 members appointed by matching local authority(ies) 15 members appointed by the professions involved	Secretary of State AHA

Title	Main Functions	Method of Appointment	Assessment
3. Area Health Authorities (Teaching) (AHA(T))	a. As for other AHAs b. Provision for university of substantial clinical teaching facilities c. Employment of consultants and senior registrars	As for other AHAs but with 1 or 2 additional members appointed on the nomination of universities and with additional appointments of members with teaching hospital experience	As for other AHAs
4. Family Practitioner Commission (FPC)	Administration of arrangements for family practitioner services	Chairman appointed by and from among members 11 members appointed by AHA (at least 1 to be a member of the AHA) 4 members appointed by teaching local authorities 15 members appointed by the professions involved	Secretary of State AHA



