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CUMBERLAND COUNTY COUNCIL
EDUCATION COMMITTEE

The School Health Service

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PREFACE

To the Chairman and Members of the Education Committee:

Mr. Chairman, Ladies and Gentlemen,

I have the honour to present the Annual Report on the School Health Service for 1967.

The school health service was brought into being to cover a gap in the medical service that existed at the start of this century and since then has provided advice and guidance to parents, teachers and others, on children's health and the child in his educational setting. With the advent of the National Health Service Act, which ensures that every child will have a general practitioner to provide general medical care, the role and form of the school health service have required far-reaching changes.

With the formation of general practitioner led family health care teams practising from central surgeries with full attachment of nurses and an increasing attachment of social workers, it seems that the stage is set for a transition to the comprehensive provision of medical advice, treatment and administrative action through those family health care teams who, presumably, will have amongst the medical members of the team one doctor who will have a special interest in paediatric medicine.

The school nurse as an entity is now merging into a community nurse associated with the general practitioner paediatrician and it may not be too far into the future when both the doctor and the nurse have part-time appointments in a paediatric unit in hospital.

The recently published Sheldon Report on Child Welfare Centres is a forward looking report, but unfortunately it excluded examination of the changing scene in school health matters. In general it seems to mirror the views and the policy of this authority. The transition away from the concept of child welfare clinics to a child health service with stronger associations with the hospital and health centre, and in particular the centralising of assessment centres in hospital, are all matters which we have accepted in this county, especially in respect of the under school age child.

Any mention of change is, of course, always emotive and especially so in a rural community. The constant problem is how to combine change with continuity, progress with tradition and the rights of the individual with the overall policy of the state or County Council. Both medicine and education are now in a constant state of change.

Health education in schools continues to be given by teachers, school nurses and health visitors but probably the approach is too narrow and we should be examining the possibility of a system of whole-life counselling for children with experts bringing in as part of a team approach to the child the hazards to healthy living that are now affecting the middle age groups. The large number of cases of heart disease, cerebro vascular accidents that are occurring in middle-aged men, the increasing numbers of malignant disease cases associated with cigarette smoking, the methods of preventing dental caries by the fluoride adjustment of public water supplies, and many other salient up-to-date facts and figures, should continue to be given to children in order that they may have the choice of the best of knowledge to run their lives in as healthy and as wholesome a manner as possible.

Organisational changes may well be seen in the forthcoming Ministry of Health "green paper" and the Local Government Commission may be further advising changes, some of which may affect the school health service.

My thanks go to my deputy, Dr. J. D. Terrell, for the preparation of this report, and to all members of the Health Department for their hard work often in difficult circumstances caused by Staff shortage.

I am, Mr. Chairman, Ladies and Gentlemen,

Your obedient servant,

John Leiper.

Principal School Medical Officer.

County Health Department,
11, Portland Square,
Carlisle.
April, 1968.

SCHOOL HEALTH SERVICE

STAFF AS AT 31.12.67

SCHOOL MEDICAL AND DENTAL STAFF

Principal School Medical Officer—

*J. Leiper, M.B.E., T.D., M.B., Ch.B., M.R.C.S., L.R.C.P., D.P.H.

Deputy Principal School Medical Officer—

*J. D. Terrell, M.B., Ch.B., D.P.H., D.C.H.

School Medical Officers—

*E. M. O. Campbell, M.B., Ch.B., D.P.H., D.T.M. & H.

D. H. Chowdbury, M.B., B.S., D.P.H., D.I.H. (resigned 31.12.67).

J. E. M. Garland, M.B.., Ch.B., D.P.H. (part-time—commenced 2.1.67).

*A. Hargreaves, M.B., Ch.B., D.P.H.

J. R. Hassan, M.B., Ch.B., D.Obst.R.C.O.G. (part-time —General Practitioner).

*J. L. Hunter, M.B., Ch.B., D.P.H. (Western Area Medical Officer).

*F. S. Rogers, M.B., Ch.B., D.P.H. (Northern Area Medical Officer).

W. S. Slater, M.B., Ch.B., M.R.C.S., L.R.C.P., D.P.H. (resigned 16.9.67).

*S. Smith, M.B., Ch.B., D.P.H. (Southern Area Medical Officer) (commenced 13.3.67).

The above are also District Medical Officers of Health and Assistant School Medical Officers.

*J. E. Ainsworth, M.B., Ch.B.

*H. M. Marks, M.B., Ch.B.

*M. Timperley, M.B., Ch.B.

K. Walker, M.B., Ch.B.

* Approved for the ascertainment of educationally sub-normal pupils.

Principal School Dental Officer—

R. B. Neal, M.B.E., T.D., L.D.S.R.C.S.

Area School Dental Officer—

I. R. C. Crabb, L.D.S.R.F.P.S.

School Dental Officers—

J. A. G. Baxter, L.D.S.R.C.S. (resigned 30.9.67).
J. Docherty, B.D.S. (resigned 31.1.67).
A. B. Gibson, B.D.S.
F. H. Jacobs, L.D.S.
A. Osuhor, B.D.S. (part-time, commenced 30.10.67).
I. H. Parsons, L.D.S.
A. R. Peck, L.D.S.
A. M. Scott, L.D.S.

MEDICAL AUXILIARY STAFF

Audiometricians—

Miss J. Gill.
Miss A. Jackson.

Orthopaedic Physiotherapists—

Miss J. A. Fraser, M.C.S.P., O.N.C. (resigned 31.3.67).
Miss J. M. Morris, M.C.S.P. (resigned 30.6.67).
Miss M. Sivewright, M.C.S.P. (part-time commenced 2.10.67).

Orthoptists—

Mrs. G. M. Richardson, D.B.O. (part-time).
Mrs. J. Scott, D.B.O. (part-time).

Speech Therapists—

Mr. M. S. Beattie, L.C.S.T. (commenced 21.8.67).
Mrs. E. M. Blacklock, L.C.S.T.).
Miss E. B. Moon, L.C.S.T. (part-time).
Mrs. S. Latimer, L.C.S.T. (part-time).
Mrs. J. Stone, L.C.S.T. (part-time) (commenced 4.10.67).

NURSING STAFF

Superintendent Nursing Officer—

Miss I. Mansbridge, M.B.E., S.R.N., S.C.M., Q.N., H.V.Cert. (retired 4.6.67).
Miss M. Blockey, S.R.N., R.S.C.N., S.C.M., Q.N., H.V.Cert. (appointed 5.6.67).

Deputy Superintendent Nursing Officer—
Appointee takes up duty July, 1968.

Area Nursing Officers—

Miss J. Reid, S.R.N., S.C.M., Q.N., H.V.Cert. (Southern Area).
Miss J. M. Crossfield, S.R.N., Q.N., H.V.Cert. (Western Area).
Miss J. M. Till, S.R.N., S.C.M., Q.N., H.V.Cert. (Northern Area).

NURSES QUALIFICATIONS CODE

1. State Registered Nurse (or Registered General Nurse).
2. State Certified Midwife.
3. Queen's Nurse.
4. Health Visitor's Certificate.
5. Registered Fever Nurse.
6. State Enrolled Nurse.
7. Registered Sick Children's Nurse.
8. Orthopaedic Nursing Certificate.
9. Diploma in Tropical Nursing.

School Nurses—

Full-time—

*Mrs. E. Fagan, 1, 3, 5	Workington
Mrs. E. Foster, 1, 7	Maryport
*Mrs. M. E. Sansome, 1, 2, 5	Workington
*Mrs. S. Miller, 1	Whitehaven
*Mrs. B. F. Wilson, 1	Whitehaven

Health Visitors/School Nurses—

NORTHERN AREA

Miss I. Arnott, 1, 2, 3, 4	Burgh/Kirkbride
Miss C. M. Bannan, 1, 2, 3, 4	Aspatria
Miss M. M. Butler, 1, 2, 3, 4	Longtown
Miss E. M. Chalkley, 1, 2, 3, 4	Penrith
Miss A. Dixon, 1, 2, 4	Penrith
Mrs. M. D. Dixon, 1, 2, 4	Silloth
Miss J. Gibson, 1, 2, 3, 4	Penrith
Miss E. Henderson, 1, 2, 3, 4	Penrith
Miss B. W. Knibbs, 1, 2, 3, 4	Brampton
Miss E. A. Lockhart, 1, 2, 3, 4	Alston
Miss E. Mercer, 1, 2, 4, 5	Wigton
Miss P. B. Simpson, 1, 2, 3, 4	Dalston/Thursby
Miss E. Tongue, 1, 2, 3, 4	Brampton

Western Area

Mrs. D. R. Bari, 1, 2, 4	Workington
Mrs. A. E. Campbell, 1, 2, 4	Keswick
Miss G. Davies, 1, 3, 4	Workington
Mrs. J. A. Graham, 1, 2, 3, 4	Workington
Mrs. M. Hedworth, 1, 2, 3	Maryport
Mrs. M. Hewitson, 1, 2, 4	Workington
Miss A. Jackson, 1, 2, 4	Workington
Mrs. M. Lythgoe, 1, 2, 4	Cockermouth
Miss J. E. Surtees, 1, 2, 4	Workington
Miss S. Twigg, 1, 2, 3, 4	Maryport

Southern Area

Miss I. M. Alcock, 1, 2, 4	Whitehaven
Mrs. I. M. Bowe, 1, 2, 3, 4	Millom
Mrs. S. Crellin, 1, 2, 4	Whitehaven
Miss E. Crosby, 1, 2, 4	Ennerdale
Mrs. A. Donald, 1, 2, 3, 4, 7	Millom
Miss M. E. Gibson, 1, 2, 4	Ennerdale
Mrs. A. Petch, 1, 2, 3, 4	Whitehaven
Mrs. I. J. Smith, 1, 2, 4	Ennerdale
Miss R. Sheppard, 1, 2, 3, 4	Ennerdale
Miss A. Singleton, 1, 2, 4	Whitehaven
Miss P. Walsh, 1, 2, 4	Ennerdale

All the above health visitors/school nurses are seconded to general practitioners.

School Nurses—

Part-time—

Northern Area

*Miss A. Bowler, 1, 2, 3, 4	Caldbeck
*Mrs. M. Dobson, 1, 2, 3, 4	Houghton/Wetheral/ Scotby
Mrs. F. M. Hurst, 1, 2, 3	Bewcastle
*Mrs. M. McCredie, 1, 2, 4	Lazonby
Mrs. M. J. Mathews, 1, 2, 3, 4	Watermillock
*Mrs. C. M. Sinclair, 1, 2, 4	Hesket

Western Area

Miss M. Casey, 1, 2, 3, 4	Keswick
*Mrs. M. E. Dobson, 1	Cockermouth
Miss M. P. Reynolds, 1, 2, 4	Cockermouth

Mrs. E. Kirk, 1, 8 — Seascale

* Seconded to general practitioners.

Dental Surgery Assistants—

Miss O. Bird
Mrs. M. Byers
Mrs. E. Hocking
Mrs. J. G. Nicholson
Miss E. A. Parmley (resigned 30.4.67)
Mrs. E. Plumb
Mrs. W. F. Reeves
Miss M. Rogan (resigned 30.3.67)
Miss M. I. Stout
Mrs. J. M. Tiffen (commenced 1.4.67)

GENERAL STATISTICS

The area covered by the Local Education Authority comprises 967,054 acres and the estimated population of the Administrative County in June, 1967, was 225,100.

The number of pupils on the school registers in January, 1968, was 39,009 compared with 38,651 in the previous year, an increase of 358.

In January, 1968, there were in the county:—

		No. of Pupils
Nursery school	1	40
Primary schools	231	23,179
Non-selective secondary schools ...	23	9,933
Grammar schools	10	5,767
Residential special schools ... ... (one for educationally subnormal boys, age range 9-16 years) (one for educationally subnormal girls, age range 9-16 years)	2	90
		39,009

THE ROLE OF THE SCHOOL HEALTH SERVICE IN COMMUNITY MEDICAL CARE

"Community care" is a term widely applied now in relation to health and welfare services provided by statutory bodies such as local authorities. The very term itself, however, indicates a very broad approach to providing the necessary services on a community basis and suggests immediately that a very wide variety of services for the community need to be viewed as an integrated whole if they are to be effective. The term "community care" might just as well have been appropriated by the providers of education or any other service vital to society as a whole. Thus the isolation of services in close compartments must be relinquished as speedily as possible and the school health service is one which has always been in danger of isolation from the general stream of health and medical provisions on the one hand and from the stream of education development on the other. Indeed, it may well be said that the effectiveness of the school health service has always been measurable in terms of the degree to which these dangers have been avoided.

The developments over recent years in the actual operation of the school health service have been towards a closer integration with the teaching staff of schools largely through more frequent contact associated with selective medical examinations. As comments later in this report will show it is only now that selective medical examinations are really shaking down to their proper and complete operation as originally envisaged. I would hope for further fruitful integration with the teaching staffs of the schools in connection with development of pastoral work as mentioned below. The other major linkage of the school health service is in the developing field of community medicine in general, and it is clear that the integration of the general practitioner is central in this.

In the world of medicine there has been in the past for various historical reasons a certain fragmentation of health and medical services for children. Many important developments in recent years have improved this situation and the most recent is the publication of the Sheldon Committee report on Child Welfare Centres. This, in some ways unfortunately, deals only with pre-school children but shows a clear picture of a service running in the future in the setting of family medical care under the direction of family doctor groups. That the same principles ought to apply to the health of the school child I have no doubt whatever. This will

involve some additional training for doctors undertaking child health work and many plans are being laid at national and regional levels for the provision of just such additional training, mainly in developmental paedriatrics. In the local context I am at present discussing with the consultant paediatricians in the county whether some short course on this subject may be made available soon to general practitioners taking up work in Cumberland in child welfare clinics or in the school health service. Under the aegis of the Northern Region Medical Officers of Health Staff Training Committee, the Health Department in this county is being asked to arrange a one-week residential course in 1969 for medical officers undertaking such work and catering to a large extent for general practitioners coming into this field. Brief reference is made later in this report by Dr. Rogers, Northern Area Medical Officer, to the beginnings of general practitioner participation in the school health service in Cumberland.

These developments medically represent the grafting of a well proved school health service on to a new stem, namely family medicine of the future, provided by groups of general practitioners supported by a full team of auxiliary workers—nurses, physiotherapists, speech therapists, etc. As in all fields of general medicine, specialist services are needed to some extent and these will continue to be given with the help of hospital consultants in the various specialties involved, notably paedriatrics, ophthalmology, E.N.T. surgery and orthopaedics. For some time to come the specialist, local authority-employed, child health medical officer will continue to have an important part in this general pattern of services working alongside the various specialists and fulfilling a continuing role in connection with the sub-normal and educationally sub-normal child. Comments by Dr. Ainsworth, School Medical Officer on page 21 show how successful the association of a school medical officer can be with the specialists in some of these fields, in this case ophthalmology. The remaining and tremendously important therapeutic service of the school health service is the dental service and, while the ultimate future may well hold an integration here also with general dental services for the community, this will take a little longer in evolution than the integration of medical services.

There are, of course, substantial difficulties in the way of fully integrating the school health service and the family doctor services in the community. Schools could not obviously serve children on a basis of parental choice to any broad extent, whereas the choice of family doctor in town areas is

still quite a wide one. It is in these urban areas that the difficulties obviously arise, where the catchment areas of schools do not correspond at all with group practice areas. Again clearly the secondary school organised on comprehensive lines accentuates this difficulty. These problems will only be solved gradually and it may be that as general practitioners assume more responsibilities and connections with child health services, including schools, that each will find overlapping of responsibility for individual children more acceptable than they have been in past general practice arrangements. It will I am sure prove much more satisfying to a general practitioner to have a more immediate say in the comprehensive management of handicapped children who are his patients with regard to their management, either in ordinary schools or in special schools.

In terms of the integration of the school health service with the schools themselves I am deeply interested in the present development of pastoral work in schools and counselling services now being developed for the pupils. It may well be that this is the natural point of contact between the schools and the health services designed to serve them. I return to this theme a little further in connection with health education later in this report.

Whatever the future of the medical officer of health (who is normally also the principal school medical officer) of local health authorities, is destined to be—and there are many thoughts afloat on this subject at the present—I hope that the medical administrator of the future with major responsibility for community health services (be his principal base in hospital or in the local authority) will continue to have a responsibility for child health services in the school setting. The school health service has I am sure, a very important future as it keeps in step with the present-day exciting developments in health services on the one hand and education services on the other.

Of the pilot scheme introducing general practitioners into the school health service in the Northern Area, Dr. Rogers writes:—

"A pilot scheme whereby the school medical inspections would be undertaken by the general practitioners in the Brampton area was planned for the commencement of the Autumn term. The teaching staff were very keen to take part in this experiment and all discussions had taken place

prior to the first medical visits when certain national problems in the profession brought the scheme to a halt. Rather than reverse any decisions that had already been made, the inspections in several schools were delayed until the end of the year, thus accounting for a reduction in the total number of inspections throughout the year. At the time of writing this report the difficulties are now overcome and the general practitioners have started their work in the schools. This is welcomed by the staff and parents concerned."

The following comments on this subject by Dr. Ainsworth, School Medical Officer, are particularly interesting, coming as they do from one with considerable experience in general practice:—

"I feel when the scheme gets under way that this could be a sensible move since the general practitioner is committed to complete family care and hence under the present situation we have to contact him about all defects requiring follow-up. This would bring the family doctor in to deal with an area of family care which he is not able to handle at present. I think this will be satisfactory in many ways for *routine* inspection as general practice is operating at the present time.

"Diffiulties could arise when the school staff wish to contact the family doctor with their many problems which arise apart from school medical inspection but may originate from the medical inspection. One can foresee general practitioners taking a more useful part in the school health service when group practices and health centres come into being because then one doctor could be responsible for the school health service apart from the supervision of handicapped children. Then this could fill the gap left by the withdrawal of the present school medical officer into a more specialised field."

I would like at this point to include the very interesting and constructive comments of the Headmaster of the junior school in Brampton where the pilot scheme referred to by Dr. Rogers above, is taking place. I am greatly indebted to Mr. Brown for his contribution to the report. He writes:—

"For myself co-operation and ease of contact are two essentials in the education-health-welfare set-up, and we are fortunate to have them in good measure in Brampton. To work effectively together, especially in preventive medicine,

there has to be a friendly, easy approach between school, parent, and all medical/dental/welfare staff.

"Several factors help in Brampton. The clinic building is close to three of the schools and not too far from the fourth. In the case of the junior and infant schools it is possible to walk into the clinic from the school grounds and many children look upon it as an extension of the school. There is a great deal to be said in favour of a situation which allows a mother to come into school to collect her child, take him to the clinic and return him to his class. When a parent cannot accompany her child she is pleased to know he can go to the clinic without having to cross a busy road.

"A second helpful factor is the increased use that is being made of local G.P.'s at the Friday afternoon Clinics and this year, for the first time, in the school medical examinations. This innovation is especially helpful to the parent who may feel more at ease with one of the Brampton group of doctors, whom she knows already. Many people are still so overawed by the aura of medical mystique, that any easing of tension thus caused is good. A relaxed parent communicates this feeling to her child, who understanding, may then grow with a sensible attitude towards healthy living.

"Personally I have found the close contact between Health Visitor, G.P. and school useful. The accessibility of the Health Visitor has often solved problems, sometimes through being able to bring her quickly into school or maybe through telephoned advice. Her knowledge of local conditions has helped both the school, Children's Officers and School Welfare Officers.

"A fourth factor is a well equipped dental clinic staffed with people who understand how children feel in a crisis. I am always pleased to recommend this department with confidence. Parents appreciate the effort to extend the service so that treatment is possible during holidays. School publicises this aspect by informing parents when children are admitted and by reminding them with a written notice every year.

"To make the service really comprehensive there are frequent visits from the audiometrician to check children with suspected hearing loss, also special help from the teacher of the deaf. In addition the Education Psychologist will visit at fairly short notice. There is so much to be said in favour

of these different examinations taking place on premises that are familiar to the children.

"Because of the interest shown in the B.B.C. Health Talks for Schools at the end of the Autumn Term, we are hoping to following this up at local level by asking one of the G.P.'s, the dentist and the health visitor from time to time to talk, demonstrate and answer questions. To familiarise our medical colleagues with the school and its children we hope they will begin to join us for school meals and on other social occasions."

Medical Examinations

Reference has already been made above to the important report on child welfare services of the Committee which sat under the Chairmanship of Sir Wilfred Sheldon dealing of course with the pre-school child. This report recommends routine examination of children at centres at approximately each birthday up to the age of four, the fourth birthday examination being regarded as the pre-school examination. The next routine examination would be after school entry and I believe this lays down a sound pattern of screening of the health of children in this age group. There was a suggestion in the Plowden Report that all school children should be medically examined before school entry. I have always felt that a great deal of the value of the first examination undertaken by the school health service lies in assessing reaction to school life and can take account of the observations and opinions of skilled observers, namely teachers. I would, therefore, propose to advise the retention of the comprehensive medical examination of school entrant children as soon as possible *after* school entry, while at the same time moving towards the Sheldon Committee's recommendations of the ideal annual pre-school examination of children, that at the fourth birthday, obviously looking forward to the early commencement of school life and taking particular note of any potential difficulties well before school entry. The first medical examination after school entry would, of course, continue to be non-selective and lay the foundation for the subsequent continuing screening process throughout school life.

1967 was the first full year of comprehensive selective medical examinations in all three areas of the county and the comments which follow by school medical officers and head teachers give evidence I think of the overall success of this

method of examination. While these comments speak for themselves to a large extent, it is interesting to notice one or two points connected with the statistics emerging from the selective medical examination. (The detailed figures are given in the Table on page 91). At the eight-year-old level, when parents complete a questionnaire which is an important help to selection, once again over a third of the children screened were selected for medical examination (1,381 out of 3,387). This is similar to the previous year. However, of those selected for examination 13.3% were found with defects compared with 17.6% the previous year. This is still above the figure which had come to be associated with non-selective examination procedure, namely around 10%. At the twelve year age level however, 7% were found to have defects compared with 10.7% last year. This referred to a group of whom over a third had been selected (1,032 out of 2,772) compared with just under a third of the same age group screened the previous year. At the non-selective leaver examination the percentage in 1967 with defects was 5% compared with 5.8% the previous year. Thus the percentage found with defects tended to be down, but shows the same trend from the younger to the older year groups.

I quote now from some of the doctors directly involved in the selective medical examination procedures.

Dr. Campbell, School Medical Officer, Western Area, writes:—

"I do not think there is any doubt in most School Medical Officers' minds that selective school medical examinations are of far greater benefit than the old routine ones.

"The preliminary visit to schools each term with the school nurse prior to the selective medical inspection gives us time for valuable discussions with the school staffs as to the health habits of their pupils.

"The school medical inspections themselves are less hurried affairs than in the past, and there is now more time to discuss any defects with the parents of the children concerned. This gives the parents more confidence and often valuable information is given by them, where before it might well have been ommitted through lack of time. I find this specially so where a child has a mild psychological disturbance, where in the past, parents were only too prone to gloss over their child's behaviour problem. They are now more willing to give a detailed history.

"Because more frequent interviews can be arranged with the parent and child, we have a better chance of getting to know and understand them—working in conjunction with the school staff greatly helps in this understanding.

"By and large, the whole process is more time consuming than the old routine inspections, but this is well worthwhile on account of the more profitable outcome."

From the Northern Area, Dr. Rogers writes:—

"Selective school medical examinations continued on the same lines as in 1966. Some confusion sometimes appears to arise in the minds of parents with regard to their presence at the medical inspection. In spite of written directions to the contrary parents have often turned up for a medical examination in the selected year groups expecting a routine examination as in previous years. Time and experience will probably correct this problem, although a re-designed questionnaire may prove an advantage."

Here I include a contribution to the report by Mrs. Pearson, Headmistress of Victoria Infants' School, Workington. I am glad that some of her valued comments indicate some success in what the teachers and staff of the School Health Service are trying to achieve together.

Mrs. Pearson writes:—

"My personal reaction to the term School Health Service is one of immense relief—for I regard the association of the Health Service and schools as a team, with the welfare of the child as their greatest consequence. The existence of a good Health Service, such as we now enjoy, alleviates much of the anxiety which burdens the teachers. We are all very much aware of the fact that children are incapable of deriving full benefit from their hours in school if they are physically or mentally unfit.

"On several occasions when I have felt disturbed about a particular individual, a 'phone call to the clinic has set my mind at rest, knowing that the problem would be followed up. The more frequent visits by doctor and nurse have helped and especially the discussion before examinations when the doctor invites confidences. To quote only a few;—

(i) A child apparently with a loss of hearing was referred and eventually had an operation for removal of tonsils.

(ii) A teacher was anxious about the spasmodic head and eye movements of a child: this was diagnosed as petit-mal.

(iii) A six-year-old girl—mother dead—father frequently in jail—ill-clothed and very thin; on investigation the home conditions were found to be very undesirable and the child was eventually taken into care.

"There are many more examples and on two occasions the parent has been helped also.

"But the problem of accommodating the staff of the Health Service during our annual medical examination is ever present with all of us. However, the happy liaison which is now enjoyed has been fostered by the mindful way in which they arrive in our building and conduct the examinations with courtesy and great efficiency.

"We realise that a certain amount of disruption of the normal routine is unavoidable but it affords us another opportunity of meeting our mothers. On our last examination we had 98% attendance of parents; this included one grandfather, two fathers and three pregnant mothers. The younger children of the families also attended and were initiated into meeting the doctor and nurses. I must add a personal tribute here to Dr. Ainsworth, who is held in high regard by all who come into contact with her; her quiet, sympathetic manner induces confidence in the children and parents, who are naturally concerned; aren't we all a little anxious about the outcome of our medical examinations?

"One result of the visit is a renewed upsurge of interest in hospital play—although always popular, I find as I move about the school, the '*doctor*', complete with white jacket and stethoscope, busily engaged in examining a patient, sometimes human, often a doll or teddy. Eye tests are a daily feature in one classroom where the '*nurse*' uses a cardboard marker, crudely manufactured but identical to the one used in tests.

"One innovation I should hope for, when staffing makes it possible, would be that speech therapists visit the schools;

I am aware splendid results are obtained by the speech therapists but parental co-operation is essential to get our young children to the clinic. When this is not forthcoming the children suffer and consequently their education is incomplete."

Dr. Ainsworth, referred to above, makes the following comments:—

"Selective medical examination now seems to be working as it is meant to and seems to be progressing satisfactorily—I think to advantage over the old method.

"There have been 'teething troubles' as there always are with new projects, but these seem to be disappearing.

"The school staffs are most helpful with bringing forward problems—these range from speech defects, queries about hearing and vision, observation on handicaps, e.g. fits, etc., to specific disabilities, e.g. spatial and emotional problems and learning difficulties. The staff at schools know a great deal about family background and this also helps us enormously in dealing with problems and gathering information to guide us.

"The more frequent termly visits give us more contact with the schools staff, which is most useful. The staff, seeing us more often, are ready and more encouraged to bring forward any doubts and worries about any child. This we welcome as it is so often a means of discovering and dealing with a problem, either physical or mental. By this more frequent contact, I feel we do and will discover more previously unsuspected problems, especially behavioural disorders and learning difficulties.

"The termly visits to school are becoming established now and we are able to follow up and see the children with handicaps, problems and defects, and as a result we can advise the parents and staff on any new difficulties or defects which arise, or any defect which is resolving and no longer requiring restriction or special attention in the school situation.

"By selecting children, we are not seeing, and therefore wasting time examining, large numbers of normal children, but are using our time much more usefully and interestingly seeing, helping and dealing with abnormalities—be they physical or mental.

"I must mention that the health visitors are also a source of help to us and pass on helpful information, e.g., slow developmental progress of a pre-school child which makes us watch for any possible learning difficulties after school entry. I feel a useful addition to help us would be to insert all health visiting cards in the school card until the first medical inspection is over, whether there is any problem or not. This would be a helpful continuity from pre-school to post-school life."

Dr. Marks, School Medical Officer in the Southern Area, writes:—

"The selective system as carried out at Millom has several good points in its favour. One session alone is devoted to discussing the children of this group with the head teacher and the health visitor. Both these people know the children and their background and they may mention a defect which has been omitted from the questionnaire form such as speech defects, a tendency to obesity, behaviour problems and slow progress in school work. These children will be added to the selective list and if necessary, they can then be referred for further advice."

Touching on a more specific topic in medical examination work, Dr. Ainsworth writes:—

"Another aspect of the school child's health in which I am interested is shortness of stature. Seeing children as we do in the school health service gives an opportunity to find and refer these children for treatment when necessary. It is obvious that many parents would not think there is anything amiss, especially if the child seems well, and hence do not give the family doctor an opportunity of finding these children.

"At a junior school there was one child in particular who stands out in my memory. She was not growing and was obviously of short stature. She was a slow learner at school. The mother was of normal size and father was a tall man. A younger child in the family was almost of the same height as this child. The child resembled no-one in the family, had a rather heavy facial expression, and looked subthyroid. Mother would not accept there was anything amiss. However, after discussing this with the family doctor he agreed to follow up this case. The results of investigation here could be interesting."

The Work of the School Nurse

Miss Reid, Southern Area Nursing Officer, comments as follows:—

"It is difficult to assess just what effect the attachment scheme has on the school nurses' work. To some extent it has complicated it, since unless the child concerned happens to belong to 'her' practice, the nurse may have to contact any one of four to five other health visitors if a problem presents itself. Often it makes little difference as long as she gets the report back again so that she knows what has happened. However, particularly in cases of infestation, when a visit is made to the child's home by someone other than the nurse who did the hygiene inspection, care has to be taken lest something of its effectiveness be lost.

"As and when the general practitioner comes into the School Health Service, this would probably have some beneficial effect on the health of the school child. The attached Health Visitor at present often sees the children grow from infancy to five years, and then loses sight of them when they go to school. Previous to attachment she would probably at least have supervised them up to leaving their junior school.

"I think both these points stress the need for there being some link between the general practitioner and the School Health Service."

Employment of Children Byelaws

The figures below show the numbers of children examined during the year in accordance with the above byelaws:—

Total examined during the year ...	269
Total number of children involved	269

Examined for the first time.	Re-examined once.	Re-examined twice.
269	13	Nil

School Clinic Work

The centre for most of the work which has in the past been carried out in school clinics will in future be the health centre or other group practice centre as far as minor ailments are concerned. In fact the school clinic and the child welfare clinic will in future be more and more centred in the premises from which family doctor groups work.

The figures are once again shown below of the numbers of children attending the clinics and shows a continuation of the trend over a number of years towards smaller numbers attending school clinics.

Clinic.	*New Cases.*	*Total Attendances.*
Anthorn	—	—
Aspatria	3	5
Brampton	21	36
Cleator Moor	4	5
Dalston	—	—
Egremont	—	—
Flatt Walks	55	79
Houghton	—	—
Hunsonby	—	—
Longtown	8	11
Maryport	44	136
Mirehouse	8	8
Millom	—	—
Park Lane	102	129
Penrith	2	4
Scotby	—	—
Seascale	—	—
Thursby	—	—
Wetheral	—	—
Wigton	16	17
Woodhouse	—	—
	263	430

SCHOOL CLINICS

Defect Code No.	Conditions for which child attended.	New Cases 1967	1966	1965	1964	1963	1962	Total Attendances. 1967	1966	1965	1964	1963	1962
1.	Cleanliness	—	5	—	1	11	—	—	5	—	1	16	—
2.	Infestation	3	—	2	17	2	—	13	—	9	34	2	—
4.	Skin diseases	40	59	36	88	147	597	80	103	62	195	408	1891
5.	Eye diseases	112	76	119	145	169	303	129	138	212	186	316	729
6.	Ear conditions	31	81	87	110	78	64	82	157	208	163	105	213
7.	Nose and throat conditions	9	7	14	25	44	50	13	7	20	53	68	80
8.	Speech defects	8	19	26	17	21	34	18	20	30	19	22	43
9.	Lymphatic glands	—	—	2	—	3	16	—	—	2	—	4	21
10.	Heart condition	1	1	1	1	3	2	1	2	4	1	3	11
11.	Lungs condition	2	3	4	6	18	37	4	4	6	6	26	358
12.	Developmental	1	3	1	2	2	6	1	5	4	3	5	13
13.	Orthopaedic	8	37	38	36	46	105	9	38	49	47	48	165
14.	Nervous system	2	6	6	20	2	5	3	17	8	70	3	32
15.	Psychological	17	18	18	13	12	25	27	21	26	21	17	45
16.	Abdominal condition ...	3	4	5	5	13	15	3	4	9	9	16	25
17.	Other conditions	26	42	56	103	103	244	47	88	69	237	188	541
		263	361	415	589	674	1503	430	609	718	1045	1247	4167

SPECIAL SERVICES

I referred in my report last year to the tendency for certain specialist services in the school health service to be offered at new modern well-equipped hospital premises rather than in school clinic buildings where comparable equipment would be very expensive and a duplication of services, and the expense which would be hard to justify in present economic circumstances. As would have been expected this trend has developed much more rapidly in West Cumberland because of the existence of the highly modern and very fully equipped West Cumberland Hospital. Practically all specialist clinics are now held there, although some are also conducted at Workington Infirmary, and the essential liaison of school health services and schools is maintained through medical and nursing staff seconded to work in some of these specialities where children's clinics are arranged. Specific reference to this is made on page 41 in connection with ophthalmology services.

The gradual involvement of family doctors in school health services will also relate favourably to the specialists' service—there will be none of the potential difficulties of a doctor with no direct connection with the family's health care team, making referrals which involve difficulties of communication with the family doctor. The co-operation of family doctors throughout the County in this difficult matter has been excellent and invaluable over the years. The family doctor rightly wishes to be in the centre of the picture if any treatment is being advised or provided for his patient, but with all the effort which is applied to these, communications are not always perfect here.

Ear, Nose, Throat and Audiology Services

In order to minimise the pressure from the school health service on the hard pressed hospital clinics of the Consultant Ear, Nose and Throat surgeons it was arranged during 1967 that all referrals would be channelled through the family doctor, except where significant hearing loss had been established. Thus many chances of double referrals and overlapping of appointments could be eliminated and the surgeons have always before them a more realistic impression of numbers of children awaiting consultation. I trust the revised procedure as far as the school medical officers are concerned will prove helpful to the surgeons. Both Mr. Venters and Mr. Robson continue their unstinted report of the improved audiology service of the school health service, although as mentioned below fewer audiology cases than usual actually passed through their hands last year.

Commenting on audiology work in the county Mr. Robson writes:—

"In West Cumberland we are able to run a deaf children's clinic once a month which is attended by a school medical officer and, if there are special problems, also by a teacher of the deaf. The equipment is adequate but some refinements would be helpful for testing the pre-school child."

He goes on to comment on the lesser degree of liaison in East Cumberland associated with limited available consultant time and a need for further expenditure on testing equipment and facilities.

Once again the main account of the audiology work of the school health service comes from the Area Medical Officer or School Medical Officer with special responsibility in this field in each area. An interesting feature of these reports this year is a tentative comparison of some of the results of the testing of infants by the health visitors, with the results of routine screening of these children as school entrants. Dr. Walker from the Southern Area also includes a brief and interesting account of retesting of a group of eight year olds in one school.

Dr. Hunter, Western Area Medical Officer, once again leads off on this subject:—

"There was no change in the procedure of ascertainment in the pre-school and school child. There were however changes and shortages in hospital consultant staff which slowed down complete assessment of cases of mild to moderate deafness. The list of staff at the beginning of this report shows also a change of audiometrician. The amount of work done in Pure Tone Sweep Testing was little affected in primary lists but retests at the end of the year fell off. I would like here to pay tribute to the wonderful work over the years, including the pioneering period of audiology in West Cumberland, of Mrs. Hicks, audiometrician who left us in 1967. Her contribution to the service was invaluable.

More detailed numbers are given in the tables on page 39 but in summary a total of 1,401 entrance were tested in the Western Area at school and of these 169 (11%) were found to have an apparent loss of hearing. On re-testing after an interval of a few months all but 56 (4%) had reverted to normal response on sweep testing. This percentage figure is

only half of the corresponding one for the previous year. In addition to routine cases 50 children were specially referred for testing through different agencies and 24 because of the imminence of ascertainment for defects other than hearing. From the combined total of routine and special cases 37 were referred for simple observation, 26 to the school medical officer, 2 to the family doctor and 8 to the otologist. (Table III).

In terms of degree of deafness four new cases of severe unilateral impairment emerged—one probably due to a fracture of the skull, one likely to be a nerve deafness whose case was taken up by the family doctor who in turn awaits a second more conclusive report from the otologist, and the remaining two cases await the result of investigation. No case of severe bilateral deafness was discovered. The moderately deaf cases (9) were all unilateral except one bilateral which was found later in the year. The balance of mild cases affecting one or both ears contained three cases of high frequency loss.

Reports received from the otologist during the year (of three current cases of 1967 and eight from the previous year) gave findings mainly of conductive loss due to enlarged tonsils and adenoids, obstructive adenoids, perforations of ear-drum and catarrhal otitis. Only one report indicated high-frequency loss.

At the end of the year 1967, the position of the state of deafness in school children in the Western Area was as follows:—

Profoundly deaf—Five children were in special schools for the deaf or partially hearing.

Children with hearing aids in ordinary school—Three children with severe deafness, twelve with moderate deafness and four with mild deafness were wearing hearing aids in school and being supervised by the teacher of the deaf.

Others in ordinary school:—

Severely deaf—No case of bilateral deafness without a hearing-aid is known to be in school. Thirty-two cases of unilateral loss are under supervision. The lesions present are evenly split between conductive and perceptive.

Moderate cases—Twenty-five unilateral and twenty-three bilateral cases are under observation.

Mild cases—This group is the largest, containing 94 unilateral and 63 bilateral cases.

"In general the total state of deafness in the school population would appear to be lessening. This may have come about by the application of new drugs to conductive conditions, such as otorrhoea, with benefit, but it is also likely that cases for treatment of such conditions have been brought to light and led to treatment by the routine and special survey of hearing that has been operating over the last few years. It is likely too that parents and teachers have become more interested in furthering the work having been confronted with good results in many cases. There does not yet appear to be a case for restricting or modifying the system of deaf case-finding in school children, or in the screening tests used in infancy."

From the Southern Area, Dr. Walker writes:—

"In 1967 the routine audiometric testing of the school entrant groups covered 1,760 children, an increase of 322 on the previous year.

"Two hundred and seventeen children had an apparent hearing loss on their first test. A second test is normally carried out eight weeks after the first one and this has been done in 118 cases. The discrepancy between these two figures is due to the fact that we were without an audiometrician for part of the last term. After the re-test of these 118 cases, 65 children had an actual loss which required investigation.

"A relationship between new cases discovered and the findings in earlier testing by the health visitor in infancy and in relation to the 'at risk' position in the peri-natal period can not yet be fully explored as the area office was only set up three years ago and as screening by health visitors was taken up gradually in different parts of the area. It has however been possible to trace positive information in a group of 66 cases of entrants with an initial hearing loss discovered in school in 1966 and 1967. All these 66 cases were noted on health visiting card and/or in the birth registers as having been tested in the first year of life and as having passed the simple screening test at that time. Only six of these cases were not entirely satisfactory on testing a second time at school. In this group of 6, factors that could have operated towards a defect of hearing were as follows:—

(i) Injury because of delayed labour (but the loss is a conductive one.)

(ii) Backwardness present as well as deafness and the loss is of the perceptive type—unilateral and moderate in degree.

(iii) Family history of otosclerosis which would not likely appear in early childhood and the deafness present of a low conductive loss.

(iv) Prematurity and neo-natal jaundice.

(v) Prematurity.

(vi) Prematurity.

(Conductive loss in cases iv to vi).

"To summarise—of 66 cases tested in infancy only one emerged at school with a perceptive hearing loss of moderate degree in one ear. The loss is such that even if present from an early age it would not likely have caused failure in passing the screening test. In other five cases, although 'at risk' factors were present at birth, deafness was acquired for conductive reasons.

"Most of these losses were mild and were kept under observation at school. Fifteen were moderate losses and were called up to a special clinic. One was found to have an acute otitis and was referred to the family doctor.

"Four cases were referred to the Ear, Nose and Throat Consultant for an opinion. One has already had his adenoids removed and a myringotomy. Reports on the other three cases have not been received yet.

"Hearing tests were carried out on 138 children in the older age groups. Most of these were referred by the medical officers from the school medical inspections but others were referred by teachers, parents and family doctors.

"After testing 98 cases were found to be normal and to have no hearing loss. Thirty had a mild loss and were kept under observation in school. Ten children had a moderate loss and were called to the clinic for examination. Three children were referred to an Ear, Nose and Throat Consultant. One has his name on the waiting list for removal of tonsils and adenoids and reports on the other two are to follow.

"At the end of 1966 there were 189 children kept under observation for mild losses. Tests were performed on these children and it was found that 60 now have normal hearing.

"In 33 cases there had been no improvement and these were called up for re-assessment.

"Fifteen of these children were referred to a Consultant and the remaining 18 are still kept under observation in school.

"The reports received are as follows:—

1 to be kept under observation at the West Cumberland Hospital.
4 to have tonsils and adenoids removed.
1 Adenoidectomy and suction clearance.
1 Re-test.
4 Awaiting reports.
4 were provided with hearing aids.
1 child was referred to the family doctor because of wax.

"During the past year 12 children of school age have been issued with hearing aids. All except one of these children had been referred as a result of defects found on routine testing or at school medical inspections. The other case had already been referred by the family doctor by the time the girl had been seen at the assessment clinic.

"Most of these cases had been seen at the clinic towards the end of 1966 and information was not available for inclusion in the previous annual report. I feel that I should mention the close co-operation and laison between the hospital service and the school health service in this respect in this area. I should like to quote one case of a ten year old boy who was seen by the school medical officer on the 18th August. He was referred to Mr. Robson, Consultant Ear, Nose and Throat Surgeon and was fitted with a hearing aid on the 1st September. Working in this manner one can feel that the authority is providing an adequate and efficient service for the school child.

"As most of the cases referred to a Consultant with more severe losses came from the older age groups, not from the entrant groups, I thought that a screening test of 8-9 year olds in one school might yield information as to whether any severe losses were being missed.

"Valley Junior School was chosen as it had a large number of children and the hearing test in this school is carried out by the health visitor who performed the initial entrant test on these children. As she is also the school

nurse she is conversant with the medical and social problems as well.

"Valley Junior second year consisted of 119 children, 85 born in 1959 and 34 in 1958. Seventeen were found to have a loss in their first sweep test. Sixteen children had a second test after eight weeks (one being absent) and at this time hearing had returned to normal in six of them but 10 still had hearing defects. This gives a figure of 8.4% of 8 year olds with hearing losses. If the figures for the entrant groups of 1966 are analysed for this area, 4.4% of children failed two sweep tests.

"An attempt was made to classify the ten with a loss into those who had been seen at a selective medical examination. Four had been selected, one was being seen for a different reason, and five had been unselected.

"When the sweep tests for the same children as entrants in 1964 were compared, eight of these were normal at the time, one was defective and being kept under observation and there was no record available of the other one.

"Most of the tests showed a slight loss which only required observation in school and re-testing. There were three moderate losses (one of which was already under observation and receiving attention). The other two will require further investigation.

"It would seem to be worthwhile taking another school next term and doing a similar survey."

Mr. Abbott serves both Southern and Western area as peripatetic teacher of the deaf. The following report relates to his work in the audiology team:—

PRE-SCHOOL CHILDREN

"During 1967 five new cases have come under my care. Two of these are children with conductive losses of a relatively minor nature. Nevertheless the impairment has been of such a degree that speech has not been forthcoming without some amplification. One child has a severe loss and is making good progress. Although it is looking a long way ahead, I am hoping that he will be able to attend a normal school eventually. The fourth child is profoundly deaf and is certain to have to attend a special school; she too is making good progress within her limitations. The

fifth child has not been assessed for hearing loss yet. This child has an additional handicap of a more serious nature and I am doubtful if she is in fact educable.

"A girl and a boy, each with a severe loss, have been integrated into the normal school system. The schools and I feel, after two and three terms respectively, that the children are well placed and are making excellent progress. A further child has been admitted to the Northern Counties School for the Deaf where he has settled in quite well. The remaining boy, who had an additional gross handicap, died earlier in the year.

"It is pleasing to state that again this year all children who have required the use of an auditory training unit have had one made available to them.

"Exactly half of the children who have been referred to me for assessment during the year have been of pre-school age. As is usual a few of the cases were far from straightforward.

1967

Not ascertained	1
Profoundly deaf	1
Severely deaf	1
Partially hearing	3
	6

PUPILS IN SPECIAL SCHOOLS

"At this time there are eleven children from West and South Cumberland in residential special schools for the deaf and one child is at a similar establishment for the partially hearing. All of these children were seen at least once during the year. Two children left during the course of the year and one child was admitted to a special school. Of the leavers one was a partially hearing boy who obtained a reasonably suitable job after some difficulty, the difficulty being shortage of jobs in the area in question. The girl who left the deaf school at the end of last year completed two terms at a local college of further education where she received training for employment as a copy typist; furthermore she now satisfactorily holds a post in a large office in this capacity. This sounds simple enough but it must be remembered that the girl is totally deaf and relies entirely on lip-

reading for following instructions as she has no useful residual hearing. The college accepted her and trained her to the state where she could obtain a job well suited to her aptitudes and abilities. Help was willingly given over and above what could be expected from the department of the college concerned. The girl, her parents and myself are extremely grateful to the lecturers concerned and also to her present employers for giving her this chance.

Children with impaired hearing in normal schools

"Currently there are 40 children under my supervision in West and South Cumberland. One of these children is in a Junior Training Centre, the rest being in local schools. All of these children possess the usual Medresco body-worn air-conduction hearing aid; however one girl uses a post-aural commercial model and at this time 10 of the children are not wearing aids because their hearing has improved to such a degree that they can manage without.

Hearing aids

"There have been eighteen new issues of hearing aids during the year, five of these to pre-school children, the rest to children attending school although two of these left school in the summer. Starting in the coming year post-aural, or ear level, aids are to be provided for children from the ages of 7 to 16 years by the Government through the hospital service. It is indeed good news that these cosmetically more acceptable, and in fact generally more convenient, aids are to be issued. However it is still true that the value of even the most expensive and electronically superb hearing aid is reduced to the quality of the ear mould with which it is used.

"There are certain disadvantages in my opinion associated with temporary ear moulds and I feel that usually it would be advisable to delay the use of the aid for the two weeks until the tailor-made mould comes through. The confidence of parents in the aid is so important at this critical stage.

"The tables below show the average hearing loss for speech on the better ear of the 40 children in local schools. Although the generally accepted way of averaging hearing loss, it does not take account of losses above 2 k.c.p.s. which often lead to particular and characteristic speech faults.

SOUTH AND WEST CUMBERLAND

Up to 30db	13
30db. to 40db.	9
40db. to 50db.	10
50db. to 60db.	6
60 + db.	2
	40

"Supervision has been carried out with these children along the following general lines although of course no two children have exactly the same problems.

1. Supervision which can include auditory training and use of the hearing aid, favourable position in class, regular checking of hearing loss and assessment of speech, etc.

2. Remedial or more specialised work such as speech improvement, lip-reading etc."

Writing on the service in the Northern Area, Dr. Timperley makes the following contribution:—

"During 1967 a total of 1,415 children in the entrant groups were tested. Of these 262 (18.5%) were found to have defective hearing mostly of a minor degree (Table I). 236 have been retested and a total of 109 (7.7%) have required further investigation or observation. (In addition 10 children were referred directly for further investigation and/or treatment as a result of their first screening test). (Table III).

"As in previous years all children transferring into junior schools from other areas who have no record of previous screening have been tested—a total of 154 of whom 23 (14.9%) failed their first test though only 12 (7.8%) required further investigation, a figure again comparable with the entrant groups.

"During the year a total of 202 'Specials' were tested. The origin of these is shown in Table II. It is again gratifying that more cases are being referred via parents and general practitioners. (In addition some children have been referred directly from the latter source to Miss Cronie, teacher of the deaf). As a total of 31.5% i.e. nearly a third, were found to

be defective, it is obvious that all concerned are becoming increasingly skilled in the clinical detection of hearing losses often of a quite minor degree and with the excellent co-operation of teaching staff it is hoped that no child with a hearing loss will remain undetected.

"With regard to specialist referral, due to the long waiting list, only four children (all 'old cases') have been seen during the year. Other children who would previously have been referred directly for an E.N.T. opinion have been referred back to their family doctor either at once or after further testing by Miss Cronie, and the exact number eventually seen by an E.N.T. Specialist is not known."

Miss Cronie, peripatetic teacher of the deaf in the Northern Area, concludes the report as follows:—

"Special clinics were held at Anthorn in co-operation with the health visitor and schools audiometrician to see children of Service personnel when they returned from Aden. Altogether 78 children of pre-school age were screened, none of them having had a hearing test at the usual age for screening. No significant losses were found in this group.

"Fifty-five children were referred by health visitors in the current year. Of these, five are under observation and one, who has a partial loss of hearing, is still under the care of an E.N.T. Specialist. It is interesting to note that in this group of children, eleven have been referred to specialists for further investigation other than hearing.

"Of seven children under observation at the end of the preceding year, six have now been screened. The seventh, a two-year old boy, was referred back to Manchester University for further investigation. He has been found to respond abnormally to sound and appears to have central auditory imperception. This has affected his ability to understand speech, to interpret and retain speech patterns, and therefore to reproduce speech and acquire language. He is making slow progress in this field but otherwise his development seems to be unimpaired.

"Two boys have now moved into the school group and the remaining two boys continue to progress favourably with their hearing aids and auditory training units.

Profoundly deaf	1
Severely deaf	1
Partially hearing	1
Central auditory imperception	1
	4

PUPILS IN SPECIAL SCHOOLS

"One girl has moved into Westmorland so there are now five children from the Northern Area at special schools outside the county. One boy has transferred to a school for deaf boys with mental handicaps; he has settled well at his new school. All children were seen during the summer holidays and contact with parents has been maintained throughout the year.

CHILDREN WITH IMPAIRED HEARING IN COUNTY SCHOOLS

"Forty-eight children are under supervision. Many of these children are on the waiting list to see a Specialist but meantime the state of their hearing has given concern to teachers and parents and I have been called on to give advice on suitable places in class and to give help to the children where necessary. Twenty-four children wear Medresco monaural air conduction hearing aids, two of which have been issued this year. One is worn full-time and the other when the wearer feels he needs it.

"One boy has transferred from the West and one girl, who has been unable to make satisfactory progress at school through lack of language and hearing impairment, is currently awaiting a term's trial in a special school.

"Thirteen children have had weekly help in English, Reading and Arithmetic. All children have had auditory training and, where necessary, lip-reading and speech improvement sessions have also been carried out.

"Hearing losses, averaged over the main speech frequencies in the better ear, are shown in the following table:

Up to 30db.	...	...	20
30-40db.	...	...	11
40-50db.	...	...	9
50-60db.	...	...	4
Over 60db.	...	...	4
			48

"A new development this year has been the inauguration of the Border Area Branch of the National Deaf Children's Society. It is run by parents of deaf children; the local Missioner to the Deaf and Peripatetic Teachers of the Deaf work as liaison officers with the Committee and anyone interested in the welfare of the deaf is welcome to attend meetings. It is already a flourishing society, with representatives from Westmorland, Cumberland, Carlisle and Dumfriesshire. Apart from keeping parents in touch with various aspects of and developments in Deaf Education, the Society has so far presented an auditory training unit to Carlisle and one to North Cumberland. These have been gratefully accepted.

"In this part of the County we now have sufficient units to provide for all children who require them."

TABLE I
ENTRANT GROUPS

Area	Year of Birth 1962	1961	1960	Total	No. with apparent loss	No. of re-tests	No. requiring investigation
North ...	1086	253	76	1415	262 (18.5%)	236	109 (7.7%)
West ...	705	533	163	1401	169 (11.0%)	143	56 (4.0%)
South ...	1050	553	157	1760	217 (12.3%)	118	65 (3.6%)

TABLE II
SPECIAL CASES REFERRED

Referred for testing by:	North	West	South	Totals
School Medical Officer	110	17	129	256
Family Doctor	6	6	3	15
Head Teacher	66	15	4	85
Parent	9	10	1	20
Speech Therapist	2	—	—	2
Teacher of Deaf	—	—	—	—
Paediatrician	—	2	—	2
Referred re 2 H.P. examination	9	24	52	85
Other—Educ. Psychologist	—	—	1	1
	202	74	190	466

TABLE III

Disposal of cases Discovered:	Routine			Special			Totals		
	North	West	South	North	West	South	North	West	South
For observation ...	72	31	50	28	6	57	100	37	107
Referred to School Medical Officer	4	22	9	—	4	29	4	26	38
Referred to General Practitioner ...	10	—	1	15	2	1	25	2	2
Referred to Otologist	1	3	4	3	5	15	4	8	19
Referred to Teacher of Deaf	22	—	1	18	—	4	40	—	5
Other	—	—	—	—	—	—	—	—	—
	109	56	65	64	17	106	173	73	171

Visual Defects

The main event in this field of work during 1967 was the transfer of the remaining ophthalmology clinics in West Cumberland to the West Cumberland Hospital. Considerable detailed work went into ensuring the continuance of a smooth liaison between the hospital department concerned and the health department or offices. A school nurse is seconded to the children's ophthalmology clinics at West Cumberland Hospital in Whitehaven and in Workington Dr. Ainsworth, School Medical Officer, has consolidated her liaison with Dr. Griffith in the school children's clinics. This kind of liaison which Dr. Ainsworth writes on below is in my view exactly the kind of specialist connection which the full-time school medical officer of the future must have.

Dr. Ainsworth writes:

"Ophthalmology clinics particularly interest me and hospital attachment to the clinics is now established. Dr. Griffith sees all new cases of school children and I see follow-up refraction cases which Dr. Griffith considers suitable. Each week I do a clinic in the hospital out-patients while Dr. Griffith carries on his weekly hospital out-patient clinic in the room next door. This is ideal because if I have any queries or problems about the cases I see, I can discuss them with him. After the clinic I bring a brief summary of each case to the Health Office so that this information can be recorded and filed in the '10M' to be available for the medical officer's information at school medical inspection. Another advantage of working with Dr. Griffith at the hospital is that when cases do not attend, or if there is for any reason a fewer number to be seen, I can join Dr. Griffith in his clinic and discuss with him various cases he is seeing.

"Since attending the eye clinic I have gained, I feel, a great deal and one can now see lesions of retina, lens and vitreous which without this teaching and experience, one could not have seen. I do not find refraction difficult now and it is helpful to see children whom one knows and sees at school."

Dr. Sethi, Consultant Ophthalmologist, has kindly written the following comments on visual defects in school children.

"The children complaining of any eye symptoms or any headaches must be referred to an Ophthalmologist. The

visual defects in school children can be brought to the notice of an Ophthalmologist by two ways. Firstly by the school medical officer and secondly by the parents of the children through their family doctors.

"The eye examination by the school medical officers should be done annually, the visual acuity of either eye must be recorded separately, one must make sure that there is adequate light for reading the test types at six metres distance (reverse test types at three metres distance). This can be easily checked by the school medical officer by recording his own visual acuity, provided his own eyes are normal or made normal by correcting glasses. When a child is brought for an eye test at school for the first time, one should spend enough time to get the child in confidence and then start recording the vision. For young children E and hand tests (extended fingers) are good methods for recording the visual acuity—child is asked to point his extended fingers in the same direction as that of block fingers on the E which points up, down, right and left. It is wise to place the child's out-stretched fingers on the chart itself until he understands and is able to point his own fingers the proper way. Then the chart is held a few feet away while the child points a few times at various E's; then tested again at 20 feet distance (6 metres). The picture charts are good but old-fashioned and less accurate than E charts. Nowadays vision Screener apparatus can be used to detect any visual defects. The school medical officer must be familiar with cover test to ascertain the extraocular muscle balance.

"Ophthalmologists are asked frequently by other doctors and by many patients, particularly parents, just what one can do about the refraction in children and illiterate people. Actually, retinoscopy enables the Ophthalmologist to determine the refractive error of an eye readily and exactly at any age in any patient. The refraction is an art which can easily be learned by school medical officers, they in turn can carry out the routine checks, this could also be carried out by an Optician or a Clinical Assistant, thus the Consultant Ophthalmologist can be relieved of doing the routine work and can devote more time to interesting and difficult cases who require intense care to attain functional cure. I would like to point out that the squint occurs in 1 to 2% of all children. The squint could be either due to motor obstacles, sensory obstacles, refractive errors or central factors. When a family history of a squint exists all children should be observed carefully and examined at intervals. The earlier in

life the squint occurs the more profound are the consequences and the more difficult is the final cure. At present great importance is placed on early recognition and treatment of squint. The attempt is made to obtain a functional cure (binocular single vision) rather than to delay the treatment and get cosmetic surgery done. Thus the squinting children must be referred to an Ophthalmologist wherever there is a suspicion of cast in the eye.

"The Ophthalmologist considers himself to be very fortunate if he has a good Orthoptist to work with. I say this because full investigation of squint pre-operative and post-operative treatment which is very time-consuming is done by the Orthoptist. It is also true that the Ophthalmologist has to play his part in diagnosis and excluding any organic, nervous, or muscular diseases, ordering correct glasses and to do surgery at the proper time. It is only the joint efforts of the Ophthalmologist and Orthoptists which can bring about a functional cure. It is needless to say that the Orthoptist must be available when the clinics are held so that matters arising can be discussed fully and the treatment started from the very beginning. I would like to add that as children are brought to the eye clinic from far and wide, around Carlisle, Hensingham or Workington, most of the investigations should be done at the first visit and parents must be told about the importance of the Orthoptic treatment. Only by doing this valuable time can be saved and earliest opportunity can be availed for the treatment of squint. One would like to point out that certain children require only correction of refractive errors, such children when co-operative do not require any mydriatic for checking the refraction, in my personal opinion should be referred to a local optician to carry out the refraction. The parents must be told in this case that if they are not satisfied at any time then they should seek our advice again.

With regard to certain school clinics, I must confess that the facilities for complete eye examinations are not enough and the time is soon coming when such clinics will be abolished and will be replaced by eye clinics for children at the main hospitals.

"Lastly I would like to say that the training and rehabilitation of the partially sighted and blind children must be looked into more fully."

In the light of Dr. Sethi's comments on the work of the orthoptist, a particularly heartening development in the ser-

vices for school children with defective vision has been the return at the end of 1967 of the first orthoptist trained under the Education Committee's scholarship scheme for training orthoptists. At the time of writing this report Miss Davies has already settled well into the work in West Cumberland, again working very closely with the Consultant Ophthalmologists in the hospitals. It is encouraging again to have a regular and adequate orthoptic service in West Cumberland. In East Cumberland Mrs. Richardson and Mrs. Scott continue their excellent work and the latter writes as follows about this, giving very interesting and instructive examples of cases which show the need for early referral. It is encouraging that she can point to a trend towards this necessary earlier referral of children with squints.

Mrs. Scott writes as follows:—

"Orthoptic work during 1967 has again been shared by Mrs. Richardson and myself. Five sessions in all have been worked per week, three at Carlisle and two at Penrith. This adequately covers the eastern half of the county. The western half has again had only part-time clinics held, but this situation will be remedied in 1968 by the appointment at the end of 1967 of Miss Davies.

"As is shown by the following charts the greatest number of new patients referred to the clinic have amblyopia in varying degrees. This condition only occurs when a squint has been neglected for some time and may mean that some parents are still not aware of the benefits of early advice and treatment. Two cases illustrating this problem are as follows:—

(a) A girl was referred to the clinic at the age of three and a half years having squinted for approximately one year. Her vision in the left (squinting) eye was then 1/60. Her left eye was occluded for one month to eliminate any tendency to develop eccentric fixation. (When the vision is very poor a point on the retina other than the macula may have been used in conjunction with the good eye, causing a permanent squint which is very difficult to eradicate). After one month the good right eye was occluded for one month and the vision in the left eye improved to 6/12, and after a further month of occlusion the vision was 6/6.

(b) A boy was referred to the clinic at the age of five and a half years having squinted for approximately three years. His vision in the right (squinting) eye was then 2/60. The same procedure was carried out as in the above case, but after 1/12 of occlusion the vision had only improved to 5/60 and it has taken five months occlusion to improve the vision to 6/12 which is still not really good enough.

"Both these children started squinting at about two and a half years of age, but in the first case the parents sought help quickly, and in the second case nothing was done till after the child started school. It is encouraging to note that an increasing number of very young patients are being referred which enables us to prevent these complications arising."

The numbers of children tested in 1967 and the numbers referred for treatment or observation are shown below, along with figures for the previous three years.

Year.	*Total No. tested.*	*Referred for treatment.*	*Referred for observation.*
1967	11,084	444	1,865
1966	12,085	452	2,028
1965	13,096	473	2,400
1964	13,933	615	2,443

The following table shows details of the cases treated during the year:—

Total number of attendances in 1967	987
Number of new cases seen	126
Number of new cases registered for treatment ...	111
Number of cases receiving treatment on 31st December, 1967	164
Treatment during year of new cases:	
Partially accommodative squint	12
Partially accommodative squint with amblyopia	6
Fully accommodative squint	7
Fully accommodative squint with amblyopia	5
Convergence excess	3
Tonic convergent squint	18
Tonic convergent squint with amblyopia ...	27

Convergent squint	1
Esophoria	3
Intermittent convergent squint	3
Amblyopia	3
Constant divergent squint with amblyopia ...	1
Divergence excess	8
Convergence weakness	7
Consecutive divergence	1
Exophoria	—
Convergence insufficiency	2
Vertical muscle palsy	3
Paralytic divergent squint	1
Total	111

Discharges during the year:

Cured	30
Cosmetic	28
Improved	11
Failed to attend	10
Left district	5
Not responding	—
Refused	—
Deceased	—
Total	84

Orthopaedic Service

As foreshadowed in my last annual report both the County Council's physiotherapists, Miss Morris and Miss Fraser, left the county's service in 1967. Their service over the years had been monumental and they have left behind many a grateful parent and child, though many of the latter whom they served are now adults taking a full and active place in the community, thanks in no small measure to the physiotherapy help received following bone and joint tuberculosis, or poliomyelitis.

One accompaniment of the departure of the two physiotherapists has been a transfer of all children's orthopaedic clinics in West Cumberland to the Hospitals. I envisage more part-time physiotherapists in the future working in the community as part of the family health care team under the leadership of the family doctor. In this capacity the physiotherapist would also serve school children as re-

quired, though the remedial gymnast may well in future be the key worker amongst this age group, considering the mainly minor orthopaedic conditions which require correction, and excluding the small number of cases which require specialist hospital care. Another group which they might well also serve are spastic children both of pre-school and school age. In this connection a link with the appropriate hospital specialists should I believe be forged. A first part-time physiotherapist has been appointed to work with a group practice in the Southern Area.

Speech Therapy

There has been considerable discussion during 1967 of an important Regional Hospital Board report produced by Dr. E. M. Morley, Consultant Adviser to the Board on speech therapy. This report suggests the likely need up to 1970 of speech therapists in each area of the northern region taking account both of hospital and local authority needs. Although details of distribution of services will need to be worked out as the years pass, it is reassuring to see that the likely establishment of speech therapists in Cumberland through the Education Committee's scholarship scheme should keep pace well with the requirements suggested by Dr. Morley. This is allowing room also for the sharing of speech therapists with the Hospital Management Committees. At the moment the establishment of speech therapists in Cumberland is three and the speech therapists in posts amount to the equivalent of 3. By the time sessions are allocated to hospitals the establishment equivalent actually working in county clinics and schools is $2\frac{1}{2}$. The Hospital Board's assessed requirement for the hospitals in the area, including Carlisle, is $1\frac{1}{2}$ and, of course, this involves Carlisle City. Without entering into the detailed complexities of distribution as between county, city, and hospitals the total number of speech therapists recommended in Dr. Morley's report for the geographical county is 8 by 1970.

During the year Mr. Beattie joined the staff in West Cumberland as a full time speech therapist and Mrs. Stone took up sessional work in East Cumberland. The following interesting report has been produced by the therapists and reflects, I am happy to say, vigorous and original thinking on their part and the introduction of elements of research and experiment which are a very healthy sign in the service.

"School children form the majority of those attending speech clinics. Parents and teachers often feel that a child's slow progress in school is the result of his defective speech.

While in certain cases this may be true, in many others both the poor speech and the slow progress in language subjects are the result of the same basic difficulty—a delayed or inadequate maturation of the cortical functions concerned with all forms of learning. In either case it is desirable that there should be maximum co-operation between teacher and speech therapist. Ideally there should be regular personal contact between them but the current case load keeps the therapists at the clinic. We endeavour to visit infant and junior schools as frequently as possible, both to exchange information about children already receiving treatment and to assess any children whose speech the school is concerned about.

"When it is not possible to visit a school we may write to ask for a report on a certain child. On our part we are always ready to supply information on request from a head teacher.

"The undoubted importance of co-operation between therapists and teachers gives rise to the question, 'Why do Speech Therapists not work in the schools?' In the first place children from different schools attend one clinic. If the therapists visited each child at school at least a third of their time would be spent travelling, with the result that many children could not be treated at all. In our view speech therapy on the school premises is not in the best interest of the child. For treatment to be effective the therapist must gain the active co-operation of the mother. Home practice is usually necessary and the mother needs to learn, by watching the therapist, how this should be done.

"A child with defective speech is self-conscious about it and anything that singles him out from his classmates, such as having speech therapy on the school premises, may exascerbate the situation and could nullify the treatment.

"In the Southern Area the need was felt to check on the progress of social maturity in some children showing hesitant and non-fluent speech with concurrent anxiety in social situations because of or in addition to the speech defect. Mr. Haigh, the Educational Psychologist, has kindly agreed to co-operate in this study. The test to be used is the Bristol Social Adjustment Scale, which will be completed by the child's teacher and then scored. A future retest will be made following some time of continuous weekly speech therapy and any changes in the social adjustment may be noted and correlated with improvement in the speech defect. The value of this study may also be that any child in need of psychiatric

help can be picked out in the early stages of emotional difficulty.

"It is hoped that training films may be made available from the British Psychological Society, through the School Educational or Hospital Clinical Psychologist to instigate a programme for some Junior or older stammerers based on systematic desensitisation of anxiety in speech situations through reciprocal inhibition by relaxation responses to feared situations.

"The trend away from isolation to group work is going ahead and the therapist in the Maryport area was introduced to the group of medical practitioners. There are plans for similar secondment to practices in the Seascale and Brampton areas.

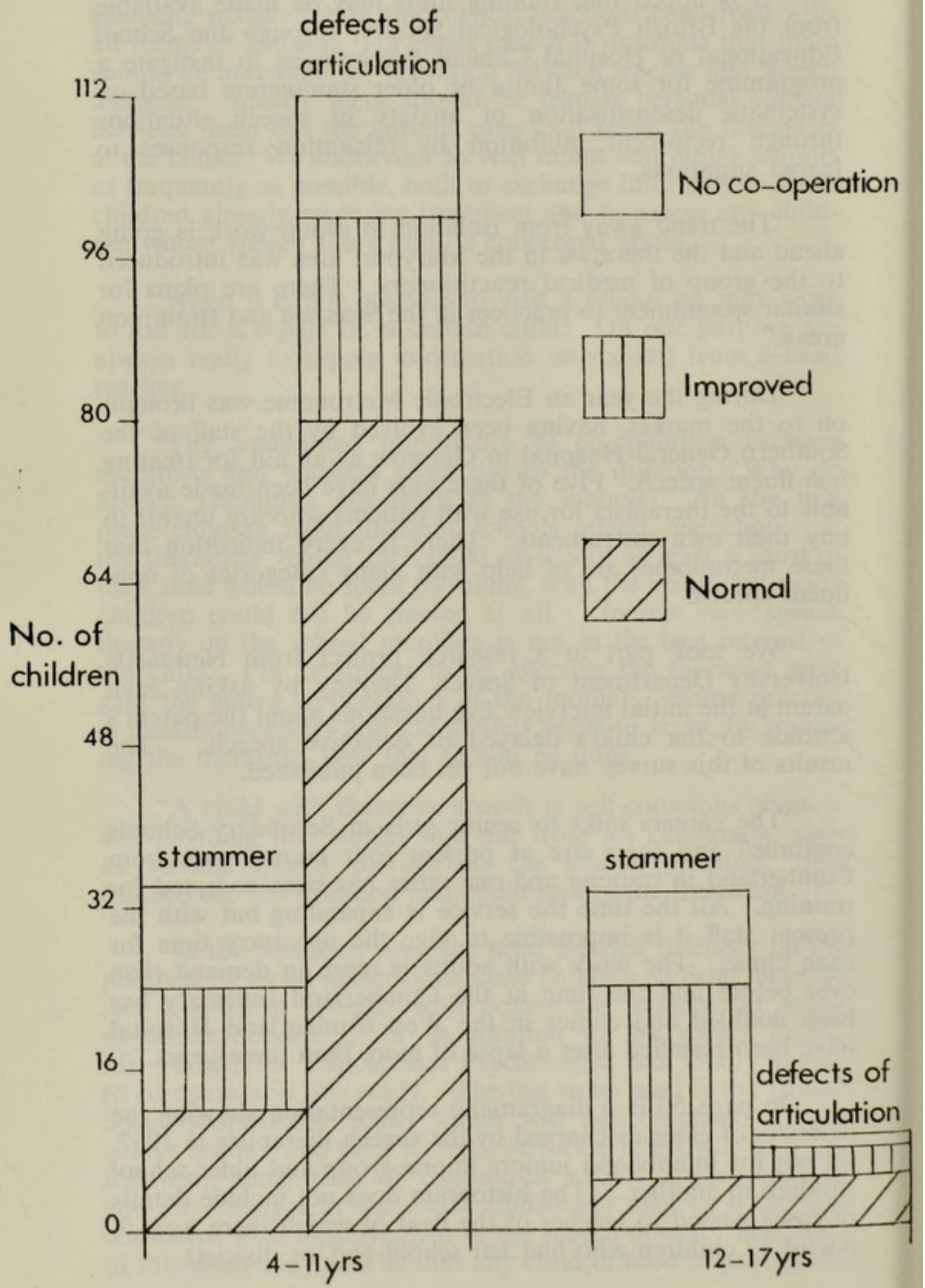
"During the year an Electronic Metronome was brought on to the market, having been evolved by the staff of the Southern General Hospital in Glasgow as an aid for treating non-fluent speech. Five of these aids have been made available to the therapists for use with patients who are unable to buy their own instruments. There is every indication that these metronomes are of help with many categories of non-fluent speech.

"We took part in a research project from Newcastle University Department of Speech Therapy by asking each parent at the initial interview five questions about the parent's attitude to the child's delayed or defective speech. The results of this survey have not yet been published.

"The careers talks to senior girls in Secondary Schools continued and there are at present four known girls from Cumberland in training and one other has been accepted for training. All the time the service is expanding but with the present staff it is impossible to give the necessary time for each clinic. The work with adults is more in demand than ever before and the time at the Cumberland Infirmary has been doubled and clinics in the West Cumberland Hospital have been restaffed after a lapse of more than three years."

On page 50 is a diagramatic representation showing the numbers of cases discharged by the speech therapists in 1967, set out for infants and juniors in one group and older school children in another. (The histogram does not include details of cases passed to teacher of the deaf of which there were 3, nor of 17 children who had left school and/or district).

SPEECH THERAPY DISCHARGES 1967



It is very interesting to see how the numbers discharged from treatment for stammer is very similar in both groups, although the proportion discharged as normal is smaller in the older age group into which has been carried many of the more difficult cases from the younger age group. The difference with regard to defects of articulation is striking. A large proportion of these children are helped greatly at the infant or junior stage and the numbers under treatment, and therefore also the numbers discharged in the older age group, is very much smaller.

The total number of cases discharged was 208 against a figure of 272 admitted to the register. Details of cases treated and attendances during the year are shown in the tables below.

	Northern Area.	*Western Area.*	*Southern Area.*	*Total.*
On register 1.1.67	111	138	105	354
Admitted	80	114	78	272
Discharged	53	104	51	208
On register 31-12-67	138	148	132	418
Particulars of cases discharged:—				
Normal	26	54	22	102
Improved, unlikely to benefit further	14	27	13	54
Lack of co-operation	7	17	8	32
Left school and/or district ...	6	6	5	17
Passed to teacher of deaf ...	—	—	3	3
Referred to child guidance ...	—	—	—	—
Total	53	104	51	208
Waiting list	1	1	25	27
Cases treated:—				
Stammer and dispraxia ...	—	1	—	1
Dyslalia	46	68	47	161
Stammer	51	86	54	191
Stammer and dyslalia ...	13	5	6	24
Sigmatism	3	3	8	14
Cleft palate	6	12	9	27
Hard of hearing	—	—	3	3
Dysarthria	1	—	2	3
Dysphonia	—	—	—	—
Dysphasia	1	—	1	2
Retarded speech development	47	57	29	133
Dyslalia and dysphonia ...	—	—	1	1
Dyslalia plus low intelligence	8	3	4	15
Lateral sigmatism	6	10	6	22
Dyspraxia	9	7	8	24
Submucous cleft	—	—	—	—
Hyponasality	—	—	1	1
Hypernasality	—	—	4	4
Stammer and dysphonia ...	—	—	—	—
Stammer and dysarthria ...	—	—	—	—
Total	191	252	183	626

Attendances:—

Northern Area:	
Allhallows	18
Aspatria	64
Carlisle	382
Penrith	473
Wigton	192
Wigton Infants' School	53
Western Area:	
Cockermouth	326
Keswick	77
Maryport	186
Workington	409
Southern Area:	
Whitehaven	816
Total	2,996

Child Guidance

The Child Guidance service has once again had a full and effective year of activity throughout the county. The medical work of the clinics continues to be shared by Dr. Burgess and Dr. Ferguson. To both, the service owes a very great deal. Then, 1967 was the first year in which the service has functioned with an establishment of three educational psychologists contributing their skills to the various teams. This has undoubtedly been a great strengthening of the service, and I am glad to be able to include below the first comments in an annual report by Mr. Haigh, the latest member to join the team of Education Psychologists in the Southern Area. His well-balanced report provides re-assurance first of all from a "newcomer" and subsequently stimulation. Mr. Hare's ever-valued comments which follow indicates the close relationship of the Child Guidance Service to the overall developmental care of young children—a subject which has been ever-increasingly occuping the attention of medical workers, including the school medical officers, engaged in child health work.

Considerable discussion has taken place both within and between the Education and Health Departments in 1967 on the possible provision of special units for maladjusted children, and of play-group type of facilities specially directed and organised for young pre-school children exposed to the circumstances which are known to produce a high proportion of psychological disturbance or maladjustment later. Even

when the best initial moves are agreed upon, progress in this field will inevitably be slow because of financial consideration but a start would be welcome.

Mr. Haigh writes:

"On commencing work in the southern area I found, of course, a well-established Child Guidance Service which compares favourably with any I had seen elsewhere during my training. The Service has in general an informal, flexible and efficient organisation; over the years it has obviously acquired a valuable status and familiarity in the community, and to a fair extent the common prejudice against psychological and psychiatric services has faded. The number of parents who fail without good reason to attend seems impressively low. Perhaps the only disappointing features have been the small number of pre-school children seen and the scarcity of referrals by general practitioners. The adequacy of the service is difficult to assess, but the proliferation of new Clinics (e.g. in Cleator Moor and Egremont) would very probably result in a rapid increase in referrals. At present, however, time forbids.

"Over my relatively short period of working in the area some fairly clear patterns of problems have emerged, and it is often possible to predict with fair accuracy the degree of success the Clinic team is likely to achieve with any particular child. There is cultural impoverishment in the area which makes itself evident in a variety of symptoms. Enuresis, by far the commonest presenting symptom among the Clinic's clientele, is frequently found to be the result not of severe emotional disturbance but of poor conditions and training in the home, combined with relatively slight but prolonged stress. Fortunately enuresis is one problem which, if not always wholly overcome, is usually markedly improved after a child's attendance at the Clinic. Indeed, where an environmental adjustment is needed our hope of success is greatest: at its simplest level this may take the form of advice to parents or the securing of material help through the appropriate agencies. Parental inadequacy is, however, made apparent also in many other ways, notably in the low level of verbal comprehension and fluency evident in so many children seen both at the Clinic and in the schools. The quality of verbal responses to projective personality tests, for example, appears poor in this area (although this is a subjective observation) compared with that of children from similar homes but in larger cities. West Cumberland, in fact, has many of the problems of a large urban centre without all its more advantageous characteristics.

"Another class of children for whom treatment at the Clinic may very probably be successful is that of the mildly disturbed whose parents are able and willing to be brought to see the root of the problem. A consequent amendment of parental attitude and insight, combined with sessions of play therapy for the child, will usually effect at least some, and often a substantial, improvement.

"It is perhaps more important to study the sorts of problems which the Child Guidance team, in present conditions, is likely to fail to resolve: only when these are defined can further provision be made for them. Honesty is also the creator of confidence: to guarantee cures as readily as Charles Atlas guarantees muscles is to breed disillusion and doubt in those who refer children to the Clinic for help. There is always a conflict between the need to treat enough children and the need to allow every child the attention he deserves. Inevitably, those who suffer most from this conflict are the severely disturbed. To a small proportion of these a small day unit for maladjusted children, at present under discussion, would offer the chance of a temporary therapeutic environment and more intensive treatment away from the normal school when this is no longer able to help or even perhaps to cope with them. Perhaps it may even be possible one day, in financially happier times, to appoint a lay psychotherapist to supplement the psychologist's work by extending the time devoted to play therapy sessions. Such services have, of course, already been established in some parts of the country, and it is to be hoped that Cumberland, advanced in so many fields, will not be late in following this trend. In fact the ideal arrangement might be for the Child Guidance Clinic, in its present form, to become almost entirely diagnostic and to allot the children, where necessary, to therapeutic sessions in which the team members would play their full roles. Such an organisation of resources would end the current attempt to fulfil several functions within a single service that is hard-pressed for time.

"The Clinic has probably the least success in treating delinquency and pre-delinquency: the cumulative evidence points to the pre-school years as the critical phase in the establishment of delinquent trends, and although no child would ever be turned away from the Clinic on these or any other grounds it is always difficult to achieve much progress with this type of problem. The only really successful approach will be preventive rather than curative, and, apart from the development of nursery school education, is likely to take the

form of intensive family casework: such a service would be, of course, outside the role of the Child Guidance Clinic.

"Finally, I believe there is still scope for strengthening the Clinic's links with the schools: perhaps occasional visits to the Clinic by Head teachers might be the first stage of the process of increasing still further awareness in the schools of the Clinic's work."

Mr. Hare offers the following comments:

"The work in the clinics in Workington and Maryport has continued throughout the year its uneventful, if steady, course. There has been a tendency for referrals to fall off from the school medical officers during this year. This is undoubtedly due to the introduction of the selective medical examination in schools. However, since the beginning of the new term in 1968, this is now tending to rectify itself after discussions with the Area Medical Officer and 1968 is likely to be as busy as previous years.

"Child Guidance is such a wide-ranging concept that reference only to the tables of numerical data relating to attendances, etc. fails to convey the immense amount of time, care and thought entailed in a referral to the clinics. So far as day to day help is concerned, a child living and functioning largely within the environment of the school is very dependent on his teachers, and possibly others supplying his emotional needs and satisfactions. Specific manipulation of his environment is often easily managed but the more subtle changes that are required and which are not easily perceived come from those most closely in contact with him.

"There is today an impressive movement in schools for changes of all kinds, ranging from new developments within curricula content and the establishment of learning situations, to deep concern over the effects of cultural and social disadvantage. None of this work is uniquely separate from the child guidance clinics, and some of it is an extension of the thought and ethos of the traditional child guidance movement.

"A re-definition of child guidance might well be considered as being in the main concerned with providing an over-view of the child's developmental environment in and out of school to ensure the maximum development of psychological skills. Such a view assumes implicity the

importance of the movement from heteronomy to automony. The child becomes responsible for himself.

"The task facing child guidance workers is often not so much the provision of specific measures for the weak and handicapped as ensuring the best conditions for maximum efficient psychological functioning. To do this involves, at any rate, the Educational Psychologists in much close and constant contact with the schools. Much informal discussion and conversation is conducted in attempts at clarification and the gaining of insight into what is happening to children as they develop throughout the educational process. The social pressures of society are involved in such an analysis, as well as consideration of the norms of conduct and behaviour.

"It is certainly gratifying to see changes occurring in traditional attitudes towards children in our society and to see this occurring more and more in school as new ideas permeate traditional institutions and thought ways."

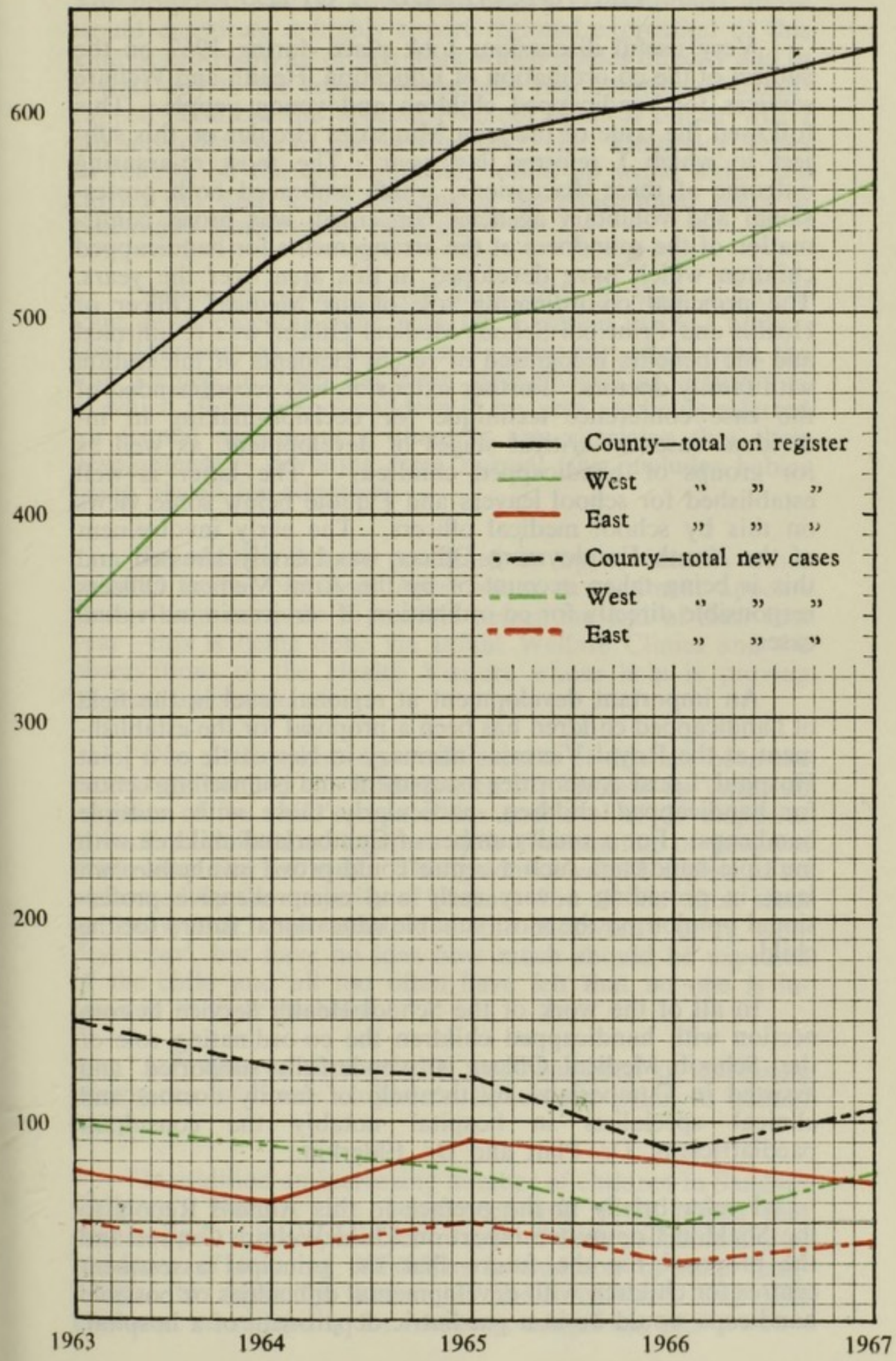
CHILD GUIDANCE CENTRES—STATISTICAL RETURN FOR THE YEAR ENDED 31-12-67

STAFF:	Carlisle:	Maryport:	Workington:	Whitehaven:	Millom:	
Psychiatrist	Dr. J. R. Burgess	Dr. T. Ferguson	Dr. T. Ferguson	Dr. T. Ferguson	Dr. T. Ferguson	
Educational Psychologist	Dr. H. Blair Hood	Mr. K. G. Hare	Mr. K. G. Hare	Mr. C. R. Haigh	Mr. C. R. Haigh	
Psychiatric Social Worker	Miss E. A. Welch	Miss E. F. Hall	Miss E. F. Hall	Mr. A. Barlee	Mr. A. Barlee	Total
Cases remaining on register at 1st January, 1967	31	7	438	19	28	523
New cases referred during year by:—						
Consultants or General Practitioners	19	—	1	4	—	24
School Medical Officers	2	5	14	19	—	40
Children's Officers	4	—	2	—	—	6
Parents	3	—	—	—	—	3
Schools	12	—	—	6	2	20
Probation Officers or Courts ...	1	—	—	1	—	2
Others	—	—	—	1	—	1
Cases re-opened during year ...	—	1	1	13	1	16
Total cases on register during year ...	72	13	456	63	31	635
Cases dealt with and closed	9	2	4	15	26	56
Cases remaining under treatment on 31-12-67	63	11	452	39	3	568
Cases awaiting treatment on 31.12.67 .	—	—	—	9	2	11
	72	13	456	63	31	635
Interviews by Psychiatrists	352	45	60	82	3	542
Interviews by Social Workers ...	311	—	—	6	—	317
Interviews by Educational Psychologists	126	67	118	125	3	439

CHILD GUIDANCE REGISTER 1963-1967

		1963	1964	1965	1966	1967
Total on Register during year.	East	74	64	91	86	72
	West	375	449	493	519	563
		449	513	584	605	635
Total new cases during year.	East	47	38	51	37	41
	West	101	99	76	58	71
		148	137	127	95	112

CHILD GUIDANCE REGISTER, 1963-1967



HANDICAPPED PUPILS

Very useful discussions took place during 1967 on the subject of the co-ordination of Education, Health and Welfare services for handicapped children and young people. This followed the issue of the joint Ministries circular on this subject to which I referred last year. The most re-assuring outcome of these discussions, which embraced both professional and voluntary agencies concerned, was broad confirmation of the soundness of the arrangements for handicapped children which have developed in this area over the years. The principal co-ordinating role of the Medical Officer of Health and Principal School Medical Officer was re-affirmed and the benefits recognised of recent elements of integration with family doctors. Further extension was recommended of the case conference technique for decision-making in individual cases at critical stages of development, as well as for groups of handicapped children. The latter is well established for school leavers and I quote below some views on this by school medical officers. The early involvement of the Youth Employment Officer was heavily stressed and this is being taken account of by the Area Medical Officers responsible directly for co-ordination of services in individual cases.

An important development at regional level in the field of handicapped children has been a proposal for the establishment at the Royal Victoria Infirmary in Newcastle of a joint Hospital/Local Authorities assessment and counselling centre for handicapped children, particularly those with multiple handicaps. For a small number of Cumberland children with multiple handicaps such a centre could prove invaluable, not least in providing a very early and comprehensive professional opinion on the most suitable educational future for the child.

In all of the work of the School Health Service in connection with handicapped children the co-ordinating role of the School Medical Officer is wonderfully supported and assisted in Cumberland by the help of family doctors and clinical specialists in hospital notably the consultant paediatricians, Dr. Platt and Dr. Elderkin.

I refer briefly in the preface to this Annual Report to the Sheldon Committee report on Child Welfare Centres and the proposal for the future that the principal assessment centres for children with developmental difficulties or possible handicaps would be in a paediatric department of a hospital,

The proposed unit at Newcastle which is mentioned above would constitute a highly expert regional expression of this kind of centre. In all of this work which relates directly and in a vital way to the future educational requirements of handicapped children, the specialist school medical officer will I am sure continue to play a vital part. Dr. Timperley writes as follows on the developmental follow-up work which she carries out and which anticipates the educational years of potentially handicapped children.

"Although it has proved impossible to start a formal joint developmental clinic with Dr. Elderkin at the Cumberland Infirmary as was hoped in the early part of the year, the link formed in 1966 has been strengthened as a result of of which all pre-school children in my area are being referred for formal assessment if there is any suspicion that their development is deviating from normal (this includes babies being placed for adoption).

"In addition I have continued to try to identify other children in the Northern Area where development appears slower than normal—if possible before the end of their first year—this is being done via Infant Welfare Clinics and the observations of the Health Visitors whose help is proving of great assistance.

"One of the most important aspects of this has been the increasing number of children seen for "follow up" with an estimate of the child's capabilities and level of development at each examination, together with the amount of progress made since the last visit. This guidance would appear to be welcomed by the majority of parents who all too often seem to know that their child is a 'bit backward', or 'a slow developer', but have no idea how much should be expected of the child and all too often have felt that no one is interested in their problem.

"A further outcome of this work has been an increasing acceptance of these children's limitations prior to school entry.

"In addition an increasing number of children in Sandath Children's Nursery are being seen and it is hoped that eventually it will be possible, in view of their probable higher incidence of learning difficulties in addition to other handicaps, to routinely screen all these children and give guidance, re suitability for fostering, adoptions, etc."

The practice of holding regular handicapped school leavers case conferences is now firmly established in each area. It is a great advantage at these meetings not only to have present those who have been working directly with the handicapped child during his school years, but also the social welfare staff and youth employment officers upon whom many of these young people will depend greatly in their earliest post-school years. The form and content of these conferences is becoming progressively more tailored to the needs of individual children as selection for discussion takes place on a more individual basis and each child's case is is considered at the most appropriate interval before the leaving date. Often this involves reconsideration of cases at successive conferences before the leaving date. Dr. Rogers, Northern Area Medical Officer, comments as follows on this subject.

"These conferences continue as in previous years and the scope was widened to include children who would be leaving in two to three years. The Youth Employment Officer felt that this gave her adequate warning of difficult placements in the future. The decision as to which Department will eventually be responsible for handicapped children when they leave school is made at these conferences and this has proved to be extremely valuable to all those sections who take part. Information arises from various sources and it is brought together round the conference table to produce a useful overall picture of the future welfare and outlook for each child."

Similarly Dr. Campbell from the Western Area comments:

"Meetings are now being held with the Youth Employment Officers at the Workington Labour Exchange in order to discuss employment for handicapped school leavers.

These meetings are arranged a few terms before the handicapped pupil leaves. By this arrangement points can be discussed and cleared up between the School Medical Officer and the Youth Employment Officer working in the school concerned and time is given to the Youth Employment Officer to find work suitable to the individual handicap.

These meetings are of great value in assessing how a handicapped school leaver is likely to fit into a given job to the greatest advantage for his handicap."

The following table shows the numbers of children reviewed at handicapped leavers conferences. The development of this arrangement is shown by the fact that the total of 118 for 1967 compared with a total of 67 cases reviewed the previous year.

HANDICAPPED LEAVERS' CONFERENCES

Cases considered were as follows:—

Deaf and partially hearing	9
Blind and partially sighted	1
Epileptic	6
Diabetic	3
Physically handicapped	30
Educationally Subnormal	69
	118

The number of handicapped pupils who require to attend special schools outside the county has remained remarkably constant over the past ten years. Apart from a slight increase in 1960/61 in the number of boys attending residential schools for the physically handicapped, the number educated out of the county has remained at about 50. On average some 20 of these are either deaf or partially hearing children and the remainder are divided between the blind and partially sighted and the physically handicapped.

CHILDREN SUFFERING FROM CEREBRAL PALSY

The numbers in this category at 31st December, 1967, are as follows:—

Number of spastic children of school age—

North Cumberland	18
South Cumberland	29
West Cumberland	19
	66

These may be divided into those:—

(a) Attending ordinary school	45
(b) Attending Percy Hedley School for Spastics, Newcastle	3
(c) At Residential Schools for the Physically Handicapped	—

(d)	At Residential Schools for the Educationally Subnormal	—
(e)	Attending Training Centre	8
(f)	At Dovenby Hospital	3
(g)	At Prudhoe Hospital	—
(h)	Having Home Tuition	—
(i)	Not attending school, not having home tuition	2
(j)	Irton Hall	5
	Special Care Unit	—
		—
		66
		—

In addition:—

Number of children under school age but within the scope of the Education Act, 1944 (i.e., 2-5 years) who are known spastics:—

North Cumberland	2
South Cumberland	8
West Cumberland	—
	—
	10
	—

Table Showing Handicapped Children in Special Schools

BLIND

	Boys.	*Girls.*
Royal Norman College, Shrewsbury ...	2	1
Royal Victoria School, Newcastle-upon-Tyne	1	—
Chorleywood College, Hertfordshire ...	—	1
Henshaws School for the Blind, Manchester	1	—
Total	4	2

PARTIALLY SIGHTED

	Boys.	*Girls.*
Royal Normal College, Shrewsbury ...	—	1
Preston School for the Partially Sighted	—	2
St. Vincent's School for the Partially Sighted, Liverpool	—	1
Total	—	4

DEAF

	Boys.	*Girls.*
Northern Counties School, Newcastle-upon-Tyne	4	1
St. John's School, Boston Spa	—	1
Royal Cross School, Preston	2	5
Total	6	7

PARTIALLY HEARING

	Boys.	*Girls.*
Northern Counties School, Newcastle-upon-Tyne	1	1
St. John's School, Boston Spa	—	1
Royal Cross School, Preston	—	1
School for Partial Hearing, Birkdale, Southport	—	2
Bridge House School, Harewood, Yorkshire	1	—
Total	2	5

EDUCATIONALLY SUB-NORMAL

	Boys.	*Girls.*
Eden Grove School, Appleby	2	—
York School, Carlisle	1	—
Higham School, Bassenthwaite Lake, Cumberland	—	34
Ingwell School, Moor Row, Cumberland	48	—
Total	51	34

EPILEPTIC

	Boys.	*Girls.*
Colthurst House, Alderley Edge, Cheshire	1	—
Total	1	—

PHYSICALLY HANDICAPPED

	Boys.	*Girls.*
Percy Hedley School, Newcastle-upon-Tyne	1	2
Irton Hall School, Holmrook, Cumberland	3	2
"The Cedars" Special School, Gateshead	—	1
Margaret Barclay School, Moberley, Cheshire	—	1
Whiteness Manor, Kingsgate, Kent ...	1	—
H. K. Campbell School, Carlisle ...	1	—
Lord Mayor Treloar, Froyle, Alton, Hants	1	—
Total	7	6

Educationally Sub-Normal Pupils

I am glad to report that the numbers of children examined in 1967 as possibly educationally sub-normal, shows an increase to 91 from a figure of 65 for the previous year. This is shown on the table on page 69, and also the fact that referrals for "2 H.P." examination have increased, mainly from the teachers and psychologists. I have felt that more junior children might benefit from this comprehensive assessment and when passing from junior to secondary school would carry with them a clearer indication of the amount and kind of special help needed.

Many children recommended by the School Medical Officer and educational psychologist for admission to residential special school, never reach this because of parental resistance to their going. When this is clearly insurmountable there is little point in retaining the child on the waiting list for the special school; thus these waiting lists do not appear very long.

The recent establishment of the special unit for junior educationally sub-normal children at Hensingham Junior School has been a great advance in this field and I am very glad this year to be able to include below an account of the early days of the unit by the teacher in charge, Mr. Gauld. He writes:

"Basically the Hensingham Progress Unit exists because the Education Act of 1944 requires Local Education Authorities to make special provision for pupils, who, by reason of limited ability or other conditions resulting in educational retardation, require some specialised form of education. The Unit draws children from schools that, for various reasons, are not themselves able to provide this special treatment. The idea of complete segregation in a special school, particularly at the Primary stage, is held by many to be an unnecessarily drastic step and in attaching the Unit to a normal Junior School it was expected that children would be able to receive the special treatment they needed whilst remaining part of the whole group.

"The Unit began after Easter 1967 with the Teacher-in-Charge and twelve children. Five more children were enrolled during the year and the teaching staff was increased by engaging a temporary, part-time teacher. The Unit is intended eventually to be staffed by two full-time, specially trained, teachers and to provide places for up to forty children. Statistics giving the incidence of educational subnormality quote figures of between 5-10% of the school population. This rough indication should, from our catchment area, provide more children-in-need than we have places for. An analysis of the handicaps of the children at the Unit shows that we are probably getting almost all of the children in our area who are of subnormal intelligence (I.Q.'s below 70) together with children who are mentally dull (I.Q.'s between 70-85) and who have additional handicaps but none of the children who make up the rest of the group that is classified as being Educationally Subnormal.

"The missing element includes children who may be quite intelligent but because of special difficulties are becoming progressively more retarded. The inclusion of this element would bring the group more into line with the wider definition of the category "educationally subnormal" as defined in the Handicapped Pupils and School Health Service Regulations in 1945. The category is defined as a broad one and draws attention to the educational problem of all seriously backward children not only the small group that are of subnormal intelligence. It makes the category an educational one and avoids stigmatizing the seriously backward as though they were a group apart. A survey to be held in the Whitehaven area at the instigation of the Authority will, in all probability, reveal many seriously re-

tarded children who would benefit from attendance at the Unit.

"Outside of lesson periods the aim is to integrate the Unit with the school. The children from the Unit and children from the Junior School for example, meet together in a small dining room for lunch. The proportion is about half and half. As the space is regarded as being part of the Unit care is taken to make it attractive and good work is displayed to help to create a favourable impression of these new children. There is no suggestion here of rejection of the one group by the other. The whole atmosphere suggests the contrary. Integration between the two groups also takes place at assemblies, playtimes and on any special occasions such as performances in the school hall.

"In the teaching of these children the emphasis in the Progress Unit is on all round development. The aim is simply to be concerned, as a sensible parent would be, in bringing up children, attempting to make the anxious less anxious, the timid less timid, the rough gentle, the closed open, and within this context to achieve learning.

"It is often suggested that the E.S.N. child is not aware of his failings and that the aims of treatment should be the fostering of happiness through compensatory activity. The implication is that E.S.N. children can be happy because of this lack of awareness or because they can develop other skills and interests. Except with children who are very low-grade or mentally ill there is little evidence for this assertion. The great majority of our children are very much aware of their failings, particularly in basic subjects. Indeed many of their behaviour problems and personal difficulties can be attributed to their feelings of inadequacy in these subjects. Therefore efforts are made to raise attainment.

"There is sometimes prejudice against special provisions on the grounds that they set pupils apart as different or inferior. If special educational treatment could be given without singling children out I should be in sympathy with this view. The Progress Unit is an attempt to fulfil a need for special educational treatment whilst seeking to preserve and ultimately improve the child's integration with society as a whole."

2 H.P. EXAMINATIONS COMPLETED IN 1967 UNDER SECTION 34 OR 57.

Recommended Special School—E.S.N.	36
Recommended Special Class—E.S.N.	28
Reported unsuitable for education at school	18
No special educational treatment required	4
Decision deferred	5
Total	91
Number of boys on waiting list for Ingwell School ...	27
Number of girls on waiting list for Higham School ...	11

NEW CASES REFERRED IN 1967

Placed under supervision for further investigation of intellectual capacity	87
Referred by:—	
School Medical Officers	13
Psychologists and Teachers	51
Consultants and Hospitals	17
Health Visitors	3
Others	3
Total	87

Supervision of Educationally Subnormal Leavers

The table on page 70 shows the number of educationally subnormal school leavers in 1965, 1966 and 1967 by distribution for supervision to social welfare officers and health visitors. In fact most of the boys concerned become the charges of the Social Welfare Officer and the girls of the health visitor. The close association of these officers (especially the health visitor) with the family doctor is a strengthening to the follow-up scheme.

The number shown in employment reflects quite a lot of painstaking work by the Social Welfare Officers and health visitors in conjunction with the Youth Employment Officers. Often this begins at one of the handicapped leavers case conferences mentioned above.

SUPERVISION OF EDUCATIONALLY SUB-NORMAL SCHOOL LEAVERS

	1965	1966	1967
Total number of leavers	55	65	73
Placed under supervision of Social Welfare Officers ...	16	17	13
How placed at end of one year:			
(a) employed	9 (10)	7 (9)	5
(b) unemployed	6 (9)	5 (6)	6
(c) unemployable	— (4)	— (—)	2
(d) at training centre	1 (1)	5 (1)	—
Placed under supervision of Health Visitors	23	24	15
How placed at end of one year:			
(a) employed	16 (9)	15 (16)	11
(b) unemployed	4 (4)	7 (4)	4
(c) unemployable	1 (4)	1 (1)	—
(d) at training centre	2 (1)	1 (2)	—

Figures in brackets denote the situation at the end of 1967, of 1965 and 1966 leavers.

DENTAL SERVICE

Mr. R. B. Neal, Principal School Dental Officer, has kindly prepared the following report on the work of the School Dental Service during the year—

"Perhaps the most important long-term achievement in connection with the School Dental Service in 1967 was the advance of preparation for the addition to the public water supply in a large part of West Cumberland, of sodium flouride to the optimum level of 1 part per million. This will take place during 1968 and will constitute a major and positive step forward in preventive dentistry. While the general level of improvement to be expected from this measure in the teeth of developing children, is known, it seemed a sound proposition to try to arrange for an accurate statistical assessment of the benefits of fluoridation as the years pass. I am very glad to say that Professor Jackson, of Leeds University has undertaken to conduct this research by arranging for the examination of the teeth of a sample group of children in the area concerned before the scheme starts and again at selected intervals thereafter. Computer analysis will be employed to show a clear picture of results at 5 and 10 years from the start. I am also grateful to Mr. Peter Townend, Consultant Orthodontist in East Cumberland, for his great interest in this subject.

"Despite many determined efforts, no full-time dental officers have been appointed in 1967 and Cumberland is desperately in need of four dental surgeons to make up the complement. Partial coverage has been arranged for all areas, but this is by no means adequate to provide full conservative and orthodontic treatment to many patients in urgent need. Help has been obtained in Workington on a part-time basis, however, from Mrs. Osuhor, a resident of Workington, who attends the clinic every morning. She is rendering invaluable assistance by freeing Mr. Crabb to attend other clinics.

"It is disappointing to have had the estimate cut again. Many clinics still have dental chairs with hard wooden seats and certainly no convenience from the point of view of the operation. Although the seriously depleted staff is very loyal and undertake extra clinics under these circumstances, one sincerely hopes that the time of severe restraint will soon be over and essential equipment be provided to bring our clinics up to date. One feels very sorry for patients and parents having to wait in a corridor at Park Lane Clinic, Workington,

but this is entirely due to lack of money with which to do the necessary conversion to provide a waiting room. We can only hope it will be provided in the near future, because waiting under such uncomfortable conditions has a most depressing effect on patients.

"Due to shortage of staff and a considerable amount of illness, not all schools have had their annual inspection, but one feels that operative work is more essential in certain areas than an inspection in the school, providing that the interval between inspections is not too great. The primary concern is that no child should suffer pain and that, as far as possible, all conservable teeth are filled. It is still comparatively easy to maintain a full service in East Cumberland, but it is the West that is suffering. Therefore, in order to provide the necessary treatment in certain clinics, two dental officers from Carlisle travel to Salterbeck Clinic, Workington, for one day a week each. This is of course, expensive as regards travelling, but it is well worth the effort, as Salterbeck is a busy clinic and serves a school population of approximately 3,000.

"A dental 'follow-up' scheme has been tried out in Workington with great success, thanks to the Superintendent Nursing Officer and the help which she has provided through school nurses and health visitors. These nurses attend school inspections, taking note of all neglected mouths and then calling at the homes to persuade the parents to ensure that the children receive treatment either from the clinic or a private practitioner. Dental health education has also been a major subject with these nurses and we are most grateful for the enthusiastic way in which they have tackled the problem.

"It is extremely gratifying to see that very many schools in Cumberland do not sell sweets and biscuits now, but have started to sell nuts, potato crisps and, in one or two schools, apples. Children can with patience and co-operation from parents and schools, be taught to eat fewer cariogenic foods but unfortunately it is rare to find these good habits instilled into young children.

"In one new and interesting respect the whole concept of dental treatment is changing, due to the fact that it has been shown that dental auxiliaries are able to carry out routine fillings and extraction of deciduous teeth under local infiltration anaesthesia more successfully in most cases than dental officers are able to. There would seem to be greater

rapport between a child and an auxiliary than there is between the child and a dental officer. This could be due to maternal instinct coming to the fore or merely because the auxiliaries are very much younger and more able to adapt themselves to the child's outlook.

"Now that the time has come when there is a grave national shortage of dentists it is only proper to adjust the school dental service to suit the needs of the patients, and by employing auxiliaries one will be able to serve the public far better and more adequately than has been possible in the past. All the treatment carried out by dental auxiliaries will be prescribed by one of the County dental officers and one can honestly say that the treatment is of an exceptionally high standard. Cumberland hopes to be operating this scheme in 1969.

"The picture of the School Dental Service at the end of 1967 is therefore one of a vigorous and extremely conscientious team of workers, dentists, technicians and chair-side attendants maintaining the good standard of service against the unhappily familiar background of staff and equipment shortages caused by national financial difficulties. At the same time the service is not being deterred from the fullest possible anticipation of new developments in dentistry which promise substantial long term benefits."

PREVENTION OF INFECTION

It is most encouraging to see in the field of vaccination and immunisation work, important developments which should ensure more comprehensive cover of the child population and improved communications between all those concerned in this work. These comprise a somewhat simplified schedule of immunisation procedures for children, linked with the use of a computer to ensure regular smooth call up for immunisation procedures as these become due. The value and effectiveness of the latter has been firmly established in the pioneering authorities who already have this. At last it seems that this sophistication of the service will be possible soon in Cumberland.

The immunisation schedule soon to supersede the present one, no longer involves a reinforcement of diphtheria and tetanus immunisation at 9-10 years, and the possibility of the protection due at school entry being given immediately before that stage, is being discussed with the general practitioners. Changes in vaccination and immunisation arrangements affecting general practitioners in various ways will make for a higher proportion of this work being done by them with the assistance of the nursing staff seconded from the local health authority and forming the family health care team. It is to be hoped that the further help offered by the computer will combine with the other changes to establish an even better overall pattern of vaccination and immunisation for children. Its value will, however, ultimately be measured in terms of improved figures of children fully protected. In the very nature of some of these changes it is quite likely that less immunisation work will be done actually in the schools. No doubt this will be welcome to teaching staffs whose helpfulness and co-operation in this field have always been invaluable.

Protection against Tuberculosis

The twelfth year of B.C.G. vaccination has not seen any significant change in the scheme which was begun in 1956. The school child continues to be screened normally between 12th and 13th birthdays by skin testing; then those showing no evidence of acquired immunity against tuberculosis, are offered B.C.G. vaccination. A routine chest X-ray check of the others is arranged. This is one vaccination which will not be taken over by general practitioners for the technical reason that the vaccine and the administration are, by common consent, best handled in centralised situations.

I am glad to report that parental acceptance of skin testing and possible subsequent B.C.G. vaccination continues at quite a high level—88.7% in 1967. Any parental indifference in giving consent is sad and disturbing in this, as in all fields of immunisation work.

The percentage of children given the Mantoux skin test, who were found positive, was 11.4% in 1967, again a marginal reduction on the previous year. Very broadly speaking this indicates a slight and very slowly continuing decline in the general extent of tuberculous infection in the community. The Mantoux (skin test) negative children were given B.C.G. vaccination and those who were positive (302) were offered chest X-ray. 250 availed themselves of this offer—some improvement in the proportion of the previous year. Fifty-two children were already under surveillance of the Chest Centre and 169 had had B.C.G. vaccination previously for some reason.

Protection against Diphtheria and Tetanus

In 1967 the following numbers of school children were immunised against diphtheria, the figures in brackets referring to the previous years:—

Primary course ...	...	1,130 (916)
Reinforcing injection	...	4,930 (5,472)

For tetanus protection the numbers were:—

Primary course ...	...	1,221 (1,096)
Reinforcing course	...	4,927 (5,118)

These figures continue to leave Cumberland very close to the national average for levels of protection of school children. While the total figure should ideally be over 7,000 protected each year against each of these infections, in practice the 6,000 "barrier" is difficult to break, and as indicated above, I hope for much help in this from the computerisation of data and the related call-up system.

Protection against Poliomyelitis.

In 1967 the total number of children receiving either initial polio vaccination at school (1,426) or school entrant

reinforcement (2,715) was 4,141. Although the figure is down on the previous two years when special efforts had been made to get this area of protection fully up to date in schools, the figure does represent pretty well the whole of one school entrant year group, and so can be regarded as satisfactory. Clearly for safety the figure must be maintained at this level.

Protection against Measles

As this report is being written detailed guidance from the Ministry of Health is awaited on the 1968 measles vaccination effort which has been announced by the Minister. All children up to 15 years who have not previously had measles or been vaccinated against it, will be offered protection by means of one injection. The routine protection of children against measles thereafter will take the form of a single injection in the second year of life.

Infectious Diseases

The table showing cases of infectious diseases in school children in 1967 is on page 77. As usual measles is the notifiable infectious disease which dominates the picture. As stated above, 1968 will see the introduction of a comprehensive measles vaccination scheme for children of school age and under. Although measles has a biennial peak of occurrence, this tends to be in the late autumn and winter months and so any one full calendar year tends to show its quota of cases incurred either at the beginning or the end of the year. This figure should drop away dramatically when the initial vaccination programme is completed.

A few notifications of dysentery appear again and hint at more unnotified cases. Nevertheless the smallness of the number indicates that no sizeable outbreak occurred in the year under review. Unfailing vigilance in the matter of personal, especially hand, hygiene among school children is the only solid safeguard against the spread of this and other gastro-intestinal infections.

CASES OF INFECTIOUS DISEASES IN CHILDREN OF SCHOOL AGE, 1967.

	Scarlet Fever	Whooping Cough	Measles (excluding Rubella)	Dysentery	Meningococcal Infection	Ac. Pneumonia	Food Poisoning	T.B. Respiratory	T.B. Meninges & C.N.S.	T.B. Other	Paratyphoid	TOTAL
URBAN:												
Cockermouth ...	—	1	1	—	—	—	—	—	—	—	—	2
Keswick ...	—	—	—	—	—	—	—	—	—	—	—	—
Maryport ...	—	2	129	—	—	—	—	—	—	—	—	131
Penrith ...	7	—	52	1	—	1	—	—	—	—	—	61
Whitehaven ...	2	—	135	1	1	—	—	—	—	—	—	139
Workington ...	1	4	69	1	—	—	—	—	—	—	—	75
RURAL:												
Alston	—	—	15	—	—	—	—	—	—	—	—	15
Border	4	9	29	—	—	—	—	—	—	—	—	42
Cockermouth ...	6	—	60	—	—	—	—	—	—	—	—	66
Ennerdale ...	—	—	130	1	—	—	—	—	—	1	—	132
Millom	11	—	114	—	—	—	—	—	—	—	—	125
Penrith	2	1	144	—	—	—	—	—	—	—	—	147
Wigton	5	1	14	—	—	—	—	—	—	—	—	20
Total ...	38	18	892	4	1	1	—	—	—	1	—	955

No notifications were received in respect of poliomyelitis, diphtheria and smallpox.

Swimming Baths

The swimming baths associated with schools in the county have continued satisfactorily in 1967 in terms of hygiene. A good working relationship has been established between the baths superintendents and the Medical Officer of Health and Public Health Inspectors of the respective district councils. The latter undertake regular water sampling for bacteriological examination and are in a position to advise the baths superintendents who keep check several times a day on the chlorination and filtration equipment of the pools.

Dr. Smith, Southern Area Medical Officer, comments on the satisfactory water samples produced by Seascale and Millom Schools in 1967 and on the roofing in of the latter pool—a necessary step towards really efficient and consistent water hygiene. Writing on the pool at Wyndham School, comment is made on the temporary occurrence of one of the minor problems which sometimes arise when imbalance occurs for a time in the purifying agents used in bath water, i.e. smarting of the eyes of the swimmers. This is easily remedied. Any occurrence of verrucae in schools is always liable to be attributed to spread of infection on the side-walks of swimming baths and constant attention is necessary to foot disinfection between changing rooms and pools. There has been remarkably little trouble of this kind in association with the school swimming baths in the county.

HEALTH EDUCATION

It seems very clear that for the future, health education in schools must become an ever more smoothly integrated element of education for living as a whole. There is nothing new in this concept—it may indeed be said that only in the measure in which this has been true in the past, has health education been effective and of real value. However newer movements in the education world certainly underline the principle and at the same time, I believe, offer new opportunities in the areas of education in which medical and nursing personnel can play a specialist role, be it a direct or sometimes an indirect one. The movement in schools towards a more broadly based pastoral care of pupils and the development of counselling services make it essential that all those aiming to be of assistance to school children in their development towards personal and social maturity should understand fully each other's part in the enterprise. This involves not only the school nurse and School Medical Officer on the health aspects of life, but the full range of advisers in this field—outstandingly the entire family health care team. Where doctors and nurses fulfil a single health-care function in the family and in the school for a child—i.e. where the family doctor and nurse can become also the school doctor and nurse, an immediate advantage should accrue. With this in mind I am arranging with Mr. Bessey Director of Education, for the doctors in the pilot areas of introduction of general practitioners into the School Health Service to visit the schools in the areas and learn more about some of the aims of schools in the modern setting. I am sure that such contacts will contribute to a more effective integration of health elements in teaching.

Meanwhile, school medical officers and school nurses have taken as full advantage as possible of opportunities to meet boys and girls, in talks and discussion on health topics. I think the following letter addressed to one health visitor after a topic in the school entitled "Before and After Birth", does credit both to the health visitor who conducted the feature and to the development of elegant and poised self-expression in the girl concerned.

"I wish to thank you for your talk on the subject of 'Before and After Birth'. Your method of explanation was easy to understand, and I feel now that my knowledge has been greatly extended on the subject. Prior to your talk it was somewhat limited. I know it may be some time before the knowledge you have given us may be needed to be put

into practice but I feel sure when the time comes to put this knowledge into practice I shall remember your words and approach the situation with a lot more confidence remembering what you have told us. The book you recommended was also very good and has helped me as I am sure it has helped most of us.

"Once again thank you for your most interesting and enlightening talk."

Writing of activities during the year in the Northern Area Dr. Rogers writes:—

"The health visitors continued their role of health educators whilst visiting the schools. They gave talks on mothercraft and personal hygiene. A talk was given on kitchen hygiene to the domestic science class at Longtown School, and an onslaught on the hazards of smoking cigarettes was given in all the secondary schools between 16th January and 1st February. The latter was supported by two excellent colour films. One must express gratitude for the very good co-operation afforded to our staff by the Head Teachers concerned. In some schools the whole programme was completely reorganised in order to allow lectures to be given to the whole school in different age groups."

Touching also on the anti-smoking campaign Dr. Ainsworth, School Medical Officer in the Western Area, writes:—

"I have given some talks in Junior and Senior schools about smoking and its dangers. Certainly I felt in the Junior school this made some impression as the children responded well afterwards with useful and thoughtful questions. In the Senior school one wonders what anti-smoking effect these talks and films have. I feel the appeal through what one gains financially from not spending on smokes carries more weight than damage to health, even although these latter points were dealt with in some detail to try to make an impression.

"My feeling is that to educate against smoking seems most effective in the Junior school age group. In this group few have started to smoke and they seem more willing to accept advice and education against smoking. When children reach the Senior school many have started to smoke in varying degrees and diseases caused by smoking seem so remote to them.

"The anti-smoking films vary very much, I feel, in having a profound effect to persuade children not to smoke. I do think that the film 'Smoking and You' would be sufficient probably at the Junior level, but not of much value at Senior level and for this age group I think 'This is your Lung' has most effect."

Both Dr. Ainsworth and Dr. Marks, School Medical Officer in Southern Area, comment on the opportunities offered by meeting individual children at medical examination, each touching on aspects of personal health and hygiene which have impressed her during the year.

Dr. Ainsworth writes:

"In the field of Health Education one does make use of the school medical inspection to advise individual children on many subjects, e.g. personal hygiene, footwear and feet, try to guide them to make good use of their education to secure the best kind of future.

"One facet that I have been particularly interested in is obesity and one continually tries to educate obese children and their mothers at each school medical inspection. I have followed these children up at each school medical inspection and repeatedly advised about diet and explained why overweight is bad mentally and physically. I must admit it is often a losing battle as so few seem to show any signs of losing weight. Some even do not try, one feels, for one reason or another, e.g. difficulty in altering dietary habits, overeating due to depression, etc. However, in spite of the poor results I feel it is important to persist. Even if it does not improve this generation it must make them more aware of the right type of diet which may have some results when our present school children have homes of their own and become parents."

Dr. Marks writes:—

"Whilst carrying out the periodic medical examinations on the school leavers; 13-14 age group, I have been impressed by the instructions which have been given to the girls in preparing them for the onset of puberty. Talks on hygiene and menstruation have been given at all schools by the Headmistress or School Nurse and some schools have had an illustrated talk by a commercial representative from a firm in the field of menstrual hygiene. All the girls seem to be well informed and thus avoid what could be a lasting psycho-

logical shock if unprepared for the onset of womanhood. About fifty per cent. of the girls examined had commenced to menstruate.

"On the other hand the talks given on personal hygiene did not appear to have gone home so forcibly as the previous ones. The general standard of cleanliness left some room for improvement and this could be raised to a slightly higher level than it is at the moment. It is very nice to see the boys and girls taking an interest in wearing all the latest fashions—short neat skirts; gay colourful underwear, slim tidy trousers, gay warm stockings and shoes, but this must be enhanced by the regular use of soap, water and deodorants. Being well groomed, having nice clean clothes and the knowledge that one is clean and fresh all helps to improve poise and give confidence during the process of growing up.

"Some girls I found to be using make up and cosmetics without proper knowledge of its application, hygiene or cleanliness. This plays an important factor in make up and personal hygiene and I feel that the schools should be given a talk by a beauty expert stressing the proper use of make up in relation to cleanliness.

"Two schools requested the showing of films on anti-smoking as they felt there was a number of adolescents who were smoking and they wished to impress upon them the dangers involved. One private school requested the loan of the films for showing in their own time and they reported that they felt some impact was made on the pupils with these films.

"Two films are usually shown, one stressing what an unpleasant dirty habit smoking can become; the other one shows a serious disease of the lung as the result of heavy smoking. These films are then followed by a short talk and a discussion is invited amongst staff and pupils."

MEDICAL EXAMINATION OF TEACHERS

Full medical examinations (including chest X-ray) are required for certain senior teaching appointments, and for those either taking up a teaching post for the first time or who have had a break in service for a period of 12 months or more; the number of such examinations during the year was 123.

For teaching appointments other than above, the completion of a questionnaire and submission of a certificate of satisfactory chest X-ray is all that is required, and from the information supplied by the candidate an assessment is made whether a medical examination is necessary. During the year 112 such questionnaires were completed.

Two hundred and twenty-one medical examinations were also carried out of candidates for entry to teacher training colleges.

Mr. Gordon S. Bessey, Director of Education, has supplied the following notes on school premises, meals and milk:

School Premises

"The remodelling and extending of Nelson Thomlinson School on the 'Nelson site' was completed. Moorclose Boys' School and Newlands Girls' School, Workington, were opened, the former being a complete new building and the latter an extension and adaptation of the former Newlands Mixed Secondary School. Victoria Girls' School and Wilson Boys' School were closed.

"A youth centre was provided at Aspatria. A kitchen and a progress class unit were added to Hensingham Junior School. A first instalment of new premises was erected for Fairfield Junior School. New premises for Fir Ends School were completed as this report was drafted.

"The managers of the undermentioned schools carried out the development shown:—

Cockermouth R.C.—new premises.

Culgaith C. of E.—remodelled.

Harrington R.C.—second instalment and completion of new premises.

Muncaster C. of E.—remodelled.

Workington St. Patrick's—two instalments of new premises, comprising hall, kitchen and two classrooms.

"Heating improvements were completed or in progress at the undermentioned schools—Arlecdon, Broughton Moor, Cumwhinton, Greystoke, Hallbankgate and The White House.

"The heating plant at the Wigton Baths was improved and converted to oil-firing.

"Improvements were made to the lavatory and sanitary accommodation at Netherhall, Moor Row and Nenthead Schools.

"Considerable improvements were made to the kitchens at Allhallows, Dovenby, Flimby, Lorton and the Valley Schools.

"Five primary schools were closed—Garrigill, Legburthwaite, Newlands C.E., Siddick and Torpenhow C.E.

School Meals

"During 1967 a mid-day meal continued to be made available for all children attending schools maintained by the Authority . A check undertaken on a day in mid-September revealed that 89.3% of children present at school took advantage of this opporunity as compared with 86.97% on a similar day in 1966. Details of the figures for the day in September, 1967, together with similar figures for the previous year are set out below:—

	Primary and Nursery Schools			Secondary Schools			All schools combined		
Year	Number of children present	Number taking meals	Percentage taking meals	Number of children present	Number taking meals	Percentage taking meals	Number of children present	Number taking meals	Percentage taking meals
1967	21,048	18,454	87.7%	14,701	13,479	91.7%	35,749	31,933	89.3%
1966	21,247	17,949	84.5%	14,907	13,494	90.5%	36,154	31,443	86.97%

"New building work together with adaptation and improvement of existing premises, has continued throughout the year. New kitchens have been provided at the following schools:—

Muncaster C. of E.
Hensingham Junior School, Whitehaven.
Overend School, Hensingham.
Moorclose School, Workington.
Newlands School, Workington.
St. Patrick's R.C. Junior School, Workington.

"By the end of 1967 the number of kitchens producing meals had reached 146.

Milk in Schools

"The figures given below show the consumption of milk by children present at maintained schools throughout the County on a day in September, 1967 and for a similar day in September, 1966:—

	Primary and Nursery Schools			Secondary Schools			All schools combined		
Year	Number of children present	Number taking milk	Percentage taking milk	Number of children present	Number taking milk	Percentage taking milk	Number of children present	Number taking milk	Percentage taking milk
1967	21,048	19,011	90.3%	15,025	7,832	52.1%	36,073	26,843	74.4%
1966	21,247	19,261	90.6%	15,213	8,186	53.7%	36,460	27,441	75.2%

"There has again been a fall in the percentage of children taking milk.

"The percentage of pasteurised milk as opposed to untreated milk consumed in schools shows a further improvement. The comparative figures for 1965/66 and 1967 are as follows:—

Untreated milk	1965	11%
	1966	8%
	1967	3%

Physical Education

Years ago, physical education was often regarded as a necessary form of light relief from the rigours and mental strain of work done in the classroom, a time to "let off steam" and stretch the limbs, after long periods of sitting at desks. Since then, the vast expansion with the framework of the words, Physical Education, to include subjects concerned with all kinds of physical activity, has resulted in physical education being regarded as an essential part of every school programme and a subject in its own right.

With the realisation that activities such as golf, badminton, sailing and camping, etc., have greater appeal and are much more likely to be pursued after leaving school than the traditional hockey and gymnastics, much has been done to foster an interest in these and other recreational subjects for older pupils. The wide choice offered provides interest for the individual and enjoyment of that choice, instead of what used to be, in many cases, unwelcome afternoons on the games field, or the impossible task of lifting an awkwardly shaped and reluctant body over a vaulting horse.

In the primary schools much good work is being done in movement training and dance, and courses have been held for teachers which have been very well attended. As new schools are built and old ones are remodelled, often providing a hall for the first time, climbing frames and other equipment, hitherto unknown, provide challenging situations for adventurous children and demand imaginative thinking in their use of it and the space around them.

Swimming continues to be a very popular form of physical education with children of all ages and the numbers wishing to swim outnumber the facilities available. However, the situation is improving with the addition of leisure pools in various parts of the county.

This year the distance certificates issued by the Amateur Swimming Association and the English Schools Swimming Association were introduced into the county with great success. They were eagerly striven for, particularly in the primary schools and notably by one school which conducted its final quota of tests in the river in a torrential downpour.

Another swimming course for primary and secondary school teachers was held for four weeks (on Tuesday evenings) at Wyndham Baths, taken by Miss H. Elkington, the A.S.A. Technical Officer. Much value was derived from this course which was well attended.

Outdoor activities, associated with the outdoor pursuits centres at Hawse End and Denton House, involving environmental studies, canoeing, rock-climbing, ski-ing, mountaineering, expedition and camping training, youth leadership training, Duke of Edinburgh Award pursuits, together with a wide variety of teachers' and youth leaders' courses in this field of physical recreation now provide a well-established entry to the full enjoyment of the Cumberland countryside.

The administration and technical work of the Cumberland and Westmorland Playing Fields Association continues to be undertaken by the Authority's officers as part of the broad concept of the education service in Cumberland. It will be of interest to the Committee to learn that much of the work now falling to the recently sponsored regional sports councils has been accepted by the Association since 1950. Technical advice upon planning, layout, construction and provision of all forms of facilities for physical recreation together with grant applications has been given to local authorities and voluntary organisations in the area during the period under review. Recently, following representations from Appleby and Lazonby the Association undertook a full enquiry into the heating of outdoor swimming pools. A survey of outdoor pools, both heated and unheated, in the area revealed that where an outdoor pool is heated not only is the improved amenity practicable and economical but it also offers increased comfort and enjoyment, the number of people learning to swim is greatly increased, the swimming season is extended and the increased popularity of the facility more than compensates for the expense of the heating installation.

Ehenside School Swimming Pool, Cleator Moor, provides an example of the advantages which may accrue from a heated pool. This pool, constructed in 1964 through voluntary effort at a cost of £7,500, was brought into use in May, 1965. Heating was installed in 1966 and swimming instruction has been given regularly during the year from early March to mid-December at a water temperature of 76 deg. F. The cost of heating during this period was £120, of £470 maintenance cost, for a total number of 17,072 individual swims, or 1.7d. per swim.

The following table of boys' swimming results at Ehenside School offers conclusive evidence of the merits of an outdoor school swimming pool, particularly if heated.

Test.	*Local Authority Bath (April/July)*	*Unheated School Pool (May/Sept.)*	*Heated School Pool (March/Dec.)*
Cumberland L.E.A. Awards			
Breadth	10/15	36	124
Length	20/30	17	96
2nd Class	12	17	64
1st Class	6	12	41

A.S.A. Survival Awards

Bronze	—	10	67
Silver	—	0	32
Gold	—	0	14

R.L.S.S. Awards

Bronze	8	10	27
Award of Merit	0	2	12
Distinction	0	0	3

60% of a total of 260 boys in the school could not swim upon entry. Now, in the fourth year all are swimmers, in the third year one boy cannot swim and in the second year there are three non-swimmers. The first year had ten non-swimmers at the conclusion of the past winter term.

The Cumberland Schools Athletic Association began its season with two residential coaching courses for boys and girls at Keswick in April involving teachers and A.A.A. national coaches. The annual County Athletic Championships were held at Carlisle in June and the National Championships at Peterborough in July. The annual Triangular match was held at Ashington, also in July.

This has been another very successful year for the Cumberland Schools Badminton Association with some outstanding results in the Junior National Tournaments. In the first ever Cumberland open Junior championships Tournament at Carlisle in December, Cumberland and Westmorland carried off the majority of the prizes and repeated this performance at the recent All England Championships. The County team had a convincing victory against Lancashire at Blackpool. Schools' Championships and coaching courses for schools and teachers were held during the season.

Indoor cricket coaching has been arranged in the evenings throughout the winter months at Workington Grammar School and a more intensive course was arranged during the Easter holidays by the Cumberland Schools' Cricket Association.

Matches were played against Lancashire, Northumberland, Durham, Cheshire and Staffordshire, resulting in one win, two losses and two draws. Two international matches were arranged—Under-15, North v. South at Penrith and All-age, North v. India at Workington.

While the regular coaching courses undertaken voluntarily by the teachers of the Cumberland Schools' Football

Association has resulted in a steady improvement in the game at all levels, the numerically superior neighbouring counties place Cumberland at a disadvantage. Losses against Northumberland and North Lancashire were only by the "odd goal" and victories were won by a similar margin against South West Scotland and the Army Apprentices School. The Association is now taking part in a Northern Counties Tournament inaugurated by the E.S.F.A. Keen interest continues to be shown in the three shield competitions arranged within the County.

The Cumberland Schools' Gymnastic Association held its annual championship at Caldew School in December. There are now three sections to cover the full range of ages and abilities of the secondary school. A team of boys is now being trained to take part in the inter-county competition at Preston. A girls' section has been formed and it is hoped that parallel activity to boys gymnastics will be developed by the women teachers in the near future, and with this in view a one-day coaching course for teachers was held at Lillyhall School, taken by Mrs. J. Groome, the national coach.

The activities of the County Hockey Association have been somewhat curtailed as regards matches against other counties due to the restrictions imposed by the Foot and Mouth epidemic. Prior to this, however, an open Tournament was held at Whitehaven and an under-16 Tournament at Wigton. Junior and Senior selection trials for the County teams and coaching also took place.

A Cumberland Schoolgirls' Netball team was formed this season and they started off well by beating Yorkshire. The Senior and Junior teams played matches against Yorkshire, Cheshire, Lancashire, Durham and I. M. Marsh College of P.E., before restrictions, due to the Foot and Mouth epidemic came into force. Cumberland also entered a team in the All England inter-county tournament in London, for the first time for many years. A personal achievement by Rita Wroe must be mentioned. She attended trials in Manchester to select a team from the North West to play Jamaica. Although she was not selected, Miss Wroe was congratulated on her play.

The Cumberland Schools' Rugby League, although small in following and centred only on the west coast, has reflected much credit on the County during the year. Four out of six matches arranged against Lancashire and Yorkshire Schools were won, two boys were selected to represent England

against France and the Chairman has been elected Chairman of the English Schools' Rugby Union at the annual general meeting held at Whitehaven in November.

The increasing popularity of rugby union football among the more populated neighbouring counties is shown in the results of the Cumberland and Westmorland Schools' Rugby Union games. The enthusiasm of teachers, the standard of coaching, the thrust and determination of boys remain as high as ever in the code—other counties are catching up. The 19 Group showed one win, one lost and one drawn while the 15 Group won two matches and sustained four losses. The rugby sevens arranged by Keswick, Ullswater and Millom Schools have again offered a popular attraction associated with the Union's activities. Coaching courses for boys and teachers have been arranged by the Union following attendance by four officers at a central coaching course sponsored by the R.F.U. at Loughborough in September.

The Cumberland Schools' Swimming Association held its Inter-town Gala at Wigton in July. This was followed up by a coaching course for promising young swimmers and selected County swimmers at Carlisle, taken by Miss H. Elkington, the national coach. Eight Cumberland swimmers represented the county after the divisional championships in Lancashire and succeeded in winning a first, three third, one fourth and one sixth positions. W. Burrill, chosen for the Divisional Team, swam in the Medley Relay at the National Gala at Leeds, winning a first badge for the Division and herself.

The Cumberland Schools' Sailing Association is now well established with expertise, equipment and a useful and much improved base at Scarness. The increased demand for sailing in schools has led the Association to revise safety arrangements to produce "standing orders" for officers of the day and to arrange a very popular sailing course for teachers which this year was staffed without outside help.

APPENDIX 'A'

Table A—Periodic Medical Inspections

Age Groups inspected (By year of birth) (1)	No. of Pupils who have received a full medical examination. (2)	PHYSICAL CONDITION OF PUPILS INSPECTED Satisfactory No. (3)	Unsatisfactory No. (4)	Pupils found to require treatment (excluding dental diseases and infestation with vermin) No. of Pupils found not to warrant a medical examination (See Note 1 above) (5)	For defective vision (excluding squint) (6)	For any other condition recorded at Part II (7)	Total individual pupils (8)
1963 and later	57	57	—	—	1	1	2
1962	2125	2125	—	—	77	177	253
1961	1479	1479	—	—	54	143	197
1960	466	466	—	—	18	58	74
1959	1257	1257	—	1715	68	188	256
1958	124	124	—	291	5	7	12
1957	64	64	—	—	5	5	10
1956	56	56	—	—	—	2	2
1955	919	919	—	1546	57	55	112
1954	113	113	—	194	7	3	10
1953	2256	2256	—	—	58	55	113
1952 and earlier	453	453	—	—	27	10	37
TOTAL	9369	9369	—	3746	377	704	1078

Table B—Other Inspections

Number of Special Inspections	162
Number of Re-inspections	5957
Total	6119

Table C—Infestation with Vermin

(a)	Total number of individual examinations of pupils in schools by school nurses or other authorised persons	91087
(b)	Total number of individual pupils found to be infested	175
(c)	Number of individual pupils in respect of whom cleansing notices were issued (Section 54(2), Education Act, 1944)	20
(d)	Number of individual pupils in respect of whom cleansing orders were issued (Section 54(3), Education Act, 1944)	—

Table D—Screening Tests of Vision and Hearing

1.	(a) Is the vision of entrants tested as a routine within their first year at school?	Yes.
	(b) If not, at what age is the first routine test carried out?	—
2.	At what age(s) is vision testing repeated during a child's school life?	At ages 8, 10 and 14.
3.	(a) Is colour vision testing undertaken?	Yes.
	(b) If so, at what age?	14) When choice of occupation or career
	(c) Are both boys and girls tested?	Yes) indicates testing advisable.
4.	(a) By whom is vision testing carried out? ...	School medical officers and school nurses.
	(b) By whom is colour vision testing carried out?	School medical officers and school nurses.
5.	(a) Is routine audiometric testing of entrants carried out within their first year at school? ...	Yes.
	(b) If not, at what age is the first routine audiometric test carried out?	—
	(c) By whom is audiometric testing carried out? ...	County Audiometricians.

Part II—Defects found by Periodic and Special Medical Inspections during the Year.

Defect Code No.	Defects or Disease.	PERIODIC INSPECTIONS Entrants (T)	Entrants (O)	Leavers (T)	Leavers (O)	Others (T)	Others (O)	Total (T)	Total (O)	Special Inspection (T)	Special Inspection (O)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
4	Skin	18	122	16	86	23	130	57	338	10	2
5	Eyes—a. Vision ...	122	490	81	357	174	871	377	1718	18	8
	b. Squint ...	20	39	4	4	9	43	33	86	—	—
	c. Other ...	6	18	2	11	8	24	16	53	—	—
6	Ears—a. Hearing ...	23	164	7	38	59	225	89	427	5	—
	b. Otitis Media	5	133	—	22	12	73	17	228	—	—
	c. Other ...	7	47	2	12	7	59	10	118	—	—
7	Nose and Throat ...	39	480	6	122	41	415	86	1017	—	4
8	Speech	48	116	3	14	20	93	71	223	2	—
9	Lymphatic Glands	3	63	—	6	—	36	3	105	—	—
10	Heart	1	80	1	35	6	84	8	199	—	—
11	Lungs	31	177	3	45	17	199	51	421	—	2
12	Developmental—										
	a. Hernia ...	4	13	2	1	1	11	7	25	—	—
	b. Other ...	6	147	3	31	12	89	21	267	—	—
13	Orthopaedic—										
	a. Posture ...	2	12	—	9	—	15	2	36	—	—
	b. Feet	52	145	5	63	29	105	86	313	3	4
	c. Other ...	24	171	2	50	18	103	44	324	—	—
14	Nervous System—										
	a. Epilepsy ...	3	9	—	7	4	20	7	36	—	1
	b. Other ...	4	24	1	7	3	17	8	48	—	—
15	Psychological—										
	a. Development	2	45	2	25	12	103	16	173	—	—
	b. Stability	27	210	2	21	39	191	68	422	1	2
16	Abdomen	8	23	—	9	10	44	18	76	—	2
17	Other	10	55	5	69	20	123	35	247	6	1

Part III—Treatment of Pupils attending maintained Primary and Secondary Schools (including Nursery and Special Schools).

Table A—Eye Diseases, Defective Vision and Squint.

	Number of cases known to have been dealt with
External and other, excluding errors of refraction and squint	—
Errors of refraction (including squint) ...	3220
Total	3220
Number of pupils for whom spectacles were prescribed	1700

Table B—Diseases and Defects of Ear, Nose and Throat.

	Number of cases known to have been dealt with
Received operative treatment—	
(a) for diseases of the ear	3
(b) for adenoids and chronic tonsillitis	36
(c) for other nose and throat conditions	7
Received other forms of treatment ...	8
Total	54
Total number of pupils in schools who are known to have been provided with hearing aids:—	
(a) in 1967	9
(b) in previous years	63

Table C—Orthopaedic and Postural Defects.

	Number of cases known to have been dealt with
(a) Pupils treated at clinics or out-patients departments	1226
(b) Pupils treated at school for postural defects	—
Total	1226

Table D—Diseases of the Skin.

(excluding uncleanliness, for which see Table C of Part I)

	Number of cases known to have been dealt with
Ringworm—(a) Scalp	—
(b) Body	4
Scabies	25
Impetigo	—
Other skin diseases	55
Total	84

Table E—Child Guidance Treatment.

	Number of cases known to have been dealt with
Pupils treated at Child Guidance Clinics	112

Table F—Speech Therapy.

	Number of cases known to have been dealt with
Pupils treated by speech therapists ...	626

Table G—Other Treatment Given.

	Number of cases known to have been dealt with
(a) Pupils with minor ailments ...	30
(b) Pupils who received convalescent treatment under School Health Service arrangements	35
(c) Pupils who received B.C.G. vaccination	1384
(d) Other than (a), (b) and (c) above	—
Total (a)—(d)	1449

Part IV—Dental Inspection and Treatment carried out by the Authority.

1. *Attendances and Treatment.*

	Ages 5 to 9	Ages 10 to 14	Ages 15 and over	Total
First Visit	4,822	4,757	1,312	10,891
Subsequent Visits ...	3,969	6 432	1,665	12,066
Total Visits	8,791	11,189	2,977	22,957

Additional courses of treatment commenced	119	158	47	324
Fillings in permanent teeth	2,366	8,080	2,719	13,165
Fillings in deciduous teeth	2,316	216	—	2,532
Permanent teeth filled	2,084	7,471	2,516	12,071
Deciduous teeth filled	2,202	207	—	2,409
Permanent teeth extracted	723	2,178	544	3,445
Deciduous teeth extracted	6,475	1,468	—	7,943
General anaesthetics	1,429	597	54	2,080
Emergencies	457	308	79	844

Number of Pupils X-rayed	179
Prophylaxis	394
Teeth otherwise conserved	807
Number of teeth root filled	36
Inlays	21
Crowns	2
Courses of treatment completed	7,373

2. *Orthodontics.*

Cases remaining from previous year	250
New cases commenced during year	155
Cases completed during year	100
Cases discontinued during year	10
No. of removable appliances fitted	258
No. of fixed appliances fitted	3
Pupils referred to Hospital Consultant	140

3. *Prostnetics.*

	5 to 9	10 to 14	15 and over	Total
Pupils supplied with F.U. or F.L. (first time)	—	—	4	4
Pupils supplied with other dentures (first time)	5	53	40	98
Number of dentures supplied	5	62	55	122

4. *Anaesthetics.*

General Anaesthetics administered by Dental Officers	1,398

5. *Inspections.*

(a) First inspection at school.	Number of Pupils	28,256
(b) First inspection at clinic.	Number of Pupils	3,355
Number of (a) + (b) found to require treatment		17,699
Number of (a) + (b) offered treatment		12,066
(c) Pupils re-inspected at school or clinic		679
Number of (c) found to require treatment		338

6. *Sessions.*

Sessions devoted to treatment	2,623
Sessions devoted to inspection	216
Sessions devoted to Dental Health Education	12

APPENDIX B.

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

During the calendar year ended 31st December, 1967:—		(1) Blind (2) Partially sighted		(3) Deaf (4) Partial hearing		(5) Physically Handicapped (6) Delicate		(7) Maladjusted (8) E.S.N.		(9) Epileptic (10) Speech Defects		Total Cols. (1)-(10)
		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
A. How many handicapped children were newly assessed as needing special educational treatment at special schools or in boarding homes?	boys	—	1	1	—	2	2	—	28	—	—	34
	girls	—	1	1	—	—	—	—	13	—	—	15
B. How many children were newly placed in special schools (other than hospital special schools) or boarding homes?												
(i) of those included at A above	boys	—	—	—	—	1	—	—	5	—	—	6
	girls	—	1	1	—	—	—	—	3	—	—	5
(ii) of those assessed prior to January, 1967.	boys	—	—	—	—	1	—	—	6	—	—	7
	girls	—	—	—	—	—	—	—	6	—	—	6
(iii) TOTAL newly placed— B(i) and (ii)	boys	—	—	—	—	2	—	—	11	—	—	13
	girls	—	1	1	—	—	—	—	9	—	—	11

PART II

Children found unsuitable for education at school

During the calendar year ended 31st December, 1967:—

(i) how many children wrere the subject of new decisions recorded under Section 57 of the Education Act, 1944? 22

(ii) how many reviews were carried out under the provisions of Section 57A of the Education Act, 1944? 3

(iii) how many decisions were cancelled under Section 57A (2) of the Education Act, 1944? 1

Handicapped Pupils awaiting places in Special Schools or receiving Education in Special Schools: Independent Schools; in Special Classes and Units; under Section 56 of the Education Act, 1944; and Boarded in Homes.

As at 18th January, 1968:—	(1) Blind (2) Partially sighted		(3) Deaf (4) Partial hearing		(5) Physically Handicapped (6) Delicate		(7) Maladjusted (8) E.S.N.		(9) Epileptic (10) Speech Defects		Total Cols. (1)-(10)
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
A. How many children from the Authority's area were awaiting places in special schools other than hospital special schools?	—	—	—	—	—	—	—	—	—	—	—
(1) Under 5 years of age											
(i) waiting before 1st January, 1967:—											
(a) day places	—	—	—	—	—	—	—	—	—	—	—
(b) boarding places	—	—	—	—	—	—	—	—	—	—	—
(ii) newly assessed since 1st January, 1967:—											
(a) day places	—	—	—	—	—	—	—	—	—	—	—
(b) boarding places	—	—	1	—	—	—	—	—	—	—	1
(2) Aged 5 years and over											
(i) waiting before 1st January, 1967:—											
(a) whose parents had refused consent to their admission to a special school											
(a) day places	—	—	—	—	—	—	—	16	—	—	16
(b) boarding places	—	1	—	—	—	—	—	46	1	—	48

(b) others												
(a) day places	boys	—	—	—	—	—	—	—	8	—	—	8
	girls	—	—	—	—	—	—	—	3	—	—	3
(b) boarding places	boys	—	—	—	—	1	—	1	12	—	—	14
	girls	—	—	—	—	—	—	—	7	—	—	7
(ii) newly assessed since 1st January, 1967:—												
(a) whose parents had refused consent to their admission to a special school												
(a) day places		—	—	—	—	—	—	—	—	—	—	—
(b) boarding places		—	—	—	—	—	—	—	5	—	—	5
(b) others												
(a) day places	boys	—	—	—	—	1	—	—	4	—	—	5
	girls	—	—	—	—	—	—	—	4	—	—	4
(b) boarding places	boys	—	1	—	—	—	2	—	14	—	—	17
	girls	—	—	—	—	—	—	—	5	—	—	5
(3) Total number of children awaiting admission to special schools other than hospital special schools—total of (1) and (2) above												
(a) day places	boys	—	—	—	—	1	—	—	18	—	—	19
	girls	—	—	—	—	—	—	—	17	—	—	17
(b) boarding places	boys	—	2	1	—	1	2	1	54	1	—	62
	girls	—	—	—	—	—	—	—	35	—	—	35

B. How many pupils from the Authority's area were on the registers of:—

(i) Maintained special schools (other than hospital special schools and special units and classes not forming part of a special school) regardless by what authority they are maintained.												
day	boys	—	—	—	—	1	—	—	1	—	—	2
	girls	—	—	—	—	—	—	—	—	—	—	—
boarding	boys	—	—	—	1	—	—	—	49	—	—	50
	girls	—	—	—	—	2	—	—	31	—	—	33
(ii) Non-maintained special schools (other than hospital special schools and special units and classes not forming part of a special school) wherever situated.												
day	boys	—	—	—	—	—	—	—	—	—	—	—
	girls	—	—	—	—	—	—	—	—	—	—	—
boarding	boys	4	—	6	1	3	—	—	—	1	—	15
	girls	2	4	8	4	2	—	—	—	—	—	20
(iii) Independent schools under arrangements made by the authority.												
day	boys	—	—	—	—	—	—	—	—	—	—	—
	girls	—	—	—	—	—	—	—	—	—	—	—
boarding	boys	—	—	—	—	3	—	—	2	—	—	5
	girls	—	—	—	—	2	—	—	—	—	—	2
(iv) Special classes and units not forming part of a special school.	boys	—	—	—	—	—	—	—	—	—	—	—
	girls	—	—	—	—	—	—	—	—	—	—	—

C. How many children from the Authority's area were boarded in homes and not already included in B above.	boys	—	—	—	—	—	—	—	—	—	—	—
	girls	—	—	—	—	—	—	—	—	—	—	—
D. How many handicapped pupils (irrespective of the area to which they belong) were being educated under arrangements made by the authority in accordance with Section 56 of the Education Act, 1944.												
(i) in hospitals	boys	—	—	—	—	6	—	—	—	—	—	6
	girls	—	—	—	—	6	—	—	—	—	—	6
(ii) in other groups, e.g. units for spastics, etc.	boys	—	—	—	—	—	—	—	—	—	—	—
	girls	—	—	—	—	—	—	—	—	—	—	—
(iii) at home	boys	—	—	—	—	1	1	—	—	—	—	2
	girls	—	—	—	—	—	—	—	1	—	—	1
E. Total number of handicapped children requiring places in special schools; receiving education in special schools; independent schools; special classes and units; under Section 56 of the Education Act 1944; and boarded in Homes.	boys	4	2	7	2	16	3	1	124	2	—	161
	girls	2	4	8	4	12	—	—	84	—	—	114

APPENDIX C

SCHOOL HEALTH SERVICE CLINIC AS AT 31.12.67

(Actual school clinic work as distinct from special clinics is being carried out either in conjunction with child welfare clinic sessions or as specially required).

ALSTON:

Dental—2nd and 4th Tuesday—all day.

ASPATRIA:

Dental—1st, 3rd and 5th Friday—all day.
Speech Therapy—Alternate Friday a.m.

BRAMPTON:

Dental—Each Wednesday—all day.
Speech Therapy—Alternate Tuesday and Thursday p.m.

CARLISLE:

Dental—Each Monday and Friday—all day.
At Eden School—as necessary.
At Caldew School—2nd and 4th Friday—all day.
Eye Specialist—Each Wednesday and Thursday a.m.
Orthoptic—Each Wednesday and Thursday a.m.; and each Friday p.m.
Child Guidance—Each Monday a.m.
Speech Therapy—Each Tuesday a.m.; each Thursday a.m.
Orthopaedic Aftercare—Each Wednesday as required.

CLEATOR MOOR:

Dental—Each Monday—all day.

COCKERMOUTH:

Dental—Each Tuesday, Wednesday and Friday—all day.
Speech Therapy—Each Thursday all day.
Eye Specialist—2nd Friday a.m.

EGREMONT:

Dental—Each Monday—all day.
Speech Therapy—Friday a.m.

KESWICK:

Dental—Alternate Thursday—all day.
Speech Therapy—2nd, 3rd and 4th Wednesday p.m.
Eye Specialist—1st Wednesday p.m.

LONGTOWN:

Dental—Each Monday—all day.

MARYPORT:

Dental—Each Wednesday and Thursday—all day.
Speech Therapy—Alternate Thursday p.m.
Child Guidance—Alternate Monday p.m.

MILLOM:

Dental—Each 2nd and 4th Tuesday and Wednesday—all day.
Child Guidance—Thursday p.m. as required.
Eye Specialist—1st and 3rd Friday a.m.
Speech Therapy—Thursday—all day.

PENRITH:

Dental—Each Tuesday, Wednesday, Thursday and Friday—all day.

Speech Therapy—Each Tuesday—all day; each Wednesday a.m.

Orthoptic—Each Wednesday—all day.

SEASCALE:

Dental—Alternate Thursday—all day.

SALTERBECK:

Dental—Each Tuesday and Thursday—all day.

SILLOTH:

Dental—Each Thursday—all day.

WHITEHAVEN (FLATT WALKS):

Dental—Each Monday, Thursday and Friday—all day.

Whitehaven Grammar School—Each Wednesday—all day.

School—Daily a.m. with medical officer attending each Wednesday morning.

Eye Specialist—Each Monday and Friday a.m.

Speech Therapy—Monday p.m., Tuesday a.m., Wednesday p.m. and Friday p.m.

Child Guidance—Each Wednesday p.m.; each Friday a.m.

WHITEHAVEN (MIREHOUSE):

Dental—Tuesday, 1st, 3rd and 5th—all day.

WIGTON:

Dental—Each Monday and Tuesday—all day.

Speech Therapy—Each Friday a.m.

WORKINGTON (PARK LANE):

Dental—Each Monday a.m., Tuesday, Wednesday and Friday—all day.

School—Thursday a.m. (1st Monthly).

Speech Therapy—Each Monday and Tuesday—all day.

Child Guidance—Each Wednesday a.m.

WORKINGTON INFIRMARY:

Eye Clinic—Each Wednesday and Thursday p.m.

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