[Report 1956] / Medical Officer of Health and School Medical Officer of Health, Derbyshire County Council.

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Derbyshire County Council

ANNUAL REPORT

OF THE

COUNTY MEDICAL OFFICER OF HEALTH

For the Year 1956

BY

J. B. S. MORGAN
B.Sc., M.B., B.Ch., L.R.C.P., M.R.C.S., D.P.H.
COUNTY MEDICAL OFFICER OF HEALTH

HEANOR, DERBYSHIRE:
ARTHUR GAUNT & SONS (*PRINTERS*) LTD.

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COUNTY HEALTH COMMITTEE

(As at 31st December, 1956)

ALDERMAN MRS. E. HARRISON
(Chairman)

ALDERMAN MRS. F. E. SHIPLEY
(Vice-Chairman)

Aldermen

MRS. G. BUXTON.
MRS. D. M. SUTTON.
T. W. WARDLEY.
F. WILSON.

Councillors

MRS. A. D. AUSTIN.
N. B. BANKS.
H. R. BENNETT.
R. J. BOAK.
H. G. BOOTH.
J. CARTER.
H. FISHER.
J. H. GREGORY.
J. W. HALL.
MRS. E. G. REDFERN.
E. F. ROWBOTTOM.
J. F. STANIER.
J. H. THOMPSON.
C. WASS.
W. H. WHITEHEAD.
J. WILLIAMSON.
E. WRIGHT.
A. F. T. WYATT.

Co-opted Members

DR. E. C. DAWSON.
A. J. WILSON, ESQ., F.R.C.S.
T. ALLSOP, ESQ.
J. CLARKE, ESQ.
MRS. S. A. JERVIS.
MRS. H. KEMP.
MRS. D. M. ASHLEY.

Ambulance Sub-Committee

ALDERMAN MRS. E. HARRISON.
ALDERMAN MRS. F. E. SHIPLEY.
ALDERMAN T. W. WARDLEY.
COUNCILLOR H. FISHER.
COUNCILLOR C. WASS.
COUNCILLOR A. F. T. WYATT.

Mental Health Sub-Committee

ALDERMAN MRS. E. HARRISON.
ALDERMAN MRS. F. E. SHIPLEY.
ALDERMAN MRS. G. BUXTON.
ALDERMAN MRS. D. M. SUTTON.
ALDERMAN T. W. WARDLEY.
COUNCILLOR N. B. BANKS.
COUNCILLOR MRS. E. G. REDFERN

Staff Sub-Committee

ALDERMAN MRS. E. HARRISON
ALDERMAN MRS. F. E. SHIPLEY.
ALDERMAN MRS. D. M. SUTTON.
COUNCILLOR N. B. BANKS.

Chesterfield Area Health Sub-Committee

Representing the County Council.	*Representing Chesterfield Corporation.*
ALDERMAN MRS. E. HARRISON.	ALDERMAN L. HEATH.
ALDERMAN MRS. F. E. SHIPLEY.	ALDERMAN W. E. TAYLOR.
ALDERMAN J. F. BIRCH.	COUNCILLOR MRS. A. COLLISHAW.
ALDERMAN MRS. D. M. SUTTON.	COUNCILLOR MRS. I .P. HITCHCOCK.
COUNCILLOR N. B. BANKS.	COUNCILLOR J. L. RADFORD.
COUNCILLOR J. CARTER.	COUNCILLOR MRS. A. WILKINSON.

A Joint Medical Services Sub-Committee deals initially with matters which are the joint concern of the Education Committee and the County Health Committee. At 31st December, 1956, its membership was as follows :—

Representing the County Health Committee.	*Representing the Education Committee.*
ALDERMAN MRS. E. HARRISON (*Chairman*).	ALDERMAN MRS. G. BUXTON.
ALDERMAN MRS. F. E. SHIPLEY.	ALDERMAN F. A. GENT.
ALDERMAN MRS. D. M. SUTTON.	COUNCILLOR MRS. O. EDEN.
COUNCILLOR N. B. BANKS.	COUNCILLOR J. B. HANCOCK.

WEIGHTS AND MEASURES AND MISCELLANEOUS SERVICES COMMITTEE

(As at 31st December, 1956)

ALDERMAN MRS. D. M. SUTTON
(*Chairman*)

ALDERMAN C. FEAKIN
(*Vice-Chairman*)

Aldermen

MRS. G. BUXTON.
T. COLLEDGE.
A. FOWLER.

Councillors

D. BARTON.
C. BOOTH.
H. G. BOOTH.
J. BRIGHTMORE.
C. H. CORK.
A. ETHERINGTON.
E. W. FIELDING.
T. T. JENNINGS.
D. LOMAS.
J. G. NEAL.
R. SKELTON.
C. WASS.
A. F. T. WYATT.

Milk Licences Sub-Committee

ALDERMAN MRS. D. M. SUTTON.
ALDERMAN C. FEAKIN.

Rural Water Supplies and Sewerage Act Sub-Committee

ALDERMAN MRS. D. M. SUTTON.
ALDERMAN C. FEAKIN.
ALDERMAN T. COLLEDGE.
COUNCILLOR H. G. BOOTH.
COUNCILLOR A. ETHERINGTON.
COUNCILLOR J. G. NEAL.
COUNCILLOR C. WASS.

To the Chairman and Members of the
Derbyshire County Council,

Ladies and Gentlemen,

I have the honour to present the 67th Annual Report on the health of the County of Derby.

The Birth Rate and Death Rate from all causes per 1,000 of the estimated population, which is 710,600, were respectively 15.34 and 12.29, whereas the corresponding rates for England and Wales were respectively 15.6 and 11.7. The percentage of illegitimate births was 3.46, as compared with 3.61 in the previous year.

There were 7,800 deaths, whereas there were 7,689 in the previous year. Out of 7,800 deaths, 1,788 were certified as being due to heart disease, 1,314 as being due to malignant disease, and 1,094 as being due to vascular lesions of the nervous system. In the case of the 1,314 deaths from malignant disease, it is interesting to observe that the lesion was in the stomach in 205 patients ; in the lung or bronchus in 233 cases ; in a breast in 132 ; and in the uterus in 63.

The headings under which deaths were tabulated were changed in 1950, and consequently the individual figures prior to that year are not strictly comparable with those that have been provided subsequently. It is proposed, therefore, to set out in the following table the deaths from respiratory tuberculosis and cancer of the lungs, only for 1950 and subsequent years :—

Year	*Deaths from*		*Total*
	Respiratory Tuberculosis	*Malignant Neoplasm of lung or bronchus*	
1950 ..	154	141	295
1951 ..	119	157	276
1952 ..	110	167	277
1953 ..	113	165	279
1954 ..	80	165	245
1955 ..	74	173	247
1956 ..	51	233	284

The number of notifications and deaths from all forms of tuberculosis during the last ten years are set out in Table XVI on page 36. From a perusal of that Table it will be seen that the figures are falling, until in the year under review only 372 new cases were notified and 57 deaths recorded.

The number of deaths from respiratory tuberculosis in 1956 was the lowest on record, while the number of deaths from a malignant neoplasm of the lung or bronchus was the highest on record; it is gratifying to be able to mention the former but distressing to report the latter. The provision of better diagnostic facilities may affect the present figures to some extent, but the inspiration of an increasing amount of impurity from the inefficient burning of fuel in the home or factory, from gaseous or particulate matter emitted during industrial processes, and from the smoking of tobacco, may well be contributory causes; it must be conceded, however, that more research is required before dogmatic statements are made on their evaluation as causative factors.

The infantile mortality rate is 24.15 deaths under one year of age per thousand live births, as compared with a provisional figure of 23.8 for England and Wales. Table III on page 21 sets out the figures for Derbyshire since 1930, and shows that the figure for 1956 was the lowest on record. Your attention is drawn to Tables IV and V, on neo-natal mortality, on pages 21 and 22.

Recently, the perinatal mortality rate has taken on a new significance (see page 22). In my opinion an interest in this mortality rate might provide much information on many matters, including the various methods used for making childbirth easier. It is hoped that the appointment of a Senior Medical Officer for Maternal and Child Welfare will enable a closer watch being kept on factors contributing to the perinatal mortality rate and on how they can be prevented.

The maternal mortality rate was 0.62 per thousand live and still births. The figure for the previous year was 0.38, which was the lowest on record. Your attention is drawn to Table IX on page 30 which shows the mortality over the last twenty years.

The number of deaths from coronary disease, including angina pectoris, continues to increase—1,069 in the year under review, compared with 962 in 1955 and 942 in 1954.

I am pleased to report there have been no notifications or death from diphtheria in Derbyshire during the year. In the previous year there was one fatality, but prior to that not a single case had been notified for three years and not a death for six years.

The mental health services in this country, as well as in other countries, leave much to be desired. We are living in an evolving Universe and perhaps it will take many generations before some of the present undesirable practices can be rectified. The Royal Commission on the Law Relating to Mental Illness and Mental Deficiency published their Report in May 1957. The fact that they deliberated for roughly three years and issued a Report of over 300 pages is an indication of the complexity of the mental health problem. Much of what the Royal Commission recommends needs new legislation; on the other hand, many pointers are given that even in the present legislative set-up,

improvements can be made. It will probably take many years before the attitude of the public generally can be changed to mental illness and mental deficiency, but I feel much can be done even now by improving co-ordination and liaison.

I was asked to present the prizes at the Inaugural Re-union of Past and Present Nurses at the Pastures Hospital on the 5th December, 1956, and I thought you might be interested in the following excerpt from my speech, as it touches on a number of the points which are dealt with at length in the Royal Commission's Report :—

"Medicine and Nursing do the greatest good to the greatest number when their functions are complementary to one another. If their functions overlap or do not meet, then they are not so efficient.

Medicine has made great advances, particularly during the last twenty-five years. The techniques that have evolved are in many instances most complicated and as a consequence have tended to increase the number of specialties. Nursing has, therefore, to be as flexible as possible so that it makes its greatest contribution to these advances. At the same time, it would be most unfortunate if in doing so it lost its basic skills. With each wave of new drugs, there seems in the bacteriological world almost a new wave of resistant strains of bacteria ; and under these circumstances reliance must be placed on the time-honoured basic skills, because there is a tendency in the urge for specialisation for them to be forgotten or never learnt. I, therefore, make a plea never to lose sight of the fundamental principles of nursing.

As time passes, I believe there will be a tendency for treatment for physical and mental illness to be merged both in the training of personnel as well as in the siting of hospitals. I think this advance may have to take place in phases. In fact, it is already being phased, for example, in the training of medical students, and psychiatrists deal with cases in out-patient departments of general hospitals. The latter has resulted in a good many patients having adequate treatment in their own homes and the admission of voluntary patients at a probably earlier stage for successful treatment. I gather that many of you nurses after taking the Certificate of the Royal Medico-Psychological Association subsequently take the general training to be a State Registered Nurse, but few in the reverse direction. Personally, I favour all nurses spending some time in mental hospitals before they are allowed to sit for the S.R.N., because only in that way are they fully equipped to deal with any eventuality. In this way the Nurse, whether employed in a hospital, whether it be general or mental, can deal with the situation, and if she is employed in the domiciliary sphere she could give the necessary help to the general medical practitioner, and the consultant psychiatrist, in treating the patient at home. Incidentally, I think that wherever possible patients should be treated at home, but this requires much co-operation from relatives.

I think it is a pity that in the past there has been a tendency to regard mental symptoms as requiring treatment away from the main stream of ill-health. In my opinion we need to reorientate our views regarding the treatment of patients at home, at work and in the hospital. Mental patients must not be stigmatised by having separate treatment from the rest of the patients. The mere fact of having different hospitals and different procedures for admission tends to stigmatise them, and on the top of all this is apt to result in patients hiding their symptoms and consequently delaying treatment, which is so successful if given early.

Doctors and Nurses should in the course of their training have such a knowledge of mental ill-health as to be able to deal with the mentally deranged at home or at work. If in-patient hospital treatment is required, the cases should be dealt with by home nurses and ambulance personnel in the course of their admission in the same way as physical illness. I know in the out-patient departments of general hospitals they are already dealt with similarly, which, of course, is a great advance.

After treatment in hospital, relatives should be just as ready to receive them back again as in physical illness, instead of in some instances placing all kinds of obstructions in the way of their return.

While mental hospitals may not have quite the glamour of general hospitals at the present time, I think they probably make a greater contribution to the sum total of human happiness. If all the members of Committees and the staff engaged in the mental health field will realise this, then they may be encouraged to go forward with their worth-while work.

In speaking to you, I know I am addressing the converted, but I gather that some of the extensions opened by Mr. Turton, the Minister of Health, in the summer at Aston Hall, and some of the extensions opened by Miss Patricia Hornsby Smith, the Parliamentary Secretary to the Minister, a few weeks ago at this Hospital, still cannot be utilised because of the shortage of nursing staff. This is a tragedy and I do hope that men and women will come forward in greater numbers to look after those that are sick in body and mind, for I do not believe there is any more rewarding task in this life."

Dr. Hilliard, the Physician-Superintendent of the Fountain Hospital, was speaking to his paper at a meeting of the Association of Hospital Management Committees at Torquay in May, 1957, on "New Trends in the Mental Deficiency Service," and I was much struck by the following remark that he made—"If you segregate people from the community, they do not learn to live in it."

Undoubtedly the mental health field will undergo a great deal of expansion and it is impossible to forecast precisely what may happen or what duties may be placed on local health authorities under any new legislation, but I am sure that the appropriate Committees of the

County Council will give serious consideration to implementing the recommendations of the Royal Commission for improving the mental health service pending the introduction of legislation.

I should like to take this opportunity of thanking Alderman Mrs. E. Harrison, the Chairman of the County Health Committee, and Alderman Mrs. D. M. Sutton, the Chairman of the Weights and Measures and Miscellaneous Services Committee, for their sympathy and support in enlisting the approval of their respective Committees and the Council to the various measures taken to improve the health of the people of Derbyshire; the Clerk and the Heads of Departments for their co-operation; and all the members of my own Department, but particularly Dr. V. J. Woodward, my Deputy, and Mr. H. R. Pedley, the Chief Clerk, for their efficiency, diligence and loyalty.

I am,

Your obedient Servant,

J. B. S. MORGAN,
County Medical Officer of Health.

County Offices,
St. Mary's Gate,
Derby.

31*st July*, 1957.

MEDICAL AND DENTAL STAFF OF THE COUNTY HEALTH DEPARTMENT
(31st December, 1956)

COUNTY MEDICAL OFFICER OF HEALTH:
J. B. S. MORGAN, B.Sc., M.B., B.Ch., L.R.C.P., M.R.C.S., D.P.H.

DEPUTY COUNTY MEDICAL OFFICER OF HEALTH:
V. J. WOODWARD, M.B., Ch.B., D.P.H.

SENIOR MEDICAL OFFICER FOR MATERNAL AND CHILD WELFARE:
GERTRUDE I. L. VILLIERS, M.B., B.Ch., B.A.O.

SENIOR MEDICAL OFFICER FOR MENTAL HEALTH:
R. M. C. TYNER, B.A., M.B., Ch.B., B.A.O., D.P.H.

SENIOR ASSISTANT COUNTY MEDICAL OFFICER:
A. H. FAIRLAMB, M.B., B.S., D.P.H.

AREA MEDICAL OFFICER FOR CHESTERFIELD BOROUGH:
J. A. STIRLING, *D.S.C.*, M.B., Ch.B., D.P.H.

ASSISTANT COUNTY MEDICAL OFFICERS:
W. J. MORRISSEY, M.B., B.Ch., D.P.H.
A. R. ROBERTSON, M.B., Ch.B., D.P.H.
MARY SUTCLIFFE, M.A., M.B., B.Ch., D.P.H.
C. G. WOOLGROVE, M.B., Ch.B., D.P.H.

COUNTY BACTERIOLOGIST:
J. L. G. IREDALE, M.B., Ch.B., D.P.H.

MATERNAL AND CHILD WELFARE MEDICAL OFFICERS:
DOROTHY M. JACKSON, M.B., Ch.B.
DOROTHY J. PERSEY, M.B., Ch.B., D.C.H., D.R.C.O.G.
MAGRIETA A. PRETORIUS, M.B., Ch.B.
CONSTANCE M. WHITE, M.B., B.S.

ASSISTANT MATERNAL AND CHILD WELFARE MEDICAL OFFICERS:
D. ADAMS, M.B., Ch.B. (from 1/10/56).
M. ALLAN, M.B., Ch.B., D.P.H.
ETHEL BLAKE, M.B., B.Ch., B.A.O., L.M., D.R.C.O.G. (from 3/9/56).
F. J. BURKE, M.D., B.Ch.
G. COCHRANE, M.A., M.B., Ch.B., D.P.H.
J. W. CRAWSHAW, M.B., Ch.B.
R. E. DEAN, L.R.C.P. & S., L.R.F.P.S.
ANNA L. FRENKIEL, M.R.C.S., L.R.C.P., D.R.C.O.G.
WINIFRED GOW, M.B., Ch.B. (from 10/1/56).
ALISON M. HAMILTON, M.B., Ch.B., D.P.H.
H. JAMES, L.R.C.P., L.R.C.S., L.R.F.P.S.G., D.P.H. (Chesterfield B.).
DOROTHEA KOFFMAN, M.D., D.P.H. (from 16/4/56).
MARGARETE KUTTNER, M.D.
JOAN M. B. LEITH, M.B., Ch.B., D.P.H. (Chesterfield B.).
MARGARET S. MAY, M.B., Ch.B.
MEINER MORRIS, M.R.C.S., L.R.C.P. (from 3/9/56).
MARY T. VASS, L.R.C.P.I., L.R.C.S.I., L.M. (from 3/9/56).

DENTAL STAFF:

Chief Dental Officer—
H. E. GRAY, L.D.S.

Dental Officers—
WILMA DRURY, L.D.S. (Part-time) (from 1/10/56).
G. H. FREEMAN (Dentist, 1921).
FLORA M. JACKSON, L.D.S. (Part-time).
ANNIE KEAN, L.D.S. (Chesterfield B.).
A. R. LITTLAR, L.D.S. (Senior Dental Officer, Chesterfield B.).
DOROTHY LITTLAR, L.D.S. (Part-time).

TABLE I.

BIRTH RATE, DEATH RATE, INFANTILE MORTALITY RATE AND DEATH RATES FROM THREE IMPORTANT INFECTIOUS DISEASES DURING THE LAST SIXTY-SIX YEARS.

Year.		*Death Rates per* 1,000 *of Population.*				Birth Rate.	Infantile Mortality per 1,000 Births.
		Small Pox.	Diphtheria & Membranous Croup.	Whooping Cough	Death Rate from all Causes.		
1891 to 1900	WHOLE COUNTY	**.028**	**.17**	**.30**	**17.1**	**33.7**	**147**
	England and Wales	.012	.27	.36	18.3	29.9	153
1901 to 1910	WHOLE COUNTY	**.004**	**.16**	**.24**	**14.1**	**28.5**	**126**
	England and Wales	.016	.17	.27	15.3	27.1	128
1911 to 1920	WHOLE COUNTY	–	**.16**	**.16**	**12.66**	**24.07**	**99**
	England and Wales	.000	.14	.18	13.85	21.90	100
1921 to 1930	WHOLE COUNTY	–	**.07**	**.10**	**10.92**	**19.73**	**70.7**
	England and Wales	.00	.08	.11	12.14	18.36	71.7
1931 to 1940	WHOLE COUNTY	–	**.07**	**.04**	**11.31**	**15.71**	**56.7**
	England and Wales	.00	.07	.04	12.26	14.93	58.6
1941 to 1945	WHOLE COUNTY	–	**.022**	**.026**	**10.94**	**18.21**	**45.6**
	England and Wales	.00	.038	.032	11.92	16.04	49.8
1946	WHOLE COUNTY	–	**.022**	**.023**	**10.96**	**19.60**	**38.95**
	England and Wales	.00	.01	.02	11.5	19.1	43.0
1947	WHOLE COUNTY	–	**.006**	**.026**	**11.26**	**20.89**	**42.81**
	England and Wales	.00	.01	.02	12.0	20.5	41.0
1948	WHOLE COUNTY	–	**.006**	**.015**	**10.42**	**18.13**	**43.45**
	England and Wales	–	.00	.02	10.8	17.9	34.0
1949	WHOLE COUNTY	–	–	**.013**	**10.93**	**17.01**	**36.5**
	England and Wales	.00	.00	.01	11.7	16.7	32
1950	WHOLE COUNTY	–	–	**.014**	**11.13**	**15.78**	**30.19**
	England and Wales	–	.00	.01	11.6	15.8	29.8
1951	WHOLE COUNTY	–	–	**.006**	**11.67**	**15.21**	**28.83**
	England and Wales	.00	.00	.01	12.5	15.5	29.6
1952	WHOLE COUNTY	–	–	**.006**	**10.56**	**15.21**	**29.64**
	England and Wales	.00	.00	.00	11.3	15.3	27.6
1953	WHOLE COUNTY	–	–	**.008**	**10.20**	**15.41**	**28.79**
	England and Wales	.00	.00	.01	11.4	15.5	26.8
1954*	WHOLE COUNTY	–	–	**.004**	**11.55**	**14.86**	**28.03**
	England and Wales	–	.00	.00	11.3	15.2	25.5
1955*	WHOLE COUNTY	–	**.001**	**.003**	**11.67**	**14.66**	**29.14**
	England and Wales	–	.00	.00	11.7	15.0	24.9
1956*	Urban Districts ..	–	–	.003	12.77	14.68	24.46
	Rural Districts ..	–	–	–	11.97	16.02	23.87
	WHOLE COUNTY	–	–	**.0016**	**12.29**	**15.34**	**24.15**
	England and Wales	–	.00	.00	11.7†	15.6†	23.8†

* See remarks at top of page 18. † Provisional.

REPORT ON THE HEALTH OF DERBYSHIRE FOR THE YEAR 1956

STATISTICS AND SOCIAL CONDITIONS

AREA AND POPULATION

The Administrative County of Derby comprises twenty-nine Sanitary Districts, four of which are Municipal Boroughs, sixteen Urban Districts and nine Rural Districts.

The County has an area of 635,456 acres, 98,065 in Municipal Boroughs and Urban Districts and 537,391 in Rural Districts.

The population of the Administrative County as estimated by the Registrar-General at the middle of 1956 was as follows :—

Municipal Boroughs	138,560
Urban Districts	222,540
Rural Districts	349,500
Total Administrative County	710,600

RATEABLE VALUE

The rateable value of the Administrative County in April, 1956, for County Rate purposes was £6,706,860, and a Penny Rate over the whole County was estimated to produce the sum of £25,695.

PHYSICAL FEATURES AND CHIEF OCCUPATIONS

The main industries which give the people of this county occupation, are coal mining carried on in the East and North-East and a small area in the South-Western portion of the County, and agriculture, particularly in the Western and Central parts of the County. The staple industries in the extreme North-Western area adjoining Lancashire are those connected with the cotton trade, whilst in the South-Eastern area adjoining Nottinghamshire the hosiery and lace trades provide the chief occupation. In this area, too, artificial silk manufacturers absorb an appreciable portion of the population. In the Northern and North-Central areas the chief industries are quarrying, limestone crushing and lime burning, working and dressing millstone grit, and silica brick making. A number of these industries come under the heading of "Refractories Industries," some of which are known to pre-dispose to pulmonary disease. In the extreme South-Western portion of the County, pottery manufacture is one of the prominent industries.

VITAL STATISTICS

The Vital Statistics relating to each District in the County for the year under review are given in Table II.

COUNTY OF DERBY. Year

TABLE II.—TABLE GIVING BIRTH RATES AND DEATH RATES FROM SEVERAL

SANITARY DISTRICTS	MEDICAL OFFICER OF HEALTH	Area in Acres (Land and Water).	POP Census 1931
(URBAN)			
ALFRETON	A. Laurie, M.B., Ch.B., D.P.H. ..	5,176	22,262
ASHBOURNE	W. J. Morrissey, M.B., B.Ch., D.P.H.	1,070	4,708
BAKEWELL	C. W. Evans, M.R.C.S., L.R.C.P. ..	3,061	3,028
BELPER	W. J. Morrissey, M.B., B.Ch., D.P.H.	4,294	14,205
BOLSOVER	A. R. Robertson, M.B., Ch.B., D.P.H.	4,526	9,808
BUXTON (Borough)	G. Cochrane, M.B., Ch.B., D.P.H. ..	6,337	16,884
CHESTERFIELD (Borough) ..	J. A. Stirling, M.B., Ch.B., D.P.H. ..	8,472	64,160
CLAY CROSS	J. R. Graham, M.B., Ch.B., D.P.H.	2,349	8,781
DRONFIELD	J. R. Graham, M.B., Ch.B., D.P.H.	3,452	6,388
GLOSSOP (Borough)	M. Sutcliffe, M.B., B.Ch., D.P.H. ..	3,323	20,001
HEANOR	A. Laurie, M.B., Ch.B., D.P.H. ..	4,417	22,482
ILKESTON (Borough)	A. Laurie, M.B., Ch.B., D.P.H. ..	3,017	33,164
LONG EATON	C. G. Woolgrove, M.B., Ch.B., D.P.H.	3,559	23,321
MATLOCK	G. L. Meachim, M.B., Ch.B. ..	16,599	16,596
NEW MILLS	M. Sutcliffe, M.B., B.Ch., D.P.H. ..	5,244	8,626
RIPLEY	A. Laurie, M.B., Ch.B., D.P.H. ..	5,415	17,713
STAVELEY	J. R. Graham, M.B., Ch.B., D.P.H.	6,504	17,845
SWADLINCOTE	M. Allan, M.B., Ch.B., D.P.H. ..	3,755	20,604
WHALEY BRIDGE	G. Cochrane, M.B., Ch.B., D.P.H. ..	3,479	4,860
WIRKSWORTH	W. S. G. Christie, M.B., Ch.B. ..	4,016	4,855
	URBAN DISTRICTS ..	98,065	340,291
(RURAL)			
ASHBOURNE	W. J. Morrissey, M.B., B.Ch., D.P.H.	86,188	11,661
BAKEWELL	H. G. Watson, M.B., Ch.B. ..	85,643	19,272
BELPER	W. J. Morrissey, M.B., B.Ch., D.P.H.	48,074	23,106
BLACKWELL	A. R. Robertson, M.B., Ch.B., D.P.H.	21,668	44,689
CHAPEL-EN-LE-FRITH ..	G. Cochrane, M.B., Ch.B., D.P.H. ..	103,393	18,449
CHESTERFIELD	J. R. Graham, M.B., Ch.B., D.P.H. ..	69,139	64,968
CLOWNE	A. R. Robertson, M.B., Ch.B., D.P.H.	13,429	17,720
REPTON	M. Allan, M.B., Ch.B., D.P.H. ..	65,653	26,438
SHARDLOW	C. G. Woolgrove, M.B., Ch.B., D.P.H.	44,204	41,097
	RURAL DISTRICTS ..	537,391	267,400
	URBAN DISTRICTS ..	98,065	340,291
	WHOLE COUNTY ..	635,456	607,691

* Rates adjusted to make allowance for sex and

Ended December 31st, 1956.

CAUSES IN EACH OF THE SANITARY DISTRICTS OF THE COUNTY.

ULATION				* *Annual Rates per* 1,000 *of Estimated Population*				Infant Death Rate per 1,000 Births
Census 1951	Estimated mid-1956	Births (Live)	Deaths	Birth Rate	Death Rate	Phthisis Death Rate	Respir-atory Death Rate	
23,385	23,480	372	241	15.37	12.11	0.10	1.26	24.19
5,439	5,480	66	90	12.53	10.35	–	0.11	–
3,356	3,530	53	61	15.91	11.92	–	1.76	–
15,714	15,660	179	182	11.32	11.74	–	1.48	33.51
10,817	11,040	214	123	19.38	14.59	–	1.07	28.03
19,568	19,120	322	256	17.68	11.78	0.14	0.74	9.32
68,558	67,240	917	811	13.09	13.15	0.08	1.69	21.81
8,553	8,950	155	98	16.45	13.14	—	1.47	25.80
7,627	8,420	123	80	13.44	11.49	0.14	1.44	24.38
18,004	17,590	244	324	14.43	14.55	0.13	1.39	28.68
24,406	24,080	378	275	15.38	14.16	0.15	1.54	31.74
33,677	34,610	597	320	17.08	12.02	0.08	1.28	21.77
28,641	29,670	412	327	13.75	12.67	0.04	1.47	33.98
17,756	18,270	246	207	13.87	11.11	0.11	0.69	24.39
8,475	8,330	118	118	15.01	13.46	0.11	1.14	25.42
18,192	18,030	295	190	16.52	12.12	0.63	1.02	27.12
17,945	17,510	259	171	14.50	13.18	0.31	1.62	23.16
20,907	19,820	252	201	12.46	12.27	0.06	1.95	35.72
5,365	5,290	76	60	14.94	11.79	–	1.18	–
4,893	4,980	78	57	16.29	11.67	–	1.02	25.64
361,278	361,100	5,356	4,192	14.68	12.77	0.09	1.35	24.46
12,019	11,710	161	100	15.39	9.22	–	0.55	24.84
19,282	18,930	233	236	13.65	11.47	0.05	0.73	30.04
28,193	29,130	376	332	13.68	11.62	0.18	1.09	21.28
43,112	42,950	754	450	17.03	13.31	0.09	1.74	29.17
19,006	18,670	247	248	14.95	12.48	0.05	1.61	28.34
75,745	91,760	1,785	834	18.09	12.54	0.07	1.23	26.33
19,072	19,150	329	201	17.52	12.38	–	1.72	27.35
31,570	34,890	520	444	15.35	11.84	0.08	1.28	21.15
75,893	82,310	1,250	763	14.73	11.12	0.06	0.99	16.00
323,892	349,500	5,655	3,608	16.02	11.97	0.07	1.22	23.87
361,278	361,100	5,356	4,192	14.68	12.77	0.09	1.35	24.46
685,170	710,600	11,011	7,800	15.34	12.29	0.08	1.28	24.15

age distribution of population—see remarks on page 18.

The birth rates and death rates for each County District and for the County as a whole for the years 1954, 1955 and 1956 are not strictly comparable with previous years. The matter is dealt with in Circular M.O.H. No. 3/1955 dated 12th April, 1955, from the Registrar General, the appropriate part of which reads as follows :—

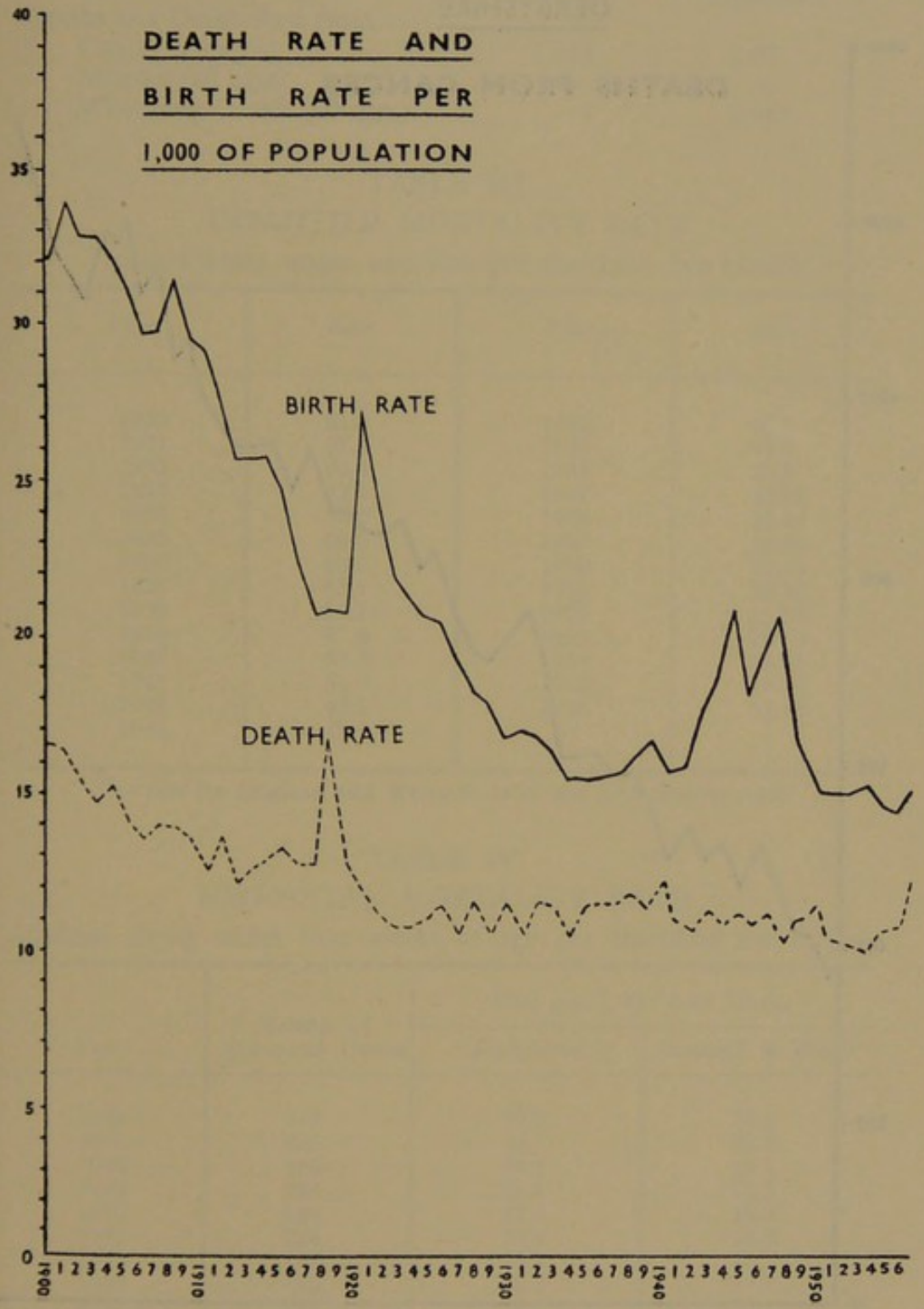
> "To make an approximate allowance for the way in which the sex and age distribution of the local population differs from that for England and Wales as a whole, the crude birth and death rates for the area should be multiplied by the appropriate area comparability factor. When local crude birth and death rates have been so adjusted, they are comparable with the crude rate for England and Wales or with the corresponding adjusted rate for any other area. The present factors are derived from the final 1951 Census populations. A fuller description of the use of the comparability factor for deaths is given in the Registrar General's Statistical Review for England and Wales for the year 1951, Text volume (pages 86 and 87)."

The comparability factors for each County District and for Derbyshire as a whole for the year 1956 have been supplied by the Registrar General.

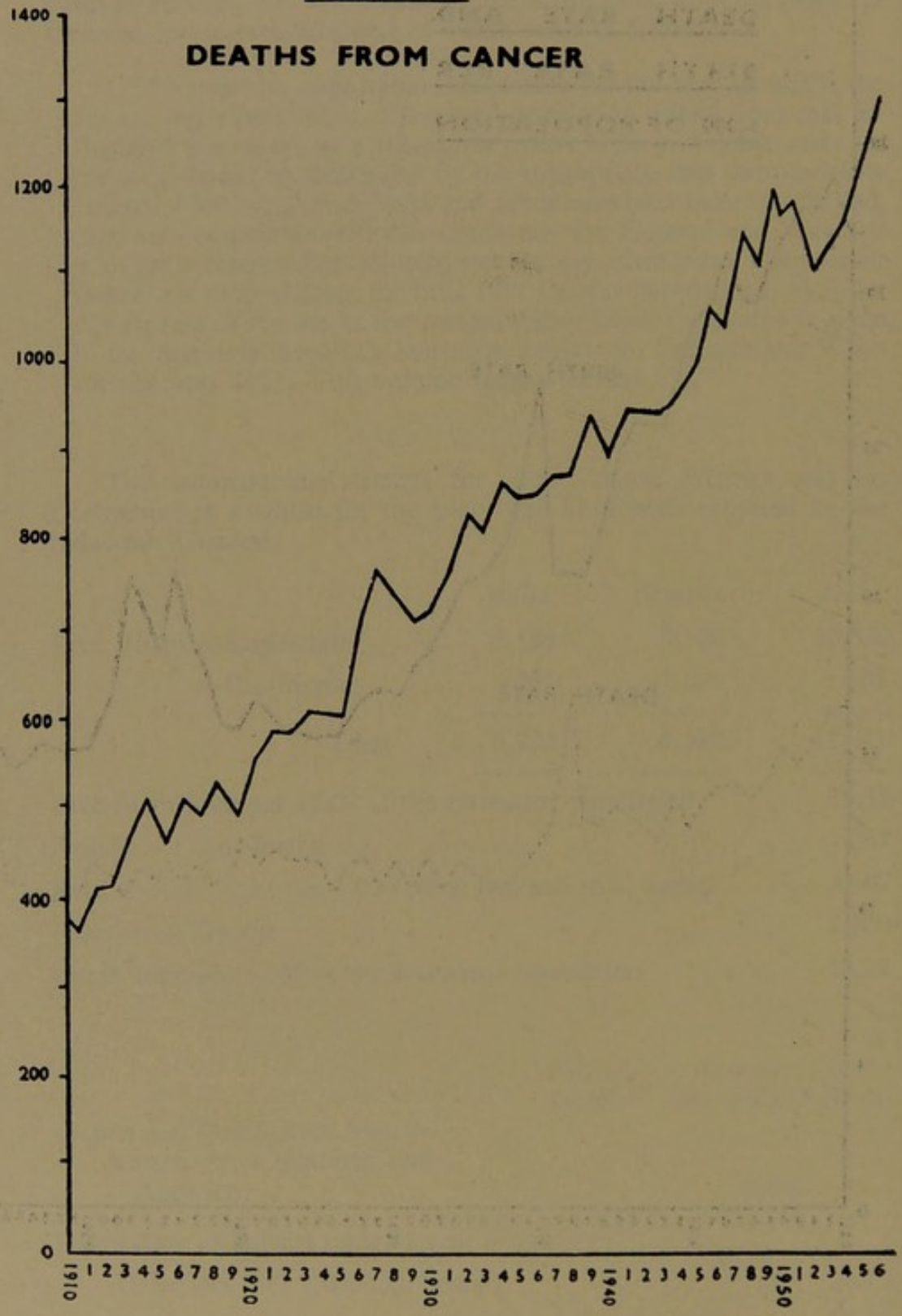
	Males	*Females*	*Total*
Live Births —Legitimate ..	5,500	5,130	10,630
—Illegitimate ..	202	179	381
Total ..	5,702	5,309	11,011

Live Birth Rate per 1,000 of the estimated population ..	15.34
Number of Still Births	267
Rate of Still Births per 1,000 (total live and still) births ..	23.67
Number of Deaths	7,800
Death Rate per 1,000 of the estimated population	12.29

	No. of Deaths	*Rate per 1,000 live and still Births*
Deaths and Death Rate from :—		
Pregnancy, Childbirth and Abortion	7	0.621
Death Rate of Infants under 1 year of age :—		
All infants (per 1,000 live births)		24.15
Legitimate infants (per 1,000 legitimate live births) ..		23.80
Illegitimate infants (per 1,000 illegitimate live births) ..		34.12


DEATH RATE AND
BIRTH RATE PER
1,000 OF POPULATION
BIRTH RATE
DEATH RATE
40
35
30
25
20
15
10
5
0
1900
1910
1920
1930
1940
1950

DERBYSHIRE


DEATHS FROM CANCER
1400
1200
1000
800
600
400
200
0
1910
1 2 3 4 5 6 7 8 9
1920
1 2 3 4 5 6 7 8 9
1930
1 2 3 4 5 6 7 8 9
1940
1 2 3 4 5 6 7 8 9
1950
1 2 3 4 5 6

Deaths and Death Rate from :—	*No. of Deaths*	*Rate per 1,000 of estimated population*
Cancer (all ages)	1,314	2.07
Measles (all ages)	—	—
Whooping Cough (all ages) ..	1	0.001

TABLE III
INFANTILE MORTALITY RATE
(Infants dying under one year per thousand live births)

Year	*Rate*	*Year*	*Rate*
1930 ..	61.4	1944 ..	42.1
1931 ..	67.4	1945 ..	44.5
1932 ..	63.4	1946 ..	38.9
1933 ..	62.2	1947 ..	42.81
1934 ..	53.0	1948 ..	43.45
1935 ..	56.6	1949 ..	36.50
1936 ..	58.2	1950 ..	30.19
1937 ..	52.1	1951 ..	28.83
1938 ..	51.1	1952 ..	29.64
1939 ..	47.4	1953 ..	28.79
1940 ..	55.4	1954 ..	28.03
1941 ..	51.0	1955 ..	29.14
1942 ..	42.2	1956 ..	24.15
1943 ..	48.1		

The rate for England and Wales in 1956 was 23.8 (provisional).

TABLE IV
NEO-NATAL MORTALITY RATE
(Infants dying under four weeks of age per thousand live births)

Year	*Number of Neo-natal Deaths*	*Rate per 1,000 Live Births*	
		Derbyshire	*England & Wales*
1946	293	23.0	24.5
1947 ..	325	23.7	22.7
1948 ..	310	25.5	19.7
1949 ..	243	21.1	19.3
1950 ..	188	17.4	18.5
1951 ..	184	17.6	18.8
1952 ..	197	18.9	18.3
1953 ..	190	17.8	17.7
1954 ..	197	18.9	17.7
1955 ..	210	20.3	17.3
1956 ..	191	17.3	16.9*

* Provisional.

TABLE V

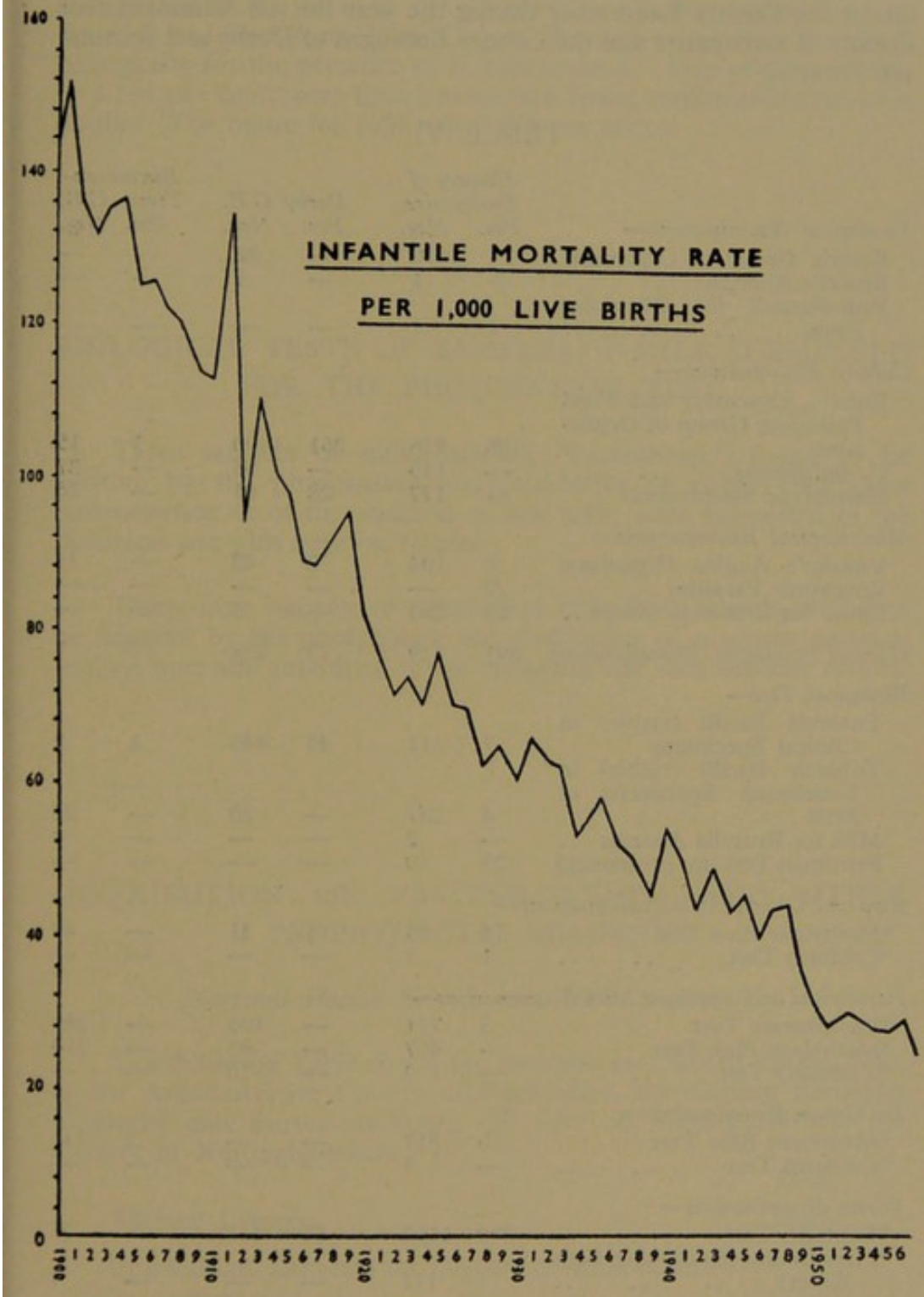
The following Table analyses the causes of death of the 191 children who died during 1956 under four weeks of age, and also shows those who died in the first week :—

Causes of Death	*Number of Deaths under 4 weeks of age*			*Number of Deaths under one week*		
	Males	*Females*	*Total*	*Males*	*Females*	*Total*
Congenital malformations ..	32	26	58	23	20	43
Birth accidents	14	12	26	14	11	25
Infections	18	4	22	11	1	12
Asphyxia	—	3	3	—	3	3
Prematurity	42	29	71	42	28	70
Congenital malformations and prematurity	3	1	4	3	1	4
Birth accidents and prematurity	4	1	5	4	1	5
Infections and prematurity ..	2	—	2	2	—	2
Totals ..	115	76	191	99	65	164

From the foregoing it will be seen that the infantile mortality rate was 24.15 per 1,000, which represents 266 children who died under one year of age (compared with a rate of 23.8 (provisional) for England and Wales). Of the 266 children, 191 (71%) died within four weeks, giving a neo-natal death rate of 17.3 per 1,000 (compared with 16.9 (provisional) for the country). Further, 164 of these infants (61%) died within the first week.

PERINATAL MORTALITY RATE

In a recent Annual Report the Chief Medical Officer of the Ministry of Health referred to the term "perinatal mortality" which was increasingly coming into use to connote a combination of stillbirths with deaths occurring during the whole or part of the neo-natal period. It was hoped by this combination to avoid the fallacies which are liable to occur when the stillbirth and neo-natal mortality rates are considered separately, as in many cases it is merely a matter of chance whether the foetus dies within the womb, in the birth passages, or immediately following birth. The concept of perinatal mortality by providing for consideration a period of time covering these events eliminates the chance effect and may enable a juster estimate to be made of the factors involved in their causation. It was suggested that probably the most useful combination would be stillbirths plus early neo-natal deaths (that is, deaths during the first week). This basis has, therefore, been used in calculating the perinatal mortality rate for Derbyshire for 1956, which is 38.22 per 1,000 total births. (The comparable figure for England and Wales, for the last Quarter of 1956, was 37.7 per 1,000).


INFANTILE MORTALITY RATE
PER 1,000 LIVE BIRTHS
160
140
120
100
80
60
40
20
0
1900 1 2 3 4 5 6 7 8 9 1910 1 2 3 4 5 6 7 8 9 1920 1 2 3 4 5 6 7 8 9 1930 1 2 3 4 5 6 7 8 9 1940 1 2 3 4 5 6 7 8 9 1950 1 2 3 4 5 6

COUNTY BACTERIOLOGICAL LABORATORY

The following Table shows the number of examinations carried out in the County Laboratory during the year for the Administrative County of Derbyshire and the County Boroughs of Derby and Burton-on-Trent :—

TABLE VI

	County of Derbyshire		*Derby C.B.*		*Burton-on-Trent C.B.*	
Serological Examinations—	*Pos.*	*Neg.*	*Pos.*	*Neg.*	*Pos.*	*Neg.*
Enteric Group of Organisms	1	10	—	22	—	—
Brucella Abortus	—	1	—	1	—	—
Paul-Bunnell for Glandular Fever	1	1	—	—	—	—
Culture Examinations—						
Enteric, Dysentery and Food Poisoning Group of Organisms	108	426	261	1990	3	15
C. diphtheriae	—	113	—	55	—	27
Haemolytic Streptococci ..	51	177	28	61	—	26
Microscopical Examinations—						
Vincent's Angina Organisms	1	104	2	48	—	13
Ringworm Parasites	2	—	—	—	—	—
Sputa for Tubercle Bacilli ..	53	885	—	3	—	—
Clinical Specimens (Miscellaneous)	591	819	73	238	7	5
Biological Test—						
Tubercle Bacilli (viable) in Clinical Specimens ..	7	111	45	446	1	8
Tubercle Bacilli (viable) in Unselected Specimens of Milk	4	287	—	20	—	24
Milk for Brucella Abortus ..	—	2	—	—	—	8
Friedman Test (for pregnancy)	25	10	—	—	—	—
Raw and Graded Milk Examinations—						
*Methylene Blue Test ..	14	65	1	31	—	49
*Coliform Test	1	1	—	—	—	—
Pasteurised and Sterilised Milk Examinations—						
*Phosphatase Test	3	721	—	106	—	282
*Methylene Blue Test ..	—	457	—	95	—	214
*Turbidity Test	—	9	—	10	—	—
Ice Cream Examinations—						
*Methylene Blue Test ..	10	317	—	—	2	148
*Coliform Test	—	3	—	—	—	—
Water Examinations—						
*Coliform Test	206	1152	55	513	5	26
*Plate Count (Swimming Bath Water)	7	111	—	—	—	4
Totals ..	1085	5782	465	3639	18	849

* Pos.—Unsatisfactory. Neg.—Satisfactory.

BIOLOGICAL TESTS FOR TUBERCLE BACILLI IN MILK

During the year, 335 unselected samples of milk, including raw and graded milk, taken in the Derbyshire County, Derby County Borough and Burton-on-Trent County Borough areas, were examined biologically for the presence of B. tuberculosis : four of the samples, or 1.194 per cent, were found to contain living transmissible tubercle bacilli. (The figure for 1955 was 0.268 per cent.).

BIOLOGICAL TESTS OF SAMPLES OF MILK SUBMITTED FOR THE PHOSPHATASE TEST

Three samples of milk, labelled "Pasteurised," found to be positive by the phosphatase test (indicative of either insufficient pasteurisation or of the addition of raw milk) were submitted to the biological test with negative results.

Thirty-nine samples of pasteurised milk from schools, found to be negative by the phosphatase test (indicative of adequate pasteurisation) were also submitted to the biological test with negative results.

DISTRIBUTION OF VACCINE LYMPH AND OTHER PROPHYLACTIC REAGENTS

National Health Service Act, 1946, *Section* 26.

The following Table shows the vaccines, etc., issued during 1956, in the Administrative County of Derbyshire, the County Boroughs of Derby and Burton-on-Trent, the City of Nottingham and the County of Nottinghamshire :—

	Doses
Vaccine Lymph	13,261
Prophylactic Reagents for Diphtheria Immunisation :—	
A.P.T.	11,104
T.A.F.	5,455
Gamma Globulin (Measles)	38

INSPECTION AND SUPERVISION OF FOOD

MILK SUPPLY

Fifteen licences were issued to pasteurisers on the 1st January, 1956. During the year two establishments ceased to be used for pasteurisation purposes and the licences were surrendered. The remaining thirteen licences were renewed at the end of the year.

The decline in the number of individual pasteurisation operators has been noted over several years—there were nineteen plants licensed in 1950—and the large private dairy companies, together with the Co-operative Societies, are gradually monopolising the treatment side of the trade.

The County Health Inspector made 262 inspections at pasteurising establishments and submitted 318 samples for examination.

The results are summarised below :—

Grade of Milk	*Satisfactory*		*Unsatis-factory*		*Total Number of samples submitted*
	M.B.	*Phos.*	*M.B.*	*Phos.*	
Tuberculin Tested (Pasteurised)	78	89	—	—	89
Pasteurised	185	227	—	2	229

Note—(*a*) M.B.—Methylene Blue Test ; Phos.—Phosphatase Test.

(*b*) Eleven samples of Tuberculin Tested (Pasteurised) milk and forty-two samples of Pasteurised milk were not subjected to the Methylene Blue Test as the atmospheric shade temperature exceeded 65°F.

There were two phosphatase test failures from the samples submitted. One occurred from a sample taken from an in-bottle pasteurisation plant, but investigations showed that the milk had been bottled and capped and taken to the cold store without being put through the treatment plant. This case gives a clear illustration of the fallibility of the human element. The phosphatase test failures, represented as a percentage of samples taken, is 0.63%. This is a slight increase on the figure for 1955, largely owing to the number of samples submitted being considerably less in 1956.

Fifty-seven samples were examined for the presence of chlorates (a quarterly examination), and none was detected in any of the samples.

The following is a list of the Pasteurising Establishments for which licences were issued for 1956 :—

Name	*Address of Establishment*
Beswick, W.	South Street Dairy, Draycott.
Crowsnest Dairies .. .. .. (Ceased to operate on March 3rd, 1956).	Swarkestone.
Haspel, C. A.	Church Farm, Ockbrook.
Hibbert, H.	Gisborne Dairy, Chapel-en-le-Frith.
Hives, Hon. J. W.	The Bendalls, Milton.
Hutchings, Messrs. S., & Sons ..	175 Derby Road, Long Eaton.
Ilkeston Co-op. Society Ltd. ..	Oakwell Dairy, Derby Road, Ilkeston.
Long Eaton Co-op. Society Ltd. ..	Meadow Lane, Long Eaton.
Longden, A. V.	27 Hardwick Square, Buxton.
Morten, Messrs. R. B., & Son ..	The Creamery, Green Lane, Buxton.
Pleasley Co-op. Society Ltd. ..	Pleasley, Near Mansfield.
Ripley Co-op. Society Ltd.	Nottingham Road, Ripley.
Shaw, R. L. .. .. (Ceased to operate on December 23rd, 1956).	Paddock Farm, West Hallam.
Wheldon, F.	94 Breedon Street, Long Eaton.
Wilts. United Dairies, Ltd.	Egginton Junction, Near Derby.

Specified Areas.

Under the Food and Drugs Act, 1955, sales of milk in a specified area are restricted to "Tuberculin Tested," "Pasteurised," and "Sterilised" grades of milk.

The Districts in the County already specified are as follows :—

	Date of operation
The Borough of Ilkeston. The Urban District of Long Eaton. The Parishes of Sandiacre and Stanton-by-Dale in Shardlow Rural District.	1st November, 1952
The Borough of Chesterfield. The Urban Districts of Bolsover, Clay Cross, Dronfield, Matlock, Staveley and Wirksworth. The Rural Districts of Blackwell and Chesterfield.	1st January, 1954
The Urban District of Swadlincote. The Rural District of Shardlow (excluding the Parishes of Sandiacre and Stanton-by-Dale, already specified).	1st October, 1954
The Parishes of Catton, Castle Gresley, Cauldwell, Coton-in-the-Elms, Drakelow, Linton, Lullington, Netherseal, Overseal, Rosliston and Walton-upon-Trent, all in Repton Rural District.	6th December, 1955

Another Order came into operation on 1st October, 1956, and included in the area concerned were the Urban Districts of New Mills and Whaley Bridge.

It is estimated that out of a County population of 710,600 some 456,500 persons are now covered by these specified Orders, or very nearly two-thirds. The corresponding geographical area covered is approximately one-third, i.e. about 220,000 acres of a total area of 635,456 acres.

Dairy Water Supplies.

Three dairies use water from their own sources. Two have chlorination plants installed and the other uses the water for cleansing only. Seven samples were taken during the year, all being satisfactory.

WATER SUPPLIES

Rural Water Supplies and Sewerage Act, 1944.

The following scheme of water supply has been submitted during the year for consideration by the Rural Water Supplies and Sewerage Act Sub-Committee :—

Authority submitting Scheme	*Parish*	*Estimated Cost*
Belper R.D.C.	Ravensdale Park and Weston Underwood	£2,825

Ministry of Housing and Local Government Inquiries.

Ashbourne R.D.C. Trial Borehole at Yeldersley and Reservoirs at Madge Hill, Atlow.

An inquiry was held on the 18th April, 1956, by an Engineering Inspector of the Ministry of Housing and Local Government into proposals by Ashbourne R.D.C. in connection with the above scheme. Because the total demand for water in the area has risen at a rate far in excess of anticipations, the need for augmenting supplies had become urgent, the Inspector was informed. In addition, water pumps at existing boreholes at Sturston and Yeldersley had been in continuous use at full capacity for a number of years and a breakdown would cause a serious shortage of water. Two reservoirs were proposed at Madge Hill each with a storage capacity of 240,000 gallons. The scheme also included provision for mains from the boreholes to these two reservoirs and extensions in that area.

SEWERAGE AND SEWAGE DISPOSAL

Rural Water Supplies and Sewerage Act, 1944.

The following schemes of sewerage and sewage disposal have been submitted to the Rural Water Supplies and Sewerage Act Sub-Committee during the year :—

Authority submitting Scheme	*Parish*	*Estimated Cost*
Chesterfield R.D.C.	Wingerworth .. .. .. (Birdholme Brook)	£5,388
Chesterfield R.D.C.	Beighton .. .. .. (Woodhouse Lane)	£12,017

MIDWIVES ACTS, 1936 - 1951

The Midwives Acts are administered by the County Council as the Supervising Authority for the whole of the Administrative County, including the Borough of Chesterfield.

Number of Midwives.—At the end of 1956 there were 191 Midwives on the County Roll—seven were Midwives in independent practice ; seven were Midwives working in private Nursing Homes ; seventy-six were Midwives working in Regional Hospital Board Hospitals and Maternity Homes ; and seventy-one were County Midwives and thirty were County Home Nurse/Midwives.

Records Received.—The following Table gives the records received, with corresponding figures for previous years :—

TABLE VII

	1951	1952	1953	1954	1955	1956
Records received :—						
Medical Help	657	510	506	432	433	411
Stillbirths	120	115	92	135	119	118
Deaths of Children	65	79	55	56	68	54
Deaths of Mothers	4	3	1	4	1	2
Laying out the dead	14	14	13	17	13	27
Liability to be a source of infection	46	91	67	66	30	44
Notification of Artificial Feeding (within 14 days)	360	403	427	474	610	623
Puerperal Pyrexia—Midwives' Cases	11	17	18	22	15	10
Ophthalmia Neonatorum—all cases	7	3	4	3	6	4

PUERPERAL PYREXIA

The Puerperal Pyrexia Regulations, 1951, require Puerperal Pyrexia to be regarded as a notifiable disease but with slight modifications, which include a revised definition of the condition. In effect the Regulations apply Sections 144, 145 and 146 of the Public Health Act, 1936, to Puerperal Pyrexia, and at the same time amend Section 144. This means that Puerperal Pyrexia is now defined as "any febrile condition occurring in a woman in whom a temperature of 100.4° Fahrenheit (38° Centigrade) or more has occurred within fourteen days after child birth or miscarriage."

The following Table shows the total number of cases of Puerperal Pyrexia notified to me over the past ten years and the case rate from this condition per 1,000 births. (The figures for 1947 exclude the Borough of Chesterfield).

TABLE VIII

Year	*No. of cases of Puerperal Pyrexia*	*No. of Live Births and Still Births in Whole County*	*Case rate per 1,000 Births*
1947 ..	37	12,637	2.92
1948 ..	33	12,452	2.65
1949 ..	28	11,852	2.36
1950 ..	24	11,295	2.12
1951 ..	21	10,846	1.94
1952 ..	36	10,623	3.39
1953 ..	54	11,272	4.79
1954 ..	44	10,391	4.23
1955 ..	23	10,351	2.22
1956 ..	25	11,021	2.27

MATERNAL MORTALITY

The maternal mortality rate for the whole County for the year 1956 was 0.62 per thousand live and still births. The following Table gives the maternal mortality rate in the County since 1937. (The figures up to and including the year 1947 exclude the Borough of Chesterfield).

TABLE IX

Year	*Rate*	*Year*	*Rate*
1937	3.89	1947	1.11
1938	3.65	1948	0.72
1939	2.15	1949	1.01
1940	2.47	1950	1.44
1941	2.57	1951	1.028
1942	2.43	1952	0.749
1943	2.20	1953	0.55
1944	1.32	1954	0.75
1945	1.42	1955	0.38
1946	1.37	1956	0.62

The Registrar-General makes available to local authorities annual statistics showing the number of deaths occurring in the County under various headings. Up to 1950 two of these headings were entitled "Puerperal and Post-Abortion Sepsis" and "Other Maternal Causes" respectively. These statistics were used to estimate the maternal mortality rate per thousand live and still births, the figure in 1949 being 1.01 per thousand. From 1950 deaths under the above headings have not been categorised in the Registrar's returns, but have been replaced by a single item entitled "Pregnancy, Childbirth, Abortion." For this reason the figures for 1950 and subsequently are not strictly comparable with the Maternal Mortality rates in earlier years.

OPHTHALMIA NEONATORUM

The incidence of Ophthalmia Neonatorum during the year 1956 and the results of treatment are set out in the following Table :—

TABLE X

Notified	*Cases Treated*		*Vision Un-Impaired*	*Vision Impaired*	*Total Blindness*	*No. of Deaths*
	At Home	*In Hospital*				
4	3	1	4	—	—	—

The number of cases and the results of treatment over the past twenty years, are expressed below in tabular form.

TABLE XI

Year	*No. of Cases*	*Vision Unimpaired*	*Vision Impaired*	*Total Blindness*	*No. of Deaths*
1937	35	35	–	–	–
1938	29	24	1	–	4
1939	26	23	–	–	3
1940	17	17	–	–	–
1941	24	23	–	–	1
1942	29	29	–	–	–
1943	31	29	1	–	1
1944	23	22	–	–	1
1945	21	21	–	–	–
1946	14	13	–	–	1
1947	10	10	–	–	–
1948	6	6	–	–	–
1949	*7	6	–	–	–
1950	7	7	–	–	–
1951	7	7	–	–	–
1952	3	3	–	–	–
1953	4	4	–	–	–
1954	3	3	–	–	–
1955	6	6	–	–	–
1956	4	4	–	–	–

* Note—One case transferred out of area.

REGISTRATION OF NURSING HOMES

The County Council acts as the Authority for the Registration of Nursing Homes under Sections 187 to 194 of the Public Health Act, 1936, for the whole of the Administrative County except the Boroughs of Chesterfield, Glossop and Ilkeston, the duties having been delegated to the Corporations of these Boroughs by the County Council under Section 194 of the same Act. Following a report after an inspection by a Medical Officer on the staff of the Health Department, consideration is given by the Weights and Measures and Miscellaneous Services Committee to the registration of premises for an approved number of maternity or general nursing beds.

The position on December 31st, 1956, regarding the Homes registered in the County, except in the Boroughs mentioned above, is shown below :—

Name and Address of Nursing Home	*Accommodation approved*
Portland Nursing Home, "Craiglands," The Park, Buxton	15 Medical Cases.
Lone Oak Nursing Home, Church Side, Hasland	1 Maternity Case.
Derby House Nursing Home, Broad Walk, Buxton	28 Medical Cases.
Ednaston Lodge, St. Mary's Nursing Home, Ednaston	20 Medical and Surgical Cases.
Dalton House, Broad Walk, Buxton ..	16 Medical Cases.
Borrowash House, Borrowash, Derby ..	17 Unmarried Mothers.

TUBERCULOSIS SCHEME

Statistics relating to new cases and deaths from the disease.

The declining incidence of tuberculosis was dealt with at some length in the Annual Report for 1955. Generally speaking this decline has continued during the year under review as the tables given later in the Report will show.

The Public Health (Tuberculosis) Regulations, 1952, require that, "Every medical practitioner who forms the opinion from evidence other than evidence derived solely from tuberculin tests that a person is suffering from tuberculosis shall, as soon as he forms that opinion, send to the Medical Officer of Health of the District in which the person is living at the time a certificate in the form set out in the first schedule to these regulations." A copy of every notification made under the Regulations must be sent to the County Medical Officer as prescribed by the Tenth Schedule of the National Health Service Act 1946 as amended by the Schedule to the National Health Service Act, 1949.

This is the first administrative step in the chain of events which includes the treatment of the patient, the provision of Care and After Care, the prevention of the spread of the disease to others, and the investigation of contacts. These events involve the General Practitioners' Service, the Hospital and Specialist Services, and the Local Authorities, which in Administrative Counties are the Sanitary Authorities as well as the County Councils.

The Ministry of Health have requested that the annual return of primary notifications and new cases coming to the knowledge of the County Medical Officer otherwise than by notification should be rendered in two parts, as follows :—

(1) Those parts of the County in the North Western Region which comprise the administrative areas of Buxton M.B., Glossop M.B., New Mills U.D., Whaley Bridge U.D. and Chapel-en-le-Frith R.D.

(2) The remainder of the Administrative County.

Table XII which follows, gives the relevant figures for the past ten years, showing the Respiratory and Non-Respiratory categories as well as males and females separately. It has not been possible however to divide them throughout this period into the two Hospital Regions as the Ministry of Health requested records to be kept in this way only from 1950. Table XIII, however, which deals only with the year under review, is given in two parts, and shows the North West of the County separately.

TABLE XII

SUMMARY OF NEW CASES REPORTED FROM 1947 UNTIL 1956 INCLUSIVE

	1947	1948	1949	1950	1951	1952	1953	1954	1955*	1956
Respiratory										
Males ..	229	251	295	246	294	276	253	238	204	195
Females ..	182	157	196	180	170	212	169	153	110	126
Total ..	411	408	491	426	464	488	422	391	314	321
Non-Respiratory										
Males ..	62	55	52	49	36	32	23	30	34	23
Females ..	56	50	49	39	47	49	34	32	34	28
Total ..	118	105	101	88	83	81	57	62	68	51
Total Pul. and Non-Pul. ..	529	513	592	514	547	569	479	453	382	372

* The figures in this column have been amended from those shown in the Annual Report for 1955, as it transpired that a number of notified cases had not been reported to me during that year.

As regards the respiratory form of the disease, whilst, as is to be expected, there has been some fluctuation in the numbers reported over the years, nevertheless the figures show a general downward trend.

There was a slight increase in the non-respiratory figures for 1955, but the decrease, which has been noted for a number of years, has continued during the year under review.

Table XIII has again been included in the expanded form which was introduced in 1954, and generally speaking the numbers shown in the various age groups have not varied markedly.

TABLE XIII

New cases of tuberculosis during 1956 either "notified" or coming to the knowledge of the Authority by other means, e.g., death returns from Local Registrars or the Registrar General.

Age Groups ..	0–	1–	2–	5–	10–	15–	20–	25–	35–	45–	55–	65–	75–	*Total All Ages*
Respiratory—														
Males	–	1	3	11	3	6	14	35	41	33	29	17	2	195
Females ..	–	–	1	6	10	13	17	34	25	9	5	4	2	126
Non-respiratory—														
Males	–	–	3	2	3	5	1	–	2	3	1	2	1	23
Females ..	–	–	2	3	2	2	4	6	3	4	–	1	1	28
Total ..	–	1	9	22	18	26	36	75	71	49	35	24	6	372

The above figures are for the whole of the Administrative County and include the numbers of cases reported in the area of the Manchester Regional Hospital Board in Derbyshire, which, however, are shown separately below.

Age Groups ..	0–	1–	2–	5–	10–	15–	20–	25–	35–	45–	55–	65–	75–	*Total All Ages*
Respiratory—														
Males	–	–	–	–	–	–	2	6	5	1	2	–	1	17
Females ..	–	–	–	–	1	1	1	5	2	–	–	–	–	10
Non-respiratory—														
Males ..	–	–	1	–	–	–	–	–	1	–	1	–	–	3
Females ..	–	–	–	–	–	1	–	–	–	2	–	–	–	3
Total ..	–	–	1	–	1	2	3	11	8	3	3	–	1	33

Details of the clinical types of cases reported are shown in the following Table :—

TABLE XIV

Pulmonary	321
Non-pulmonary :—	
Glands	26
Meningitis	4
Bones and Joints	7
Abdominal	5
Genito-Urinary	8
Lupus	—
Other forms	1
Total	372

DEATHS FROM TUBERCULOSIS

As will be seen from Table XV, the deaths from all forms of this disease have been falling rapidly over the last few years ; the figures returned for 1956 are the lowest on record and are only a third of the number recorded in 1950.

TABLE XV

	1950	1951	1952	1953	1954	1955	1956
Respiratory ..	154	119	110	113	80	74	51
Non-respiratory ..	18	23	12	12	12	10	6
	172	142	122	125	92	84	57

The death rates per thousand of the population are as follows :—

	1950	1951	1952	1953	1954	1955	1956
Respiratory ..	0.22	0.17	0.16	0.16	0.11	0.11	0.08
Non-respiratory ..	0.03	0.03	0.02	0.02	0.02	0.02	0.01
	0.25	0.20	0.18	0.18	0.13	0.13	0.09

The provisional figure for England and Wales supplied by the Registrar-General for 1956 is 0.12 deaths per thousand of the home population.

Comparison of the figures of deaths from various causes, as given in Appendix II, reveals the fact that tuberculosis is not now the killing disease that it was in the past. A number of factors, including the higher standard of living, early detection of the disease, combined with improved methods of treatment, have all played their part in bringing about this satisfactory state of affairs, but, of course, there should be no relaxation in the campaign against the disease.

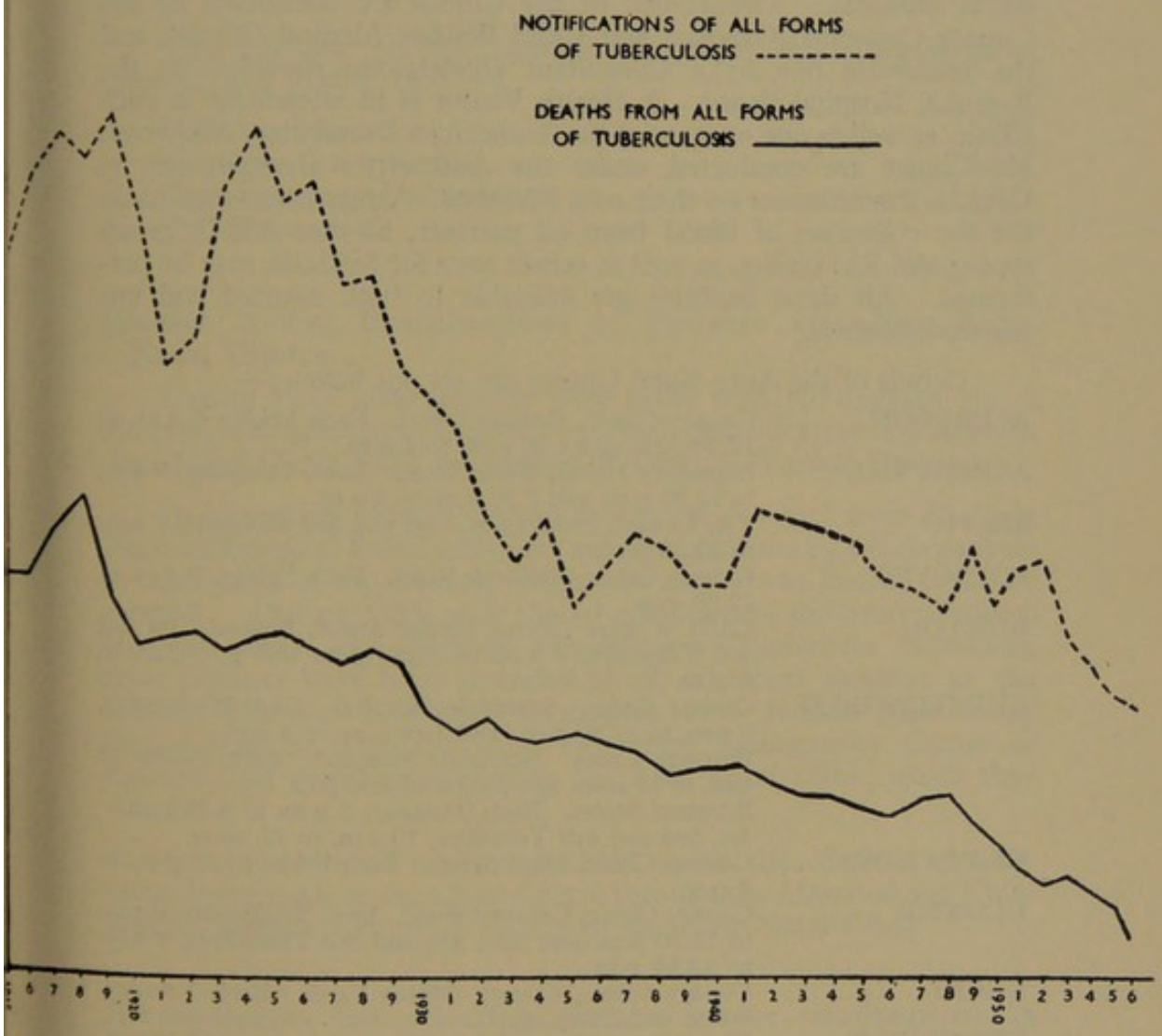
The table below shows the notifications and deaths in Derbyshire for the last ten years.

TABLE XVI

Year ..	*New Cases*	*Deaths*	*Year*	*New Cases*	*Deaths*
1947 ..	529	242	1952 ..	569	122
1948 ..	513	243	1953 ..	479	125
1949 ..	592	205	1954 ..	453	92
1950 ..	514	172	1955 ..	*382	84
1951 ..	547	142	1956 ..	372	57

* This figure has been amended from that shown in the Annual Report for 1955 as it transpired that a number of notified cases had not been reported to me during that year.

TUBERCULOSIS



NATIONAL HEALTH SERVICE ACT, 1946
CARE OF MOTHERS AND YOUNG CHILDREN
(Section 22)

ANTE-NATAL SCHEME

Ante-Natal Clinics.

Twenty-three Ante-Natal Clinics are maintained by the Authority: seven in Municipal Boroughs, twelve in Urban Districts and four in Rural Districts. Twenty-two of the Clinics are conducted by the County Council's Maternal and Child Welfare Medical Officers, and the remaining one by a Consultant Obstetrician provided by the Regional Hospital Board. A Health Visitor is in attendance at each Clinic, as well as one or more of the Authority's Domiciliary Midwives. No Clinics are conducted under the Authority's arrangements by General Practitioners on their own premises. Arrangements are made for the collection of blood from all patients, so that A.B.O. group typing and Rh. typing, as well as serum tests for Syphilis, may be performed. All these facilities are available to both married and unmarried mothers.

Details of the Ante-Natal Clinics are set out below :—

ALFRETON ..	County Clinic, Grange Street. Each Friday, 9 a.m. to 12.30 p.m. and 1.30 p.m. to 4 p.m.
ASHBOURNE ..	Maternity Home, Green Road. Each Thursday, 9 a.m. to 12.30 p.m. and 1.30 p.m. to 4 p.m.
BELPER	The Cedars, Field Lane. 1st and 3rd Mondays, 9 a.m. to 12.30 p.m.
BOLSOVER ..	County Clinic, Welbeck Road. Each Friday, 9 a.m. to 12.30 p.m.
BUXTON	Child Welfare Centre, Bridge Street, Buxton. 1st and 3rd Tuesdays, 9 a.m. to 12.30 p.m. and 1.30 p.m. to 4 p.m.
CHESTERFIELD	County Cases. Scarsdale Hospital. Each Wednesday, 9 a.m. to 12.30 p.m. and 1.30 p.m. to 4 p.m. Borough Cases. Scarsdale Hospital. Each Friday 10 a.m. to 12 noon and 2 p.m. to 4.30 p.m. Edmund Street. Each Tuesday, 2 p.m. to 4.30 p.m. 1st, 3rd and 4th Tuesdays, 10 a.m. to 12 noon.
CLAY CROSS ..	County Clinic, High Street. Each Friday, 1.30 p.m. to 4 p.m.
CLOWNE	County Clinic, Creswell Road. Each Wednesday, 9 a.m. to 12.30 p.m. and 2nd, 4th and 5th Thursdays, 9 a.m. to 12.30 p.m.
DERBY	County Clinic, County Offices Yard. Each Tuesday, 9 a.m. to 12.30 p.m.
DRONFIELD ..	The Grange. 2nd and 4th Mondays, 9 a.m. to 12.30 p.m.
ECKINGTON ..	Wesleyan School. 1st, 3rd and 5th Thursday, 9 a.m. to 12.30 p.m. and 1.30 p.m. to 4 p.m.
FRECHEVILLE ..	County Clinic, Fox Lane. 1st, 3rd and 5th Mondays, 9 a.m. to 12.30 p.m. and 1.30 p.m. to 4 p.m.
GLOSSOP ..	Municipal Buildings. 2nd and 4th Mondays, 9 a.m. to 12.30 p.m.
HEANOR ..	County Clinic, Wilmot Street. 1st and 3rd Wednesday, 1.30 p.m. to 4 p.m.
ILKESTON ..	County Clinic, Albert Street. 2nd and 4th Mondays, 2 p.m. to 4 p.m. and each Thursday 1.30 p.m. to 4 p.m.

LONG EATON ..	4 Nottingham Road. Each Wednesday, 9 a.m. to 12.30 p.m. and 1.30 p.m. to 4 p.m.
MATLOCK ..	Dean Hill House, Causeway Lane. 1st and 3rd Thursday, 9 a.m. to 12.30 p.m.
RIPLEY	Cottage Hospital. 2nd and 4th Fridays, 1.30 p.m. to 4 p.m.
SHIREBROOK ..	Cliff House, Church Drive. Each Monday, 9 a.m. to 12.30 p.m.
STAVELEY ..	County Clinic, Lime Avenue. 2nd and 4th Thursdays, 9 a.m. to 12.30 p.m. and 1.30 p.m. to 4 p.m.
SWADLINCOTE..	County Clinic, Alexandra Road. 2nd and 4th Tuesdays, 9 a.m. to 12.30 p.m.

The following are the number of sessions and attendances at these Clinics during 1955 :—

Half-day Sessions	1,321
Number of new Cases	3,837
Total number of attendances	15,018
Post-Natal visits	619

Routine X-Ray Examinations of Patients attending Ante-Natal Clinics.

During 1953, arrangements were made with Nottingham No. 2 Hospital Management Committee by which patients attending Ilkeston Ante-Natal Clinic could be x-rayed at Ilkeston General Hospital.

In November 1954, a circular letter was received from Sheffield Regional Hospital Board which set out arrangements by which patients in other parts of the County, within the area of the Board, could be x-rayed. During 1955, with the co-operation of the other Regional Hospital Boards and Hospital Management Committees concerned, these facilities have been extended to all expectant mothers in the County, who may now avail themselves of a routine chest x-ray during pregnancy, at the Mass Miniature Radiography Centre or Camera Unit most convenient to the Ante-Natal Clinic which they attend.

Special ante-natal sessions are held at all the centres, appointments being made at the Chest Centre through the Maternal and Child Welfare Medical Officer in charge of the Ante-Natal Clinic.

Arrangements for selecting women whose confinement in Hospital is recommended on medical or social grounds.

The provision of Hospital accommodation for maternity cases is the responsibility of Regional Hospital Boards. To facilitate the administrative arrangements concerning the large number of patients desiring hospital or maternity home accommodation, Bed Bureaux have been set up at Chesterfield and Derby by the Sheffield Regional Hospital Board. Forms of application for admission are available at the Authority's ante-natal clinics, and these are passed to the respective Bed Bureaux.

Where admission to a hospital bed is recommended on medical grounds, this is sufficient to ensure invariably that a bed is made available, providing arrangements are not left until the last moment. In most cases, however, applications are based on social need, and such cases are referred to this authority for a report on the home circumstances. In the light of that report, which is made after a visit to the patient's home by one of the Health Visitors, a recommendation is made as to the necessity for a Hospital or Maternity Home bed.

In practice the scheme has worked smoothly and no changes are envisaged at the present time.

The following is an analysis of cases visited by Health Visitors for a report on the home circumstances :—

DERBY BED BUREAU	
Suitable for home confinement	30
Hospital accommodation desirable but not essential	76
Home conditions unsuitable and hospital confinement necessary	270
Miscellaneous visits (i.e. cancellations, miscarriages, removals from district, etc.)	1
CHESTERFIELD BED BUREAU	
Suitable for home confinement	70
Hospital accommodation desirable but not essential	294
Home conditions unsuitable and hospital confinement necessary	600
Miscellaneous visits (i.e. cancellations, miscarriages, removals from district, etc.)	5
OTHER HOSPITALS OUTSIDE THE AREAS OF THE DERBY AND CHESTERFIELD BED BUREAUX	
Suitable for home confinement	—
Hospital accommodation desirable but not essential	93
Home conditions unsuitable and hospital confinement necessary	127
Miscellaneous visits (i.e. cancellations, miscarriages, removals from district, etc.)	1

CHILD WELFARE CENTRES

During 1956, Gleadless and Tupton Infant Welfare Centres were opened.

The number of sessions and attendances at the County Council Infant Welfare Centres during 1956 are set out below :—

Half-day sessions	4,163
Number of new cases under one year of age	6,565
Number of children who attended during the year and who were born in :—	
1956	7,455
1955	4,720
1954-51	4,290
Total number of children who attended during the year	16,465
Number of attendances made by children who, at the date of attendance, were :—	
Under one year	77,546
One but under two	16,262
Two but under five	11,190
Total attendances during the year	104,998

CARE OF PREMATURE INFANTS

(i.e., Babies weighing 5½ lbs. or less at birth).

Local Health Authorities are required by the Ministry of Health to provide statistics about premature babies. Since the inception of the National Health Service information has been obtained from hospitals regarding premature births and the survival of premature infants in hospitals, and from Local Health Authorities in respect of births at home or in Private Nursing Homes, together with information from both sources in respect of infants admitted to hospital after birth elsewhere. It was found by the Ministry of Health that this dual source of information gave rise to considerable inaccuracies and discrepancies in the returns, and as a consequence it was considered appropriate for the Local Health Authority, as the Authority ultimately responsible for the care of all infants in its area, whether born at home or in hospital, to assume responsibility for the collection and transmission of information in respect of all premature infants. Accordingly, from the beginning of 1953, the statistics provided by the Local Health Authority relate to hospital births as well as domiciliary and nursing home births, thus constituting a complete record of the occurrence of each premature birth (live and still) and of the survival of premature infants in the area of the Local Health Authority.

Statistics for the year 1956 are set out below :—

Number of premature live births notified (as adjusted by transfer notifications) :—

(*a*)	In Hospital	538
(*b*)	At Home	196
(*c*)	In private Nursing Homes	38
	Total..	772

Number of premature stillbirths notified (as adjusted by transfer notifications) :—

(*a*)	In Hospital	98
(*b*)	At Home	22
(*c*)	In private Nursing Homes	2
	Total..	122

Of the 538 premature live births who were born in hospital thirty-six died within twenty-four hours of birth and 473 survived twenty-eight days.

Of the 196 born at home, thirty-eight were transferred to hospital on or before the twenty-eighth day, and of the remainder eleven died within twenty-four hours of birth and 143 survived twenty-eight days.

Of the thirty-eight born in Private Nursing Homes thirty-five survived twenty-eight days, and two died within twenty-four hours.

The Council's Home Help Scheme is available for premature infants, provided the need is certified by the Doctor attending the case.

The Council has agreed to the provision of certain equipment for the domiciliary nursing of premature infants. No charge will be made for the loan of the equipment but if it is damaged, other than that which can be accounted for by fair wear and tear, the actual cost of repair or replacement will have to be paid.

The equipment will be issued in units and each unit will comprise the following articles :—

1. One Cot Set consisting of (*a*) One Cot, (*b*) Two Cot Ends, (*c*) Four Rails, (*d*) Four Lining Rods, (*e*) One Tray, (*f*) One Box, (*g*) One Key.
2. Two Cot Linings.
3. One Cot Mattress.
4. Four Cot Blankets.
5. One Feeding Bottle.
6. One Mucus Catheter.
7. Two Hot Water Bottles.
8. One Hot Water Bottle Cover.
9. One Mackintosh Sheet.
10. One Thermometer.
11. One Set of Premature Infant Clothing comprising (*a*) Two Vests, (*b*) One Gown without hood, (*c*) Two Gowns with hood.

In the event of a Unit being required for a patient under the care of a doctor or midwife, the following should be approached as appropriate :—

Northern part of the County excluding the Borough of Chesterfield.

	Telephone Nos.
Miss M. Blackbird, Supervisor of Midwives, County Clinic, Brimington Road, Chesterfield.	Day—Chesterfield 2773. Night—Chesterfield 6288.

Chesterfield Borough only.

Mrs. S. M. Street, Supervisor of Midwives, Town Hall, Chesterfield.	Day—Chesterfield 3232, Ext. 256. Night—Ashover 284.

Southern part of the County.

Miss M. C. Jackson, Supervisor of Midwives, County Offices, St. Mary's Gate, Derby.	Day—Derby 47131, Ext. 112. Night—Duffield 2101.

Supply of Dried Milks, etc.

The County Council has for many years supplied Dried Milks and certain proprietory preparations at Infant Welfare Centres and

Ante-Natal Clinics at cost price. At Ante-Natal Clinics simple preparations of iron in tablet form (Tab. Ferri Sulphatis Co.) and also of calcium with vitamins (Tab. Calciferol Co.) are prescribed by the Clinic Medical Officers in suitable cases. The range of preparations sold varied in different parts of the County, and during 1953 an enquiry was started whereby the opinions were sought of all the Maternal and Child Welfare Medical Officers and the Health Visitors, as to what should constitute a restricted list of preparations which could be supplied at all County Clinics. Meetings were also held with Health Visitors and Doctors, and as a result a list of preparations was selected which produced the greatest measure of agreement, not only amongst the Health Visitors but also the Medical staff.

The list which was published in my Annual Report for 1955 was again considered at a meeting of the Department's Medical Officers held at Clowne Clinic in October of the year under review, when particular attention was given to the possibility that excessive Vitamin D may be responsible for otherwise unexplained illness in babies. It is now thought that hypercalcaemia may be related to the excessive intake of Vitamin D. Dried milks as well as cereals are fortified, and if a baby takes Cod Liver Oil he may well be receiving something like 2,000 international units instead of the originally recommended 600 to 700. There are children who appear to be sensitive to Vitamin D and react unfavourably to this increased dosage. As a result of the discussions between the Medical staff it was agreed that Cod Liver Oil Emulsion be deleted from the approved list and that Lactagol be added. The revised list is now as follows :—

Virol.
Maltoline with Iron.
Colact.
Rose Hip Syrup.
Adexolin in Liquid Form.
Lactagol.

WELFARE FOODS SERVICE

The distribution of Welfare Foods during 1956 followed the same lines as in previous years. Total issues of National Dried Milk and Cod Liver Oil fell by approximately 3% and 5½% respectively, while those of Vitamin A and D Tablets and Orange Juice rose by approximately 7% and 9½% respectively. As before, demands for Cod Liver Oil were greatest during the winter whereas those for Orange Juice in the Summer. The figures of Welfare Foods issued in the County area during the year ended 31st December, 1956 are as follows :—

	National Dried Milk	*Cod Liver Oil*	*Vitamin A. & D. Tablets*	*Orange Juice*
Issued against coupons—				
(*a*) By stamps	347,673	—	—	404,598
(*b*) Free	4,469	75,205	34,306	4,281
Issued to—				
N.H.S. Hospitals ..	1,158	—	—	1,097
Day Nurseries	205	698	—	1,784
Issued at full price ..	1,451	—	—	—
Totals ..	354,956	75,903	34,306	411,760

It was found possible to effect some economies by revising the times of openings at a few of the less busy distribution centres. This was done by reducing the days of opening at Ashbourne, Belper, Chapel-en-le-Frith and Glossop, with a corresponding reduction in the services of the staff employed at these places. On the other hand, owing to increased demand and at the request of the Health Visitor, it was found necessary to distribute Welfare Foods each week for the Infant Welfare Centres at Brimington, Eckington and Killamarsh instead of on alternate weeks as before. In order to allow staff to attend at these and other Clinics the distribution Centre at the Divisional Welfare Office, Newbold Road, Chesterfield is now closed on Tuesday, Wednesday and Thursday afternoons.

Arrangements were also made for Welfare Foods to be available at the Infant Welfare Centres which were opened at New Tupton and Gleadless, and distribution at Whitwell was transferred to the Infant Welfare Centre at the Parish Hall from the Methodist Church Schoolroom. The voluntary distribution centre at Hillstown was discontinued in November as issues were negligible, the mothers in this area obtaining their requirements from the County Clinic at Bolsover.

With the exception of Hillstown all existing distribution centres continued their activities. Details of the distribution centres are set out below :—

ALFRETON URBAN DISTRICT

4 Church Street, Alfreton	Monday to Friday, 9.15 a.m. to 12.45 p.m., 2 p.m. to 5 p.m., except 1st and 3rd Thursday afternoons in month. Saturday, 9 a.m. to 12 noon.
Mission Room, Ironville	4th Friday, 3.30 p.m. to 4.30 p.m.
Social Service Centre, Swanwick ..	4th Thursday, 2 p.m. to 4 p.m.

ASHBOURNE URBAN DISTRICT

4 Town Hall Yard, Ashbourne ..	Tuesday and Thursday, 9.15 a.m. to 12.45 p.m. 2 p.m. to 5 p.m. Saturday, 9 a.m. to 12 noon.
Clinic, St. John Street, Ashbourne ..	Wednesday, 2 p.m. to 4 p.m.

ASHBOURNE RURAL DISTRICT

Rose Bank, Kirk Ireton	Any time.
School House, Kniveton	Any time.
Post Office, Yeaveley	Shop hours.

BAKEWELL URBAN DISTRICT

Town Hall, Bakewell	Monday, 9.15 a.m. to 12.45 p.m., 2 p.m. to 5 p.m. Saturdays 9 a.m. to 12 noon.
Clinic, Town Hall, Bakewell ..	2nd and 4th Wednesdays, 1.30 p.m. to 4 p.m.

BAKEWELL RURAL DISTRICT

Abney House, Baslow	1st Wednesday, 2 p.m. to 4 p.m.
Clinic, Memorial Hall, Bradwell	1st and 3rd Tuesdays, 2 p.m. to 4 p.m.
Calver Chapel, Calver	1st Wednesday, 3 p.m. to 4 p.m.
Williams Deacons Bank, The Square, Eyam	2nd and 4th Thursdays, 1.30 p.m. to 3.30 p.m.
Kenwood House, Grindleford ..	1st and 3rd Thursdays, 1.30 p.m. to 3.30 p.m.
The Vicarage, Great Longstone ..	2nd and 4th Wednesdays, all day.
Lathkill Cottage, Over Haddon ..	Alternate Thursdays, 1.30 p.m. to 3.30 p.m.
Clinic, Methodist Chapel, Hathersage..	1st and 3rd Thursdays, 1.30 p.m. to 3.30 p.m.
St. John's Comfort Centre, Church Lane, Rowsley	Alternate Wednesdays, 2 p.m. to 4 p.m.
Clinic, Wesleyan Chapel Schoolroom, Tideswell	2nd and 4th Tuesdays, 1.30 p.m. to 3.30 p.m.
Mr. J. Burton, Main Street, Winster	Shop hours.
Clinic, Village Hall, Youlgreave ..	Alternate Tuesdays, 1.30 p.m. to 3.30 p.m.

BELPER URBAN DISTRICT

County Clinic, Field Lane, Belper	Monday, 9.15 a.m. to 12.30 p.m. Tuesday and Thursday, 9.15 a.m. to 12.45 p.m. 2 p.m. to 5 p.m. Saturday, 9 a.m. to 12 noon.
The Bridge Stores, Milford.. ..	Friday, 9 a.m. to 5 p.m.

BELPER RURAL DISTRICT

Clinic, British Legion Club, Allestree	Tuesday, 2.30 p.m. to 4.30 p.m.
Clinic, Devonshire Street Schoolroom, Ambergate	1st and 3rd Mondays, 2.30 p.m. to 4 p.m.
Tor Cafe, Crich	Shop hours.
Post Office Stores, Derby Road, Denby	Shop hours.
1 Milford Road, Duffield	Tuesday, 2.30 p.m. to 5 p.m.
Mr. D. Mackenzie, Holloway ..	Shop hours.
35 Highfield Road, Kilburn ..	Shop hours.
Main Road Stores, Smalley ..	Tuesday, 2 p.m. to 4 p.m.
Woodland View Cafe, Whatstandwell	Alternate Wednesdays, 2 p.m. to 4 p.m.

BOLSOVER URBAN DISTRICT

County Clinic, Welbeck Road, Bolsover	Monday and Thursday, 9.15 a.m. to 12 noon. Tuesday and Friday, 9.15 a.m. to 12.45 p.m., 2 p.m. to 5 p.m. Saturday, 9 a.m. to 12 noon.
Clinic, Colliery Schools, New Bolsover	2nd and 4th Thursdays, 2 p.m. to 4 p.m.

BLACKWELL RURAL DISTRICT

Jackson Memorial Hall, Doe Lea	Alternate Tuesdays, 3 p.m. to 4.15 p.m.
Young Vanish Inn, Glapwell	Alternate Tuesdays, 3.30 p.m. to 4.30 p.m.
St. John's Ambulance Hall, Langwith	Monday, 2 p.m. to 3 p.m.
Mission Room, Langwith Junction	Monday, 3.30 p.m. to 4.30 p.m.
Welfare Foods Van, Tennyson Way, Mickley	Alternate Mondays, 2 p.m. to 2.45 p.m.
Clinic, Crompton Street Chapel, New Houghton	1st and 3rd Thursdays, 2 p.m. to 4 p.m.
Clinic, Church Hall, Newton	2nd and 4th Thursdays, 2 p.m. to 4 p.m.
Westmoorland House, Palterton	Alternate Wednesdays, 3 p.m. to 4 p.m.
Slade Lane Chapel, Pinxton	Tuesday, 2 p.m. to 4 p.m.
Cliff House, Church Drive, Shirebrook	Wednesday, 10 a.m. to 12 noon, 2 p.m. to 4 p.m.
Bethel Methodist Chapel, South Normanton	Alternate Tuesdays, 2.30 p.m. to 4 p.m.
Elm Tree Inn, Scarcliffe	1st and 3rd Tuesdays, 2 p.m. to 4 p.m.
Church Hall, Tibshelf	1st and 3rd Thursdays, 2 p.m. to 4 p.m.

BUXTON BOROUGH

18-20 High Street, Buxton	Monday to Friday, 9.15 a.m. to 12.45 p.m., 2 p.m. to 5 p.m. Saturday, 9 a.m. to 12 noon.
Clinic, Child Welfare Centre, Buxton	Monday, 2 p.m. to 4 p.m.

CHAPEL-EN-LE-FRITH RURAL DISTRICT

Mr. A. F. Hancock, Bamford	Shop hours.
Mr. W. M. Howe, Bamford	Shop hours.
Mr. A. F. Hancock, Castleton	Shop hours.
Schools Canteen, Eccles Road, Chapel-en-le-Frith	Friday, 9.15 a.m. to 12.45 p.m., 2 p.m. to 5 p.m.
Mr. J. Woodward, Marple Road, Charlesworth	Shop hours.
Clinic, Lower Lane, Chinley	1st and 3rd Wednesdays, 2 p.m. to 4 p.m.
Clinic, Methodist Schoolroom, Hayfield	1st and 3rd Tuesdays, 2 p.m. to 4 p.m.
Mr. A. F. Hancock, Hope	Shop hours.

CHESTERFIELD RURAL DISTRICT.

Clinic, Women's Institute, Ashover	2nd and 4th Fridays, 2 p.m. to 3.45 p.m.
Clinic, Trinity Chapel Schoolroom, Brimington	Thursday, 2 p.m. to 4 p.m.
Clinic, Church Schoolroom, Beighton	Alternate Mondays, 2 p.m. to 4 p.m.
Clinic, Congregational Chapel, Calow	2nd and 4th Mondays, 2 p.m. to 4 p.m.
Clinic, Memorial Chapel, Eckington	Monday, 2 p.m. to 4 p.m.
Clinic, Fox Lane, Frecheville	Friday, 2 p.m. to 4 p.m., also 2nd and 4th Wednesdays, 2.30 p.m. to 4 p.m.
Clinic, Methodist Chapel, Grassmoor	Alternate Wednesdays, 2.30 p.m. to 4 p.m.
Clinic, St. Peter's Church, Basegreen, Gleadless	Wednesday, 2 p.m. to 4 p.m.
Clinic, Mission Church, Holmwood	Alternate Wednesdays, 2 p.m. to 4 p.m.
Clinic, Village Hall, Holymoorside	4th Tuesday, 2 p.m. to 4 p.m.
Clinic, Bridge Street, Killamarsh	Tuesday, 2 p.m. to 4 p.m.
Community Hut, Masborough	Alternate Mondays, 11 a.m. to 12 noon.
Clinic, Church Hall, Main Road, New Tupton	2nd and 4th Fridays, 2 p.m. to 4 p.m.

Clinic, Miners' Welfare Institute, North Wingfield	1st, 3rd and 5th Thursdays, 2 p.m. to 4 p.m.
Clinic, Rupert Street, Pilsley ..	1st and 3rd Thursdays, 2.30 p.m. to 3.30 p.m.
Memorial Hall, Ridgeway	Alternate Fridays, 2.30 p.m. to 3.30 p.m.
Clinic, Zion Methodist Chapel, Stonebroom	Alternate Mondays, 3 p.m. to 4 p.m.
Clinic, Methodist Schoolroom, Unstone	3rd Tuesday, 2 p.m. to 4 p.m.

CHESTERFIELD BOROUGH

Divisional Welfare Office, Newbold Road, Chesterfield	Monday and Friday, 9.15 a.m. to 12.45 p.m., 2 p.m. to 5 p.m. Tuesday, Wednesday and Thursday, 9.15 a.m. to 12 noon. Saturday, 9 a.m. to 12 noon.
Town Hall, Chesterfield	Monday to Friday, 9.15 a.m. to 12.45 p.m., 2 p.m. to 5 p.m. Saturday, 9 to 12 noon.
Clinic, Edmund Street, Whittington Moor, Chesterfield	Monday and Wednesday, 2 p.m. to 4.30 p.m.
Clinic, Village Hall, Hasland Park, Chesterfield	Tuesday, 2 p.m. to 4 p.m.
Clinic, Jawbones Hill, Derby Road, Chesterfield	Monday, 2 p.m. to 4.30 p.m.
Clinjc, Wellington Street, New Whittington, Chesterfield ..	Tuesday, 2 p.m. to 4.30 p.m.
Clinic, Gospel Mission, Old Road, Brampton	Thursday, 2 p.m. to 4 p.m.

CLOWNE RURAL DISTRICT

County Clinic, Creswell Road, Clowne	Tuesday, 2 p.m. to 4 p.m.
Methodist Chapel, Creswell ..	Alternate Tuesdays, 2 p.m. to 3.45 p'm.
Clinic, Parish Hall, Whitwell ..	2nd and 4th Thursdays, 2 p.m. to 4 p.m.

CLAY CROSS URBAN DISTRICT

County Clinic, High Street, Clay Cross	Tuesday, 9.15 a.m. to 12.45 p.m., 2 p.m. to 5 p.m. Thursday and Saturday, 9 a.m. to 12 noon.

DERBY BOROUGH

3 Bold Lane, Derby..	Monday to Friday, 9.15 a.m. to 12.30 p.m., 1.45 p.m. to 5 p.m. (except Thursday afternoons). Saturday, 9 a.m. to 12 noon.

DRONFIELD URBAN DISTRICT

Clinic, The Grange, Dronfield ..	Monday, 2 p.m. to 4 p.m., also 2nd and 4th Monday, 9.30 a.m. to 12 noon.
76 Carr Lane, Dronfield Woodhouse	Alternate Tuesdays, 2 p.m. to 4 p.m.

GLOSSOP BOROUGH

Municipal Buildings, Glossop ..	Tuesday and Thursday, 9.15 a.m. to 12.45 p.m. 2 p.m. to 5 p.m. Saturday, 9 a.m. to 12 noon.
Clinic, c/o The Library, Hadfield ..	Alternate Wednesdays, 2.30 p.m. to 4 p.m.

HEANOR URBAN DISTRICT

County Clinic, Wilmot Street, Heanor	Monday to Friday, 9 a.m. to 12.45 p.m., 2 p.m. to 5 p.m. Saturday, 9 a.m. to 12 noon.

ILKESTON BOROUGH

County Clinic, Albert Street, Ilkeston	Monday to Friday, 9.15 a.m. to 12.45 p.m., 2 p.m. to 5 p.m. (except Thursday afternoon). Saturday, 9 a.m. to 12 noon.
Clinic, Wesley Street Schoolroom, Cotmanhay	2nd and 4th Thursday, 2 p.m. to 4 p.m.

LONG EATON URBAN DISTRICT

County Clinic, 4 Nottingham Road, Long Eaton	Monday, 9.15 a.m. to 12.15 p.m. Tuesday to Friday, 9.15 a.m. to 12.45 p.m., 2 p.m. to 5 p.m. Saturday, 9 a.m. to 12 noon.
St. Andrew's Church Hall, Tamworth Road, New Sawley ..	Thursday, 2.30 p.m. to 4 p.m.

MATLOCK URBAN DISTRICT

County Clinic, Causeway Lane Matlock	Tuesday to Friday, 9.15 a.m. to 12.45 p.m., 2 p.m. to 5 p.m.
Mrs. M. Prince, Ember Lane, Bonsall	Any time.
Mr. R. Carter, Chemist, Market Place, Cromford	Shop hours.
Sub Post Office, Darley Bridge ..	Daily 9 a.m. to 5 p.m. (except Thursday afternoons).
Sub Post Office, Dale Road North, Darley Dale	Shop hours, excluding Saturday.
Spa Medical Stores, Matlock Bath..	Tuesday, 9 a.m. to 6 p.m.
The Korna Stores, Tansley ..	Shop hours.
Sub Post Office, Wensley	Shop hours.

NEW MILLS URBAN DISTRICT

County Clinic, High Lea Hall, New Mills	Monday and Thursday, 9.15 a.m. to 12.45 p.m. 2 p.m. to 5 p.m.

REPTON RURAL DISTRICT

The Schools, Bretby	Alternate Wednesdays, 3 p.m. to 4 p.m.
General Stores, Linton Road, Castle Gresley	Shop hours.
Parish Room, Etwall	Wednesday, 2.30 p.m. to 4.30 p.m.
Avenue Stores, Gresley	Shop hours.
General Stores, Hartshorne ..	Shop hours.
Public Hall, Scropton Road, Hatton	Wednesday, 2 p.m. to 4 p.m.
Main Street, Hilton	Wednesday, 2 p.m. to 4 p.m.
Clinic, Methodist Church, Station Road, Mickleover	2nd and 4th Thursday, 2 p.m. to 4 p.m.
Church Farm, Netherseal	Any time.
Clinic, Methodist Chapel, Woodville Road, Overseal	1st and 3rd Fridays, 2 p.m. to 4 p.m.
Clinic, The Village Hall, Repton	2nd and 4th Tuesdays, 2 p.m. to 4 p.m.
Parish Room, Rosliston	Alternate Wednesdays, 1.30 p.m. to 3.30 p.m.
Post Office, Walton-on-Trent ..	Shop hours.
General Stores, 68 Swadlincote Road, Woodville	Shop hours (excluding Saturdays).

RIPLEY URBAN DISTRICT

Shirley House, Shirley Road, Ripley	Monday to Friday, 9.15 a.m. to 12.45 p.m., 2 p.m. to 5 p.m. Saturday, 9 a.m. to 12 noon.
Clinic, Church School, Heage ..	2nd and 4th Wednesdays, 2 p.m. to 4 p.m.

SHARDLOW RURAL DISTRICT

Clinic, Nunsfield House, Boulton Lane, Alvaston	Thursday, 10 a.m. to 12 noon, 2 p.m. to 4 p.m.
Clinic, Memorial Hall, Aston-on-Trent	1st and 3rd Tuesdays, 2 p.m. to 4 p.m.
Clinic, Women's Institute, Victoria Avenue, Borrowash ..	1st and 3rd Mondays, 2 p.m. to 4 p.m.
Clinic, Church of Christ, Reginald Road, Chaddesden	Wednesday, 10 a.m. to 12 noon, 2 p.m. to 4 p.m.
Clinic, Methodist Chapel, High Street, Chellaston	2nd and 4th Tuesdays, 2 p.m. to 4 p.m.
Clinic, New Church Hall, Draycott	2nd and 4th Wednesdays, 2 p.m. to 4 p.m.
Clinic, Co-operative Guild Room, Little Eaton	2nd and 4th Mondays, 2 p.m. to 4 p.m.
Grange Hall, Park Lane, Littleover	1st and 3rd Tuesdays, 2 p.m. to 4 p.m.
Clinic, The Bungalow, Penn Lane, Melbourne	Wednesday, 1.30 p.m. to 4 p.m.
Clinic, Memorial Institute, Sandiacre	Monday, 2 p.m. to 4 p.m.
Clinic, St. Stephen's Church Hall, Sinfin Lane, Sinfin	2nd and 4th Mondays, 2 p.m. to 4 p.m.
Clinic, Methodist Church, Lodge Lane, Spondon	Friday, 10 a.m. to 12 noon, 2 p.m. to 4 p.m.
The Rectory, Stanton-by-Bridge ..	Wednesday, 2.30 p.m. to 5 p.m.
Clinic, Memorial Institute, West Hallam	1st and 3rd Thursdays, 2 p.m. to 4 p.m.

STAVELEY URBAN DISTRICT

County Clinic, Lime Avenue, Staveley	Tuesday and Thursday, 9.15 a.m. to 12.45 p.m. 2 p.m. to 5 p.m. Wednesday and Friday, 9.15 a.m. to 12 noon. Saturday, 9 a.m. to 12 noon.
Clinic, Ebenezer Chapel, Barrow Hill	1st, 3rd and 5th Wednesdays, 2.15 p.m. to 4 p.m.

SWADLINCOTE URBAN DISTRICT

County Clinic, Alexandra Rd., Swadlincote	Monday to Friday, 9.15 a.m. to 12.45 p.m., 2 p.m. to 5 p.m. (except Wednesday afternoons) Saturday, 9 a.m. to 12 noon.

WHALEY BRIDGE URBAN DISTRICT

Mechanics Institute, Whaley Bridge	Tuesday, 9.15 a.m. to 12.45 p.m., 2 p.m. to 5 p.m. Saturday, 9 a.m. to 12 noon.

WIRKSWORTH URBAN DISTRICT

Southams General Stores, The Green, Middleton-by-Wirksworth ..	Shop hours.
Town Hall, Wirksworth	Tuesdays, 2 p.m. to 4 p.m.

DENTAL CARE OF EXPECTANT AND NURSING MOTHERS AND PRE-SCHOOL CHILDREN

Mr. Gray, the Chief Dental Officer, has written the following report :—

"Expectant and Nursing Mothers.

As in the past number of years, it was not possible to carry out the scheme for the systematic examination and treatment of expectant and nursing mothers, who attended the ante-natal clinics, on account of the extreme shortage of staff. Throughout the year, the dental staff varied between the equivalent of five and one-eleventh and six and one-eleventh whole-time officers and their services were almost wholly devoted to the school children and spread over exceedingly large numbers ranging from 6,000 to 30,000 per officer, so that anything like a complete service for either class was out of the question, and, as a result, only a few expectant mothers were seen and these were cases mostly in need of urgent treatment for the relief of pain.

Pre-School Children.

Over 950 attendances were made by pre-school children. 736 received inspections and of 688 found with defects, 666 were treated. The majority of the parents of these children sought attention for them chiefly on account of pain, while a small minority wished advice and a periodical check-up. A few were treated as the result of inspections carried out at the Day Nurseries and others were treated following advice given by the Child Welfare Medical Officers at the Infant Welfare Clinics and by the Health Visitors, in the course of their routine home visits. Many of these children attended the clinics without appointments and whenever possible were given immediate attention. Treatment was chiefly by extraction. A small amount of conservative work was done, mostly at the wish of parents, but only in cases where the dentition, as a whole, was good, and the co-operation of the patient was obtainable. Palliative measures in the form of silver nitrate dressings were used in order to prolong the usefulness of teeth partly decayed, and delay the necessity for their removal as long as possible.

General anaesthetics were given on 401 occasions. These were administered by the School Medical Officers and each child was medically examined beforehand.

Many of these young children had extremely poor dentitions and the impression formed in the preceding two or three years that the incidence of caries is increasing, that the disease is appearing much earlier in life, and is much more rapid in character, was much strengthened. Inquiries about diet nearly always revealed a history of the regular consumption of sweets at all times of the day and much starchy food. Much advice was given and leaflets on the choice of foods and instruction in oral hygiene were distributed.

The following table gives particulars of the number of expectant and nursing mothers and pre-school children examined and treated and the work done for them :—

	Expectant and Nursing Mothers	*Pre-School Children*
Number examined	19	736
Needing treatment	19	688
Attendances	26	958
Treated	19	666
Made dentally fit	6	255
Fillings	2	32
Extractions	35	1,186
General anaesthetics	10	401
Silver nitrate treatment ..	—	360
Dressings	5	74
Scalings and gum treatment ..	2	1
Crowns and inlay	—	—
Radiographs	—	—
Full upper and lower dentures	—	—
Partial upper and lower dentures	—	—

Except for a minority who have some degree of immunity, dentistry cannot control dental disease for the masses, and it seems certain that the only hope for this lies in some definite form of prevention. At present the fluoridation of water supplies promises help in this direction. In parts of America where this has been in operation for a number of years, the incidence of caries has been greatly reduced. If an appreciable reduction could be brought about in this country, a great load would be shed from the dental services, and the need for the terrific amount of extraction work greatly reduced, leaving more time to devote to the work of preservation. In view of the extreme shortage of dentists and the great amount of ill-health caused by dental disease, it appears only logical that wherever possible, Health Authorities should bring into operation any known and tried measure which has a preventive action."

ILLEGITIMATE CHILDREN — YEAR 1956

The following table shows the way illegitimate children were cared for in the County during the year under review :—

TABLE XVII

1. The number of illegitimate births known to the Welfare Authority for the period 1/1/56 to 31/12/56	148
Number of unmarried mothers	147
Number of Widows	1

2. The number in which the mother and Child :—

(*a*)	Returned to live with mother's parents (of these three attended a Day Nursery in the County) ..	39
(*b*)	Returned to live with other relatives	4
(*c*)	Found or were helped to find lodgings where they could live together .. .. (Of these, thirty-three were accommodated in Borrowash House Mother and Baby Home).	35
(*d*)	The number of mothers living in a house of her own	1
(*e*)	Had to separate, the child going to a Children's Home .. .. (One of these in a private residential nursery).	3
(*f*)	Had to separate, the child going to the care of a Foster Mother	1
(*g*)	In domestic service and had child with her	1

3. The number of illegitimate children who had been or were being legally adopted 40

4. The number of mothers who have married since the birth of the child 15

5. The number of mothers who, with their babies, are living with the Father of the child, though not married to him .. 8

6. The number of illegitimate children who have died during the year 1
(This child died whilst still in Hospital).

During the year seventeen unmarried mothers included in the total of 148 were accommodated in Vernon Street Home, Derby, which is conducted by the Derby Diocesan Council for Moral Welfare. The County Council has an arrangement for the admission of unmarried mothers to this Home, the mothers usually being resident for a month before the birth of the child. They are then transferred to one of the Maternity Homes for their confinements, and where necessary return to the Home usually for a further two months, making a total stay of approximately three months.

Fifty Mothers who could not be accommodated in Vernon Street went to homes outside the County.

From April, 1948, to May 1950, this service was free but in May 1950 the County Health Committee resolved that the Home should be requested to collect the sum of £1 1s. 0d. per week from each girl accommodated wherever possible, in view of the fact that she would be in receipt of benefits from National Insurance or the National Assistance Board. As benefits from the National Insurance and the National Assistance Board were increased to 40/- per week in April 1955, the amount collected from each girl was increased to 32/6d. per week, thus leaving her with 7/6d. "pocket money" per week.

REPORTS RECEIVED FROM MATERNAL AND CHILD WELFARE MEDICAL OFFICERS

Reports from the Maternal and Child Welfare Medical Officers were included in this part of my Annual Report for the first time in 1952. This year I again wrote to the Maternal and Child Welfare Medical Officers, in the following terms :—

"As in previous years I am asking Maternal and Child Welfare Medical Officers on the Staff of my Department to submit reports on their work during the past year.

Medical Officers should report on the whole field of their work, including the following subjects :—

(1) General health and nutrition of the children, including the level of Mothercraft observed among the Mothers attending Infant Welfare Centres in the area ;
(2) Cleanliness and communicable diseases ;
(3) The Diphtheria Immunisation Scheme ;
(4) The role of the Medical Officer and Health Visitor in Health Education at Ante-Natal Clinics or Infant Welfare Centres ;
(5) Methods used at Ante-Natal Clinics to follow up non-attenders and the measure of success obtained by these methods ;
(6) The integration of clinic services with other aspects of the wider Health Service.

Apart from the above, special comment on aspects in which Medical Officers are particularly interested would be welcomed. The following are examples :—

(*a*) Observations on the premature baby ;
(*b*) The incidence of breast feeding ;
(*c*) The early detection of special physical defects—blindness, aphasia, deafness, epilepsy, etc.;
(*d*) The early detection of mental defects ;
(*e*) Minor orthopaedic defects, e.g. flat feet, knock knee, etc., in the two to five age group ;
(*f*) The incidence of different diseases in different parts of the area, examples are Bronchitis and Gastro-intestinal conditions ;
(*g*) Problem families and evidence of child neglect ;
(*h*) Accidents at play and in the home ;
(*i*) In the case of Ante-natal Clinics, observations on relaxation and post-natal exercises where these have been advised.

It will be helpful if your report is written in a form suitable for inclusion in my Annual Report, and I should like to receive it not later than the 14th June, 1957."

DR. D. M. JACKSON.

"The health and nutrition of children attending Infant Welfare Centres is good and the standard of mothercraft is still rising with the improvement in housing in different areas. The relation between housing and mothercraft is particularly noticeable in the matter of breast-feeding, since it is very difficult for a young mother to withstand the suggestion from other people living in the same house, that her baby is hungry and needs a bottle every time he is heard to cry. The mother also develops her own character through the sense of responsibility that comes of being on her own with her child all day and the baby has a greater sense of security if regularly handled by parents only and not passed from hand to hand when hungry, tired or uncomfortable.

It is very rarely that any criticism can be made of the cleanliness of children attending Infant Welfare Clinics, indeed it is less uncommon to note a mother in the Ante-natal Clinic who is careless in her clothes and person, though very rarely and only in members of known problem families to any serious extent. While undesirable, it is often understandable that an expectant mother who is endeavouring to secure an adequate amount of rest, should do so at the expense of the care of her own person rather than of her house or family.

Diphtheria immunisation is readily accepted but carried out to an increasing extent by the family Doctor and less by the Clinic.

Attendances at Ante-Natal Clinics are for the most part regular and enthusiastic, and any mothers who do not appear when expected are contacted either by post if in the early stages of pregnancy, or by the Health Visitor or Midwife in person when the matter of Ante-Natal care is more urgent. The only cases liable to be overlooked are those attending Nursing Home or Hospital Clinics since we have to assume that they will not be returning and should not be aware of it if they were referred back to us for intermediate attendances. However, they seem to come along quite regularly of their own accord on these occasions and I have no knowledge of any defaulters."

DR. D. J. PERSEY.

"*Infant Welfare Centres.*

The general standard of health and nutrition of children attending the Infant Welfare Centres known to me is certainly very good. As a general rule I find that mothers are very thoughtful about matters concerning the well-being of their offspring and that a high level of Mothercraft is shown. On the whole, the children attending the centres have a clean and attractive appearance though sometimes the amount of clothing may be excessive. It is interesting how mothers always attribute their baby's irritability to an alimentary disturbance, and never look to see whether their baby is not uncomfortably hot and sticky.

The mothers appear eager to produce their problems and submit their questions about infant feeding and baby care generally, and I find that the greater part of the Infant Welfare session is spent in this aspect of Health Education. Mothers seem often to be very anxious with their first babies and I feel that these cases derive a great deal of help, sympathy and encouragement from the clinic staff which gives them confidence and helps them to avoid awkward situations which might otherwise arise. I have the impression that mothers do attend very regularly with their first babies, but with subsequent additions to the family, it is not always possible for them to make a regular attendance.

Diphtheria Immunisation seems to be done in most cases by the general practitioner usually combined with whooping cough immunisation, and in many of the cases known to me, the immunisation has been completed by the time the child is six months old. When the principle of immunisation is fully explained to them

only a small proportion of mothers remain conscientious objectors, and I do immunise at the Infant Welfare Centres all those whose mothers elect to bring them to the Centre for diphtheria immunisation.

Ante-Natal Clinics.

Attendance at Ante-Natal Clinics appear highest in those areas where the general practitioners do not run their own Ante-Natal sessions, but once mothers start to attend the clinic they do come regularly and there are few defaulters. These few are followed up by either the health visitor or midwife, and given a further appointment. Post-Natal attendances at the clinics are poor, but a number are asked to attend the maternity unit at which they were confined, and some of those confined at home do attend their general practitioner for a Post-Natal examination.

A number of expectant mothers attending their own doctor for Ante-Natal care are sent up to the clinics for blood samples to be taken for Rhesus and Kahn investigations. This procedure is not very satisfactory as problems arise when repeat samples are required or when patients are sent late in pregnancy and a report is not received before the confinement takes place. I feel that it is preferable that the doctor carrying out the Ante-Natal care of a patient should also be responsible for the blood investigations.

Health Education at the Ante-Natal Clinics has to be carried out individually for the convenience of the mothers attending. On the whole this is satisfactory as each mother may need different advice and personal problems are often best discussed confidentially.

Co-operation between the various branches of the Health Services appears to have been good, although the return of the Ante-Natal Record Cards to clinics, duly completed after a confinement, would be much appreciated."

DR. C. M. WHITE.

"*Ante-Natal Clinics.*

The number of patients attending Ante-natal clinics still appears to be on the decrease, as many more are now seeking home confinement due to improved housing facilities. The majority of these patients receive Ante-natal care from their own doctors, although a few of them are referred to the clinics for Rhesus investigation.

Haemoglobinometers have now been provided and a scheme is on foot to provide relaxation and exercise classes for expectant mothers. It would seem that the ideal arrangement would be for these to be conducted at the clinics, after the patient's medical examination, as it seems rather doubtful if, say, mothers with large families will wish to take a special bus journey, probably from a long distance, in order to attend a class.

Infant Welfare Centres.

The number attending these centres remains at a steady level and the mothers seem appreciative and are regular attenders.

The incidence of breast feeding is not as high as might be desired although efforts are made to impress mothers with its advantages.

More interest is being taken in vaccination and most infants have the combined immunisation from their own doctors. The number being immunised at clinics against diphtheria alone is now very small indeed. Some of the smaller centres are in very poor buildings, and it is to be hoped that more suitable accommodation will become available and encourage a larger attendance."

NURSERY PROVISION FOR CHILDREN UNDER FIVE

DAY NURSERIES

The Authority's five Day Nurseries at Chaddesden, Glossop, Ilkeston and Long Eaton, continued to operate satisfactorily, and no major changes took place.

Provision of New Nurseries.

No new Nurseries were provided during the year under review. It will be remembered that the only project in hand is that consideration will be given, at some future date, to the erection of a Nursery at Glossop. It may be said that there are no immediate plans for further Day Nursery provision.

Student Training.

During the year under review thirteen students from the County Day Nurseries completed a two-year course of training and twelve were successful in gaining the Certificate of the National Nursery Examinations Board.

The students received courses of Further Education, and attended a training centre for this purpose on two days per week. While in the Nursery they are, of course, continuously under expert supervision and receive practical training while taking part in the daily life of the Nursery. For this reason, the Ministry of Health has laid down that students in training shall not rank as full members of the staff, but three student places shall be regarded as equivalent to one full-time member. Students from Chaddesden Day Nursery attend a course of Further Education at Derby, while those from Glossop attend a course at the Training Centre in Southall Street, Manchester. Arrangements have been made for the Ilkeston and Long Eaton Students to attend the Nursery Training Centre in Nottingham.

Charges to Parents.

The charge to parents has remained at 5/- per day since 1st February, 1953, but in cases of hardship and where more than one member of the same family attends a Nursery, the charge is reduced but not below 3/- per day per child in the case of the latter.

From 1st April, 1957, the maximum charge has been increased to 6/6d., while the minimum remained at 3/-. The scale of charges to decide when a reduction in the maximum shall be made is as follows :—

Net weekly earnings of parent and spouse (if any)						*Charges per day*	
£	s.	d.		£	s.	d.	s. d.
Not exceeding				8	0	0	3 0
8	0	1	to	9	0	0	5 0
9	0	1	to	10	0	0	5 6
10	0	1	to	11	0	0	6 0
Exceeding				11	0	0	6 6

Where the net weekly earnings are less than £12, the charge for a second child to be 1/- per day less than the assessed charge for the first child, subject to a minimum of 3/- per day for each child.

The Chairman and Vice-Chairman are authorised to deal with any cases of hardship.

The number of parents who, at any one time, ask for a reduction on the maximum charge is very small, being as a rule in the region of twenty-four.

Medical and Dental Inspection.

The children attending Day Nurseries are examined at regular intervals by one of the Authority's Medical Officers. Each child, on being admitted to the Nursery, is medically examined at the next visit of inspection and thereafter at approximately six-monthly intervals. In addition, the Medical Officer sees any children with minor ailments, these being dealt with in the appropriate manner. Orthopaedic defects often come to light when children are attending Day Nurseries, and through the General Practitioners and Orthopaedic Clinics in the different areas it is gratifying to see that these are discovered early and remedied during the child's stay in the Nursery. Medical reports have been uniformly satisfactory. Special visits are also made in the case of infectious disease, and in addition, visits of inspections are carried out from time to time by Medical members of the Central Office staff and by the Superintendent Health Visitor.

Dental Inspections are carried out by Mr. H. E. Gray, the Chief Dental Officer, who reports as follows :—

> "The Day Nurseries received periodical inspections throughout the year. With few exceptions, all the children were found to have good or reasonably good dentitions. A few required extractions and several others treatment of a minor nature. This was carried out at the nearest dental clinic."

Protection of Children against Tuberculosis—Ministry of Health Circular 64/50.

In accordance with the recommendations of the Joint Tuberculosis Council contained in the above Circular, all the staffs of Day Nurseries are subject to an x-ray examination of the chest before appointment and annually thereafter. This is laid down in the conditions of service set out in the application forms signed by all candidates for nursing posts in the County Nurseries, while a similar form agreeing to an initial and annual x-ray is signed by domestic staff before appointment.

This is a valuable step in the prevention of the spread of the disease by adults who regularly come into contact with organised groups of children.

During the year, nursing and domestic staffs at the five Nurseries administered by the County Health Committee were x-rayed in groups by arrangements with the Mass Miniature Radiography Units operating in or near Derbyshire. Our thanks are due to the Directors of these Units for their ready co-operation.

Chaddesden Day Nursery.

The following report has been received from Mrs. Murdock, the Matron :—

"Number of children on the register January, 1956 ..	42
Number of children admitted during 1956	39
Number of children who have attended in 1956	82
Average number of children on the register in 1956 ..	42
Average daily attendance under two years	7.1
Average daily attendance two to five years	27.3
Number on waiting list	27

The Nursery continues to be useful to parents, and attendances have been excellent during the year. Great appreciation is shown by the parents for the love, care and attention given to their children.

The health of the children has been very good. There were eight cases of German Measles in June and July and one case of impetigo in December. Ten children were immunised against diphtheria during the year. The good food, fresh air and happy atmosphere play a great part in maintaining the good health of the children.

The Nursery equipment is in good order. I cannot speak too highly of the Works Dept., for the prompt attention given to requisitions made.

The new formica topped kitchen table, tiling behind all sinks, the remaining iron pipes replaced with copper ones and the vegetable larder built at the end of the pram shed have greatly improved the hygienic standard of the Nursery and are appreciated by all.

I have an efficient and happy staff and I cannot speak too highly of the part they play in the running of the Nursery.

I am always pleased to welcome members of the County Health Committee. They take a keen interest in the welfare of the children and staff. Their visits have been enjoyable and we look forward to further visits."

Glossop Day Nursery.

Mrs. S. Cooper, the Matron of this Nursery, reports as follows :—

"Children on register, January, 1956	53
Number of children admitted during 1956	60
Number of children who attended during 1956	113
Average number of children on register during 1956 ..	50
Average daily attendance—children under two years ..	10¼
Average daily attendance—children two to five years ..	30

We have two names on the waiting list. These children will be admitted when their mothers find work. One is a priority—the parents having separated. We are now able to admit children of any age-group at once, as numbers are down since fees were increased in April of this year. Thirteen children were taken out of the Nursery because of these increases. One mother ceased work, twelve continued to work. Of two mothers, each with two children attending, one gave up working to look after her children at home, the other continued to work, finding someone else to look after her children. The balance of the thirteen consisted of children from one child families, and these are now being looked after by relations.

Regularity of attendance is excellent, as always. Two children stay off one Monday in three, when father is on night work and is home that day. One child stays off on Wednesdays when grandmother has him for the day to make the fees 26/-. Attendances are always low in the early months of the year when coughs and colds are prevalent. In February and March 1956, we had snow and biting winds, one child had Whooping Cough and was sent home. The usual disinfecting was carried out. In May there was a mild epidemic of Enteritis in Glossop, two of our children were sent home. Mothers and older children seemed to be affected more than our children, but the Nursery had a great many absences because of this.

Wash basins have been fitted in each of the three Nurseries, supplied with hot water from an electric geyser, for hand washing by staff as a precautionary measure against the spread of infection. Other equipment has been supplied, including an electric washing machine and gas boiler, both of which are great time savers and very useful. In addition, an electric fire has been supplied for the staff room. The pipes in the children's bathroom have been encased with perforated metal covers to prevent the children burning their legs on the hot pipes. We have had a number of toys and play equipment supplied for the children, including out-door toys for toddlers and older children. These are very welcome.

Domestic staff is a real problem. When one person is off duty no-one is willing to do chores and it is a real trouble to keep the Nursery clean—scrubbing floors does not appeal to anyone.

We have a large staff dining room, with ante-room and Isolation room adjoining which have bare boarded floors. It would be a great help if these could be covered with cork linoleum.

Members of the County Health Committee visited us on four occasions during the year. These visits are of great help and encouragement to myself and the staff and they show the interest taken in the Nursery by the County Health Committee.

There is a good supply of everything necessary to maintain well-fed healthy children. The County Health Authority's regard for the maintenance of supplies of food and materials needed for the smooth running of the Nursery is appreciated."

Station Road Day Nursery, Ilkeston.

Miss B. M. Wright, the Matron, reports as follows :—

"During 1956, eighty-two children attended the Nursery. In January thirty-eight were on the register, and throughout the year the average has been thirty-six. There have been fifty-two admittances and forty-nine discharges. The average attendance for the year was 8.9 for the under two years and 15.2 for over two years, making a total average attendance of 24.1. This is a 1.8 increase on the average attendance for 1955, which was 22.3. The increase in the average attendance may be due to the fact that we have had very little infection in the Nursery, only three cases of Chicken-Pox apart from the usual common cold.

There are no children on the waiting list as mothers usually come to the Nursery before getting work, and when they have found employment it is often possible to admit the child without delay.

The children appear to have stayed for longer periods this year, and the attendances have been relatively good. School holidays, when older children look after the young ones, and colds, has been mainly the cause of non-attendance.

Three children have attended the Orthopaedic Clinic, on the advice of the Senior Maternal and Child Welfare Medical Officer, for the correction of genu valgum—the results of which have been good.

An addition to the Nursery has been the provision of a new Fire Escape and also Fire Screen, this provides a second exit from the upper floor.

The grounds have been thoroughly weeded and cleared in preparation for Spring seeding.

The staff have much appreciated the new Slaxon Gas Washer, and two new sinks for the laundry. It is at this point I would like to say how pleased I was to receive a new carpet for the office.

Staff changes for the year were only the resignation of the two Nursery Students in August after being successful in passing their N.N.E.B. examination. Their vacancies have been filled.

It has been a pleasure to receive Members of the County Health Committee when they have visited the Nursery, and I hope for further visits in 1957, when I hope the Nursery will continue to prove a useful amenity in this area."

Whitworth Road Day Nursery, Ilkeston.

I have received the following report from Miss E. M. Clarke, the Matron :—

"Number of children on the register, January, 1956 ..	51
Number of children admitted during 1956	40
Number of children who have attended in 1956	91
Average number of children on the register during 1956..	53
Average daily attendance under two years	10
Average daily attendance two to five years	30
Total average daily attendance	40
Number of children who have left during 1956	40

We had twenty-six children on the waiting list at one period during 1956, they were absorbed as children left, which is mainly at Easter and September. Less children were admitted during the year, but less children left. The reasons for admissions remain the same, mainly economic, although only three parents were paying the reduced rate. I still think the nursery serves a very useful purpose and it is very much appreciated by mothers.

Last year was a very good year as regards infectious diseases. We had isolated cases of Chicken Pox, Mumps, Measles and Whooping Cough. We had no epidemics apart from Virus Meningitis when ten children were absent for a short period.

We are extremely pleased with the wash-house extension and also the new staff toilet attached to the children's lavatory unit. We have also received nine new children's stacking chairs and two formica topped children's tables. The office, isolation room, staff room, corridor and children's ablutions have been heated with gas fires and heaters, which proved to be most efficient during the bad weather.

The grounds are now motor-scythed and are kept in a much better condition. The grass lawn is beginning to look really good, we are indeed grateful and so are the parents and staff.

Unfortunately we have had very few visits from members of the County Health Committee, we always enjoy their visits and interest in the Nursery.

The Senior Medical Officer for Maternal and Child Welfare has examined the children monthly and also immunised children when necessary. The Students have watched the immunising as part of their training.

Five Students sat their N.N.E.B. examination and all were successful.

One Nursery Nurse left to take her teaching training and one was engaged to replace her. More of the Students go to Colleges to take their teacher's training after they have gained their N.N.E.B. I think this is because (1) there are so few vacancies for Nursery Nurses in the district, owing to training of too many Students in a small area and (2) the uncertainty of the future of Day Nursery work.

The Nursery junior and senior staff have worked loyally and well for the benefit of the children.

I am grateful for being allowed to examine for the National Nursery Board's Examination."

Long Eaton Day Nursery.

Mrs. M. Walsh, the Matron has reported as follows :—

"Number of children on the register in January, 1956 ..	53
Number of children admitted during 1956	40
Number of children who have attended in 1956	88
Average number of children on the register in 1956 ..	52
Average daily attendance under two years	11.8
Average daily attendance two to five years	28.5

The number of children on the waiting list at the end of December was ninety-four. As in previous years, I try and deal with this as fairly as possible, always giving preference to hardship cases, and at the same time dealing with emergency cases not on the waiting list. On the whole the children have attended fairly regularly during the year, the main causes of absences being coughs and colds and slight illness of mothers during winter months.

During the year there were six cases of German Measles, two of Chicken-pox, one of Measles, one of Mumps and five of Whooping Cough.

Five Students sat for their N.N.E.B. examination in July and four passed. These five resigned on 31st August and were replaced by new Students.

A small wooden shed for perambulators was erected outside the Baby Nursery. This a great help when it rains or to protect the babies in prams from cold winds. The hot pipes in the Tweenie Nursery have been covered over. This covering serves a double purpose—the children use it as a shelf to put their toys on, to sit on, and even to stand on to look out of the windows.

A "Sno-White" gas drying cabinet was installed during the year. This has proved a great boon after years of worrying over the drying of clothes in wet weather. Other new equipment included tiled surrounds to the kitchen sinks, formica top to the kitchen table, chromium taps to replace old brass ones, one pair of scales for weighing older children and some new toys.

The County Health Committee members continued to visit us. These visits are much appreciated, as the Committee members always show a keen interest in the welfare of the Nursery."

Admission of Derbyshire Children to Nottinghamshire Day Nurseries.

Several years ago an agreement was reached with the Nottinghamshire County Council, whereby children residing on the eastern border of Derbyshire could attend Nottinghamshire Day Nurseries, the difference between the charge to the parent and the cost per child-day being met by the Derbyshire County Council.

Admission of Derbyshire Children to Sheffield Day Nurseries.

It was agreed in principle that Derbyshire children be allowed to attend Sheffield Day Nurseries, the Derbyshire County Council being responsible for the difference between the actual cost and the charge made to the parent. All cases are referred to the Chairman of the County Health Committee for approval after the actual assessment of the cost to the County Council has been ascertained by the Sheffield Authority.

Training of Pupil Assistant Nurses.

The arrangement continued during the year whereby two Pupil Assistant Nurses employed by the Derby Area No. 1 Hospital Management Committee should work for a period of six or eight weeks at one of the Day Nurseries to gain experience. The Management Committee supplied their services free of charge, and the Derbyshire County Council provided their meals.

Annual Conference of the National Association of Nursery Matrons.

The Annual Conference of the National Association of Nursery Matrons was held on 10th and 11th March, 1956 at Brighton, and the Matrons of the Long Eaton and Glossop Day Nurseries were allowed to attend.

MIDWIFERY SERVICE

(Section 23)

General arrangements for the Service.

The County Council in July, 1948, became the responsible Authority for providing a domiciliary Midwifery Service for the whole of the Administrative County, including Chesterfield. The Area Medical Officer, assisted by a Maternal and Child Welfare Medical Officer and one non-medical Supervisor of Midwives, supervises the Midwifery Service in Chesterfield Borough, under the general direction of the County Medical Officer of Health. The remainder of the County is administered from the central office in Derby, and the County Medical Officer is assisted in carrying out the necessary supervision of Midwives by the Deputy County Medical Officer, a Senior Maternal and Child Welfare Medical Officer, and two non-medical Supervisors of Midwives.

Regarding midwives employed in Institutions, supervision is exercised by the Maternal and Child Welfare Medical Officers, as well as the non-medical Supervisors of Midwives—again, of course, under the general direction of the County Medical Officer of Health.

Regarding the midwives employed by the County Council, it has not been possible in all areas to divorce Midwifery completely from Home Nursing. This is partly due to the qualifications and grading of nurses transferred from Nursing Associations in 1948 and partly to the fact that in sparsely populated areas it results in the area to be covered becoming unwieldy. The travelling would then be excessive, bearing in mind the number of cases a midwife is expected to attend. The divorce of Midwifery from Home Nursing is a desirable aim, but I do not think that this can be achieved entirely in this County because of its geographical features. An idea of the staffing position for the period under review can be obtained from the following table :—

	Number of Midwives on the staff at the end of						
	1950	1951	1952	1953	1954	1955	1956
County Midwives ..	83	83	73	71	69	72	71
Home Nurse Midwives ..	38	37	35	35	32	30	30

In order to enable the domiciliary midwives to make the best use of their time and also to transport equipment, including Analgesia apparatus, to their patients, the Authority agreed to grant travelling allowances to Midwives for the use of motor cars. In addition, the Authority's "assisted purchase of cars scheme" was extended to Midwives wishing to obtain loans for this purpose. At the time of writing this Report sixty-six Midwives out of a total of seventy-one are using motor cars.

The areas covered by County Midwives and Home Nurse-Midwives have been drawn having regard to (1) the amount of work performed; (2) the convenience of patients; (3) the situation of the Midwives' residences; and (4) the "mobility" of Midwives.

It has been estimated that each Midwife can undertake approximately sixty-six cases per annum, and it has been stated that one Midwife is required for 5,000 to 6,000 of the population in an urban area. It is intended on this estimation, that her duties shall include ante-natal care, attendance at the confinement and nursing of the mother and baby for a minimum of fourteen days during the lying-in period.

At the end of 1956 there were 191 Midwives on the County Roll—seven were Midwives in independent practice; seven were Midwives working in private Nursing Homes; seventy-six were Midwives working in Regional Hospital Board Hospitals and Maternity Homes; and seventy-one were County Council Midwives and thirty were County Council Home Nurse/Midwives.

Uniform.

All Midwives on the staff are provided with the official uniform recommended by the Central Midwives Board.

Housing.

It is a rule of the Authority that a Nurse should live in the area for which she is primarily responsible, in order that she may be readily available when called upon. Difficulty has occasionally been encountered in the past by Nurses in securing accommodation in some areas, although a number of Local Sanitary Authorities have been extremely helpful in letting houses either directly to the County Council for occupation by a Midwife, or to the officer concerned.

Where this assistance from the Local Sanitary Authorities has been forthcoming, very little difficulty has been experienced in filling vacancies.

Statistics.

The following Table sets out certain relevant figures regarding the Midwifery Service for the years 1950 to 1956 :—

TABLE XVIII

	1950	1951	1952	1953	1954	1955	1956
Number of cases attended by Midwives employed by the Authority :							
(i) As Midwives	3,808	3,264	2,918	2,938	3,047	3,039	3,349
(ii) As Maternity Nurses	1,488	1,609	1,561	1,510	1,385	1,352	1,402
Total ..	5,296	4,873	4,479	4,448	4,432	4,391	4,751
Number of cases in which Gas and Air was administered	2,311	2,167	2,192	2,501	2,667	2,611	2,651
Number of cases in which Pethidine was administered :							
(i) When acting as a Midwife ..	–	241	579	900	1,186	1,297	1,693
(ii) When acting as a Maternity Nurse	–	613	598	488	479	826	704
Number of cases in which Trilene was administered :							
(i) When acting as a Midwife ..	–	–	–	–	–	–	323
(ii) When acting as a Maternity Nurse	–	–	–	–	–	–	130

Gas and Air Analgesia.

The number of Midwives in practice in the County at the end of the year who were qualified to administer Gas and Air Analgesia in accordance with the requirements of the Central Midwives Board, was as follows :—

Domiciliary Midwives	101
Employed in Homes and Hospitals in the National Health Service	61
Employed in Nursing Homes or Maternity Homes not in the National Health Service	5

The number of cases where gas and air analgesia was administered by Midwives in domiciliary practice during the 1956 was 2,651.

Facilities are provided to enable domiciliary Midwives practising in the area to attend courses of instruction in the administration of analgesics in institutions approved by the Central Midwives Board.

In all cases where Gas and Air Analgesia is administered by a Midwife in domiciliary practice, a "second person" must be present who is acceptable to the patient as well as to the Midwife.

At the end of the year 1956, all the 101 Midwives and Home Nurse/Midwives on the staff of the Department were trained in the administration of Gas and Air Analgesia and were in possession of sets of apparatus.

As a consequence of the authority contained in Statutory Instrument No. 380 of 1950, the Dangerous Drugs Regulations, 1950, authorising Midwives who have notified their intention to practise to the Local Supervising Authority to be in possession of and to administer medicinal opium, tincture of opium, and pethidine, all Midwives were issued with Dangerous Drugs Books, and arrangements were made for the issue of pethidine from the Central Office. The numbers of cases in which pethidine was administered since these Regulations came into force are set out below:—

1951	854
1952	1,177
1953	1,399
1954	1,665
1955	2,135
1956	2,397

Trichloroethylene B.P. (Trilene).

By the end of March 1957, all midwives employed by the County Council will have been instructed in the use of, and provided with, Trilene Inhalers, as an alternative method of inhalational analgesia to Gas and Air. The number of midwives supplied with Trilene Inhalers at the end of 1956 was sixty-three.

The Inhalers are of a type approved by the Central Midwives Board for use by midwives, the same conditions being enjoined regarding the medical examination and the presence of a "second person" as with Gas and Air analgesia.

The number of cases where Trilene was administered by midwives in Domiciliary practice during the year 1956 was 453.

Relaxation.

Midwives in Derbyshire have been sent for many years by the County Council on refresher courses run by the Royal College of Midwives. Latterly the courses have included lectures on relaxation.

Gas and Air analgesia, trilene analgesia, pethidine, and other drugs, as well as relaxation exercises, are all methods designed to reduce suffering during childbirth, and while it is important that the wishes of patients should be respected it is advisable that whether one or more of these methods should be used in a particular case be left to the discretion of the doctor or midwife, who have the expert knowledge to assess the medical condition at the time.

Refresher Courses.

The County Council's proposals under Section 23 of the National Health Service Act provide for sending Midwives on Post Certificate Courses at suitable intervals. Up to 1955 seven Midwives were sent annually to Courses arranged by the Royal College of Midwives, fees and expenses being paid by the Authority. In addition, the Supervisors of Midwives attend in rotation the annual post-certificate courses conducted by the Association of Supervisors of Midwives.

The Minister of Health has, however, given approval under Section 30 of the Midwives Act, 1951, to rules made by the Central Midwives Board. This was contained in Statutory Instrument 1955, No. 120, which came into operation on the 1st February, 1955. Section "G" of the rules dealing with Refresher Courses for Midwives is to be obligatory from the 1st January, 1958, after which date Midwives will be required to attend Refresher Courses every five years. In order that all Midwives shall be brought into line it was arranged to send thirty-two Midwives during 1955, thirty-two during 1956, thirty-two during 1957, and the balance during 1958.

Training of Pupil Midwives.

Arrangements were made with the Sheffield Regional Hospital Board for the training of Pupil Midwives in the Chesterfield area The arrangements provided for the Regional Hospital Board paying : (1) the pupil Midwives' salaries ; and (2) £2 2s. 0d. per week to the Midwife for providing board and lodging for each pupil ; while the County Council pays £20 per annum to the Midwifery Teacher.

The Midwife in the Maternity Service.

The Royal College of Midwives have issued a Memorandum on Policy, and it was thought that the following excerpt from it might prove of interest :—

"*The Midwife in the Maternity Service.*

The Royal College of Midwives believes that if the best possible care is to be given to the mothers and babies of the country the Maternity Service must continue to be based on the provision of an adequate number of well-educated, well-trained and experienced midwives. At the same time the College welcomes the provision, under the National Health Service Act 1946, for maternity medical services to be given by general practitioner obstetricians, and for the attendance of consultant obstetricians, should the need arise.

The midwife today is trained to be "the practitioner of normal midwifery" (Report of the Working Party on Midwives, para. 102), and as a member of the obstetric team she should be given a share in the planning and organisation of the Service. Only thus will the mother and baby be best served and the best type of midwife find sufficient scope within the Service.

The function of the midwife should be substantially the same whether she is engaged in institutional or domiciliary practice, and in the following paragraphs we have outlined what we believe should be the scope of her work.

The Responsibility of the Midwife.

1. *Ante-Natal Care.*

The responsibilities of the midwife for the clinical care of the expectant mother are determined by the Rules of the Central Midwives Board.

The routine ante-natal care of the expectant mother should be recognised as the duty of the midwife in association with the doctor, who is responsible for the general medical care and attendance when need arises.

We believe it is of vital importance for the midwife to continue to exercise her clinical skill, including the ante-natal examination of women attending Local Authority clinics or other centres. Many doctors are now undertaking ante-natal care in their own surgeries, but this does not absolve the domiciliary midwife from taking the full share of responsibility. In hospital practice, where the obstetricians attend every ante-natal clinic, we consider it essential that there should also be ante-natal sessions conducted by midwives.

The midwife has always been a teacher of individual mothers, but today she is taking a much larger part in the ante-natal teaching of groups of mothers, and we are glad that her responsibility for this important work is increasing and will increase in the future.

Classes for the mothers in ante-natal clinics should be organised by the midwife in co-operation with other members of the health team. The midwife herself should give the teaching on the physiology of labour and the preparations for it, the use of inhalational analgesics, the preparations for the baby, and breast feeding. Provided she has had the appropriate experience, the midwife may and often does, give instruction on relaxation and ante-natal exercises to small groups of mothers.

In our opinion, the assessment of the suitability of the home conditions for confinement should be made by the midwife in consultation, where necessary, with the patient's own doctor.

2. *Care during Labour.*

Every mother should be under the constant care of a midwife during the whole of her labour. Although a doctor may be present for part of the time, the midwife should continue to take full responsibility for the majority of normal deliveries. She can administer inhalational analgesics and, under the Dangerous Drugs Acts, she can give certain pain-relieving drugs. It is thus within her power, and it is her duty, to give the mother adequate relief from pain during labour.

3. *Post-Natal Care.*

The responsibility of the midwife for the care of the mother and baby is a very important one. They should, if possible, be looked after during the post-natal period by the same midwifery team who cared for them throughout pregnancy and labour. We deplore the practice in some hospitals of sending the mother and baby home, or to other premises, within a few days of confinement since this makes it impossible to give them continuity of care.

The care of mothers and babies should remain the responsibility of midwives for at least twenty-eight days. It is the duty of the midwife to encourage the mother to attend for a post-natal examination and to make the necessary appointment.

We are strongly of the opinion that premature babies should be nursed by midwives."

HEALTH VISITING
(Section 24)

All the health visiting services in the County are carried out directly by the Authority and, therefore, no agency arrangements with other bodies are in force. Nearly all of the Health Visitors are also School Nurses. Their work in the latter capacity has been dealt with in my Annual Report as Principal School Medical Officer to the County Education Committee. A great deal of the work for the County Health Committee has already been referred to in Section 22, as a substantial part of the care of mothers and young children is in their hands. Including the Superintendent Health Visitor, the establishment provides for the employment of sixty-nine Health Visitors, who would also act as School Nurses.

In 1955 consideration was given to the recasting of Health Visitors' areas bearing in mind the following points :—

(1) that the best use should be made of the existing staff ;
(2) that in order to make the work more interesting, where possible certain parts of rural areas should be joined to industrial areas ;
(3) that the recent housing development which is taking place particularly in the overspill areas around Derby and Sheffield should be carefully considered ;
(4) the Health Visitors who were in receipt of car allowances ;
(5) certain areas in which Health Visitors might at once (or on a suitable subsequent occasion) be granted car allowances ;
(6) school enrolments ;
(7) pre-school population ;
(8) the fixed appointments at clinics.

Early in the year under review the proposals for recasting Health Visitors' areas were approved by the appropriate Committees and by the end of the year they were put into operation.

One of the helpful results of this recasting is that there are now fifty instead of thirty-one approved car areas which enables more domiciliary visiting to be carried out. This is borne out by the fact that over 5,000 more families have been visited during the year under review than in the previous year.

The granting of telephones to Health Visitors was approved early in the year. This is a great help to them in their day to day duties and also helps to promote more satisfactory liaison with General Practitioners and Hospital Staffs. By the end of the year there were only sixteen Health Visitors without telephones for whom application had been made.

It will be noted that the attendances at Infant Welfare Centres have increased in the year under review as compared with those of the previous year, 62% of the babies born having been taken to an Infant Welfare Centre at least once.

Health Education at the clinics has again been stressed and in addition to the 135 formal mothercraft talks, informal discussions on health subjects take place in every clinic. Many Health Visitors also

spend much of their off duty time in giving lectures to local organisations, such as, the Women's Institutes, and St. John's Cadets.

There is still a national shortage of Health Visitors and it has not been possible to obtain the number required in this County; at the end of 1956 fifty-eight Health Visitors were employed in an authorised establishment of sixty-nine, although the number needed ought to be somewhere between 130 and 140.

Training of Health Visitors.

In view of the shortage of candidates to the Health Visiting branch of the nursing profession, a scheme is in operation whereby State Registered Nurses under thirty-five years of age who hold the certificate of the Central Midwives' Board or the first certificate under the new Central Midwives' Board's rules, will be assisted in undertaking training for the post of Health Visitor under certain conditions. Briefly these conditions provide for the County Council being responsible for the full cost of training at an approved training centre, and the student being paid three-quarters of the minimum of the Health Visitor's salary for the first twelve months. Of this period, approximately nine months will be spent as a student and the remainder as a Health Visitor on the County Council's staff. A further important condition is that, if required, the candidate will remain on the staff of the County Council for at least two years after the completion of training. A formal agreement is drawn up between the nurse and the Authority to ensure the necessary financial safeguards, in view of the Authority's expenditure in providing for the nurse's training.

Two students completed their course of training and three commenced under this scheme during the year under review.

In all there are nine Health Visitors in this County who were trained under this scheme since 1949.

STATISTICS RELATING TO MATERNAL AND CHILD WELFARE

Statistics regarding the Authority's Maternal and Child Welfare Services are submitted annually to the Ministry of Health, and appear at the end of this Report (Appendix I).

Certain facts are extracted for use in the Department, but appear likely to be of general interest and are set out in a convenient form, in Table XX for easy reference. The headings under which the statistics appear are self-explanatory, and give a summary of the position from year to year with regard to certain of the services provided under Section 22 of the National Health Service Act. (It will be appreciated that all the figures are based on the number of notified births, which varies slightly from the number of registered births, provided by the Registrar-General).

TABLE XIX

MATERNAL AND CHILD WELFARE.

1.	Ante-Natal Clinics—		
	Number of sessions		1,321
	New Cases		3,837
	Ante-Natal attendances		15,018
	Post-Natal attendances		619
2.	Visits to Homes—		
	Number of children under five years of age visited during year		43,829
	Expectant mothers :—		
	First visits		2,334
	Total visits		3,181
	Children under one year of age :—		
	First visits		9,790
	Total visits		28,690
	Children age one and under two years :—		
	Total visits		15,218
	Children age two but under five years :—		
	Total visits		34,034
	Tuberculous Households :—		
	Total visits		2,983
	Other cases :—		
	Total visits		7,529
	Total number of families or households visited by Health Visitors		37,690
3.	Infant Welfare Centres :—		
	Number of sessions		4,163
	Number of new cases :—		
	Under one year of age		6,565
	Number of children who attended during the year and who were born in :—		
	1956	7,455	
	1955	4,720	
	1954-51	4,290	
	Total number of children who attended during the year		16,465
	Number of attendances made by children who, at the date of attendance, were :—		
	Under one year	77,546	
	One but under two	16,262	
	Two but under five	11,190	
	Total attendances during the year		104,998
4.	Mothercraft—Number of Lectures		135

TABLE XX

	1950	1951	1952	1953	1954	1955	1956
NUMBER OF NOTIFIED BIRTHS.							
Live Births	11,044	10,619	10,387	11,039	10,122	10,130	10,769
Still Births	251	227	236	233	269	221	250
Total Births	11,295	10,846	10,623	11,272	10,391	10,351	11,019
DOMICILIARY MIDWIFERY.							
L.H.A. Midwives—Number of cases attended as Midwives	3,808	3,264	2,918	2,938	3,047	3,039	3,349
as Maternity Nurses	1,488	1,609	1,561	1,510	1,385	1,352	1,402
Total	5,296	4,873	4,479	4,448	4,432	4,391	4,751
Midwives in private practice, number of cases attended: as Midwives	50	30	17	2	9	1	2
as Maternity Nurses	34	28	22	20	8	16	3
Total	84	58	39	22	17	17	5
Domiciliary Cases—Grand Total	5,380	4,931	4,518	4,470	4,449	4,408	4,756

Number of Domiciliary Cases attended as a percentage of all notified births	47.6	45.5	42.5	39.65	42.8	42.4	43.16
ANALGESIA.							
Number of cases in which inhalational analgesics were administered by L.H.A. Midwives in Domiciliary practice	2,311	2,167	2,192	2,501	2,667	2,611	3,104
Number of cases of Analgesia as a percentage of domiciliary births	43.6	43.9	48.5	55.95	59.9	59.46	65.3
ANTE-NATAL CLINICS.							
Number of L.H.A. Clinics	24	24	23	22	22	23	23
Number of new cases attending during the Year ..	5,159	4,663	4,467	4,183	3,976	3,777	3,837
Number of new ante-natal cases as a percentage of all notified births	45.7	43.0	42.0	37.1	38.3	36.5	34.8
POST-NATAL CLINICS.							
Number of L.H.A. Clinics	2	2	2	2	2	2	2
Number of new cases attending during the year (including post-natal cases at Ante-Natal Clinics) ..	409	532	409	394	487	514	559
Number of new post-natal cases as a percentage of all notified births	3.6	4.9	3.8	3.49	4.68	4.97	5.07
INFANT WELFARE CENTRES.							
Number of L.H.A. Centres	82	83	86	85	85	86	88
Number of Voluntary Centres	3	3	3	3	3	3	2
Number of children who first attended an Infant Welfare Centre during the year (under one year) ..	6,051	5,923	6,115	6,374	6,995	6,245	6,663
Number of first attendances of children under one year of age at I.W.C.'s as a percentage of notified live births ..	54.79	55.77	58.87	57.74	69.17	60.3	61.87

HOME NURSING SERVICE

(Section 25)

Home Nursing, which is an important part of the many-sided National Health Service, has continued much on the same general lines since its inception in July, 1948.

The treatment and nursing attention which the nurses are able to give patients in their own homes relieves the pressure on hospital beds, as patients may be discharged earlier than would otherwise be the case. The service is also of great value to the general practitioners. It will readily be understood that statistics alone cannot give a real indication of the varied services rendered by the home nurses. A measure of the increase which has taken place can be gauged by the fact that in 1949 (the first full year the service was in operation) the number of cases visited was 11,149, and the actual visits 286,424; whereas in 1956, 16,881 patients were visited, and the number of visits was 393,688.

A considerable amount of the nurses' time is taken up in attention to the elderly, and this is borne out by the fact that of the patients visited in 1956, 30% were over sixty-five years of age at the time of the first visit. 3% of the cases visited were under five years of age. 20% of all the patients visited had more than twenty-four visits paid to them by the nurses.

In Appendix I to this report, is given a copy of the Annual Return to the Ministry of Health of the Services provided by the Authority. In part 1, section 6, an analysis of the type of work the nurses are now called upon to carry out is given, showing the number of cases and visits to medical, surgical, infectious diseases, tuberculosis, maternal complications and others.

With the increasingly wide use of drugs in the treatment of patients, nurses are now called upon to administer a large number of injections for a variety of diseases under the direction of the patients' own doctors.

The following shews the staffing position at the end of each year since the coming into operation of the County Council Home Nursing Service :—

	1948	1949	1950	1951	1952	1953	1954	1955	1956
Full time—									
Home Nurse Midwives	44	43	38	37	35	35	32	30	30
Home Nurses ..	81	91	104	99	99	99	103	108	112
TOTAL ..	125	134	142	136	134	134	135	138	142
Part-time	2	–	2	3	2	–	–	–	–
TOTAL full-time and part-time ..	127	134	144	139	136	134	135	138	142

It is the Council's policy to separate wherever possible, Home Nursing from Midwifery, because of the danger of spreading infection from the general cases to women in child-birth. It will be seen from the above that progress has been made in this direction, and in fact when a vacancy occurs, the position is reviewed to see if any changes can be made, bearing in mind the efficiency of the service.

The County Council has approved the policy of nurses being granted car allowances as it is realised, (1) that it is in the interests of the patient, as nursing aid arrives quicker; (2) it contributes to the health and convenience of nurses, particularly in bad weather and at night; (3) it is cheaper to the Authority because the nurses can perform more work by covering a wider area. The Authority has also a scheme by which nurses and midwives are able to obtain loans towards the purchase of cars. Many nurses take advantage of this scheme, and the number using cars has increased considerably; in fact, at the time of writing, 120 out of 141 nurses are now using motor vehicles in connection with their duties.

It is a rule of this Authority that nurses should live in the areas for which they are responsible in order that they may be readily available when called upon. In this connection Local Housing Authorities usually co-operate readily with the County Council, by letting houses either to the nurses or to the County Council, for occupation by a home nurse. This arrangement has many advantages, as it is cheaper to allot a house on a housing estate than for the County Council to build an individual house, and furthermore it usually ensures that a nurse resides where there is a concentration of population.

Post-certificate courses play an important part in the service and the County Health Committee has agreed that thirty nurses may attend such courses every year. This ensures that every nurse has an opportunity of attending a course every five years. She is thus able to keep abreast of the latest methods of treatment and nursing practice. This is particularly important at the present time when there are so many new developments in medicine. The nurses themselves speak highly of the value of these courses.

VACCINATION AND IMMUNISATION

(Section 26)

Diphtheria.

During the last few years there has been a nationwide diminution in the incidence of this disease. However it is important that health workers should continue the propaganda for immunisation. This matter was stressed in 1955 and it is pleasing to see that there has been some improvement in primary immunisation in 1956, as the following table shows :—

TABLE XXI

Immunisation against Diphtheria.

	Primary	*Booster*
1952.. ..	7,488	6,748
1953.. ..	6,730	4,727
1954.. ..	7,531	5,862
1955.. ..	7,677	8,028
1956.. ..	8,314	5,831

It is gratifying to report that no notifications or death from this disease were recorded in the County during the year.

The following table gives details of the children who completed a course of immunisation or received a reinforcing dose during 1956, in the form required by the Ministry of Health :—

TABLE XXII

DIPHTHERIA IMMUNISATION RETURN FOR THE YEAR ENDED 31st DECEMBER, 1956

	AGE at date of final injection (as regards A) or of reinforcing injection (as regards B)			
	Under 1	*1 to 4*	*5 to 14*	*Total*
A. NUMBER OF CHILDREN WHO COMPLETED A FULL COURSE OF PRIMARY IMMUNISATION IN THE AUTHORITY'S AREA (including temporary residents) TOTAL FOR THE YEAR	3,255	2,946	2,113	8,314
B. NUMBER OF CHILDREN WHO RECEIVED A SECONDARY (REINFORCING) INJECTION (i.e., subsequently to primary immunisation at an earlier age). TOTAL FOR THE YEAR	—	512	5,319	5,831

TABLE XXIII

The following is a copy of the return submitted to the Ministry of Health relating to the immunisation position in the child population at the 31st December, 1956.

IMMUNISATION IN RELATION TO CHILD POPULATION

Number of children at 31st December, 1956, who had completed a course of Immunisation at any time before that date (i.e. at any time between 1st January, 1942 and 31st December, 1956).

Age at 31.12.56 i.e. Born in Year	Under 1 1956	1—4 1952-1955	5—9 1947-1951	10—14 1942-1946	Under 15 Total
Last complete course of injections (whether primary or booster) .. A. 1952-1956	3,255	18,998	25,380	11,876	59,509
B. 1942–1951 ..	—	—	22,518	33,212	55,730
C. Estimated mid-year child population	10,600	41,800	116,800		169,200
Immunity Index 100 A/C	30.7%	45.4%	31.0%		35.17%

The best picture of the effect of immunisation can be obtained by viewing the country as a whole, and the following table shows the truly remarkable decrease in the disease that has taken place since 1945 :—

Year	*Deaths*	*Corrected Notifications*
1945	722	18,596
1946	472	11,986
1947	244	5,609
1948	156	3,575
1949	84	1,890
1950	49	962
1951	33	664
1952	32	376
1953	23	266
1954	9	182
1955	13	169
1956	8 (provisional)	63

Poliomyelitis.

The Minister of Health announced in January, 1956, that a British vaccine giving protection against poliomyelitis had been developed, and that, with the limited amount available, it was hoped to inoculate in May and June of that year, between a quarter and half a million children between the ages of two and nine years.

The vaccine. Two firms are manufacturing the vaccine in this country and the strains of virus used have been carefully chosen, particular emphasis being placed on low virulence. The most stringent tests are being applied to ensure that the vaccine is "safe," including testing by tissue culture methods of serial samples, and tests on rhesus monkeys sensitised with cortisone (which has the effect of making them more susceptible to infection with the virus). Additional tests are performed to exclude the possibility of the vaccine having been contaminated by pathogenic organisms.

The initial scheme. Details of the initial scheme for using the new vaccine were given by the Ministry of Health in Circular 2/56 (19th January, 1956). It was stated that a certain amount of the vaccine was expected to become available during May and June and the Minister was anxious that local health authorities should have an opportunity of using the limited quantities before the start of the "polio season."

The proposals made were designed to secure a fair distribution amongst those age groups in which the disease is most prevalent and to secure information which would help in devising the best possible scheme of distribution when substantial quantities became available later on. The vaccine was to be offered without charge to local health authorities, who would provide vaccination as part of their arrangements under section 26 of the National Health Service Act, 1946. The expenditure incurred in making the arrangements would rank for the usual Exchequer Grant. It was proposed to release the vaccine batch by batch as soon as they had passed the very stringent safety tests which were being applied.

The initial scheme envisaged that the vaccine would be made available on a voluntary bases for children born between 1947 and 1954 inclusive, although it was realised that only a small number of the five and a half million children in those age groups in England and Wales would be able to be vaccinated in May and June. Those children who were registered but could not be dealt with in May or June would receive priority later on when larger supplies became available.

The scheme provided that parental consent in writing must be received in time to enable local authorities to send, not later than 14th April, 1956, to the Medical Research Council's Statistical Research Unit, the total number of acceptances for children in each month of birth in each age group. It was pointed out that it would not be possible to distribute vaccine to any authorities who had not provided the information by that date. The selection of the children who were to receive vaccination from among those registered was to be made according to a centrally determined plan designed to maintain an even spread throughout the eligible age groups which would be based on the months of birth. When the national picture had been studied, local authorities were to be informed by the Ministry which months in each age group had been selected for vaccination.

The Circular intimated that for the time being, in view of the limited quantity of vaccine available, and the short time available in which to organise this first stage of the scheme, the vaccine would be administered on behalf of the local health authority only. It was stated that general medical practitioners would be given an opportunity to participate at a later stage, when larger supplies became available.

The Circular suggested that most local health authorities would need to amend their approved "Proposals" under the National Health Service Act in order to be able to provide vaccination against poliomyelitis. Actually, in December, 1955, the Derbyshire County Council had already submitted the following amendment to their Proposals to the Ministry for approval, which was duly given :—

> "Vaccination and Immunisation. Other diseases : The Council proposes also to make arrangements for offering to persons in its area, or to any groups of such persons, immunisation against any other disease in respect of which authority is sought from and given by the Minister of Health. The Medical Officer of Health will be responsible for keeping records directed towards assessing the value of any such forms of immunisation."

The Ministry's circular acknowledged that the time in which to plan and carry out the vaccinations was extremely limited and in consequence a very heavy burden would be placed on the local health authorities ; but the Minister thought it right to make available immediately all the vaccine which could be produced and he urged authorities to do their utmost to see that the maximum use was made of the limited supplies. To this end it was appreciated that it might be necessary to defer some of their routine work.

(In fact, the amount of time which had to be devoted to the scheme by the Assistant Maternal and Child Welfare Medical Officers and School Medical Officers in giving the injections inevitably resulted in a decrease in the number of children who were examined at school medical inspections. On the administrative side, it proved necessary for the clerical staff of the Department to work several hundreds of hours overtime. However, if the vaccine proves to be as efficacious as it is hoped it will be, no doubt it will be generally agreed that the time and energy devoted to the task was well worth while).

The Appendix to the Circular 2/56 included a note on the development of polio' vaccine in the United States ("Salk vaccine", so named after the medical scientist who was responsible for its development at the University of Pittsburg, Pennsylvania). It was pointed out that "vaccination against poliomyelitis is a new development, and it is not yet possible to assess beyond the limited period in which the vaccines have been in use the duration of the protection afforded. More detailed information of this type which will emerge only from continued use of the vaccine will be of value in determining the method of its use in the future."

It was also laid down that after the vaccinations had started each Authority would be required to forward reports on all notified cases of poliomyelitis in their areas, giving details of registration or of vaccination. A record card, in a form prescribed by the Ministry, was also to be kept for each child registered for vaccination.

Preparing the local scheme. The first problem was that of providing the means to ensure that the parents of every child in the eligible age groups were given an opportunity of registering their children, if they so wished, for vaccination. It was decided to print a letter, addressed to the parents or guardians, to which was appended a copy of the Ministry's note on the development of the vaccine, as well as a form of consent. Before the letters were sent out, the Derbyshire Local Medical Committee were consulted, and it was agreed that a copy of the letter would be sent to every general medical practitioner in the County before it was circulated to parents, so that the Doctors would be aware of its contents. This was regarded as important, because it was suggested in the letter that before coming to a decision, parents might like to consult their own Doctors. At the same time, a letter was sent to the general medical practitioners giving a short list of the references to the vaccine which had appeared in the medical journals, and they were informed that arrangements would be made for a note to be handed to the parents or guardians of the children at the time of vaccination, for transmission to their own Doctors, so that in the event of any untoward symptoms subsequently arising their Doctors would have precise information of what had been injected.

The distribution of the letters to approximately 90,000 parents of the children in the selected age groups presented a large scale operation. As far as school children were concerned the letters were distributed through the Education Services, and I should like to take this opportunity of expressing my appreciation of the co-operation of the Director of Education and the Divisional Education Officers, and their staffs, as well as the Teachers, whose ready help did so much to ease this problem. In order to cover children attending independent schools, a communication was also sent to the Heads of such schools in the County in which they were asked to forward to the parents of their pupils copies of the circular letter and consent form. So far as the younger children were concerned, the Health Visitors undertook the task of distribution to the parents of children who had not commenced attending school. In order to cover any loophole which inadvertently might have been left uncovered, notices concerning the scheme were inserted in appropriate newspapers.

In view of the importance of this new scheme, at the request of the County Health Committee a copy of the explanatory circular letter was sent for information to all the Members of the County Council.

Whilst this activity was going on, arrangements were also made for meetings to be held of the Medical staff and the health visiting

staff, in order that the administrative as well as the technical aspects of the scheme might be fully discussed. It was thought that this would contribute towards the smooth running of the scheme when the actual inoculations were commenced.

Numbers registered, and actual inoculations. The return which was sent to the Medical Research Council's Statistical Research Unit early in April, 1956, showed that 10,528 boys and 9,544 girls had been registered for vaccination (total, 20,072, which was roughly between twenty and twenty-five per cent of those eligible for registration).

In the first instance the Ministry decided that children born in the following months should be vaccinated with the first batches of the vaccine to become available—November in each of the years 1947 to 1954, and March in each of the years 1951 to 1954. A "reserve month" was also designated in the event of vaccine being available (August 1947 to 1954). At the end of May, further months were designated as follows—"selected months" : August 1947 to 1954 and October 1951 to 1954 ; "reserve months" : May 1947 to 1954. The scheme was suspended during July to November inclusive (the usual months when polio is prevalent). The following are the numbers of children who were inoculated during 1956 :—

	Boys	*Girls*	*Total*
No. of children who received two injections (the complete course) during 1956..	1,189	1,084	2,273
No. of children who received one injection only, during 1956 ..	88	58	146

Summary—Year 1956. It will be seen, in short, that out of roughly 90,000 children in the age groups entitled to be registered for vaccination against poliomyelitis, 20,072 (about 22%) were actually registered. In 1956, 2,273 of these children received the complete course and 146 received one injection, so that during 1957 it will be necessary to give priority to completing the courses for the latter 146 children and giving two injections to the remaining 17,653 children.

The programme for 1957. The foregoing survey covers the work done in relation to this scheme during the year under review. However, it may not be out of place to refer here to the programme for 1957, because shortly before Christmas the Ministry of Health issued Circular 22/56 which indicated the arrangements to be made in the new year, when it was hoped that regular supplies of the vaccine would become available.

It was proposed that the vaccine would be made available for the children already registered ; as each batch passed the tests it would be divided among Authorities roughly in the proportion of the numbers

of registered children in their areas. The vaccine could be used to vaccinate registered children in any order, but priority should be given to those who had already had only one injection.

Under the new arrangements, general medical practitioners were to be given an opportunity to take part in the scheme from January onwards, and the details were to be settled locally between the local health authority and the local medical committee. All general practitioners, whether providing services under the National Health Service or not, should be given an opportunity to vaccinate any registered children who were their patients, but it would be left to each practitioner to decide whether he wished to take part in the arrangements. It was laid down that parents should be informed that as an alternative to having their children vaccinated by the local health authority they might ask the family Doctor if he was willing to perform the vaccination. If a practitioner decided at this stage not to take part in the scheme, he would have the right to change his mind later.

The Ministry's circular concluded by pointing out that the offer of vaccination to children other than those already registered depends on the production of larger quantities of the vaccine. Whilst it was hoped that this might be possible later in 1957, no precise indication could be given at that stage.

At the time of drafting these comments the programme for 1957 is under way, and will be the subject of a report next year.

Small Pox.

In recent years the country as a whole has been practically free from this disease, and the same general remarks regarding propaganda apply, as in the case of diphtheria. It is pleasing, therefore, to see that there has been some improvement in the number of vaccinations and re-vaccinations in 1956. Details are given in the following table :—

Vaccination against Small Pox

	Vaccination	*Re-vaccination*
1952.. ..	1,612	729
1953.. ..	1,939	795
1954.. ..	1,815	568
1955.. ..	1,816	476
1956.. ..	2,276	564

TABLE XXIV

The following is a copy of the Annual Return for the year ended 31st December, 1956, which was submitted to the Ministry of Health, relating to the vaccination position.

I. NUMBER OF PERSONS VACCINATED (or RE-VACCINATED) DURING PERIOD.

Age at date of Vaccination	*Under* 1	1	2 *to* 4	5 *to* 14	15 *or over*	TOTAL
Number Vaccinated	1,492	179	183	112	310	2,276
Number Re-vaccinated..	10	17	22	62	453	564

II. NUMBER OF CASES SPECIALLY REPORTED DURING PERIOD. (Age groups as above).

(*a*) Generalised Vaccinia ..	—	—	—	—	—	—
(*b*) Post Vaccinal Encephalomyelitis	—	—	—	—	—	—
(*c*) Death from complications of vaccination other than (*a*) and (*b*) ..	—	—	—	—	—	—

Other Diseases.

Evidence has been produced which suggests that whooping cough immunisation is of some value. The same remark also applies in respect of tetanus. The County Health Committee in September, 1956, decided that authority be sought from the Ministry of Health to make arrangements (*a*) for offering the triple prophylactic against diphtheria, whooping cough and tetanus, and also (*b*) for offering immunisation against diphtheria, whooping cough or tetanus, singly or in combination, which would enable the appropriate primary or boosting injection(s) to be offered at the most suitable times.

It was also decided that the Ministry of Health be approached to see whether they would provide the prophylactics mentioned in (*a*) and (*b*) above free of charge, in the same way as they already provide the antigen against diphtheria and vaccine against smallpox. The Ministry's decision was not known at the end of the year, and it is anticipated that this matter will be the subject of further comments in the next Annual Report.

AMBULANCE SERVICE
(Section 27)

Structure and Organisation.

During the year there were no further developments in the structure and organisation of the Ambulance Service, which continued to be wholly directly operated by the County Council from four main stations manned throughout the twenty-four hours and ten sub-stations manned during the day-time only. In respect of the latter, night cover was afforded by stand-by arrangements augmented by the main stations' resources, with the exception of Bolsover and Glossop, where complete night cover was given respectively by the Chesterfield Ambulance Station operated by the County Council, and the Stalybridge Ambulance Station operated by the Cheshire County Council.

Whilst stand-by arrangements at the Heanor Station were not entirely dispensed with, they were considerably diminished, but depending from time to time on the availability of manpower at the main ambulance station at Ripley.

Consequent upon the inauguration of the additional main stations, the County Health Committee agreed that the superintendents of those stations should supervise the day stations within their own telephone area during the absence of the day station superintendents for short periods. The desirability of such an arrangement was particularly apparent with the routing of all emergency calls through main stations and the introduction of radiotelephony by which the main station superintendents have more control over the Ambulance Service vehicles operating in their area. The system of control by a minimum number of main stations was commended by the Ministry of Health in circular 5/56 received during the year. It was pointed out that there were disadvantages in a form of organisation with large numbers of separate controls as it tended to divide the service into a number of small unconnected units, and so impede the proper co-ordination and sorting of demands on authorities' services as a whole.

The following procedure is adopted for calling an ambulance :—

(*a*) *Urgent Calls.*

If ambulance transport is required to deal with an urgent case, such as a street accident, all that is necessary is to call the Telephone Exchange Operator and ask for "Ambulance." The caller would be automatically put through to the appropriate Ambulance Station, where the call would be accepted and dealt with regardless of whom the caller might be.

(*b*) *Non-Urgent Calls.*

If a patient is suffering from a non-urgent condition, an ambulance or other form of suitable transport would be provided as appropriate, on the authority of a doctor, dentist, nurse or midwife, providing, of course, the patient cannot reasonably be required to travel by public transport.

The Council has kept all hospitals and other institutions for the sick, all general medical practitioners, dentists, nurses, domiciliary midwives, the Police, the Fire Service and Telephone Authorities, in or serving the County, informed of the addresses and telephone numbers of the ambulance stations in the County and the method of calling an ambulance.

The following is an up-to-date list of addresses and telephone numbers of the County Council's Ambulance Stations :—

Ambulance Station	*Telephone Number*		*Address*
	7 a.m. – 7 p.m.	7 p.m. – 7 a.m.	
MICKLEOVER	Derby 53916		Station Road, Mickleover, Derby.
Ashbourne ..	Ashbourne 441		Green Road, Ashbourne.
Ilkeston	Ilkeston 936	Derby 53916	Manor House, Manners Road, Ilkeston.
Long Eaton ..	Long Eaton 1055		Old Hall Depot, The Green, Long Eaton.
Swadlincote ..	Swadlincote 7041		Darklands Road, Swadlincote.
RIPLEY	Ripley 75		Ivy Grove, Ripley.
Heanor	Langley Mill 3141	Ripley 75	Wilmot Street, Heanor.
Matlock	Matlock 706		Town Hall, Bank Road, Matlock.
CHESTERFIELD	Chesterfield 6282	Chesterfield 6282	Ashgate, Chesterfield.
Bolsover	Bolsover 2121		Church Street, Bolsover.
BUXTON	Buxton 2012		Park Road, Buxton.
New Mills ..	New Mills 3333	Buxton 2012	Hague Bar Road, New Mills
Bakewell ..	Bakewell 393		Baslow Road, Bakewell.
Glossop	Glossop 504	Stalybridge 2650	Talbot House, Talbot Road, Glossop.

Note—For all emergency cases, call the Telephone Exchange and ask Operator for "AMBULANCE."

The arrangements which were made at the inception of the Service whereby the New Mills Ambulance Station gave ambulance cover to the Disley area on behalf of the Cheshire County Council throughout the twenty-four hours of the day were continued. Similar reciprocal arrangements in force since the "appointed day" with other neighbouring authorities along the whole of the County boundary were continued in the interests of economy and efficiency.

Consultations have taken place from time to time with the staffs of the various hospitals from whom the majority of the demands are received for ambulance transport, with a view to effecting economies where possible, and eliminating the possibility of undue delay in dealing particularly with out-patients and discharges from hospitals.

Ministry of Health circular 5/56 dated 6th April, 1956, referred to above was issued following a survey which the Ministry's Officers had carried out when thirty-seven authorities in England and Wales were visited. It was pointed out in that circular that it was noticeable during the course of the survey that those authorities which had good and close liaison with their hospital authorities had, as a rule, worked out mutually satisfactory arrangements which ensured both that the patients carried were only those genuinely in need of special transport and that the most economic use was made of available ambulance capacity; unnecessary calls on the ambulance service were avoided and patients were saved from missed appointments or lengthy delays. Regional Hospital Boards, Hospital Management Committees and Boards of Governors were reminded of the importance of appointing a Transport Officer to co-ordinate all calls made on the ambulance service from his hospital/s. The Ministry issued to hospital authorities, from which 60% of all calls on the ambulance service originate, a leaflet intended particularly for the use of hospital doctors responsible for ordering ambulance transport, together with a suggested notice to patients about the need for the proper use of the ambulance service.

As in the past, arrangements for long distance journeys have been dealt with by the central office. Ambulance authorities into whose areas patients were being taken were generally notified of the journeys, as well as where practicable, authorities through whose areas empty vehicles were expected to return; this arrangement which conforms to the Ministry of Health's recommendation in circular 5/56 ensures that vehicles and crews can be utilised, where convenient, on the homeward route.

Hospital Car Service.

No demands were made on this supplementary service during the year as the sitting case vehicles operated by the County Council were able to deal with all requests received.

Conveyance of Mental Patients.

The arrangement which was introduced last year whereby ambulance transport was provided from the new main station at Mickleover for the transportation of mental patients to and from The Pastures Hospital, Mickleover, was continued during the year; the ambulance station is situated a distance of approximately one mile from the hospital and, therefore, the services of specially trained attendants can be readily utilised. The transportation of mental patients falling outside the scope of this arrangement is dealt with by ambulance service vehicles located at other ambulance stations in the County.

Conveyance of Patients by Rail.

Continued efforts have been made to bring to the notice of hospitals and general medical practitioners the advantages of the use of ambulance/rail/ambulance transport particularly in respect of requests for long distance journeys ; this has resulted in the number of journeys by rail in 1955 being practically doubled during the year under review. The voluntary organisations of the British Red Cross and St. John have been of valuable assistance to the ambulance service in providing escorts particularly in connection with this mode of transportation ; at the same time the Railway Executive have continued their excellent co-operation in respect of invalid reservations.

Infectious Diseases.

The general ambulance service has been utilised, as in the past, for the transportation of all cases of infectious diseases requiring transport and no specific vehicles were allocated for that purpose. Personnel have been instructed in the technique of transportation of such patients and in the disinfection of ambulance bedding, equipment and vehicles.

To minimise the risk to personnel from contact with any case of smallpox which might arise, the policy whereby roughly half of the staff at each ambulance station is vaccinated each year has been pursued ; this means in effect that the arrangement provides for personnel to be vaccinated biennially as recommended by the Ministry of Health on the 5th September, 1956 in circular letter (H.M.(56)79).

The following table shows the number of vaccinations carried out in respect of ambulance personnel during the past five years :—

Year	*Smallpox Vaccinations*
1952	61
1953	63
1954	42
1955	81
1956	88

Major Accidents.

The procedure for dealing with major accidents was described at length in my report for 1955. The question of stock piling of equipment to deal with any such accident which might arise was reviewed and additional equipment, including first aid dressings and blankets, was purchased for that purpose.

Premises.

The County Council pursued its policy in respect of the erection of new premises for the ambulance service in accordance with the capital building programme, but in some instances difficulties were met regarding the acquisition of suitable sites. The work on the new ambulance station in Baslow Road, Bakewell, which was begun in November, 1955, has progressed, but was not completed by the end of 1956; no other ambulance stations were in course of erection during the year.

Telecommunications.

As indicated in my report for 1955, the Council's scheme for radiotelephony provides for a fixed station with monitor receiver at each of the four main stations, namely Chesterfield, Buxton, Mickleover and Ripley; three of those fixed stations were operating in 1956 and the remaining fixed station, which is sited at the "Cat and Fiddle" and remotely controlled from the Buxton Ambulance Station by means of a G.P.O. land line, is complete and operating at the time of writing this report. The following indicates the number of mobile equipments operating under the respective fixed stations at the present time :—

Controlling Base Station	*Sub-Station*	*Number of Mobile Equipments*
Buxton		6
	Bakewell	3
	New Mills	2
	Glossop	2
Chesterfield		8
	Bolsover	2
Mickleover		7
	Ashbourne	2
	Ilkeston	3
	Long Eaton	2
	Swadlincote	3
Ripley		6
	Heanor	2
	Matlock	3
	Total	51

The County Council has pursued the policy of equipping with radiotelephony only those ambulances (including light ambulances) which are fitted with a 12-volt electrical system. As and when the older ambulances fitted with the 6-volt electrical equipment are passed out of Service, consideration will be given to the replacement vehicles being brought into the radiotelephony scheme.

There can be no doubt that the introduction of two-way radio in the ambulance service has improved the efficiency of the service and afforded a means of closer liaison between stations. This has permitted a fuller measure of co-ordination of resources with consequent economy, the extent of which it is not easy to assess.

Personnel.

Safe Driving Awards.

In accordance with the Council's policy all drivers were entered during the year for the Safe Driving Competition of the Royal Society for the Prevention of Accidents. The following Table shows the results of the 1956 competition, together with those of the previous five years :—

Year	Entered	Not eligible	Disqualified	Diploma	5 year medal	Bar to 5 year medal	10 year medal	Bar to 10 year medal	15 year Brooch	Bar to 15 year Brooch	Exemptions
1951 ..	123	2	22	94	–	1	–	1	–	–	3
1952 ..	127	4	21	92	3	2	–	3	–	–	2
1953 ..	120	6	24	65	16	3	–	1	1	–	4
1954 ..	114	3	29	53	11	15	–	2	–	–	1
1955 ..	121	2	20	64	10	22	–	2	–	1	–
1956 ..	185	5	31	110	7	29	–	1	–	2	–

Every endeavour has been made to reduce the number of accidents by advice given from time to time to driver/attendants by the County Ambulance Officer and the County Road Safety Organiser ; in addition, prior to appointment, all personnel are required to pass satisfactorily a driving test conducted by the Council's Station Superintendents on ambulance service vehicles.

The total number of accidents during the year was 160 compared with 159 for 1955 ; the number of accidents, however, in which ambulance drivers were considered to some degree blameworthy expressed as a percentage of the total number of accidents was 25.6% compared with 33% for last year. When considering the total number of accidents involved it must be borne in mind that all accidents, no matter how trivial and irrespective of whether they occur on the public highway or not, are reported. All accidents reported were investigated and in cases of carelessness or negligence appropriate action was taken.

Analysis of the accidents shows that whilst the majority were of a minor nature, there were in fact one or two in respect of which the damage sustained proved somewhat costly to reinstate. There is no doubt that the increased width of ambulances, the difficult narrow roads which have to be negotiated, and in many instances, the inadequate parking facilities at hospitals, are contributory factors to the comparatively high incidence of accidents.

The important problem of accidents, however, is constantly under review.

Establishment.

The following table shows the authorised establishment of ambulance personnel :—

TABLE XXV

Ambulance Station	*Station Superintendents*	*Shift Leaders*	*Driver/ Attendants*	*Female Clerks*
Ashbourne ..	1	–	6	–
Bolsover	1	–	8	–
Buxton	1	4	24	–
Bakewell ..	1	–	7	–
Chesterfield ..	1	4	29	1
Glossop	1	–	7	–
Heanor	1	–	8	–
Ilkeston	1	–	8	–
Long Eaton ..	1	–	8	–
Matlock	1	–	8	–
Mickleover ..	1	4	24	–
New Mills ..	1	–	6	–
Ripley	1	4	28	–
Swadlincote ..	1	–	6	–
	14	16	177	1

Vehicles.

During the year the following new replacement vehicles were ordered—Six Bedford/Lomas Light Ambulances on the CA Chassis.

The following vehicles were operated on the 31st December, 1956 :—

TABLE XXVI

Location	*Number of Ambulances*	*Number of Light Ambulances*	*Number of Cars*
Ashbourne	2	1	–
Bakewell	3	–	1
Bolsover	3	1	–
Buxton	6	1	1
Chesterfield ..	9	1	–
Glossop	2	1	1
Heanor	3	–	1
Ilkeston	3	–	1
Long Eaton ..	3	1	1
Matlock	3	–	1
Mickleover ..	6	1	2
New Mills	3	–	–
Ripley	8	1	2
Swadlincote	3	–	1
Pool	7	–	–
Totals ..	64	8	12

The following Table shows the number of patients conveyed and the mileages covered by Ambulances, Light Ambulances and Sitting Case Cars during the year.

1956	*Cars*			*Light Ambulances*			*Ambulances*			*Totals*		
	Accident or Emergency	*Total Cases*	*Mileage*	*Accident or Emergency*	*Total Cases*	*Mileage*	*Accident or Emergency*	*Total Cases*	*Mileage*	*Accident or Emergency*	*Total Cases*	*Mileage*
January	77	3,161	28,701	9	692	6,507	979	13,294	98,951	1,065	17,147	134,159
February ..	53	2,730	27,155	7	622	5,653	896	13,758	100,257	956	17,110	133,065
March	67	2,994	30,377	16	964	9,161	995	13,690	100,728	1,078	17,648	140,266
April	75	2,588	25,265	16	882	8,959	895	14,280	96,270	986	17,750	130,494
May	62	2,508	25,701	31	1,481	12,909	994	13,600	95,617	1,087	17,589	134,227
June	41	2,137	21,499	25	1,842	15,586	891	12,597	90,331	957	16,576	127,416
July	48	2,352	21,122	19	1,457	15,633	942	12,160	93,329	1,009	15,969	130,084
August	24	1,458	15,970	28	1,774	16,492	959	12,488	91,925	1,011	15,720	124,387
September ..	38	1,813	19,319	40	1,154	12,333	999	12,321	92,450	1,077	15,288	124,102
October	26	2,369	24,248	23	1,190	11,538	951	13,381	101,916	1,000	16,940	137,702
November ..	46	2,373	24,008	26	1,294	12,763	946	13,529	94,695	1,018	17,196	131,466
December ..	32	1,703	17,971	33	1,312	12,290	976	11,752	88,501	1,041	14,767	118,762
	589	28,186	281,336	273	14,664	139,824	11,423	156,850	1,144,970	12,285	199,700	1,566,130

The following Table shows the development of the service since July, 1948 :—

TABLE XXVIII

Month	*Average Daily Mileage*								
	1948	1949	1950	1951	1952	1953	1954	1955	1956
January	—	2,676	3,560	4,100	3,901	4,234	4,193	4,223	4,328
February ..	—	3,021	3,556	4,115	3,929	4,316	4,348	4,460	4,583
March	—	3,297	3,716	4,132	3,874	4,390	4,571	4,498	4,525
April	—	2,999	3,440	4.091	3,856	4,174	4,319	4,342	4,349
May	—	2,973	3,900	4,135	4,129	4,167	4,450	4,527	4,330
June	—	3,018	4,039	4,356	3,710	4,215	4,376	4,534	4,247
July	1,717	3,204	3,890	4,262	4,113	4,401	4,363	4,454	4,196
August	1,888	3,346	3,639	3,895	3,792	4,044	4,071	4,441	4,012
September ..	2,143	3,496	3,669	3,716	4,122	4,492	4,333	4,649	4,137
October	2,328	3,453	3,901	3,890	4,203	4,557	4,316	4,455	4,442
November ..	2,791	3,547	4,081	3,906	4,018	4,549	4,448	4,565	4,382
December ..	2,674	3,257	3,743	3,554	3,946	4,050	4,183	4,186	3,831

The following Table shows the average number of miles travelled per patient since the 5th July, 1948 :—

Year	*Miles*
1948	14.3
1949	13.3
1950	11.8
1951	11.0
1952	9.3
1953	8.7
1954	8.4
1955	8.2
1956	7.8

During the year the total number of patients conveyed compared with 1955 showed an increase of 2.11% whilst there was a decrease in the mileage of 3.24%. A review of the total number of patients conveyed and mileages covered annually shows that there has been a steady increase in both instances since the inception of the service with two exceptions, namely, in 1952 when there was a comparatively slight decrease in the mileage, and the year under review when the mileage covered compared with the previous year was reduced by 52,509. Whilst it is appreciated that an increase in the number of patients conveyed would be expected to result in a decrease in the average number of miles travelled per patient due to the fact that they would be attending the hospital centres to which ambulances normally travel, it should be borne in mind that 1956 was the first year during which radiotelephony was in operation and it must be presumed, therefore, that that medium of communication contributed largely to the appreciable reduction in mileage covered during the year. During 1956 radiotelephony was operating for approximately only seven months from three out of four fixed Stations and only a proportion of the vehicles were fitted with radiotelephony equipment ; it may be that a full year's working of radio throughout the whole County would have brought about an even greater reduction in the mileage covered, but it is probably unwise to draw too firm conclusions on an experience extending over only a portion of a year.

PREVENTION OF ILLNESS — CARE AND AFTER CARE
(Section 28)

The County Council as a Local Health Authority may, with the approval of the Minister of Health, make arrangements for the purpose of the prevention of illness, the care of persons suffering from illness or mental defectiveness, or the after-care of such persons. The powers, under this section, therefore, extend over a wide field, and are inter-related with the general practitioner and hospital and specialist services provided respectively under parts II and IV of the National Health Service Act as well as the many other enactments administered by the County Council and the District Councils. A close liaison is maintained with the appropriate hospitals, the County Welfare Officer as well as Medical Officers of Health of Sanitary Districts in carrying out the manifold powers and duties which constitute modern social medicine. For example, when a patient requires admission to hospital, particularly if it is for a long stay, a report is requested from a Health Visitor to help the Hospital staff to determine the priority for admission; the County Welfare Officer is informed, in appropriate cases, as he has duties under the National Assistance Act for safeguarding a person's effects while he is in hospital; the Children's Officer is informed where help is required in arranging for the care of children; while the Home Nurse, the Home Help and the Health Visitor, are contacted in suitable cases as their assistance may facilitate the early return of the patient to his home.

All the Home Nurses are provided with a stock of sick room equipment, which is thus readily available for loan to patients when nursed in their own homes. Special bedsteads, mattresses, commodes, and wheel chairs (both self-propelled and push types) are also loaned on a temporary basis. Special walking aids are provided to help cripples, usually children, to learn or re-learn to walk. All these articles are loaned free of charge. The Council's service is becoming more widely known and accordingly the demand for these articles, particularly wheel chairs, is increasing considerably.

In addition, the Council has for a number of years made a grant to the British Red Cross Society, in consideration of the assistance provided through their Medical Loan Scheme to Derbyshire residents.

In the event of a person suffering from a permanent or semi-permanent disability, wheel chairs of various kinds, including those that are motor propelled, may be provided through the Hospital and Specialist Service.

TUBERCULOSIS

Bacillus Calmette Guerin—(B.C.G.) vaccination against Tuberculosis.

(1) *Contact Scheme.* Since 1950, the Ministry of Health has made available supplies of vaccine for individual chest physicians who wish to use it on their own medical responsibility for contacts of cases of pulmonary tuberculosis. The scheme is largely confined to children, but in addition a small number of hospital nurses are vaccinated.

The number of persons vaccinated during the last seven years is as follows :—

1950	.. ..	38
1951	.. ..	164
1952	.. ..	195
1953	.. ..	269
1954	.. ..	379
1955	.. ..	387
1956	.. ..	339

(2) *School Children.* In November 1953 the Minister of Health stated that he was prepared to agree to Local Health Authorities, in consultation with the appropriate Local Education Authority, extending their approved schemes to include the vaccination of older school children in and if possible towards the end of the year preceding their fourteenth birthday. It was stated that any proposed new scheme should not prejudice the existing scheme for the vaccination of contacts.

A full report was submitted to the Joint Medical Services Sub-Committee in December, 1953, when it was decided not to extend B.C.G. vaccination to thirteen year old children. At that time a National Trial of B.C.G. and other anti-tuberculosis vaccines was in progress, and it was felt undesirable to anticipate results of the experiment. In 1956 the First (Progress) Report to the Medical Research Council by their Tuberculosis Vaccines Clinical Trials Committee, was issued and as the summary may be interesting it is given below :—

"A controlled clinical trial of B.C.G. and vole bacillus vaccines in the prevention of tuberculosis in adolescent boys and girls started in September, 1950. By December, 1952, approximately 56,700 volunteers, all in their final year at secondary modern schools in or near North London, Birmingham, and Manchester, had been included ; nearly all were aged between 14½ and 15 years. Those found at an initial radiographic examination to be suffering from tuberculosis, and those known to have been in recent contact with a case of pulmonary tuberculosis at home, were excluded from the trial. This first report presents preliminary results after each participant had been in the trial for two and a half years, with supplementary incomplete information up to four years.

At the initial examination, each entrant had a chest radiograph and an intracutaneous test with 3 T.U. (tuberculin units) ; those with negative reactions to 3 T.U. were tested with 100 T.U. Those negative to both strengths were allocated by a random process to an unvaccinated, a B.C.G.-vaccinated, or a vole-bacillus-vaccinated group. The participants were thus automatically classified on entry into the following five groups ; tuberculin negative, left unvaccinated (13,300 entrants) ; tuberculin negative, B.C.G. vaccinated (14,100) ; tuberculin negative, vole bacillus vaccinated (6,700) ; tuberculin positive to 3 T.U. (16,000) ; and tuberculin positive to 100 T.U. but not to 3 T.U. (6,600). Vole bacillus vaccine was not used in the London area, and was not available for all of the time in the Birmingham and Manchester areas. Many of the volunteers had a second examination (similar to the first) three to five months after entry, while they were still at school. No participant was vaccinated or revaccinated by the investigating teams subsequent to the examination on entry.

After leaving school, participants in each of the five groups have been followed with similar intensity by means of a fourteen-month cycle of inquiry and examination, each cycle consisting of a postal inquiry, a home visit by a health visitor, and an examination which, as before, included a chest radiograph and tuberculin tests. As a result, contact was made with 94% of the participants by at least one of these three means within eighteen months

of entry ; information has since been obtained from many of the remaining 6%. In addition to these methods of discovering the cases of tuberculosis which arose, information from notification lists of medical officers of health and from chest clinic records was also made available.

All definite and suspected cases of tuberculosis have been reviewed and classified by an independent assessor, who, to avoid bias, was kept unaware both of the results of all the tuberculin tests and of whether any vaccination had been performed. A total of 165 definite cases began within two and a half years of entry to the trial. Of these 63% were of pulmonary tuberculosis and 22% of pleural effusion without evidence of pulmonary tuberculosis ; 68% of the cases were severe enough for the patients to be taken off work for at least three months. There was no death from the disease during the two and a half years.

The annual incidence of tuberculosis in the tuberculin-negative unvaccinated group was 1.94 per 1,000 ; in the B.C.G.-vaccinated group it was only 0.37 per 1,000 ; and in the vole-bacillus-vaccinated group only 0.44 per 1,000. (Strictly this last figure should be compared with the incidence among those participants in the Birmingham and Manchester areas who were admitted concurrently with those given vole bacillus vaccine—namely, with 2.06 per 1,000 in the negative unvaccinated group and 0.31 per 1,000 in the B.C.G.-vaccinated group). Each vaccine therefore conferred a substantial and similar degree of protection against tuberculosis over a period of two and a half years in adolescence. The strength of the earlier batches of vole bacillus vaccine was below the standard intended.

The protection conferred by each vaccine was evident soon after it had been given, and was still substantial between two and two and a half years after entry. Supplementary incomplete information up to four years suggests that the protection is maintained for this period. Although the numbers of cases in the vaccinated groups were small, the evidence does not indicate that protection was limited to tuberculosis in particular sites, nor that the pulmonary lesions were less extensive or severe in those who had been vaccinated but developed the disease.

Complications of vaccination consisted of occasional regional adenitis and delayed healing of the local lesion. Two cases of erythema nodosum were also attributed to B.C.G. vaccine. In addition, a number of those given vole bacillus vaccine developed lesions, indistinguishable from lupus vulgaris, at the site of vaccination ; up to the end of June, 1955, twenty-two of these had required treatment.

Among the entrants with a positive reaction to 3 T.U. the annual incidence of tuberculosis was 1.75 per 1,000, compared with 0.74 per 1,000 among those positive only to 100 T.U. The annual incidence was particularly high among those with strong reactions to 3 T.U. on entry (15 mm. induration or more)—namely, 2.93 per 1,000, compared with 0.78 per 1,000 among those with 5–14 mm. induration. Thus, in this age group those highly sensitive to tuberculin appear to have a special risk of developing tuberculosis.

The annual incidence of 0.74 per 1,000 among those positive only to 100 T.U. compares with 1.94 per 1,000 in the concurrent negative unvaccinated group. These results are not those which would be expected if positive reactions to 100 T.U. only were non-specific for tuberculosis infection. The interpretation of weak reactions to tuberculin requires further investigation.

If no participant in the present trial had been vaccinated, a total of 246 cases of tuberculosis would have been expected within two and a half years of entry ; if all the tuberculin-negative entrants had received B.C.G. vaccine a total of 111 would have been expected. This represents an expected reduction of 55% in the total incidence of tuberculosis for the two and a half years. However, 134 cases of previously unsuspected definite tuberculosis which were present on entry were excluded from the trial, nearly all as a result of the initial radiographic examination. In the absence of this radiograph, many of these cases would apparently have arisen after entry, and the apparent reduction in the total incidence of tuberculosis would have been only of the order of 35%.

The implications of these interim findings for the use of vaccination in the control of tuberculosis in adolescents are discussed. The trial is still in progress, and later reports will contain more detailed analyses over longer periods of time."

In July 1956 the Ministry of Health issued Circular 14/56 on B.C.G. Vaccination in school children, which reads as follows :—

"*B.C.G. Vaccination of School Children*

1.—I am directed by the Minister of Health to refer to Circular 22/53 in which he expressed his willingness to approve proposals by local health authorities to offer B.C.G. vaccination against tuberculosis to thirteen-year-old children. The authority will recollect that this age was chosen because it enables the great majority of children to be vaccinated in what was their penultimate year at school and to leave school with such protection as the vaccine afforded. The decision whether or not to offer vaccination to these children was left to each authority.

2.—The Minister realised when this circular was issued that some authorities would wish to await the results of a large scale trial undertaken by the Medical Research Council on the effect of the vaccination of children aged fourteen to fifteen. These children were vaccinated between 1950 and 1952 and have been kept under observation since the date of their vaccination. The first report of the Medical Research Council's Committee on Tuberculosis Vaccines has now been published and shows that vaccination offers a substantial degree of protection when given to children of this age. It is nevertheless recognised that until there has been a longer follow-up of children in the trial it will not be possible to assess whether protection afforded by the vaccine persists throughout the period of risk in adolescence. The report specifically endorses the value of the vaccination of children between their thirteenth and fourteenth birthdays.

3.—The Minister has noted that not all local health authorities have yet taken power to offer B.C.G. vaccination in accordance with the arrangements set out in Circular 22/53 and that other authorities, although they have taken the necessary powers by amending their approved proposals, have not made full use of their powers. The Minister appreciates that in both cases authorities may have been awaiting the publication of the report of the Medical Research Council's Committee. Now that the report has confirmed the value of the vaccination of children between their thirteenth and fourteenth birthdays the Minister feels that those authorities who have not yet taken power to offer the protection afforded by the vaccination to school leavers should now do so, and that those authorities who have not hitherto made full use of their powers should intensify their efforts with a view to securing the vaccination of a larger number of school leavers in their area.

4.—In the case of those authorities whose approved proposals do not allow for the provision of B.C.G. vaccination for school children, the Minister would suggest that an amendment to the proposals should follow the model form shown below.

> 'The Council will also make arrangements to offer B.C.G. vaccination to any other classes of person as may be approved from time to time by the Minister of Health.'

The adoption of an amendment on these lines, which provides for the extension of B.C.G. vaccination to other sections of the population as may be approved by the Minister, will obviate the necessity of the submission of further amendments if arrangements for the futher extention of this form of vaccination to other classes of the population are contemplated in the future."

The matter was considered by the County Health Committee at their meeting in September 1956 and it was decided to ask the Minister's approval to amend the proposals under section 28 of the National Health Service Act as follows :—

"The Council will also make arrangements to offer B.C.G. vaccination to any other classes of person as may be approved from time to time by the Minister of Health."

It was also agreed :—

(*a*) that the scheme for B.C.G. vaccination be introduced gradually for children between their thirteenth and fourteenth birthdays, throughout the administrative County, as the necessary staff, equipment, etc. become available ;

(*b*) to recommend to the Salaries and Establishment Committee that six additional whole-time medical officers be appointed to enable the additional work to be carried out ;

(*c*) to authorise the County Medical Officer to arrange for the training of appropriate medical officers, and that the Chairman be authorised to approve any necessary expenditure.

Towards the end of December the Minister signified his approval to the County Council's proposals under Section 28 of the National Health Service Act being amended in accordance with the Committee's decision.

With the kind co-operation of Professor W. Gaisford of St. Mary's Hospital, Manchester, and Professor F. Heaf of the University of Wales, Cardiff, arrangements were made for twenty of the Council's Medical Officers to attend Courses of Training in Tuberculin Testing and Vaccination Techniques. Owing to extreme pressure of work due largely to the new poliomyelitis vaccination scheme it has not been possible up to the time of writing this Report in July, 1957, to implement the B.C.G. Scheme on the lines envisaged.

Consultant Chest Physicians.

For some years past reports from some of the Consultant Chest Physicians have been included in this part of my Annual Report. The Consultant Chest Physicians who are responsible for the major part of the County are Dr. T. A. Blyton, whose Headquarters are at Chesterfield, and Dr. H. Morrow Brown, whose Headquarters are in Derby. It will be appreciated that as the Chest Physicians are employed by the Regional Hospital Boards as well as by the Local Health Authority, the areas which they cover do not always conform to Local Government boundaries.

Parts of the County are covered by other Consultant Chest Physicians ; in the north-west, areas are under the control of Dr. E. R. Smith and Dr. E. Ratner, whose headquarters are in Stockport and Ashton-under-Lyne respectively ; and the area adjoining Sheffield is under the control of Dr. H. Midgley Turner.

I am grateful to Dr. T. A. Blyton for the following report :—

Annual Report of the Consultant Chest Physician, North Derbyshire Area.

"During the past year 102 new cases of pulmonary tuberculosis have been notified in North Derbyshire out of 330,000 persons at risk, giving an incidence of approximately thirty-one per 100,000. Most of these were found to be T.B. positive prior to the commencement of treatment, and it is only the occasional case that has been treated without bacterial confirmation of the presence of the disease. In such cases tuberculosis has been the most likely diagnosis. In seven of the cases of pulmonary tuberculosis notified and confirmed bacteriologically there has been a dual pathology, with cancer of lung as the second disease. This is now becoming a more common occurrence since both tuberculosis and cancer of lung are more and more comparatively prevalent in middle and older age men, and both diseases seem to have an association with cigarette smoking.

There has, over the last five years, been a progressive decline in the incidence of pulmonary tuberculosis and the ultimate eradication of the disease has now become a short term possibility. The extension of case finding measures becomes the urgent responsibility of the whole of the Health Services, not only belonging to the County Council, but also to the Regional Hospital Board.

Prevention—Case Finding.

This involves more frequent tuberculin testing of children of pre-school age in Child Welfare and Chest Clinics, and also in the Out-Patient Departments of Hospitals. A positive tuberculin reactor in this age group leads to the discovery of an acute case of pulmonary tuberculosis amongst the close contacts of the affected child. The tuberculin test should therefore be more widely carried out—it is, in any case, one of the simplest of all tests to do and to read—and its introduction into all clinics for the young is long overdue.

B.C.G.

Another measure, which will in due course help to wipe out this disease is the introduction of B.C.G. vaccination of "school leavers." It is understood that such a scheme is about to be introduced into the County of Derbyshire. Vaccinations have been carried out of all contacts who are tuberculin negative in the North Derbyshire area, and very few parents have refused to allow their children to be so vaccinated.

Examination of Contacts.

During the year 5.7 contacts per new case of pulmonary tuberculosis have been examined. This figure may on the surface seem to be satisfactory, but let us, for one moment examine the question of contact case finding a little closer.

Perhaps the following incident may help us to realise what can and does happen almost every year :—

Mrs. A. lived in rooms at Mrs. B's house ; Mrs. B. developed pulmonary tuberculosis and was admitted to hospital for treatment as a sputum positive case. Mrs. A. and her family were examined as contacts until on the return of Mrs. B. from hospital, Mrs. A's family obtained a separate house in the same town. Owing to some difference of opinion between the families concerned nobody seemed to know the address of Mrs. A. However, cards that were sent out to Mrs. A. to her old address seemed to produce no result and she failed to attend for further contact examination. Mrs. A. soon developed acute pulmonary tuberculosis with a large cavity in one lung and her child aged ten months fell ill and was soon found to have tuberculous meningitis. A sister's child was brought to Mrs. A's house on visits from a town in the neighbouring county. This child was soon found to have extensive destruction of its small lungs by tuberculous disease. Mrs. A. has since done well on treatment in hospital, but the story of the children is unfortunately quite another matter.

This is not an isolated case, they occur year by year, and are due to inadequate knowledge of tuberculosis by those who are diseased, and by the contacts of the diseased.

However, great enthusiasm for the eradication of this disease is needed in all concerned in health matters in order that such happenings as this may never occur. Admittedly most of the people amongst whom such tragedies do occur are from problem families who will not listen to reason, but on the other hand, it may be that if more interest and more determination to get such people examined was shown on the part of all concerned, we would be far nearer to eradicating tuberculosis.

It is still my own opinion that the provision of a full-time Health Visitor attached to the Chest Clinic for the area is the answer to the proper care of contacts, and until such time as this facility is available then tragedies like the one I have just quoted are bound to occur. In the vacant Health Visitor areas of Derbyshire little if any regular attention can be paid to the tuberculous patient undergoing domiciliary treatment, and next to no attention is paid to the contacts. Such contacts come for examination if they so wish, and they are too often left alone if they decline, at first, to attend. It has already been stated that it is usually problem families that come to grief, but in the case of tuberculosis such families are not necessarily uneducated or in the low income levels. These people need talking to frequently and persistently before they can be persuaded to use all the available facilities for the prevention of the disease.

A frequent complaint from the Health Visitors themselves is that they have very little information about the patients they visit, and this problem has not been solved by monthly consultations at Chesterfield Chest Clinic. Most new cases of pulmonary tuberculosis

during the year were in some form of contact with known old cases, and in at least 20% this contact was close and therefore such cases should have been found early, if indeed they could not have be prevented. Unfortunately, very few of these cases were, in point of fact, early. Most of them were fairly advanced.

The Work of the Chest Clinic.

In the Clinics of North Derbyshire during the year approximately 2,500 new patients were seen—2,000 of these at the Chesterfield Chest Clinic—and there was a total attendance of approximately 13,000 persons. Chronic bronchitis was the most frequent abnormal condition found and the incidence of this disease appeared to be very high in the area. Most of those affected were, or had been heavy cigarettte smokers, but a large number of them also worked in industries associated with noxious fumes, e.g. foundries, coke-ovens and chemical plants. However, it is significant that the majority of sufferers from chronic bronchitis were heavy cigarette smokers.

A great drawback to the work during the year has been the inadequate space for the staff and comfort for the patients at the Chesterfield Chest Clinic. We hope, however, to have the facilities of the new Clinic at Marsden Street during the next year.

Out-Patient Investigations.

Now that carcinoma of the bronchus is on the increase, more bronchoscopies are being done in an attempt to discover cases of cancer of the bronchus in the early stages when surgical treatment may be successful. 107 bronchoscopies have been done on ninety-nine patients, the majority of whom gave a history of coughing up blood, or had abnormal appearances in the chest radiograph. As a result of bronchoscopic appearances or of examination of tissue removed at bronchoscopy, twenty-eight cases of cancer of lung were detected. Unfortunately only six of these were fit for operation and worse still, the surgeon was only able to remove the growth in two of these. A third case which was normal on bronchoscopy was operated on successfully and the carcinoma removed.

Suspected cases of cancer of lung are investigated within a few days of the first attendance at the Chest Clinic, and if operative treatment is considered necessary, this is carried out within, at most, a few weeks. Even so, the results make very sordid reading. The problem can only be solved by educating the public, especially the young, not to smoke, and also by reducing atmospheric pollution, especially at the sites where men and women carry out their work.

Walton Hospital.

All types of chest diseases are now treated at this Hospital. During the year 561 persons were admitted compared with 216 in 1951. Although the average daily number of hospital beds occupied

was only approximately ninety-five (giving a percentage occupancy of 65%) the turnover of beds has increased yearly, and the amount of medical work done at the Hospital has also proportionately increased.

Although the simpler forms of heart surgery have been done here for the first time during the last year, the number of major operations has declined. This is due to the drop in the incidence of pulmonary tuberculosis and the increased efficacy of drug treatment in this disease. However, there is still a small number of cases of pulmonary tuberculosis in which thoracic surgery can play a major part in effecting a cure, and these cases are treated here mainly by resection of lung. Other operations for this disease are now rarely performed at this hospital. Only eighty major chest operations were performed here during the year.

The treatment of chronic non-tuberculous respiratory diseases has become one of the major roles of the hospital. These include cases of bronchiectasis, chronic bronchitis and emphysema. Good Laboratory facilities are therefore more essential than ever, and we wish to express our thanks for the valuable work done for our Clinics and hospital by the County Laboratory, and the Pathological Laboratory of the Chesterfield Royal Hospital with its sub-branch at Walton Hospital."

With reference to Dr. Blyton's suggestion that chest clinics should have "their own Health Visitors" I would mention that in September, 1953 the Ministers of Health and Education for England and Wales and the Secretary of State for Scotland appointed a Working Party with the following Terms of Reference :—

"To advise on the proper field of work, the recruitment and training of Health Visitors in the National Health Service and School Health Service."

The following comments on the Working Party's Report appeared in the *British Medical Journal* of 16th June, 1956.

"No witness came out strongly in favour of specialisation, and it was deprecated by the working party. It means an increase in multiple visiting of homes, and not infrequently the stigma attached by neighbours to the 'special visitor'—the suggestion of uncleanliness or infection. As to tuberculous patients, there was no doubt about the health visitor's important part in educating them and their families about the nature of the disease and the prevention of infection, in tracing contacts and persuading them to attend for examination, and in supervising arrangements in the home for the care of the patient. Most witnesses regarded the health visitor as the practical welfare worker, but the British Tuberculosis Association had different views, desiring a wholly specialised staff permanently based on clinics and carrying out the duties of a hospital out-patient nurse. In favour of this they were prepared to forgo the advantages of the health visitor's training and her knowledge of family life. The working party strongly supported the view that the health visitor had an important function to perform in the home supervision of tuberculous patients."

The above is quoted to show that while the Working Party deprecated specialisation the British Tuberculosis Association holds a contrary view. Personally I favour the "all-purpose" Health Visitor as do, I believe, the majority of my colleagues in the Public Health Service.

There is a nation-wide shortage of qualified Health Visitors but if doctors favour special visitors for just one disease, such as, tuberculosis, diabetes, etc., then I think a State Registered Nurse without the additional midwifery and health visiting qualifications is all that is necessary.

Mass Radiography.

This service is provided by the Regional Hospital Boards, and whilst there is not a Unit based in Derbyshire the following four Mobile Mass Miniature Radiography Units operate within the County from time to time :—

Sheffield Regional Hospital Board.
- Nottingham Area No. 2 Unit, based on Nottingham.
- South Yorkshire Area Unit, based on Doncaster.
- Sheffield Area Unit, based on Sheffield.

Manchester Regional Hospital Board.
- Unit No. 3, based on Stockport.

In addition there are static Units in Nottingham and Sheffield to which cases may be referred.

Close liaison has been established between the Medical Directors of the Units, the County Medical Officer, and District Medical Officers. This is particularly the case when the Units carry out specific investigations with a view to tracing the source of infection e.g., in schools.

It will, of course, be understood that it is not possible to give accurate figures of the number of Derbyshire residents who avail themselves of the service, as surveys are often carried out at places bordering the county, when people from both Derbyshire and neighbouring areas may be examined. Complete results of the surveys are, of course, not immediately available, as some time must elapse before the full investigations are known.

Nottingham Area No. 2 Unit. This Unit is under the control of Dr. W. Guthrie, who has kindly provided a report and statistics on the work of his unit, from which it has been ascertained that eight surveys were undertaken in Derbyshire (excluding the County Borough of Derby), during the year, six of which were mainly for the general public and school children and two were at collieries.

Number of persons Examined.

	Males	*Females*	*Total*
General Public, Employees, and Training Colleges	6,503	6,928	13,431
School Children	2,796	2,738	5,534
Total ..	9,299	9,666	18,965

Of the 18,965 persons examined forty-eight were classified as tuberculous. This gives a rate of 2.5 per 1,000. The details are shewn in the following table :—

	Males	*Females*	*Total*
Active Pulmonary Tuberculosis.. ..	2	2	4
Observation Pulmonary Tuberculosis ..	21	13	34
Inactive Pulmonary Tuberculosis ..	4	6	10
Total ..	27	21	48

Seventeen persons were found to have abnormalities of a non-tuberculous nature and appropriate action was taken. The comparable figures for 1955 were 23,783 persons examined, sixty were classified as tuberculous, giving a rate of 2.5 per thousand and fifty-four were found to have abnormalities of a non-tuberculous nature. In the two Industrial Groups, the average response was 43%, while for school children the average was 80%.

Dr. Guthrie's Unit covers the south western part of Nottinghamshire, the County Borough of Derby, and the southern and central parts of Derbyshire. The following appropriate excerpts from a report he has kindly provided are given with his permission :—

"*School Children.*

This group is divided into those thirteen years of age and over, and those under thirteen years of age.

Group I (thirteen years of age and over). This has proved an interesting group this year. The incidence of active Pulmonary Tuberculosis was .06% (.03% in boys and .09% in girls i.e., three times as high in the case of the girls). Last year the incidence was .02% and in 1954 .03%. It seems, therefore, that this year apart from its educational value Mass Radiography has been well worth while in this group. The incidence in those x-rayed for the first time and also in those x-rayed previously was the same i.e., .06%. All the school children in this group were x-rayed routinely and not for any special reason such as a previously discovered case of active Pulmonary Tuberculosis in the school, and most of the cases were found in different schools in Mansfield and district, or Derby. It will be interesting to see next year whether this high incidence in this group is maintained or not.

Group II (Under thirteen years of age). No case of active Pulmonary Tuberculosis was found as in most years previously, in this group.

Doctor's Cases.

As in the previous year, the statistics seem to indicate that in order to 'pick up' as many cases as possible of pulmonary tuberculosis, Mass Radiography should be concentrated, as much as possible, on the following groups :

1. Doctor's Cases.
2. Miners.
3. Elderly Men.
4. Younger age groups in both sexes and possibly now also in the group of females thirty-five to forty-five.

In the group comprising the older men it will be noted that the percentage of the total coming for x-ray is small, and every effort is made on this Unit to induce attendance for x-ray."

The South Yorkshire Unit, of which Dr. V. E. Sherburn is the Medical Director, operates mainly outside the County, but nevertheless it undertook four surveys in North-East Derbyshire during the year. Dr. Sherburn has kindly submitted a report on the work of his unit, and with his permission the following excerpts are given :—

"*Surveys carried out.*

During the year the Unit operated at thirty-six different sites. The types of surveys were as follows :— eighteen General Public surveys in Miners' Welfares, Church Halls, Local Authority Halls, etc., ten Factory Visits, one Colliery (not available to the general public), three Grammar Schools, one visit to Doncaster to examine the current year's school-leavers (and school staffs), and a survey of the personnel of the R.A.F. Station, Scofton, Notts., and visits to St. Catherine's M.D. Institution and Western Hospital (Part III).

Public sessions.

When public sessions were held, the general practitioners in the area were invited and encouraged to refer patients for examination. Many more patients were referred by their own doctors than is shown statistically, for this is more frequently advised by oral rather than written instruction. Statistically only those examinees attending with a written request from the practitioner are counted as 'doctors referrals.' It is interesting to observe that many practitioners still refer patients for M.M.R. examination despite the increasing availability of camera units, probably because of the informality of the former type of examination.

School-leavers were also examined at convenient locations either at special sessions or more usually in small groups during the general public sessions.

No special sessions were held for the examination of ante-natal cases this year as last year's sessions were poorly attended. For this, and other reasons, such sessions were regarded as impracticable.

Policy.

There has been no material change in policy over the last twelve months. We have continued as mobile as possible and to re-visit at two to three year intervals. Further streamlining of factory visits has occurred, by the grouping of certain factories together enabling these examinations to be carried out more efficiently.

Co-operation.

Once again we must record our thanks to all sides of industry, local authorities and the various Medical Officers (both local authority and industrial) who have helped us so readily. The continued co-operation of the Chest Physicians, Thoracic surgery teams and General Practitioners has been much appreciated.

The Mass Radiography Service has been criticised recently for their tendencies to favour visits to factories, at the expense of the general public. It has been the policy of this unit to hold as many public sessions as possible, and it will be noted that over half the number of people attending, did so, at sessions available to the general public. It must however be appreciated, that factory visits have been the most economical type of survey carried out by the unit. Large numbers can be x-rayed in a short time, and it is unusual for less than 90% of the available employees to attend for examination. Further, these numbers are not affected by site of location or inclement weather, and the rather surprising relative incidence of active tuberculosis, fully justifies these surveys. This last year's work has shown that the 'pick-up' rate has been over 30% higher in the factory groups than in the general public.

This, of course, does not merit any radical change in policy, and we will continue to attempt to make the service available to as many people as possible within economical limits."

The statistics appended to Dr. Sherburn's report have not been given as it will be realised from what has been stated above that the majority of the persons x-rayed were not Derbyshire residents, nevertheless the remarks in his report are interesting and apply in a general way.

Three of the surveys carried out in Derbyshire were Industrial and one for the general public. A total of 7,135 persons including school children were x-rayed, and eight cases of active tuberculosis were discovered.

The Sheffield Area Mass Radiography Service, of which Dr. W. J. Wilson, is the Medical Director, comprises a static unit, situated at Ellin Street, Sheffield, and a mobile unit which operates from time to time in this County. Dr. Wilson reports that during the year the mobile unit carried out two surveys in Derbyshire : one industrial at an engineering works at Chesterfield, where the response rate was 79% of the persons available, and a public survey in that town. The attendance at the two surveys was 4,530 males and 3,558 females, total 8,088. Thirty-six persons were referred to the Chest Clinic, five to the general hospital for further investigation and eighty to their own doctor.

The following are excerpts from Dr. Wilson's Annual Report on the work of the Sheffield Area Mass Radiography Service for 1956, and are of general interest :—

"*Policy.*

This has remained the same as in the two previous years. The Static Unit continued to provide a permanent service for the examination of members of the General Public and an ever increasing number of selected groups. The centre remained open throughout the year and did not close in August as in 1955.

The Mobile Unit serves a very densely populated and highly industrial area. Every effort was made to cover the area as widely as possible but priority was given to factories which had never previously been visited.

The usual annual surveys were held at Rotherham, Barnsley and Chesterfield and adequate facilities for the General Public were provided.

General Public.

The public sessions at Ellin Street were again well attended and an increase of over 3,000 over the previous year was noted. The evening sessions were particularly well patronised and even during the busiest periods examinees were dealt with promptly and waiting time reduced to a minimum.

The Mobile Unit held public sessions at the three big towns and there was an increase in attendances of 4,000 over the previous year's figures.

Industrial Surveys.

The Mobile Unit visited sixteen factory sites during 1956 and joint surveys were held where ever possible, thus enabling many small firms to participate. Nine of these initial surveys and seven were repeat visits, after intervals of three to four years.

There is no doubt that Mass Radiography retains its popularity in industry and repeated requests for both initial and repeat surveys continued to be received from all parts of the area. Priority was given to industrial premises not previously visited, which resulted in a greater proportion of examinees being x-rayed for the first time.

School Children.

The Static Unit x-rayed 8,951 Sheffield children and 4,846 from other areas were examined by the Mobile Unit.

By arrangement with the Medical Officer of Health and the School Medical Service, particular attention was devoted to Mantoux Positive children in the thirteen plus age group. This practice will gradually replace the routine examination of school leavers but during 1956 the total number examined included a large residue of older children who had not been tuberculin tested and a number whose parents had refused this examination.

In the later part of the year special arrangements were also made to x-ray parents and adult relatives of the Mantoux Positive children and an encouraging response was obtained.

Ante-Natal Patients.

Attendances were the highest recorded since the scheme began in 1954 and 3,552 x-ray examinations were carried out. Most of these patients were referred from local authority Ante-Natal Clinics but the service was also used by a large City Hospital and by local authorities outside Sheffield.

There was also a steady increase in the number of patients referred by local general practitioners.

Patients referred by General Practitioners.

This service is now well established and has become increasingly popular with both doctors and patients in Sheffield and district. This appears to be mainly due to the speed, convenience and informality of the service and opportunity of attending during the evening sessions without loss of working.

During the year 7,517 patients were referred for miniature film examination compared with 6,452 in 1955.

It should be noted that these figures refer only to those patients attending with a doctor's letter. They do not include a large number of persons who came to the Centre on their doctor's advice but without a written request. In every case, however, a report was sent to the family doctor.

Active Tuberculosis.

The total number of cases (265) discovered in 1956 showed a decline of 14 per cent over the previous year's figures of 311. There were 163 men almost equally distributed in the two age groups under forty-five and over forty-five. Of the 102 women with active disease 86 per cent were under forty-five and 73 per cent under thirty-three.

The Static Unit discovered slightly more cases in 1956 but owing to the higher totals examined the rate per 1,000 fell from 4.9 in 1955 to 4.2. A slight increase in incidence rates was noted in organised groups, ante-natal patients and National Service entrants and a decrease in other groups.

There was a marked fall in the numbers discovered by the *Mobile Unit*—fifty-one cases in 1956 compared with 106 in the previous year. This mainly occurred in the organised groups but the incidence rates for all groups combined fell from 2.5 to 1.1 per thousand.

Acknowledgements.

I wish to express my sincere thanks for the friendly co-operation received from Medical Officers of Health, Chest Physicians and General Practitioners in the area and also from the Medical Staffs of General Hospitals.

The valuable assistance of Managements, Industrial Medical Officers and Welfare Officers in Industry was also greatly appreciated.

I should like to conclude by thanking all members of the staff for their hard work throughout the year and for their loyal service at all times."

The Mass Radiography Unit based on Stockport is under the direction of Dr. J. Rimington, and he reports that the unit did not carry out any surveys in Derbyshire during the year.

In a service such as Mass Radiography, the measure of success cannot be gauged merely by statistics, but from the reports of the Medical Directors of the Units, it is clear that much valuable work is being done. There can be little doubt that cases of tuberculosis and other abnormalities are discovered much earlier than otherwise would be the case, when the prospects of successful treatment are much brighter. It is pleasing to see that the general practitioners are making considerable use of the service.

The number of persons x-rayed each year from 1951 when the units first commenced large scale operations in the county, are as follows :—

Year.	*Number of persons x-rayed.*
1951	31,312
1952	30,406
1953	35,460
1954	54,411
1955	42,529
1956	34,188
Total	228,306

Occupational Therapy for Patients suffering from Tuberculosis.

By agreement with the County Welfare Committee the Craft Instructors of the Welfare Department give instruction to tuberculous patients on the recommendation of a Chest Physician. The County Health Committee has agreed to accept financial responsibility for the appropriate portion of the salaries and travelling expenses of the Craft Instructors.

National Association for the Prevention of Tuberculosis.

The County Council has for some years made an annual grant to this Association. It is a voluntary body which has been in existence for some fifty-eight years and has done great work in the campaign against the disease.

Village Settlements.

The demand in this County for accommodation at these Settlements is only small. From time to time Derbyshire patients are admitted to Sherwood Village Settlement. Two patients from this County have been in the Settlement for three years, and one patient for nearly two years, and all three have now been classified as "full settlers." A fourth patient was admitted in 1956 but he only remained there for a short time. The County Council has accepted financial responsibility for the maintenance of these patients in the Settlement.

BLINDNESS AND PARTIAL SIGHTEDNESS

This subject is one which has also been dealt with at some length in previous Annual Reports. The following tables provide a record of the number of registered blind persons in the County, and it will be seen that latterly the incidence of blindness is higher in females than in males; they also indicate that it is an affliction particularly of advancing years.

TABLE XXIX

NUMBER OF REGISTERED BLIND PERSONS FROM 1929 to 1956.

Year ended 31st December	All ages			Year ended 31st December	All ages		
	M.	F.	T.		M.	F.	T.
1929	370	296	666	1943	549	552	1,101
1930	408	333	741	1944	560	526	1,086
1931	413	360	773	1945	543	496	1,039
1932	410	378	788	1946	529	487	1,016
1933	449	401	850	1947	510	474	984
1934	488	440	928	1948	503	470	973
1935	529	458	987	1949	509	493	1,002
1936	553	483	1,036	1950	541	567	1,108
1937	580	503	1,083	1951	556	596	1,152
1938	561	523	1,084	1952	589	634	1,223
1939 (Mar. 31st)	—	—	1,075	1953	605	681	1,286
1940	547	540	1,087	1954	623	756	1,379
1941	567	539	1,106	1955	630	796	1,426
1942	566	547	1,113	1956	654	854	1,508

M—Males. F.—Females. T.—Total.

TABLE XXX

INCIDENCE OF BLINDNESS IN AGE GROUPS FROM 1943 TO 1956

Year ended 31st Dec.	Under 5			Aged 5 to 16			Aged 17 to 64			Aged 65 and over			All ages		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
1943	2	1	3	8	7	15	270	212	482	269	332	601	549	552	1,101
1944	2	1	3	9	5	14	267	194	461	282	326	608	560	526	1,086
1945	1	–	1	9	4	13	278	194	472	255	298	553	543	496	1,039
1946	1	–	1	11	7	18	258	158	416	259	322	581	529	487	1,016
1947	3	–	3	11	7	18	254	163	417	242	304	546	510	474	984
1948	3	1	4	10	7	17	256	169	425	234	293	527	503	470	973
1949	4	1	5	12	4	16	227	167	394	266	321	587	509	493	1,002
1950	4	4	8	16	5	21	226	181	407	295	377	672	541	567	1,108
1951	3	2	5	15	6	21	233	187	420	305	401	706	556	596	1,152
1952	3	1	4	16	7	23	239	204	443	331	422	753	589	634	1,223
1953	3	2	5	18	6	24	235	203	438	349	470	819	605	681	1,286
1954	4	4	8	21	4	25	238	202	440	360	546	906	623	756	1,379
1955	5	4	9	19	6	25	233	208	441	373	578	951	630	796	1,426
1956	5	6	11	18	5	23	252	212	464	379	631	1010	654	854	1,508

The following table shows the number on the register of Blind Persons for the last seven years.

TABLE XXXI

Year Ended 31st March	0–4	5–10	11–15	16–20	21–30	31–39	40–49	50–59	60–64	65–69	70—	Total
1950	6	6	11	10	36	50	78	123	81	120	501	1,022
1951	5	8	12	8	34	52	83	126	88	114	556	1,086
1952	6	9	9	11	29	60	90	131	93	122	607	1,167
Year Ended 31/12/52	4	10	12	13	28	61	91	134	99	139	632	1,223
31/12/53	5	13	11	16	29	59	86	149	99	143	676	1,286
31/12/54	8	16	9	18	31	63	87	147	94	140	766	1,379
31/12/55	9	16	9	18	27	58	89	152	97	133	818	1,426
31/12/56	11	12	11	16	33	57	95	165	98	135	875	1,508

A standard form of medical report and certificate (Form B.D.8) was introduced by the Ministry of Health, and has been in use in the country for a number of years. Wherever possible ophthalmologists of consultant status are asked to examine applicants for registration and complete the forms. As they contain information of a medical and confidential nature they are interpreted in the County Health Department and with the written consent of the persons concerned, particulars on broad lines are transmitted to the County Welfare Officer for registration purposes.

During the year Forms B.D.8. were received in respect of 350 persons, and of this number, 282 were certified blind or partially sighted, (including two who in a previous year had been certified "Not Blind"), thirty-one were certified not blind, or partially sighted, and thirty-nine were re-examinations (including the two mentioned above). Analysis of the re-examinations revealed the following information :—

Category	Blind remaining Blind	7
,,	Partially Sighted remaining Partially Sighted ..	12
,,	Partially Sighted to Blind..	12
,,	Blind to Partially Sighted..	3
,,	Blind to Not Blind	3
,,	Not Blind to Blind	1
,,	Not Blind to Partially Sighted	1

TABLE XXXII

A. FOLLOW-UP OF REGISTERED BLIND AND PARTIALLY SIGHTED PERSONS.

	Cause of Disability				
	Cataract	*Glaucoma*	*Retrolental Fibroplasia*	*Others*	*Total*
(i) Number of cases registered during the year in respect of which Section F of forms B.D.8 recommends :—					
(*a*) No Treatment ..	45	20	1	78	144
(*b*) Treatment (Medical, Surgical or Optical)	77	11	—	50	138
(ii) Number of cases in (i) (*b*) above which on follow-up action have received treatment	32	9	—	30	71

B. OPHTHALMIA NEONATORUM

(i) Total number of cases notified during the year 4
(ii) Number of cases in which
(*a*) Vision lost .. .. –
(*b*) Vision Impaired .. .. –
(*c*) Treatment continuing at end of year .. .. .. –

The Ministry has asked that particular reference should be made to cataract and glaucoma in old people and retrolental fibroplasia in premature infants. Statistics with regard to cataract and glaucoma prior to 1953 are not readily available, but the following table shows the number of persons suffering from these diseases who were registered as Blind or Partially sighted in the years 1953 to 1956, which clearly indicates that these diseases are more prevalent in the upper age Groups.

TABLE XXXIII

		Under 50	50–60	60–70	70–	Total
Cataract ..	1953	14	5	32	126	177
	1954	10	9	22	145	186
	1955	1	5	19	110	135
	1956	4	6	18	94	122
Glaucoma ..	1953	1	1	7	11	20
	1954	–	3	3	8	14
	1955	1	1	5	14	21
	1956	1	2	5	23	31

It is pleasing to see that the number of persons registered as blind or partially sighted due to cataract has decreased considerably in the last two years. Two factors may play a part in this decrease, namely :— (1) possibly people are seeking medical advice and treatment earlier than formerly, and (2) surgical treatment may now be carried out at an earlier stage in the development of the condition than was the case in the past. Glaucoma on the other hand is showing an increase, particularly in the older age group, but of course, people are living longer nowadays.

With regard to retrolental fibroplasia, this is an eye condition in infants which most unfortunately results in blindness, and which it has been suggested is due to an excessive amount of oxygen being administered in cases of prematurity. Happily in this County the incidence has been small, only six cases having been reported, three in 1952, two in 1955 and one in 1956. The births occurred in the years 1952 and 1953 and all the children were born or nursed for prematurity in hospitals.

It is thought that the following excerpt (which amongst other things deals with cataract and glaucoma) from an excellent report by Professor Arnold Sorsby and published by the Ministry of Health in 1956 on "Blindness in England—1951-1954" might prove of interest:—

"*Causes.*

The assumption of an increasing number of blind postulates no change in the causes of blindness. The decline of infectious disease as a cause of blindness has almost come to an end and, unless purposive and effective action is taken, there is, in fact no reason to anticipate any considerable change in the major blinding affections. Cataract is the one substantial cause that should show a significant reduction from the exploitation of available measures.

Some tasks.

Since nothing short of a massive—and unexpected—therapeutic advance can prevent a substantial and progressive increase in the number of blind in the foreseeable future, palliative measures—both administrative and clinical—assume a compelling interest, and fundamental researches become an inescapable necessity. Some possibilities require stressing :—

Administrative measures.

Cataract. Since the previous study—in which it was stressed that some 80 per cent of those registered as blind from cataract had had no treatment—more beds have been made available for patients requiring cataract operation, whilst more expert opinion in certification as blind is ensuring that such blindness is likely to be treated. These measures should help, but the complexity of the problem is shown by the fact that as much as 36 per cent of the newly registered as blind are over the age of eighty. In fact, amongst those registered as blind from cataract there are almost as many octogenarians and nonagenarians as in all the age groups below eighty. Geriatric care is therefore likely to be needed in a high proportion, if surgical treatment is to become feasible on a substantial scale. The co-ordination recently effected between the South Western Hospital with its geriatric patients, Lambeth Hospital with its beds and general services and the Royal Eye Hospital with its ophthalmic facilities, may well prove a significant development. It is likely that a fuller exploitation of the facilities of the general medical services and possibly of the supplementary ophthalmic services will become essential. That so many of the blind over the age of seventy are referred for certification by the National Assistance Board implies that under existing conditions there

is an inadequate relationship between the elderly and their general practitioners and the ophthalmic centres. At registration many of those blind from cataract are old and frail, but could in all probability have undergone a cataract operation comfortably and safely some years earlier. The National Health Service with its proud aim of providing health services and not merely treatment in sickness, appears to have an excellent field of action with the aging population. For one thing the supervision of the ocular health of the aged is not an unworthy task for the general practitioner, working in harmony with the ophthalmic centres. To create such harmonious contacts between the three parties should not prove an administrative impossibility.

Glaucoma. The setting up of glaucoma clinics, whilst unlikely to give immediate results on a large scale, should do much for individual patients. The greatest value of such clinics will probably lie in the concentration of material and in so compelling a clearer appreciation of the issues involved. As yet, few such clinics are available—and the toll of blindness from glaucoma is now some 1,600 annually with many thousands suffering gross visual damage.

Injuries. Industrial injuries present a simpler problem than non-industrial injuries, if only because the conditions under which they occur are much more uniform and so more readily amendable to analysis and control. Detailed data are, however, lacking and these will have to be obtained before any effective measures can be instituted. Two possibilities present themselves for the collection of the necessary data. A special follow-up enquiry on those registered blind from trauma in recent years might make it possible to define retrospectively the conditions under which the blinding accidents have occurred. Alternatively a steady stream of information might be made available by adequate notification of all accidents—non-industrial as well as industrial—leading to serious ocular injury—and this would cover not only the some 430 individuals registered each year as blinded (exclusively or in part) by injury, but also many hundreds in the general population who lose the sight of one eye through this cause. Some administrative action on blindness from injury seems imperative, and it is well worth meeting the difficulties inherent in such action, for there is much promise in the preventive measures that would become feasible.

Clinical developments.

A number of affections, whilst not figuring with any high incidence in the blind statistics as a whole, have a considerable significance in some age groups. Iritis and iridocyclitis, diadetic lesions, the hypersentive cardiovascular disturbances, and the neurological affections (which in this context stand for diseases of the central nervous system, optic atrophy from intracranial tumours, and optic atrophy of unknown origin) are all significant in themselves and together are responsible for a substantial proportion of the blind. These disorders are all the more significant because generally they produce blindness during the active years of life—together they are responsible for about 25-30 per cent of cases in each of the different age groups between twenty and sixty—and apart from blindness, they produce much visual disability. The problems they all present are aspects of general medicine as much as of ophthalmology.

If the congenital and hereditary affections are included amongst the general medical disorders, some 80 per cent or more of the blind under fifty present fairly well defined problems in general medicine. Hope in these affections lies not in an expansion of the surgical facilities available, but in the creation of clinical units which can draw on the potentialities of both ophthalmology and general medicine, even if this involves some departure from the traditions of ophthalmology as an essentially surgical speciality. The need for such medical-ophthalmological units has been emphasized by recent developments in the treatment of the cardiovascular diseases and possibly also of their ocular complications, whilst intensive clinical studies on diabetes, the inflammatory diseases, and the neurological

affections, are themselves not without promise. Units of this type would for the present be mainly clinical research units, but they would not lack therapeutic interest.

Clinical research units would have no dearth of problems to study, for apart from those of medical-ophthalmological interest, there are many more purely ophthalmic in character. Recent developments in optics, which allow the use of lenses in gross visual disabilities are amongst the issues that await systematic clinical research facilities. Furthermore the field for clinical research becomes immense if the urgently needed studies on the clinical genetics of the blinding affections are undertaken on an adequate scale.

Fundamental research.

Beyond the immediate clinical issues lies the need for an understanding of the major blinding diseases of today. In none is there any prospect of early solution of the complex problems involved. It is gratifying that in recent years considerable facilities for fundamental ophthalmological research have become available, but in view of the size and scope of the problems at issue, it would be unrealistic to regard these developments as anything but an auspicious beginning."

CHILDREN NEGLECTED OR ILL-TREATED IN THEIR OWN HOMES

In July, 1950, a joint circular was issued by the Home Office, Ministry of Health and Ministry of Education relating to the action which might be taken on the discovery of neglect or ill-treatment of children in their own homes. It was pointed out that in their capacities as health authority, education authority, welfare authority, housing authority, and as the authority for the purposes of the Children's Act, 1948, local authorities have power to assist families and so avoid the enforced removal of children from their homes. The National Assistance Board might be able to help families in need of financial assistance, and voluntary organisations exist which have been formed to deal with this sort of problem. It was thought, therefore, that if effective help is to be given at an early stage, it is essential that there should be co-ordinated use of the statutory and voluntary services. To this end it was suggested that the necessary co-operation could be achieved by the designation of a particular officer to be responsible under the authority for enlisting the interest of those concerned and devising arrangements to secure full co-operation among all the local services, statutory and voluntary, which are concerned with the welfare of children in their own homes. All significant cases of child neglect should be reported to the designated officer so that after the needs of the family as a whole had been considered, agreement might be reached as to how the local services could best be applied to meet those needs.

Following the receipt of the joint circular a Conference was held of representatives of the County Council, County District Councils, appropriate marriage guidance councils and councils for moral welfare, the British Red Cross Society, the Derby Invalid Children's Aid Association, National Society for the Prevention of Cruelty to Children, the National Assistance Board, the Derbyshire Probation Service and

the Derbyshire Constabulary. It was agreed that the County Council's Children's Officer should be responsible for co-ordinating the arrangements, and, after detailed consideration, the conclusion was reached that the most effective method of dealing with this problem would be not to set up area committees or sub-committees, but to invest the Children's Officer with power to act. As a result, the co-ordinating officer is able, immediately a case of child neglect is brought to his notice, to contact through the local Child Care Officer the other Social Workers who have knowledge of the case.

The matter was further considered in the Department in November 1954, when the following circular was drafted and sent to medical and child guidance staff, Health Visitors/School Nurses, Midwives, and Mental Health Social Workers :—

3rd December, 1954.

"Dear Sir/Madam,

Neglected Children, or Children Ill-Treated in their own Homes.

I am sure you are all interested, both by inclination and as a part of your duties, in the general welfare of children. In recent years the social conscience has been increasingly concerned to see what can be done to eliminate child neglect, and the ill-treatment of children in their own homes which sometimes regrettably takes place.

Neglect or ill-treatment arises from a variety of causes, several of which are the particular concern of workers in the health field—for example, inept home management, poor health of a parent, bad housing, mental subnormality, and so on. This is a problem, however, which has many facets ; the causes are varied and sometimes complex, and it may not be possible to find a simple solution. Several Departments of the County Council may have a contribution to make—the Children's Department, the Education Department, the Health Department, the Welfare Department—as well as voluntary associations, such as the N.S.P.C.C.

With the above in mind, it is desirable that there should be a means of co-ordinating the actions of all the available resources appropriate to a particular problem. To this end, the County Council's Children's officer has been designated as the Co-ordinating Officer for securing the full co-operation of appropriate statutory and voluntary services in the locality, which are concerned with the welfare of children in their own homes. It has been agreed that all cases of child neglect or ill-treatment and cases where, having regard to the prevailing conditions, there is likely to be neglect, coming to the notice of any statutory or voluntary Service, but with which such service cannot deal, should be reported to the County Council's Children's Officer in order that he, acting where necessary on the advice of the Clerk of the County Council, can deal with the case or refer it to the services best suited to deal with the problem.

The problems you are likely to meet in this connection may be classified in a general way under three heads :—

(i) those with which you are able to deal yourself ;

(ii) those in which you feel it would be helpful to have the services of colleagues in the Health Department (e.g. a Home Nurse might feel that a Health Visitor's advice would be helpful, or in some cases the Home Help Service may be useful) ;

(iii) those in which it is thought that other Departments of the County Council, or voluntary services, have a part to play.

Under (i) above, you yourself will, of course, take action ;

As regards (ii), you should not hesitate to write to me where necessary ;

In the case of (iii), you should not attempt to enlist help directly, but you should let me have a report in order that I may bring the Children's Officer into the picture as Co-ordinating Officer. I might say that I have informed the Children's Officer that I am agreeable for him or a member of his staff to confer with Health Visitors in any cases I have referred to him on the understanding that he informs me of the results of the Conference before action is taken. Similarly, in any case which should be brought to the notice of the Children's Officer urgently, direct contact should be made with the Children's Department (telephone Derby 43486). In these cases a written report should be sent to me as soon as possible.

Finally, I would like to stress that the aim should be to keep families together. There may be cases in which prosecution and the removal of a child from its parents will be the only possible course but it is important that early and effective action is taken in an attempt to remove or at any rate mitigate the causes of the problem, having regard to the needs of the family as a whole. If the right help is not given in time, children who might otherwise have remained with their parents may have to be removed from home because the conditions have worsened beyond control. You should, therefore, endeavour to decide as early as possible whether action is desirable under categories (ii) and (iii) above."

At the same time the Director of Education drew the attention of teachers to ways in which help might be given to further the welfare of these children.

It so happened that the Ministry of Health also issued a circular (No. 27/54) on the 30th November, 1954, which amongst other matters stressed that the Health Visitor, whose work now extends to cover the whole field of prevention of ill-health, including the prevention of mental ill-health, is by reason of her close contact with families with young children, particularly well placed to recognise the early signs of failure in the family which may lead to the disruption of normal home life, with the consequent risk to the mental health of the children.

Reference was also made to the work of voluntary associations as well as the possibilities of using the services of trained social case workers, or specially selected "home helps" to work with the mother and teach her housecraft. The use of special convalescent and re-training facilities for this type of mother, it was suggested, also has a limited but valuable application. It was stated that the suggestions made in this circular were not intended to conflict in any way with what had been said about the arrangements for co-ordination in the joint circular of July, 1950. Copies of Circular 27/54 and the circular of December 3rd, 1954, to the staff of the County Health Department, were sent to the Children's Officer, the Director of Education and the County Welfare Officer.

An arrangement has been made by the County Council, through their Children's and Welfare Committees, for the services of the Superintendent and Matron of a Home for homeless families which accommodates mothers and children for a limited period, to be utilised for the rehabilitation and after-care of families. At the end of their stay in temporary accommodation (which is limited to three months) the majority of the families make the effort and find rented accommodation where the Superintendent and Matron keep in close contact with the family to ensure that their material resources are adequate

(e.g., the supply of beds and bedding), and supervise the family budget, doing much to ensure that the family is not evicted again and the children brought into care. A proportion of the salaries of the two Officers is borne by the Children's Committee.

The question of "problem families" was further considered during 1956, when the Clerk of the County Council asked for information concerning the numbers brought to notice during the preceding twelve months.

Insofar as the County Health Department is concerned, a review of the matter showed that thirty-eight families had been brought to notice by Health Visitors, seven by staff of the School Health Service, two by Midwives, three by Hospital Almoners, and seven from miscellaneous sources, a total of fifty-seven families during a period of a year. In forty-nine instances it was considered advisable to refer the matter to the co-ordinating officer. All the families, of course continued under Health Visitor's supervision; in nine instances Housing Managers were consulted; the W.V.S., the County Welfare Officer, the Home Help Service, or the N.S.P.C.C. were also concerned in a number of the cases.

As regards special training facilities, the Authority, in association with other bodies, has provided financial assistance to enable a mother and two children to have the benefit of two month's training at Spofforth Hall Training Centre for Mothers and Children.

At the time of writing, this difficult problem is still actively under consideration and doubtless further comments on the matter will appear in the next Annual Report.

HOME HELP SERVICE
(Section 29)

General Administrative Arrangements.

As a general rule the service has operated on similar lines to the previous year but as more Home Helps have been available it has been possible to review many cases at the end of the first few weeks and then at quarterly intervals.

If reference is made to the "Progress" table it can be seen that an increased number of cases have received help this year, i.e., 1,122 as compared with 870 in 1955 and 750 in 1954.

Availability of Service.

The service is available in various cases, of which the following are examples :—

(*a*) Maternity.

(*b*) Where a housewife falls sick or must have an operation.

(*c*) Where a wife is suddenly called away to visit her husband in hospital and arrangements have to be made to look after the children.

(*d*) Where elderly people are infirm, or one of whom suddenly falls ill.

(*e*) Where several members of a household are ill at the same time.

(*f*) Where a doctor requests that a Home Help is necessary to help with a premature infant.

(*g*) Tuberculosis.

The last named presents particular difficulties, in spite of the fact that Home Helps attending cases of tuberculosis are paid an additional wage of 2d. per hour ; whilst such cases are entitled to the facilities available, special safeguards have to be imposed to protect the personnel.

The following recommendations of a committee of medical officers of Local Health Authorities and Chest Physicians of wide experience working in the area of the Manchester Regional Hospital Board are regarded as being most useful in dealing with this difficult problem:—

(1) All Home Helps employed in a household where there is an infectious case of tuberculosis should be over forty years of age, and should not have young children of their own.

(2) Home Helps for this work could be drawn from three groups :
   (*a*) Tuberculous women with arrested disease, recommended by the Chest Physician as suitable for the work.
   (*b*) Close relatives of the patient who are already family contacts. In this connection the County Health Committee has laid down certain conditions. It is suggested that where family contacts are employed the age limit may be lowered to thirty years in suitable cases.
   (*c*) Ordinary domestic helps may be employed subject to the safeguards set out under (1) above i.e., that they are over forty years of age and do not have young children of their own.

(3) The precautions against infection will vary according to the type of person employed. Home Helps with arrested tuberculosis (group 2 (*a*) above) would, of course, be acquainted with anti-tuberculosis measures and would be under regular supervision by a Chest Physician. Family contacts (group 2 (*b*) above) would also be under the close examination and supervision of the Chest Physician.

   Ordinary Home Helps (group 2 (*c*)) should be radiographed on appointment and subsequently at six monthly intervals.

   It is desirable to transfer the Helps at intervals to other types of cases, so as not to use them exclusively for tuberculosis households.

(4) Home Helps should receive instruction in anti-tuberculosis measures, and this is carried out by the Chest Physician who certifies the Help as suitable for such employment.

(5) No Home Help should undertake nursing duties, and the use of masks and gloves is not recommended.

(6) It is necessary to obtain the consent of the patient to the disclosure to the Home Help of the nature of the problem, and the Help should only undertake the work as a volunteer.

Conditions for Home Helps.

The present hourly rate for Home Helps is 2/10⅛d. per hour. Travelling expenses together with travelling time in excess of forty minutes each day at the normal rate of pay is also paid.

Progress.

The progress of the service during the last three years can be seen from the following table :—

	1954	1955	1956
Home Helps employed ..	88	108	118
Cases served	750	870	1,122
Home Help Organisers employed	1	1	2

Employment of Relatives.

There are cases which arise from time to time when the only person able to take on the duties of a Home Help is a relative of the patient. As a safeguard in such cases the County Health Committee has made a rule that a relative may be employed only on the authorisation of the Chairman and the Vice-Chairman. A condition of approval is that there is no other suitable Home Help available within reasonable travelling distance, who is willing to undertake the case, and that the Health Visitor for the area should recommend the number of hours to be worked, which in any case should not exceed forty-four per week.

Rules of Assessment.

It was intended that the recovery of the cost of providing Home Helps should be made in accordance with a suitable scale of assessment, and the present rules are, therefore, set out in full for easy reference.

RULES OF ASSESSMENT

(*Revised 23rd January*, 1956).

1. The person to be assessed will be the head of the household of the house at which the Home Help is engaged. For the purpose of this rule an apartment, flat or rooms let without attention and meals will be regarded as a house.

2. The assessment will be based on the "assessable income" of the household, which will be calculated in the following manner.

3. For the purpose of computing the "assessable income" of the household, there will be determined the "gross income" calculated in the following manner :—

Nature of Income.	*Amount to be brought into Account*
(a) Wages, salaries, pensions and/or estimated value of emoluments (e.g. board and lodging) of the head of the household and wife, and any dependent member of the household, after the deduction of income tax and employee's contribution towards superannuation and national insurance but with no deductions of any other nature.	The full amount.
(b) Contribution to the household income by a non-dependent member of the household.	One-half of the net weekly income in excess of 30/-d.
(c) (i) Where the person assessed owns the house in which he resides, any sum which might be obtained by him, by selling it or borrowing money on the security of it shall be disregarded. (ii) All other capital assets including war savings shall be aggregated. (iii) The first £400 of the amount arrived at in (ii) to be disregarded. (iv) The next £400 to be treated as equivalent to a weekly income of 6d. for each £25. (v) If the amount arrived at in (ii) exceeds £800 full cost will be charged.	
(d) Payment by a lodger for full or part board.	One sixth of a payment up to 30/-d. and one-half of the excess over 30/-d.
(e) Proceeds of sub-letting.	The full amount.
(f) All other income or means.	The full amount including family allowances and maternity allowances under Section 15 of the National Insurance Act, 1946, but excluding attendance allowance under Section 14 of that Act.

For the purpose of this rule a mother, mother-in-law, father, father-in-law, son, son-in-law, daughter, or daughter-in-law will be treated as a non-dependent unless it is to the advantage of the household that he or she should be treated as a dependent member. All other relatives will be treated as lodgers.

4. From the "gross-income" of the household calculated in accordance with the Rule 3, there will be deducted :—

(a) The disregards specified in the 2nd Schedule to the National Assistance Act, 1948, so far as they have not been allowed in computing the amount to be brought into account in the "gross income" by Rule 3 (c) and (f) and excluding the attendance allowance under Sec. 14 of the National Insurance Act, 1946, and the maternity allowance under Sec. 15 of that Act in maternity cases.

(b) Reasonable expenditure on the following outgoings by the head of the household and wife :—

(i) Fares to and from place of work and incidental expenses necessarily incurred in connection with employment.

(ii) Sick Club and Trade Union subscriptions.

(iii) Rent general and special rates, water-rates and charges and mortgage principal and interest of the house (as defined in Rule 1) in which the household is living. Schedule 'A' tax actually paid and not allowed in any other way will also be allowed.

(iv) Contributions towards maintenance of relatives not forming part of the household.

(v) Any other amounts which, having regard to the circumstances appear to be reasonable, e.g. hire purchase instalments on necessaries other than clothing and footwear, school fees, abnormal expenses arising out of sickness.

(c) Personal allowances for the personal needs of members of the household (Revised to take effect from 23rd January, 1956).

Members of Household.	*Amounts to be allowed per week*
Head of household or adult wholly or partially maintaining other members of the household resident with him, or adult living alone ..	40/0d.
Head of household and wife	67/0d.
Other dependents over 16 years (each)	23/6d.
Dependent children under 16 years :	
First child	17/6d.
Other children (each)	13/0d.
Housekeeper (if any)	24/6d.
Adult living in lodgings	Actual cost of board and lodgings plus 17/0d. per week.

The resultant figure will be "assessable income" of the household.

5. The amount to be paid will be a percentage of the aggregate of the following amounts, viz.:—

One third of the first £ of assessable income.
One half of the second £ of assessable income.
Two thirds of the remainder of assessable income.

The percentage will be :—

Hours of work	
Not more than 5 ..	30
6—10 ..	40
11—15 ..	50
16—20 ..	60
21—25 ..	70
26—30 ..	80
31—35 ..	90
36—40 ..	100

Where part of a week only is worked in the first and last weeks of service the charge will be at an hourly rate calculated by dividing the weekly assessment by the number of hours of help requested.

6. In maternity cases the amount payable per week will be increased by a percentage of the attendance allowance under Section 14 of the National Insurance Act, 1946, for the first four weeks, subject to Rule 7.

7. In no case is the assessed hourly rate charged to exceed the full cost charge which until further notice is to be taken as 3/6d. per hour*.

8. There will be a minimum charge of 2/6d. per week where the number of hours worked is not more than 20 and 5/0d. per week where the number of hours worked is more than 20. These charges will not be made in the following cases :—
   (i) Old age pensioners with no other source of income. Where an old age pensioner has other income apart from his pension the minimum charge must not exceed the assessable income.
   (ii) Cases being assisted by the National Assistance Board, unless there is an income to be brought into account under Rule 3 (b) or 3 (d).

9. Where an allowance is being made in any case by the National Assistance Board the case will be regarded as a "nil" assessment, subject to confirmation being received from the Board that the allowance does not include any amount for domestic help. If the allowance includes an amount for domestic help, such amount will be collected in full. This rule will not apply if there is income to be brought into account under Rule 3 (b) or 3 (d).

RESOURCES TO BE DISREGARDED IN ACCORDANCE WITH THE PROVISIONS OF THE 2nd SCHEDULE TO NATIONAL ASSISTANCE ACT, 1948 AND RULE 4 (a).

1. Wholly disregarded :—
   Death Grant under Section 22 of National Insurance Act, 1946.

2. Disregarded up to £1 per week in aggregate :—
   (a) The first 10/6d. of sick pay from a friendly society or trade union.
   (b) The first 10/6d. of any superannuation in respect of former employments not being :
      (i) on account of a pension under the O.A.P. Act, 1936, or W.O. and O.A.C.P. Acts, 1936 to 1941.
      (ii) retirement pension under the National Insurance Act, 1946.
   (c) (i) retired pay or pension to which Section 16 of the Finance Act, 1919 applies, including dependents allowances (wounds and disability pension).
      (ii) disablement pension awarded under the Personal Injuries (Emergency Provisions) Act, 1939, including any increase for dependents.
      (iii) Workmens compensation.
      (iv) Disablement benefit under Section 12 of National Insurance (Industrial Injuries) Act, 1946.

* This rate increased from 3/3d. per hour to 3/6d. per hour on 30th April, 1956.

MENTAL HEALTH SERVICE
(Section 51)

The Mental Health Service is the responsibility of the Local Health Authority and the work is administered by the County Health Committee with the assistance of its Mental Health Sub-Committee.

Staff.

The work in the Mental Health field is under the control of the County Medical Officer of Health. A number of Medical Officers who have special experience in Mental Deficiency have been authorised by the County Health Committee to act as Certifying Officers under the Mental Deficiency Acts, 1913-1938.

During 1955 the County Council decided to appoint a Senior Medical Officer for Mental Health which, incidentally, was looked upon with favour by the Ministry of Health. The post was advertised and Dr. R. M. C. Tyner was appointed and took up duty on the 7th November, 1955. While the County Medical Officer of Health is responsible for the organisation and control of the Mental Health Services, the Senior Medical Officer's duties will include giving advice on mental health matters; the medical direction, under the County Medical Officer, of the Mental Health Social Workers and Duly Authorised Officers; the supervision of the Authority's Occupation Centres; acting as one of the Petitioning Officers under the Mental Deficiency Acts, and also acting as one of the Approved Medical Practitioners for giving certificates under the Mental Deficiency Acts, where appropriate.

The staff of the Mental Health Section, apart from the Senior Medical Officer, comprises three Clerks, nine Occupation Centre Staff, two Home Teachers, three Mental Health Social Workers, ten Duly Authorised Officers and five relief Duly Authorised Officers. The Duly Authorised Officers also act as Welfare Officers and, as such, are on the staff of the County Welfare Department. No Psychiatric Social Workers are employed in the Mental Health Section.

At the 31st December, 1956, the following had been appointed by the County Health Committee as Petitioning Officers under the Mental Deficiency Acts:—

Dr. J. B. S. Morgan
Dr. V. J. Woodward
Dr. R. M. C. Tyner
Dr. A. H. Fairlamb.

It was thought that the appointment of four medical officers to act as Petitioners would enable the work to proceed without interruption in the event of sickness, holidays, etc., arising.

Mental Health Social Workers are mainly concerned with the supervision, care and after-care of mental defectives and their duties are as enumerated below:—

(1) Investigations concerning the ascertainment of mental defectives;
(2) Preparing information for and assisting with Petitions under the Mental Deficiency Acts;
(3) Visiting and reporting on the general care and home conditions of mental defectives under statutory supervision, voluntary supervision and under "Guardianship Orders";
(4) Advising parents on the training of mentally defective children, and giving information about Institutions and admission thereto;
(5) Finding employment in suitable cases;
(6) Arranging attendance at Occupation Centres;
(7) Supervising mental defectives on licence or holiday leave from Institutions;

(8) Co-operating with other Social Workers such as Psychiatric Social Workers, Almoners, Probation Officers, etc., dealing with the special needs of mental defectives and patients suffering from mental illness.

Occupation Centres.

Occupation Centres are established to provide for mentally defective children, excluded from school under Section 57 of the Education Act, 1944, and reported to the Local Health Authority on being found to be suffering from a disability of mind of such a nature or to such an extent as to make them incapable of receiving education at school.

In the County there are three full-time Occupation Centres situated at Chesterfield, Ilkeston and Spondon. Each of these Centres is staffed by a Supervisor and two Assistant Supervisors. In October, 1956, part-time Occupation Centres were established at County Council Clinics at Buxton (every Wednesday and Friday mornings); Chinley (all day Tuesdays and Thursdays); and Matlock (all day Mondays). These part-time Centres are staffed by a Senior Assistant Home Teacher and an Assistant Home Teacher, but when difficulties arise on account of the absence of one of the Home Teachers, for example illness, Mrs. J. Smith, an Untrained Attendant, who is attached to Dr. G. Kuttner, one of the School Medical Officers, will deputise for a Home Teacher.

The Supervisors of the full-time Centres and the Senior Assistant Home Teacher of the part-time Centres direct the work of the staff and are responsible for the teaching and organising arrangements. Even in the smallest full-time Centre a minimum staff of three is necessary if reasonable efficiency is to be maintained. Where the staff numbers less than three it is difficult to arrange a curriculum suited to the ability and aptitude of the children attending the Centre. Furthermore, in an establishment of two, great difficulties can be encountered when a member of the staff is incapacitated due to illness.

The aims of the Occupation Centre are to meet the individual needs of each child, and to develop any ability a child may have. In an Occupation Centre little emphasis is laid on purely academic subjects but the training is more of a practical nature. The pupils are instructed in habit training, handwork, and simple domestic tasks so that they become useful citizens and more adaptable to their social environment.

Free mid-morning milk is provided to patients under the age of sixteen years attending the whole-time Occupation Centres. A hot mid-day meal is also available through the School Meals Services for the patients who attend the three whole-time Centres and for those who attend the part-time Centres at Chinley and Matlock, as they are in attendance at those Centres in the mornings as well as the afternoons.

The pupils are reviewed each year by a visiting Medical Officer, in addition to frequent visits by the Senior Medical Officer for Mental Health.

The Occupation Centres are appreciated by many parents who are relieved of the strain caused by the presence of an untrained defective in the family.

Chesterfield.

This Centre is held at the Ragged School, Markham Road, Chesterfield, and had an average of about forty-two pupils on the register during the year. The staff employed was as follows :—

Supervisor : Miss G. F. Perry, Diploma of the National Association for Mental Health.

Two Assistant Supervisors : Mrs. M. L. Hill and Mrs. E. E. Stringfellow.

The Supervisor reports as follows concerning the activities at the Centre during the year :—

"The New Year commenced with forty-two children attending. Four of these were excluded because of their unsuitability and two left. Six were admitted filling these vacancies.

It has been encouraging to hear that two ex-adults have obtained light work, one in a Remploy factory, the other on a building site. They are both doing well.

Miss Ross Hogg the Tutor of the Manchester Course came to assess the National Association Mental Health student who had spent several weeks at the centre.

All the handwork completed during twelve months was sold at the Annual Open Day in July. Many parents were present and we were very pleased to welcome Councillor Gregory at the performance which followed the sale.

On a fine afternoon in July, forty-one children and staff were taken on an outing to Clumber Park, Nottingham. In previous years only the older boys and girls were able to go, but this time, owing to the kindness of Mr. Wetton who provided a larger coach, the smaller ones were taken too. On arrival, a suitable spot was found where everyone enjoyed games and a picnic tea. Later, each received an ice-cream given by Mr. Wetton.

Owing to the bad weather in the summer, walks to the Queen's Park were less frequent but nevertheless thoroughly enjoyed.

1956 ended with the Christmas Party, each child being presented with a gift, an orange, apple, sweets and chocolate."

Ilkeston.

This Centre is held at St. Mary's Schoolroom, Hallcroft Road, Ilkeston. The average number of pupils on the register during 1956 was forty-one. The staff employed was as follows :—

Supervisor : Miss E. M. Martin, trained at the Nottingham Occupation Centre and has attended a Refresher Course for Supervisors of Occupation Centres arranged by the National Association for Mental Health.

Two Assistant Supervisors : Mrs. L. Buck and Miss W. Fowler have attended Refresher Courses arranged by the National Association for Mental Health.

The Supervisor reports as follows concerning the activities at the Centre during the year :—

"A decrease of three in the number on the register of the Ilkeston Occupation Centre was shown during 1956. Only one new child was admitted, three left and one was taken off the roll, leaving thirty-nine as against forty-two the previous year. This made the average age higher than it has been for some time, and brought the standard of handwork higher also. Four patients made no improvement in any way. On the credit side, however, five made remarkable progress, and of these, two were boys who had previously been very slow starters.

Three staff and thirty-seven children had a wonderful time at Wicksteed Park on June 19th, lunch and tea being taken in the spacious cafe there. The waitresses remarked on the good behaviour of the children. The miniature train and a ride in the boat again delighted everyone, and ices and sweets were provided. Half the cost was defrayed by the County Council.

On November 15th a new venture was tried. Parents were invited to walk into the Centre during sessions, and see the normal working day of the children. Surprise, at the response to routine, and pleasure at seeing the patients actually sewing, weaving, pegging, drawing and counting was expressed by all. Cane plant and flower holders were the novelty of the year, and proved very popular.

All the handwork was sold on the morning of December 11th, when the receipts were £66 0s. 6d. A concert was given on the same morning and a feature of the nativity play was the clear speech of a number of children who had memorised individual verses. This was a great improvement on any previous attempt.

The dancing of four senior girls was also of a very high standard.

The year ended on a jubilant note with the Annual Christmas Party, complete with all the usual trimmings. Every child received a gift and a bag of fruit, nuts and sweets, after an exceptionally good tea, on December 19th.

The Inner Wheel and Rotary Club, provided a conjuror and also gave an ice cream cake and nuts and fruit.

The premises still are the "fly in the ointment" but we hope that by the time the next report is given great alterations and improvements will have taken place."

Spondon.

This Centre is held at the Methodist Church Schoolroom, Lodge Lane, Spondon, and serves the fringe area around Derby Borough. The average number of pupils on the register during 1956 was thirty. The staff employed was as follows :—

Supervisor : Miss V. L. Coxon, Diploma of the National Association for Mental Health.

Two Assistant Supervisors : Mrs. E. P. Heather and Miss P. E. Bates have attended Refresher Courses arranged by the National Association for Mental Health.

The Supervisor reports as follows concerning the work of the Centre :—

"The year started with thirty children on the register, two were admitted and three left.

There is a steady and encouraging improvement by most of the children, three have however, still made no progress, and two have deteriorated.

On January 25th a party of twenty-four children visited the Pantomime at the "Hippodrome" Derby.

An afternoon Outing was held on May 11th, when the children saw the Well Dressings at Tissington.

As in the previous year, the children were given a day's trip to the sea, when we again went to Ingoldmells, starting from the Centre at 8.0 a.m. Lunch was provided by the School Meals Service. During the day large quantities of lemonade, ice-cream and chocolate were consumed by the children.

As the weather was kind to us the day was greatly enjoyed with much paddling in the sea and games on the sands. Everyone was home, tired but happy by 9.40 p.m. Sticks of rock were brought back for those not able to be present.

It is most gratifying when the children are away from the Centre on these occasions, to have them praised for their orderly and good behaviour.

There was no charge to the parents for any of the Outings.

The Social Worker called three or four times during the year, and visits were made by members of the Health Committee.

On November 10th, the second 'Annual Autumn Fayre' was held with great success.

Our third Christmas Party was held on December 19th. Parents were again invited and were pleased with the progress of the children. The older ones presented 'The Sleeping Beauty,' in mime, and also gave a demonstration of skipping. The younger ones, Action Songs and a P.T. display. We were once more given a large tree complete with lights. There was the usual feast and crackers, a visit by Santa Claus, and to take home, fruit, sweets and balloons.

The term finished with a day of party games on December 21st. An extra week's holiday was given in order that the painting of the premises could be completed before our return in 1957."

Part-time Centres.

Part-time Centres have been established at the following County Council Clinics :—

(*a*) Bridge Street, Buxton. Every Wednesday and Friday mornings. (Average number on the register was eleven pupils).

(*b*) Lower Lane, Chinley. All day Tuesday and Thursday. (Average number on the register was ten pupils).

(*c*) Dean Hill House, Causeway Lane, Matlock. All day Monday. (Average number on the register was nine pupils).

The staff employed was as follows :—

Senior Assistant Home Teacher : Mrs. D. Handley.
Assistant Home Teacher : Miss B. A. Morten.

The Senior Assistant Home Teacher reports as follows concerning the activities at the Centres since they opened in October, 1956 :—

"This period was used chiefly as a 'settling-in' period, the purpose of which was to judge the capabilities of each child.

General activities were used in connection with Reading, Writing and Arithmetic—W. S. of Buxton and D. W. of New Mills were outstanding and reached a good standard. Other activities included painting, drawing, wool winding balls, plasticine modelling, brick building, puzzles and coloured gummed-paper pictures. These were undertaken at all centres. Knitting was attempted by girls but generally was of poor quality. The children enthusiastically prepared for the Christmas parties by making paper doilies and colourfully patterned serviettes. Christmas cards were made for parents. Physical activities were very limited owing to lack of space.

The following articles were begun :—

At Matlock—
One cushion cover—satin stitch wool embroidery.
One runner—satin stitch wool embroidery.
One embroidered picture.

At Buxton—
Two woollen rugs.
One embroidered picture.
One runner—cross stitch embroidery.

At Chinley—
Three wollen rugs.
One cushion cover—satin stitch wool embroidery.

With the exception of three children who had had previous experience in rug making, these were all first attempts of good quality.

No articles were completed in the short time available."

Co-ordination with Regional Hospital Boards and Hospital Management Committees.

As in previous years, cordial relations and close co-operation have been maintained with the various Regional Hospital Boards and Hospital Management Committees. Mental Health Social Workers have continued to visit mental defectives on licence or on holiday leave from Institutions. Periodical progress reports are forwarded to the Medical Superintendents concerned. Where necessary, suitable places of work are found by Social Workers for a number of the cases on licence from Institutions. A number of patients after working satisfactorily on licence for about one year are released from Order but still remain under voluntary supervision by the Social Workers.

Under the National Health Service Act, the responsibility for patients on licence or on holiday leave from institutions rests with the various Hospital Management Committees, but since many institutions do not employ their own Social Workers, arrangements are made with the Medical Superintendents of Mental Deficiency Hospitals to have the work done by officers of the Local Health Authority. Also on behalf of the Management Committees of the various Mental Hospitals, arrangements have been made for the Duly Authorised Officers to visit the homes of patients due to be allowed leave of absence on trial under Section 55 of the Lunacy Act, 1890, or about to be boarded out under Section 37, and regular reports are forwarded to the Medical Superintendents.

With the co-operation of Derby No. 3 Hospital Management Committee and the Hospital Management Committees of other Mental Hospitals, arrangements have been made with the County Ambulance Service for trained attendants to be available, where necessary, for the conveyance of patients to those hospitals.

Voluntary Associations.

The National Association for Mental Health.

This Association is of assistance in arranging courses of instruction in mental deficiency which are attended by Medical Officers of the Council with a view to their being approved as Certifying Officers under the Mental Deficiency Acts.

Arrangements have also been made with the Association for different trainees to work at the Chesterfield Occupation Centre for periods of six weeks as part of the training required for the Diploma in Mental Health granted by the Association.

The Association is also instrumental in arranging temporary accommodation in urgent cases.

The Guardianship Society, Brighton.

Three mental defectives subject to Guardianship Orders live near the South Coast and are under the supervision of the Guardianship Society.

Work undertaken in the Community.

(*a*) *Under Section* 28 *of the National Health Service Act*, 1946.

The work of the Mental Health Social Workers is chiefly concerned with the care and after-care of mental defectives under the Mental Deficiency Acts. 880 cases under statutory supervision and 490 cases under voluntary supervision were visited during 1956 in their homes bi-monthly or quarterly, but more frequent visits are made if required. Much helpful advice is given in regard to the completion of forms for the National Assistance Board, the National Insurance offices and other public departments. A continuous record of each case is kept in the Central Office, compiled from the detailed reports of the Social Workers on their visits.

(*b*) *Under the Lunacy and Mental Treatment Acts*, 1890-1930.

During the year 1956, as shown in the following tables, 1,413 patients were admitted to Mental Hospitals and in respect of 426 of these, orders were obtained by Duly Authorised Officers. Also advice and information were given to patients and relatives in the case of a number of patients admitted voluntarily under the Mental Treatment Acts. It is noteworthy that more than half the cases admitted to Mental Hospitals during the year were admitted voluntarily without the stigma of certification, and it is encouraging that more and more people are realising that mental illness is similar to many other illnesses in that early treatment can bring about complete recovery.

During the period 1st January 1956 to 31st December 1956, the following numbers of patients were admitted to Mental Hospitals :—

TABLE XXXIV

	Males	*Females*	*Total*
The Pastures Hospital, Mickleover	442	503	945
Scarsdale Hospital, Chesterfield	52	45	97
Kingsway Hospital, Derby	82	132	214
Ollerset View Hospital, New Mills	—	4	4
Parkside Mental Hospital, Macclesfield	21	39	60
Andressey Hospital, Burton-on-Trent	3	4	7
Mapperley Hospital, Nottingham	14	19	33
Carlton Hayes Hospital, Leicester	2	—	2
St. Thomas' Hospital, Stockport	5	6	11
Middlewood Mental Hospital, Sheffield	8	14	22
St. Matthews Hospital, Burntwood, Lichfield	6	2	8
Saxondale Hospital, Nottingham	1	2	3
Boundary Park Hospital, Oldham	—	1	1
Winwick Hospital, Winwick	—	1	1
Barnsley Hall Hospital, Bromsgrove	—	1	1
Cheadle Hospital, Cheadle	—	1	1
Bootham Park Hospital, York	—	1	1
Rauceby Hospital, Sleaford	1	—	1
St. George's Hospital, Stafford	1	—	1
	638	775	1,413

These patients were admitted in the circumstances set out in the following table :—

TABLE XXXV

	Males	*Females*	*Total*
Lunacy Act, 1890.			
Summary Reception Orders (Sec. 16)	74	136	210
Duly Authorised Officer's 3-day Orders (Sec. 20)	53	40	93
Justices' 14-day Orders (Sec. 21)	42	64	106
Mental Treatment Act, 1930.			
Temporary Patients (Sec. 5)	5	11	16
Voluntary Patients	463	524	987
Criminal Justice Act, 1948.			
Voluntary (Sec. 4)	1	—	1
	638	775	1,413

(c) *Under the Mental Deficiency Acts*, 1913-1938.

Guardianship.

The cases under Guardianship Orders are visited by a Medical Officer with a special experience in mental deficiency as well as regularly by Social Workers.

Admissions to Hospitals for Mental Defectives.

The following table shows the number of patients admitted to Hospitals for Mental Defectives during the year 1956 :—

TABLE XXXVI

Under age 16		*Over age 16*		*Total*		*Total cases*
M.	*F.*	*M.*	*F.*	*M.*	*F.*	
6	3	19	14	25	17	42

Cases urgently awaiting admission to Hospitals for Mental Defectives, 31st December, 1956.

TABLE XXXVII

Area	*Under 16*		*Over 16*		*Total*		
	M.	*F.*	*M.*	*F.*	*M.*	*F.*	*T.*
Manchester Regional Hospital Board area (Population 69,000)	5	4	3	3	8	7	15
Sheffield Regional Hospital Board Area .. (Population 641,600)	30	17	25	25	55	42	97
Whole County	35	21	28	28	63	49	112

The urgent waiting list has been as follows during the last few years :—

1952	1953	1954	1955	1956
126	151	177	170	112

In addition to these cases on the urgent waiting list there is a number of other mental defectives awaiting admission to Hospitals when beds can be provided by the Regional Hospital Boards. Any of these may become urgent at any time owing to the death or illness of aged parents, etc.

Short Term Stay.

In order to afford some measure of relief to harassed parents of mental defectives awaiting admission to Hospitals, four beds have been reserved by the Sheffield Regional Hospital Board for short-term stay and during the year, thirty-four cases were admitted for periods of three to eight weeks. This has been greatly appreciated by the parents who have been able to take a holiday or have a rest from the continual care of the defective child.

Cases dealt with during 1956.

The following table gives details of the number of mental defectives reported and dealt with during the year 1956 and also shows the number of mental defectives "ascertained" in the County on the 1st January, 1957 :—

TABLE XXXVIII

MENTAL DEFICIENCY ACTS, 1913-1938

Name of Local Health Authority : Derbyshire.

	During 1956				*Total cases on Authority's registers as at 1st January*, 1957			
	Under age 16		*Aged 16 and over*		*Under age 16*		*Aged 16 and over*	
	M.	*F.*	*M.*	*F.*	*M.*	*F.*	*M.*	*F.*
1. *Particulars of cases reported during* 1956 :—								
(a) Cases at 31st December ascertained to be defectives "subject to be dealt with." Action taken on reports by:—								
(i) Local Education Authorities on children								
(1) While at school or liable to attend school	16	15	–	–	–	–	–	–
(2) On leaving special schools	2	1	–	2	–	–	–	–
(3) On leaving ordinary schools	1	–	–	–	–	–	–	–
(ii) Police or by Courts ..	–	–	1	1	–	–	–	–
(iii) Other Sources	4	2	7	8	–	–	–	–
(b) Cases reported but not regarded at 31st December as defectives "subject to be dealt with" on any ground.. ..	5	4	22	23	–	–	–	–
(c) Cases reported but not regarded as defectives by 31st December and thus excluded from (a) or (b)	3	–	5	5	–	–	–	–
(d) Cases reported in which action was incomplete at 31st December, 1956 and are thus excluded from (a) or (b) ..	1	1	2	4	–	–	–	–
Total number of cases reported during the year :—	32	23	37	43	--	–	–	–

	During 1956				*Total cases on Authority's registers as at 1st January, 1957*			
	Under age 16		*Aged 16 and over*		*Under age 16*		*Aged 16 and over*	
	M.	*F.*	*M.*	*F.*	*M.*	*F.*	*M.*	*F.*
2. *Disposal of cases.*								
(a) Of the cases ascertained to be defectives "subject to be dealt with" number :—								
(i) Placed under Statutory Supervision ..	23	17	4	6	181	150	252	297
(ii) Placed under Guardianship	–	–	–	–	–	–	2	2
(iii) Taken to "Places of Safety"	–	–	–	–	1	–	–	–
(iv) Admitted to Hospitals ..	–	1	4	5	27	21	238	294
(b) Of the cases not ascertained to be defectives "subject to be dealt with" number :—								
(i) Placed under Voluntary Supervision ..	1	1	18	21	7	5	231	247
(ii) Action unnecessary ..	4	3	4	2	–	–	–	–
Total of item 2	28	22	30	34	216	176	723	840
3. *Classification of defectives in the Community on* 1.1.57								
(a) Cases included in item 2 (a) (i) to (iii) above in need of Institutional care :—								
(1) In urgent need of hospital care :—								
(i) "cot and chair" cases	–	–	–	–	10	6	–	5
(ii) ambulant low grade cases	–	–	–	–	16	12	5	6
(iii) medium grade cases	–	–	–	–	8	3	14	12
(iv) high grade cases ..	–	–	–	–	1	–	9	5
(2) Not in urgent need of hospital care :—								
(i) "cot and chair" cases	–	–	–	–	2	1	–	–
(ii) ambulant low grade cases	–	–	–	–	5	1	5	4
(iii) medium grade cases	–	–	–	–	4	5	18	14
(iv) high grade cases ..	–	–	–	–	–	–	4	8
Total of item 3 (a) ..	–	–	–	–	46	28	55	54

	Under age 16		*Aged 16 and over*	
	M.	*F.*	*M.*	*F.*
3. *Classification of defectives in the Community on* 1.1.57 (*continued*)				
(b) Of the cases included in items 2 (a) (i) and (ii) and 2 (b) (i) overleaf, number considered suitable for :—				
(i) occupation centre	76	60	19	27
(ii) industrial centre	–	–	27	26
(iii) home training	–	2	4	4
Total of item 3 (b)	76	62	50	57
(c) Of the cases included in item 3 (b) number receiving training on 1.1.57 :—				
(i) in occupation centre (including Voluntary Centres)	52	43	7	12
(ii) in industrial centre	–	–	–	1
(iii) from a home teacher in groups *	4	5	10	13
(iv) from a home teacher at home (not in groups)	–	–	–	–
Total of item 3 (c)	56	48	17	26

* These are part-time occupation centres conducted at clinics by two home teachers.

4. Number of Mental Defectives who were in Institutions, under Community Care (including Voluntary Supervision) or in "Places of Safety" on 1st January, 1956, who have ceased to be under any of these forms of care during 1956.

	M.	*F.*	*T.*
(a) Ceased to be under care	5	10	15
(b) Died, removed from area, or lost sight of ..	25	32	57
Total	30	42	72

5. Of the total number of mental defectives under Supervision or Guardianship or no longer under care.

(a) Number who have given birth to children while unmarried during 1956 2

	Males	*Females*
(*b*) Number who have married during 1956 ..	3	8

6. Number of mental defectives for whom short term care was arranged by the local health authority during 1956 and admitted to National Health Service Hospitals :—

Under age 16		*Age 16 and over*	
M.	*F.*	M.	*F.*
15	12	2	5

APPENDIX I.

NATIONAL HEALTH SERVICE ACT, 1946

LOCAL HEALTH SERVICES

PART I.

RETURN RELATING TO SERVICES PROVIDED BY OR ON BEHALF OF THE COUNCIL AS LOCAL HEALTH AUTHORITY AND OF THE WORK DONE DURING THE YEAR 1956

1. Births.

Actual number of births in the Authority's area during the year as notified under Section 203 of the Public Health Act, 1936, or Section 255 of the Public Health (London) Act, 1936, and the number as adjusted by any notifications transferred in or out of the area :—

(1)	Live Births		Stillbirths		Totals	
	Actual (2)	Adjusted (3)	Actual (4)	Adjusted (5)	Actual (6)	Adjusted (7)
(a) Domiciliary ..	4,798	4,801	74	73	4,872	4,874
(b) Institutional ..	4,617	5,971	105	176	4,722	6,147

2. Ante-Natal and Post-Natal Clinics.

NOTES : A list giving the names and addresses of any clinics (*a*) discontinued and (*b*) started during the year should be attached.

Clinics provided by another Local Health Authority and used by agreement or by a voluntary organisation which the Authority subsidise but which are situated in the area of another authority should *not* be included, but a separate note should be attached showing the number of such clinics used by mothers resident in the Authority's area and the number of sessions held *per month* and if readily available, statistics as in columns (4) to (6) in respect of these women.

In cols. (4)-(6) women examined post-natally at ante-natal clinics should be included in the post-natal (not the ante-natal) figures and also shown separately between dotted lines.

In col. 5 enter for ante-natal clinics women who had *not* previously attended any clinic of the Local Health Authority during current pregnancy, and for post-natal clinics women who had *not* previously attended any post-natal clinic of the Local Health Authority after last confinement.

(1)	Number of clinics provided at end of year (whether held at Child Welfare Centres or other premises) (2)	Number of sessions now held **per month** at clinics included in col. (2) (3)		Number of women in attendance (4)		Total number of attendances during the year (6)	
		Medical Officers Sessions	• Mid-wives Sessions	Number of women who attended during year	Number of new cases included in col. (4) (5)	Medical Officers Sessions	Midwives Sessions*
Local Health Authority Clinics:							
(*a*) Ante-natal clinics ..	23	109	—	4,636	3,837	15,018	—
(*b*) Post-natal clinics ..	2	2	—	570 516	559 504	619 531	- -
Clinics provided by Voluntary Organisations:							
(*c*) Ante-natal clinics ..	—	—	—	—	—	—	—
(*d*) Post-natal clinics ..	—	—	—	- -	- -	- -	- -

*Where no Medical Officer is present.

3. Child Welfare Centres.

NOTES: A list giving the names and addresses of any centres (*a*) discontinued and (*b*) started during the year should be attached.

Centres provided by another Local Health Authority and used by agreement, or by a voluntary organisation which the Authority subsidise but which are situated in the area of another authority, should *not* be included, but a separate note should be attached showing the number of such centres used by children resident in the Authority's area and the number of sessions held *per month*, also, if readily available, statistics as in columns (4)-(12) in respect of these children.

Attendances by mothers for the purpose of obtaining welfare foods, etc. only should not be included in the Table.

Attendances at specialist clinics or for special treatment, e.g., orthopaedic clinics, sunlight treatment, etc. should not be included in the Table.

Centres provided by: (1)	Number of centres provided at end of year (2)	Number of Child Welfare sessions now held per month at centres in col. (2) (3)	Number of children who first attended a centre of this Local Health Authority during the year, and who at their first attendance were under 1 year of age (4)	Number of children who attended during the year and who were born in: 1956 (5)	1955 (6)	1954-51 (7)	Total Number of children who attended during the year (8)	Number of attendances during the year made by children who at the date of attendance were: Under 1 year (9)	1 but under 2 (10)	2 but under 5 (11)	Total attendanc during th year (12)
(*a*) L.H.A. ..	88	334	6,565	7,455	4,720	4,290	16,465	77,546	16,262	11,190	104,998
(*b*) Vol. Org. ..	2	7	98	79	73	50	202	1,143	289	137	1,569

4. Dental Care of Expectant and Nursing Mothers and Children under School Age.

(*a*) Number of Officers employed at end of year on a salary basis in terms of whole-time officers to the maternity and child welfare service :—

(1) Senior Dental Officer	0.25
(2) Dental Officers	0.89

(*b*) Number of Officers employed at end of year on a sessional basis in terms of whole-time officers to the maternity and child welfare service — None

(*c*) Number of dental clinics in operation at end of year — 13

(*d*) Total number of sessions (i.e. equivalent complete half days) devoted to maternity and child welfare patients during the year — 44*

(*e*) Number of dental technicians employed in the Local Health Authority's own laboratories at the end of the year — None

* 44 in Chesterfield Borough (None specifically set aside in the remainder of the County for expectant and nursing mothers and pre-school children).

Dental Treatment Return.

A. NUMBERS PROVIDED WITH DENTAL CARE :

	Examined	Needing Treatment	Treated	Made Dentally Fit
pectant and Nursing Mothers	19	19	19	6
ildren under Five	736	688	666	255

B. FORMS OF DENTAL TREATMENT PROVIDED :

	Scalings and Gum Treatment	Fillings	Silver Nitrate Treatment	Crowns or Inlays	Extractions	General Anaesthetics	Dentures Provided		Radiographs
							Full Upper or Lower	Partial Upper or Lower	
pectant and Nursing Mothers	2	2	—	—	35	10	—	—	—
ildren under five	1	32	360	—	1,086	401	—	—	—

Health Visiting and Tuberculosis Visiting.

Visiting.

	HEALTH VISITORS										TUBERCULOSIS VISITORS
	Number of children under 5 years of age visited during year	Expectant mothers*		Children under 1 year of age†		Children age 1 and under 2 years	Children age 2 but under 5 years	Tuberculous Households‡	Other cases§	Total number of families or households visited by Health Visitors	Total visits paid to tuberculous households¶
		First visits	Total visits ‖	First visits	Total visits ‖	Total visits ‖	Total visits ‖	Total visits ‖	Total visits ‖		
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
..H.A	43,829	2,334	3,181	9,790	28,690	15,218	34,034	2,983	7,529	37,690	—
Vol. Org.	—	—	—	—	—	—	—	—	—	—	—

"No access" visits not included between dotted lines above — 8,525.

*These figures should not include visits paid by a midwife-health visitor who is to attend the confinement as a midwife or maternity nurse.
The "first visit" to an expectant mother is the first visit paid by a health visitor during any one pregnancy.

†The "first visit" to a child under 1 year old is the first visit paid by a health visitor of this Local Health Authority after the birth of the child.

‡This heading relates to visits made by health visitors not employed solely on tuberculosis work (as to which see col. (12)).

§"Other cases" should include visits for such purposes as reporting on still-births and infant deaths, infectious disease, care of old people, hospital after-care, etc.

‖"No access" visits should be **excluded** from the total, but the number shown between dotted lines. A "no access" visit is one in which the health visitor does not make contact with the person intended to be visited or a responsible representative of that person.

¶This heading relates to visits made by health visitors and tuberculosis visitors employed solely on tuberculosis work.

B. Clinics.

(*a*) Total number of attendances made by health visitors at local health authority clinic sessions during the year 7,787

(*b*) Total number of attendances by whole-time tuberculosis visitors at chest clinic sessions during the year .. .. —

6. Home Nursing.

(1)	Medical (2)	Surgical (3)	Infectious Diseases (4)	Tuberculosis (5)	Maternal Complications (6)	Others (7)	Totals (8)	Patients included in (2)-(7) who were 65 or over at the time of the first visit during the year* (9)	Children included in (2)-(7) who were under 5 at the time of the first visit during the year* (10)	Patients included in (2)-(7) who had had more than 24 visits during the year (11)
Number of cases attended by Home Nurses during the year :— (*a*) L.H.A. ..	11,329	3,741	54	408	99	1,250	16,881	6,128	500	3,48
(*b*) Vol. Org. under arrangements with the Authority	—	—	—	—	—	—	—	—	—	—
Number of visits paid by Home Nurses during the year :— (*c*) L.H.A. ..	287,604	66,178	888	13,118	1,051	24,849	393,688	206,186	2,498	226,36
(*d*) Vol. Org. under arrangements with the Authority	—	—	—	—	—	—	—	—	—	—

* The number of visits paid to the special classes of patients in columns (9), (10) and (11) should be shown under items (c) and (d) as appropriate.

7. Domestic Help.

(i) Number of Domestic Help Organisers employed at the end of the year :—

(*a*)	Whole-time	2
(*b*)	Part-time	Nil.

(ii) Number of Domestic Helps employed at the end of the year :—

(*a*)	Whole-time	54
(*b*)	Part-time	64

(iii) Number of cases where domestic help was provided during the year* :—

(*a*)	Maternity (including expectant mothers)	194
(*b*)	Tuberculosis	–
(*c*)	Chronic sick including aged and infirm	813
(*d*)	Others	115

*A case should be counted only once, even if help ceased and recommenced during the year.

All cases should be counted, even if help began in the preceding year.

8. Distribution of Welfare Foods.

Number and type of distribution points at end of year :—

(*a*)	Maternity and child welfare centres..	69
(*b*)	Others	74

9. Day Nurseries (including 24-hour Nurseries) as at end of year.

NOTE : A list giving the names and addresses of any Day Nurseries (*a*) opened, (*b*) closed during the year should be attached.

(1)	Number (2)	Number of approved places		Number of children on the register at the end of the year		Average daily attendance during the year	
		Under 2 (3)	2–5 (4)	Under 2 (5)	2–5 (6)	Under 2 (7)	2–5 (8)
Nurseries maintained by the Council	5	91	134	68	164	49	126
Nurseries maintained by Voluntary Organisations by arrangement with the Council under Section 22 of the Act	—	—	—	—	—	—	—

10. Daily Minders receiving fees from the Authority under Section 22 of the National Health Service Act, 1946, at end of year.

(*a*)	Number of minders	Nil.
(*b*)	Number of children cared for	Nil.

11. Mother and Baby Homes—(i.e. Homes or hostels for unmarried mothers and their babies).

: and Address of Home or Hostel (1)	Number of beds				Number of admissions (ignoring re-admissions after confinement) during the year (6)	Number of admissions in col. (6) for which the authority was responsible (7)	Average length of stay	
	Total beds (excluding maternity and labour and cots) (2)	*Maternity (excluding labour and isolation) (3)	Labour beds (4)	Cots (5)			Ante natal (8)	Post natal † (9)
Provided by the Authority :—		N	I	L				
Provided or used by Voluntary Organisations with which the Authority make arrangements under S. 22 (1) or to which the Authority make payment under S. 22 (5):—		N	I	L				

(*c*) Number of cases sent by the Authority during the year to homes other than those mentioned in (*a*) and (*b*) above, payment being made on an *ad hoc* basis :—

(1) Expectant Mothers	64
(2) Post-Natal Cases	67

*A separate form M.C.W. 96a, should be furnished for each institution with *maternity* beds included in the above table. Immediate information should be sent to the Principal Medical Officer for the Region and addressed to him at the Ministry of Health, Savile Row, W.1, of every occurrence in any of these institutions of :—

(*a*) DEATH ;
(*b*) OPHTHALMIA NEONATORUM, PEMPHIGUS AND *INFECTIVE GASTRO-ENTERITIS* ; AND
(*c*) AN OUTBREAK OF OTHER INFECTIOUS DISEASES.

†Exclusive of the lying-in period.

12. Illegitimate Children (with special reference to Circular 2866).

(i) Do the Authority employ a Social Worker for the purpose of Circular 2866

(*a*) themselves ?	No
(*b*) in combination with another Local Health Authority ?	No

(ii) If not, what arrangements are made for this work to be undertaken ? The Superintendent Health Visitor has been specially deputed to keep illegitimate children under particular observation.

PART II.

MIDWIVES ACT, 1951.

RETURN BY LOCAL SUPERVISING AUTHORITY.

1. Midwives.

NOTE : Midwives engaged in both domiciliary and institutional practice should be included in the capacity in which they are mainly employed.

	Number of Midwives practising in the area of the Local Supervising Authority at end of year.		
	Domiciliary Midwives	Midwives in Institutions	Total
(*a*) Midwives employed by the Authority	101	–	101
(*b*) Midwives employed by Voluntary Organisations—			
(i) Under arrangements with the Local Health Authority in pursuance of Section 23 of the National Health Service Act, 1946	–	–	–
(ii) Otherwise (including Hospitals not transferred to the Minister under the National Health Service Act)	–	–	–
(*c*) Midwives employed by Hospital Management Committees or Boards of Governors under the National Health Service Act :—			
(i) Under arrangements with the Local Health Authority in pursuance of Section 23 of the National Health Service Act, 1946	–	20	20
(ii) Otherwise	–	62	62
(*d*) Midwives in Private Practice (including Midwives employed in Nursing Homes)	7	1	8
Totals	108	83	191

2. Deliveries Attended by Midwives.

NOTES: This table relates to *women* delivered, not in the case of multiple births, to infants.

Where midwives are engaged in both domiciliary and institutional practice, cases attended by them should be separated into domiciliary or institutional.

Where institutional midwives are employed by a Hospital Management Committee or Board of Governors responsible for several institutions situated in the areas of more than one Local Supervising Authority, the cases attended by them should be included in the return of the Authority in whose area the cases are located.

Domiciliary cases attended by midwives (cols. (2)-(6)) should *not* include cases delivered in institutions but attended by domiciliary midwives on discharge and before the 14th day. This information should be provided at item (e).

	Number of deliveries attended by Midwives in the area During the year					
	Domiciliary Cases					
	Doctor not booked		Doctor booked			
(1)	Doctor present at time of delivery of child (2)	Doctor not present at time of delivery of child (3)	Doctor present at time of delivery of child (either the booked Doctor or another) (4)	Doctor not present at time of delivery of child (5)	Totals (6)	Cases in Institutions (7)
Midwives employed by the Authority ..	56	1,039	1,346	2,310	4,751	—
Midwives employed by Voluntary Organisations— (i) Under arrangements with the Local Health Authority in pursuance of Section 23 of the National Health Service Act, 1946	—	—	—	—	—	—
(ii) Otherwise (including Hospitals not transferred to the Minister under the National Health Service Act) ..	—	—	—	—	—	—
Midwives employed by Hospital Management Committees or Boards of Governors under the National Health Service Act ..	—	—	—	—	—	3,377
Midwives in Private Practice (including Midwives employed in Nursing Homes)..	—	1	3	1	5	399
TOTALS ..	56	1,040	1,349	2,311	4,756	3,776

(*e*) Number of cases delivered in institutions but attended by domiciliary midwives on discharge from institutions and before the fourteenth day, 1,283.

(*f*) **Breast Feeding.**

Number of domiciliary cases in which the infant was wholly breast fed at the fourteenth day, 3,848.

3. Medical Aid under Section 14 (1) of the Midwives Act, 1951.

Number of cases in which medical aid was summoned during the year under Section 14 (1) of the Midwives Act, 1951, by a Midwife, whether a fee was payable by the Local Health Authority or not :—

(*a*)	Domiciliary cases :—	
	(i) Where the Medical Practitioner had arranged to provide the patient with maternity medical services under the National Health Service ..	280
	(ii) Others	262
	Total	542
(*b*)	Cases in Institutions	318

4. Administration of Inhalational Analgesics.

(1) **Institutional Midwives.**

Number of **Institutional** Midwives in practice in the area at the end of the year qualified to administer inhalational analgesics in accordance with the requirements of the Central Midwives Board :—

(*a*)	Employed in homes and hospitals in the National Health Service	61
(*b*)	Employed in nursing homes or in maternity homes and hospitals not in the National Health Service	5

(2) **Domiciliary Midwives.**

NOTE : The information asked for item (*d*) in columns (3)-(10) should be supplied where available.

(1)	Number of **domiciliary** midwives practising in the area at end of year who were qualified to administer inhalational analgesics in accordance with the requirements of the Central Midwives Board (2)	Number of sets of apparatus for the administration of inhalational analgesics in use at end of year		Number of cases in which inhalational analgesics were administered by midwives in **domiciliary** practice during the year:-				Number of cases in which pethidine was administered by midwives in **domiciliary** practice during the year :—	
				When doctor was present at time of delivery of child		When doctor was not present at time of delivery of child		When doctor was present at time of delivery of child	When doctor was not present at time of delivery of child
		Gas and air (3)	"Trilene" (4)	Gas and air (5)	"Trilene" (6)	Gas and air (7)	"Trilene" (8)	(9)	(10)
(*a*) Domiciliary Midwives employed directly by Local Health Authority	101	102	63	788	130	1,863	323	704	1,693
(*b*) Domiciliary Midwives employed under Section 23 by voluntary organisations as agents of Local Health Authority	—	—	—	—	—	—	—	—	—
(*c*) Domiciliary Midwives employed under Section 23 by hospital authorities as agents of Local Health Authority	—	—	—	—	—	—	—	—	—
(*d*) Domiciliary Midwives in private practice or employed by organisations not acting as agents of Local Health Authority	2	2	—	—	—	—	—	—	—
Totals	103	104	63	788	130	1,863	323	704	1,693

PART III.

RETURN OF WORK DONE BY THE AUTHORITY UNDER :—

1. Nurseries and Child-minders Regulation Act, 1948.

	Number registered at end of year	Number of children provided for
Premises :		
(*a*) Factory	Nil.	Nil.
(*b*) Other nurseries	Nil.	Nil.
Daily Minders	Nil.	Nil.

2. Registration of Nursing Homes (Sections 187 to 194 of the Public Health Act, 1936).

	Number of Homes	Number of beds provided for		
		Maternity	Others	Totals
Homes first registered during year ..	—	—	—	—
Homes on the register at end of year	6	18	79	97

Names of the Councils of any County Districts to which the powers and duties of the County Council have been delegated under Section 194 of the Public Health Act, 1936, and particulars of the powers delegated.

Chesterfield Corporation, Glossop ,, , Ilkeston ,, } The powers and duties of the County Council for the respective areas.

PART IV.

PREMATURE BIRTHS

NOTES : This section covers live births and still-births of 5½ lbs. or less at birth.

Births in an ambulance or in the street should be listed under the place to which the case is immediately transferred.

1. Number of Premature Live Births Notified (as adjusted by any notifications transferred in or out of the area).

(*a*) In hospital	538
(*b*) At home	196
*(*c*) In private nursing homes	38
Total	772

2. Number of Premature Still-Births Notified (as adjusted by any notifications transferred in or out of the area).

(*a*)	In hospital	98
(*b*)	At home	22
*(*c*)	In private nursing homes	2
	Total	122

*"Private nursing homes" includes nursing homes and maternity hospitals and homes not in the National Health Service and Mother and Baby Homes where women are confined in the Home.

NOTE : The totals in the table below should correspond with the appropriate figures in items 1 and 2 above, e.g. the sum of the totals in cols. (5) and (8) of the table should correspond with item 1 (*b*) above.

Weight at birth	PREMATURE LIVE BIRTHS															Premature Still-births		
	†Born in Hospital			Born at home and nursed entirely at home			Born at home and transferred to hospital on or before 28th day			Born in nursing home and nursed entirely there			Born in nursing home and transferred to hospital on or before 28th day					
	Total	Died within 24 hours of birth	Survived 28 days	Total	Died within 24 hours of birth	Survived 28 days	Total	Died within 24 hours of birth	Survived 28 days	Total	Died within 24 hours of birth	Survived 28 days	Total	Died within 24 hours of birth	Survived 28 days	Born in hospital	Born at home	Born in nursing home.
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)
(*a*) 3 lb. 4 oz. or less (1,500 gms. or less)	69	22	28	12	8	3	5	1	2	–	–	–	–	–	–	39	8	1
(*b*) Over 3 lb. 4 oz. up to and including 4 lb. 6 oz. (1,500-2,000 gms.)	115	11	101	10	–	10	18	–	15	4	1	3	–	–	–	26	5	–
(*c*) Over 4 lb. 6 oz. up to and including 4 lb. 15 oz. (2,000-2,250 gms.)	103	1	98	9	1	7	8	1	6	7	–	6	–	–	–	8	1	1
(*d*) Over 4 lb. 15 oz. up to and including 5 lb. 8 oz. (2,250-2,500 gms.)	251	2	246	127	2	123	7	1	5	27	1	26	–	–	–	25	8	–
Totals	538	36	473	158	11	143	38	3	28	38	2	35	–	–	–	98	22	3

†The group under this heading will include cases which may be born in one hospital and transferred to another.

PART V.

STAFF RETURN.

NURSING STAFF EMPLOYED AT THE END OF THE YEAR BY THE AUTHORITY, AND BY VOLUNTARY ORGANISATIONS AND HOSPITALS UNDER ARRANGEMENTS WITH THE AUTHORITY FOR SERVICES UNDER PART III OF THE N.H.S. ACT.

NOTES: Where a nurse is engaged in more than one service (e.g. a superintendent nursing officer or a home nurse-midwife) she should be shown as part-time in *each* of the services in which she is engaged, and should be given the whole-time equivalent of her work in *each* of these services in the columns provided.

A health visitor (or home nurse or midwife) who also does school nursing duties should be shown as part-time, together with the whole-time equivalent of her work after deduction of time spent in school nursing duties. Nurses employed solely as whole-time school nurses whether or not holding the health visitor's certificate, should not be included anywhere in this return.

1. Health Visiting, Tuberculosis Visiting, Clinic Duties, Care and After-Care.

	Administrative and Supervisory Nursing Staff (excluding Health Visitor Tutors)			Health Visitors except those in Cols. (8)-(10)			Tuberculosis Visitors†			Other Nurses		
(1)	Whole-time (2)	Part-time (3)	Equiv. Whole-time of (3) (4)	Whole-time* (5)	Part-time* (6)	Equiv. Whole-time of (6) (7)	Whole-time* (8)	Part-time* (9)	Equiv. Whole-time of (9) (10)	Whole-time (11)	Part-time (12)	Equiv. Whole-time of (12) (13)
Local Health Authority ..	—	3	1.5	—	56	39.2	—	—	—	—	—	—
				—	—		—	—				
Voluntary Organisation ..	—	—	—	—	—	—	—	—	—	—	—	—
				—	—		—	—				

*Health Visitors and Tuberculosis Visitors acting as such by virtue of a dispensation given under Regulation 5 of the National Health Service (Qualifications of Health Visitors and Tuberculosis Visitors) Regulations, 1948, should be included and also shown separately between dotted lines.

†This relates to health visitors and tuberculosis visitors employed solely on tuberculosis work.

2. Domiciliary Midwifery.

(A).

(1)	Administrative and Supervisory Nursing Staff			Domiciliary Midwives		
	Whole-time* (2)	Part-time* (3)	Equivalent Whole-time of (3) (4)	Whole-time† (5)	Part-time† (6)	Equivalent Whole-time of (6) (7)
(*a*) Local Health Authority ..	— —	3 3	1.5	71 3	30 —	15
(*b*) Voluntary Organisations ..	— —	— —	—	— —	— —	—
(*c*) H.M.C. or B.G.				— —	— —	—

*Non-Medical Supervisors of Midwives should be included and also shown separately between dotted lines.

†Midwives approved as teachers should be included and also shown separately between dotted lines.

(B). Pupil Midwives.

Number of pupils who have completed their district training in the area during the year as part of a Part II Midwifery course taken :—

(i) Wholly on the district .. .. .. —

(ii) Partly on the district 7

3. Home Nursing.

(1)	Administrative and Supervisory Nursing Staff			State Registered Nurses (S.R.N., R.S.C.N., and R.F.N.)			Enrolled Assistant Nurses			Student Home Nurses		
	Whole-time (2)	Part-time (3)	Equiv. Whole-time of (3) (4)	Whole-time* (5)	Part-time* (6)	Equiv. Whole-time of (6)* (7)	Whole-time* (8)	Part-time* (9)	Equiv. Whole-time of (9)* (10)	Whole-time* (11)	Part-time* (12)	Equiv. Whole-time of(12)* (13)
(*a*) Local Health Authority ..	1	2	1	103	23	12	8	7	3	—	—	—
				—	—	—	—	—	—	—	—	—
(*b*) Voluntary Organisation ..	—	—	—	—	—	—	—	—	—	—	—	—
				—	—	—	—	—	—	—	—	—

*Male nurses should be included and also shown separately between dotted lines.

4. Nurses Engaged on Combined Duties.

(*a*) Number of nurses engaged in health visiting and school nursing 58
(*b*) Number of nurses engaged in home nursing and midwifery 30
(*c*) Number of nurses engaged in health visiting, home nursing and midwifery .. .. .. —
(*d*) Others (please specify) .. .. —

5. Administrative Nursing Staff (excluding Health Visitor Tutors)*

Actual number of nurses whose duties in the services in 1, 2 and 3 above are :—

(*a*) wholly administrative and supervisory 4
(*b*) partly administrative and supervisory 3

6. Total Staff.

Actual number of nursing staff represented in the tables under 1, 2 and 3 above, including administrative nursing staff but **excluding** students and pupils whose employment in these three services is :—

(*a*) Whole-time 275
(*b*) Part-time .. .. —

7. Nursery Staff—Day Nurseries.

		Matrons		Deputy Matrons		Other Staff—Excluding Domestics					
	Nursery Supervisors †	State Registered i.e. S.R.N., R.S.C.N. or R.F.N.	Others	State Registered i.e. S.R.N., R.S.C.N. or R.F.N.	Others	S.R.N.'s R.S.C.Ns R.F.N's	S.E.AN.s	Nursery Nurses	Wardens	Nursery Assistants and other staff (excluding domestics)	Nursery Students
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
H.A.	— —	3	2	1	3	—	2	8	5	12	30
ol. g.*	— —	—	—	—	—	—	—	—	—	—	—

†The number of part-time Supervisors should be included and also shown between dotted lines.

*Refers to staff employed by Voluntary organisations providing a day nursery service by arrangement with the Local Health Authority under Section 22 of the Act.

8. Vacancies.

Number of vacancies for nursing staff at the end of the year (i.e. additional staff which the Authority would employ immediately if available) expressed in terms of the equivalent of whole-time staff under each heading :—

(*a*) Health Visitors 10
(*b*) Tuberculosis Visitors .. .. —
(*c*) Domiciliary Midwives 3
(*d*) Home Nurses 2
(*e*) Day Nursery Staff (specify grades).
Nursery Nurse 1

COUNTY OF DERBY

Table of Deaths during the year 1956 in each of the Sanitary Districts, Classified according to Diseases.

APPENDIX II.

DISTRICTS	DEATHS FROM VARIOUS CAUSES																																		
	Tuberculosis, Respiratory	Tuberculosis, Other	Syphilitic Disease	Diphtheria	Whooping Cough	Meningococcal Infections	Acute Poliomyelitis	Measles	Other Infective and Parasitic Diseases	Malignant Neoplasm, Stomach	Malignant Neoplasm, Lung Bronchus	Malignant Neoplasm, Breast	Malignant Neoplasm, Uterus	Other Malignant and lymphatic Neoplasms	Leukaemia Aleukaemia	Diabetes	Vascular Lesions of Nervous System	Coronary Disease, Angina	Hypertension with heart disease	Other Heart Diseases.	Other Circulatory Diseases.	Influenza	Pneumonia	Bronchitis	Other Diseases of Respiratory System	Ulcer of Stomach and Duodenum	Gastritis, Enteritis and Diarrhoea	Nephritis and Nephrosis	Hyperplasia of Prostate	Pregnancy, Childbirth, Abortion	Congenital malformations	Other defined and ill defined diseases	Motor Vehicle Accidents	All other Accidents	Suicide	Homicide and operations of war	All Causes
(URBAN)																																				
ALFRETON	2	–	1	–	–	–	–	–	1	10	7	4	–	24	–	1	42	41	6	26	12	2	11	12	–	2	–	3	2	1	2	15	4	7	3	–	241
ASHBOURNE	–	–	–	–	–	–	–	–	–	4	3	3	–	6	–	–	14	3	1	13	1	–	1	8	–	2	–	1	–	1	4	–	2	–	–	90
BAKEWELL	–	–	–	–	–	–	–	–	1	4	3	3	–	3	–	–	14	3	1	9	1	–	1	5	–	2	–	1	–	1	3	–	–	–	–	61
BELPER	–	–	–	–	–	–	–	–	–	11	6	4	2	8	1	2	24	34	5	21	15	–	14	5	4	3	1	3	–	1	3	–	–	–	–	182
BOLSOVER	–	–	–	–	1	–	–	–	–	2	1	2	1	7	2	1	15	15	7	30	8	–	3	6	–	3	–	1	–	–	9	2	5	1	–	123
BUXTON (Borough) ..	3	–	1	–	–	–	–	–	–	6	9	5	4	21	–	1	39	54	5	50	4	1	4	11	–	2	–	2	–	1	–	3	1	6	2	–	256
CHESTERFIELD (Bor'gh)	5	2	2	–	–	–	–	–	1	28	21	10	7	68	3	11	98	102	36	160	49	1	45	52	6	2	–	6	4	1	12	49	7	14	3	–	811
CLAY CROSS	–	–	–	–	–	–	–	–	–	6	3	1	–	5	–	3	5	13	1	22	7	–	2	6	3	1	–	1	1	–	2	5	5	4	2	–	98
DRONFIELD	1	–	–	–	–	–	–	–	–	5	3	3	1	10	–	–	8	8	–	15	2	1	4	4	1	–	–	–	–	–	3	4	1	2	–	80
GLOSSOP (Borough) ..	3	–	1	–	–	–	–	–	–	6	11	6	5	27	–	2	56	45	2	57	7	4	9	17	1	4	–	2	–	–	5	32	1	8	5	–	324
HEANOR	3	2	–	–	–	–	–	–	–	2	10	7	1	22	–	–	52	43	3	37	12	4	12	12	1	4	–	3	–	–	4	25	2	11	1	–	275
ILKESTON (Borough) ..	2	–	–	–	–	–	–	–	–	6	15	6	3	37	1	3	58	43	5	46	9	–	12	20	2	3	1	3	1	–	4	23	3	7	1	–	320
LONG EATON	1	–	2	–	–	–	–	–	2	9	12	5	3	24	2	2	44	41	8	56	13	1	14	18	2	2	2	4	3	–	3	35	3	8	4	–	327
MATLOCK	2	1	–	–	–	–	–	–	–	5	5	4	1	18	1	2	37	22	–	45	16	–	3	9	1	4	1	5	2	–	3	14	3	3	2	–	207
NEW MILLS	1	–	–	–	–	–	–	–	–	–	2	1	2	12	2	2	21	12	3	16	19	–	–	10	–	–	3	3	1	–	1	10	–	2	–	1	118
RIPLEY	1	–	1	–	–	–	–	–	–	2	2	1	2	15	1	1	30	32	4	29	6	1	8	4	3	2	–	1	–	–	2	29	3	5	2	–	190
STAVELEY	4	–	–	–	–	–	–	–	1	6	9	3	–	12	–	–	19	29	6	30	8	–	10	10	1	5	–	4	1	–	1	13	1	2	1	–	171
SWADLINCOTE	1	1	–	–	–	–	–	–	–	8	7	1	3	14	–	1	25	24	6	36	13	–	6	21	5	–	–	3	2	–	2	18	–	4	1	–	201
WHALEY BRIDGE ..	–	–	–	–	–	–	1	–	–	2	2	–	2	4	–	–	8	8	–	13	4	1	3	2	–	–	–	2	1	–	–	6	–	–	–	–	60
WIRKSWORTH	–	–	–	–	–	–	–	–	–	3	2	–	–	6	–	1	6	10	2	14	1	–	2	2	1	–	–	1	1	–	–	4	2	–	–	–	57
URBAN DISTRICTS ..	29	6	8	–	1	–	1	–	6	125	133	69	37	343	13	33	625	586	101	725	228	16	162	231	35	36	20	52	24	5	46	323	40	96	36	1	4,192
(RURAL)																																			
ASHBOURNE	–	–	1	–	–	–	–	–	–	1	–	1	–	13	–	–	20	18	3	19	5	–	4	2	–	1	–	2	–	–	2	2	1	2	3	–	100
BAKEWELL	1	–	–	–	–	–	–	–	1	3	5	2	1	25	2	2	42	22	5	54	16	2	3	10	–	3	–	1	5	–	4	18	2	6	1	–	236
BELPER	5	–	2	–	–	–	–	–	–	5	15	15	4	29	3	2	53	50	10	40	16	–	19	9	3	5	–	2	3	1	7	27	4	7	2	–	332
BLACKWELL	3	–	–	–	–	1	–	–	1	12	12	5	2	44	1	1	49	42	6	85	22	1	26	25	7	7	–	3	6	–	1	54	7	15	2	–	450
CHAPEL-EN-LE-FRITH	1	–	–	–	–	–	–	–	–	2	9	2	–	25	1	2	33	32	8	48	9	–	6	21	5	3	1	3	1	–	2	23	1	5	2	–	248
CHESTERFIELD	5	–	–	–	–	1	–	–	2	23	20	10	6	74	4	4	109	115	23	150	46	5	28	39	10	7	1	4	7	1	15	72	13	28	10	–	834
CLOWNE	–	–	–	–	–	–	–	–	2	9	2	–	2	15	1	3	30	21	6	36	9	–	15	12	1	4	–	–	3	–	3	17	1	6	2	–	201
REPTON	3	–	3	–	–	–	–	–	–	3	12	8	3	25	2	2	45	69	13	92	29	–	22	21	5	6	1	1	2	–	1	51	4	14	5	–	444
SHARDLOW	4	–	–	–	–	–	–	–	–	22	25	20	8	88	2	3	88	114	22	122	37	2	31	28	7	9	1	11	7	–	5	79	7	14	7	–	763
RURAL DISTRICTS ..	22	–	6	–	–	2	–	–	6	80	100	63	26	338	16	19	469	483	96	646	189	10	154	167	38	45	7	32	34	2	40	343	40	97	38	–	3,608
URBAN DISTRICTS ..	29	6	8	–	1	–	1	–	6	125	133	69	37	343	13	33	625	586	101	725	228	16	162	231	35	36	20	52	24	5	46	323	40	96	36	1	4,192
WHOLE COUNTY ..	51	6	14	–	1	2	1	–	12	205	233	132	63	681	29	52	1,094	1,069	197	1,371	417	26	316	398	73	81	27	84	58	7	86	666	80	193	74	1	7,800

DERBYSHIRE EDUCATION COMMITTEE

REPORT

OF THE

Principal School Medical Officer

ON THE

Health & Well-being of School Children

FOR THE

Year ended 31st December, 1956

J. B. S. MORGAN,
B.Sc., M.B., B.Ch., D.P.H., L.R.C.P., M.R.C.S.,
Principal School Medical Officer.

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DERBYSHIRE EDUCATION COMMITTEE

(As at 31st December, 1956)

ALDERMAN F. A. GENT

(Chairman)

COUNCILLOR J. B. HANCOCK

(Vice-Chairman)

Aldermen

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MRS. A. M. BELFIELD
T. M. BENNISON
MRS. G. BUXTON
MRS. M. CANTRILL
C. FEAKIN
R. FEWKES
MRS. E. HARRISON
MRS. F. E. SHIPLEY
MRS. D. M. SUTTON
E. SWALE
J. TURNER
REV. E. J. WASS
F. WILSON

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MRS. O. EDEN
E. W. FIELDING
B. HILDITCH
C. D. LEWIS
D. PRINCE
J. B. ROBINSON
E. F. ROWBOTTOM
L. STONES
H. TURNER
J. WILLIAMSON

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MRS. E. E. ARMSTRONG
PROF. E. J. W. BARRINGTON
C. BEMROSE, ESQ
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R. A. KIRKMAN, ESQ.
A. S. McWILLIAM, ESQ.
H. MILES, ESQ.
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H. SCARBOROUGH, ESQ.
RIGHT REV. BISHOP G. SINKER
MRS. M. G. C. SULLEY, M.A.
MRS. E. WEBB
REV. FATHER L. J. WILLIAMSON

SPECIAL SERVICES SUB-COMMITTEE OF THE DERBYSHIRE EDUCATION COMMITTEE

(As at 31st December, 1956)

ALDERMAN F. A. GENT

(Chairman)

COUNCILLOR J. B. HANCOCK

(Vice-Chairman)

Aldermen

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H. TURNER
J. WILLIAMSON

Co-opted Members

MRS. E. E. ARMSTRONG
R. A. KIRKMAN, ESQ.
H. SCARBOROUGH, ESQ.
MRS E. WEBB

A Joint Medical Services Sub-Committee deals initially with matters which are the joint concern of the Education Committee and the County Health Committee. At 31st December, 1956, its membership was as follows :—

Representing the County Health Committee :

ALD. MRS. E. HARRISON *(Chairman)*
ALD. MRS. F. E. SHIPLEY
ALD. MRS. D. M. SUTTON
COUN. N. B. BANKS

Representing the Education Committee :

ALD. MRS. G. BUXTON
ALD. F. A. GENT
COUN. MRS. O. EDEN
COUN. J. B. HANCOCK

ANNUAL REPORT

of the PRINCIPAL SCHOOL MEDICAL OFFICER on the Health and Well-being of School Children for the Year ended 31st December, 1956.

To the Chairman and Members of the Derbyshire Education Committee

Ladies and Gentlemen,

I have the honour to present my thirteenth Annual Report on the health and well-being of children attending schools maintained by the Derbyshire Education Authority.

The school population continues to rise as is shown by the fact that in 1947 the number of pupils attending primary and secondary schools was 87,107, whereas the corresponding figure for 1956 was 116,699. It is important that a watchful eye be kept on the staffing ratio ; otherwise there is a possibility of a deterioration in the medical service provided.

On the whole, the general condition of children has been maintained at a high level. It should be pointed out, however, that there is a tendency for more and more children to be referred for treatment for defective vision : in 1947 the rate per thousand was 47.8, whereas in 1956 it was 88.66. There may be many factors contributing to these figures, but in evaluating them, "increased incidence" has always to be weighed against "better ascertainment" : for example, there may be an increased incidence from the greater use of eyes for pleasure or work at school or at home—longer years at school, more taking the "11-plus examination," late hours watching television, are things that come readily to mind ; on the other hand, there may be better ascertainment due to advances in medical knowledge and training or an increased staffing ratio.

When all is said and done, the greater use of the eyes brings with it more knowledge and pleasure, even though at times it results in the need for the correction of defective vision by spectacles.

There has been heavy pressure on the staff during the year dealing with the inauguration of the poliomyelitis vaccination scheme and the pressure is likely to be even greater in 1957. The Ministry of Health has taken great pains to make sure that the vaccine is safe, and for good reasons when the unfortunate experience with the Salk vaccine in America is remembered.

Undoubtedly the vaccine confers a degree of immunity, but only experience will determine its duration. It is important, therefore, that the Ministry of Health's instructions be carried out regarding who should have the vaccine, and when, and that the records be completed meticulously, because only in this way are firm answers obtained to a number of questions that the administration of this vaccine has posed.

It is inevitable that special schools for the handicapped in a County like Derbyshire, covering as it does approximately a thousand square miles, require residential accommodation. I am glad, however, that a start has taken place in providing Day Special Schools in the more densely populated areas at Long Eaton and, shortly, in Chesterfield, because, to quote an old French proverb, "Nothing can ever replace the milk or the heart of a mother."

Dr. A. Laurie terminated his duties on the 30th November, 1956, after being on the staff since 1st June, 1954. He had been appointed a Medical Officer in the School Health Section of the Department of Health for Scotland. He is a man of high intelligence, personality, character and ability, and I wish him well in his new sphere of activity, where his qualities of mind and character must surely bring him success.

In concluding this introductory letter, I must thank Ald. F. A. Gent, the Chairman of the Education Committee, for his encouragement and never-failing courtesy, Mr. J. L. Longland, the Director of Education, and his staff, for their co-operation ; and the members of my own staff for much assistance, not least Dr. V. J. Woodward (my Deputy), Dr. A. H. Fairlamb (Senior Assistant), Mr. H. R. Pedley (Chief Clerk) and Mr. E. Dilks (Chief Sectional Clerk), during a year when there has been much pressure on the Department for a variety of reasons.

Your obedient Servant,

J. B. S. MORGAN,
Principal School Medical Officer.

County Offices,
St. Mary's Gate,
Derby.

11th June, 1957.

GENERAL INFORMATION AND STATISTICS

Area and Population of Administrative County.

	Municipal Boroughs	Urban Districts	Rural Districts	Totals
Number of Sanitary Districts	4	16	9	29
Area in acres	21,149	76,916	537,391	635,456
Population, Mid-1956 ..	138,560	222,540	349,500	710,600

Primary and Secondary Schools.

Divisional Executive	Types of Schools and Numbers		Average No. on Registers	
North-west	Primary ..	80	9,290	13,691
	Secondary ..	14	4,401	
North-east	Primary ..	118	23,075	33,762
	Secondary ..	32	10,687	
Mid-Derbyshire ..	Primary ..	80	11,543	17,625
	Secondary ..	15	6,082	
South-east	Primary ..	65	13,254	19,099
	Secondary ..	14	5,845	
South	Primary ..	97	13,920	20,091
	Secondary ..	16	6,171	
Chesterfield ..	Primary ..	26	6,765	12,431
	Secondary ..	14	5,666	
Total — Whole Administrative County	Primary ..	466	77,847	116,699
	Secondary ..	105	38,852	

Nursery Schools and Nursery Classes.

Divisional Executive	Number of Schools or Classes		Approx. No. on Registers
North-west ..	Schools ..	1	40
	Classes ..	1	20
North-east ..	Schools ..	1	40
	Classes ..	6	128
South-east ..	Classes ..	2	61
Chesterfield ..	Classes ..	7	276

Special Schools.

	Approx. No. on Registers
Brambling House Open Air School and Children's Centre, Chesterfield	127
Bretby Orthopaedic Hospital Special School, Bretby	34
John Duncan (E.S.N. Girls') School, Buxton ..	40
Overseal Manor (E.S.N. Boys') School	40
Talbot House, Glossop (Cerebral Palsy)	19
Long Eaton Day Special School (E.S.N., Mixed) (opened 3rd September, 1956)	90

Boarding Homes for Maladjusted Pupils.

Holly House, Chesterfield	11
Stretton House, Stretton	24

New Schools.

The following New Schools were opened during the year :—

North-East Division	*Date of Opening*
Beighton, Hackenthorpe, The Rainbow Forge County Infants School	9th January, 1956
Mid-Derbyshire Division	
Matlock, The Charles White County Secondary School	11th September, 1956
South Division	
Etwall, John Port County Secondary Mixed School	10th September, 1956
Breadsall Hilltop County Infants School ..	3rd September, 1956

Schools Closed during the year.

Mid-Derbyshire Division	*Date of Closure*
Shottle Endowed Voluntary Controlled J. M. & I. School	5th October, 1956

Births, and their effect on school population.

The number of pupils attending maintained primary and secondary schools shown above has increased in recent years and from 1946 onwards the following Table gives the position annually :—

1946 ..	82,895	1952 ..	106,323
1947 ..	87,107	1953 ..	109,099
1948 ..	91,875	1954 ..	112,021
1949 ..	95,595	1955 ..	114,744
1950 ..	97,511	1956 ..	116,699
1951 ..	100,973		

These figures are a reflection of the births in the County during the preceding years as well as the raising of the school leaving age from 14 to 15 years in 1947. Below are set out the numbers of live births in the administrative county from 1940 :—

1940	..	9,898	1949	..	11,534
1941	..	10,078	1950	..	10,799
1942	..	11,032	1951	..	10,440
1943	..	11,724	1952	..	10,425
1944	..	13,149	1953	..	10,663
1945	..	11,393	1954	..	10,417
1946	..	12,710	1955	..	10,329
1947	..	13,714	1956	..	11,011
1948	..	12,152			

Schemes of Divisional Administration.

(1) Under a Scheme of Divisional Administration approved by the Minister of Education on 25th June, 1945, the Administrative Area of the Authority (excluding the Borough of Chesterfield which is an Excepted District) has been partitioned into five Divisions. So far as the School Health Service is concerned, it is a function of the various Divisional Executives to consider reports of the Principal School Medical Officer and to make, where necessary, recommendations to the Authority relating to that Service.

(2) The Borough of Chesterfield is an Excepted District for which the Divisional Executive is the Borough Council. A scheme of Divisional Administration made by the Borough Council was approved by the Minister of Education on 7th November, 1945. Briefly, the Borough Council exercises the following functions in respect of the Borough relating to the School Health Service in particular :—

(i) The duty of providing special educational treatment for those children who have been ascertained as needing such treatment.

(ii) The duty of carrying out the medical inspection of pupils in attendance at any school maintained by the Authority and securing that such pupils are enabled to receive free medical treatment in accordance with the arrangements made by the Authority.

(iii) The exercise of the duties relating to the power to ensure cleanliness.

(iv) The powers and duties relating to reports to local authorities under the Mental Deficiency Acts.

(v) The duty of carrying out the medical inspection of pupils receiving primary or secondary education otherwise than at school, and of securing that such pupils are enabled to receive free medical treatment in accordance with the arrangements made by the Authority.

(vi) Where an arrangement has been made between the Authority and the Proprietor of an Independent School in the Borough, the duty of carrying out the medical inspection of pupils in attendance at the school, and securing that the pupils are enabled to receive free medical treatment in accordance with the arrangements made by the Authority.

Staff.

The Ministry of Education requested a numerical return of the staff of the School Health Service on 31st December, 1956, and the following information was provided :—

STAFF OF THE SCHOOL HEALTH SERVICE (excluding Child Guidance) :—

Principal School Medical Officer .. .. J. B. S. Morgan
Principal School Dental Officer .. .. .. H. E. Gray

	Number of Officers	Numbers in terms of full-time officers employed in the School Health Service
(*a*) Medical Officers (including the Principal School Medical Officer)—*		
(i) Whole-time School Health Service	—	—
(ii) Whole-time School Health and Local Health Services	26	13.90
(iii) General Practitioners working part-time in the School Health Service ..	—	—
(*b*) Physiotherapists, Speech Therapists, etc. (Specify)—		
(i) Orthopaedic Physiotherapists	2	1.40
(ii) Speech Therapists ..	8	6.38
(*c*) (i) School Nurses	59	17.70
(ii) No. of above who hold a Health Visitor's Certificate	53	
(*d*) Nursing Assistants	4	2.85

*—All Medical Officers of the School Health Service other than those employed part-time for specialist examination and treatment only.

	Officers employed on a salary basis		Officers employed on a sessional basis	
	Number of Officers	Numbers in terms of full-time officers employed in the School Dental Service	Number of Officers	Numbers in terms of full-time officers employed in the School Dental Service
(*e*) Dental Staff:				
(i) Principal School Dental Officer ..	1	0.75	—	—
(ii) Dental Officers ..	7	4.32	—	—
(iii) Orthodontists (if not already included in (*e*) (i) or (*e*) (ii) above ..	—	—	—	—
Total ..	8	5.07	—	—

	Number of Officers	Numbers in terms of full-time officers employed in the School Dental Service
(iv) Dental Attendants ..	6	5.07

The following Table gives details of the staff during the year (including Child Guidance staff) :—

Staff	Proportion of whole-time (expressed as a percentage) devoted to	
	School Health Service	Public Health
PRINCIPAL SCHOOL MEDICAL OFFICER—		
J. B. S. Morgan, B.Sc., M.B., B.Ch., L.R.C.P., M.R.C.S., D.P.H.	15%	85%
DEPUTY PRINCIPAL SCHOOL MEDICAL OFFICER—		
V. J. Woodward, M.B., Ch.B., D.P.H.	40%	60%
SENIOR MEDICAL OFFICER FOR MENTAL HEALTH—		
R. M. C. Tyner, B.A., M.B., B.Ch., D.P.H. ..	2½%	97½%
SENIOR ASSISTANT MEDICAL OFFICER—		
A. H. Fairlamb, M.B., B.S., D.P.H.	65%	35%
SCHOOL MEDICAL OFFICERS—		
K. J. Barker, M.B., Ch.B. (Left 29/3/56) ..	80%	20%
Ethel A. Blake, M.B., B.Ch., B.A.O., L.M., D.R.C.O.G. (Commenced 3/9/56)	80%	20%
F. J. Burke, M.D., B.Ch.	75%	25%
J. W. Crawshaw, M.B., Ch.B.	80%	20%
Helen Dean, M.B., Ch.B. (From 12/3/56 to 29/9/56)	80%	20%
R. E. Dean, L.R.C.P.S., L.R.F.P.S.	80%	20%
Anna L. Frenkiel, M.R.C.S., L.R.C.P., D.R.C.O.G.	80%	20%
Winifred Gow, M.B., Ch.B. (6/11ths from 10/1/56 until 27/5/56 ; whole-time thereafter)	80%	20%
Alison M. Hamilton, M.B., Ch.B., D.P.H. ..	80%	20%
Dorothea Koffman, M.D., D.P.H., (Commenced 16/4/56)	80%	20%
Margarete Kuttner, M.D.	70%	30%
Meiner Morris, M.R.C.S., L.R.C.P. (Commenced 3/9/56)	80%	20%
Mary T. Vass, L.R.C.P.I., L.R.C.S.I., L.M. (Commenced 3/9/56)	80%	20%
(Two vacancies).		
PART-TIME SCHOOL MEDICAL OFFICERS—		
D. Adams, M.B., Ch.B. (Commenced 1/10/56) ..	40%	5%
M. Allan, M.B., Ch.B., D.P.H.	23%	77%
G. Cochrane, M.A., M.B., Ch.B., D.P.H. ..	25%	75%
A. Laurie, M.B., Ch.B., D.P.H. (Left 30/11/56)..	25%	75%
Margaret S. May, M.B., Ch.B.	50%	5%
W. J. Morrissey, M.B., B.Ch., D.P.H.	35%	65%
A. R. Robertson, M.B., Ch.B., D.P.H.	35%	65%
Mary Sutcliffe, M.A., M.B., B.Ch., D.P.H. ..	35%	65%
C. G. Woolgrove, M.B., Ch.B., D.P.H.	35%	65%
BOROUGH SCHOOL MEDICAL OFFICER for Chesterfield Excepted District—		
J. A. Stirling, *D.S.C.*, M.B., Ch.B., D.P.H. ..	24%	76%
SCHOOL MEDICAL OFFICERS for Chesterfield Excepted District—		
H. James, L.R.C.P., L.R.C.S., L.R.F.P.S.G., D.P.H.	72%	28%
Joan M. B. Leith, M.B., Ch.B., D.P.H.	28%	72%

Staff	Proportion of whole time (expressed as a percentage) devoted to	
	School Health Service	Public Health
CHILD GUIDANCE AND SPEECH THERAPY STAFF—		
CONSULTANT CHILDREN'S PSYCHIATRISTS—		
D. J. Salfield, B.Sc., M.D., D.P.M. (9/11ths of salary payable by Regional Hospital Board) ..	80%	10%
(One vacancy).		
EDUCATIONAL PSYCHOLOGISTS—		
Grace M. Hamer, M.A. (Chesterfield Excepted District)	50%	—
Miriam E. S. Flint, B.A.	50%	—
Jean Ingham, B.A. (Chesterfield Excepted District)	50%	—
D. Young, B.Sc.	50%	—
PSYCHIATRIC SOCIAL WORKERS—		
(Two and a half vacancies).		
SOCIAL WORKERS— ..		
Ethel N. Ives (Chesterfield Excepted District) ..	50%	—
Joyce Martin (Commenced 1/9/56)	90%	10%
SPEECH THERAPISTS—		
Anne B. Chapman, L.C.S.T. (Left 31/12/56) ..	90%	10%
Margaret A. Chidlow, L.C.S.T. (Left 13/7/56) ..	90%	10%
Ann Creed, L.C.S.T.	90%	10%
Edna Curry, L.C.S.T. (Commenced 27/8/56) ..	95%	5%
Ann M. Fleming, L.C.S.T. (Left 31/12/56) ..	90%	10%
Dorothy R. Hartley, L.C.S.T. (Left 2/11/56) ..	90%	10%
Diana S. Lampard, L.C.S.T. (Left 5/10/56) ..	90%	10%
Margaret R. Marsh, L.C.S.T.	50%	5%
Mary E. Smith, L.C.S.T.	33%	3%
Jean F. Ward, L.C.S.T. (Chesterfield Excepted District) (Left 19/8/56)	100%	—
Hazel Winter, L.C.S.T. (Commenced 3/9/56) ..	90%	10%
Helen Wright, L.C.S.T. (Chesterfield Excepted District) (Commenced 8/10/56)	100%	—
(Four vacancies).		
DENTAL STAFF—		
PRINCIPAL SCHOOL DENTAL OFFICER—		
H. E. Gray, L.D.S.	75%	25%
DENTAL OFFICERS—		
G. H. Freeman (Dentist, 1921)	75%	25%
G. Hutton, L.D.S. (Left 3/4/56)	75%	25%
PART-TIME DENTAL OFFICERS—		
Wilma Drury, L.D.S. (Commenced 1/10/56) ..	68%	23%
I. Hesketh, L.D.S.	16%	4%
Flora M. Jackson, L.D.S.	42%	13%
Dorothy Littlar, L.D.S.	42%	13%
(Eight and nine-elevenths vacancies)		
Chesterfield Excepted District—		
A. R. Littlar, L.D.S. (Borough Senior Dental Officer)	91%	9%
Annie Kean, L.D.S.	100%	—
(One vacancy)		

GENERAL CONDITION OF THE PUPILS

Three general medical inspections of the school children take place, arranged so that every pupil is inspected during (i) the first year of compulsory school attendance, (ii) the first year of attendance at a secondary school, and (iii) the last year of compulsory school attendance.

In addition children under five years old are inspected as soon as possible after they begin to attend school, and pupils who stay beyond the age of fifteen years are inspected during their last year at school. Pupils specially brought forward are also examined, and those previously observed to have defects requiring observation or treatment are re-examined. No routine general medical inspection is carried out in the "junior" departments or schools; School Medical Officers, therefore, have been requested to make a point of getting in touch with Headteachers of such departments or schools at least once a year to afford them an opportunity of bringing forward any children requiring to be specially examined or re-examined.

As mentioned last year, the County Council agreed in 1955 to increase the establishment by seven Assistant Maternity and Child Welfare Medical Officers and School Medical Officers. At the end of 1953 we had the equivalent of 8.4 whole-time School Medical Officers; at 31st December, 1954 the figure was 9.3; at 31.12.55 it was 10.5; and at the end of 1956 it had increased to 13.9, leaving only two vacancies to be filled.

Notwithstanding this improvement in the medical staffing position, it will be seen from Table I of the Appendix to this Report (which sets out the Ministry of Education statistical tables) that the number of pupils examined at periodic medical inspections totalled 27,734, which is comparable with 29,982 in the previous year. This decrease is accounted for by the amount of time which was devoted by the School Medical Officers during the year to the scheme for vaccinating certain children against poliomyelitis, details of which are given later in this Report.

The number inspected in the three main groups for periodic medical inspection (entrants, children in their first year as seniors, and leavers) was 24,948, comparable with 29,388 last year. This decrease is partly due to the reason just given, but also partly to the fact that, in accordance with the Ministry of Education's notes in connection with their statistical tables for 1956, the figure for "additional periodic inspections" now includes "children who missed the usual periodic inspections," whereas they were formerly added to the figures for the age group inspection which they had just missed.

The following Table shows the numbers examined during 1956 by the School Medical Officers in the three main age groups, and the numbers found to require treatment. The latter figure is also expressed as a percentage of those examined and for comparison the last published percentages for England and Wales are also given.

Group	Number of Pupils Inspected	Total Individual Pupils found to Require Treatment		
		Derbyshire		England and Wales (1955), Percentage of Nos. inspected
		Number	As percentage of Column 2	
Entrants ..	10,318	1,735	16.82	14.77
Second Age Group ..	8,710	1,669	19.16	15.93
Leavers ..	5,920	1,107	18.69	14.60
Totals ..	24,948	4,511	18.08	15.14

Prior to 1946 an attempt was made to classify the "nutritional state" of children into four groups ranging from "excellent" to "bad." The assessment of nutrition was subjective and thus lacked precision due to differing standards of judgement. From 1947, therefore, School Medical Officers were asked to estimate a child's "general condition" as "good," "fair," or "poor" ("fair" meaning "satisfactory"). Differing standards of assessment, of course, were still possible, particularly between the categories of "fair" and "good," although it was thought that greater reliance could be placed on the numbers recorded as "poor." Commencing in 1956, the Ministry have asked that the "physical condition" of the pupils inspected in the periodic inspection groups should be classified as "satisfactory" or "unsatisfactory." The figures for 1956 are set out in detail in Table I 'D' in the Appendix, but the following is a brief summary :—

Classification of the Physical Condition of Pupils inspected.

Divisional Executive	Satisfactory	Unsatisfactory
	%	%
North-west	98.13	1.87
North-east	97.77	2.23
Mid-Derbyshire	99.26	0.74
South-east	95.25	4.75
South	98.16	1.84
Chesterfield	93.83	6.17
Whole Administrative County ..	97.28	2.72

It will be seen that the number of children examined in the periodic age groups whose "physical condition" was classed as "unsatisfactory" amounted to 2.72% of those examined. This is not strictly comparable with the classifications made in earlier years, but for what the figures are worth it may be recalled that since 1947 the percentages of children whose "general condition" was classed as "poor" have been : 3.6 ; 4.1 ; 4 ; 3.2 ; 2.12 ; 2.21 ; 1.45 ; 1.54 and 1.8.

As already indicated, in 1956 the number of pupils who were thought to be in need of treatment was approximately 18% of those examined in the three main age groups. This may be compared with 19½% in 1955 and about 17 or 18% in the previous few years. The number whose "physical condition" was classed as "unsatisfactory," however, was, as already stated, about 2¾%, which is only (roughly) a sixth of the percentage found to need treatment. The defects found to need treatment, of course, cover a wide range (including, for example, skin conditions, speech defects and psychological disorders), and these are of varying degrees of severity. It would not be expected, therefore, that the presence of a defect—even one which needs treatment—would necessarily result in a child's physical condition being classed as "unsatisfactory." It seems clear, however, that the factor of a personal assessment enters into this classification, and differing standards as between the various School Medical Officers are inevitable.

In my Annual Report for 1955 I commented on certain conditions which appeared to be more common than hitherto. I refer to these conditions below :—

Skin conditions. Last year the number thought to require treatment was 21.7 per 1,000 inspections, comparable with roughly 15 per 1,000 in the preceding years. I am happy to say that in 1956 the rate fell to 16 per 1,000.

Vision. Since 1953 I have had reason to comment on a tendency for more children to be referred for treatment for defective vision. The rate per 1,000 increased from 47.8 in 1947 to 69.9 in 1952 and to 87.3 in 1953. In 1954 it dropped to 84.5, but in 1955 it rose again to 87.16. The figure for 1956 shows still a further increase to 88.66 per 1,000.

Squint. In 1952 cases of squint, which had previously been between 9 and 10 per 1,000 inspections, rose to 13.3 ; in 1953 the figure was 15.9 and in 1954 and 1955 it rose to 16.56 and 16.91. For 1956 the figure has dropped to 10.96 per 1,000.

Cervical Glands. Last year I commented on an apparently marked increase in the number of children thought to require treatment for cervical glands, the rate having risen sharply, from roughly 3 to 4.5 per 1,000, to 12.64 per 1,000 (379 cases compared with 81 in 1954). Commencing in 1956 the Ministry's Tables make provision for the inclusion of a figure showing the number of children found to have defects of the "lymphatic glands" requiring treatment, instead of a figure for "cervical glands." The new terminology, however, includes the cervical glands.

The number of pupils thought to require treatment on account of lymphatic glands in 1956 was 35, giving a rate of only 1.26 per 1,000, so that whatever may have been the reason for the sharp increase in 1955, it is clear that it was not maintained. It may be recalled that it was suggested last year that there may have been a widespread,

though patchy, increase in the number of cervical glands requiring treatment, although it was noted that the emphasis was in the north-east of the county. Speaking generally, some of the School Medical Officers suggested that the increase may have been due to the severe winter, reinforced by the comparatively long waiting lists for tonsil and adenoid operations, together with a more conservative approach to such operations. As regards the north-east in particular, one of the School Medical Officers working in that area thought the increase may have been partly accounted for by an influx of population mainly from overcrowded and condemned areas outside the county. This Officer reports that during 1956, however, she did not see a single case of tuberculous glands of the neck. She mentions that a new "tonsils unit" was opened in Sheffield which deals with cases within three months so that the waiting list, which was very large in 1955 (about three years) was completely cleared by April of 1956. A further point she made was that dental treatment became available at Clowne and Frecheville clinics and this helped in clearing many infected mouths and cervical lymph glands. Last—but not least—she states that housing conditions have improved and only a few families live in overcrowded, damp and unheated dwellings; this is reflected in the decreased number of upper respiratory tract infections. There is also a better understanding of the principles of hygiene among parents, and they apply them more readily.

Nose and Throat defects. The rate per 1,000 of pupils thought to require treatment for nose and throat defects has varied over the past few years from 28 to 49, the figure for 1956 being 20.2 per 1,000.

Towards the end of 1955 Dr. Henderson, the Principal Medical Officer of the Ministry of Education, wrote to School Medical Officers mentioning that there has long been controversy about the indications for tonsillectomy in children, and there have been wide variations in the rates of operation, even in adjacent areas of broadly similar type. Dr. Henderson pointed out that it is difficult, from the hospital figures, to find out the tonsillectomy rate for a given County or County Borough, and there was clearly a need for a further study of this subject. It is necessary, before such a study can be started, to have accurate information about the tonsillectomy rates in different areas. Dr. Henderson pointed out that the School Health Service is in a unique position to obtain this information about children in maintained schools, and he asked that, commencing in 1956, the School Doctors, during their examinations of children at periodic medical inspections, should note those who had undergone tonsillectomy at any time previously. I am setting out below the figures which have been obtained in Derbyshire for the year 1956 :—

Periodic Age Groups Inspected	Numbers Inspected		Numbers and percentage found to have had Tonsillectomy			
	Boys	Girls	Boys	%	Girls	%
Entrants	5,402	4,916	368	6.8	290	5.9
Children in their first year as seniors	4,577	4,133	785	17.1	732	17.7
Leavers	2,993	2,927	553	18.5	574	19.6

SANITARY INSPECTIONS IN SCHOOLS

It is customary for School Medical Officers on completing routine school medical inspections to submit to the Principal School Medical Officer a report on the school premises, including brief notes on cleanliness, heating, lighting, ventilation, water supply, washing arrangements, cloakroom facilities, sanitary arrangements, and the playground. Matters which appear to require attention or investigation are brought to the notice of the Director of Education.

In addition, the services of the County Public Health Inspector are utilised to inspect in particular the sanitary arrangements at schools and the hygiene arrangements in school canteens. These visits are "advisory" in nature ; the County Public Health Inspector gives advice on small matters directly to the teachers but more important matters are reported to the Principal School Medical Officer in the first instance, to whom, in any case, a report is submitted after each inspection. This is considered, and forwarded to the Director of Education with any necessary observations. The quality of the water supply is also investigated, and if necessary improvements are recommended. Special attention is paid in this connection to the rural schools. Work has been, and is still being, continued under the programme (which was mentioned in my Annual Report for 1954) for carrying out improvements to the sanitary arrangements where this is desirable at some of the older schools in various parts of the County.

Swimming Baths.

Although many of the schools include training for swimming in their curriculum, there is only one swimming bath in the County for which the Education Authority itself is responsible ; this is the open air bath at Ashbourne.

In 1951 this bath was renovated so that it included modern treatment plant. Since then, pupils from many schools in the area have used it, although the facilities there have been extended to youth and similar organisations as well as to members of the public.

As an indication of the usefulness and popularity of the bath, it has been estimated that some 14,991 children and 2,334 other persons attended during the 1956 season.

From a health point of view the standards attained at this bath are almost wholly admirable ; there have been extremely few unsatisfactory samples, and then only in abnormal circumstances. The treatment plant has proved reliable and, to date, of adequate capacity. Much credit for the successful operation of the bath must go to the attendant in charge who, from the inception of the undertaking, has shown keen interest and understanding of the problems which inevitably arise from time to time.

PROVISION OF MEALS, AND THE MILK-IN-SCHOOLS SCHEME

Meals.

The statistics provided in Table 'A' show the numbers of meals consumed and the number of children for whom milk was provided. The number of school meals remained steady in 1956.

The Education Committee is continuing with its programme of modernisation of both kitchens and sculleries. A large part of the work involved in putting into effect the Committee's policy of each kitchen and scullery having a wash-hand basin and sterilising sink has been carried out; the balance of work is to be done as soon as possible.

Members of canteen staffs have been encouraged to attend the specialist courses held at Littleover Secondary School Training Kitchen during 1956 and the number of employees successfully completing the courses—which deal with the preparation, storage and handling of food and the principles of personal hygiene—has been very encouraging.

Source and quality of Supply of Milk under the Milk-in-Schools Scheme.

Sampling of school milk supplies was carried out by Mr. Rowley, the County Public Health Inspector. All pasteurised milks are submitted to the phosphatase test (for efficiency of pasteurisation), and all raw milks to the biological test (for tubercle bacilli). Pasteurised milks, too, are tested for tubercle bacilli (although not so frequently as raw milks), but each source of supply is examined at least once a year by biological methods. Any pasteurised milk which fails to pass the phosphatase test is examined for tubercle bacilli as a matter of course.

Canteen milk supplies have been subjected to the same procedure. The following table combines figures in respect of both classes of milk :—

	Phosphatase		Tubercle Bacilli		Total No. of samples submitted
	Satis-factory	Unsatis-factory	Satis-factory	Unsatis-factory	
Pasteurised ..	140	1	36	—	141
Tuberculin Tested..	—	—	23	—	23
Ungraded ..	—	—	12	—	12

For the second year in succession, examinations of the raw milks all proved negative.

TABLE A

MEALS and MILK PROVIDED on a day in October, 1956

DIVISIONAL EXECUTIVE	CHILDREN PRESENT		MEALS PROVIDED				MILK PROVIDED			
	Numbers		Numbers		% of Numbers present		No. of Children		% of Numbers present	
	Prim.	Sec.	Prim.	Sec.	Prim.	Sec.	Prim.	Sec.	Prim.	Sec.
North-west ..	8,700	4,165	4,191	2,752	48.1	66.0	7,399	2,906	85.0	69.9
North-east ..	21,029	9,983	9,786	5,114	46.5	51.5	19,261	6,971	91.6	69.5
Mid-Derbyshire	10,739	5,746	3,543	3,016	33.0	52.5	9,536	4,028	89.0	70.0
South-east ..	12,281	5,546	3,383	2,062	27.5	37.0	11,018	3,119	89.6	56.2
South	13,085	5,851	5,268	2,957	40.3	50.5	11,538	3,824	88.1	65.2
Chesterfield ..	6,493	5,346	2,319	2,602	35.7	48.6	5,802	3,399	89.3	63.6
TOTALS—Whole Administrative County	72,327	36,637	28,490	18,503	39.3	50.5	64,554	24,247	89.2	66.2

The following Table shows the number of schools, including independent schools, supplied with milk on the 31st December, 1956. The Education Committee endeavour at all times to obtain the highest grades of milk and it is encouraging to know that of 649 establishments 641 receive pasteurised milk.

Type of Milk	Divisional Executive												Totals—Whole Administrative County	
	North-west		North-east		Mid-Derbyshire		South-east		South		Chesterfield			
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Pasteurised	108	98.12	163	100.0	107	99.08	87	100.0	135	96.43	41	100.0	641	98.77
Tuberculin Tested..	2	1.88	—	—	1	0.92	—	—	4	2.86	—	—	7	1.08
Ungraded	—	—	—	—	—	—	—	—	1	0.71	—	—	1	0.15
Totals ..	110	100.0	163	100.0	108	100.0	87	100.0	140	100.0	41	100.0	649	100.0

PROTECTION OF SCHOOL CHILDREN AGAINST TUBERCULOSIS

The following steps are taken to minimise the risk of school children becoming infected by adults who are suffering from tuberculosis :—

(i) *Teachers :* An X-ray examination is enjoined for teachers entering the profession : students completing training are X-rayed and the results made available to the College Medical Officer ; and teachers entering service otherwise than from College are X-rayed as part of their medical examination on appointment.

The Ministry's requirements are, of course, observed concerning the suspension from and return to duty of a teacher found to be suffering from respiratory tuberculosis.

The Ministry has pointed out that there are not sufficient facilities available for X-ray examination of the chest to make it possible to give an annual test to all teachers and other adults whose work brings them into close contact with groups of school children, without diverting resources from other uses for which they are urgently needed. It was suggested, however, that it should not be difficult for teachers and others concerned to take increasing advantage of the services of the mass radiography units provided by Regional Hospital Boards. These services are, of course, free and confidential, and it will be appreciated that the examinations are not compulsory. This matter was referred to the Teachers Advisory Committee, which recommended that the Authority should draw the attention of all teachers to the need for periodic examinations, and this has been done.

(ii) *Staff other than teachers :* The Committee decided that full-time staff in the categories mentioned below should be required to undergo an X-ray examination on appointment ; that the Ministry's rules concerning the suspension from and return to duty of a teacher suffering from respiratory tuberculosis be applied to them ; and that their attention be drawn to the desirability of being X-rayed annually:—

> Residential staffs of boarding schools and homes ; staffs of nursery schools ; clerical assistants ; welfare supervisors ; laboratory assistants ; caretakers ; school meals staff (except those at central kitchens).

It is customary for the Director of Education to send a Monthly Circular to all Schools, and this medium is used to keep the matter before the staff, at the same time giving details of the facilities available for free X-ray examinations (e.g. the whereabouts from time to time of the mass radiography units).

Mass Miniature Radiography.

The mass radiography service is organised by Regional Hospital Boards, and enables large numbers of people to have their chests X-rayed expeditiously at convenient centres. It is a valuable aid to preventive medicine, aimed particularly at the early detection of cases of pulmonary tuberculosis (although other conditions may also be discovered).

Normally four mass radiography units operate in the County—the Nottingham Area No. 2 Unit, based on Nottingham (Medical Director, Dr. W. Guthrie) ; the South Yorkshire Area Unit based on Doncaster (Dr. V. Sherburn) ; the Sheffield Area Unit, based on Sheffield (Dr. W. J. Wilson) ; and the Manchester No. 3 Unit, based on Stockport (Dr. J. Rimmington).

At the time of writing this report I have received particulars of ten surveys which were carried out during 1956, which included just over 5,100 school children, mainly those who were 13 years old. This, however, is not the total figure for the year because some time inevitably must elapse before complete details can be made available.

MEDICAL EXAMINATION OF PROSPECTIVE TEACHERS

Candidates applying for entry to teachers' training colleges are required to be medically examined concerning their fitness to follow a course of teacher-training. Applicants who are school pupils are examined by the School Medical Officer of the area in which they live—this has the advantage that he will have been concerned with, or have access to the records of their medical examinations at school. Applicants for admission after national service, or after a course of training not taken under the Training of Teachers Regulations, or mature entrants, who have had no recent connexion with the school health service, are examined by the School Medical Officer of the area in which they reside, which will often be the area in which they attended school.

The Minister of Education has said that it is not practicable at present, in view of the lack of facilities, to require an X-ray examination of the chest of all entrants to training (although, of course, an X-ray will be taken if in the opinion of the examining medical officer it is desirable).

Intending entrants to the teaching profession who complete an approved course of training are examined by the College Medical Officer at the end of the course. Other entrants to service are examined by the School Medical Officer of the appointing education authority. It is a requirement of the Minister of Education that an X-ray examination of the chest is included as an essential part of all medical examinations on entry to the teaching profession.

The Derbyshire Education Authority administers a Teachers' Training College; students completing training are X-rayed and the results made available to the College Medical Officer.

During the year the following examinations were carried out by School Medical Officers :—

Entrants to training colleges, university departments of education and approved art schools	312
Entrants to the teaching profession	107

INFESTATION WITH VERMIN

The total number of examinations and re-examinations of children in schools to detect the presence of nits or lice was 217,325, and they revealed 2,316 individual children infested. This is just under 2% of the school enrolment. Ten years ago the figure was roughly 7%, and the incidence has been gradually falling since that time. Whilst it is pleasing to record the improvement which has taken place, there are no grounds for complacency. With the modern methods of treatment available this is a condition which ought to be completely eradicated. I am sure that the Health Visitors and Teachers in particular are doing all they can in the way of Health Education and giving practical advice and encouragement to deal with this unpleasant condition, but a minority of parents are so unco-operative that the children are re-infested at home. (The Authority's scheme for cleanliness inspections remains as described in my Annual Report for 1953).

SCHOOL CLINICS

The Ministry of Education asked for a return showing the school clinic facilities as at 31st December, 1956 ; a copy of the information given appears below. In subsequent pages of this Report more detailed information is provided.

I. NUMBER OF SCHOOL CLINICS (*i.e.*, premises at which clinics are held for school children) provided by the Local Education Authority for the medical and/or dental examination and treatment of pupils attending maintained primary and secondary schools.

Number of School Clinics	29

II. TYPE OF EXAMINATION AND/OR TREATMENT

provided, at the school clinics returned above, either directly by the Authority or under arrangements with the Regional Hospital Board, for examination and/or treatment to be carried out at the clinic.

Examination and/or Treatment (1)	Number of School Clinics (*i.e.*, premises) where such treatment is provided—	
	Directly by the Authority (2)	Under arrangements made with Regional Hospital Boards or Boards of Governors of Teaching Hospitals (3)
A. Minor Ailment and other non-specialist examination or treatment	25	—
B. Dental	23	—
C. Ophthalmic*	3	17
D. Ear, Nose and Throat ..	—	—
E. Orthopaedic	—	17
F. Paediatric†	—	—
G. Speech Therapy ..	17	—
H. Others (specify):— Sunray ..	1	—

*—Arrangements made with the Supplementary Ophthalmic Service are returned in column (2) and those made with the Hospital and Specialist Service in column (3).

†—Clinics for Children referred to a specialist in children's diseases.

III. CHILD GUIDANCE CENTRES.

(1) Number of Child Guidance Centres provided by the Authority—12.

(2) Staff of Centres :—

	Number	Aggregate in terms of the equivalent number of whole-time officers
Psychiatrists	1	0.8
Educational Psychologists ..	4	2.0
Psychiatric Social Workers ..	—	—
Paediatricians, Play Therapists, Social Workers, etc. (excluding Clerks) (specify):— Social Workers	2	1.4

Minor Ailments.

Table 'B' shows the clinics at which facilities are provided for the treatment of minor ailments. Altogether, 1,517 children made 5,732 attendances. Most of the work took place—as might be expected—in the four relatively compact municipal boroughs where daily clinics were held. Most of the sessions for treatment are quite short, and are conducted by Health Visitors, who are frequently attending the clinic premises for other purposes, such as for giving advice on infant welfare. At sessions attended by Medical Officers, it is possible to include the examination of special cases discovered at routine school medical inspections requiring more elaborate examination—(it will be realised that occasionally, due to the pressure of work at the inspections, the latter are not always practicable). Immunisation against diphtheria is also available on demand as well as medical examination of children desiring to know if they are fit to undertake certain forms of employment.

Minor Ailments

TABLE B

Annual Return of work carried out at Minor Ailment Clinics—Year ended 31st December, 1956

Minor Ailment Clinic	When Held	Actual Number of Clinic Sessions	Children Attending Maintained Schools													
			No. of Individual Children who attended during the year							Total Number of Attendances during the year						
			Divisional Executive							Divisional Executive						
			North-west	North-east	Mid-Derbyshire	South-east	South	Chesterfield	Total	North-west	North-east	Mid-Derbyshire	South-east	South	Chesterfield	Total
Alfreton. Grange Street ..	Wednesday, a.m.	44	–	–	25	–	–	–	25	–	–	58	–	–	–	58
Ashbourne. St. Oswald's ..	2nd and 4th Wednesday, a.m.	21	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Belper. Field Lane ..	2nd and 4th Monday and 1st, 3rd and 5th Saturday, a.m.	36	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Bolsover. Welbeck Road ..	2nd and 4th Thursday, a.m. ..	9	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Buxton. Bridge Street ..	Daily	166	141	–	–	–	–	–	141	344	–	–	–	–	–	344
Chesterfield. Brimington Road	2nd and 4th Friday, a.m. ..	12	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Chesterfield Excepted District :— (*a*) Town Hall .. (*b*) Edmund Street, Newbold Moor	Daily, a.m. / Daily, p.m.	420	–	–	–	–	–	644	644	–	–	–	–	–	2421	2,421
Chinley. Lower Lane ..	1st, 3rd and 5th Saturday, a.m. ..	24	–	–	–	–	–	–	–	–	–	–	–	–	–	–

Derby. County Offices Yard	Tuesday, p.m. and 2nd and 4th Saturday, a.m. ..	23	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Dronfield. The Grange ..	Saturday, a.m. ..	25	–	35	–	–	–	–	35	–	70	–	–	–	–	70
Frecheville. Fox Lane ..	Saturday, a.m. ..	46	–	73	–	–	–	–	73	–	113	–	–	–	–	113
Glossop. Municipal Bldgs.	Daily, a.m. ..	252	316	–	–	–	–	–	316	1772	–	–	–	–	–	1,772
Heanor. Wilmot Street ..	1st, 3rd and 5th Saturday, a.m. ..	27	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Ilkeston. Albert Street ..	Daily, a.m. ..	254	–	–	–	236	–	–	236	–	–	–	775	–	–	775
Long Eaton. 4, Nottingham Rd.	Saturday, a.m. ..	49	–	–	–	5	–	–	5	–	–	–	16	–	–	16
Matlock. Causeway Lane ..	Saturday, a.m. ..	31	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Melbourne. Penn Lane ..	Wednesday, a.m. ..	51	–	–	–	–	15	–	15	–	–	–	–	58	–	58
New Mills. High Lea Hall ..	2nd and 4th Saturday, a.m. ..	24	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Ripley. Infants' C. School	3rd Thursday, a.m.	12	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Shirebrook. Cliff House ..	Wednesday, a.m. ..	47	–	6	–	–	–	–	6	–	15	–	–	–	–	15
Staveley. Lime Avenue ..	Monday a.m. and 4th Saturday, a.m.	11	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Swadlincote. Alexandra Road ..	2nd and 4th Wednesday	46	–	–	–	–	3	–	3	–	–	–	–	4	–	4
Totals	.. .. ..	1,644	457	132	25	241	18	644	1,517	2116	284	58	791	62	2421	5,732

Dental Work.

A statistical report appears in Table V in the Appendix. Mr. H. E. Gray, the Principal School Dental Officer, has provided the following report :—

"1956 was another year in which the school dental service fell far short of requirements due to the longstanding staff shortage. The provision of comprehensive treatment to all who needed it would have required about thirty-eight full-time officers, whereas the available staff averaged only 15% of this. During the first three months of the year, there were five full-time and two part-time officers (an equivalent of 6 1/11th full-time officers) and for the next six months, four full-time and two part-time officers, a decrease brought about by a resignation. In the autumn hopes for improvement materialised. A part-time officer was appointed and commenced duty at the beginning of October at the Frecheville Clinic, working ten sessions per week, and later another appointment of a full-time officer to take up duty in January 1957 was made. Thus the year ended with the staffing position approximately the same as at the beginning, but with a small improvement in the service about to take place.

It was a difficult year. The service was very thinly spread over large numbers, and under such conditions it was often difficult to keep clinical routines running smoothly and provide prompt attention. Serious interruptions were caused by illness, and the loss of an officer brought a halt to the services in the areas served by Dronfield and Frecheville Clinics. Fortunately it was possible to re-open the Frecheville Clinic after six months. The North-eastern administrative division of the County had the greatest share of the service by reason of staff living in or near that area. The Clinics in the North-western division were all unstaffed and have been so since the middle of 1950. One officer covered parts of the Mid-Derbyshire and the South-eastern and Southern divisions, while Chesterfield Borough had two full-time officers.

The new Clinic at Clowne, which became operative at the beginning of the year, has proved very popular and although it has only been possible to staff it part-time, much has been done to meet the immediate needs in and around that district.

Towards the end of the year, the Authority gave serious consideration to means aimed at improving the service, and making the working conditions more attractive. Approval was given to the following measures :—

(1) The employment of part-time officers on a sessional basis at fees comparable with those paid by neighbouring Authorities.

(2) The full-time officers of the staff to have the option of working, voluntarily, additional sessions in the evenings for an appropriate fee.

(3) Vacancies for full-time officers to be advertised with a travelling allowance, where this is considered necessary.

(4) Premises to be made inviting and attractive by appropriate decorations and where possible improvements carried out to facilitate the work, the latter to include better recovery room accommodation, and rinsing facilities.

(5) A scheme to modernise the surgeries and improve the dental equipment. (Of the twenty-three Clinics, about half have modern equipment and other items of varying standards. Where necessary, dental units, shadowless operating lights and general anaesthetic apparatus of the latest type are to be installed, and outdated furnishings and fittings gradually replaced. This is largely by way of an investment, for inviting and well equipped clinics can play an important part in recruitment, and enable a high standard of treatment to be provided).

Inspections.

Of the school population of over 116,000, 12,108 received dental inspections at the routine visits to schools and 6,490 special inspections were made of children who attended the Clinics as casuals, making a total of 18,598 children inspected or approximately 16% of the enrolment. 16,966 (91%) were found with defects and offers of treatment were given to 14,209. All those found with defects at the school inspections were not referred for treatment due to the impossibility of providing complete treatment to all who required it. The service given was largely of a skeleton nature, as the dental officers were faced with numbers far in excess of the accepted ratio of one officer to 3,000 children. They ranged from 6,000 to 30,000 per officer and meant that a policy of selection had to be followed.

Opportunities for extraction treatment were given to all those found with gross caries and sepsis. Conservative treatment was limited to those whose dentitions were in relatively good order and were likely to remain sound for a considerable time after attention. To have attempted full treatment in all cases would have been futile, as the intervals between successive school inspections were rarely less than three years, and in many instances very much longer.

It was noted at the school inspections that some children were under the care of the family dentists, and received regular attention, but the number was not large as a rule and varied in different areas. The acceptance rates for treatment were generally very high, often between 80% and 90%. There were also some less than 50% and a few as low as 30%. Where these low rates prevailed it was sometimes found that an appreciable number of children were having treatment by their own dentist.

Attendances and Treatment.

Over 10,600 children received treatment and they made over 17,000 attendances. A great deal of the clinical time was taken up by children who made casual attendances, chiefly for the relief of pain. An overall average of 45% of the clinical time was devoted to them, and at clinics where only occasional sessions were held practically all the time was taken up in giving emergency and palliative treatment.

The high proportion of time devoted to urgent treatment meant delay in dealing with the children referred at the school inspections.

Every effort was made to give comprehensive treatment to as many as possible, but only one in three was classified as dentally fit after receiving attention. This may seem low, but the basis of the assessment was that as far as could be ascertained the permanent dentition was free of caries and that no further treatment was likely to be required for about a year.

Extraction work far outweighed conservative and preventive treatment. This was the opposite of what should have been the case, but was the inevitable result of the lack of timely inspection and treatment. 4,890 permanent teeth were extracted against 3,221 conserved. 380 of these were sound teeth removed to correct irregularity or overcrowding. Over 16,400 temporary teeth were extracted, the great majority of them septic. Priority for filling treatment was given to the permanent teeth, but in a very limited number of cases fillings were inserted in temporary teeth. This was usually at the express wish of parents.

Extraction work involving one or two teeth was mostly done under local anaesthetics. Special sessions were set apart for those who required multiple extractions under a general anaesthetic. 4,900 general anaesthetics were given. The school medical officers acted as anaesthetists on those occasions and each patient was medically examined before the anaesthetic was administered.

Minor operations, totalled over 3,000 and consisted principally of silver nitrate treatments, dressings, scalings and gum treatment, and miscellaneous items such as repairs to teeth chipped or broken in accidents.

Orthodontic treatment. A small amount of this specialised treatment for irregularities of the teeth and jaws was carried out. The cases dealt with were of a relatively simple nature. Appliances of the removable type were used, and were constructed under private contract.

No orthodontic specialist is employed by the Authority, but it is hoped in the future to have specialist assistance for this work. Discussions between the Authority and the Sheffield Regional Hospital Board have taken place as to how specialist advice and treatment may be made available for the more complicated cases, which usually require long and intricate treatment.

While the staff shortage continues, only a very limited time can be devoted to this work and as it is very time consuming, it must necessarily take second place to the work of preservation. Many irregularities and the need for their correction could be prevented if frequent and regular inspections were possible. The early diagnosis and correction, often by simple procedures, of certain conditions and habits which cause malposition of teeth would eliminate lengthy and costly treatment later on, when parents become aware that all is not as it should be, and want something done. Unfortunately this ideal is very far off, but whenever cases in this category came to light, the appropriate advice and treatment was given.

The following table gives a summary of the orthodontic work carried out :—

Number of new cases begun during the year ..	24
Number carried forward from previous year	8
Number completed treatment during the year ..	10
Number discontinued treatment during the year ..	1
Pupils treated with appliances	19
Removable appliances fitted	19
Fixed appliances fitted	—
Total attendances	109

Forty-six children were supplied with artificial teeth. They were all partial dentures, fitted chiefly to replace front teeth lost through caries or in accidents.

Children in the care of the Authority, resident in Children's Homes, received attention. All were inspected. Little treatment was required, except for some of the new admissions. It was gratifying to find that the dentitions of the children who had been long in residence compared more than favourably with those encountered in the course of every-day routine work.

Children in the Authority's Special Schools and Boarding Homes for Maladjusted pupils also received inspections. In one instance where no clinical facilities were available, the Authority agreed that treatment be provided by a local dental practitioner with remuneration on the same basis as in the National Health Service.

Treatment of pre-school children and expectant and nursing mothers was integrated with that for the school children. No special sessions were set apart for them. (An account of this work appears in the Annual Report of the Medical Officer of Health).

There seems little doubt that dental disease has increased very considerably in the last few years. It is now no uncommon occurrence to find children of six and seven years of age with every permanent molar tooth affected by decay, some so severely that they cause pain

and require to be extracted. In the older age groups it is the same story, widespread caries, much of it of a rapid and uncontrollable type. In the 1950 Report, the result of a survey by the Principal Dental Officer on the incidence of caries in children aged five, carried out on the lines recommended by the Ministry of Education, was published. This showed that just under 20% of these children were free of dental disease and that the average number of decayed, missing or filled teeth ("D.M.F. teeth") was 4.6 per child. In 1955 and 1956 the Principal Dental Officer, in the course of school inspections, continued this survey and it was found that the percentage of children with no caries had fallen to 13.3%, while the average number of D.M.F. Teeth per child had risen to 6.0, an alarming increase of over 20% in the incidence of decay in the last five or six years. The following table gives the details. Unfortunately the numbers examined were not large, but the children came mostly from the same localities.

Derbyshire	No. of children aged five examined	No. of decayed, missing or filled teeth	No. of children with no defect	% of children with no defects	Average No. of decayed missing or filled teeth per child
1950	495	2,288	98	19.8	4.6
1955 and 1956	442	2,683	60	13.3	6.0

No doubt the increased consumption of sweets and the large amounts of starchy food eaten are much to blame. Many children have the habit of eating sweets and biscuits between meals and in schools it is not uncommon to find that many of the children have biscuits with their milk, probably one of the worst combinations for causing decay.

It is difficult to change habits and customs, and as it becomes more and more evident that dentistry by itself cannot completely control caries, other means must be looked for, especially in the field of prevention. No definite method is yet known, but experiments in the fluoridation of water supplies in America, have had the effect of making the teeth much more resistant to decay. This is a great advance. It is by no means the complete answer but if a reduction could be brought about by similar means in this country, much ill-health and misery following dental troubles would be prevented."

Visual Defects.

Table 'C' shows the number of children who attended the eye clinics and the number of attendances. Treatment was provided at the Authority's eye clinics under two schemes as follows :—

(i) *Supplementary Ophthalmic Services.*

Medical Officers on the Ophthalmic List attended three clinics and were paid on a sessional basis by the Authority, which recovered from the Supplementary Ophthalmic Services Committee of the Local Executive Council a fee for each refraction carried out. Prescriptions for glasses are written on a form provided by the Supplementary Ophthalmic Services Committee and sent to the Secretary of that Committee so that arrangements may be made for the glasses to be provided.

(ii) *Hospital Eye Service.*

Seventeen of the Authority's eye clinics were conducted by Ophthalmic Consultants who have contracts with the Sheffield Regional Hospital Board. The spectacles which are prescribed are provided under arrangements made by the Hospital and Specialist Services.

School children, like other members of the community, may consult their private Doctors with a view to treatment and glasses being provided under the National Health Service. In this connection, certain figures have kindly been provided by the Derbyshire Executive Council relating to work performed by Ophthalmic Medical Practitioners and Ophthalmic Opticians outside the Authority's scheme, and these figures are included in Group 1 of Table IV in the Appendix to this Report.

Health Visitors are informed of the treatment prescribed for patients who attend County Eye Clinics, in order that they may be followed up and if there is any neglect in securing the treatment advised a report can be made with a view to the matter being rectified.

TABLE C

Annual Return of work at Eye Clinics—Year ended 31st December, 1956

Eye Clinic	When Held	Actual Number of Clinic Sessions	Children Attending Maintained Schools													
			Number of Individual Children Treated							Total Number of Attendances						
			Divisional Executive							Divisional Executive						
			North-west	North-east	Mid-Derbyshire	South-east	South	Chesterfield	Total	North-west	North-east	Mid-Derbyshire	South-east	South	Chesterfield	Total
Alfreton. Grange Street (*c*) ..	1st, 2nd, 3rd & 4th Wednesday, p.m...	34	–	41	278	–	–	–	319	–	58	355	–	–	–	413
Belper. Field Lane ..(*c*) ..	3rd Tuesday, a.m.	10	–	–	91	–	–	–	91	–	–	116	–	–	–	116
Bolsover. Welbeck Road (*f*) ..	1st and 3rd Wednesday, a.m. ..	15	–	119	–	–	–	–	119	–	143	–	–	–	–	143
Buxton. Bridge Street (*e*) ..	Each Monday a.m.	58	585	–	–	–	–	–	585	625	–	–	–	–	–	625
Chesterfield. Brimington Rd. (*f*)	2nd and 4th Friday a.m. ..	18	–	215	–	–	–	–	215	–	252	–	–	–	–	252
Chesterfield Excepted District. Town Hall ..(*d*) ..	Wednesday and Thursday, a.m. ..	77	–	–	–	–	–	735	735	–	–	–	–	–	1258	1,258
Clowne. Creswell Road (*f*) ..	2nd and 4th Wednesday, p.m...	18	–	158	–	–	–	–	158	–	187	–	–	–	–	187
Derby. Walker Lane (*b*) ..	Each Monday, a.m.	42	–	–	42	20	509	–	571	–	–	68	27	620	–	715

Dronfield. The Grange (*f*) ..	2nd and 4th Friday, p.m. ..	15	–	107	–	–	–	–	107	–	128	–	–	–	–	128
Frecheville. Fox Lane ..(*f*) ..	2nd and 4th Wednesday, a.m. ..	19	–	176	–	–	–	–	176	–	209	–	–	–	–	209
Glossop. Municipal Bldgs. (*a*)	1st, 3rd and 5th Saturday, a.m. ..	21	223	–	–	–	–	–	223	320	–	–	–	–	–	320
Heanor. Wilmot Street (*c*) ..	5th Wed. p.m. and 1st Tuesday, a.m. ..	13	–	–	–	130	–	–	130	–	–	–	168	–	–	168
Ilkeston. Albert Street (*b*) ..	1st and 3rd Friday, a.m. ..	22	–	–	–	247	–	–	247	–	–	–	306	–	–	306
Killamarsh. Sec. Mod. School (*f*)	1st and 3rd Friday, a.m. ..	17	–	114	–	–	–	–	114	–	133	–	–	–	–	133
Long Eaton. Grange School (*b*) ..	2nd and 4th Tuesday, a.m. ..	19	–	–	–	197	–	–	197	–	–	–	258	–	–	258
Matlock. Dean Hill House, Causeway Lane (*c*)	2nd and 4th Friday, a.m. ..	16	22	6	94	–	26	–	148	21	13	107	–	50	–	191
New Mills. High Lea Hall (*e*) ..	1st Friday, a.m.	13	57	–	–	–	–	–	57	110	–	–	–	–	–	110
Shirebrook. Cliff House (*f*) ..	1st and 3rd Friday, p.m. ..	19	–	152	–	–	–	–	152	–	195	–	–	–	–	195
Staveley. Lime Avenue (*f*) ..	1st and 3rd Wednesday, p.m. ..	17	–	135	–	–	–	–	135	–	161	–	–	–	–	161
Swadlincote. Alexandra Road (*b*)	2nd and 4th Thursday, p.m. ..	19	–	–	–	–	219	–	219	–	–	–	–	258	–	258
Totals	.. .. ..	482	887	1223	505	594	754	735	4,698	1076	1479	646	759	928	1258	6,146

Medical Officer Conducting Clinic :— (*a*) Dr. B. Boas ; (*b*) Dr. J. E. Coates ; (*c*) Dr. D. B. H. Dawson; (*d*) Dr. W. T. C. Lumley and Dr. H. C. Muirhead ; (*e*) Dr. N. Warwick ; (*f*) Dr. W. T. C. Lumley.

TABLE D

Annual Return of Orthopaedic Work—Year ended 31st December, 1956

Orthopaedic Clinic	When Held	Actual Number of Clinic Sessions	Children Attending Maintained Schools													
			Number of Individual Children who attended during the year							Total Number of Attendances during the year						
			Divisional Executive							Divisional Executive						
			North-west	North-east	Mid-Derbyshire	South-east	South	Chesterfield	Total	North-west	North-east	Mid-Derbyshire	South-east	South	Chesterfield	Total
Alfreton. Grange Street ..	Thursday, a.m. and p.m.	94	–	29	44	–	–	–	73	–	198	329	–	–	–	527
Bolsover. Welbeck Road ..	Friday, p.m. ..	46	–	28	–	–	–	1	29	–	129	–	–	–	2	131
Buxton. Bridge Street ..	4th Friday, alt. months	5	26	–	–	–	–	–	26	28	–	–	–	–	–	28
Chesterfield. Brimington Road ..	1st and 3rd Wednesday, a.m. and p.m. and 2nd and 4th Wednesday, a.m.	70	–	59	–	–	–	2	61	–	224	–	–	–	4	228
Chesterfield Excepted District. Town Hall	Tuesday and Friday	121	–	–	–	–	–	121	121	–	–	–	–	–	584	584
Chinley Lower Lane ..	2nd and 4th Monday, a.m. and p.m.	40	21	–	–	–	–	–	21	75	–	–	–	–	–	75

Clay Cross. High Street ..	Monday, p.m. ..	45	–	63	–	–	–	2	65	–	299	–	–	–	6	305
Derby. County Offices Yard	Thursday, a.m. and p.m.	98	–	–	15	6	222	–	243	–	–	77	18	1187	–	1,282
Dronfield. The Grange ..	2nd Wednesday p.m.	12	–	†	–	–	–	–	†	–	42	–	–	–	–	42
Glossop. Municipal Buildings	2nd and 4th Tuesday, a.m. and p.m.	40	84	–	–	–	–	–	84	236	–	–	–	–	–	236
Heanor. Wilmot Street ..	Friday, p.m. ..	47	–	–	2	46	–	–	48	–	–	8	470	–	–	478
Ilkeston. Albert Street ..	Wednesday, a.m. and p.m.	96	–	–	–	63	–	–	63	–	–	–	460	–	–	460
Long Eaton. 4, Nottingham Rd.	Friday, a.m.	47	–	–	–	47	–	–	47	–	–	–	369	–	–	369
Matlock. Dean Hill House, Causeway Lane ..	Tuesday, a.m. and p.m.	90	11	–	51	–	8	–	70	86	–	312	–	28	–	426
Shirebrook. Cliff House ..	Friday, a.m. ..	46	–	13	–	–	–	–	13	–	92	–	–	–	–	92
Staveley. Lime Avenue. ..	Monday, a.m. ..	45	–	44	–	–	–	–	44	–	357	–	–	–	–	357
Swadlincote. Alexandra Road ..	1st and 3rd Tuesday, a.m. and p.m.	48	–	–	–	–	74	–	74	–	–	–	–	383	–	383
Totals	.. .. ..	990	142	236	112	162	304	126	1,082	425	1341	726	1317	1598	596	6,003

† Sessions attended by Orthopaedic Physiotherapist only—figures included in those for Chesterfield, Brimington Road, Clinic.

Orthopaedic and Postural Defects.

The Orthopaedic clinics conducted on County Council clinic premises continue to be visited by Orthopaedic Specialists employed by Regional Hospital Boards. Table 'D' indicates the attendances made by school children, and further particulars appear in Table IV, Group 3, of the statistics at the end of this Report. The number of individual children who visited the clinics was 1,082, attendances totalling 6,003. These figures are comparable respectively with 1,025 and 5,888 in the previous year.

Sunray Clinics.

During the year, 230 children made 2,473 attendances at the sunray clinics at the Town Hall, Chesterfield, and at Brambling House Open Air School, Chesterfield. Fifty-one sessions were held.

HANDICAPPED PUPILS

The Tables that follow are reasonably easy to follow but it might be useful to comment on a comparison between the figures obtaining at the end of 1955 and those at the end of 1956, as follows :—

		1955 *Return*		1956 *Return*	
A.	Handicapped pupils newly placed ..	153		170	
B.	Handicapped pupils newly assessed as requiring education at Special Schools	192		395	
C.	(i) (a) Attending Special Day Schools	153		211	
	(b) Attending Special Boarding Schools	248		252	
	(ii) Attending Independent Schools	36		41	
	(iii) Boarded in homes	47		23	
D.	Education under Section 56—hospitals	8		54	
	Education under Section 56—home tuition	32		38	
E.	Awaiting admission—day schools ..	105	171	261	377
	Awaiting admission—boarding schools	66		116	

Waiting Lists.

The figures of 171 (in 1955) and 377 (in 1956) are not so formidable as they appear at first sight. They can be broken down into E.S.N. and others as follows :—

	E.S.N.	*Others*
1955	134	37
1956	338	39

The E.S.N. waiting lists have been adjusted as between "day school" and "boarding school" for the 1956 return to take into account the assessment of pupils who may be admitted to the proposed Chesterfield Day Special (E.S.N.) School in approximatley two years' time. The great majority of the E.S.N. children awaiting vacancies in Special Schools are attending ordinary schools.

During the year a survey was carried out in the catchment area for the Chesterfield Day Special (E.S.N.) School and the results of the survey appear in column 'E' (i) (a), where 260 pupils are shown to be requiring places in Day Special Schools.

The Day Special School for Educationally Sub-Normal Children sited in the Long Eaton area was opened in September and at the end of its first term there were ninety children on the register. It is hoped that building work will commence on the Chesterfield School in October, 1957, and plans are being made to provide a Day Special School for Educationally Sub-Normal Children near Ripley to serve those parts of the County between the Long Eaton and Chesterfield Day Special School catchment areas, as well as a residential special school for educationally sub-normal boys, which may be sited in the Breadsall area.

A scheme has been agreed with the Board of Governors of the Derby Royal School for the Deaf whereby places shall be available for day pupils. At the beginning of the Summer Term, 1957, it is proposed that a small number of children now attending the school as residents, shall become day pupils ; the needs of each pupil have, of course, been carefully considered and discussed with both school and parents.

DERBYSHIRE EDUCATION COMMITTEE

RETURN OF HANDICAPPED PUPILS FOR WHOLE ADMINISTRATIVE COUNTY — YEAR 1956.

Categories	(1) Blind (2) Partially Sighted		(3) Deaf (4) Partially Deaf		(5) Delicate (6) Physically Handicapped		(7) Educationally sub-normal (8) Maladjusted		(9) Epileptic	Total (1)—(9)
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
In the calendar year :—										
A. Handicapped pupils newly placed in Special Schools or Boarding Homes ..	3	5	6	2	42	5	86	20	1	170
B. Handicapped pupils newly assessed as needing special educational treatment at Special Schools or in Boarding Homes	2	6	10	2	34	11	306	22	2	395
On or about 31st January, 1957 :—										
C. Number of Handicapped Pupils :—										
(i) On the registers of special schools as—										
(*a*) Day Pupils ..	–	1	6	1	69	8	74	52	–	211
(*b*) Boarding Pupils ..	12	11	53	17	21	25	84	15	14	252
(ii) On the registers of Independent Schools under arrangements made by the Authority	–	–	–	–	–	8	27	6	–	41
(iii) boarded in Homes and not already included under (i) or (ii) ..	–	–	–	–	–	–	–	23	–	23
Total (C)	12	12	59	18	90	41	185	96	14	527
On or about 31st January, 1957 :—										
D. Number of Handicapped Pupils receiving education under arrangements made under Section 56 of the Education Act, 1944:—										
(i) In hospitals	–	–	–	–	54	–	–	–	–	54
(ii) In other groups ..	–	–	–	–	–	–	–	–	–	–
(iii) At home	–	1	–	–	5	29	1	–	2	38
On or about 31st January, 1957 :—										
E. Number of Handicapped Pupils who were requiring places in special schools—										
(i) Total—										
(*a*) Day	–	–	1	–	–	–	260	–	–	261
(*b*) Boarding	2	11	6	1	5	9	78	3	1	116

Categories	(1) Blind (2) Partially Sighted		(3) Deaf (4) Partially Deaf		(5) Delicate (6) Physically Handicapped		(7) Educationally sub-normal (8) Maladjusted		(9) Epileptic	Total (1)—(9)
Included in the above totals :—	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
(i) Handicapped Pupils who had not reached the age of five—										
(*a*) awaiting day places	–	–	–	–	–	–	–	–	–	–
(*b*) awaiting boarding places	1	1	1	–	–	–	–	–	–	3
(ii) Handicapped Pupils who had reached the age of five but whose parents had refused to give consent to their admission to a special school :—										
(*a*) awaiting day places	–	–	–	–	–	–	9	–	–	9
(*b*) awaiting boarding places	–	1	–	–	–	–	5	–	–	6

(i) During the financial year ended 31st March, 1956, the amount spent on arrangements under section 56 of the Education Act, 1944 for the education of handicapped pupils otherwise than at school, was £6,064/0/0d.

(ii) The number of pupils on the registers of Hospital Special Schools on or about 31st January, 1956, was 77.

RETURNS FOR DIVISIONAL EXECUTIVE AREAS

Division	Categories	(1) Blind (2) Partially Sighted		(3) Deaf (4) Partially Deaf		(5) Delicate (6) Physically Handicapped		(7) Educationally sub-normal (8) Maladjusted		(9) Epileptic	Total (1)—(9)
		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
North-west	A	1	–	1	–	1	–	2	3	–	8
	B	–	–	1	–	1	2	8	3	–	15
	C (i) (*a*) ..	–	–	–	–	–	–	–	–	–	–
	C (i) (*b*) ..	2	2	6	2	2	2	4	2	3	25
	C (ii)	–	–	–	–	–	1	3	1	–	5
	C (iii) ..	–	–	–	–	–	–	–	7	–	7
	Total (C) ..	2	2	6	2	2	3	7	10	3	37
	D (i)	–	–	–	–	13	–	–	–	–	13
	D (ii)	–	–	–	–	–	–	–	–	–	–
	D (iii) ..	–	–	–	–	–	6	–	–	–	6
	E (i) (*a*) ..	–	–	–	–	–	–	–	–	–	–
	E (i) (*b*) ..	1	–	–	–	–	2	8	1	–	12
	E (ii) (*a*) ..	–	–	–	–	–	–	–	–	–	–
	E (ii) (*b*) ..	1	–	–	–	–	–	–	–	–	1
	E (iii) (*a*) ..	–	–	–	–	–	–	–	–	–	–
	E (iii) (*b*) ..	–	–	–	–	–	–	1	–	–	1
North-east	A	1	1	4	1	5	3	6	3	–	24
	B	1	–	6	1	7	5	169	4	1	194
	C (i) (*a*) ..	–	1	4	–	6	5	3	2	–	21
	C (i) (*b*) ..	6	1	15	4	5	6	29	1	2	69
	C (ii)	–	–	–	–	–	2	6	1	–	9
	C (iii) ..	–	–	–	–	–	–	–	5	–	5
	Total (C) ..	6	2	19	4	11	13	38	9	2	104

RETURNS FOR DIVISIONAL EXECUTIVE AREAS

Division	Categories	(1) Blind (2) Partially Sighted		(3) Deaf (4) Partially Deaf		(5) Delicate (6) Physically Handicapped		(7) Educationally sub-normal (8) Maladjusted		(9) Epileptic	Total (1)—(9)
		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
North-east	D (i)	–	–	–	–	–	–	–	–	–	–
	D (ii)	–	–	–	–	–	–	–	–	–	–
	D (iii) ..	–	–	–	–	–	7	1	–	–	8
	E (i) (*a*) ..	–	–	–	–	–	–	189	–	–	189
	E (i) (*b*) ..	1	1	2	–	3	3	20	–	1	31
	E (ii) (*a*) ..	–	–	–	–	–	–	–	–	–	–
	E (ii) (*b*) ..	–	–	–	–	–	–	–	–	–	–
	E (iii) (*a*) ..	–	–	–	–	–	–	6	–	–	6
	E (iii) (*b*) ..	–	–	–	–	–	–	3	–	–	3
Mid-Derbyshire	A	1	2	–	–	4	1	3	–	–	11
	B	1	2	–	–	2	3	32	–	–	40
	C (i) (*a*) ..	–	–	1	–	–	–	1	2	–	4
	C (i) (*b*) ..	1	5	6	4	4	5	22	–	1	48
	C (ii)	–	–	–	–	–	1	8	1	–	10
	C (iii) ..	–	–	–	–	–	–	–	5	–	5
	Total (C) ..	1	5	7	4	4	6	31	8	1	67
	D (i)	–	–	–	–	–	–	–	–	–	–
	D (ii)	–	–	–	–	–	–	–	–	–	–
	D (iii) ..	–	–	–	–	1	4	–	–	–	5
	E (i) (*a*) ..	–	–	–	–	–	–	5	–	–	5
	E (i) (*b*) ..	–	1	1	–	–	3	38	–	–	43
	E (ii) (*a*) ..	–	–	–	–	–	–	–	–	–	–
	E (ii) (*b*) ..	–	–	1	–	–	–	–	–	–	1
	E (iii) (*a*) ..	–	–	–	–	–	–	–	–	–	–
	E (iii) (*b*) ..	–	–	–	–	–	–	1	–	–	1
South-east	A	–	1	–	–	6	–	55	1	1	64
	B	–	2	2	–	5	–	76	2	1	88
	C (i) (*a*) ..	–	–	1	1	–	–	54	–	–	56
	C (i) (*b*) ..	1	1	3	–	7	3	15	–	2	32
	C (ii)	–	–	–	–	–	2	3	1	–	6
	C (iii) ..	–	–	–	–	–	–	–	2	–	2
	Total (C) ..	1	1	4	1	7	5	72	3	2	96
	D (i)	–	–	–	–	14	–	–	–	–	14
	D (ii)	–	–	–	–	–	–	–	–	–	–
	D (iii) ..	–	–	–	–	–	1	–	–	–	1
	E (i) (*a*) ..	–	–	–	–	–	–	56	–	–	56
	E (i) (*b*) ..	–	4	2	–	2	–	2	1	–	11
	E (ii) (*a*) ..	–	–	–	–	–	–	–	–	–	–
	E (ii) (*b*) ..	–	–	–	–	–	–	–	–	–	–
	E (iii) (*a*) ..	–	–	–	–	–	–	–	2	–	2
	E (iii) (*b*) ..	–	–	–	–	–	–	–	–	–	–

RETURNS FOR DIVISIONAL EXECUTIVE AREAS

ivision	Categories	(1) Blind (2) Partially Sighted		(3) Deaf (4) Partially Deaf		(5) Delicate (6) Physically Handicapped		(7) Educationally sub-normal (8) Maladjusted		(9) Epileptic	Total (1)—(9)
		(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
tth	A	–	–	1	–	6	–	16	2	–	25
	B	–	–	1	1	4	–	19	2	–	27
	C (i) (*a*) ..	–	–	–	–	–	–	16	–	–	16
	C (i) (*b*) ..	2	1	12	6	3	6	10	1	1	42
	C (ii)	–	–	–	–	–	2	2	2	–	6
	C (iii) ..	–	–	–	–	–	–	–	4	–	4
	Total (C) ..	2	1	12	6	3	8	28	7	1	68
	D (i)	–	–	–	–	18	–	–	–	–	18
	D (ii)	–	–	–	–	–	–	–	–	–	–
	D (iii) ..	–	–	–	–	–	11	–	–	2	13
	E (i) (*a*) ..	–	–	1	–	–	–	10	–	–	11
	E (i) (*b*) ..	–	1	1	1	–	–	10	–	–	13
	E (ii) (*a*) ..	–	–	–	–	–	–	–	–	–	–
	E (ii) (*b*) ..	–	1	–	–	–	–	–	–	–	1
	E (iii) (*a*) ..	–	–	–	–	–	–	1	–	–	1
	E (iii) (*b*) ..	–	–	–	–	–	–	–	–	–	–
esterfield	A	–	1	–	1	20	1	4	11	–	38
	B	–	2	–	–	15	1	2	11	–	31
	C (i) (*a*) ..	–	–	–	–	63	3	–	48	–	114
	C (i) (*b*) ..	–	1	11	1	–	3	4	11	5	36
	C (ii)	–	–	–	–	–	–	5	–	–	5
	C (iii) ..	–	–	–	–	–	–	–	–	–	–
	Total (C) ..	–	1	11	1	63	6	9	59	5	155
	D (i)	–	–	–	–	9	–	–	–	–	9
	D (ii)	–	–	–	–	–	–	–	–	–	–
	D (iii) ..	–	1	–	–	4	–	–	–	–	5
	E (i) (*a*) ..	–	–	–	–	–	–	–	–	–	–
	E (i) (*b*) ..	–	4	–	–	–	1	–	1	–	6
	E (ii) (*a*) ..	–	–	–	–	–	–	–	–	–	–
	E (ii) (*b*) ..	–	–	–	–	–	–	–	–	–	–
	E (iii) (*a*) ..	–	–	–	–	–	–	–	–	–	–
	E (iii) (*b*) ..	–	1	–	–	–	–	–	–	–	1

Special Reports.

(1) *Overseal Manor.*

The following report has been provided by Dr. Malcolm Allan, the School Medical Officer who pays regular visits to this Special School :—

"The School has been inspected each term and at other essential times. Some of the children show considerable mental and physical improvement, and the whole atmosphere of the School is very pleasant. Fortunately this year there was no outbreak of infectious disease, although the children come from widely scattered areas."

(2) *John Duncan Special School.*

Dr. G. Cochrane, the School Medical Officer who visits this School, has provided the following report :—

"The children, who are examined each term, at the John Duncan School, seem intensely happy and are well cared for. The training given at this School seems to impart incalculable benefit to those who have been able to assimilate the education."

(3) *Talbot House, Glossop.*

Dr. M. Sutcliffe, the School Medical Officer who is in regular contact with the School, has reported as follows :—

"There have been nineteen children in residence at Talbot House Special School, the full complement being twenty. In spring a small outbreak of whooping cough was notified, two cases occurring in March and two in April. Throughout the year upper respiratory infections have been fairly prevalent.

Since April, children from the age of six years have attended a public swimming bath once a week. Although their progress is slow, they do learn confidence in the water and find relaxation and a wider range of movement easier to acquire.

As very few of the children had received any diphtheria prophylaxis, immunisation was carried out during the year."

Miss Curry, the Speech Therapist, has reported as follows :—

"Since August 27th, 1956, a Speech Therapist has attended Talbot House Special School each morning and two afternoons per week. Seven children received speech therapy ; the three most serious speech cases who suffer from athetoid dysarthria are receiving treatment each day. The remainder of the time was almost equally divided among the other four children whose speech is intelligible but irregular in either pitch, tone, volume or rhythm, indicating difficulties in breath control.

With the aid of a tape recorder, it has been possible to indicate these speech differences and difficulties, especially to the older children who have listened critically to their own speech and are learning to overcome some of their defects. Even the youngest child once convinced that it is her own voice, enjoys trying to speak differently and hearing the results.

Speech Therapy with the cerebral palsied child does not progress rapidly, and those improvements which are noticed may not become established for many weeks or months. Yet speech therapy is of great value to these children, and the time spent with them in 1956 has been most instructive and interesting."

Cases reported to Local Health Authority.

During the year the following numbers of pupils were reported by the Education Authority to the Local Health Authority, as being ineducable (section 57 (3), Education Act, 1944), and as requiring supervision after leaving school, by reason of a disability of mind (section 57 (5), Education Act, 1944) :—

Divisional Executive	Under section 57 (3) of the Education Act, 1944		Under section 57 (5) of the Education Act, 1944	
	Boys	Girls	Boys	Girls
North-west	2	3	—	—
North-east	8	5	2	1
Mid-Derbyshire	2	1	—	1
South-east	2	1	—	—
South	2	3	1	1
Chesterfield	—	2	—	—
Totals ..	16	15	3	3

CEREBRAL PALSY

At a conference of local education authorities of the North Midlands held in 1947 the Derbyshire County Council was asked to explore the possibility of establishing a Unit for the treatment and training of children suffering from cerebral palsy. In order to assess the extent of the problem the information already in the County Health Department was reviewed and an inquiry was addressed to all medical practitioners practising in the administrative county for their co-operation in indicating the extent of the condition in their practices. Arrangements were made for the School Medical Officers to submit up-to-date reports on all the children thought to be suffering from cerebral palsy. The findings of this investigation were set out in detail in my Annual Report for 1953. Briefly, eighty-six children were found to be suffering from cerebral palsy, of whom thirty-one were considered to have normal intelligence, twenty-nine to have some degree of backwardness and thirteen to be seriously subnormal but educable, and thirteen to be ineducable. The "educational treatment" recommended was as follows : to attend ordinary schools, forty-nine ;

admission to special hospital schools, fifteen; home care and those regarded as ineducable, twenty-two. The incidence of the condition was 1.0 per 1,000 pupils, and it was interesting to read subsequently that the estimated incidence for England and Wales was also 1.0 per 1,000. In 1954, the Derbyshire Education Authority opened their residential special school for cases of cerebral palsy, at Talbot House, Glossop.

I have recalled the above because during the year now being reviewed the Chesterfield and District Branch of the National Spastics Society consulted the County Council regarding the facilities available for patients in their area afflicted with cerebral palsy. It was thought it would be useful to arrange for a case-by-case survey to be carried out to ascertain the needs of each patient, how far those needs were being met, and if there were any deficiencies, how best they could be remedied. In order that a uniform standard might be applied it was agreed that the Senior Assistant Medical Officer on the Staff of the County Council, Dr. A. H. Fairlamb, should undertake this survey. The names of the patients were kindly provided by the Branch and the patients or their parents were very co-operative in giving details of the medical and social histories. Dr. Fairlamb's report on his survey was on the following lines :—

"(1) I wish to report on a survey carried out in respect of a series of cases in the Chesterfield Area, which are believed to be cases of Cerebral Palsy.

(2) Cerebral palsy has been defined as a syndrome or number of syndromes rather than a disease, which resulted from non-progressive brain damage shortly before or after birth. There are disturbances of voluntary movement, muscle tone and co-ordinated muscular activity; the intellect and emotions; seizures are common and specific learning difficulties arise. Included in this investigation are all cases which conform to the definition given above, and it will be appreciated that some are so slightly handicapped that very little or no treatment is needed, but at the other end of the scale there are cases suffering from severe physical disability accompanied by gross mental retardation.

NUMBERS INVESTIGATED

(3) A total of eighty-six cases was investigated and of this number eight have been rejected on the grounds that they are not true cases of cerebral palsy. Two cases are under the care of a Paediatrician in Derby; two cases were not able to be found at the addresses given.

The Table below summarises these results :

Table I

Number of cases of cerebral palsy in the Chesterfield area ..	74
Number not considered 'spastic'	8
Number in the Derby area	2
Number unable to be traced	2
Total	86

For convenience I have divided these seventy-four cases considered 'spastic' into three groups : (a) pre-school age group; (b) children of school age (accepting the age of sixteen years as the age of leaving school for a handicapped pupil); and (c) those over compulsory school age. The numbers involved in the separate groups are twelve, forty-five and seventeen respectively.

Table II gives an indication of the age and sex distribution of the cases visited :—

Table II

Age	0—4	5—14	15—29	30—49	50+	Total
Male	7	23	9	3	1	43
Female	5	16	6	4	–	31
Totals	12	39	15	7	1	74

Of the total number of cases investigated, seventeen (22.9%) are considered ineducable, and considering those of school age only thirty-two (71%) are considered educable and thirteen (29%) ineducable.

(4) (*a*) *PRE-SCHOOL GROUP (NUMBER OF CASES* 12).

(i) This group comprises twelve children of ages ranging from one year to four and a half years old. Eleven of these are under the care of Consultant Paediatricians attached to hospitals in the Sheffield, Nottingham and Chesterfield areas. Only one child has treatment privately in London (this is a private arrangement on the part of the parents). All children attending hospital attend regularly for surveillance.

(ii) *Physiotherapy and Occupational Therapy.*

In seven instances this is provided at the hospital the child attends, on an average of two sessions weekly ; two cases are supervised by the hospital but the exercises are carried out at home by the parents. In one instance therapy is a private arrangement with a therapist in London.

Two children are not provided with physiotherapy but both appear very backward and would not be able to co-operate in the carrying out of exercises at present.

(iii) *Speech Therapy.*

This appears to be required in one case but is not provided at present. In the case of seven children speech therapy is not required and in a further four instances speech has not developed sufficiently to enable them to benefit from speech training.

(iv) *Educational Requirements.*

I would say that ten children appear to be educable and two probably ineducable but as yet no accurate assessment of educability has been carried out, mainly because of the ages of the children concerned. This assessment can be readily carried out by officers of the Authority when the child reaches school age.

(v) In general, I think all requirements in respect of medical advice, speech therapy, physiotherapy, educational assessment and guidance for the parents can be provided for by the hospitals and Local Health and Education Authorities. I would hesitate to advise any change from the present routine without a prior consultation with the Paediatric Consultants who have these children under their care.

(*b*) *CHILDREN OF SCHOOL AGE (NUMBER OF CASES* 45)

(i) In this group, a total of forty-five cases are involved, thirty-two are deemed to be educable and thirteen ineducable ; the latter group have been reported to the Local Health Authority in accordance with the Education Act, 1944.

The Table below gives an indication of the type of education provided for those thirty-two cases which are considered educable.

Table III

Type of School	Male	Female	Total
Primary or Secondary Modern	9	9	18
Grammar	1	1	2
Special Cerebral Palsy	2	3	5
Special for Delicate Children	2	–	2
Rudolf Steiner	1	–	1
School for the Blind	1	–	1
Home Tuition	–	1	1
No school or Home Tuition	2	–	2
	18	14	32

The multiplicity of type of school provided gives, I think, a clear idea of the complexity of the problem and to my mind the necessity for the careful assessment of each case individually.

Regarding the type of education being provided at present, I would like to make the following comments :—

Four children who are attending ordinary school do not appear to be making adequate progress and for educational reasons a different type of education may be needed. Three of these children appear to be educationally sub-normal and admission to a school for E.S.N. pupils would be desirable ; the fourth child will probably need to be admitted to a special school for spastic children later. Another child attending ordinary school is probably dull and backward and requires additional help in his present school.

The two children who are not receiving education will probably be able to attend a special school for cerebral palsied children later.

I would emphasize that the pupils referred to in the above paragraphs are reviewed regularly by the School Medical Officers for the areas and have not merely been discovered as a result of this investigation.

I feel that the needs of the educationally subnormal pupils will be met when the new Day Special School is available at Chesterfield. Regarding vacancies for spastic children, I understand that places at residential schools are much more readily available than in previous years.

(ii) *Speech Therapy.*

Speech therapy requirements in the school age group amount to fourteen cases and treatment is provided in nine cases. The deficiency in this instance can be remedied quite easily by reference to a Speech Therapist working at a County Clinic.

(iii) *Physiotherapy and Occupational Therapy.*

This form of therapy appears to be required in twenty-two cases and has been provided in twenty cases. Apart from two instances where private arrangements have been made it is provided for by various hospitals in the area. On an average two sessions weekly are provided but in some cases physiotherapy and occupational therapy have been curtailed to obviate loss of schooling. The Orthopaedic Surgeon, who has seen many of these cases is of the opinion that more than two sessions weekly would be beneficial but the difficulty is the interruption of the children's education.

Eight cases were considered to be severely mentally retarded and not amenable to therapy at present.

(iv) *Cases reported as Ineducable.*

A total of seventeen cases has been reported as ineducable. This number comprises thirteen children of school age and four adults. Many of this group, although they are severely handicapped physically, are also grossly mentally retarded and in some the mental defect would appear to be more serious than the physical defect. Only five of these cases would appear to be suitable for an Occupation Centre. These cases should be able to be dealt with by the Occupation Centre at Chesterfield if the parents are willing for them to attend. The unfortunate group of twelve who are not suitable for Occupation Centre training require a great deal of individual attention and present a great problem to the parents. In fact four cases are already on the urgent waiting list for admission to the Mental Deficiency Institutions.

A Centre where children may be left to relieve parents of the strain of looking after their children might be useful for this group of cases.

The Social Workers for Mental Deficiency visit these cases regularly and the Mental Health Section of the County Health Department keep in close touch with the Regional Hospital Board with a view to obtaining vacancies in Mental Deficiency Institutions for this type of urgent case.

(c) *CASES OVER COMPULSORY SCHOOL AGE (NUMBER OF CASES* 17).

Included in this group are seventeen cases : eight do not wish to attend a Centre and four have been reported as ineducable.

The County Welfare Department have been very helpful in providing craft instruction for eleven of these cases. I understand from the County Welfare Officer that craft instruction can be provided for the six cases who are not receiving it at present. At present the majority of cases receive craft instruction for one session per week. Only one adult has been able to obtain employment as a handicapped person and this has been irregular at the best of times.

(5) SUMMARY OF FINDINGS

(a) *The pre-school age group* of twelve children appears to be provided with adequate medical care and attention from consultant medical authorities at the various hospitals in the Sheffield, Nottingham and Chesterfield areas. The children attend regularly for surveillance and I would hesitate to alter this routine without consulting the specialist in charge of the case.

(b) *The School Age Group.* In the main, those children who are educable are receiving education adequate for their needs. There are in the group six children who will probably require a different type of schooling from that provided at present. Two of these six children are not at school at present and would benefit from temporary attendance at a Centre in Chesterfield, but I would emphasize that their attendance would probably be a temporary measure until they were ready to attend a special school for spastics.

For those children in this group who are ineducable and not suitable to attend an Occupation Centre the outlook is gloomy, particularly as in many cases a great deal of individual attention is required. In my opinion twelve cases come into this category ; four of these must be considered as temporary since their names are on a waiting list for institutional care in Mental Deficiency Institutions. There is no doubt a Centre would be useful in these cases as a relief function for the parents for one morning and/or afternoon a week.

(6) **THE TABLE BELOW SUMMARISES THE FINDINGS OF THIS SURVEY IN SEPARATE GROUPS :—**

Table IV

(a)	**Pre-school Group,** number of cases		12
(b)	**Children of school age** who are considered educable		32
	(i) Number attending ordinary schools	20	
	(ii) Number attending special schools	9	
	(iii) Number having home tuition	1	
	(iv) Number not attending school or having home tuition	2	
		32	
	(v) Cases reported as ineducable (including 4 adults)		17
	(vi) Cases suitable for an Occupation Centre	5	
	(vii) Cases not suitable for an Occupation Centre ..	12	
		17	
	(viii) Number of the above who are listed for urgent residential institutional care	4	
(c)	**Adults**—Number of cases		17
	Number wishing to attend a Centre	9	
	Number not wishing to attend a Centre	8	
		17	

The children referred to in items (iv) and (vii) of the above table could be considered for a special centre ; in so far as *six* of these are concerned I would consider them as *temporary candidates only*, since two are educable and will probably attend a special school later and a further four have been listed for residential institutional care in Mental Deficiency Institutions. The main difficulty with this group is that nearly all these ineducable children are severely handicapped both physically and mentally and because of their low level of attainment require a good deal of individual care and attention. I do not think that it would be practical to have all these childen attending at the same time. Attendance at a Centre for one morning and/or afternoon a week would be helpful to parents but in this aspect a centre would merely serve as a relief function. If *adults* are to be considered eligible for attendance *it would appear that nine of those visited wish to attend a Centre* in Chesterfield. I understand that the County Welfare Department can provide craft instruction for those who are not already receiving it.

(7) Finally, I would like to quote the views of a meeting of experts on Cerebral Palsy at a discussion at the Centenary Meetings of the Society of Medical Officers of Health this year :

'Cerebral Palsy was a social problem. Parents needed assistance if they were to manage properly their severely disabled child ; home helps, sitters-in for one night a week, holiday homes for the children (such as the John Horniman Home, Worthing, run by the Invalid Children's Aid Association) that allowed parents to have a holiday on their own, were examples quoted of social help that could be given to parents.

It would be of more benefit to the children if money were spent on these forms of social assistance for parents rather than on bricks and mortar for children, especially now that there, practically, is sufficient special school accommodation available.' "

It so happens that the Report of the Chief Medical Officer of the Ministry of Education for the year 1955, includes a section which deals with "The Young Handicapped Child," and special mention is made of cerebral palsy. In my opinion, Sir John Charles's comments sum up the problem of cerebral palsy excellently, and therefore I think it will be of value to members if I quote them below :—

"*The Child with Cerebral Palsy.*

The heterogeneous collection of brain injuries and disorders which are grouped under general term of cerebral palsy has received considerable attention of recent years following a long period of almost complete medical neglect. This apparent lack of interest was not due to inhumanity but rather to helplessness. Adequate tools of research had not been forged. The etiology and pathology were uncertain, the death rate was high and so little was known regarding treatment that survival offered the victim small hope of rehabilitation. It was seldom realised that the obvious motor disabilities might be only part of a much more widespread brain-injury and that at least some of the child's apparent educational inaccessibility might be due to malfunctioning of the sensory organs or their cortical connections, in the presence of intellectual faculties which were relatively intact.

There is now danger that the equally erroneous opposite view may be tenaciously upheld, and because inaccurate diagnoses have been made in the past and because one or two able "spastics" have wielded powerful pens in the present, it must necessarily follow that every brain-injured child is an example of talent locked-up. Careful psychological assessment of all known school-age children in several areas has shown that although about three quarters are educable in normal or special schools, the remaining one-quarter are ineducable although some of these are trainable. No useful purpose is served when emotion is allowed to bias judgment. Efficient treatment centres cannot materialize overnight in the absence of sufficient numbers of trained staff. In the past the chief emphasis in treatment was laid on motor reablement particularly locomotion, with less concern for manipulation, although control of the shoulders and upper limbs precedes control of the lower limbs in the normal developmental sequence. It has only recently been realised that the associated speech defects are not due solely to neuro-muscular inco-ordination, but that a considerable proportion of these children suffer from aphasias of central origin, or from partial deafness, particularly of the high tone type. The cadences and vowel sounds of speech may be plainly audible and imitatively reproduced, although for lack of consonant discrimination the speech they hear is grossly distorted and what they say is completely unintelligible. To the inexperienced observer, such children might appear not partially deaf, but mentally defective. Similarly, although oculomotor disabilities are obvious, it has also only recently been realised that many of these children have defects of visual perception, particularly with regard to stereoscopic vision and spatial relationships, so that they may find it difficult to associate a three-dimentional moving object with its pictured representation in a book, or, while instantly recognizing printed figures and letters, many find it impossible to copy them down on paper. These children frequently also have difficulty in appreciating their own position and movements in space, so that they confuse top and bottom, inside and outside, left and right. Even dressing and undressing are tedious processes of trial and error. Fits are also common. The resulting mental confusion and emotional frustration may give rise to serious problems of behaviour. As the child grows older and his undamaged faculties mature, he may be able to invent tricks to circumvent his difficulties, but standard psychological tests will usually lay bare his inadequacies.

At present the study of etiology, symptomatology, pathology and prognosis is rendered difficult by confusion of terminology, multiplicity of treatment methods and lack of follow-up studies. There is, however, general agreement concerning the need for early diagnosis and referral for treatment, and for good team work, under the direction of an interested medical officer, of physiotherapists, speech therapists, psychologists and teachers. It seems

possible that inherited vulnerability is a factor in its causation, and there is little doubt that noxious environmental influences in the first trimester of pregnancy, and the hazards of prematurity, kernicterus and anoxia in the perinatal period are also involved, but at present much of its etiology and pathology remains obscure.

In most centres for the treatment of young cerebral palsied children, the importance of securing the mother's full co-operation in the daily management of her child's disability is well realised. Treatment at this stage is a disciplined way of living rather than a series of bi-weekly physiotherapy sessions. Although terminology and therapeutic methods differ, the plan of treatment in every centre is broadly based on relaxation and the application of developmental principles. The child is prompted by every possible means to reproduce, in orderly progression, the sensory and motor sequences of normal development. Hence he is encouraged to manipulate play-things before he is expected to use feeding utensils, to sit and roll before he crawls, to stand before he walks. At home he is encouraged to look and to listen, to vocalize his needs, to use his hands, and to explore his environment. Progress is inevitably slow, but periodic cinematographic records leave no doubt that improvement may be confidently expected and that the earlier treatment is started the more promising are the results.

The Counselling of Parents.

In the daily care of their sick or handicapped children, mothers have shown themselves such willing and responsive pupils that it is now possible, under suitable guidance, to entrust them with ever-increasing responsibilities in treatment. This has proved of great benefit to the child as well as relieving pressure on hospital beds and out-patient departments. The emotional dependence of young children and the significance of affectionate adult-child relationships during early childhood are well understood. Deeper insight has led to the realization that personal relationships within the family are constantly growing and changing and that the mother, in order to keep her natural impulse sweet and strong, must continually renew it by love and willing service. Maternal instinct, however vigorous, cannot be expected to cope unaided with the distresses and difficulties of rearing a handicapped child. Guidance by experts is essential.

Training mothers to carry out physical procedures demands patience and careful supervision, but it is comparatively simple. The counselling of parents with regard to their emotional attitudes is a more delicate matter. Left to themselves, the parents of handicapped children tend to choose one of four ways of dealing with their problem. One group, out of their compassion and distress, spoil and over-protect their child so that he lives a hot-house existence, resented by his siblings and ignored by his contemporaries. Another group, feeling revulsion or guilt, reject the child, neglecting his welfare or shifting his entire responsibility to anyone who will accept it. No other child in the world is so deprived as the handicapped child whose parents have abandoned him to strangers. The third group, in their anxiety to compensate the child (or perhaps themselves) for his handicap, deny its existence and force him to make physical and mental effort beyond his capacity. The fourth group accept the child with love and serenity for what he is, acknowledging his handicap, but encouraging him to make the best of his assets and to learn independence. All four groups are in need of support and guidance, and this difficult task must be approached with adequate knowledge.

At least two voluntary organizations, one hospital and a few public health departments are pioneering in this field. Three small residential units have been established where the mothers may live with their young children for one or two weeks whilst the child's condition and needs are assessed and the mother receives expert tuition in the management of his physical handicap and psychological difficulties. During this time the mother is shown how she may use the recurring situations of ordinary home life for informal teaching and practice. She is able to talk out her problems with knowledgeable and sympathetic people and is given reassurance and encouragement to persevere. One or two forward-seeing local authorities have

established special observation clinics for handicapped babies as part of their normal M. & C.W. Services. The sessions are held in the ordinary welfare centres. The number of appointments is kept within reasonable limits so that the doctors may have adequate time to assess the child's progress since the last visit, and above all time to listen to the mother's difficulties and to discuss possible means of overcoming them. The mothers particularly welcome the opportunity of meeting other mothers similarly situated whilst being spared the distress of waiting with mothers of normal children in the ordinary clinics. In all these special services, friendly relations with the family doctors and consultants are maintained, and to such good purpose that knowledge of their work is rapidly spreading and the child's age at referral is steadily falling.

It is in the nature of the growing body to be tirelessly active, and of the growing mind to be intensely curious. The child who is always quiet and docile, and content to seek no adventure in his environment, is in need of careful investigation. It has become increasingly obvious, that, even in the hands of experts, the diagnosis of retardation in early childhood is difficult and uncertain. Every child must be given the benefit of doubt at least until he has passed beyond the hope of spontaneous learning of the particular function in which he appears to be backward. The process of structural maturation itself occasionally produces unexpected improvement. Training in the critical period may eventually achieve functional recovery. It is important therefore that the paediatrician (using the word in its widest sense) should cultivate a wise and sensitive alertness to early and minor deviations from normal development, and, in all his examinations, consider the whole child.

The young handicapped child in Britain to-day can look forward to a longer and healthier life. He is entitled to expect that the community will endeavour to make that life as happy, useful and rich in experience as his handicap will allow, whilst maintaining a sense of proportion with regard to his rightful share of the provisions generally available. Although the financial cost of his care and training is greater than that of ordinary children the percentage of handicapped children in the whole community is very small and, in return for the efforts made on his behalf, he subscribes generously to the common fund of knowledge we are accumulating concerning the every-day miracle of human growth and development."

CHILDREN WITH DEFECTIVE HEARING
AUDIOMETRIC SURVEY

In my Report for 1956 this matter was dealt with at some length, and after reviewing the subject generally I concluded by quoting a Report from Dr. A. H. Fairlamb, the Senior Assistant Medical Officer, on a "pilot survey" which he had carried out, using the "sweep-frequency method" at a Junior School. Dr. Fairlamb ended his report by suggesting that "similar pilot surveys be carried out in other schools in the County before any firm conclusions are drawn as to the value of routine audiometric surveys."

Two further surveys were carried out in 1956, and the following are relevant excepts from Dr. Fairlamb's reports :—

(1) *Matlock C. of E. School* :— "The results of this survey are as indicated in the table below :—

	Boys	Girls	Total
Number of Children Tested	167	129	296
Number of Children who failed first test ..	27	12	39
Number of Children who failed second test	13	5	18

From the table it will be seen that of the total of 296 children eighteen or 6% failed the screening test at the fifteen decibel level. Those children who failed were given a complete audiometric examination. Of the total of eighteen cases, eleven cases were found to have audiograms within normal limits and should be able to continue education in an ordinary school. In four of the remaining seven cases the defect of hearing was present in one ear only and of the remaining three children, two appeared to be suffering from congenital deafness of moderate degree and another had signs of a chronic sinus infection."

(2) *Bakewell Methodist School* :— "The ages of the children tested in this school ranged from seven years to eleven years and in all a total of 205 pupils were investigated. Detailed results of this small survey are indicated in the table below :—

	Boys	Girls	Total
Number of Children tested	113	92	205
Number of Children who failed first test . .	11	8	19
Number of Children who failed second test	4	5	9

From the table it will be noted that of the total number of children tested, nine or 4.39% failed the two screening tests at the fifteen decibel level. In this group, one child failed due to backwardness and inability to co-operate in carrying out the test, another a known epileptic was sedated with phenobarbitone and a further three subjects had wax present in one or both ears. The Health Visitor visited the parents of those children requiring treatment and advised them to consult their own practitioner about this.

Following treatment, I carried out a full audiometric examination on 18.7.56 on those children who had failed the two preliminary screening tests. Amongst this group there was no instance where the hearing was so defective that admission to a special school for the partially deaf was necessary. Two of the three children referred to previously who had wax present in their ears now presented a normal audiogram. In the case of the third child there was slight bilateral deafness. Examination of the ears showed evidence of an old ear infection but no evidence of an active otitis media. The Head Teacher was advised to give the child an advantageous position in the class.

In four other cases deafness of varying degree was detected in one ear only and in all of these cases the hearing defect was compensated by normal hearing in the other ear. I advised the headmaster about these defects so that these children can be kept under observation and given a suitable position in class.

The School Medical Officer for the area has also been advised of these findings in order that these cases can be reviewed from time to time."

Following the three surveys which have been mentioned above, Dr. Fairlamb reached the conclusion that :—

"For routine screening for the detection of hearing defects the sweep frequency technique is an efficient and reliable method of making screening tests of the hearing of five and six year olds and is superior to the gramophone audiometer. The latter, which is administered as a group test cannot be used with children less than eight years old and even then children who are retarded educationally have difficulty in writing down the numbers which they hear.

A total of 889 children were tested in these three surveys and of this number only two children were found to be suffering from defects of hearing of such magnitude as to interfere with their education in an ordinary school. For one of these children arrangements were already being made for his admission to a school dealing

with partially deaf children. I have since learned that he has been returned from this school as suitable for an ordinary school. Apart from the two cases referred to previously, minor hearing defects were discovered in twenty-two cases. All the children were placed in Category Grade I since they were able to obtain benefit from education provided in an ordinary school. Many of these children were found to be suffering from nasal and ear conditions which could be detected by careful clinical examination. Arrangements were made for these children to be referred for treatment by an Ear, Nose and Throat Specialist by their own practitioners.

I would not recommend routine screening tests on all children on these findings, but would suggest audiometric tests being carried out on special groups, such as, children referred by School Medical Officers following school inspection, children suffering from speech defects and children who are educationally retarded. This latter group would include pupils attending special residential schools for educationally sub-normal pupils in the County."

The value of audiometric surveys is discussed at some length in the Report of the Chief Medical Officer of the Ministry of Education for the years 1954 and 1955, which was received in January, 1957. It was interesting to see that Dr. Fairlamb was not alone in reaching the conclusion expressed in the last paragraph of his report, as will be seen from the following quotation from the Chief Medical Officer's Report:—

"Some doctors doubt whether the routine use of audiometry is justified having regard to the small numbers of handicapped children found ; they consider that it should be reserved for the examination of special cases referred by parents, teachers, and school nurses, because of a suspected hearing loss.

There are several groups of children which might well be chosen specially for audiometric survey : educationally sub-normal children, those with speech defects, and those with cerebral palsy. In every area these groups of children should be accurately tested for hearing loss.

Accumulation of wax in the ears is often responsible for failure to pass an audiometric test ; so, too, is the presence of chronic otitis media. The audiometer is an instrument for diagnosing a defect of hearing, not aural disease. Routine use of the electric auriscope should be the first step in any scheme for audiometric surveys."

It is relevant to mention here that the Authority has purchased an electric auriscope for each School Medical Officer for use at periodic school medical inspections and at clinic sessions.

MALADJUSTED PUPILS.

The establishment authorises the appointment of a whole-time and a part-time Children's Psychiatrist. The Sheffield Regional Hospital Board, in consultation with the County Council, has appointed Dr. D. J. Salfield to act as Consultant Children's Psychiatrist in the part of the administrative County which lies within the area of the Board ; he devotes the majority of his time to the treatment of maladjusted

children. As regards the part of Derbyshire within the area of the Manchester Regional Hospital Board, a few cases are referred from time to time to the Psychiatrist for that Region for treatment.

Towards the end of the year, the establishment for Educational Psychologists was increased from four to five officers. Four of the posts were filled throughout 1956, and the additional post was filled from mid-1957.

It has proved impossible to secure the services of a qualified Psychiatric Social Worker for several years, but a half-time social worker was employed throughout the year in connection with the child guidance facilities at the Children's Centre, Brambling House, Chesterfield, and towards the end of the year a whole-time social worker was appointed to serve elsewhere in the Country.

The following report has been received from Dr. Salfield :—

"The arrangement concerning the division of his time between the various Authorities and hospitals has continued in the past year, and again as far as the County Service is concerned about one day is spent at Walker Lane Clinic, Derby, and half to one day at Ilkeston. More regular visits have been paid to the Authority's hostel for maladjusted children at Stretton House, and also group therapy has been started there with the children. The Psychiatrist's services have also continued to be given to other more occasional duties, such as visits to the Children's Department Homes, etc.

The continuing handicap of inadequate accommodation will, it is hoped, be remedied within the forseeable future. The demands on the Service are still on the increase, and it has therefore been necessary, in spite of the addition of a Social Worker to the Child Guidance staff, to restrict the Psychiatrist's work in most cases to consultative and advisory help. It is hoped that direct therapy will be more efficiently done as soon as premises permitting play therapy, and group therapy also with the parents, are available.

Various new techniques have been introduced during the past year, and amongst these the little time consuming one of special relaxation exercises has proved rather promising.

The Child Guidance Service has again benefited by the co-operation of the County Medical Officer and his staff, and increasing interest has also been forthcoming from general practitioners. Liaison with the Education and Probation Departments has been particularly gratifying and it is felt that also other departments may, in the course of time, feel that the Child Guidance Service may be of positive help to them.

The functioning of the Service is certainly not aided by the division of the Psychiatrist's time between several Authorities and hospitals, and it may be recorded here that he has formed the opinion that multiple allegiances in the Child Guidance Service are not favourable in general to its smooth working.

We trust to continue to have the County Medical Officer's interest and support."

Statistical Information (excluding work done at Brambling House, Chesterfield)—

CHILD GUIDANCE WORK	Divisional Executive					Totals
	North-west	North-east	Mid-Derby-shire	South-east	South	
(1) Cases Closed during 1956 :—						
(i) Adjusted	1	5	7	5	3	21
(ii) Improving	5	2	10	4	15	36
(iii) Unadjusted	1	–	2	2	3	8
(iv) Miscellaneous	10	–	7	12	13	42
(v) Diagnostic and advice only	1	2	4	3	1	11
Totals	18	9	30	26	35	118
(2) Cases having regular Interviews for Psychiatric Treatment, Play-Therapy, or Remedial Teaching :—						
(a) Psychiatrist—						
(i) Making satisfactory progress	–	–	1	4	5	10
(ii) Some improvement ..	–	–	1	2	1	4
(iii) No improvement	–	–	2	6	1	9
Totals	–	–	4	12	7	23
(b) Educational Psychologists :—						
(i) Making satisfactory progress	1	–	–	–	2	3
(ii) Some improvement ..	–	–	2	–	1	3
(iii) No Improvement	1	–	2	–	3	6
Totals	2	–	4	–	6	12
(3) Cases having only Occasional Interviews, or under Supervision :—						
(i) Making satisfactory progress	9	2	13	16	18	58
(ii) Some improvement ..	5	1	15	8	9	38
(iii) No improvement	–	1	8	9	8	26
(iv) Diagnostic and Other ..	–	–	–	–	–	–
Totals	14	4	36	33	35	122
(4) Cases Recently Opened ..	–	–	2	3	–	5
(5) SUMMARY :—						
(i) Number of "current cases"	16	4	44	45	48	157
(ii) Number of "closed cases"	18	9	30	26	35	118
Total Number of Cases dealt with during 1956 ..	34	13	74	71	83	275
(6) Number of Cases on Waiting List for first interview as at 31st December, 1956 ..	–	–	1	7	3	11

CHILD GUIDANCE WORK	Divisional Executive					Totals
	North-west	North-east	Mid-Derby-shire	South-east	South	
(7) Psychiatrist's Interviews with Patients	3	8	65	139	144	359
Psychiatrist's Interviews with Parents	5	6	70	108	91	280
Psychiatrists' Visits :—						
(i) to Schools	–	–	–	–	4	4
(ii) to Homes	4	–	1	3	3	11
(iii) to Institutions						20
Total number of siblings of patients seen	–	–	–	2	3	5
Number of Interviews with Probation Officers, Social Workers, etc.	1	–	–	1	6	8
Number of Reports to Magistrates						8
(8) Educational Psychologists' Visits :—						
(i) to Schools	16	29	27	36	36	144
(ii) to Homes	25	38	23	43	22	151
Number of Child Guidance Cases tested	27	23	23	43	41	157

The following Table indicates the sources from which patients were referred to the Child Guidance Service during the year :—

School Medical Officer	30
Private Doctors	31
Hospitals	13
Teachers	13
Courts and/or Probation Officers	12
Others	37

SPEECH THERAPY.

The establishment authorises the employment of eleven Speech Therapists (including one in Chesterfield Excepted District and one whose services are available for the treatment of the pupils at the Authority's special school for children suffering from cerebral palsy, at Talbot House, Glossop). At the beginning of 1956 we had the services of seven whole-time and two part-time therapists ; at the end of the year there were six whole-time and two part-time officers, but two had tendered their resignations to take effect on the last day of the year, so that 1957 began with only four whole-time and two part-time therapists. It is hoped that the vacancies will be filled as more qualified speech therapists become available during the year. The following are particulars of the speech therapy clinics (April, 1957) :—

Clinic	*Held on*	*Speech Therapist*
Alfreton	Mondays, Wednesdays and Thursdays	Miss Winter
Ashbourne ..	Mondays a.m. and Tuesdays	Miss Creed
Belper	Tuesdays and Fridays ..	Miss Winter
Bolsover	.. ..	Vacant
Buxton	.. ..	Vacant
Chesterfield .. (Brimington Rd.)	.. ..	Vacant
Clay Cross ..	.. ..	Vacant
Clowne	.. ..	Vacant
Derby	Mondays, Wednesdays and Thursdays	Mrs. Marsh
Dronfield	2nd and 4th Tuesdays and each Thursday	Mrs. Smith
Frecheville ..	1st, 3rd and 5th Tuesdays ..	Mrs. Smith
Glossop	1st, 3rd and 5th Tuesdays p.m. and Fridays	Miss Curry
Hatton	Mondays p.m.	Miss Creed
Heanor	.. ..	Vacant
Ilkeston	.. ..	Vacant
Long Eaton ..	.. ..	Vacant
Matlock	.. ..	Vacant
New Mills ..	Wednesdays p.m.	Miss Curry
Shirebrook ..	.. ..	Vacant
Staveley	.. ..	Vacant
Swadlincote ..	Wednesdays, Thursdays a.m., and Fridays	Miss Creed

(Note : Speech therapy sessions are also conducted, by Miss Wright, at clinics in Chesterfield Borough for children resident in the Borough.)

I asked the Speech Therapists to let me have their observations on the work in their areas during the year, and the following are some of the comments they have made :—

MISS CHAPMAN (Bolsover, Chesterfield, Clowne, Shirebrook, and Staveley Clinics) : "The treatment given in these clinics during the first full year of their operation has indeed justified the appointment of a Speech Therapist in this area. This is particularly shown by the comparatively large number of Secondary School children who have been referred for treatment. These children have been requiring help for a considerable number of years, and a great effort has been made to admit them for treatment.

The majority of cases in this area are stammerers and children suffering from defects of articulation of a functional nature. There are also four partially deaf children (one of whom is a stammerer), four cleft palate cases and one child whose speech is affected by cerebral palsy."

MISS CREED (Derby and Long Eaton) : "Speech Therapy clinics have been conducted four days a week at Long Eaton and one day a week at Derby, thus covering an area from Chaddesden to Long Eaton, the greater demand for speech therapy being from Chaddesden and Spondon school children. Parents and schools are, on the whole, co-operative and eager to help the children with their home practice. The main difficulty, however, is giving treatment to infant children who are too young to come to clinics on their own. Attendance throughout the year has been good."

MISS CURRY (Glossop and New Mills Clinics) : "During the year 1956, no Speech Therapy was given at Glossop and New Mills until September when a new Speech Therapist was appointed. This report therefore refers to only the last four months of 1956.

A great part of this time has been spent in recalling, reviewing and tracing former patients, of whom several had left the district, and others felt that speech therapy was no longer required. Of the latter only one was discharged, the others being suspended for a further review in 1957. Introductory visits have been made to the majority of schools in the areas, in order that relationships may be established, and the Heads encouraged to refer for speech therapy those children who they feel may require some help in this direction. The response from some schools has been good. Tuesday, Wednesday and Friday afternoons have been devoted to work at the central clinics where many of the new referrals and parents have been interviewed. During the last three months it has been possible to organise and carry out a time table for actual speech therapy."

MRS. MARSH (Derby Clinic) : "Clinics have been conducted for three days weekly at Walker Lane, Derby. Now that the catchment area for this clinic consists solely of the district immediately surrounding Derby Borough, together with Melbourne, the waiting list is reduced to a minimum and cases are commenced within a few weeks of referral.

Certain types of cases have been conspicuous by their absence, notably cleft palate and spastic children, and one wonders whether there are none in this area, or whether the need for their referral to the speech clinic is not being realised.

Results of treatment have been good and only one child has had to be discharged without showing an improvement, as she was leaving the district. This is an improvement on last year, when several cases had to be discharged through non-co-operation of the parents."

MRS. SMITH (Dronfield and Frechville Clinics): "There are no names on the waiting list for Dronfield Clinic, and the case load is not heavy. There are forty-three names on the waiting list for Frechville Clinic, where the case load is heavy. Children who were referred at the end of 1955 are still waiting for an appointment. Two sessions per week is not adequate for this area.

School co-operation in both areas is very good indeed. Although school visits are not possible co-operation is maintained through telephone calls and letters. Also in both Clinics several children who were at the bottom of the class when commencing treatment are now at or near the top of the class.

Parents co-operation is also very good, personal contact being maintained by periodic written home reports and interviews."

MISS WINTER (Alfreton and Belper Clinics): "Attendance at the clinics has been good. Since September seventy children have attended and of those nine have been discharged and eight are attending fortnightly prior to discharge.

Thirty-nine schools have been visited, and there are still some twenty to be visited. Great help and co-operation came from all Head and class teachers, and 100 children's names were sent for ascertainment. It is very pleasing to see that so many children in the Infants Schools are being referred, in this way the speech defects are caught and corrected before incorrect speech becomes too firmly established.

All speech therapy has been carried out individually so far, but groups of stammerers are to be formed, and it is hoped this will help the patients gain more insight into their speech difficulty. All cases are attending weekly, parents co-operate well and carry out home practice faithfully. Some cases would benefit from more than one appointment a week, but outstanding work is such that this, at the moment, is impossible.

Equipment at the clinics is good. Accommodation is not entirely suitable, but co-operation with other Staff at the clinics eases the situation.

All cases can be said to have made some improvement, particularly those with articulatory defects. The stammerers appear to have made the least improvement, as their progress fluctuates, but most of them are slowly but surely improving.

Speech Therapy is welcomed by parents and teachers alike, and so much of the work done is helped by the high standard of co-operation on all sides."

SPEECH THERAPY	Divisional Executive					Totals
	North-west	North-east	Mid-Derby-shire	South-east	South	
(1) Number of Patients who received Treatment during the year :—						
New Cases—						
Stammerers	3	26	5	22	3	59
Articulation Defects ..	13	31	13	61	19	137
Other Speech Disorders ..	1	5	1	2	1	10
Old Cases—						
Stammerers	11	47	9	28	9	104
Articulation Defects ..	6	38	31	37	27	139
Other Speech Disorders ..	2	6	6	3	2	19
Total Number of Individual Patients	36	153	65	153	61	468
Total Attendances for Treatment	218	2824	527	2763	855	7187
(2) Results of Treatment of Cases seen during 1956 :—						
Cases Closed :—						
Stammerers—						
Cured	–	–	–	15	–	15
Improved	–	7	–	15	2	24
Not improved	–	3	–	2	1	6
Discontinued for various reasons	3	5	1	4	1	14
Articulation Defects—						
Cured	–	12	6	43	18	79
Improved	–	4	2	7	3	16
Not improved	–	–	–	–	–	–
Discontinued for various reasons	5	8	–	5	–	18
Other Speech Disorders—						
Cured	1	–	–	2	–	3
Improved	–	1	–	–	1	2
Not improved	–	–	–	–	–	–
Discontinued for various reasons	2	–	1	–	–	3
Total number of Cases Closed	11	40	10	93	26	180
Cases Still Under Treatment—						
Stammerers	11	58	13	14	8	104
Articulation Defects ..	14	45	36	43	25	163
Other Speech Disorders ..	–	10	6	3	2	21
Cases seen once for initial examination and advice only	36	–	–	–	7	43
Total Number of Cases already seen, Carried Forward to 1957	61	113	55	60	42	331

SPEECH THERAPY	Divisional Executive					Totals
	North-west	North-east	Mid-Derby-shire	South-east	South	
3) Number of Patients Waiting to be seen for the first time, as at 31st December, 1956	3	165	12	23	7	210
4) Visits :—						
To Schools	12	29	39	54	4	138
To Homes	–	1	–	14	5	20
5) Number of Interviews with Parents	45	164	53	467	102	831
6) Total Number of Sessions conducted at Clinics						1,830

MEDICAL EXAMINATIONS OF CHILDREN FOR EMPLOYMENT

During the year the School Medical Officers examined 486 pupils desiring to undertake part-time employment. Certificates of fitness were given in 483 instances, and in three cases it was decided that the suggested employment would be prejudicial to the health or physical development of the children and render them unfit to obtain proper benefit from education.

PREVENTIVE INOCULATIONS

Diphtheria.

The scheme for immunising children against diphtheria continued on similar lines to those of previous years. Children ought to be immunised against diptheria shortly before reaching their first birthday, and it is desirable that a reinforcing injection be given when school life begins. This matter is dealt with fully in my Annual Report as County Medical Officer of Health, but I should like to say here that the co-operation of the Teachers is most valuable in facilitating the provision of primary or reinforcing inoculations in schools.

Poliomyelitis.

In his Report for 1954/55 the Chief Medical Officer of the Ministry of Education referred to the announcement made in January, 1956, by the Minister of Health that a British vaccine giving protection against poliomyelitis had been developed, and that, with the limited amount available, it was hoped to inoculate in May and June of that year, between a quarter and half a million children between the ages of two and nine years. It was suggested that Principal School Medical Officers might record in their Annual Reports their experiences so far as school children are concerned, but as this matter is no doubt of

general interest, it is proposed to refer in the following comments to the scheme as a whole, even though the responsibility for its operation rests on the Local Health Authority rather than the Education Authority.

The vaccine. Two firms are manufacturing the vaccine in this country and the strains of virus used have been carefully chosen, particular emphasis being placed on low virulence. The most stringent tests are being applied to ensure that the vaccine is "safe," including testing by tissue culture methods of serial samples, and tests on rhesus monkeys sensitised with cortisone (which has the effect of making them more susceptible to infection with the virus). Additional tests are performed to exclude the possibility of the vaccine having been contaminated by pathogenic organisms.

The initial scheme. Details of the initial scheme for using the new vaccine were given by the Ministry of Health in Circular 2/56 (19th January, 1956). It was stated that a certain amount of the vaccine was expected to become available during May and June and the Minister was anxious that local health authorities should have an opportunity of using the limited quantities before the start of the "polio season."

The proposals made were designed to secure a fair distribution amongst those age groups in which the disease is most prevalent and to secure information which would help in devising the best possible scheme of distribution when substantial quantities became available later on. The vaccine was to be offered without charge to local health authorities, who would provide vaccination as part of their arrangements under section 26 of the National Health Service Act, 1956. The expenditure incurred in making the arrangements would rank for the usual Exchequer Grant. It was proposed to release the vaccine batch by batch as soon as they had passed the very stringent safety tests which were being applied.

The initial scheme envisaged that the vaccine would be made available on a voluntary basis for children born between 1947 and 1954 inclusive, although it was realised that only a small number of the five and a half million children in those age groups in England and Wales would be able to be vaccinated in May and June. Those children who were registered but could not be dealt with in May or June would receive priority later on when larger supplies became available.

The scheme provided that parental consent in writing must be received in time to enable local authorities to send, not later than 14th April, 1956, to the Medical Research Council's Statistical Research Unit, the total number of acceptances for children in each month of birth in each age group. It was pointed out that it would not be possible to distribute vaccine to any authorities who had not provided the information by that date. The selection of the children who were to receive vaccination from among those registered was to be made according to a centrally determined plan designed to maintain an even spread throughout the eligible age groups which would be based on the months of birth. When the national picture had been studied, local authorities were to be informed by the Ministry which months in each age group had been selected for vaccination.

The Circular intimated that for the time being, in view of the limited quantity of vaccine available, and the short time available in which to organise this first stage of the scheme, the vaccine would be administered on behalf of the local health authority only. It was stated that general medical practitioners would be given an opportunity to participate at a later stage, when larger supplies became available.

The Circular suggested that most local health authorities would need to amend their approved "Proposals" under the National Health Service Act in order to be able to provide vaccination against poliomyelitis. Actually, in December, 1955, the Derbyshire County Council had already submitted the following amendment to their Proposals to the Ministry for approval, which was duly given :—

> "Vaccination and Immunisation. Other diseases : The Council proposes also to make arrangements for offering to persons in its area, or to any groups of such persons, immunisation against any other disease in respect of which authority is sought from and given by the Minister of Health. The Medical Officer of Health will be responsible for keeping records directed towards assessing the value of any such forms of immunisation."

The Ministry's circular acknowledged that the time in which to plan and carry out the vaccinations was extremely limited and in consequence a very heavy burden would be placed on the local health authorities ; but the Minister thought it right to make available immediately all the vaccine which could be produced and he urged authorities to do their utmost to see that the maximum use was made of the limited supplies. To this end it was appreciated that it might be necessary to defer some of their routine work.

(In fact, the amount of time which had to be devoted to the scheme by the Assistant Maternity and Child Welfare Medical Officers and School Medical Officers in giving the injections inevitably resulted in a decrease in the number of children who were examined at school medical inspections. On the administrative side, it proved necessary for the clerical staff of the Department to work several hundreds of hours overtime. However, if the vaccine proves to be as efficacious as it is hoped it will be, no doubt it will be generally agreed that the time and energy devoted to the task was well worth while).

The Appendix to the Circular 2/56 included a note on the development of polio' vaccine in the United States ("Salk vaccine", so named after the medical scientist who was responsible for its development at the University of Pittsburg, Pennsylvania). It was pointed out that "vaccination against poliomyelitis is a new development, and it is not yet possible to assess beyond the limited period in which the vaccines have been in use the duration of the protection afforded. More detailed information of this type which will emerge only from continued use of the vaccine will be of value in determining the method of its use in the future."

It was also laid down that after the vaccinations had started each Authority would be required to forward reports on all notified cases of poliomyelitis in their areas, giving details of registration or of vaccination. A record card, in a form prescribed by the Ministry, was also to be kept for each child registered for vaccination.

Preparing the local scheme. The first problem was that of providing the means to ensure that the parents of every child in the eligible age groups were given an opportunity of registering their children, if they so wished, for vaccination. It was decided to print a letter, addressed to the parents or guardians, to which was appended a copy of the Ministry's note on the development of the vaccine, as well as a form of consent. Before the letters were sent out, the Derbyshire Local Medical Committee were consulted, and it was agreed that a copy of the letter would be sent to every general medical practitioner in the County before it was circulated to parents, so that the Doctors would be aware of its contents. This was regarded as important, because it was suggested in the letter that before coming to a decision, parents might like to consult their own Doctors. At the same time, a letter was sent to the general medical practitioners giving a short list of the references to the vaccine which had appeared in the medical journals, and they were informed that arrangements would be made for a note to be handed to the parents or guardians of the children at the time of vaccination, for transmission to their own Doctors, so that in the event of any untoward symptoms subsequently arising their Doctors would have precise information of what had been injected.

The distribution of the letters to approximately 90,000 parents of the children in the selected age groups presented a large scale operation. As far as school children were concerned the letters were distributed through the Education Services, and I should like to take this opportunity of expressing my appreciation of the co-operation of the Director of Education and the Divisional Education Officers, and their staffs, as well as the Teachers, whose ready help did so much to ease this problem. In order to cover children attending independent schools, a communication was also sent to the Heads of such schools in the County in which they were asked to forward to the parents of their pupils copies of the circular letter and consent form. So far as the younger children were concerned, the Health Visitors undertook the task of distribution to the parents of children who had not commenced attending school. In order to cover any loophole which inadvertently might have been left uncovered, notices concerning the scheme were inserted in appropriate newspapers.

In view of the importance of this new scheme, at the request of the County Health Committee a copy of the explanatory circular letter was sent for information to all the Members of the County Council.

Whilst this activity was going on, arrangements were also made for meetings to be held of the Medical staff and the health visiting staff, in order that the administrative as well as the technical aspects of the scheme might be fully discussed. It was thought that this would contribute towards the smooth running of the scheme when the actual inoculations were commenced.

Numbers registered, and actual inoculations. The return which was sent to the Medical Research Council's Statistical Research Unit early in April, 1956, showed that 10,528 boys and 9,544 girls had been registered for vaccination (total, 20,072, which was roughly between twenty and twenty-five per cent of those eligible for registration).

In the first instance the Ministry decided that children born in the following months should be vaccinated with the first batches of the vaccine to become available—November in each of the years 1947 to 1954, and March in each of the years 1951 to 1954. A "reserve month" was also designated in the event of vaccine being available (August 1947 to 1954). At the end of May, further months were designated as follows—"selected months": August 1947 to 1954 and October 1951 to 1954; "reserve months": May 1947 to 1954. The scheme was suspended during July to November inclusive (the usual months when polio is prevalent). The following are the numbers of children who were inoculated during 1956:—

	Boys	*Girls*	*Total*
No. of children who received two injections (the complete course) during 1956..	1,189	1,084	2,273
No. of children who received one injection only, during 1956 ..	88	58	146

Summary—Year 1956. It will be seen, in short, that out of roughly 90,000 children in the age groups entitled to be registered for vaccination against poliomyelitis, 20,072 (about 22%) were actually registered. In 1956, 2,273 of these children received the complete course and 146 received one injection, so that during 1957 it will be necessary to give priority to completing the courses for the latter 146 children and giving two injections to the remaining 17,653 children.

The programme for 1957. The foregoing survey covers the work done in relation to this scheme during the year under review. However, it may not be out of place to refer here to the programme for 1957, because shortly before Christmas the Ministry of Health issued Circular 22/56 which indicated the arrangements to be made in the new year, when it was hoped that regular supplies of the vaccine would become available.

It was proposed that the vaccine would be made available for the children already registered; as each batch passed the tests it would be divided among Authorities roughly in the proportion of the numbers of registered children in their areas. The vaccine could be used to vaccinate registered children in any order, but priority should be given to those who had already had only one injection.

Under the new arrangements, general medical practitioners were to be given an opportunity to take part in the scheme from January onwards, and the details were to be settled locally between the local health authority and the local medical committee. All general practitioners, whether providing services under the National Health Service or not, should be given an opportunity to vaccinate any registered children who were their patients, but it would be left to each practitioner to decide whether he wished to take part in the arrangements. It was laid down that parents should be informed that as an alternative to having their children vaccinated by the local health authority they might ask the family Doctor if he was willing to perform the vaccination. If a practitioner decided at this stage not to take part in the scheme, he would have the right to do so later.

The Ministry's circular concluded by pointing out that the offer of vaccination to children other than those already registered depends on the production of larger quantities of the vaccine. Whilst it was hoped that this might be possible later in 1957, no precise indication could be given on this point.

At the time of drafting these comments the programme for 1957 is under way, and will be the subject of a report next year.

NATIONAL SURVEY OF THE HEALTH AND DEVELOPMENT OF CHILDREN

A Joint Committee of the Institute of Child Health (University of London), the Society of Medical Officers of Health, and the Population Investigation Committee, have been following the health, growth and development of about 6,000 children born between March 3rd and 9th, 1946, drawn from all social classes and from all parts of Great Britain. The main aims of the Inquiry are to collect information on a national scale on accidents, illnesses, growth and development; to show in what ways the health and growth of young children are affected by environment; to trace the history of a large group of prematurely born children who have been individually "matched" with children born at term; and to observe the achievement of children against the background of their ability, health and opportunities.

As regards the children born in this County, the Authority's Health Visitors co-operated in the original survey in 1946, when the babies were aged six weeks, in 1948, when they had attained two years of age, and in 1950 when they were four years old.

The Joint Committee hope to continue the Inquiry throughout the primary school period, and sought the co-operation of the Education Committee, which was readily given, early in 1952, when the children were, of course, of school age. The Joint Committee felt that it would be sufficient for the purpose of the inquiry if the children concerned were clinically examined at seven, nine and eleven years of age. In addition, the assistance of Teachers has been obtained in keeping standardised records of absences from school since September, 1952. Arrangements are made for Health Visitors to visit the homes so that a check may be made on the reasons for the longer absences, and so that up-to-date information may be recorded concerning accidents, hospital admissions, infectious diseases, and home conditions. It was proposed to carry out the final clinical medical examination in October, 1956, but it is understood that a number of School Medical Officers suggested that the examination be postponed until early in 1957. Arrangements were, therefore, made for the School Doctors to examine early in 1957, the sixty children in this County still enrolled in the survey, and for the Health Visitors to pay home visits to them.

REPORTS RECEIVED FROM SCHOOL MEDICAL OFFICERS

The following are relevant extracts from reports which I have received from individual School Medical Officers :—

Dr. Sutcliffe (Part of N.W. Division) :—

"(1) The general health and well-being of the children during 1956 has been satisfactory and there has been an improvement in the clothing and footwear.

Unfortunately dental caries is widespread in all age groups.

(2) In 1956, 83% of the children took the free issue of one-third of a pint of milk per day and 40.3% had school dinners. The numbers participating vary considerably between different schools ; with regard to milk from 62% in a secondary school to 100% in a primary school and with regard to dinners from 11% in a primary school near the centre of the town to 65% in an outlying school.

In only one of the seventeen schools in the area are the meals cooked on the premises, the rest are provided with meals from a Central Kitchen. Dinners which have to be carried any distance in insulated containers lose some of their palatableness and flavour during transit.

(3) At the medical inspections the children were grouped according to their physical condition :

S (satisfactory) = 96.2%
U (unsatisfactory) = 3.7%

The figures given are not comparable with those for previous years as 1956 was the first year in which a new system of classification was used i.e. two categories (S. and U.) instead of three (A., B. and C.).

Apart from dental decay the chief defects were errors of refraction and minor orthopaedic conditions.

(4) Unceasing efforts have again been made by the Health Visitors and the School Nurse to reduce the incidence of infestation with head lice. It has proved a difficult task with very little result to show for the energy expended. The incidence was 7.4% of the school population compared with 8.4% in 1955 and was highest in September, following the long summer holidays. Certain careless, lazy families continue to be verminous in spite of all the endeavours of the School Health Service.

Impetigo was again prevalent, particularly during the autumn term when thirty-two cases out of a total of sixty were treated at the minor ailments clinic.

There were no cases of scabies.

(5) At the clinics in Glossop and Hadfield primary immunisation against diphtheria was completed for 122 children under five years and for twenty-six children of school age. Reinforcement injections of diphtheria prophylactic were given to ninety-one children. For the second year in succession there has been a decrease in the number of reinforcement doses given at the clinics.

A few families show little interest in either immunisation or vaccination. Never having seen a case of diphtheria or known of one in the immediate neighbourhood some of the younger parents are unable to realise that so serious a disease exists. Increased efforts must be made to educate these families to ensure that the school population is completely protected.

(6) Many defects still exist in the hygienic conditions in some of the older schools in the area but improvements are slowly being effected. The sanitary, cloakroom and washing accommodation at two of the voluntary aided schools has been brought up to modern standards and plans have been passed for similar improvements at a third school of this type.

The ventilation, lighting and heating are reasonable in most of the schools but some of the school canteens are unsatisfactory.

(7) A total of 179 cases of infectious diseases was notified from the schools, 175 being from primary schools. The most prevalent infection was chickenpox which accounted for 119 cases, and of these thirty-two occurred in May and sixty-three in June.

There was an outbreak of upper respiratory infection at one of the primary schools in February which reduced the attendance to 70%. After the half-term break of one week, the infection ceased to spread and the attendance rose to 90%.

The infections of note were poliomyelitis, three cases ; infective hepatitis, seven cases ; and sonne dysentery, six cases. The poliomyelitis infections occurred in September and in October in males aged six, eight and twelve years respectively. The first two were brothers and attended a primary school. A sister of theirs attended the same secondary school as the twelve year old boy, who was the last to become ill. Fortunately all three cases were of mild, non-paralytic type and all made a complete recovery. The source of infection was not traced.

(8) There has been effective liaison in the care of children between the paediatric sections of the Ashton, Hyde and Glossop Hospital Group and the School Health Service. Information is exchanged between the departments and the health visitors undertake the after-care of children discharged from hospital.

(9) During the statutory medical inspections of entrants, second age group and leavers in 1956 the state of immunisation against diphtheria was noted. It was found that the percentages of children in the three groups who had been inoculated during the first five years of life were 77.3, 79.0 and 80.5 respectively. The object of the immunisation campaign is to secure the protection of not less than 75% of babies before their first birthday and to boost the immunity thus obtained at five and ten years. In the Glossop area, although the majority of children have their primary immunisation before starting school, fewer than half the number complete the course of injections during the first year. Since protection takes about three months to develop and as young children are in the greatest danger, it is essential that the child should be safeguarded as soon as possible.

On further inquiry it was found that only a small proportion of the children had received reinforcement or booster injections at the recommended four to five year intervals. Unless reinforcement doses are given the children cannot be considered to be sufficiently protected and the degree of immunity among the child population will decrease. Parents still need to be reminded that unless an adequate level of immunity is maintained during school life diphtheria will not be completely eliminated and could return in its former severity."

Dr. Cochrane (Part of N.W. Division) :—

"(1) *General health and well-being of the children :* For the children in the Borough of Buxton, where the social and economic conditions may be considered relatively very good, the standard of general health in the school children remains high. There were no epidemics of infectious disease and the examinations of the school children revealed relatively few major ailments and largely very minor ailments for which little treatment was necessary.

(2) *School meals ; milk-in-schools scheme :* The number of pupils has been estimated at 2,916 and of this number approximately 49.13% take school meals and 74.4% take school milk.

(3) *Physical condition of the children :* As already mentioned in paragraph (1), the children enjoy very good health. The one outstanding defect is the state of the teeth and I feel quite sure that until the dental service has been re-established there can be little hope for much improvement. Every endeavour is made to have the children seen by the dentist of parental choice and my experience is that the dental surgeons are most co-operative.

(4) *Cleanliness of pupils :* Of the 2,364 examined, nineteen pupils were found to have pediculosis. There were three cases of ringworm, no cases of scabies, but fifteen cases of impetigo received treatment.

(5) *Diphtheria Immunisation :* The year 1956 gave a very poor return for immunisation against diphtheria, the lowest number since the campaign began. This may be explained partly by (1) cessation of immunisation during the summer months, and mainly (2) by the refusal of parents to have their children immunised for diphtheria alone. There is a widespread desire to have the children given injections to cover whooping cough as well as diphtheria, and this service is being provided by the family doctor. Those children who require a booster dose are given the necessary injection at special sessions.

(6) *Hygienic conditions of schools :* The older schools (as previous reports have indicated) lack modern arrangements. In many schools the type of flushing is inadequate ; there are no facilities for warm or hot water and one can hardly expect a high standard of hygiene (the washing of the hands after the use of the toilet) when the facilities are not provided.

(7) *Infectious Diseases :* Three cases of scarlet fever occurred in the year 1956, one of pneumonia and one of whooping cough. There were no cases of measles reported in the school children.

(8) *Inter-relationship of the National Health Service and the School Health Service :* Reports continue to be supplied in respect of the children who have received treatment at Hospital (other than cases sent for operation—Tonsils and Adenoids—for which no records are available) and the medical records of the children are thus much more accurate and of great value for the knowledge of the child during school life."

Dr. Gow (Parts of N.W. and N.E. Divisions) :—

(1) *General health and well-being of children :* In almost all cases this was very good, and in no case unsatisfactory.

(2) *School meals ; Milk-in-schools scheme :* These are enjoyed by a good proportion of children, with very beneficial results. Some children will not take milk and some do not stay to dinner, and very often these are the ones who need it most. On the whole, the school milk and meals are valued and appreciated by the parents.

(3) *Physical condition of the children :* Uniformly good in country districts, only a few less satisfactory cases in the industrial areas.

(4) *Cleanliness of Pupils :* Mostly excellent, only a few are unwashed at medical inspections.

Pediculosis uncommon, usually seen only in a few "problem families."

Impetigo—One case only seen in 1956.

Scabies—No cases seen.

(5) *Diphtheria Immunisation :* On the whole a very ready response. Many parents prefer their children to receive their reinforcing injections at school as being a saving of trouble to the parents and of alarm to the children. Regarding primary immunisation, very many parents wish their children to be protected both against whooping-cough and diphtheria. In the schools thirty-three children received primary immunisation, and 126 children reinforcing injections. There is always a small number of parents who refuse immunisation, sometimes explanation and reassurance will change their minds. Many thanks are due to the assistance of the Teaching Staff in circulating leaflets and advising parents to let their children be immunised.

(6) *Hygienic conditions of Schools :* There is still one school with no water supply at all, and several with no hot water supply. Several have only chemical closets, and though these are well managed it cannot be denied that waterborne sanitation would be better. The above illustrate the great variation in hygienic conditions throughout the area ; many schools are excellent in every respect.

(7) *Canteen Facilities :* In several schools dinners are served in a classroom, which entails much awkward shifting of tables, etc.; a dining room would avoid this and also provide the necessary change of atmosphere at mealtimes.

(8) *Infectious Diseases :* Chicken-pox, measles, scarlet fever, and whooping cough have occurred ; the degree of severity has been slight.

(9) *Inter-relationship of N.H.S. and S.H.S. :* This is extremely good in almost every case.

(10) *Smallpox Vaccination :* I am much struck by the very low proportion of children who have been vaccinated against smallpox. Many parents look with surprise when asked if their children have been vaccinated, quite a number do not know what vaccination is. I find a widespread attitude among parents that vaccination against smallpox is old-fashioned and no longer necessary because smallpox does not occur nowadays. In view of the increased opportunities of infection reaching this country through the prevalence of air travel, I feel it is important to try to increase the number of children who are vaccinated.

(11) *Vision*: My observations support those recently expressed by the Ministry of Health concerning the number of visual defects among children entering school. Without presuming to give a reason for this I should like to stress the importance of testing the vision of entrants. This may take a little longer than with older children, but a reliable impression can be obtained with childern over four years using a picture eye-card."

Dr. Kuttner (Parts of N.W., Mid- and S. Divisions) :—

(1) *The general health and well-being of the children :* The good standard of general health and well-being of school-children in my area has been maintained during the year. None of the pupils examined had to be classified as being of unsatisfactory physical condition.

There was a fairly severe and wide-spread outbreak of whooping cough, mainly in the Matlock area. This caused much absence of pupils from school—particularly infant and junior schools—and a considerable amount of catarrhal chest conditions in children even after the return to school. Symptons of chicken-pox, mumps, rubella and scarlet fever have been mild where they occurred in my area. Measles, however, continues to be fairly severe in symptoms.

(2) *School meals, milk-in-schools scheme :* Milk in school is taken by the majority of pupils but there is a decrease in the number of children taking school meals, particularly since the price increase of meals in September.

(3) *Cleanliness of pupils :* The condition of clothing and personal cleanliness of school children is, on the whole, satisfactory, I have seen no scabies, four cases of tinea circinata, six of impetigo.

(4) *Diphtheria Immunisation :* Requests for and consents to diphtheria immunisation have been fewer this year than in previous years. This is partly due to the fact that the majority of general practitioners have now adopted the method of combined immunisation, but more so to a deplorable degree of indifference on the part of the parents who have no knowledge of the danger of the infection and do not realise the value of protection offered to their children with immunisation.

(5) *Hygienic conditions of schools :* Hygienic standards in old and small schools have again been much improved during the year, though they cannot be raised to the high standard of hygiene in new schools. More consideration should, I think, be given to hygiene of school dining rooms. In the majority of the schools in my area class-rooms have to be used as dining rooms and school desks as dining tables.

(6) *Inter-relationship of the National Health and School Health Service :* Medical Practitioners in my area continue to be co-operative and helpful in every way."

Dr. Frenkiel (Part of N.E. Division) :—

"During the year 1956 my School Health area was re-organised and the number of schools visited reduced. This allowed for more frequent medical examinations of children, more continuous follow-up of cases and more efficient service as a whole. The conclusions drawn are also more instructive.

In all, over 2,100 children were examined. The general health of children continued to improve. The number of children suffering from chronic upper respiratory infection, otorrhea, and similar drawbacks to well-being, was smaller than in the previous year. The change of the area now allotted to me may account for this relative improvement, as the schools in the suburban area of Sheffield visited by me are less numerous. When separate schools are compared the improvement seems absolute.

The number of children classified as unsatisfactory is less than 1.5%. These children are either suffering from inadequate nutrition or some form of organic disease which interferes with their normal development.

School meals were not so popular this year ; I think for reasons of economy very often.

Most of the children classified as unsatisfactory were investigated with the help of a Health Visitor and very often the family doctor when a possible remedy was sought.

General cleanliness of children has improved ; hygienic standards have risen ; fewer cases of pediculosis and impetigo were noted throughout the school population.

Diphtheria immunisation "booster dose" campaign was started this year and over 760 children were immunised at schools and thirty-six in the I.W.C. The number of refusals is small on the whole but prominent in Eckington area (35% refusal rate at school).

Hygienic conditions in most of the schools are quite good, but there are a few which still need substantial improvements in order to comply with the Public Health standards. Most of the faults were pointed out in the reports on school premises submitted after school medical inspection, and I am pleased to say that architectural and sanitary improvements were executed in some cases within a short time, whereas in others they were provided and will be completed in the coming year.

During the year 1956 epidemics of chickenpox, whooping cough and mumps swept through the N.E. area. Apart from mumps, which seemed unusually severe, the epidemics were mild. In October, 1956 there was an epidemic of sore throat confined to Eckington area. This presumably streptococcal infection was followed by three cases of rheumatic fever which were later sent to convalescent hospitals. This point brings out the importance of the helpful information obtained from the hospital reports on school children. It is usually these reports that help us to trace the delicate or physically handicapped child who is away from school so often; also the co-operation of General Practitioners and their helpful attitude is most valuable.

Enuresis: During the year 1956 I have continued the study of enuresis nocturna and once a month an Enuretic Clinic has been conducted in Frecheville. In Clowne children treated are seen during Minor Ailment Clinics and at the Infant Welfare Clinics. The principles involved in treatment were outlined previously; twenty-eight new cases were treated with good results and now discharged; there were eleven failures, (including four partially successful cases followed by relapse). A three-year-old girl was the youngest patient; a fifteen-year-old boy was the oldest child. Both were successfully treated and are now discharged. There are fifty-eight children still under observation at schools and in County Clinics."

Dr. Adams (Part of N.E. Division) :—

"The period covered by this report is from November 1st to December 31st, 1956. During this period a total of 191 routine and ninety-nine special examinations were performed. (I am employed part-time in conjunction with a D.P.H. Course).

(1) *General Health and Well-being of the children :* This is on the whole very satisfactory. The children are well cared for and only an occasional child is not satisfactory : they come from a large family, the parents being social problems. The attendance of a parent at routine examinations was 87% which indicates the parental interest and high degree of co-operation of the teaching staff. Chronic infection of nose and throat due to enlarged tonsils was the most common condition, 10% of all children, routine and special, examined in the entrants group being affected.

(2) *School Meals, Milk-in-schools scheme :* These services are most valuable and appreciated and used by a majority of the pupils. The meals are well balanced and give the advantage that a child who is in danger of developing a feeding problem is removed from one common cause, the influence of an over-anxious parent, for the main meal of the day.

(3) *Physical condition of the children :* This is good, growth and weight gain are satisfactory for the majority of the children.

(4) *Cleanliness of pupils :* This is satisfactory. Most of the children were clean and well clothed. The improved washing facilities on the new estates undoubtedly contributes to this result. No cases of scabies or lice infestation were seen.

(5) (*a*) *Diphtheria Immunisation :* A fairly good response was obtained to attempts to immunise the entrant group at school. A significant proportion wished to take the child to the general practitioner to obtain the triple immunisation.

(*b*) *Vaccination :* This is poor. Only 13% of children had been vaccinated.

(6) *Hygienic conditions of schools :* The schools visited are of recent construction and conditions are favourable to the pupil, giving the advantages of modern methods of heating, lighting and ventilation. Toilet and washing provision is adequate.

(8) *Infectious diseases :* No undue prevalence of any infectious disease occurred during the period.

(9) *Inter-relationship of the National Health Service and the School Health Service :* Relationship with the National Health Service is good and general practitioners co-operate well with the School Health Service."

Dr. Burke (Part of N.E. Division) :—

"(1) The general health and well-being of the school children may be considered satisfactory. The general condition and physique of 1,603 children attending Primary, Secondary Modern and one Grammar School has been recorded.

Children under 5 years old	number	146	Satisfactory	89.8%
			Unsatisfactory	10.2%
Entrants	number	535	Satisfactory	91.2%
			Unsatisfactory	8.7%
Second age group ..	number	523	Satisfactory	95.2%
			Unsatisfactory	4.7%
Third age group	number	399	Satisfactory	96.2%
			Unsatisfactory	3.7%

The percentage of children found to be unsatisfactory is higher in the under five and entrants groups than in the upper age groups, the reason being that children in the lower age groups are more liable to respiratory catarrh, which often is complicated by bronchitis, and to infections such as measles, whooping cough, etc. I can recollect only two cases, both of entrants, in which there was evidence of inadequate diet and neglect of proper home care, and this was not due to poverty but rather to improvidence on the part of the parents.

(2) *School Meals :* Seven schools in the area have kitchens for cooking school meals, which are served in the canteens or in the main rooms. School meals are brought to the remaining schools from the Central Kitchen at Eckington. The meals are well cooked and properly served as a rule. On the whole the meals cooked on the school premises are more appetising than those which are brought from the Central Kitchen because of the liability of the latter to cooling during transport.

School Milk : There is no doubt in my opinion of the value of milk in schools.

(3) *Physical condition of the children :* Minor degrees of knock knee and flat feet were found at medical inspection. Few children were found who could not take part in the ordinary physical training and games suitable for their ages, on account of physical handicaps, or heart trouble, or other causes of delicacy.

The question having been raised of the design of the chairs used in the class rooms being a cause of faulty posture I have noted during the year the types of chairs used. Most of the schools are provided with hardwood chairs with straight backs and horizontal seats of an older pattern in various sizes. Some of the newer chairs have the backs and seats raked backwards slightly, apparently for convenience in stowing and for appearance. Chairs of this design are not very suitable because a child sitting has to lean forward to reach the desk or table, and there is no support for the back. The chairs with straight upright backs and horizontal seats are better in my opinion, which coincides with the opinion of other medical officers given previously.

(*Note :* With regard to the design of school chairs, it may be mentioned that the Medical Research Council have been consulted and the chairs have been designed to anthropometric standards after careful research. The designs have been accepted by the Ministry and are being used by the main furniture manufacturers).

(4) *Cleanliness, etc. :* No children were found at medical inspections to be suffering from scabies or pediculosis. Some cases of pediculosis were reported to me as having been found by the School Nurses at their inspections, and having been cleared from infestation. There are a few families in my area whose cleanliness both of person and clothing is very unsatisfactory, needing the constant attention and admonition of the Health Visitors, but on the whole the standard of cleanliness is satisfactory.

Impetigo : Six children were found to have impetigo on face or limbs. All were treated by their family doctors.

Scalp ringworm : One boy aged five was found to have tinea capitis. The fungus found was Microsporon Audouini. He was referred to the family doctor.

Body ringworm : Two children were found to have tinea circinata without any infection of their scalps. They were treated by their family doctors.

The sources of infection were not discovered in any of these cases.

(5) *Diphtheria Immunisation :* I have records of fifty-three refusals of immunisation. It is not possible to estimate the number of parents who would not have their children immunised because some parents did not return the consent forms to the schools. Some parents could not give a rational reason for their refusal, others objected to their children being hurt, and others objected because there is no diphtheria about.

A summary of immunisation performed is given below.

At schools—Immunisation completed	..	under 5 years	13
		5 to 15 years	222
		Reinforcements	600
At school clinics—Immunisation completed		under 5 years	2
		5 to 15 years	21
		Reinforcements	7

Parents prefer usually to have their children immunised at school rather than at the clinics in most cases, because they had rather not be present when the injections are given. As a rule the children behave very well and do not show alarm. No serious reactions of any kind have occurred.

(6) *Hygienic conditions of schools :* Ventilation, lighting and heating of the schools are adequate. All the schools have water carriage sanitation and main drainage, and main water supply. The provision continues of basins in the cloak rooms with containers of liquid soap and paper towels, replacing the troughs and cotton hand towels in use heretofore. The liquid soap and paper towels are distinct improvements in hygiene. The supply of hot water for the wash basins is not usual. At Poolsbrook hot water is supplied to the village from the colliery and the school shares the supply. At Arkwright Town School an electric water heater has been, or is being, installed to supply the basins in the cloak rooms. A few schools have hot and cold water supplied to the cloak-room basins.

Canteens : Full canteen equipment is provided at Staveley Grammar School, at Whaley Thorns Primary and Secondary Schools, at Hollingwood Secondary School, and at Speedwell Infants School. In three other schools, Langwith Bassett, Scarcliffe and Arkwright Town meals are cooked in kitchens on the premises and are served in the main rooms. At Scarcliffe C. School there is a pantry with a meat safe at the kitchen, but there is no refrigerator. At Langwith Bassett School there is a pantry with a refrigerator. There is no separate wash basin or toilet for the kitchen staff. At Arkwright Town School there is a refrigerator which is too large to stand in the kitchen. There is no separate wash basin or toilet for the kitchen staff. At Arkwright Town steam is said to be troublesome during cookery and washing-up. Fitting an extraction fan has been suggested. At Barrow Hill Primary School the small scullery is scheduled for improvement. There is no separate wash basin or toilet. At Staveley C. of E. School the servery is very small. There is no toilet or wash basin adjacent to the servery.

The cleanliness of the canteens and serveries is satisfactory. The staff understand the use of the sterilisers for crockery and cutlery where these have been fitted. All the canteens and serveries in the schools have been inspected during the year.

(7) *Infectious Diseases :* There have been no serious outbreaks of infectious disease. Measles, mumps, chicken pox and whooping cough have occurred. Six cases of mild scarlet fever at Barrow Hill Primary School during the autumn caused serious concern to the Head Master. There was no apparent source of infection.

(8) The relations between the National Health Service and the School Health Service continue to be satisfactory. The reports received from hospitals are very valuable. The practitioners in the area are very co-operative and helpful. They avail themselves readily of the help which can be given by the School Health Services, particularly in the treatment of handicapped children.

(9) *Epilepsy :* Five children were found to be epileptics. In all cases the fits were placed under control by drugs as soon as diagnosed. None of the children was found to be unfit to attend ordinary day schools. Two doubtful cases were referred for further observation. The number of cases found represents an incidence of 3.1 per 1,000."

Dr. M. May (Part of N.E. Division) :—

(1) *The general health and well-being of the children* is satisfactory in all age groups, and has been maintained throughout the year.

(2) *School Meals ; Milk in schools scheme :* These two schemes are continuing to prove most useful and helpful in promoting the physical well-being of the children. The standard of meal varies considerably between areas but on the whole the food is nutritious and appetising.

(3) *Physical condition of the Children :* This has been kept to a satisfactory standard on the whole. Dental treatment has made a considerable difference to the numerous children with carious teeth. There are still however a number of children whose nutrition is borderline.

(4) *Cleanliness of Pupils :* The incidence of scabies in this area has been negligible. Impetigo is more common but is on the whole treated early and competently. The incidence of pediculosis has been reduced by about 50% in the last two years except in one area. The completion of a new housing estate and the rehousing of a large number of families has promoted added cleanliness and freedom from these complaints.

(5) *Diphtheria Immunisation :* The response to this scheme amongst five and eleven year children has been good. On the other hand there is now no demand for infant immunisation at the clinics, most mothers availing themselves of the triple injections offered by the general practitioners.

(6) *The Hygienic Conditions of Schools :* This varies widely from the excellent conditions of the new school to the undecorated dirty and cramped surroundings of some of the older types. Subsidence is affecting schools in certain areas and repairs are progressing to buildings and playgrounds. Ventilation and lighting are adequate while heating and sanitation facilities usually vary with the age of the building.

(7) *Infectious Diseases :* There has been an epidemic of an unknown virus infection in this area of a considerable magnitude occurring from September to November. Some of the earlier cases were admitted to hospital with symptoms of meningism. Other virus infections have also been noticeably high.

(8) *Inter-relationship of the National Health Service and the School Health Service.* This is working well. Most children are referred immediately to their own Doctor when a physical defect is detected and adequate treatment results.

(9) It has been of interest to observe the number of children requiring treatment for tonsils and adenoids who have received treatment and the number who have received none. When allied conditions such as otitis media are present operation appears to improve the condition considerably. There are, however, a number of children whose parents ignore medical advice and who gradually improve in health after a number of years."

Dr. Robertson (Part of N.E. Division) :—

"*General Health and Well-being :* This has been satisfactory throughout the year. Well-being is, I feel, a good description. The children are well and bright and many of them show 'positive' health, to use the new description.

School Meals, Milk in Schools : As always, these are very good. The standard maintained is high. The school meals staff are all willing and keen workers and I would like to record my appreciation of the splendid work they do. They seem to be following a vocation, not just working in a job.

Physical Condition : On the whole, this is excellent and I see no reason for any future alteration.

Cleanliness of Pupils : Generally, the boys and girls are clean. It is interesting to record the views of one headmaster (many of his pupils have no bath at home). He finds that cleanliness in the school has increased since showers were installed. It is encouraging to find these facilities being used when they are provided.

Diphtheria Immunisation : This continues to be done, and done up to date. Much of the credit for this goes to the teachers in the infant and junior schools. They are very good at finding out the immunisation state of their pupils. Also, many general practitioners go out of their way to immunise school children.

Value of Periodic Medical Inspections : Much has been written lately about the value or otherwise of the above. I have no doubt that they are of value and I wish to give two indications in support of my belief.

1. A girl aged ten-and-a-half was seen in school in February of this year. She had a congenital heart lesion (this had been known since 1952). She had never been seen by a specialist. Accordingly, it was suggested to the mother that she should see her own doctor regarding specialist advice. She did so, and, by September the child had had an operation. She is now very fit and there is every reason to believe that the operation has been successful. Now, when would this operation have occurred if the child had not been seen in school ? I believe that she could have gone years before anything was done. Of course, I know the obvious answer to this. It's easy to say that I have

picked only one case out of very many exams. In other words, it can be said that a whale has been used to catch a sprat. Well, that is so, but my defence is that it is of vital importance to the 'sprat' in this case that it should be caught as soon as possible.

2. All secondary school children are examined during their first year. I find that a surprising number have defective vision (the incidence is higher in girls than boys and higher in grammar school than in secondary modern). Hardly any of these children show symptoms and they are amazed when told about their defect. Again, surely the periodic medical inspection is vindicated, as is the follow-up of these children at regular intervals. It has been suggested that these examinations could be done by other people or by other systems. Perhaps they could. But, all I know is that they are done under the School Health Service and done well. In my area, there are no 'ifs' nor 'buts' nor 'perhaps' about it. The examinations are made and many children benefit by the provision of suitable glasses."

Dr. Morris (Parts of N.E. and Mid-Divisions) :—

"(1) *The General Health and well-being of the children :* The average standard of health and well-being of the children in this area is satisfactory. My general impression is that they are well cared for. They are well nourished, well clothed and happy.

(2) *School Meals :* While conducting medical inspections in several schools I have found that the meals served to the children at lunch time have been wisely chosen, well cooked and served with every care. Menus are selected with due attention to variety and dietetic needs. The teaching staff take pride in seeing that the pupils are trained in laying the tables and in serving the food. Praise is due also for the effort made to decorate each table and to conduct the meal in a pleasant and friendly atmosphere. The cooking in all the schools is good and in some of them it is of a very high standard.

The majority of the children enjoy the mid-morning milk. There are however a few children who need coaxing. It might be advisable to serve these childen a few minutes earlier than the others to allow the slow drinkers to finish a bottle without losing their playtime.

(3) *Physical condition of the children* is generally good. During my visits, however, I have found several cases of children aged four to five with defective vision and in some cases the defect was marked.

A few cases of flat feet were recorded amongst infants and referred for treatment. Most of these were found to be wearing sandals or pumps.

The condition of children's teeth varies from district to district. In the rural parts dental decay of the milk teeth is less than that which occurs in the mining areas.

(4) In my experience the standard of *cleanliness* is praiseworthy. I have not seen any cases of pediculosis, impetigo or scabies.

(5) *Diphtheria Immunisation :* When the parents hear that there is a medical officer in attendance at a school they are most eager for their children to be immunised. In the mining areas I have been amazed at the way the fathers themselves come to ask me whether their children can also have 'injections against Polio and T.B.' The mining communities are alive to the benefits of all recent advances and eager to secure them for their children.

(6) I have no adverse comment to offer on the *Hygienic conditions of the schools.* All defects that have been noticed are receiving attention or will do so in the near future. Heating, lighting and sanitation are generally satisfactory throughout the area. Classrooms and cloakrooms are clean and sanitation facilities are regularly supervised.

(7) I have not come across any case of *Infectious Disease,* apart from a mild epidemic of mumps. In certain schools, however, a high percentage of children suffer from frequent colds and bronchitis.

(8) An outstanding feature in this area is the manner in which parents respond to the invitation to be present when their children are examined.

Another feature which I should like to mention is the valuable assistance given by the Health Visitors in this district. Their personal interest and friendliness coupled with efficiency maintain a delightful atmosphere in schools and clinics.

While on this point I wish also to pay a generous tribute to the splendid co-operation I have found among the Head Teachers of the schools in this area."

Dr. Morrissey (Part of Mid-Derbyshire) :—

"(1) *The General Health and well-being of the children* has remained satisfactory. The very poor weather conditions and absence of sunshine during the summer months was not followed by any apparent ill effects during the autumn and winter. School attendance figures have remained at a very satisfactory level.

(2) *School Meals ; Milk-in-schools scheme :* The number of children taking school meals has remained low in the urban district. The percentage is higher in the village schools and shows little change from previous years. Uptake of school milk remains at about 60%.

(3) *Physical condition of the children :* The physical condition of very few children was classed as unsatisfactory.

(4) *Cleanliness of pupils :* No case of scabies was seen and the incidence of impetigo was very much less than in 1955. The number of cases of head infestation remains very low and the same families continue to supply the bulk of the cases.

(5) *Diphtheria Immunisation :* The response of parents continues to be satisfactory. The actual numbers done in the schools this year was much below previous years, mainly because of the anti-poliomyelitis vaccination scheme and an outbreak of polio in the Belper Urban District in the summer and autumn months.

(6) *Hygienic conditions of schools :* Good progress has been made in connection with the school meals service. Almost all serveries and canteens have now been provided with sterilising sinks, and perhaps of equal importance, are staffed by suitable people. Most of the schools are old and lacking in many modern facilities but on the whole the cleanliness, lighting, ventilation and heating are satisfactory. Very few of the schools have hot water for handwashing for the children.

(7) *Infectious diseases :* Two cases of poliomyelitis occurred in one school at the close of the summer term. Five further cases occurred in the Belper Urban District at regular intervals of about three to four weeks. All cases except the last came from the same small district and had some connection either directly or indirectly with the same school. No case occurred in any child who had received anti-poliomyelitis vaccine.

(8) *Inter-relationship of the National Health Service and the School Health Service :* The general practitioners of the area are very co-operative when approached about problems concerning their patients, but the traffic seems rather one-sided ; very few requests for information about schools have been received from them.

(9) *Educationally sub-normal and maladjusted pupils :* Full ascertainment of educationally sub-normal pupils is only possible with the co-operation of the schools. This is lacking in many places for various reasons, the absence of a day special school being one. Many parents are unwilling to accept residential schools, and in these cases, especially in an overcrowded junior school, ascertainment may merely result in the child's name being placed on a register. Through the co-operation of the headmaster of one secondary modern school I have been able to examine, during the past few years, almost all the entrants whom he considers educationally sub-normal or low-normal. They had an I.Q. range from sixty up to eighty-eight. None of these children presented any severe behaviour problems, and the small classes in this particular school allowed a considerable amount of individual attention to be given to them in class. From my observations of their progress, I would say that most children with an I.Q. of sixty-five upwards can be satisfactorily dealt with in the ordinary school under these conditions. They avoid the stigma which is often attached to a special school and which could also be attached to children in special classes. Special E.S.N. Schools are required to serve this area mainly for children who require extra supervision on account of behaviour problems as well as very low intelligence."

Dr. Laurie (Part of Mid-Derbyshire) :—

(*January 1st to November 30th*, 1956).

"(1) *General Health and well-being of the children.*

(*a*) *Routine School Inspections :* The medical inspection of 370 children was carried out at schools in the Alfreton area during the above period. The majority of the children seen were of the

five to seven age group. Of the total number examined, forty-eight were found to be suffering from some illness or disability requiring treatment and forty-eight, whilst not requiring treatment, required to be placed under observation.

The most common defects and diseases discovered amongst the children examined, in order of frequency and percentage of total children examined, were as follows :— Diseases of the nose and throat 7.6% ; diseases of the lungs 4.9% ; squint 2.2% ; defects of vision 2.2% ; diseases of the ear 2.2% ; diseases of the skin 2.2%. Many of the defects and diseases found were of a very mild nature.

Parents were present at 142 of the medical inspections of the boys and 130 of the girls. The attendance of parents at the routine medical inspections of infants was very good and indicates a real interest in these examinations, but it is unfortunate that there is often a poor attendance at the inspections of senior pupils, for the parents could give much information of value to the examining doctor.

(*b*) *Minor Ailments Clinic :* A clinic is held once a week and during the year 143 children were examined. The most common defects found, in order of frequency and percentage of children seen were :— Defects of vision 20.3% ; speech 8.4% ; nose and throat 5.6% ; skin 2.8% ; squint 2.1% ; psychological stability 2.1%.

(2) *Schools, School Meals, Milk-in-Schools Scheme :* Several improvements have been carried out at schools in the area during 1956 and whilst the more modern schools are admirable in their layout, the conditions for teaching in the older schools, particularly those accommodated in Church Halls, are quite unsatisfactory.

No complaints have been received during the year on the School Meals or the Milk in Schools Scheme.

(3) *Physical Condition of the Children :* An assessment was made of the physical condition of the children examined at routine medical inspections by placing them in two categories, satisfactory and unsatisfactory. Of the 370 children seen, only one child, a boy, was regarded as being completely unsatisfactory, due to poor general physical condition resulting particularly from unsatisfactory care.

(4) *Cleanliness of Pupils :* The examination of some 2,400 pupils at cleanliness inspections revealed fifty-seven (2.4%) to be suffering from head lice infestation ; five of these were boys, being approximately 8.8% of the total children affected.

(5) *Immunisation :* A further attempt has been made to improve the immunisation state of the children in the area and 219 injections of diphtheria immunisation material have been given. About two-thirds of this total was for primary immunisation and the rest for reinforcement.

1956 was an important year in the work against poliomyelitis and a total of 278 injections of vaccine were administered during the months of May and June. No untoward result was noted.

(6) *Infectious Disease :* There was no serious outbreak of infectious disease in school children during the year. The most prevalent illness of this type was whooping cough (fifty-three cases notified).

(7) *Inter-relationship of the National Health Service and the School Health Service :* I would like again to refer to the co-operation which is given by general practitioners in this area in regard to the school health services and also to the helpful information received from hospitals.

Dr. Hamilton (Part of S.E. Division) :—

(1) *General Health :* This is on the whole good. It is quite striking, however, as one comes to know the Borough better, that it becomes possible to tell without asking, which area a child inhabits who has either bronchiectasis, chronic bronchitis or a chronically unhealthy upper respiratory tract. Children whose health has formerly been an anxiety to their parents, improve rapidly when a move is made to one or other of the two new housing estates.

(2) *School Meals* : These continue to be a great convenience for families where both parents are at work. Furthermore a child who for one reason or another is displaying feeding difficulties at home, can often be materially benefited by eating in common with other children, where no particular notice is taken of his behaviour with regard to his food.

(3) *Physical Condition :* Only two cases of malnutrition have been seen, both apparently due to incorrect feeding rather than under feeding. The over-weight children are still with us, and often, by the physical distribution of the fat, do not so much suggest temporary adolescent glandular dysfunction, as the eating of too many sweets, ices and other carbohydrate foods.

(4) *Cleanliness :* A few cases of pediculosis have been seen and these tend to recur in the same children. Some cases of impetigo have been treated at the minor ailment clinic.

(5) *Diphtheria Immunisation :* Immunisation is offered in each infant school, at the minor ailments clinic and at the infant welfare clinic. When done at school the mother has the minimum of trouble as she is not asked to attend. Unfortunately, however, with the drop in cases and deaths from diphtheria, the urgency of the matter is becoming dimmed, and many parents are refusing to give consent for a variety of somewhat curious reasons. This is a pity in Ilkeston, which used to have a very high immunisation rate. Besides this there are the parents who want the child (usually an infant) immunised, but want whooping cough protection at the same time.

(6) *Hygienic conditions :* It can be truly said that in the Ilkeston Borough there is no school which is not at least tolerably satisfactory even if it is old, and several that are almost all that could be desired. What old schools lose in brightness and lightness, moreover, they often gain in warmth and relative quietness, due to the more substantial walls. It is to be deprecated that when a new school

is projected, more use is not made in drawing up the plans, of the experienced opinions of those who are going to use it, that is, teachers, school doctor, school nurse and canteen staff.

(7) *Infectious Diseases.* No very wide-spread epidemic seems to have occurred this year. Mumps appeared in the late Spring. Later there were cases of measles, whooping cough and chickenpox, but nothing massive, and no half-empty schools have been encountered on the day of a medical examination.

(8) *Relationship with the National Health Service :* Most of the doctors are co-operative in this area.

(9) The children requiring psychological assistance do not tend to decrease in number. The factors governing this are very numerous, but perhaps one of the basic ones is the general feeling of insecurity among adults, in spite of higher wages and more material comforts. Children rapidly absorb an atmosphere surrounding their parents, and when this is one of deep-seated insecurity they are bound to start their emotional life already partially handicapped."

Dr. Blake (Parts of Mid- and S.E. Divisions) :—

"During the four months since my appointment commenced, I have visited twenty-three schools in this area, and have examined 1,171 children in the following categories :—

			Re-Exams and Special Exams	
	Boys	Girls	Boys	Girls
Entrants	228	204	24	40
2nd Age Group	219	247	19	60
Leavers	49	65	10	6

The remaining four schools comprised of junior boys and girls requiring annual re-examinations, had been visited prior to September, 1956.

General Health and well-being of the children :

	A	B
Entrants	79.1%	20.9%
2nd Age Group	73.4%	26.6%
Leavers	83.4%	16.6%

The major number of children appear well fed and cared for. In some instances in which this was not the case, either no parent was present, or both parents had employment. The following Table will serve to show the predominating defects in the three groups examined, being expressed in percentages of the total number of children in each group :—

	Nose and Throat	Squint	Vision	Cardiac murmurs	Lung conditions	Ortho-paedic
trants	27.9	5.3	–	5.3	4.7	3.7
cond Age Group ..	10.3	(100% treated)	14.5	4.3	1.5	2.2
avers	3.3	–	14	2.6	1.1	–

The incidence of nose and throat disorder is highest in the entrant group. In this locality one is aware of the prevalence of productive coughing and expectoration in public, in the adult population, and I would suggest that amongst other causes here is a menace to the infant's first lymphatic line of defence. In this group not all the cases picked out for observation require operative treatment, and in the older group examinations the defect incidence shows a sharp decrease. At this point the tonsillectomy rate as found, may be of interest :—

Entrants	5.2%
2nd Age Group	15.3%
Leavers	21.9%

Eyes : In the present day, parents are quick to notice and seek help in cases of squint. Defects of vision show quite a high incidence amongst the 2nd Age Group and Leavers. On enquiry, it is amongst the 11-plus group that most time is given to watching the T.V. screen.

Cardiac Murmurs : The greater numbers picked up in the younger ages appear to be mainly functional in origin. The smaller numbers in the leavers are under observation and care.

Teeth : One sees an inordinate amount of dental caries in the younger children, and a disregard of dental hygiene in the older ones. Added to this parents tend to indulge their children to excess in sweet-eating. The day when the 'Saturday Penny' had to stretch has passed long since. It is the exception to find parents who are alive to the care of the first teeth, and the inadequacy of facilities for regular professional attention is great.

Orthopaedic conditions : There were a small number of postural defects in the quickly growing asthenic types, which were referred for physiotherapy. In giving advice about footwear, besides adequate length, ample toe room, and the straight inner line, parents were advised against buying, for younger children, shoes of the platform type that did not have a distinct heel piece.

School Meals and Milk : Most of the children take mid-morning milk, and buy biscuits in those schools which provide them. Some of the older schools have had new canteen equipment installed. The quality of the food varies in different schools in the area. The quantity is always adequate. The eagerness with which succeeding 'sittings' queue up shows how much the meals are appreciated. It is pleasing to see the way the Help System works, both in organising the meals, and in disciplining the children.

Physical Condition of the Children : is generally very good. This is best observed by watching them at their free play periods.

Cleanliness : Only two cases of pediculosis were seen during the course of the inspections. No case of impetigo or scabies was found.

Diphtheria Immunisation: During December sixty-four children were given primary immunisation injections, and 154 were given booster injections. The vaccination against smallpox in the area would appear to have fallen considerably over the years, judging by the following percentage rate found :—

Entrants	6.2%
2nd Age Group	17.8%
Leavers	21.0%

Hygienic condition of schools : In the majority of schools ventilation, heating and sanitation are satisfactory. Some of the older schools fall short in their lighting, which is still maintained by gas.

Infectious Diseases : Apart from minor outbreaks of measles and chicken pox in the early Spring there have been no major epidemics.

Inter-relationship of the National Health Service and School Health Service : Contacts with the general practitioners in the area have been cordial and co-operative.

The reports from the Hospitals, through the County Offices, have been helpful in putting one in touch with those cases which require following up. The help and support of the Health Visitors has been much appreciated.

Dr. Koffman (Parts of Mid-, S.E. and S. Divisions) :—

(1) *The general health and well-being of the children :* On the whole this is satisfactory, although the first age group show a rather high incidence of upper respiratory infection, particularly during the colder months of the year. The large numbers of palpable cervical lymph-glands in this group are most likely due to the above infections coupled with the carious dental state which these young children show to a marked degree. These facts are the most likely cause of poor appetite of which some parents and school-meal supervising teachers complain. However, in spite of these handicaps the majority of the children concerned show a reasonable standard of nutrition.

Although the children in the second age group appear physically in better condition than the first group, here the mental well-being is not all that might be desired. The incidence of nail-biting is very high, parents comment on 'nervousness' ; but enuresis is on the whole an isolated phenomenon. These children have just passed through the 11-plus scholarship examination when seen and I feel that much of the tension found is due to the aftermath of this strain.

The third age group appear in good condition and seem to have lost to some extent their nervous tension although the nail-biting incidence appears still higher than in the first age group. I have been surprised at the apparent lack of interest in their future careers, particularly in many of the boys who seem neither to know nor care what kind of occupation they are to follow. Girls more often appear to have made up their minds what they intend to do on leaving school. (Area 21 does not have any Grammar Schools—the above observation relates to Secondary Modern Leavers only). This apathy towards their future life is more noticeable in schools with a large number of pupils from 'Social Class V' homes than in those where 'Social Class III' predominates.

In this connection it is perhaps of interest that the physical state of the pupils does not seem markedly influenced by the Social Class category of their home.

(2) *School Meals ; Milk in Schools Scheme.* The palatability of the 'School Dinner' varies considerably ; meals cooked and eaten on the same premises are obviously more palatable than those sent out to small schools. The percentage of unimaginatively prepared meals of poor balance is fairly high. I understand that this fault is frequently due to the food preferences of the childen themselves who are not used to such dishes as raw vegetables, salads, etc. I would prefer to see fresh fruit served occasionally as a dessert rather than the starchy pudding, particularly since many children get very little fresh fruit at home.

Potatoes are 'mashed'—or just falling to pieces on their own—much too often—with the resultant loss (probably complete) of Vitamin C. I would like to see experiments in cooking the right kind of potatoes in their skins, perhaps letting the children do the skinning at the table.

In some schools a number of parents find the price of the meals too high, and send sandwiches to school which are eaten on the premises. These children are a special problem of discipline to the school, as they cannot be properly supervised during the luncheon break and may get into mischief. My numbers are too small to remark on any possible physical differences between the "sandwich" versus the "cooked dinner" pupils.

The Milk-in-Schools Scheme appears to work satisfactorily. Milk bottle cleansing leaves much to be desired. Crates full of dirty, unrinsed bottles are the rule rather than the exception. Children could profitably be taught the rudiments of food receptacle hygiene and shown a bottle rinsing routine.

(3) *Physical condition of Children :* This is closely connected with their general health. Growth does not appear obviously retarded in those young children suffering from recurrent upper respiratory infections and poor appetite. Although a number of these children are a little below average weight and height, they appear to have made up for this by the twelfth year, i.e. the time of the second medical inspection. A longitudinal growth study of this group of cases should be of interest.

(4) *Cleanliness of Pupils :* This is good with most children. A few stand out as constant offenders and usually belong to Social Class IV and V. Schools serving a community with a high percentage of these homes show naturally a higher incidence than those whose catchment area contains a majority of Social Class III homes.

Children are usually scrubbed before being presented to the doctor, but often tell-tale marks remain to show the usual standard (dirt between the shoulder blades and quite often pityriasis versicolor is in evidence).

Pediculosis Capitis is still found in small to moderate numbers in certain schools, but some schools have not had more than one isolated case or even none for long periods. I think it is impossible to eradicate the nuisance completely with the number of school nurses at present available in Area 21. Impetigo cases are not very numerous. Teachers appear well aware of its infectiousness and urge parents in good time to see the family doctor. I have not seen a case of scabies.

(5) *Diphtheria Immunisation :* This is carried out routinely in the schools. The number of 'boosts' are about three to four times that of 'primary' inoculations. The incidence of 'primaries' is somewhat higher in smaller, isolated communities where the parents have found the visit to the family doctor too much of an effort to have the child immunized in babyhood.

(6) *Hygienic conditions in Schools :* This varies considerably, nearly always associated with the age of the building. The newer schools are comfortably heated and properly ventilated. In the older school ventilation rarely means fresh air entry but rather icy draughts. On the whole teachers are so frightened of oxygen lack that some windows are always open and those children unlucky to sit near them are bound to be considerably chilled during the winter months, especially as they are usually quite a distance from the uncomfortably hot open fire.

Toilet facilities in these older type schools are nearly always in the open, whether they have main services or not. It is possible that some at least of the complaints of constipation in the first age group might be due to reluctance to cross an icy yard to visit an even icier toilet. The danger of freeze-up in mains-connected toilets is an additional nuisance. Cleanliness of toilets varies between school caretakers but is on the whole satisfactory.

(7) *Infectious Diseases :* German Measles were prevalent during the summer months. Cases of 'virus meningitis' appeared in West Hallam—as far as I am aware the children affected had few meningitic signs and were not away from school for any length of time.

Minor gastro-intestinal disease occurred sporadically in a number of schools. However, no more than one or two children were affected at any one time. I feel that food poisoning can be ruled out.

(8) *Inter-relationship of the National Health Service and the School Health Service :* Personal contact has been made in a number of cases and co-operation with family doctors has been found good, although the system of referral to the Hospital Specialist Services via the family doctor appears cumbersome and may lower the prestige of the School M.O. in the eyes of certain parents."

Dr. Vass (Part of S.E. Division) :—

"My report for 1956 will not be very comprehensive, as I started to work for the County only in September. I shall endeavour to give a brief outline of my impressions.

(1) *The general health and well-being of children :* The standard of health is on the whole, high. Most of the children were happy and well fed, quite a number were apparently over-fed.

(2) *School Meals :* This is an excellent and essential service in a community where so many mothers go out to work. The meals are adequate and appetizing, especially where prepared on the school's premises.

(3) *Physical condition of the children :* Generally good. The incidence of dental caries was high ; quite a number of boys had very 'dirty' mouths.

(4) *Cleanliness of Pupils :* On the whole satisfactory. Still a few families harbour 'head-lice', but thanks to the excellent work done by the Health Visitors these are very few. I have seen no case of scabies, one of athlete's foot, and only two of mild impetigo.

(5) *Diphtheria Immunisation :* In Long Eaton immunisations have been done at the Clinic, on alternate Thursdays. In the coming year, I hope to give the booster dose in the schools, also as many primary immunisations as possible.

(6) *Hygienic conditions of schools* : Good on the whole, except in a few of the older schools.

(7) *Inter-relationship of the National Health Service and the School Health Service :* The few local doctors I have been in contact with, have been very helpful. The hospital reports are of great assistance."

Dr. R. Dean (Parts of Mid- and S. Divisions) :—

"(1) *The General Health and Well-being* of the children in this area is very good. The poor Summer weather apparently produced no noticeable increase in ill-health ; on the contrary, catarrhal conditions of the upper respiratory tract appeared to be remarkably slight during the Autumn term, and occurred mainly in the entrant group.

(2) *School Meals and Milk in Schools Scheme* appear to be working satisfactorily and to the benefit of the children's health and stamina.

(3) *Cleanliness of Pupils :* Two cases of Pediculosis capitis were observed. Cleanliness of new entrants was of a high standard.

(4) *Diphtheria Immunisation* was carried out whenever possible in primary schools. Head Teachers played a useful part in obtaining parental consent. A number of children coming forward for this service have not been immunised in infancy.

(5) *Hygienic Conditions of Schools :* Much has been done in the past year to improve the existing facilities by painting and repair work. One servery was found to be unhygienic as regards structure and equipment. This was reported in the usual way.

(6) *Infectious Diseases :* A mild outbreak of dysentery occurred in an urban area during the summer, some members of affected families escaping infection."

Dr. J. Crawshaw (Parts of S. Division) :—

"(1) *The General Health and Well-being of the Children :* The great majority of the children are very healthy and lively : they appear to enjoy life, even during medical inspection and immunisation.

There is little chronic disease of lungs and ears following infections in early childhood and infancy. This improvement is largely due to anti-biotic treatment of acute conditions.

Many children go to bed too late to have the rest they require after energetic days at school. Children hate going to bed even when they are tired and make the excuse that they want to see the adult television, although the more intelligent are probably bored by it.

(2) *School Meals :* These are of great importance especially in Rural Class Areas where the children cannot go home for dinner. Where the mother goes out to work the school meals ensure that the children have a nourishing dinner at the time when it is most needed.

Milk in schools is of great importance, but I feel that heavy weight teenagers should not be pressed to have it.

(3) *Physical Condition of the Children :* This is generally very good.

(4) *Cleanliness of the Pupils :* This is very good—I rarely see a really dirty child. There is little pediculosis but I have seen a few cases of mild impetigo during the year.

I have seen no scabies for about five years.

(5) *Diphtheria Immunisation* is welcomed by most of the parents, but very many children reach school age before they have the primary immunisation.

(6) *The Hygienic Condition of the Schools* is steadily improving in this area and in most cases is very good.

(7) *Inter-relationship of the National Health Service and the School Health Service :* I find that the General Practitioners are very willing to investigate and treat any pupil I may send to them.

The Hospital Reports are also of considerable value."

Dr. Allan (Part of S. Derbyshire) :—

(1) From the examination of the school children at the routine medical inspections, from seeing them in their classrooms, and especially from the observations during school playtime or on sports' days it is obvious that the general health and well-being of the children in the area is good.

(2) Nearly all the children fall into nutrition category 'S' and the very few who are in category 'U' are usually suffering from some definite illness. The children's good health and high standard of nutrition is the result of wise home care assisted by school meals and school milk. I am always pleased to see teachers and children dining together in a pleasant dining hall, and I think it is wholly unsatisfactory for the child to have his school meal at his desk in the classroom.

(3) The standard of cleanliness is excellent, and during the year I have only seen a very few cases of impetigo and pediculosis and none of scabies.

(4) Most of the General Practitioners in the area are using the triple prophylactic, diphtheria, tetanus and pertussis, which of course is attractive to the parents. For the boosting or reinforcing doses, I feel sure the best response is at the school medical examination for entrants. The assistance of the Head Teachers in diphtheria immunisation is invaluable, for frequently they can overcome the refusal of a parent whom the Doctor and Nurse have failed to persuade.

(5) Because of subsidence in the area, a tremendous amount of repair and replacement work has been done in the schools and a number of schools have been re-decorated which is most encouraging to the teacher and the children. It would be a great help to the teaching staff in some schools if they could have better accommodation and more lavatory facilities. The Swadlincote Clinic premises are too small for the amount of work being done, and they are situated near the top of one of the steepest roads in Swadlincote, and it would greatly facilitate the clinical work if a new clinic could be built in the neighbourhood of the Swadlincote Civic Centre which is already planned and parts of which are now being built.

(6) The co-operation between the medical services becomes better each year, and the co-operative work undertaken by the practitioners and the School Health Service increases. The hospital reports are of very great assistance when the school child has his routine inspection at school and at any other special examinations.

(7) I have been interested during the year, in epileptic school children from their own particular angle as patients. It is natural that as a group, epileptics tend to receive less attention because of the chronic and ordinarily unspectacular nature of their illness. The practitioners have a harassing time attending to the acute and sub-acutely ill, and often have only time to repeat the script for the epilpetics who, in most cases, do not attend the surgery, but have their tablets fetched by one or other parent. In some degree this applies to the consultants as well, for as one epileptic said sadly to me, 'He talks to mother, not to me, the patient.' Moreover, the school child epileptic thinks little of his treatment which is a tablet or capsule. He sees his surrounding grown-ups swallow tablets galore, and often without any real benefit, and naturally concludes they are not much good and transfers these conclusions to his own tablets. It would be well worth while if some simple explanation of the rationale of the treatment was given to the school epileptic. Moreover, the custody of the tablets should be the responsibility of the parent or guardian, and the school child should only have the tablets necessary for school hours. At one school, a secondary school child was found to have in his trouser pocket in a paper bag sixty, half-grain phenobarbitone tablets, and the playground was common to the secondary and primary schools."

Report from the Excepted District of Chesterfield.

The following report has been received from Dr. J. A. Stirling, the Borough School Medical Officer, concerning the Excepted District of Chesterfield :—

"A good standard of general health of the school children in Chesterfield has been maintained during the year 1956. The system of classification of the general condition of children inspected by the School Medical Officers has been changed, which makes comparison with previous years difficult. The examining Medical Officer forms a general impression of the child's physical fitness and classifies the child according to the following scale : S—satisfactory ; U—unsatisfactory. The figures for 1956 are as follows :—

Satisfactory—93.83% Unsatisfactory—6.17%

The value of medical examination has again proved itself by the fact that 543 children required medical treatment. By far the largest number of defects requiring treatment are ophthalmic in nature, and in fact, 129 children (3.7%) required treatment, while 427 children (12.3%) had visual defects which needed careful watching. This again showed that the number of children with eye defects is steadily rising, and it may be that this is at any rate partly due to the fact that a large number of children watch television for many hours.

The next most important reason for referral of a child to a consultant is for ear, nose and throat complaints. Ninety-four children (2.7%) required treatment, while 404 children (11.6%) required further observation. Many of these children required tonsillectomy and adenoidectomy, and while this procedure is to be deprecated without good cause, it is still of considerable value in appropriate cases.

The third main reason for referral of children for a specialist's opinion occurs in the psychiatric field, and during the year seventy-seven children were under treatment at the Children's Centre.

The co-operation of parents at school medical inspections has been most pleasing and the attendance of parents at the routine medical inspections was very good indeed and generally speaking, they showed great interest in the welfare of their children. There is still, however, that hard core of uninterested parents who allow their children to be examined unaccompanied on entrance to school.

42.08% of the children received school meals, and although milk is provided free and is available for all pupils, it is disappointing to have to report that 22% do not take it.

The fact that the School Medical Officer is also Medical Officer of Health and Area Medical Officer for Part 3 Services of the National Health Service Act, makes for close co-ordination. The Hospital Authorities have continued to co-operate excellently in connection with the treatment of children referred by the School Medical Officers and also by the notification of children requiring follow-up after Hospital treatment.

The School Clinics continued to function as in previous years, and the arrangements made with the Chesterfield Hospital Management Committee, whereby the ophthalmic and orthopaedic clinics are held in our buildings and staffed by hospital specialists, have remained satisfactory.

The School Nurses carried out 33,648 examinations for uncleanliness during the year. These examinations resulted in only 182 individual children found to be infested which represents 1.52% of the total school population. This represents a small nucleus of children who are continually being re-infested at home. Powers for compulsory cleanliness of school pupils exist, but are seldom required since the unclean child is excluded from school for cleansing purposes. In the year 1956 cleansing notices were issued in respect of only thirty children, whilst no cleansing orders at all were issued.

During this year, there has been a change of Speech Therapist as Miss Ward left in August to go to America, and Miss H. Wright, her successor, commenced in October. Throughout the year eighty-eight children received weekly treatment for various defects, such as stammering, cleft palate, cerebral palsy, and articulatory disorders. Apart from the regular patients 115 children were seen at intervals of two to six months. The parents of these children were also interviewed and advice given for the best method of dealing with the child's disability. Thirty-five new cases were interviewed. Fifty-one children were discharged as cured, and fifteen were suspended.

These fifteen children will be seen after three months to see if they have maintained a sufficiently high standard of speech to be discharged. A number of schools have been visited as it is felt that co-operation from the teachers is invaluable, particularly in cases where the parents are not co-operating to help the child to overcome his defect.

Brambling House Open Air School has continued to fulfil its main excellent function of restoring to full health the delicate children of the Borough, and by arrangement with the County Medical Officer certain selected physically handicapped children from the surrounding districts. Typical conditions for which children were admitted to the school were: cases of bronchitis, asthma, rheumatic heart disease, anaemia, and social conditions resulting in a physical deterioration. It is again pleasing to report that there has been almost a complete absence of epidemic illness in the Open Air School, even when these have been prevalent in other schools. It is a point to bear in mind as to what could be done in other schools if a similar policy of open air conditions and 100% school meals were applied to these also.

The year 1956 was the first year for some time that we have had the services of a Child Psychiatrist and this has resulted in a larger number of maladjusted children having treatment at the Children's Centre, and no doubt the fruit of this will be seen in future years.

The Heart School of nine beds which is established at the Ashgate Annexe of the Royal Hospital continued to function during the year, having dealt with five borough children in addition to fifteen from the county area.

The artificial sunlight clinics are now firmly established as part of the School Health Service both at the Town Hall Clinic and at Brambling House, and the results obtained in the treatment of certain types of cases has, in general, been good.

The work of the Home Teacher has increased so much that it has been found necessary to employ an additional home teacher. This is an excellent service for those children who are unable to attend school on account of severe physical handicap, and also for children who require to be away from school for a considerable period due to illness. Apart from the educational aspect this service has a great rehabilitation value.

Holly House Children's Hostel has continued to fulfil its useful function in enabling maladjusted children whose homes are unsuitable, or who live too far away from the Centre, to receive treatment."

TABLES OF THE MINISTRY OF EDUCATION

Ministry of Education—Medical Inspection Returns—Year ended 31st December, 1956
Local Education Authority—Derbyshire

TABLE I

Medical Inspection of Pupils attending Maintained Primary and Secondary Schools (including Special Schools)

	Divisional Executive						Totals
	North-west	North-east	Mid-Derbyshire	South-east	South	Chesterfield	
A. Periodic Medical Inspections :							
Age Groups inspected and Number of Pupils examined in each :—							
Entrants	1,247	3,072	1,401	1,613	1,961	1,024	10,318
Children in their first year as seniors	895	2,241	1,142	1,151	1,927	1,354	8,710
Leavers	677	1,716	817	945	822	943	5,920
Totals	2,819	7,029	3,360	3,709	4,710	3,321	24,948
Additional Periodic Inspections*	287	846	840	14	497	302	2,786
Grand Totals	3,106	7,875	4,200	3,723	5,207	3,623	27,734
B. Other Inspections :—							
Number of Special Inspections	326	1,687	205	423	1,170	1,158	4,969
Number of Re-inspections	978	1,332	1,445	393	2,263	3,308	9,719
Totals	1,304	3,019	1,650	816	3,433	4,466	14,688

* Children at Special Schools or who missed the usual periodic inspection.

TABLE I (*continued*)

C.—Pupils found to require Treatment

Number of Individual Pupils found at periodic medical inspection to require treatment (excluding Dental Diseases and Infestation with Vermin).

Notes.—(1) Pupils found at Periodic Medical Inspections to require treatment for a defect are not excluded from this return by reason of the fact that they are already under treatment for that defect.

(2) No individual pupil is recorded more than once in any column of this Table, and therefore the total in column (4) will not necessarily be the same as the sum of columns (2) and (3).

Divisional Executive	Group	For Defective Vision (excluding Squint)	For any of the Other Conditions recorded in Table III	Total Individual Pupils
North-west ..	Entrants	40	156	179
	Second Age Group ..	141	89	217
	Leavers	154	57	197
	Total	335	302	593
	Additional Periodic Inspections	20	76	96
	Grand Total ..	355	378	689
North-east ..	Entrants	20	686	688
	Second Age Group ..	218	274	433
	Leavers	162	162	284
	Total	400	1,122	1,405
	Additional Periodic Inspections	47	126	170
	Grand Total ..	447	1,248	1,575
Mid-Derbyshire	Entrants	20	124	136
	Second Age Group ..	89	93	171
	Leavers	66	57	116
	Total	175	274	423
	Additional Periodic Inspections	89	41	115
	Grand Total ..	264	315	538

TABLE I (*continued*)

Divisional Executive	Group	For Defective Vision (excluding Squint)	For any of the Other Conditions recorded in Table III	Total Individual Pupils
South-east ..	Entrants	10	167	175
	Second Age Group ..	70	174	242
	Leavers	85	131	202
	Total	165	472	619
	Additional Periodic Inspections	4	6	9
	Grand Total ..	169	478	628
South ..	Entrants	9	394	400
	Second Age Group ..	128	357	463
	Leavers	72	144	211
	Total	209	895	1,074
	Additional Periodic Inspections	18	140	140
	Grand Total ..	227	1,035	1,214
Chesterfield ..	Entrants	7	152	157
	Second Age Goup ..	40	108	143
	Leavers	32	66	97
	Total	79	326	397
	Additional Periodic Inspections	3	146	146
	Grand Total ..	82	472	543
Totals—Whole Administrative County ..	Entrants	106	1,679	1,735
	Second Age Group ..	686	1,095	1,669
	Leavers	571	617	1,107
	Total	1,363	3,391	4,511
	Additional Periodic Inspections	181	535	676
	Grand Total	1,544	3,926	5,187

TABLE I (*continued*)

D.—Classification of the Physical Condition of Pupils inspected during the Year in the Age Groups

Divisional Executive	Age Group	Number of Pupils Inspected	Satisfactory		Unsatisfactory	
			No.	% of Col. (3)	No.	% of Col. (3)
(1)	(2)	(3)	(4)	(5)	(6)	(7)
North-west	Entrants	1,247	1,230	98.63	17	1.37
	Second Age Group	895	871	97.32	24	2.68
	Leavers	677	675	99.70	2	0.30
	Additional Periodic Inspections	193	180	93.26	13	6.74
	Totals	3,012	2,956	98.13	56	1.87
North-east	Entrants	3,072	2,985	97.16	87	2.84
	Second Age Group	2,241	2,196	97.98	45	2.02
	Leavers	1,716	1,693	98.65	23	1.35
	Additional Periodic Inspections	846	825	97.51	21	2.49
	Totals	7,875	7,699	97.77	176	2.23
Mid-Derbyshire	Entrants	1,401	1,384	98.78	17	1.22
	Second Age Group	1,142	1,135	99.39	7	0.61
	Leavers	817	810	99.14	7	0.86
	Additional Periodic Inspections	840	840	100.00	—	—
	Totals	4,200	4,169	99.26	31	0.74
South-east	Entrants	1,613	1,522	94.35	91	5.65
	Second Age Group	1,151	1,087	94.43	64	5.57
	Leavers	945	924	97.78	21	2.22
	Additional Periodic Inspections	14	13	92.85	1	7.15
	Totals	3,723	3,546	95.25	177	4.75
South	Entrants	1,961	1,927	98.26	34	1.74
	Second Age Group	1,927	1,883	97.71	44	2.29
	Leavers	822	813	98.90	9	1.10
	Additional Periodic Inspections	435	428	98.39	7	1.61
	Totals	5,145	5,051	98.16	94	1.84
Chesterfield	Entrants	1,024	955	93.26	69	6.74
	Second Age Group	1,354	1,306	96.45	48	3.55
	Leavers	943	890	94.38	53	5.62
	Additional Periodic Inspections	146	102	69.86	44	30.14
	Totals	3,467	3,253	93.83	214	6.17
Totals—Whole Administrative County	Entrants	10,318	10,003	96.95	315	3.05
	Second Age Group	8,710	8,478	97.34	232	2.66
	Leavers	5,920	5,805	98.05	115	1.95
	Additional Periodic Inspections	2,474	2,388	96.52	86	3.48
	Grand Totals	27,422	26,674	97.28	748	2.72

TABLE II

Infestation with Vermin

NOTES.—A statement as to the arrangements made by the Local Education Authority for the examination and cleansing of infested pupils appears in the body of this Report.
All cases of infestation, however slight, are recorded.
Items (ii), (iii) and (iv) relate to individual pupils and not to instances of infestation.

	Divisional Executive						Totals
	North-west	North-east	Mid-Derbyshire	South-east	South	Chesterfield	
(i) Total number of examinations in the schools by the school nurses or other authorised persons	27,285	48,364	32,937	33,297	41,794	33,648	217,325
(ii) Total number of individual pupils found to be infested	362	968	293	293	218	182	2,316
(iii) No. of individual pupils in respect of whom cleansing notices were issued (Section 54 (2) Education Act, 1944) ..	—	—	—	—	—	30	30
(iv) No. of individual pupils in respect of whom cleansing orders were issued (Section 54 (3), Education Act, 1944) ..	—	—	—	—	—	—	—

TABLE III

Return of Defects found by Medical Inspection in the Year ended 31st December, 1956

PART I—WHOLE ADMINISTRATIVE COUNTY

Note—All defects noted at Medical Inspection as requiring treatment are included in this return, whether or not this treatment was begun before the date of inspection.

A.—PERIODIC INSPECTIONS

Defect Code No. (1)	Defect or Disease (2)	Periodic Inspections				Total (including *all other* age groups inspected)	
		Entrants		Leavers			
		Requiring treatment (3)	Requiring observation (4)	Requiring treatment (5)	Requiring observation (6)	Requiring treatment (7)	Requiring observation (8)
4	Skin	162	129	168	87	446	295
5	Eyes—*a.* Vision ..	106	136	571	384	1,544	957
	b. Squint ..	224	66	68	10	304	133
	c. Other ..	37	32	22	18	104	68
6	Ears—*a.* Hearing ..	22	58	13	17	45	105
	b. Otitis Media	62	126	22	38	114	186
	c. Other ..	28	78	9	34	54	172
7	Nose and Throat ..	381	1,082	58	97	560	1,431
8	Speech	87	83	14	8	136	112
9	Lymphatic Glands ..	25	640	1	55	35	836
10	Heart	12	123	12	85	34	250
11	Lungs	138	369	30	79	241	559
12	Developmental— *a.* Hernia ..	49	51	1	5	66	68
	b. Other ..	30	126	13	44	80	308
13	Orthopaedic— *a.* Posture ..	21	64	36	40	94	199
	b. Feet ..	235	187	103	77	442	377
	c. Other ..	225	343	39	64	360	487
14	Nervous System— *a.* Epilepsy ..	14	13	11	7	40	24
	b. Other ..	43	46	7	14	52	83
15	Psychological— *a.* Development	11	44	7	18	58	102
	b. Stability ..	19	161	7	88	105	453
16	Abdomen	41	30	11	8	53	66
17	Other	86	144	51	58	229	374

TABLE III (*continued*)

B.—SPECIAL INSPECTIONS

Defect Code No. (1)	Defect or Disease (2)	Special Inspections	
		Requiring treatment (3)	Requiring observation (4)
4	Skin	136	31
5	Eyes—*a.* Vision	411	380
	b. Squint	113	38
	c. Other	98	24
6	Ears—*a.* Hearing	19	36
	b. Otitis Media ..	35	30
	c. Other	21	14
7	Nose and Throat	141	282
8	Speech	52	40
9	Lymphatic Glands	21	105
10	Heart	18	83
11	Lungs	56	85
12	Developmental— *a.* Hernia	11	12
	b. Other	18	25
13	Orthopaedic— *a.* Posture	15	17
	b. Feet	84	36
	c. Other	56	57
14	Nervous System— *a.* Epilepsy	16	11
	b. Other	18	21
15	Psychological— *a.* Development ..	110	48
	b. Stability	33	56
16	Abdomen	11	18
17	Other	181	92

TABLE III (*continued*)

Return of Defects found by Medical Inspection in the Year ended 31st December, 1956

PART II—DIVISIONAL EXECUTIVES

Defect Code No.	Defect or Disease	Periodic Inspections																							
		Entrants												Leavers											
		Requiring Treatment						Requiring observation						Requiring Treatment						Requiring observation					
		Divisional Executive						Divisional Executive						Divisional Executive						Divisional Executive					
		North-west	North-east	Mid-Derbyshire	South-east	South	Chesterfield	North-west	North-east	Mid-Derbyshire	South-east	South	Chesterfield	North-west	North-east	Mid-Derbyshire	South-east	South	Chesterfield	North-west	North-east	Mid-Derbyshire	South-east	South	Chesterfield
4	Skin	11	60	15	14	42	20	14	36	9	13	39	18	29	36	11	27	39	26	11	5	5	9	7	50
5	Eyes–*a.* Vision	40	20	20	10	9	7	29	65	11	5	24	2	154	162	66	85	72	32	33	100	25	33	22	171
	b. Squint	40	60	27	43	33	21	13	15	10	11	8	9	8	7	5	43	4	1	–	1	–	2	1	6
	c. Other	6	8	5	3	9	6	3	9	1	6	1	12	3	2	1	10	3	3	–	3	1	1	2	11
6	Ears–*a.* Hearing	–	13	2	1	5	1	6	23	5	7	5	12	1	5	1	2	1	3	3	4	1	6	1	2
	b. Otitis Media	1	20	9	2	24	6	11	26	14	32	32	11	–	6	1	5	6	4	1	4	2	17	5	9
	c. Other	3	24	–	–	1	–	7	7	1	3	8	52	–	6	–	1	2	–	1	–	–	–	1	32
7	Nose and Throat	27	177	37	38	62	40	153	393	90	125	199	122	2	31	6	10	7	2	11	29	11	10	11	25
8	Speech	9	28	10	6	21	13	22	22	3	9	17	10	–	2	4	4	2	2	1	1	1	2	1	2
9	Lymphatic Glands	1	18	–	1	3	2	29	302	29	112	118	50	–	1	–	–	–	–	–	11	4	17	5	18
10	Heart	–	3	2	2	5	–	6	23	4	50	25	15	–	4	1	2	5	–	13	18	5	17	6	26
11	Lungs	5	39	19	9	47	19	54	77	38	68	81	51	1	2	5	6	13	3	9	9	14	19	12	16
12	Developmental—																								
	a. Hernia	1	37	2	–	7	2	3	16	8	2	10	12	–	–	1	–	–	–	2	–	1	–	–	2
	b. Other	–	12	5	2	9	2	2	32	4	26	45	17	–	2	–	1	6	4	–	10	–	1	2	31
13	Orthopaedic—																								
	a. Posture	1	12	1	5	2	–	11	23	4	5	17	4	10	7	–	13	5	1	2	7	2	3	6	20
	b. Feet	22	110	10	32	56	5	35	66	19	18	22	27	12	21	8	28	27	7	10	16	2	5	8	36
	c. Other	19	94	2	21	76	13	22	90	5	67	124	35	1	9	6	7	13	3	7	13	6	6	20	12
14	Nervous System—																								
	a. Epilepsy	1	7	2	1	3	–	4	4	1	1	3	–	1	1	1	4	2	2	1	–	2	3	–	1
	b. Other	3	34	–	1	5	–	3	15	6	2	17	3	–	4	1	1	–	1	–	2	2	5	3	2
15	Psychological—																								
	a. Development	2	2	5	1	1	–	8	17	5	5	7	2	–	–	3	1	2	1	3	3	3	5	3	1
	b. Stability	1	8	1	–	6	3	24	14	12	39	36	36	–	–	1	4	–	2	–	–	3	5	5	75

Defect Code No.	Defect or Disease	Periodic Inspections												Special Inspections									
		Total (all age groups)																					
		Requiring Treatment						Requiring observation						Requiring Treatment						Requiring observation			
		Divisional Executive						Divisional Executive						Divisional Executive						Divisional Executive			
		North-west	North-east	Mid-Derbyshire	South-east	South	Chesterfield	North-west	North-east	Mid-Derbyshire	South-east	South	Chesterfield	North-west	North-east	Mid-Derbyshire	South-east	South	Chesterfield	North-west	North-east	Mid-Derbyshire	South-east	South	Chesterfield
4	Skin	46	102	36	43	139	80	30	55	24	18	66	102	3	28	4	7	15	79	2	12	3	4	1	9
5	Eyes–*a.* Vision ..	355	447	264	169	227	82	122	180	129	33	144	349	36	80	37	29	114	115	32	54	13	9	88	184
	b. Squint ..	58	78	56	24	62	26	16	19	33	7	12	46	8	24	7	38	22	14	6	14	1	10	3	4
	c. Other ..	15	18	11	11	28	21	3	13	2	6	12	32	1	19	–	3	9	66	4	5	–	–	7	13
6	Ears–*a.* Hearing ..	1	14	5	1	13	11	17	20	17	9	20	22	–	10	1	4	2	2	4	13	3	6	3	7
	b. Otitis Media	2	34	11	3	45	19	23	22	34	17	59	31	3	13	1	1	6	11	7	12	2	5	4	–
	c. Other ..	3	38	2	1	6	4	10	14	1	2	15	130	–	3	–	–	2	16	2	4	–	–	–	8
7	Nose and Throat ..	31	252	66	28	123	60	213	407	172	65	353	221	2	59	9	26	24	21	31	123	10	42	58	18
8	Speech	17	29	18	8	36	28	26	24	12	5	18	27	–	28	2	2	7	13	6	18	–	8	3	5
9	Lymphatic Glands ..	1	17	3	–	12	2	41	361	52	112	178	92	2	14	–	–	2	3	6	82	–	8	3	6
10	Heart	–	4	2	3	14	11	27	61	20	21	58	63	–	4	–	–	7	7	5	29	2	35	8	4
11	Lungs	7	47	21	8	80	78	80	97	101	47	134	100	4	11	3	4	7	27	5	26	8	26	17	–
12	Developmental—																								
	a. Hernia ..	1	36	11	1	14	3	10	14	15	2	13	14	–	7	–	2	1	1	2	7	–	1	2	–
	b. Other ..	–	21	7	3	34	15	7	75	8	12	90	116	2	8	–	–	4	4	–	14	–	6	1	
13	Orthopaedic—																								
	a. Posture ..	17	17	6	18	32	4	22	47	23	9	48	50	–	8	–	4	3	–	5	5	–	5	1	1
	b. Feet ..	46	121	31	56	162	26	73	77	48	15	51	113	8	15	1	16	24	20	12	10	2	3	–	9
	c. Other ..	41	88	17	28	160	26	38	108	27	51	200	63	2	24	1	5	12	12	3	29	–	13	5	7
14	Nervous System—																								
	a. Epilepsy ..	3	9	4	2	12	10	7	7	4	4	1	1	2	5	–	1	2	6	–	7	–	3	1	–
	b. Other ..	1	32	1	1	11	6	7	20	12	3	28	13	–	6	–	–	5	7	1	6	–	–	11	3
15	Psychological—																								
	a. Development	2	3	5	–	46	2	21	25	22	6	17	11	80	10	3	–	4	13	6	18	4	10	5	5
	b. Stability ..	1	9	2	1	15	77	36	18	34	35	57	273	–	3	1	2	6	21	9	10	2	14	5	16
16	Abdomen	–	39	3	–	8	3	7	29	11	3	–	16	–	4	2	–	2	3	1	14	2	–	1	–
17	Other..	8	65	12	25	64	55	36	82	20	39	56	141	–	23	2	9	13	134	7	49	3	16	2	15

TABLE IV

Treatment of Pupils attending Maintained Primary and Secondary Schools (including Special Schools)

GROUP 1.—EYE DISEASES, DEFECTIVE VISION AND SQUINT.

	Number of Cases known to have been dealt with													
	By the Authority							Otherwise						
	Divisional Executive							Divisional Executive						
	North-west	North-east	Mid-Derby-shire	South-east	South	Chester-field	Totals	North-west	North-east	Mid-Derby-shire	South-east	South	Chester-field	Totals
External and Other, excluding errors of refraction and Squint ..	–	23	10	27	1	85	146	1	2	20	15	39	7	84
Errors of refraction (including Squint) ..	859	–	–	–	–	–	859*							7,077†
Totals	859	23	10	27	1	85	1,005							7,161†
Number of Pupils for whom Spectacles were Prescribed	599	–	–	–	–	–	599*							4,895†

GROUP 2.—DISEASES AND DEFECTS OF EAR, NOSE AND THROAT.

	Number of Cases known to have been Treated													
Received Operative Treatment :—														
(*a*) for diseases of the ear	–	–	–	–	–	–	–	–	–	–	–	–	2	2
(*b*) for adenoids and chronic tonsilitis ..	–	–	–	–	–	–	–	30	257	60	97	92	204	740
(*c*) for other nose and throat conditions ..	–	–	–	–	–	–	–	2	1	–	–	5	4	12
Received other forms of treatment	–	7	1	36	–	33	77	–	19	3	29	30	27	108
Totals	–	7	1	36	–	33	77	32	277	63	126	127	237	862
Total number of pupils in schools who are known to have been provided with hearing aids :—														
(*a*) in 1956	–	–	–	–	–	–	–	1	4	–	1	–	3	9
(*b*) in previous years ..	–	–	–	–	–	–	–	4	3	–	2	1	7	17

GROUP 3.—ORTHOPAEDIC, AND POSTURAL DEFECTS.

	By the Authority							Otherwise						
	Divisional Executive						Totals	Divisional Executive						Totals
	North-west	North-east	Mid-Derby-shire	South-east	South	Ches-ter-field		North-west	North-east	Mid-Derby-shire	South-east	South	Ches-ter-field	
Number of Pupils known to have been treated at clinics or out-patient departments	–	–	–	–	–	–	–	142	236	114	172	421	138	1,223

GROUP 4.—DISEASES OF THE SKIN (excluding uncleanliness, for which see Table II).

	Number of Cases Treated or Under Treatment during the Year By the Authority						
	Divisional Executive						Totals
	North-west	North-east	Mid-Derbyshire	South-east	South	Chesterfield	
Ringworm—(i) Scalp	–	–	–	–	–	–	–
(ii) Body	–	–	–	1	–	5	6
Scabies	–	–	–	–	–	–	–
Impetigo	–	8	–	23	1	16	48
Other Skin Diseases	–	46	–	33	1	120	200
Totals	–	54	–	57	2	141	254

TABLE IV (*continued*)

GROUP 5.—CHILD GUIDANCE TREATMENT.

	Divisional Executive						
	North-west	North-east	Mid-Derbyshire	South-east	South	Chesterfield	Totals
Number of Pupils treated at Child Guidance Clinics under arrangements made by the Authority	37	54	74	71	83	148	467

GROUP 6.—SPEECH THERAPY.

	Number of cases treated or under treatment during the year by the Authority						
	Divisional Executive						
	North-west	North-east	Mid-Derbyshire	South-east	South	Chesterfield	Totals
Number of Pupils treated by Speech Therapists under arrangements made by the Authority	36	160	65	153	61	212	687

GROUP 7.—OTHER TREATMENT GIVEN.

(*a*) Number of cases of miscellaneous minor ailments treated by the Authority ..	539	57	2	111	15	608	1,332
(*b*) Pupils who received convalescent treatment under School Health Service arrangements	–	–	–	–	–	–	–
(*c*) Pupils who received B.C.G. vaccination							128
(*d*) Other than (*a*), (*b*) and (*c*) above (specify) :—				–	–	230	230

TABLE V

Dental Inspection and Treatment carried out by the Authority

	North west	North east	Mid-Derby-shire	South east	South	Ches-ter-field	Totals
Number of pupils inspected by the Authority's Dental Officers:—							
(*a*) at periodic inspections ..	–	9,364	822	132	568	1,222	12,108
(*b*) as specials	–	1,739	149	581	1,208	2,813	6,490
TOTAL	–	11,103	971	713	1,776	4,035	18,598
Number found to require treatment	–	10,072	782	685	1,716	3,711	16,966
Number offered treatment ..	–	7,672	689	661	1,631	3,556	14,209
Number actually treated ..	–	5,150	310	609	1,332	3,257	10,658
Number of attendances made by pupils for treatment, *including* those recorded at heading 11(h) below	–	8,388	394	742	1,856	5,748	17,128
Half-days devoted to Periodic (School) :—							
Inspection	–	80	5	1	4	8	98
Treatment	–	1,100	30	62	252	731	2,175
TOTAL	–	1,180	35	63	256	739	2,273
Fillings :—							
Permanent Teeth	–	1,507	154	174	463	1,431	3,729
Temporary Teeth	–	47	4	11	14	234	310
TOTAL	–	1,554	158	185	477	1,665	4,039
Number of teeth filled :—							
Permanent Teeth	–	1,293	130	153	380	1,265	3,221
Temporary Teeth	–	45	4	11	13	217	290
TOTAL	–	1,338	134	164	393	1,482	3,511
Extractions :—							
Permanent Teeth	–	1,743	128	334	752	1,933	4,890
Temporary Teeth	–	9,020	459	904	2,290	3,774	16,447
TOTAL	–	10,763	587	1,238	3,042	5,707	21,337
Administration of general anaesthetics for extraction	–	1,398	174	571	512	2,252	4,907
Orthodontics :—							
(*a*) Cases commenced during the year	–	9	–	–	4	11	24
(*b*) Cases carried forward from previous year	–	3	1	1	1	2	8
(*c*) Cases completed during the year	–	5	–	2	1	2	10
(*d*) Cases discontinued during the year	–	1	–	–	–	–	1
(*e*) Pupils treated with appliances	–	6	–	–	4	9	19
(*f*) Removable appliances fitted	–	6	–	–	4	9	19
(*g*) Fixed appliances fitted ..	–	–	–	–	–	–	–
(*h*) Total attendances	–	65	–	1	18	25	109
Number of pupils supplied with artificial dentures	–	14	2	3	3	24	46
Other operations :—							
Permanent Teeth	–	978	72	71	230	329	1,680
Temporary Teeth	–	868	74	122	327	25	1,416
TOTAL	–	1,846	146	193	557	354	3,096