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Derbyshire County Council

ANNUAL REPORT

OF THE

COUNTY MEDICAL OFFICER OF HEALTH

For the Year 1959

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, 1959)

ALDERMAN MRS. E. HARRISON
(Chairman)

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

Aldermen

MRS. G. BUXTON.
N. GRATTON.
J. W. HALL.
MRS. D. M. SUTTON.
T. W. WARDLEY.
A. F. T. WYATT.

Councillors

N. B. BANKS.
J. CARTER.
G. W. COCKER
S. F. COLLINS
H. FISHER.
J. H. GREGORY.
J. HAWORTH.
M. HEWITT
MRS. B. IVINSON.
J. LOMAS.
C. J. MERREY.
C. V. MOORE.
MRS. E. G. REDFERN.
P. REVILL.
MRS. A. S. THICKETT
H. T. TISDALE.
W. H. WHITEHEAD.
J. WILLIAMSON.
E. WRIGHT.

Co-opted Members

DR. E. D. FORSTER.
A. J. WILSON, ESQ., F.R.C.S.
T. ALLSOP, ESQ., O.B.E., J.P.
J. CLARKE, ESQ.
MRS. S. A. JERVIS.
MRS. M. H. SMITH.
MRS. D. M. ASHLEY.

Ambulance Sub-Committee

ALDERMAN MRS. E. HARRISON.
ALDERMAN MRS. F. E. SHIPLEY.
ALDERMAN T. W. WARDLEY.
ALDERMAN A. F. T. WYATT.
COUNCILLOR H. FISHER.
COUNCILLOR H. T. TISDALE.
COUNCILLOR W. H. WHITEHEAD.

Mental Health Sub-Committee

ALDERMAN MRS. E. HARRISON.
ALDERMAN MRS. F. E. SHIPLEY.
ALDERMAN MRS. G. BUXTON.
ALDERMAN J. W. HALL.
ALDERMAN MRS. D. M. SUTTON.
ALDERMAN T. W. WARDLEY.
COUNCILLOR N. B. BANKS.
COUNCILLOR J. CARTER.
COUNCILLOR H. FISHER.
COUNCILLOR J. H. GREGORY.
COUNCILLOR MRS. E. G. REDFERN
COUNCILLOR J. WILLIAMSON.
DR. E. D. FORSTER.

Co-opted Members:—
DR. W. J. BARBOUR AND THE MEDICAL SUPERINTENDENTS OF:—
KINGSWAY HOSPITAL, ASTON HALL HOSPITAL, PASTURES HOSPITAL AND WHITTINGTON HALL HOSPITAL.

Staff Sub-Committee

ALDERMAN MRS. E. HARRISON.
ALDERMAN MRS. F. E. SHIPLEY.
ALDERMAN MRS. D. M. SUTTON.
ALDERMAN T. W. WARDLEY.
ALDERMAN A. F. T. WYATT.
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.	COUNCILLOR MRS. B. A. BRIGHTMORE.
ALDERMAN MRS. D. M. SUTTON.	COUNCILLOR R. H. BROOMHEAD.
COUNCILLOR N. B. BANKS.	COUNCILLOR MRS. A. COLLISHAW.
COUNCILLOR J .CARTER.	COUNCILLOR MRS. L. TIDESWELL
MRS. S. A. JERVIS.	

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, 1959, 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 MRS. O. EDEN.
ALDERMAN MRS. D. M. SUTTON.	ALDERMAN F. A. GENT.
COUNCILLOR N. B. BANKS.	ALDERMAN J. B. HANCOCK.

WEIGHTS AND MEASURES AND MISCELLANEOUS SERVICES COMMITTEE

(As at 31st December, 1959)

ALDERMAN C. FEAKIN
(*Chairman*)

COUNCILLOR T. T. JENNINGS
(*Vice-Chairman*)

Aldermen

MRS. G. BUXTON.	MRS. D. M. SUTTON.
T. COLLEDGE	T. W. WARDLEY.
A. FOWLER.	C. WASS.
N. GRATTON.	A. F. T. WYATT.

Councillors

D. BARTON	F. W. ELDRIDGE.
MRS. B. M. BASTAPLE.	MRS. D. HARDMAN.
H. G. BOOTH.	A. E. HEESOM.
F. R. BOTT.	J. H. HIGGINBOTTOM.
J. T. CHADWICK.	D. PRINCE.
G. W. COCKER.	J. J. SHEEHY.
MRS. S. DALLY.	

Milk Licences Sub-Committee.

ALDERMAN C. FEAKIN.	COUNCILLOR T. T. JENNINGS.

Rural Water Supplies and Sewerage Act Sub-Committee.

ALDERMAN T. COLLEDGE.	COUNCILLOR H. G. BOOTH.
ALDERMAN C. FEAKIN.	COUNCILLOR F. W. ELDRIDGE.
ALDERMAN C. WASS.	COUNCILLOR T. T. JENNINGS.
	COUNCILLOR J. J. SHEEHY.

To the Chairman and Members of the
Derbyshire County Council.

Ladies and Gentlemen,

I have the honour to present the 70th 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 732,800) were respectively 15.87 and 12.22 whereas the corresponding rates for England and Wales (provisional) were 16.5 and 11.6. The percentage of **illegitimate births** was 3.52, as compared with 3.36 in the previous year. (The figure for England and Wales in 1959 was 5.1%).

There were 7,856 **deaths,** whereas there were 8,078 in the previous year. Of the 7,856 deaths, 1,296 were certified as being due to heart disease, 1,351 as being due to malignant disease, and 1,159 as being due to vascular lesions of the nervous system. In the case of the 1,351 deaths from malignant disease, the lesion was in the stomach in 206 patients; in the lung or bronchus in 250 cases; in a breast in 123; and in the uterus in 58.

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 lung, 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	278
1954 ..	80	165	245
1955 ..	74	173	247
1956 ..	51	233	284
1957 ..	51	210	261
1958 ..	46	230	276
1959 ..	34	250	284

The number of notifications and deaths from all forms of **tuberculosis** during the last twelve years are set out on page 44. From a perusal of the Table it will be seen that in the year under review, 307 new cases were notified and thirty-nine deaths recorded, which are the lowest figures that have ever been recorded in this county.

The **infant mortality rate** is 23.34 deaths under one year of age per thousand live births, which may be compared with a provisional figure of 22.2 for England and Wales—incidentally, the figures are the lowest that have been recorded both in the county and in the country. The Table on page 19 sets out the figures for Derbyshire since 1930. Your attention is also drawn to the Tables on pages 19 and 20 relating to neo-natal and early neo-natal mortality, as well as the comments on peri-natal mortality.

The **maternal mortality** rate was 0.41 per thousand live- and still-births. (For England and Wales the provisional figure was 0.38). The Derbyshire figure for 1955 was 0.38, which was the lowest on record; for 1956 it was 0.62, for 1957, 0.51, and for 1958, 0.51. Your attention is drawn to the Table on page 40 which shows the mortality over the last twenty years.

The number of deaths from **coronary disease,** including angina pectoris, was 1,190 in the year under review, compared with 1,213 in 1958, 1,008 in 1957, 1,069 in 1956, 962 in 1955, and 942 in 1954.

I am pleased to report that there have been no notification or death from **diphtheria** in Derbyshire during the year.

There has been an extension of the arrangements for **Health Education,** particularly by the medical, dental and health visiting staff during the year, but health education should occupy a more prominent place in our advice whenever an opportunity presents itself, whether the patient be young or old. Somebody asked a doctor, "When should Health Education begin?" The doctor replied, "In the cradle, because there he learns that he cannot have what he wants when he wants it!"

When Mr. Derek Walker-Smith, the Minister of Health, was presenting the **Mental Health** Bill for its second reading in Parliament, he said, "One of the main principles we seek to procure is our reorientation of the Mental Health Service from the institutional care towards care in the community. This is not, however, just a Local Authority matter. Hospital and Local Authorities both have their part to play and neither can make the maximum contribution without the other, nor, indeed, without the co-operation of the public in accepting the presence of suitable patients in the community. There is still plenty of educational work required in this latter context."

An attempt has been made in the body of this Report to summarise the new Mental Health Act, particularly for the benefit of persons who may be called upon in the community to give advice to patients or relatives. The Act will be replacing the Lunacy Act, 1890, the Mental

Deficiency Acts, 1913 to 1938, and the Mental Treatment Act, 1930. A summary must result in certain omissions, as is shown by the fact that only twenty-three sections and one Schedule have been quoted from an Act containing 154 sections and eight Schedules!

Comment on the new Mental Health legislation was put very neatly in an editorial of the *Nursing Mirror* in November, 1959, as follows:— "Psychiatry and general medicine are being integrated, with benefit to both." Certainly psychiatry has not had the place it deserves, but the new legislation provides opportunities for progress to be made. An essential factor in progress is freedom to experiment, and occasionally when experiments are carried out, mistakes occur. As Dr. W. A. L. Bowen said when speaking to his paper at the Royal Society of Health Congress at Torquay in April, 1960, on the "Cycle of Fashion" in the Evolution of Hospital Psychiatric Services, "What is currently fashionable is not necessarily endurable!"

Once again I should like to take this opportunity of thanking (i) Ald. Mrs. E. Harrison, the Chairman of the County Health Committee, Ald. C. Feakin, the Chairman of the Weights and Measures and Miscellaneous Services Committee, and Ald. F. A. Gent, the Chairman of the Education Committee, for their support in obtaining the agreement of their respective Committees for implementing measures for improving the health of the people of Derbyshire ; (ii) the Clerk and Heads of Departments for their co-operation ; and (iii) all the members of my own Department for their assistance in trying to apply health principles, but not least Dr. Woodward, my Deputy, Mr. Gray, the Principal Dental Officer, the Senior Medical Officers, the Supervisors of Nursing and Health Visiting, the Ambulance Officer, the Public Health Inspector and the Chief Clerk.

I am,

Your obedient servant,

J. B. S. MORGAN,

County Medical Officer of Health.

County Offices,
Matlock.
(*Telephone No. Matlock* 3411)
4th *August*, 1960

MEDICAL AND DENTAL STAFF OF THE COUNTY HEALTH DEPARTMENT (31st DECEMBER, 1959)

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
ISABEL M. McCULLOUGH, L.R.C.P. & S.I., D.C.H., D.R.C.O.G.

SENIOR MEDICAL OFFICER FOR MENTAL HEALTH
MARGARET FYNNE, B.A., M.B., B.Ch., B.A.O., L.M., D.P.H.

SENIOR MEDICAL OFFICER FOR SCHOOL HEALTH AND HEALTH EDUCATION:
JULIA M. D. CORRIGAN, M.B., B.Ch., B.A.O., 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., B.A.O., D.P.H.
A. R. ROBERTSON, M.B., Ch.B., D.P.H.
F. D. F. STEEDE, M.B., B.Ch., B.A.O., D.P.H.
MARY SUTCLIFFE, M.A., M.B., B.Ch., D.P.H.
P. WEYMAN, L.R.C.P., L.R.C.S., L.R.F.P., & S., D.P.H.
C. G. WOOLGROVE, M.B., Ch.B., D.P.H.

MATERNAL AND CHILD WELFARE MEDICAL OFFICERS :
SUZANNE BURTON BLACKBURN, M.B., B.S., D.R.C.O.G.
ETHEL A. BLAKE, M.B., B.Ch., B.A.O., L.M., D.R.C.O.G.
CHRISTINA CATHERINE GLYNN, M.B., B.Ch., B.A.O., D.C.H.
DOROTHY M. JACKSON, M.B., Ch.B.

ASSISTANT MATERNAL AND CHILD WELFARE MEDICAL OFFICERS :
M. ALLAN, M.B., Ch.B., D.P.H.
FRANCES G. BRILL, B.A., M.B., B.Ch., B.A.O.
J. W. CRAWSHAW, M.B., Ch.B.
R. E. DEAN, L.R.C.P.S., L.R.F.P.S.
J. DUTHIE, M.B., Ch.B.
WINIFRED GOW, M.B., Ch.B.
ALISON M. HAMILTON, M.B., Ch.B., D.P.H.
TONIE FRANCES HAYNES, M.B., Ch.B.
H. JAMES, L.R.C.P., L.R.C.S., L.R.F.P.S.G., D.P.H. (Chesterfield B).
EMILY BRENDA JOHN, M.R.C.S., L.R.C.P., M.B., B.S.
MARGARETE KUTTNER, M.D.
JOAN B. M. LEITH, M.B., Ch.B., D.P.H. (Chesterfield B.)
D. R. McCAULLY, M.D., B.Ch., B.A.O., D.P.H.
MARGARET J. NETTLESHIP, M.B., Ch.B., D.P.H.
G. J. O'CONNOR, M.B., B.Ch., B.A.O.
G. STOREY, B.Sc., M.B., B.S., L.R.C.P., M.R.C.S.
TEISI URTSON, Med.-Dip., (University of Tartu)
MARY T. VASS, L.R.C.P.I., L.R.C.S.I., L.M.

DENTAL STAFF :

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

Dental Officers :
WILMA S. DRURY, L.D.S. (Part-time)
G. H. FREEMAN, (Dentist, 1921)
FLORA M. JACKSON, L.D.S. (Part-time)
DOROTHY LITTLAR, L.D.S. (Part-time)
ILSE B. MANN, L.D.S. (Part-time)
F. E. WELTON, L.D.S.
A. R. LITTLAR, L.D.S., (Senior Dental Officer, Chesterfield Borough)
ANNIE KEAN, L.D.S. (Chesterfield Borough).

BIRTH RATE, INFANT MORTALITY RATE AND DEATH RATE DURING THE LAST SIXTY-NINE YEARS.

Year		Birth Rate *per* 1,000 *of Population*	Infantile Mortality *per* 1,000 *Births*	Death Rate from all Causes *per* 1,000 *of Population*
1891 to 1900	WHOLE COUNTY	**33.7**	**147**	**17.1**
	England and Wales	29.9	153	18.3
1901 to 1910	WHOLE COUNTY	**28.5**	**126**	**14.1**
	England and Wales	27.1	128	15.3
1911 to 1920	WHOLE COUNTY	**24.07**	**99**	**12.66**
	England and Wales	21.90	100	13.85
1921 to 1930	WHOLE COUNTY	**19.73**	**70.7**	**10.92**
	England and Wales	18.36	71.7	12.14
1931 to 1940	WHOLE COUNTY	**15.71**	**56.7**	**11.31**
	England and Wales	14.93	58.6	12.26
1941 to 1950	WHOLE COUNTY	**18.25**	**41.99**	**10.94**
	England and Wales	17.02	42.88	11.72
1951	WHOLE COUNTY	**15.21**	**28.83**	**11.67**
	England and Wales	15.5	29.6	12.5
1952	WHOLE COUNTY	**15.21**	**29.64**	**10.56**
	England and Wales	15.3	27.6	11.3
1953	WHOLE COUNTY	**15.41**	**28.79**	**10.20**
	England and Wales	15.5	26.8	11.4
1954*	WHOLE COUNTY	**14.86**	**28.03**	**11.55**
	England and Wales	15.2	25.5	11.3
1955*	WHOLE COUNTY	**14.66**	**29.14**	**11.67**
	England and Wales	15.0	24.9	11.7
1956*	WHOLE COUNTY	**15.34**	**24.15**	**12.29**
	England and Wales	15.6	23.7	11.7
1957*	WHOLE COUNTY	**15.76**	**24.33**	**12.13**
	England and Wales	16.1	23.1	11.5
1958*	WHOLE COUNTY	**15.79**	**25.94**	**12.59**
	England and Wales	16.4	22.6	11.7
1959*	Urban Districts ..	15.01	24.09	12.42
	Rural Districts ..	16.88	22.68	12.05
	WHOLE COUNTY	**15.87**	**23.34**	**12.22**
	England and Wales	16.5†	22.0†	11.6†

* See remarks on pages 14–15. † Provisional.

REPORT ON THE HEALTH OF DERBYSHIRE FOR THE YEAR 1959

On 8th January, 1960, the Ministry of Health issued Circular 1/60, concerning "Annual Reports of Medical Officers of Health for 1959", The first paragraph of the circular reads as follows :—

> "1. I am directed by the Minister of Health to refer to Regulations 5 (3) and 15 (5) *of the Public Health Officers Regulations, 1959, and to ask that the Council will give directions for the preparation of the Annual Report of the Medical Officer of Health for the year 1959. The Regulations define the scope of the Annual Report and enable the Medical Officer of Health to comment on any matter which he thinks desirable in relation to the public health of his area. The Minister regards the report as an essential and valuable appraisal of the state of the public health in each area throughout the country. In addition to dealing with the main features of the year, including any subjects of special topical interest such as (in counties and county boroughs) the development of the authority's mental health services, it is requested that the report should cover the following matters . . ."

(The circular then gives particulars of certain points which should be covered in the annual report relating to vital statistics, midwifery, health education and so on).

Regulation 5 of the Public Health Officers Regulations, 1959, which is mentioned above, reads as follows :—

"MEDICAL OFFICERS OF HEALTH OF COUNTIES.

Duties.

5. A medical officer of health of a county shall, in respect of the county for which he is appointed, in addition to any other duties which may be assigned to him by the county council, carry out the following duties:—

(1) he shall inform himself as far as practicable respecting all matters affecting or likely to affect the public health in the county and be prepared to advise the county council on any such matter; and for this purpose he shall visit the several county districts in the county as occasion may require, giving to the medical officer of health of each county district prior notice of his visit, so far as this may be practicable;

(2) he shall perform all the duties imposed on a medical officer of health of a county by statute and by any orders, regulations or directions from time to time made or given by the Minister;

(3) he shall as soon as practicable after the 31st day of December in each year make an annual report to the county council for the year ending on that date on the sanitary circumstances, the sanitary administration and the vital statistics of the county, containing in addition to any other matters upon which he may consider it desirable to report, such information as may from time to time be required by the Minister, and furnish the Minister with as many copies of such report as the Minister may from time to time require;

(4) he shall furnish the Minister with one copy of any special report which he may make to the county council."

* (Regulation 15 (5), which is mentioned in the Ministry's circular, is applicable to Medical Officers of Health of District Councils).

AREA, POPULATION AND RATEABLE VALUE

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 1959 was as follows :—

Municipal Boroughs	139,340
Urban Districts	227,560
Rural Districts	365,900
Total Administrative County	732,800

The rateable value of the Administrative County in April, 1959, for the County Rate purposes was £8,034,192, and a penny rate over the whole County was estimated to produce the sum of £32,022.

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

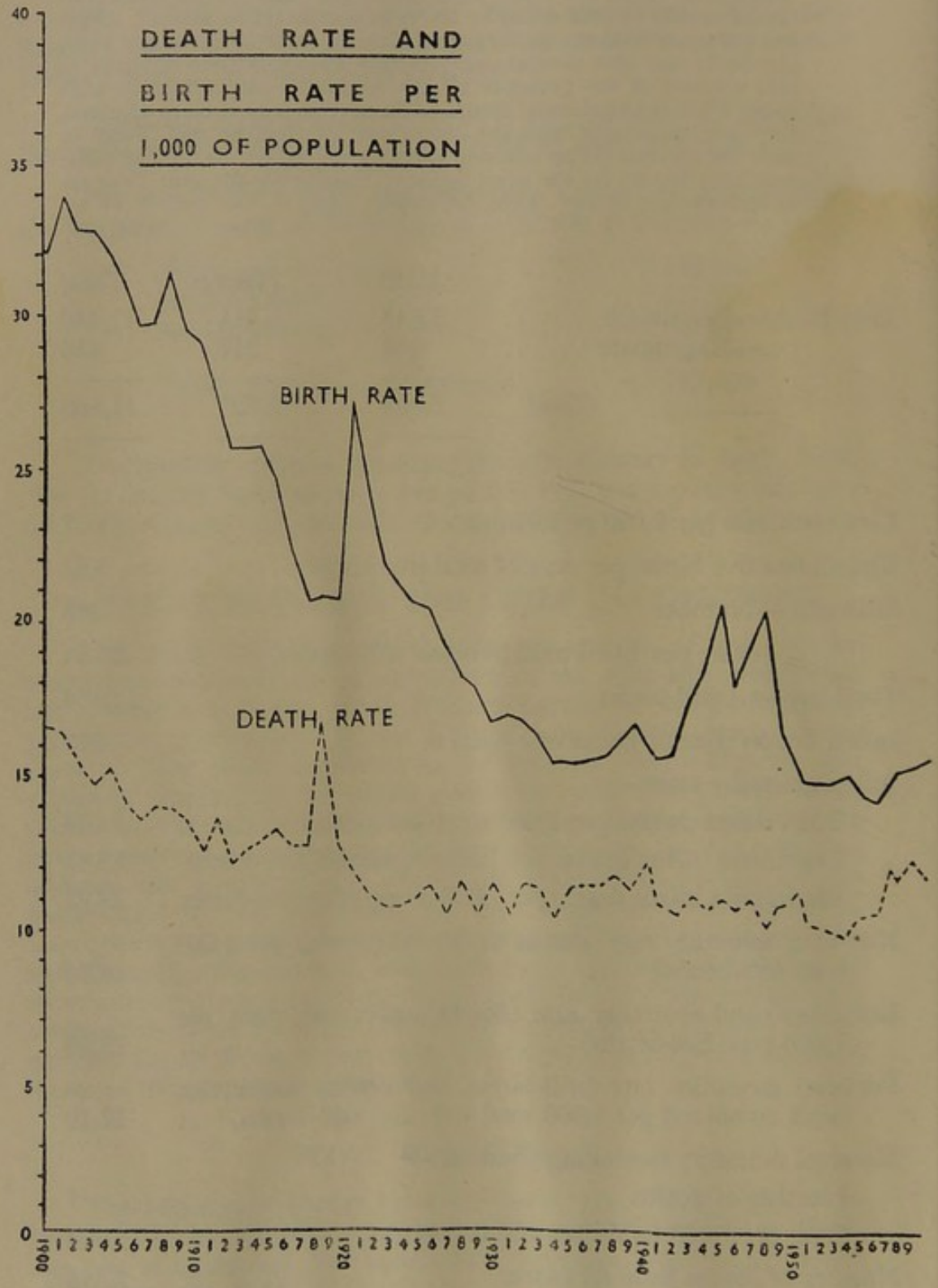
The Ministry of Health has asked for certain vital statistics to be presented in Annual Reports in a uniform manner, in order to facilitate ease of reference. The figures have therefore, been set out below on the lines suggested.

(NOTE: The birth and death rates for each County District and for the County as a whole for the years 1954 and onwards are not strictly comparable with previous years. The reason for this is that to make an approximate allowance for the way in which the sex and age dis-

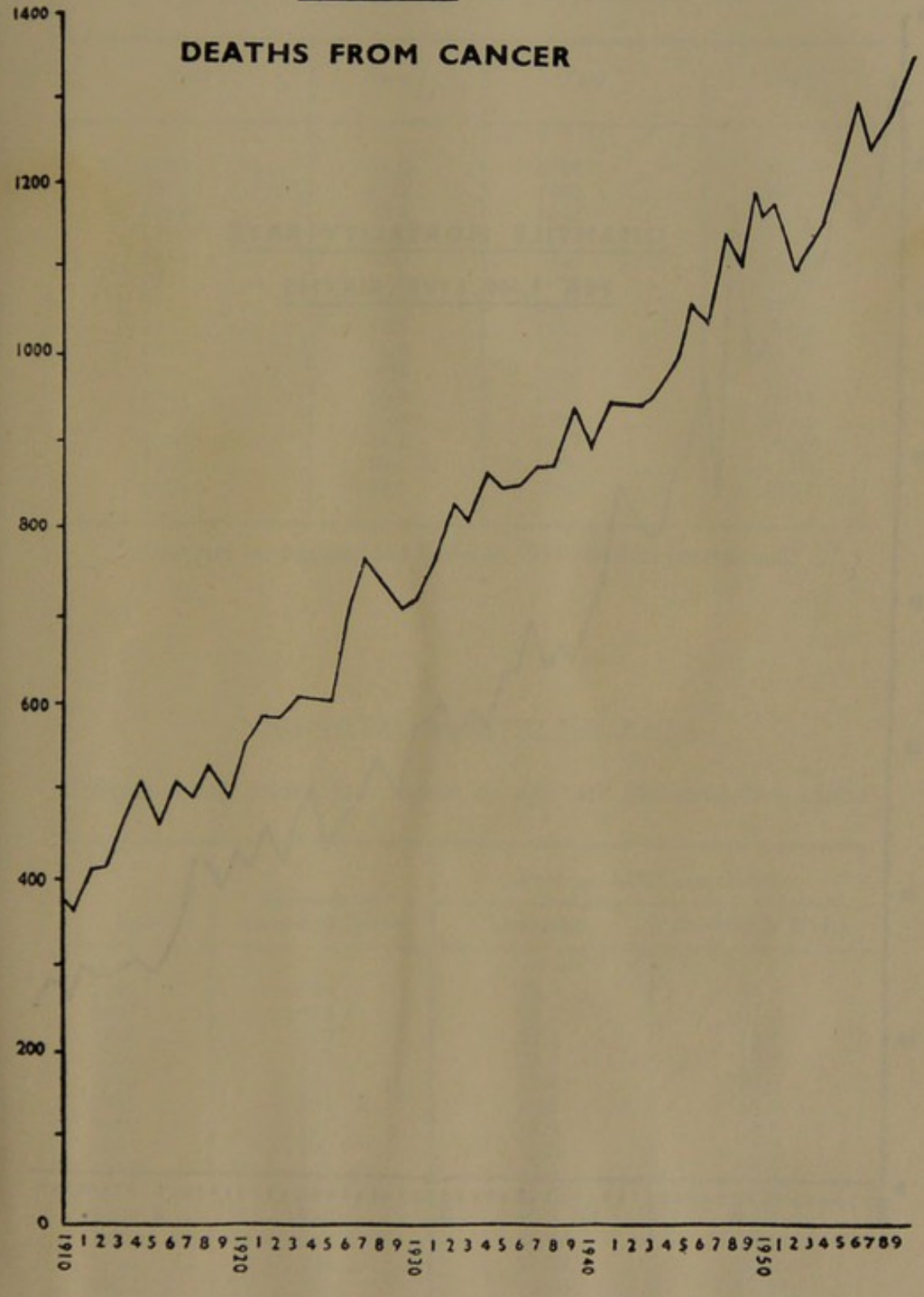
tribution of the local population differs from that for England and Wales as a whole, the crude birth and death rates for the areas concerned should be multiplied by an "area comparability factor", which has been provided by the Registrar-General since 1954. Since 1957, the death rate area comparability factors have also been adjusted to take account of the presence of any residential institutions in each area. When the 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 rates for any other area. The comparability factors for the administrative County for the year 1959 are as follows—for births: 0.98; for deaths 1.14.)

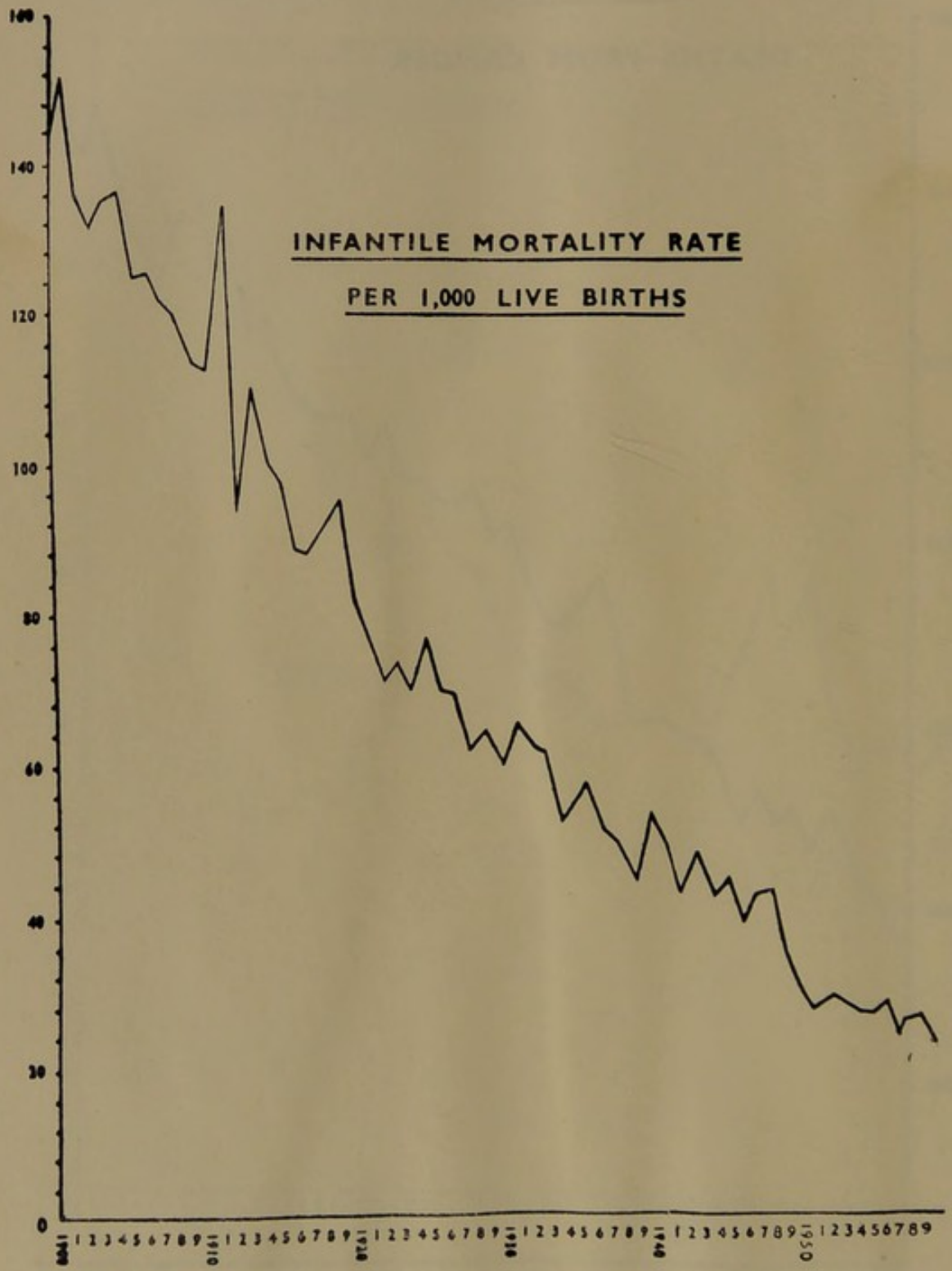
	Males	*Females*	*Total*
Live births—Legitimate ..	5,839	5,611	11,450
—Illegitimate ..	206	212	418
Total	6,045	5,823	11,868

Live birth rate per 1,000 population	15.87
Illegitimate live births per cent of total live births	3.52
Stillbirths—Number	286
—Rate per 1,000 total live-and still-births	23.54
Total live-and still-births	12,154
Infant deaths (deaths under one year)	277
Infant mortality rates—	
Total infant deaths per 1,000 total live-births	23.34
Legitimate infant deaths per 1,000 legitimate live-births	23.32
Illegitimate infant deaths per 1,000 illegitimate live-births	23.92
Neo-natal mortality rate (deaths under four weeks per 1,000 total live-births)	16.36
Early neo-natal mortality rate (deaths under one week per 1,000 total live-births)	13.99
Perinatal mortality rate (still-births and deaths under one week combined per 1,000 total live- and still-births) ..	37.19
Maternal mortality (including abortion)—	
Number of deaths	5
Rate per 1,000 total live- and still-births	0.4
Number of deaths from all causes	7,856
Death rate per 1,000 of the estimated population	12.22
Deaths from Cancer (all ages)	1,351
Death rate from Cancer	2.10


DEATH RATE AND
BIRTH RATE PER
1,000 OF POPULATION
BIRTH RATE
DEATH RATE
40
35
30
25
20
15
10
5
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 0 9 1950 1 2 3 4 5 6 7 8 9

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 7 8 9


INFANTILE MORTALITY RATE
PER 1,000 LIVE BIRTHS
160
140
120
100
80
60
40
20
0
1900
1910
1920
1930
1940
1950

INFANT MORTALITY RATE

(Infants dying under one year per thousand live births)

Year	*Rate*	*Year*	*Rate*
1930 ..	61.4	1945 ..	44.5
1931 ..	67.4	1946 ..	38.9
1932 ..	63.4	1947 ..	42.81
1933 ..	62.2	1948 ..	43.45
1934 ..	53.0	1949 ..	36.50
1935 ..	56.6	1950 ..	30.19
1936 ..	58.2	1951 ..	28.83
1937 ..	52.1	1952 ..	29.64
1938 ..	51.1	1953 ..	28.79
1939 ..	47.4	1954 ..	28.03
1940 ..	55.4	1955 ..	29.14
1941 ..	51.0	1956 ..	24.15
1942 ..	42.2	1957 ..	24.33
1943 ..	48.1	1958 ..	25.94
1944 ..	42.1	1959 ..	23.34

The rate for England and Wales in 1959 was 22.2 (provisional)

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	16.8
1957 ..	211	18.46	16.5
1958 ..	228	19.72	16.2
1959 ..	194	16.36	15.8*

* Provisional

EARLY NEO-NATAL MORTALITY RATE

(Infants dying under one week per 1,000 live births)

Number of early neo-natal deaths	166
Early neo-natal mortality rate	13.99

The following Table provides an analysis of the causes of death of the 194 children who died during 1959 under four weeks of age, as well as of the 166 children who died during 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 ..	15	21	36	11	15	26
Birth accidents	11	4	15	11	4	15
Infections	11	8	19	8	3	11
Asphyxia	5	9	14	5	9	14
Prematurity	39	34	73	39	32	71
Congenital Malformations and prematurity	2	2	4	1	2	3
Birth accidents & prematurity	3	2	5	3	2	5
Infections and prematurity ..	8	7	15	6	4	10
Haemolytic disease of New-born..	3	3	6	3	3	6
Other	5	2	7	4	1	5
Totals ..	102	92	194	91	75	166

Summary:—From the foregoing pages it can be seen that the infant mortality rate was 23.34 per 1,000, which represents 277 children who died under one year of age (compared with a rate of 22.2 (provisional) for England and Wales). Of the 277 children, 194 (70%) died within four weeks giving a neo-natal death rate of 16.36 per 1,000 (compared with 15.8 (provisional) for the country). Further, 166 of those infants (60%) died within the first week (giving an early neo-natal mortality rate of 13.99 per 1,000 live births.)

PERI-NATAL MORTALITY RATE

The peri-natal mortality rate (i.e, still-births and deaths under one week combined, per 1,000 total live and still-births), for 1959 was 37.19 (compared with a rate of 34.2 (provisional) for England and Wales).

The term "peri-natal mortality" is used to connote a combination of still-births with deaths occurring during the whole or part of the neo-natal period. It is hoped by this combination to avoid the fallacies which are liable to occur when the still-birth 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 peri-natal 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 has been suggested that probably the most useful combination is still-births plus deaths during the first week.

In the June, 1960 issue of the Monthly Bulletin of the Ministry of Health and the Public Health Laboratory Service appeared an article entitled, "A Study of Peri-natal Mortality" by Dr. Eileen M. Ring. In this article she advocated the following measures to reduce peri-natal mortality :—

> "Careful selection of women in the vulnerable groups for confinement in a consultant maternity unit so that all the resources of modern medicine are immediately available to them and their infants if required. Enough emergency beds should be kept for unforeseen social and obstetric emergencies including women in premature labour.
>
> Regular and thorough antenatal care as outlined in the Memorandum on Antenatal Care Related to Toxaemia. Prompt recognition and treatment of complications of pregnancy are of utmost importance and there should be enough antenatal beds available. Emphasis is laid on blood pressure, urine testing and weight recording to detect early toxaemia, and routine blood tests to recognise anaemia and rhesus incompatibility. Advice about diet should be available. Non-attenders at antenatal clinics should be assiduously followed up.
>
> Expert attention during labour and the skilful use of analgesics and anaesthetics are essential to reduce the incidence of birth injury and asphyxia.
>
> There should be good schemes for baby care in each area. Premature infants and sick mature infants suffering from birth injury, asphyxia, haemolytic disease of the newborn, should have the advantage of skilled care in special baby care units staffed by specially trained nurses under the direction of a consultant paediatrician.
>
> *Continuing Enquiry into the Causes of Perinatal Mortality.*
>
> Clinical conferences between hospital, local health authority staffs and family doctors are likely to be of value in pointing the way to preventive measures. A perinatal mortality enquiry carried out in 1958 by the National Birthday Trust Fund is expected to give valuable information about women who are at special risk of perinatal loss as a result of social environment, parity and abnormalities of pregnancy and labour.
>
> Further research is needed on:—
>
> Toxaemia of pregnancy which is probably the most frequent medical condition associated with perinatal mortality.
>
> Causes and prevention of premature labour.
>
> Congenital malformations especially the effects on the foetus of virus infections in pregnancy.
>
> Nutrition in pregnancy.
>
> Mechanism of respiration and the prevention of asphyxia and atelectasis."

INSPECTION AND SUPERVISION OF FOOD

MILK SUPPLY

Pasteurised Milk.

Twelve licences were issued to pasteurisers for the year 1959. The following is a list of establishments so licensed, showing the changes that took place during the year.

Name	*Address of Establishment*
W. Beswick* .. .. (Ceased to operate after 30.4.59).	South Street Dairy, Draycott.
Gisborne Dairy Ltd.	Manchester Rd., Chapel-en-le-Frith
The Hon. J. W. Hives .. .. .. (Ceased to operate after 30.9.59).	The Bendalls, Milton.
S. Hutchings & Sons Ltd.	Derby Road, Long Eaton.
Ilkeston Co-op. Society Ltd.	Derby Road, Ilkeston.
Mrs. E. M. Longdon .. .. .. (Ceased to operate after 31.3.59).	Buxton.
Long Eaton Co-op. Society Ltd. ..	Meadow Lane, Long Eaton.
R. B. Morten & Sons	The Creamery, Green Lane, Buxton
Pleasley Co-op. Society Ltd.	Pleasley.
Ripley Co-op. Society Ltd.	Nottingham Road, Ripley.
G. L. White .. .. (From 1.5.59).	South Street Dairy, Draycott.
Wilts United Dairies Ltd.	Eggington, Derby.
F. Wheldon	94 Breedon Street, Long Eaton.

* (This business was transferred to G. L. White on 1/5/59).

During the year two pasteurisers ceased to operate, Mrs. E. M. Longdon, Buxton, and J. W. Hives, the Bendalls, Milton. The latter had an "in-bottle" pasteurisation plant, quite uncommon in this country, and this seems to be a suitable opportunity to comment on the loss of a very interesting and unique plant.

With automatic time/temperature control coupled to a locking bar preventing removal of milk before time, the plant was almost "fool-proof" and yet very simple to use. The processed milk had extra-ordinary keeping quality and, at the same time, kept a good cream line, an important factor in the milk trade. Such plants as these are eminently suitable for use abroad, in places where labour and other standards require a simple but safe means of pasteurising raw milk.

The County Health Inspector made 165 inspections at pasteurising establishments and submitted 216 samples of milk for examination. Sample results are summarised below :—

Grade of Milk	*Satisfactory*		*Unsatisfactory*		*Total number of samples submitted*
	M.B.	*Phos.*	*M.B.*	Phos.	
Tuberculin Tested (Pasteurised)	58	87	—	—	87
Pasteurised	84	129	—	1	129

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

(*b*) Nineteen samples of Tuberculin Tested (Pasteurised) Milk and forty-five samples of Pasteurised Milk were not subjected to the Methylene Blue Test as the atmospheric shade temperature exceeded 65°F. at the time of testing.

The one phosphatase test failure was attributed to under-temperature pasteurisation, in a holder plant. Thirty-nine samples were examined for the presence of chlorates, none being detected in any of the samples. The overall sampling record can, therefore, be considered satisfactory.

It is now ten years since the 1949 Regulations transferred control of pasteurising and sterilising establishments from district councils to Food and Drugs authorities. It may be of interest to review here the changes that have taken place in that time.

Several practical improvements have been brought into effect as the result of legislation. The more important ones are :—

(1) The use of over-lapping bottle caps has been made compulsory.

(2) The bottling of pasteurised milk on premises other than those on which it had been processed has been prohibited.

(3) In a much wider enactment the Specified Area legislation, starting in 1952, has brought about far reaching developments in the milk trade itself and in the sale and distribution of designated milks to the people of this country.

From a technical point of view, there has been constant progress in the improvment of all branches of the dairy plant industry. The modern bottle washing machine has proved itself to be efficient, reliable and suprisingly long lasting; a life of fifteen to twenty years is common for these machines. The bottle filling and capping machines have gradually been "streamlined," rendering them much more reliable and easier to maintain, and noise has been almost overcome in

some of the latest models Mechanical handling of bottles and crates has been developed to a remarkable extent, particularly to the benefit of the high gallonage processers. The holder-type pasteurising plant is gradually disappearing from the scene, although there are still a number of them in use in small dairies. The high-temperature short-time pasteurising plant has become completely established, and although the basic design has changed little over the last ten years the appearance has been considerably enhanced by full use of stainless steel and improved instrument panelling. It would appear that little more can be done to improve the notable reliability of the H.T.S.T. plants in use today. The replacement of brine cooling by chilled water cooling has helped in the prevention of plant corrosion.

Cleansing, and sterilizing of plants has become more scientific. The custom has gradually become established for the greater use of chemicals particularly acids, and the list of Ministry approved oxidising agents grows longer, almost month by month. One of the latest improvements is known as "in-place" cleansing of certain parts of the plant, particularly storage tanks. The operation cuts manual labour to the minimum. In fact, one of the problems of the dairy industry over the last ten years—an adequate and efficient labour force—is gradually being overcome by the use of such mechanical aids as this.

What of the future? It seems that the H.T.S.T. process as we now know it is likely to be with us for the forseeable future, but appearing on the horizon is ultra-high temperature processing. The final product from this process is a substitute for sterilized milk rather than for pasteurised milk, but it may well eventually offer serious competition to the latter, particularly in big towns and cities. One of the major problems of the dairy trade is the present necessity for a seven-day week. A long keeping quality milk, such as may be obtained by the ultra high temperature method, may well be one way of solving this problem.

As far as containers are concerned there is little evidence that cartons have yet done more than touch the fringe of the pasteurised milk market, as there are trade problems bound up with the introduction of cartons on a large scale. It is encouraging to see that a start is being made in one or two parts of the country with a supply of school drinking milk in 1/3 pint cartons. The next ten years should certainly see an increasing use of the carton for household milk supplies, although progress is likely to be slow.

With regard to the raw milk being produced for pasteurisation, it may be of interest to mention at this point that the whole of the administrative County was included in a much larger area which was the subject of the *Tuberculosis (Central England Eradication Area) Order*, 1960, which came into operation on 1st March, 1960. This County is now, therefore, fully covered by legislation which is designed to prevent the introduction and spread of bovine tuberculosis. It is reasonable to assume, therefore, that in the future the supplies of raw milk to the pasteurising dairies will be of an increasingly higher standard as the remaining ungraded herds are changed to Tuberculin Tested.

As far as Derbyshire itself is concerned a review of some statistics for the ten year period just completed may be of interest.

For the year 1950, 20 pasteurising establishments were licensed by the County Council, as the Food and Drugs authority. By the end of 1959 the number licensed had dropped to 10. There has been a steady decline approximately at the rate of one per year. Three new pasteurisers were licensed during the period but all gave up processing later.

Of the original 20 plants, no less than 15 were of the holder type; of the three additional plants two were holder plants and the other an "in-bottle" plant. The remainder were, of course, H.T.S.T. plants. Conversions from holder to H.T.S.T. were carried out in three establishments during the ten-year period. The present position is therefore, that there are 10 pasteurisers in the area, 7 with H.T.S.T. plants and 3 with holder plants.

The gallonage of milk pasteurised has decreased with the lesser number of plants in use. In 1950, it was approximately 20,000 gallons per day; at the end of 1959 it was approximately 15,000 gallons per day. There have, however, been some steady increases in individual dairy figures, the most noticeable one being at Dairy A, the output from which rose from 170 to nearly 1,600 gallons per day over the 10 years. Dairy B increased its ouput from 3,000 to 4,150 gallons per day in spite of strong competition in the area. On the other hand one or two of the very small dairies remained at practically the same figure for the whole period. As has been mentioned before in these Reports, a number inevitably succumbed to pressure from the combines and either sold out or undertook the purchase of milk already pasteurised.

Sampling figures are also likely to be of interest. Over the whole ten years a total of 3,156 samples have been taken and examined for the statutory tests (apart from the occasions on which the atmospheric shade exceeded 65°F. when the methylene blue test was not carried out). Of these 15 failed the methylene blue test and 56 the phosphatase test. The overall percentage of phosphatase test failures is therefore 1.77. However, note the percentage for the five years 1950/54—2.50, and that for the last five years 1955/59—0.06. Indeed, one of the satisfactory features of the period has been the decline in the annual number of failures, following the transfer. The following summary shows this clearly :—

	Samples	
	Satisfactory	*Unsatisfactory*
1950	347	23
1951	362	11
1952	398	12
1953	411	8
1954	351	7
1955	367	2
1956	316	2
1957	179	2
1958	153	3
1959	216	1

The phosphatase test failures came from the following types of plant :—

H.T.S.T. ..	5
Holder	50
In bottle ..	1

The surprising thing about these figures is not the number of holder failures but those from H.T.S.T. plants—0.9% of the total. However, it is known that one of the five failures was the result of the mixture of properly pasteurised milk and raw milk in a storage tank. The "in-bottle" failure was due entirely to the human element—a bottle of raw milk was wrongly capped as pasteurised and not put through the plant at all.

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 S.E. Derbyshire 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 Swadlicote. S.E. Derbyshire Rural District (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.
The Rural District of Clowne.	10th April, 1956.
The Urban Districts of New Mills and Whaley Bridge.	1st October, 1956.
The Borough of Glossop.	6th April, 1959.

It is estimated that approximately seven-tenths of the population of the administrative County area is now covered by specified areas extending over approximately a third of the acreage.

COUNTY DISTRICT COUNCILS' AREAS

LOCAL GOVERNMENT ACT, 1958.

Delegation of Functions.

Under the provisions of Section 26 of the Local Government Act, 1958, the councils of any borough or urban district with a population of 60,000 or more are entitled to make a scheme for the delegation of certain health and welfare functions; further, county district councils who are not automatically entitled to make a delegation scheme may apply to the Minister of Health for his consent to do so and the Minister may consult the County Council on the application.

The functions to be included in a delegation scheme, insofar as the County Council's Health Services are concerned, are as follows:—

(*a*) Under Part III of the National Health Service Act, 1946 (as amended by the Mental Health Act, 1959)—health centres; care of mothers and young children; midwifery; health visiting; home nursing; vaccination and immunisation; prevention of illness and after-care (apart from the care or after-care in residential accommodation of persons suffering from mental illness, and domestic help.);

(*b*) The registration and regulation of private day nurseries and child minders (under the Nurseries and Child Minders' Regulation Act, 1948).

The only county district council in the administrative county of Derbyshire entitled automatically to make a scheme of delegation is the Municipal Borough of Chesterfield, and they have given notice of their intention to make a scheme.

Three other district councils (Blackwell, Chesterfield, and South-East Derbyshire Rural District Councils) applied to the Minister for consent to make delegation schemes. In so far as rural districts are concerned, the Minister may only give his consent if he is satisfied after consultation with the County Council that there are "special circumstances" by reason of which a rural district council ought to be allowed to make a scheme. The Minister may not give his consent in any other case. After considering the factors mentioned in the district councils' applications, as well as the County Council's observations, the Minister informed the three district councils that he was satisfied that the factors they mentioned could not be regarded as special circumstances by reason of which they ought to be allowed to make a delegation scheme, and therefore, he was unable to consent to their applications.

The Chesterfield Borough Council also applied to the Minister for the delegation of the County Councils' functions under Section 28 of the National Health Service Act (as amended by the Mental Health Act, 1959) so far as they relate to the care or after-care in residential accommodation of persons suffering from mental illness. The Minister can give his consent to the inclusion of these additional functions in a scheme of delegation only if he is satisfied after consultation with the County Council that there are "exceptional circumstances" justifying the exercise of the functions by the borough council The Minister came to the conclusion that no exceptional circumstances exist in the Borough of Chesterfield to justify the delegation of these additional functions.

It is open to the borough and district councils to apply again for the Minister's consent in 1968, or at an earlier date if the area of the borough or rural district is altered or their circumstances are otherwise affected by an order of the Minister of Housing and Local Government made in pursuance of a review by the Local Government Commission for England or by the County Council under the provisions of Section 28 of the Local Government Act, 1958.

LOCAL GOVERNMENT ACT, 1933 (SECTION 111).

The County Council's Scheme under Section 111 of the Local Government Act, 1933, for the appointment of District Medical Officers of Health who are restricted from engaging in private practice, which was made after consultations with the District Councils, involves the division of the County into ten groups. In many instances arrangements have been made whereby the District Medical Officer of Health also serves the County Council as an Assistant County Medical Officer/ School Medical Officer. The following table shows the position as at 31st December, 1959 :—

Area No.	*County Districts*	*Population*	*Whether Section 111 scheme is operative*	*Proportion of time of Medical Officer devoted to*	
				District Council work	*County Council work*
1	Clay Cross Urban ..	10,010	Yes	Whole-time	None
	Dronfield Urban ..	10,170			
	Staveley Urban ..	17,420			
	Chesterfield Rural ..	95,620			
		133,220			
2	Bolsover Urban ..	11,720	Yes	8/11ths.	3/11ths.*
	Blackwell Rural ..	43,600			
	Clowne Rural ..	19,390			
		74,710			
3	Glossop Borough ..	17,400	Yes	9/22nds.	13/22nds*
	New Mills Urban ..	8,490			
		25,890			
4	Buxton Borough ..	19,350	Yes	7/11ths.	4/11ths.*
	Whaley Bridge Urban	5,270			
	Chapel-en-le-Frith Rural	18,490			
		43,110			
5	Bakewell Urban ..	3,560	No.	Part-time.	None
	Matlock Urban ..	18,420			
	Bakewell Rural ..	18,670			
		40,650			
6	Long Eaton Urban	31,120	Yes	7/11ths	4/11ths*
	S.E. Derbyshire Rural	90,950			
		122,070			
7	Swadlincote Urban ..	19,640	Yes	8/11ths	3/11ths*
	Repton Rural ..	37,460			
		57,100			
8	Ilkeston Borough ..	35,060	Yes	8/11ths	3/11ths*
	Alfreton Urban ..	23,480			
	Heanor Urban ..	23,990			
	Ripley Urban ..	17,980			
		100,510			
9	Ashbourne Urban ..	5,510	In operation apart from Wirksworth Urban District	6/11ths	5/11ths*
	Belper Urban ..	15,800			
	Wirksworth Urban ..	4,980			
	Ashbourne Rural ..	11,720			
	Belper Rural ..	30,000			
		68,010			
10	Chesterfield Borough	67,530	Yes	52%	48%†

*Indicates that the Medical Officer of Health also acts as an Assistant County Medical Officer/School Medical Officer.

†Indicates that the Medical Officer of Health also acts as the Area Medical Officer

COUNTY OF DERBY. Yea

TABLE GIVING BIRTH RATES AND DEATH RATES FROM SEVERAL CAUSES

SANITARY DISTRICTS	MEDICAL OFFICER OF HEALTH	Area in Acres (Land and Water).	POP Census 1931
(URBAN)			
ALFRETON	P. Weyman, L.R.C.P., L.R.C.S., L.R.F.P. & S., D.P.H.	5,176	22,262
ASHBOURNE	W. J. Morrissey, M.B., B.Ch., B.A.O., 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., B.A.O., D.P.H.	4,294	14,205
BOLSOVER	A. R. Robertson, M.B., Ch.B., D.P.H.	4,526	9,808
BUXTON (Borough)	F. D. F. Steede, M.B., B.Ch., B.A.O., 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	P. Weyman, L.R.C.P., L.R.C.S., L.R.F.P. & S., D.P.H.	4,417	22,482
ILKESTON (Borough)	P. Weyman, L.R.C.P., L.R.C.S., L.R.F.P. & S., 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	P. Weyman, L.R.C.P., L.R.C.S., L.R.F.P. & S., 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	F. D. F. Steede, M.B., B.Ch., B.A.O., D.P.H.	3,479	4,860
WIRKSWORTH	W. S. G. Christie, M.B., Ch.B. ..	4,016	4,855
TOTALS OF URBAN DISTRICTS ..		98,065	340,291
(RURAL)			
ASHBOURNE	W. J. Morrissey, M.B., B.Ch., B.A.O., 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., B.A.O., D.P.H.	47,074	23,106
BLACKWELL	A. R. Robertson, M.B., Ch.B., D.P.H.	21,668	44,689
CHAPEL-EN-LE-FRITH ..	F. D. F. Steede, M.B., B.Ch., B.A.O., 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
S.E. DERBYSHIRE	C. G. Woolgrove, M.B., Ch.B., D.P.H.	44,204	41,097
TOTALS OF RURAL DISTRICTS ..		537,391	267,400
TOTALS OF URBAN DISTRICTS ..		98,065	340,291
TOTALS OF WHOLE COUNTY ..		635,456	607,691

* Adjusted to make allowance for sex and

Ended December 31st, 1959.

IN EACH OF THE SANITARY DISTRICTS OF THE COUNTY.

ULATION		Births (Live)	Deaths	*Rate per 1,000 of Estimated Population**		Infant Death Rate per 1,000 Births	*Comparability Factors*	
Census 1951	Estimated Mid-1959			Birth Rate	Death Rate		for Births	for Deaths
23,385	23,480	353	252	14.59	12.67	34.0	0.97	1.18
5,439	5,510	69	64	12.90	10.80	—	1.03	0.93
3,356	3,560	41	79	12.09	11.33	—	1.05	0.51
15,714	15,800	220	242	13.78	11.65	31.82	0.99	0.76
10,871	11,720	235	100	20.51	11.18	42.55	1.00	1.31
19,568	19,350	332	253	17.84	12.03	18.07	1.04	0.92
68,558	67,530	990	853	14.09	13.14	27.27	0.96	1.04
8,553	10,010	128	85	11.89	10.45	23.44	0.93	1.23
7,627	10,170	201	108	17.40	14.02	4.97	0.88	1.32
18,004	17,400	286	249	16.93	12.17	17.48	1.03	0.85
24,406	23,990	375	231	15.33	11.94	18.67	0.98	1.24
33,677	35,060	515	317	14.54	11.57	17.48	0.99	1.28
28,641	31,120	482	322	15.33	11.89	26.97	0.99	1.15
17,756	18,420	245	203	13.57	10.92	32.65	1.02	0.99
8,475	8,490	136	124	15.48	14.46	22.06	1.06	0.99
18,192	17,980	257	199	14.29	12.73	23.35	1.00	1.15
17,945	17,420	288	162	16.21	12.46	24.31	0.98	1.34
20,907	19,640	256	218	12.91	12.99	27.35	0.99	1.17
5,365	5,270	66	63	12.90	12.43	30.03	1.03	1.04
4,893	4,980	88	58	18.21	11.99	11.36	1.03	1.03
361,278	366,900	5,563	4,182	15.01	12.42	24.09	0.99	1.09
12,019	11,720	157	123	14.87	11.45	12.74	1.11	1.09
19,282	18,670	243	245	14.31	11.94	41.15	1.10	0.91
28,193	30,000	454	337	15.89	11.46	22.03	1.05	1.02
43,112	43,600	803	429	17.87	14.15	26.15	0.97	1.26
19,006	18,490	263	247	15.82	12.83	26.62	1.12	0.96
75,745	95,620	1,774	851	18.07	12.19	16.91	0.93	1.37
19,072	19,390	329	206	17.14	12.53	30.40	1.01	1.18
31,570	37,460	594	420	16.17	11.77	37.04	1.02	1.05
75,893	90,950	1,688	816	18.92	14.25	18.36	0.93	1.27
323,892	365,900	6,305	3,674	16.88	12.05	22.68	0.98	1.20
361,278	366,900	5,563	4,182	15.01	12.42	24.09	0.99	1.09
685,170	732,800	11,868	7,856	15.87	12.22	23.34	0.98	1.14

age distribution of population, etc.—see remarks on pages 14—15.

GENERAL SANITARY ADMINISTRATION

Estimated number of houses :—

Municipal Boroughs and Urban Districts	120,364
Rural Districts	119,308
	239,672

	Municipal Boroughs and Urban Districts			*Rural Districts*		
	No. on Register	*Increase or Decrease during 1959*	*Inspections made*	*No. on Register*	*Increase or Decrease during 1959*	*Inspections made*
Bakehouses	162	—12	467	48	—9	74
Canal Boats	—	—	—	—	—	—
Common Lodging Houses ..	3	—	82	—	—	—
Dairies	99	—26	524	64	+1	27
Factories and Workplaces ..	2,021	+61	2,748	887	—34	593
Houses Let in Lodgings ..	6	—	8	—	—	—
Ice Cream Premises—						
(*a*) Manufacturers	27	—3	154	14	—2	33
(*b*) Dealers	1,433	+48	1,102	1,172	+83	508
Market Stalls	492	+15	5,754	25	—	951
Milk Distributors	489	+22	524	511	+18	320
Moveable Dwellings—						
(*a*) Sites	70	—3	225	77	—6	188
(*b*) Dwellings	415	+59	600	847	+55	1,746
Offensive Trades	17	—	27	3	—	8
Outworkers	689	—79	106	275	—41	241
Preserved Food Stores ..	526	—5	1,765	210	+3	903
Shops	5,213	—7	4,206	3,477	—32	2,569
Slaughterhouses—						
(*a*) Public Abbattoirs ..	1	—	764	—	—	—
(*b*) Private	84	—2	9,716	90	—3	11,082
Knackers Yards..	3	—	37	9	—	24

Water Supplies

No schemes of water supply have been submitted to the Rural Water Supplies and Sewerage Act Sub-Committee of the County Council during the year.

The following table summarises the information regarding water supplies in the county. It shows that 99.6% of the population of the Boroughs and Urban Districts has a mains water supply available, whilst the corresponding figure for the Rural Districts is approximately 94.4%.

	Municipal Boroughs and Urban Districts		*Rural Districts*	
		Estimated Population Involved		*Estimated Population Involved*
No. of Houses:				
(*a*) Connected to mains	119,873	365,261	112,670	345,631
(*b*) Supplied from standpipes on mains	118	356	264	899
(*c*) not supplied from standpipes or mains	430	1,255	2,690	8,366
No. of Connections made during year:				
(i) existing houses	16	110	95	297
(ii) new houses	1,696	—	3,245	—
(iii) other premises	56	—	97	—

Sewerage and Sewage Disposal.

Information is given below of the position in the County with regard to sewerage and sewage disposal. Boroughs and Urban Districts have 97.2% of their houses connected to sewers, whilst Rural Districts have a corresponding figure of approximately 87%. It is clear that a number of additional schemes are required in some of the Rural Districts before the position can be said to be satisfactory.

	Municipal Boroughs and Urban Districts		*Rural Districts*	
		Estimated Population Involved		*Estimated Population Involved*
No. of Houses:				
(*a*) connected to sewers	117,176	356,750	103,562	318,474
(*b*) not connected to sewers ..	3,152	9,956	11,994	36,292
No. of connections made during year:				
(i) existing houses	34	88	301	688
(ii) new houses	1,560	—	3,274	—
(iii) other premises	33	—	20	—
No. of conversions of other closets to W.C.s	118	—	330	—

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

Authority submitting Scheme	Parish	Estimated Cost
Bakewell R.D.C.	Baslow and Bubnell plus seven other parishes	£378,717
Blackwell R.D.C.	Ault Hucknall (Astwith village) ..	£4,445

Housing.

There are some interesting figures in the following Table on Housing. With regard to Slum Clearance, it seems clear that there has not been the progress made which was anticipated when the first five year programme was submitted to the Minister. A total of 2,902 houses have been demolished or closed, out of the original estimate of 6,628. The slowing down in the rate of Council house building in the last year or so has obviously influenced the speed with which rehousing of families from condemned properties can be carried out.

Following the House Purchase and Housing Act, 1959, which required local authorities to make "standard" grants for certain improvement works there has been a considerable impetus in the number made—1,157 in 1959 as against a total of 4,641 for the five years 1955-59.

SLUM CLEARANCE FOR FIVE YEARS FROM 1955

	Estimated No. of unfit Houses at 1955	*Estimated No. of houses to be demolished in first five years*	*Total No. of Houses Demolished or closed*		*No. of families rehoused during* 1959 *in Council owned dwellings*
			1959	1955-59	
Municipal Boroughs & Urban Districts	5,244	3,525	545	1,962	480
Rural Districts	5,462	3,103	630	940	836

IMPROVEMENT GRANTS

	No. approved during 1959	*Total No. approved since* 1949
Municipal Boroughs & Urban Districts..	596	2,260
Rural Districts	561	2,381

NEW HOUSING

	No. of new dwellings completed during 1959	
	by local authorities	*by private enterprise*
Municipal Boroughs & Urban Districts . .	626	988
Rural Districts	1,755	1,484

Swimming Baths.

The following Table shows the number of swimming baths in the County, and the results of the investigations of the samples taken.

	No. of Baths		*Samples taken*	
	Public	*Private (Open to Public)*	*Satisfactory*	*Unsatisfactory*
Municipal Boroughs & Urban Districts	12	5	112	33
Rural Districts	2	3	10	1

Refuse Collection and Disposal.

The position in the Administrative County area with regard to refuse collection is that all authorities except one carry it out by direct labour. Ilkeston Borough employ contractors for this work. There are a total of 75 tips in use. It is claimed that 43 of them are fully "controlled", 16 are said to be "partly controlled" and 16 "uncontrolled". Although the difficulty of recruiting labour for this type of work is very real at present, much can be done with mechanical aids, bonus schemes etc.

	Collection		*Disposal*		
	Direct Labour	*Contract*	*No. of Controlled Tips*	*No. of Uncontrolled Tips*	*Incinerators*
Municipal Boroughs & Urban Districts	19	1	22	5	2
Rural Districts	9	—	34	14	—

Prevention of Atmospheric Pollution.

County district councils now have considerable powers under the provisions of the Clean Air Act, 1956, to control atmospheric pollution. Such provisions can be broadly divided into two parts, viz :—

(*a*) general regulatory powers;
(*b*) power to establish smoke control areas.

District Councils may also make bye-laws requiring new buildings to have satisfactory arrangements for heating and cooking so as to prevent the emission of smoke.

Many Authorities in the County are taking an active interest in this vital matter. In particular, many are maintaining recording apparatus and taking regular readings, The following are some examples of such records, which may be of general interest.

Station	*Readings*			
	Total Solids (Tons per sq. mile)		*Sulphur Absorbed (Mg. per 100 sq. cms. per day)*	
	Monthly		*Daily average over each month*	
	Highest	*Lowest*	*Highest month*	*Lowest month*
Alfreton U.D.C.				
High Street, Alfreton	23.24	6.78	1.69	0.52
Bolsover U.D.C.				
Woodhouse Lane, Bolsover ..	19.74	8.54	—	—
Moor Lane, Bolsover	16.01	10.17	2.59	0.69
Cundy Road, Bolsover	—	—	2.47	0.87
Chesterfield Borough				
Queens Park	16.48	7.30	1.83	0.44
St. John's Road Depot	17.49	10.05	3.04	0.68
Sewage Works	18.99	9.85	2.64	0.79
Glossop Borough				
Average monthly deposit over 12 months 6.8 tons per sq. mile.				
Heanor U.D.C.				
Langley Mill	12.32	4.24	—	—
Staveley U.D.C.				
Hartington Colliery	25.28	14.75	5.22	1.58
Staveley Works	30.48	12.81	—	—
Barrow Hill	27.65	13.37	—	—
Swadlincote U.D.C.				
Average monthly deposit over six months 15.37 tons per sq. mile.				
Average sulphur determination over six months 2.01 mg per day.				

Generally speaking, authorities are seeking to improve the position by informal action, particularly as far as industrial undertakings are concerned.

With regard to smoke control areas only two authorities appear to have taken definite steps. Chesterfield Borough reports as follows :—

"During the year the Borough Council have submitted proposals to the Ministry to establish two Smoke Control Areas in the Borough, and preliminary approval has been given to these proposals.

The Areas comprise a Central Area of 90 acres containing some 637 premises, and a residential estate of 428 acres containing approximately 1,300 premises. The final survey in respect of the Central Area has now been completed and the order is being submitted to the Minister for approval".

A smoke control area at Holymoorside, put forward by Chesterfield R.D.C. and the subject of a public enquiry, was not confirmed by the Ministry.

Milk Sampling.

There were 18 failures of raw milk to the methylene blue test, out of a total of 120 samples. On the other hand, the 252 pasteurised milk samples showed only 3 such failures. There were two phosphatase test failures out of 347 samples examined.

It is gratifying to note that there were only 2 positive T.B. samples as a result of biological examinations carried out on 197 samples. Both were from T.T milk.

	Raw Milk		*Heat-treated Milks*					
			Pasteurised				*Sterilised*	
	Meth. Blue Test		*Meth. Blue Test*		*Phos. Test*		*Turbidity Test*	
	Sat.	*Unsat.*	*Sat.*	*Unsat.*	*Sat.*	*Unsat.*	*Sat.*	*Unsat.*
Municipal Boroughs & Urban Districts ..	83	16	202	—	268	2	22	—
Rural Districts	19	2	47	3	77	—	5	—

	Biological Examinations			
	No. examined for tubercle	*No. Positive*	*No. examined for B. Abortus*	*No. Positive*
Municipal Boroughs & Urban Districts—				
(*a*) Tuberculin-Tested ..	132	2	9	—
(*b*) Ungraded	30	—	1	—
Rural Districts—				
(*a*) Tuberculin-Tested ..	30	—	9	2
(*b*) Ungraded	5	—	5	—

Ice Cream Sampling.

The Boroughs and Urban Districts carry out ice cream sampling fairly consistently, but the Rural Districts not nearly to the same extent. It should be realised, perhaps, that most ice cream sold to-day is from one or other of the big manufacturers and that most retailers have good storage facilities. It is not suprising, therefore, that 83% of the samples examined fell into Grades 1 and 2.

	No. of Samples Taken	*No. in provisional grade**			
		1	2	3	4
Municipal Boroughs & Urban Districts	437†	269	103	33	18
Rural Districts	120	68	32	17	3

* The appendix to Ministry of Health Circular 8/59 gave advice on tests for practical cleanliness of ice cream. The following is the "recommended provisional grading based on the methylene blue reduction test, in which readings are taken half-hourly":—

Provisional grade	*Time taken to reduce methylene blue*
1	fails to reduce in 4 hours.
2	2½-4 hours.
3	½-2 hours.
4	0.

† The test was not carried out on 14 samples.

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 1959 there were 181 Midwives on the County Roll—six were Midwives working in private Nursing Homes; seventy-nine were Midwives working in Regional Hospital Board Hospitals and Maternity Homes; and sixty-eight were County Midwives and twenty-eight were County Home Nurse/Midwives.

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

	1954	1955	1956	1957	1958	1959
Records received:—						
Medical Help	432	433	411	352	738	751*
Stillbirths	135	119	118	129	137	114
Deaths of Children	56	68	54	71	67	55
Deaths of Mothers	4	1	2	1	2	–
Laying out the dead	17	13	27	15	15	20
Liability to be a source of infection	66	30	44	46	42	45
Notification of Artificial Feeding (within 14 days)	474	610	623	741	874	898
Puerperal Pyrexia—Midwives' Cases	22	15	10	13	7	6
Ophthalmia Neonatorum—all cases	3	6	4	5	3	3

* It will be seen that since 1958 there has been a substantial increase in the records received for Medical Help. It is thought that this is accounted for by the following circular letter which was sent by me on 31st January, 1958, to all Midwives practising in the administrative County:—

Dear Madam,

On receiving the Midf. 2 Return Forms for 1957 it has become apparent that there is some misunderstanding of the requirements of Section 14 of the Midwives Act, 1951 relating to Medical Aid.

Midwives either in domiciliary practice or in institutions which do not have resident medical officers are statutorily required to complete a form calling in medical aid in any emergency. (See Rules 14 and 38 of Section E of the Central Midwives Board Rules). One copy of this form is kept by the nurse, one copy given to the General Practitioner and one copy sent to the Local Health Authority in each instance. This rule applies even in "Booked" cases where the General Practitioner has accepted responsibility to provide Maternity Medical Services.

This rule is largely formulated to protect the midwife and it is hoped that the appropriate forms will be filled in in all cases of emergency."

It will be observed from the above Table that there has been an increasing number of notifications of artificial feeding. In this connection your attention is drawn to a statement by Sir Truby King, the great New Zealand doctor who did so much to influence world opinion on the standards of child care: "The most loving act a mother can do is to nurse her child".

PUERPERAL PYREXIA

The Puerperal Pyrexia Regulations, 1951, require puerperal pyrexia to be regarded as a notifiable disease. Puerperal Pyrexia is 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.

Year	*No. of cases of Puerperal Pyrexia*	*No. of Live Births and Still Births in Whole County*	*Case rate per 1,000 Births*
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
1957 ..	21	11,721	1.79
1958 ..	18	11,861	1.52
1959 ..	20	12,154	1.64

MATERNAL MORTALITY

The maternal mortality rate for the whole County for the year 1959 was 0.41 per thousand live- and still-births. The following Table gives the maternal mortality rate in the County since 1940. (The figures up to and including the year 1947 exclude the Borough of Chesterfield).

Year	*Rate*	*Year*	*Rate*
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
1947	1.11	1957	0.51
1948	0.72	1958	0.51
1949	1.01	1959	0.41

(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. 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 1959 and the results of treatment are set out in the following Table :—

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

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

Year	*No. of Cases*	*Vision Unimpaired*	*Vision Impaired*	*Total Blindness*	*No. of Deaths*
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	–	–	–
1957	5	5	–	–	–
1958	3	3	–	–	–
1959	3	3	–	–	–

* 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, 1959 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.
Derby House Nursing Home, Broad Walk, Buxton	31 Medical Cases.
Ednaston Lodge, St. Mary's Nursing Home, Ednaston	20 Medical and Surgical Cases.
Borrowash House, Borrowash, Derby. ..	17 Unmarried Mothers.

TUBERCULOSIS

New Cases and Deaths.—The decline in the incidence of tuberculosis has continued during 1959 when the number of new cases and deaths reported were the lowest recorded. The disease became notifiable in 1912 and the first available figures for the new cases and deaths are those for 1914. The following Table shows the numbers for that year, and thereafter at ten-yearly intervals to 1954, and finally the figures for 1959 :—

TUBERCULOSIS

	Respiratory		*Non-Respiratory*	
	New Cases	*Deaths*	*New Cases*	*Deaths*
1914	867	383	362	156
1924	829	359	338	117
1934	442	243	202	74
1944	432	202	163	43
1954	391	80	62	12
1959	267	34	40	5

These figures show the great progress which has been made in the campaign against the disease. Improved methods of treatment which were introduced largely after the end of World War II have been of great value, particularly in reducing the number of deaths. No doubt through the influence of the National Health Service Act greater emphasis has in latter years been given to health matters, and there is a tendency for people to seek medical advice earlier than previously. Furthermore, through the agency of mass radiography, cases of tuberculosis have been discovered at an earlier stage of the disease when treatment can be more beneficial.

In previous Annual Reports attention has been drawn to the number of cases of pulmonary tuberculosis occurring in the older age groups in males and in 1959 half the male cases reported occurred in the age groups forty-five and over whilst in females in the same age groups the number is about a quarter of the total cases.

SUMMARY OF NEW CASES REPORTED FROM 1948 UNTIL 1959 INCLUSIVE

	1948	1949	1950	1951	1952	1953	1954	1955	1956	1957	1958	1959
Respiratory												
Males	251	295	246	294	276	253	238	204	195	212	209	184
Females ..	157	196	180	170	212	169	153	110	126	119	105	83
Total ..	408	491	426	464	488	422	391	314	321	331	314	267
Non-Respiratory												
Males ..	62	52	49	36	32	23	30	34	23	25	18	12
Females ..	56	49	39	47	49	34	32	34	28	31	34	28
Totals ..	118	101	88	83	81	57	62	68	51	56	52	40
Total Pul. and Non-Pul. ..	529	592	514	547	569	479	453	382	372	387	366	307

New cases of tuberculosis during 1959 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	–	2	5	6	2	9	12	25	31	31	38	14	9	184
Females.. ..	–	–	–	4	3	9	13	21	10	12	8	3	–	83
Non-respiratory—														
Males	–	–	1	2	1	2	2	3	–	1	–	–	–	12
Females.. ..	–	–	3	3	1	1	1	9	3	2	3	1	1	28
Total ..	–	2	9	15	7	21	28	58	44	46	49	18	10	307

Deaths from Tuberculosis.

The following Table gives details for the last five years :—

	1955	1956	1957	1958	1959
Respiratory	74	51	51	46	34
Non-respiratory	10	6	5	5	5
	84	57	56	51	39

The death rate per 1,000 of the population during each of the last five years is as follows :—

	1955	1956	1957	1958	1959
Respiratory	0.11	0.08	0.07	0.06	0.046
Non-Respiratory	0.02	0.01	0.01	0.01	0.007
	0.13	0.09	0.08	0.07	0.053

The provisional figure for England and Wales supplied by the Registrar General for 1959 is 0.085 deaths per thousand of the home population.

The Table below shows the notifications and deaths in Derbyshire for the last twelve years.

Year	*New Cases*	*Deaths*
1948	513	243
1949	592	205
1950	514	172
1951	547	142
1952	569	122
1953	479	125
1954	453	92
1955	382	84
1956	372	57
1957	387	56
1958	366	51
1959	307	39

On the 8th June, 1960, the Ministry of Health issued Circular 10/60, in which it commended a report prepared by the Standing Tuberculosis Advisory Committee on the "Future of the Chest Services", particularly in regard to the probable future trends in tuberculosis. In view of the responsibility of local authorities for certain aspects of tuberculosis the report is quoted at length below. Attention is drawn particularly to the effects of B.C.G. vaccination in paragraph three and the importance of the preventive side of tuberculosis work in paragraph nine.

"CENTRAL HEALTH SERVICES COUNCIL

Standing Tuberculosis Advisory Committee
The Future of the Chest Services

1. The integrated system of chest clinics, hospitals and sanatoria throughout the country which, together with the preventive services of the local health authorities, is now usually known as the Chest Services developed from the Tuberculosis Service. The probable future trends of tuberculosis are therfore an important factor to be taken into account in considering the future of the Chest Services.

2. The available statistics of recent years are given in the accompanying tables. Table I shows the notification rates for respiratory tuberculosis per 100,000 of the population for England and Wales 1948–58 by age and sex. In both males and females the 0–4 and 5–14 age groups show a diminishing notification rate since 1950. The highest notification rates have hitherto been in

the 15–24 age group. Logan and Benjamin in the G.R.O. Study, Number 10, on Tuberculosis Statistics state that, since the young adult is most vulnerable to pulmonary tuberculosis, the notification rate at age 15–24 has been and probably still is a sensitive index of the contemporary balance of forces of infection and resistance in the community. In this age group, especially in females, the notification rate is falling steeply and has been since 1950–51. It would be reasonable to suggest that some of this rapid improvement may be due to the introduction of chemotherapy, which from that time has been bringing many cases under control more quickly than before and reducing their period of infectivity.

3. Since 1953, B.C.G. vaccination of school children at the age of 13 has been official policy and gradually increasing numbers of school children have been vaccinated. The scheme now includes all school-leavers. It is too early for this programme of vaccination to have made a substantial difference to the notification rates of the 15–24 year olds, but we expect it to play a larger part in the near future. The number and proportion of school children of age 13 giving a positive reaction to the tuberculin test are declining.

The percentage of school children reacting to the test at the age of 13 varies widely in different parts of the country, as will be seen from Table V. The national figures are as follows :—

1955	..	23.6	1956	..	22.5
1957	..	19.8	1958	..	17.7

In the meantime the annual number of vaccinations among school children is increasing. In 1958 it rose to 241,434 and the total of vaccinations among school children under the scheme reached 819,000 by the end of 1958. In 1958 however, less than half of the 13 year olds received the preliminary tuberculin test under the scheme. On April 30th, 1959, the scheme was extended to include older students; this should increase the total number vaccinated. The heavy demands on local authorities made by the early stages of the poliomyelitis vaccination scheme have made it difficult for some of them to proceed as vigorously as was hoped with B.C.G. vaccination. But as the more immediate demands of the poliomyelitis scheme are met it should be possible to make a concerted effort to increase the percentage of B.C.G. vaccinated school-leavers. As these children join the 15—20 and 20–25 year age groups the rate of decline in respiratory tuberculosis should increase.

4. The decline in the notifications of respiratory tuberculosis since 1948 in the different age groups is shown in Tables II and III. Those born in the 1950's have had far fewer natural infections with tuberculosis than those born in previous decades, and those developing active disease since 1948 have had the advantage of the more effective treatment which anti-bacterial drugs offer. It is reasonable to assume that fewer silent infections, some of which could break down at later ages, have occurred within the past decade. There should therefore be fewer cases of tuberculosis in the 25–45 age group in the next ten to twenty years—an improvement which may be expected to accelerate with the passage of time.

Another measure of the infector pool is the notifications of tuberculosis of the meninges and C.N.S. Table IV gives these in the different age groups for the last five years and confirms the other evidence of its rapid reduction.

5. A quantitative forecast from the various figures mentioned above might prove to be wide of the mark. The possibility of the persistence of a certain level of tuberculosis as a result of drug resistant organisms, or even a secondary epidemic of drug resistant tuberculosis, cannot be excluded, and the level of tuberculosis among older men will probably fall more slowly than that among young adults because it is to a greater extent the result of breakdown of old infection. It will be seen from

Table III that, whereas notifications in males under 45 have been approximately halved in the last ten years, there has been almost no decrease among males over 45. The extent to which the older men are still likely to break down with respiratory tuberculosis, or have relapses, will of course vary widely in different areas. Thus special provision for tuberculosis will need to be maintained in the foreseeable future, the extent of that provision varying from area to area.

6. Uncertainty about the future of the specialty of diseases of the chest, including tuberculosis, is effectively limiting the recruitment of able men to it.

In the past the chest physician's work has been predominantly among tuberculous patients and his experience was principally in tuberculosis. With the steady decline in the number of cases of tuberculosis, non-tuberculous diseases of the chest have constituted an increasing proportion of the work of the chest physicians. The problems presented require a broad knowledge of general medicine and the physician who has to deal with them not only must by background and training be able to cope with them, but should not be left to work in isolation. If a physician is to deal with these problems efficiently he requires the resources of a general hospital at his side.

The chest physician should, therefore, be a member of the staff of a general hospital, since it is clear that, even if tuberculosis declines still further, physicians with specialised knowledge of diseases of the chest will still be needed. In this way, he will be able to give his colleagues the benefit of his special knowledge and receive the benefit of theirs. It is not envisaged that every patient with symptoms referable to the chest should go to the chest physician, any more than that every patient with symptoms referable to the heart should go to the cardiologist. But just as the cardiologist, the neurologist and other specialists are ready to give their advice on particular problems in their own specialty, so should the chest physician be available to bring his particular knowledge to any cases of respiratory disease upon which his colleagues may consult him.

7. In the meantime, as long as tuberculosis continues, the management of tuberculous patients should remain a primary duty of the chest physician. At the present stage of the epidemic of tuberculosis it is of course more important than ever before that the chest physician should work closely with the Medical Officer of Health on the epidemiological and preventive implications which may arise. The end of the endemic prevalence of tuberculosis in our community can now be seen as an attainable objective, although it may still be many years ahead.

8. For these reasons the normal pattern for the future should be that appointments in chest diseases should be to the staffs of general hospitals, the chest clinic becoming integrated into the general out-patient department of the hospital and sharing the general services of the department. Only if some such policy as this is adopted will young doctors considering their future careers see in diseases of the chest the prospect of continuing work during their lifetime, even though the decline in tuberculosis continues.

Moreover, not only the chest physicians but the training grades of registrar and senior registrar should be appointed to hospitals, not merely to chest clinics, and where possible to general hospitals. The work of the trainee grades should be closely integrated with the general medical work of the hospital, and these grades should never work only in chest clinics, though their work should include adequate experience of preventive work in tuberculosis.

The role of the general practitioner in the prevention and treatment of tuberculosis will be increasingly important. The teaching of medical students on tuberculosis and the provision of facilities for post-graduate study will therefore remain of first importance. Similarly, instruction in the problems of tuberculosis will continue to be important in the training of nurses and health visitors.

9. The importance of the preventive aspects of tuberculosis work will continue even though the incidence of tuberculosis as a clinical problem continues to diminish. Indeed, with the increase in the proportion of the population who have never been exposed to natural infection, it is more important than ever that all new cases should be notified, so that steps can be taken to prevent the spread of the disease. The Medical Officer of Health has a statutory duty as regards prevention of disease and he is responsible for a wide range of preventive and social services. In the provision of some of these services he and the chest physician collaborate. These services can be divided into two broad groups, (1) to the tuberculous patient and his family, and (2) to the community.

(1) The chest physician, with the social worker and health visitor, works with the general practitioner to meet the varied medical, personal and economic needs of patients and their families and the problems which frequently occur during the illness and follow-up period. The methods developed in chest clinics to make available social help for the tuberculous are already being applied where appropriate to the other respiratory diseases treated. They should be maintained when the chest clinic is integrated with the general hospital.

(2) The chest physician is in contact with the public health service in the personal preventive aspects of his work, e.g. examination of contacts and application of after-care services. Services to the community, such as B.C.G. vaccination of school-leavers and general preventive measures, are the direct province of the Medical Officer of Health. The amount of work requiring to be done in connection with these public health measures is likely to remain comparatively unchanged for a long time. Careful epidemiological study of each new case, especially in childhood, and attention to groups at special risk, such as middle-aged men, will become of increasing importance as the incidence of clinical cases diminishes. The familiar aspects of preventive work will diminish with the diminishing incidence of tuberculosis, but will need to be maintained in quality and uniformity.

10. Until new hospitals are built or extensions are made to existing out-patient departments some chest clinics will continue to function outside the general hospital. Nevertheless, in planning new out-patient departments provision should be made for a chest unit. In any new hospital, beds should be available for diseases of the chest, and some of these, with appropriate safeguards against cross-infection, should be set aside for cases of tuberculosis; in existing general hospitals such provision should be made where practicable. Where it is not, existing sanatoria and chest hospitals which are suitable by reason of siting and present facilities could be used as chest departments of nearby hospitals or run in close association with them. Since the chest physician relies to a considerable extent on the services of the radiological department adequate provision for his special needs must be made within that department. The aim should be the close integration of the chest clinic into the out-patient department, sharing the various services and amenities of the department as do other specialties. This would provide the chest physician with the full range of hospital out-patient services and give to patients the amenities of the general out-patient department, subject only to measures to prevent spread of infection, and nurses working in the chest unit would no longer be separated from their colleagues and could obtain combined training at the general and chest units.

11. The recommendations and conclusions in this memorandum substantially agree with those made by the Joint Tuberculosis Council in their Report on the Future Service for Tuberculosis and Disease of the Chest published in October, 1958."

TABLE I

Respiratory Tuberculosis: Notification rates per 100,000 population, by sex and age, England and Wales, 1948–1958

	All Ages		0–	5–	15–	25–	35–	45–	65 and over
	E. & W.	Derbyshire							
Males									
1948	117	75	44	51	215	161	117	139	64
1949	119	87	46	49	180	159	122	146	68
1950	111	72	53	49	159	154	107	135	67
1951	115	86	53	48	170	156	117	141	72
1952	112	81	52	51	165	147	116	135	77
1953	110	73	49	49	155	133	114	139	85
1954	100	68	41	40	143	125	106	126	82
1955	92	58	36	34	125	110	96	121	81
1956	88	55	29	28	115	101	92	121	87
1957	82	59	26	23	99	97	90	114	87
1958	76	58	26	21	88	86	80	108	85
1959		50							
Females									
1948	86	47	46	58	244	151	68	35	17
1949	85	58	44	53	238	155	71	35	17
1950	82	53	43	52	238	152	69	31	16
1951	81	49	50	52	229	149	68	33	16
1952	80	62	49	53	216	148	71	35	16
1953	77	49	45	52	201	141	73	34	18
1954	68	44	37	44	187	124	63	30	17
1955	60	31	35	38	156	112	59	30	17
1956	55	35	30	21	139	101	57	29	18
1957	49	33	30	27	116	90	55	29	17
1958	43	29	25	24	97	79	46	27	16
1959		23							

The Derbyshire figures for all ages have been inserted for purposes of comparision. It is not possible to provide figures for the age groups separately.

Table II

Respiratory Tuberculosis: Number of Notifications, by sex and age, England and Wales and Derbyshire, 1952–1958

England & Wales	*All Ages*	0–	5–	10–	15–	20–	25–	35–	45–	55–	65–	75–
Males												
1952	23,711	926	926	706	2,053	2,424	4,643	3,750	3,870	2,882	1,313	218
1953	23,342	849	904	708	1,878	2,365	4,268	3,588	4,054	3,024	1,431	273
1954	21,376	698	742	611	1,727	2,168	4,057	3,211	3,693	2,809	1,388	272
1955	19,641	610	632	543	1,586	1,825	3,469	2,975	3,440	2,912	1,349	300
1956	18,801	490	528	453	1,345	1,807	3,093	2,870	3,434	3,012	1,455	314
1957	17,562	447	401	414	1,141	1,541	2,694	2,798	3,165	2,904	1,430	357
1958	16,420	443	356	376	1,002	1,481	2,566	2,500	2,942	2,986	1,401	366
Females												
1952	18,193	840	804	833	2,694	3,440	4,762	2,358	1,294	693	370	107
1953	17,575	741	805	840	2,512	3,183	4,577	2,378	1,262	737	422	118
1954	15,597	607	643	772	2,372	2,888	4,077	1,977	1,096	650	399	116
1955	13,939	556	591	665	2,044	2,337	3,545	1,892	1,150	629	403	127
1956	12,541	453	479	554	1,713	2,116	3,143	1,832	1,031	676	399	145
1957	11,308	484	428	483	1,415	1,770	2,731	1,785	1,041	636	393	142
1958	9,971	415	391	439	1,174	1,554	2,356	1,498	996	627	386	134
Derbyshire												
Males												
1952	276	11	9	15	20	23	52	40	44	35	20	7
1953	253	10	7	4	24	29	39	40	47	30	21	2
1954	238	7	15	9	13	28	51	33	35	24	19	4
1955	197	8	9	4	8	18	44	33	33	26	14	—
1956	195	4	11	3	6	14	35	41	33	29	17	2
1957	212	6	6	6	14	16	33	30	32	32	31	6
1958	209	7	4	8	15	13	26	36	30	42	20	8
Females												
1952	212	10	20	5	27	36	66	19	15	4	9	1
1953	169	10	9	6	19	28	49	23	9	10	6	—
1954	153	9	12	7	19	22	39	24	11	6	2	2
1955	106	4	4	5	8	19	28	13	12	9	3	1
1956	126	1	6	10	13	17	34	25	9	5	4	2
1957	119	3	7	5	13	20	23	25	13	5	3	2
1958	105	5	1	7	13	13	29	17	5	8	6	1

TABLE III

Respiratory Tuberculosis: Numbers of Notifications, by sex and age, England and Wales and Derbyshire, 1948 and 1958

Year	0–		15–		25–		45 *and over*		*All ages*	
England & Wales	*Male*	*Female*	*Male*	*Female*	*Male*	*Female*	*Male*	*Female*	*Male*	*Female*
1948	2,297	2,422	5,417	7,158	9,235	7,328	7,763	2,351	24,712	19,259
1958	1,175	1,245	2,483	2,728	5,066	3,854	7,695	2,143	16,420	9,971
Derbyshire										
1948	17	16	49	56	87	62	98	23	251	157
1958	19	13	28	26	62	46	100	20	209	105

Percentage Decline in Notification in Ten Years 1948–58

0–14 *years*		15–24 *years*		25–44 *years*		45– *years*	
Male	*Female*	*Male*	*Female*	*Male*	*Female*	*Male*	*Female*
49	49	54	62	45	47	1	9

It will be seen from the Table on page 48 that 1948 is not a particularly good year to choose for a comparision in Derbyshire.

Page 48 shows the true overall picture.

TABLE IV

Tuberculosis of Meninges and C.N.S.: Numbers of Notifications, by sex and age, England and Wales, 1954–58

Age	1954		1955		1956		1957		1958	
	Male	*Female*	*Male*	*Female*	*Male*	*Female*	*Male*	*Female*	*Male*	*Female*
All ages ..	326	366	248	284	219	214	150	177	129	133
0– ..	104	108	78	77	67	42	41	58	40	37
5– ..	115	106	86	96	71	77	44	49	32	34
15– ..	54	80	36	58	35	53	33	34	27	20
25– ..	32	48	30	34	28	27	15	28	14	26
45– ..	20	15	13	14	16	12	13	6	12	11
65 and over ..	1	8	3	3	1	3	4	1	3	4
Unknown ..	—	1	2	2	1	—	—	1	1	1

TABLE V

Proportion of 13–year old children reacting to the tuberculin test, 1958

(Figures taken from Local Health Authorities' returns to M.R.C. Tuberculosis Research Unit)

	Number of L.H.A's.
Less than 10 per cent positive	11
10–15 per cent positive..	31
15–20 per cent positive..	34
20–25 per cent positive..	21
More than 25 per cent positive	16
No tests in 1958	27
No returns for 1958	5
TOTAL	145

NATIONAL HEALTH SERVICE ACT, 1946

CARE OF MOTHERS AND YOUNG CHILDREN (Section 22)

ANTE-NATAL SCHEME

Twenty-four Ante-Natal Clinics are maintained by the Authority: seven in Municipal Boroughs, twelve in Urban Districts and five in Rural Districts. Twenty-three 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.

The Area Health Sub-Committee for Chesterfield, which is responsible to the County Health Committee for the day-to-day administration of the County Council's Health Service in the Borough, conducted two Ante-natal Clinics, namely at Scarsdale Hospital and at a Clinic in Edmund Street.

Details of the Ante-natal Clinics conducted to serve the remainder of the administrative County are as follows :—

ALFRETON ..	County Council Clinic, Grange Street, Alfreton. Each Friday, 9 a.m. to 12.30 p.m. and 1.30 p.m. to 4.15 p.m.
ASHBOURNE ..	Ante-Natal Clinic, St. Oswald's Hospital, Ashbourne. Each Thursday, 9 a.m. to 12.30 p.m. and 1.30 p.m. to 4.15 p.m.
BELPER	County Council Clinic, The Cedars, Field Lane, Belper. 1st and 3rd Mondays, 9 a.m. to 12.30 p.m.
BOLSOVER ..	County Council Clinic, Welbeck Road, Bolsover. Each Friday, 1.30 p.m. to 4.15 p.m.
BUXTON	Child Welfare Centre, Bridge Street, Buxton. 1st and 3rd Tuesdays, 9 a.m. to 12.30 p.m.
CHESTERFIELD	Derbyshire County Council Clinic, Scarsdale Hospital. Each Wednesday, 9 a.m. to 12.30 p.m. and 1.30 p.m. to 4.15 p.m.
CLAY CROSS ..	County Council Clinic, High Street, Clay Cross. Each Friday, 9 a.m. to 12.30 p.m.
CLOWNE	County Council Clinic, Cresswell Road, Clowne. Each Wednesday, 9 a.m. to 12.30 p.m. and 2nd, 4th and 5th Thursday, 9 a.m. to 12.30 p.m.
DERBY	County Council Clinic, Cathedral Road, Derby. Each Tuesday, 9 a.m. to 12.30 p.m.
DRONFIELD ..	County Council Clinic, The Grange, Dronfield. Each Monday, 9 a.m. to 12.30 p.m.

ECKINGTON ..	County Council Clinic, Gosber Street, Eckington. Each Tuesday, 9 a.m. to 12.30 p.m.
FRECHEVILLE ..	County Council Clinic, Fox Lane, Frecheville. 1st, 3rd and 5th Mondays, 9 a.m. to 12.30 p.m.
GLOSSOP ..	Municipal Buildings, Glossop. 2nd and 4th Mondays, 9 a.m. to 12.30 p.m.
HACKENTHORPE	County Council Clinic, Main Road, Hackenthorpe. 2nd, 4th and 5th Thursdays, 1.30 p.m. to 4.15 p.m.
HEANOR	County Council Clinic, Wilmot Street, Heanor. 1st and 3rd Wednesdays, 1.30 p.m. to 4.15 p.m.
ILKESTON ..	County Council Clinic, Albert Street, Ilkeston. 2nd and 4th Monday, 2 p.m. to 4.15 p.m. and each Thursday, 9 a.m. to 12.30 p.m.
LONG EATON ..	County Council Clinic, 4 Nottingham Road, Long Eaton. Each Wednesday, 9 a.m. to 12.30 p.m. and 1.30 p.m. to 4.15 p.m.
MATLOCK ..	County Council Clinic, Dean Hill House, Causeway Lane, Matlock. 1st and 3rd Thursdays, 9 a.m. to 12.30 p.m.
RIPLEY*	County Council Clinic, Derby Road, Ripley. 2nd and 4th Fridays, 1.30 p.m. to 4.15 p.m.
SHIREBROOK ..	County Council Clinic, Cliff House, Church Drive, Shirebrook. Each Monday, 9 a.m. to 12.30 p.m.
STAVELEY ..	County Council Clinic, Lime Avenue, Staveley. 2nd and 4th Thursdays, 9 a.m. to 12.30 p.m. and 1.30 p.m. to 4.15 p.m.
SWADLINCOTE	County Council Clinic, Alexandra Road, Swadlincote. 2nd and 4th Tuesdays, 9 a.m. to 12.30 p.m.

* On 1st January, 1960, a new County Council Clinic was opened in Ripley (in Derby Road) and the ante-natal clinic which was previously conducted at Ripley Cottage Hospital transferred to the new premises.

The following are the number of sessions and attendances at these Clinics during 1959 :—

Half-day Sessions	1,320
Number of New Cases	2,924
Total number of attendances ..	13,248
Post-Natal visits	555

Valuable work in health education has been carried out by the Health Visitors and Midwives at the Ante-Natal Clinics. The Health Visitor speaks to the patients singly or in groups whilst the Midwife is with the Doctor.

Relaxation classes have been held at Alfreton, Clay Cross, Clowne, Derby, Dronfield, Hackenthorpe, Ilkeston, Long Eaton, Shirebrook, Swadlincote and Heanor during 1959. These classes have proved of great value to the expectant mothers and are also a means of promoting good mental health and allaying the fear of child birth. Many aspects of child care are discussed, and visual aids (such as film strips) are used Ten Midwives attended a Mothercraft and Relaxation Course in 1959. There is now a total of nineteen midwives trained in Mothercraft and Relaxation.

Routine X-Ray Examinations of Expectant Mothers.

A communication from the Sheffield Regional Hospital Board in July, 1959 intimated that, following consideration of the Interim Report of the Adrian Committee on radiological hazards to patients, the routine x-raying of expectant mothers at the Mass Miniature Radiography Centres would be discontinued. The Board recommended that revised arrangements should be made for the routine x-ray of these patients, using full size films with stringent limitation of field size. The routine X-raying of expectant mothers has, therefore, been discontinued.

Ante-Natal Care related to Toxaemia.

All Medical Officers conducting ante-natal clinics have received a copy of the Memorandum on ante-natal care related to Toxaemia and every effort has been made to implement the suggestions made in this Memorandum.

Supervision.—The importance of regular ante-natal care is impressed on all patients attending the ante-natal clinics. They are asked to attend every month up to the 30th week, every fortnight from 30th-36th week and every week, where possible, from the 36th -40th week. It is, however, difficult to evolve a "pattern of supervision" as many patients transfer to hospital ante-natal care if and when their application for a hospital bed is accepted.

Examination.—A routine medical examination is carried out at the patient's first visit to the Clinic. Any abnormalities detected at these preliminary examinations are referred to the patient's General Practitioner or, with his approval, to the appropriate hospital Consultant. The blood pressure is recorded, the patient weighed and the urine tested at all subsequent visits. Midwives are asked to visit any patient requiring close observation during the interval between their attendances at the clinic.

Blood Testing.—All Medical Officers have been supplied with Sahli Haemoglobinometers so that haemoglobin estimations may be made. Ferrous sulphate and Ferrous Gluconate tablets are supplied at the clinic. Patients not responding to these tablets are referred to their own doctor for alternative treatment. A sample of blood is taken from all patients whose blood group has not already been typed. These samples are sent to the Sheffield Regional Blood Transfusion Service who report on the blood group, Rh. factor and Kahn test in each case. Tests for antibodies are also carried out at 32nd—34th weeks on all Rh. negative patients when requested by the Regional Blood Transfusion Service.

Ante-Natal Records.—Each patient attending the clinic receives a card on which is recorded a copy of the findings at each examination. The patient keeps this card in an envelope together with her appointment card and particulars of her blood group. She is instructed to bring this envelope with her when attending for ante-natal examination whether at the General Practitioner's surgery or at hospital.

Follow-up Failures.—Cases who fail to attend the ante-natal clinic on the appointed day are followed up either by letter or by the domiciliary midwife. It is not possible to evolve a water-tight system as the local authority are not informed when patients are transferred to hospital for ante-natal care or are admitted to hospital or a maternity home for their confinement.

Mothercraft and Relaxation Classes.

Classes are now held at the following County Council Clinics :—

Alfreton; Buxton; Clay Cross; Clowne; Derby; Dronfield; Eckington; Glossop; Hackenthorpe; Heanor; Ilkeston; Long Eaton; Matlock; Shirebrook and Swadlincote.

There has been an increased demand from mothers wishing to attend. The Health Visitor and Midwife who conduct the classes limit the numbers according to the accommodation available and they also feel that they make more personal contact by talking to small groups of patients. Most of the mothers who attend are expecting their first baby but other mothers are encouraged to come particularly if they are unduly apprehensive.

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 appropriate Bed Bureau.

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 :—

	Bed Derby	*Bureaux Chesterfield*	*Other Hospitals*
Suitable for home confinement	43	73	8
Hospital accommodation desirable but not essential	255	184	56
Home conditions unsuitable and hospital confinement necessary	640	736	144
Miscellaneous visits (i.e. cancellations, miscarriages, removals from district, etc.) ..	39	78	6

CHILD WELFARE CENTRES

During 1959 two new Infant Welfare Centres were opened in the County, namely, at Breadsall and Eyam, bringing the total to ninety-seven.

The number of sessions and attendances at the County Council's Infant Welfare Centres during 1959 are set out below :—

Half-day sessions	4,379
Number of new cases under one year of age	8,949
Number of children who attended during the year and who were born in :—	
1959	7,089
1958	5,724
1957-54	4,745
Total number of children who attended during the year	17,558
Number of attendances by children who, at the date of attendance, were :—	
Under one year	98,064
One but under two	20,700
Two but under five	11,921
Total attendances during the year	130,685

CARE OF PREMATURE INFANTS

(i.e., Babies weighing 5½lbs. 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 1959 are set out below :—

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

(a)	In Hospital	561
(b)	At Home..	234
(c)	In Private Nursing Homes	25
	Total..	820

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

(a)	In Hospital	110
(b)	At Home..	26
(c)	In Private Nursing Homes	5
	Total	141

Of the 561 premature babies who were born in hospital fifty-seven died within twenty-four hours of birth and 471 survived twenty-eight days.

Of the 234 born at home, sixty-one were transferred to hospital on or before the twenty-eighth day, and of the remainder six died within twenty-four hours of birth and 161 survived twenty-eight days.

Of the twenty-five born in Private Nursing Homes twenty-one 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.

Southern part of the County.

Miss M. C. Jackson, Supervisor of Midwives, County Offices, Matlock.	Day—Matlock 3411. Night—Duffield 2101.

Chesterfield Borough only.

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

Supply of Extra Vitamins, etc.

The County Council has for many years supplied certain proprietary preparations at Infant Welfare Centres and Ante-Natal Clinics at cost price. At Ante-Natal Clinics simple preparations of iron in tablet form (Tabs. Ferri. Sulphatis Co.), Ferrous Gluconate, and also of calcium with vitamins (Tab. Calciferol Co.) are prescribed by the Clinic Medical Officers in suitable cases.

In June of the year under review Ostermilk and Ovaltine were added to the list of preparations supplied in previous years. The preparations now sold at Infant Welfare Centres are as follows :—

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

"WELFARE FOODS" SERVICE

The introduction of Ostermilk, mentioned in the foregoing paragraph, proved very popular, many mothers taking advantage of the opportunity to obtain supplies at reduced prices. One result, however, was a fall over the year of about 12% in the issues of National Dried Milk, as mothers find it more economical to purchase the clinic pack of Ostermilk and use their Welfare tokens for liquid milk. Issues of Cod Liver Oil during the year were lower than in 1958 while those of Vitamin A and D Tablets and Orange Juice rose slightly. Many mothers prefer Adexolin to Cod Liver Oil as babies take it more readily. Charges for Orange Juice and National Dried Milk remained at 5d. per bottle and 2/4d. per tin respectively.

The following figures show the issues of "Welfare Foods" in the County area during the year :—

	National Dried Milk Tins	*Cod Liver Oil Bottles*	*Vitamin A. & D. Packets*	*Orange Juice Bottles*
Issued against coupons—				
(*a*) By stamps	174,520	—	—	287,243
(*b*) Free	5,010	40,746	33,351	1,174
Issued to—				
N.H.S. Hospitals ..	1,115	1	—	1,340
Day Nurseries	21	324	—	588
Issued at full price ..	3,237	—	—	—
Totals	183,903	41,071	33,351	290,345

Various changes were made in connection with distribution centres. New centres were opened at Breadsall, Loscoe, Stoney Middleton, Brailsford and Bakewell (the first named being at an Infant Welfare Centre and the last three at local shops). At Creswell, South Normanton, Langwith and Mosborough distribution was transferred from separate premises to the Infant Welfare Centres; and the voluntary centre at Glapwell was closed, owing to lack of attendance. All other centres continued unchanged.

The following Table shows the numbers and types of distribution centres serving County residents :—

Location	*At Clinics or Infant Welfare Centres*	*At other Premises*
Chapel-en-le-Frith R.D. ..	2	6
Glossop Borough	2	–
New Mills U.D.	1	–
Whaley Bridge U.D. ..	1	1
Buxton Borough	1	1
Bakewell R.D.	4	10
Bakewell U.D.	1	1
Matlock U.D.	2	7
Wirksworth U.D.	1	1
Ashbourne R.D.	–	4
Ashbourne U.D.	1	1
Repton R.D.	3	10
Swadlincote U.D.	1	–
Chesterfield R.D.	21	–
Chesterfield Borough ..	7	1
Bolsover	2	–
Staveley U.D.	2	–
Clay Cross U.D.	1	–
Dronfield U.D.	1	1
Clowne R.D.	3	–
Blackwell R.D.	6	5
Alfreton U.D.	1	3
Belper R.D.	2	7
Belper U.D.	1	1
Derby Borough	1	–
South-East Derbyshire R.D.	13	2
Ripley U.D.	1	1
Heanor U.D.	1	1
Ilkeston Borough	3	–
Long Eaton U.D.	1	1
Totals	87	65

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

Mr. Gray, the Senior Dental Officer, has provided the following report :—

"As in previous years, it was not possible to carry out this work on a large scale due to staff limitations, but nevertheless the amount of time devoted to mothers was appreciably greater than in the last two years. A larger number were treated and the amount of treatment was considerable. In denture work alone, forty-seven full and partial dentures were made and fitted compared with fifteen the year before. It was not always easy to meet the demands of these patients and the longer courses of treatment usually required meant delay and less time for the school children.

Of the pre-school children treated, the majority attended the clinics on account of pain. Others were referred through the infant welfare clinics, the health visitors and by general medical practitioners and a number were treated following routine dental inspections at the Day and Residential Nurseries and the Children's Homes. Priority was given to children in these institutions and inspections were carried out at least once in the year.

When parents brought these younger ones for the first time, they were encouraged to have regular check-ups in the future and it is gratifying to report that many of them do take advantage of the clinical facilities for this.

Most of the treatment consisted of extractions and in connection with this, 276 general anaesthetics were administered. Educational propaganda was used, aimed at prevention and a new feature was the use of appropriate lantern illustrations and talks by the health visitors to parents attending the infant welfare clinics. It is hoped to widen greatly this field of work in the near future.

The amount of decay found in these young children continued to be very great and of a rapid type. It was not uncommon for a child of between three and four to have to lose two, three or more teeth, often associated with abscess, teeth which should have lasted for eight or nine years.

Some investigation was made into the diet of children with extremely carious teeth and it was found that in such cases there was one factor which always appeared—an excess of sugar from a very early age. With bottle fed babies, sugar was added to the feed and later the diet supplemented with vitamin syrups and sweetened drinks.

When still quite young, the taste for sweetened food was developed to such an extent that savoury foods were rejected and cereal and dessert meals had to be well sugared before they would be eaten. There was the more or less daily consumption of sweets and biscuits, all this coupled with the widespread belief that the growing child needs sugar for energy. It cannot be too strongly stressed that sugar is not a body building food, indeed it can be said that its excessive consumption is definitely harmful.

The following Table sets out the details of the work done for mothers and pre-school children, with the comparative totals for 1958 in brackets :—

	Expectant and Nursing Mothers			*Pre-School Children*		
	County	*Chesterfield Borough*	*Total*	*County*	*Chesterfield Borough*	*Total*
Number Examined ..	105	1	106(90)	641	188	829(842)
Number with defects	100	1	101(90)	406	165	571(660)
Attendances	337	1	338(206)	610	267	877(987)
Treated	93	1	94(70)	370	178	548(628)
Made Dentally fit ..	52	1	53(25)	132	115	247(248)
Fillings	59	—	59(38)	14	21	35(61)
Extractions	307	2	309(237)	602	286	888(1058)
General Anaesthetics	26	1	27(24)	230	149	379(376)
Silver Nitrate treatments.. ..	2	—	2(—)	250	26	276(297)
Dressings	13	—	13(2)	30	20	50(61)
Scalings	34	—	34(29)	—	1	1(5)
Full upper and lower dentures	32	—	32(6)	—	—	—(—)
Partial upper and lower dentures ..	15	—	15(9)	—	—	—(—)

ILLEGITIMATE CHILDREN

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

1. Number of illegitimate births known to the Welfare Authority for the period 1/1/59 to 31/12/59 164
   Number of unmarried mothers 161
   Number of widows 3
2. The number in which the mother and child :—
   (*a*) returned to live with mother's parents 66
   (*b*) returned to live with other relatives 4
   (*c*) found or were helped to find lodgings where they could live together (of these, 26 were accommodated in Borrowash House Mother and Baby Home) .. 33
   (*d*) had to separate, the child going to the care of a foster mother 1
   the child going to a Residential Nursery 5
3. The number of illegitimate children who had been or were being legally adopted 24
4. The number of mothers who have married since the birth of the child 8
5. The number of mothers who, with their babies, are living with the father of the child, though not married to him 18
6. The number of illegitimate children who have died during the year (2 died within 2 days of birth) 4
   Still-births 1

During the year 55 unmarried mothers included in the total of 164 were accommodated in various Mother and Baby Homes, for whom financial responsibility was accepted by the Derbshire County Council. (The Home for unmarried mothers at Vernon Street, Derby, was closed on 31st December, 1958, and since that date arrangements have been made to accommodate unmarried mothers at Borrowash House, or at 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 the Ministry of National Insurance or the National Assistance Board. As these benefits were increased to 50/. per week in February, 1958, the amount collected from each girl was increased to 40/- per week, thus leaving her with 10/- 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 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. (Relevant excerpts may be quoted in my Annual Report).

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) Immunisation procedures:—
  (i) diphtheria immunisation;
  (ii) whooping cough vaccination, etc.;
  (iii) poliomyelitis vaccination;

(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, with particular reference to the liaison between Hospitals, General Practitioners, and the Local Authority.

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*) The incidence of different diseases in different parts of the area, examples are Bronchitis and Gastro-intestinal conditions.

(*f*) Problem families and evidence of child neglect.

(*g*) Accidents at play and in the home.

(*h*) Incidence of anaemia in the ante-natal period, observations on relaxation and post-natal exercises where these have been advised.

I am giving you early notice of the matter because I am anxious to receive your report **not later than 4th January, 1960."**

Dr. McCullough, Senior Medical Officer for Maternal and Child Welfare.

"The demand for hospital confinement on social grounds appears to remaim approximately the same. About 70% of the patients visited by the Health Visitor to assess home conditions were recommended for hospital confinement. Although patients occasionally resent this visit it does give the Health Visitor a valuable early contact with expectant mothers at which she can stress the importance of regular ante-natal care and explain the special services available to them. The majority of patients recommended for hospital booking are delivered in hospital, but there are still a considerable number of early discharges particularly in the south of the County. The appointment of several part-time midwives has helped to take the burden of the additional nursings off the shoulders of the regular midwives. With the present shortage of full-time midwives this may have to become a feature of the midwifery service. Parentcraft and Relaxation classes are now being held at eleven clinics. As more midwives attend the special course on this subject it is hoped to commence a class in every clinic. In a few areas it is not possible to accommodate all the mothers wishing to come. Priority is given to patients attending the Local Authority Ante-natal Clinic, especially those expecting their first baby. If there are then any vacancies they are offered to mothers referred by General Practitioners, many of whom are keen that their patients should attend. At these classes the patients get to know their local midwife and health visitor and feel they know to whom they can turn for advice both before and after the baby is born. The occasional showing of films has also been much appreciated. There continues to be a good attendance at the Infant Welfare Centres. Patients are constantly encouraged to have their children immunised but the majority prefer to attend their General Practitioner where they are given triple antigen. If more immunisations could be carried out it would give

the doctor an opportunity of seeing children who might otherwise not be brought to them All the staff and patients appreciate the pleasant surroundings provided by the new clinics.

The Toddler Clinic at Derby has now been running for a year. Children of about three years have been invited to attend from the neighbouring clinics of Alvaston, Chaddesden, Chellaston, and Allestree. About 60% of the mothers issued with invitations have kept their appointments. No significant defects have been discovered among the children examined. Doctors and Health Visitors in other areas have been asked to encourage mothers to bring their children to the clinic for an annual examination but not many avail themselves of this opportunity.

Thirty-nine children born in 1959 have been placed on the Handicapped Register. Of these, three have died. It is gratifying to note that many of those previously on the register have benefited from medical or surgical treatment. These cases are still visited regularly but some can eventually be taken off the register. *At present there are five children under two years notified as deaf.* Health Visitors who have been specially trained in the assessment of deafness in young children are asked to visit these families to give help and guidance to the parents in combating the special diffiiculties which arise, particularly in the development of speech. At present there are three Health Visitors with special training in this subject".

Dr. S. B. Blackburn.

"1. *General Health and Nutrition.* Excellent in most areas—an occasional lapse in some more industrial areas but on the whole the infants attending the clinics are well fed, adequately clothed and well cared for, which indicates a high standard of mothercraft.

2. *Cleanliness and communicable disease.* On the whole a high standard of cleanliness is seen—again the offenders are most commonly seen in industrial areas rather than rural or semi-rural.

3. *Immunisation Procedures, Diphtheria and Pertussis.* A fair proportion of infants have been immunised against these diseases, either at the clinics or by their own doctor but there should be a wider response. In many cases mothers are quite ignorant of what injections the child has received, a fact which could easily lead to confusion at a later age when booster doses etc. are due.

Polio Vaccination. There seems to be a considerable decrease in the number of polio vaccinations at the clinics—very few new cases and many "third" injections. This could mean either that more local doctors are giving them or that the response is falling off. There is still a good response amongst pregnant mothers but not many other young adults.

4. *Health Education at Clinics.* In those clinics where facilities are available for organized instruction in health education, there seems to be considerable interest among the mothers. In less well equipped centres, health education is of necessity sporadic.

5. *Methods for following up non-attenders at Ante-natal Clinics.* The recalcitrant mothers are contacted by Health Visitor or Midwife either by letter or visit. A reasonable response to these methods is obtained.

6. *Integration of clinic services with other aspects of the Health Service.* There is very little contact between clinic doctors and those in general practice, but I have not found any lack of co-operation either between General Practitioners or the hospitals.

Comments :—

(a) *Premature baby.* Not a high proportion of prematurity is seen amongst clinic attenders. I have not seen any cases of backwardness, either physical or mental, in premature infants at the clinics.

(b) *Breast feeding.* Not a high incidence of breast feeding is seen after the first few weeks. This is more noticeable in industrial and prolific areas.

(c & d) *Early detection* of mental and physical defects should be possible if the infants are examined regularly, but there is a considerable decrease in the numbers of "over one year" children in regular attendance at the Infant Welfare Clinics.

(e) *Incidence of different diseases in different parts of the area.* Bronchitis seems to be equally prevalent in all areas. Gastro-intestinal disorders are not particularly common and do not seem to have any sociological prevalence. This would support the high level of child care seen in most areas.

(f) *Problem families.* Much more evident in industrial areas but no real evidence of child neglect seen.

(g) *Accidents.* No major accidents encountered—an occasional minor bump or scratch was seen.

(h) (i) *Anaemia in ante-natal period.* All ante-natal patients are given Fersolate as a routine with Ferrous Gluconate as a rescue if they fail to respond to Fersolate or (as is quite often the case) where Fersolate is not tolerated. Only one severe case of anaemia which did not respond to oral iron was seen and she was referred to her own doctor for further investigation and treatment.

(ii) *Relaxation classes* have been found to be extremely beneficial in the majority of cases. Considerable extension of this plan could be undertaken with advantage".

Dr. E. A. Lois Blake.

"*The General Health* of the children brought regularly to the Infant Welfare Clinics, who are seen in the main during their first eighteen months of life, is good.

Nutrition. Breast feeding is still maintained by only a small proportion of mothers after the puerperium. There is an increasing interest in the earlier introduction of mixed feeding. Most of the foods used come out of a tin.

Mothercraft. The infants on the whole are both cleanly, comfortably and sensibly clothed for every season of the year.

I have had to report one case of scabies during the year.

Immunisation procedures. The majority of patients attending the Ante-natal Clinics consent to poliomyelitis vaccination. In some areas ante-natal patients are referred to the clinics for vaccination only. At the time of vaccination mothers are advised of the appropriate times for immunisation of the expected infant. This along with the gathering injections of the poliomyelitis scheme, has I feel, led to a marked increase during the year, in the demand for separate pertussis and diphtheria immunisations, at the Infant Welfare Clinics.

Health Education. The most successful item in this category has been the introduction of Relaxation and Exercise classes taken by the midwives with instruction in mothercraft by the Health Visitor. As these classes are also open to patients not attending the clinic for ante-natal care, there are waiting lists for the series of six sessions in some areas.

Films in Health Education have been shown during clinic sessions, but in general the premises do not lend themselves to both running concurrently.

I feel that the most potent force in Health Education in the clinics which I attend, is the comfortable congregating waiting room, with constantly changed posters, blackboard maxims and display sets, and if possible, a cup of tea which encourages the mothers to discuss and digest the advice given by the Health Visitor and Medical Officer.

Ante-Natal Clinic Attendance. There have been fewer defaulters in keeping appointments during the year. These have been followed up as heretofore, by the local midwives who have also been most helpful in visiting patients between attendances where necessary, and in tracing patients transferring through bookings to Hospital Clinics. There is no system as yet by which the County Clinics are notified of patients booked for hospital attendance and confinement.

Integration. I have never asked in vain for a booking through the Scarsdale Hospital Booking Department, and have always received prompt advice on patients referred by letter to the Consultant.

Apart from returned ante-natal attendance cards, it would be helpful for future record, and of interest, to have the *ultimate* history of some of the abnormal cases referred. No doubt this history is sent to the General Practitioner, so it might be possible for a duplicate copy to be sent to the Clinic concerned".

Dr. C. C. Glynn.

"In the three month period during which I have worked in the Maternal and Child Welfare Department I have not been impressed by the attendance at the Clinics.

Two of the Maternity Clinics, namely Long Eaton and Ilkeston Ante-natal Clinic, are well attended, those at Ripley and Swadlincote are barely supported. Both of these latter clinics average two patients, though the clinics are well equipped and satisfactorily staffed. They are, however, off the main highway, but I think the chief reason for poor attendance is that the family doctors in those areas are particularly interested in midwifery and carrying out most of their own ante-natal examinations. The patients sometimes attend the clinic for the sole purpose of having blood typed, or for post-natal examination !

The attendance at the Infant Clinics is very good indeed, but there is a marked falling off in the "toddler" age group.

Standard of Cleanliness and mothercraft on the whole is very good.

General health of children attending the clinics is satisfactory, and congenital defects relatively rare (among the infants two heart lesions and one mongol + congenital heart disease and two cases of congenital disclocation of the hip, both female, in past three months).

No case of hypervitaminosis or vitamin deficiency, though many mothers still run on the generous side with vitamins A and D.

No communicable disease apart fron upper respiratory infections among attenders at clinics.

Immunisation is available at all Infant Welfare Clinics, but the majority of the children attend their own doctors for these procedures. However, there is a gradual increase in the numbers having pertussis immunisation at an earlier age—I think some advance could be made here by advice to mothers re incidence and danger of whooping cough in the first six months of life. Most infants are still given combined Diphtheria and Pertussis (+ Tetanus) immunisations in the later months.

Most pregnant mothers avail themselves of the poliomyelitis vaccination and the children are usually protected also, but smallpox vaccination is tending to be omitted in many cases.

Non-attenders or rather defaulters from the ante-natal clinics are visited by the local Health Visitor and checked Non-attenders at Infant Welfare Clinics are not usually followed up unless some abnormality was present. Attendance is usually carried out regularly up to and usually, though not so regularly, for post-natal examination.

The importance of Health Education must be stressed, but in the busier clinics it is not always possible to devote enough time to this aspect of preventive medicine, and much repetition is involved. Perhaps special sessions in mothercraft, dietetics, etc., could be extended.

I think much helpful work could be done at "Mothercraft and Relaxation" classes especially for primigravidae.

Liaison with hospitals I think is very good, but I feel there is much room for improvement in relations with local general practitioners. The situation is still rather delicate, and I think much could be done if the Medical Officers and the Family Doctors could meet for discussions, papers and lectures of common interest e.g., by Obstetricians and Paediatricians. I think there is still some resentment among some Family Doctors against the clinics, and conflicting advice is occasionally given to mothers. This fortunately does not frequently happen, but it often helps if the medical colleagues know each other, and there is good-will and a mutal concern for the patients' welfare on both sides.

Breast feeding. Incidence is high in first few weeks, but many mothers fail to continue unless they feel they have an adequate supply for baby's needs, and I think there is insufficient use of complementary and supplementary feeding.

Finally, I think facilities for Haemoglobin estimation should be available as the Sahli method is both inaccurate and time consuming. Could Sheffield do Hb. or specimens if sent in Wintrobe bottles with routine Group and Rh. typing ? Or perhaps arrangements could be made with certain hospitals in the area to carry out Hb. estimations, e.g. one day a week ?

As I have worked for only a comparatively short time with the Derbyshire County Council during the past year, I cannot speak with authority on all aspects of the service, but on the whole the standard of care provided is high ; and the Health Visitors perform an excellent service".

Dr. D. M. Jackson.

"The infants attending the Infant Welfare Centres are for the most part clean, healthy and well cared for. The standard of mothercraft attained by the younger mothers of sixteen to nineteen is well up to the overall average, which is undoubtedly high.

Without reference to actual numbers or statistics, my impression is that the general demand for poliomyelitis vaccination has led to a wider acceptance of diphtheria, whooping cough and tetanus immunisation. Many of those who ask for "the lot" are even responding to the suggestion of smallpox vaccination. All these are carried out mainly by the general practitioners, but there are still some who wish for it to be done at the clinic.

There has been a good response to invitations to attend the Toddler Clinic—small attendances having coincided with particularly bad weather or the prevalence of chickenpox or other infectious disease in the area.

The general health of these toddlers, aged about three-and-a-half years, has not been quite so good as that of the babies attending the Infant Welfare Centre, but this is to be expected as those with problems are much more likely to attend than those without.

At the same time I have been much impressed by the slow gain in weight over the interval when they are not attending the clinic. At one year the average weight must be well over 25 lbs. and those who continue to attend occasionally over the next few months are still gaining at a rate averaging several ounces a week, and yet very few have reached a weight of more than 35 lbs. by three-and-a-half years. I am quite sure that if these children could with advantage have gained more weight, the lack of it is not due to any economic stringency. Beyond this negative observation, I have not been able to find any common factor. Some drink little or no milk, others are short of sleep, but these are the exception rather than the rule".

NURSERY PROVISION FOR CHILDREN UNDER FIVE

DAY NURSERIES

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

Student Training.

During the year under review nine students from the County Day Nurseries completed a two-year course of training and seven were successful in gaining the Certificate of the National Nursery Examination 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, continually 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.

Since 1st October, 1959, the maximum charge to parents has been increased from 6/6d. to 10/0d. per day, while the minimum charge

has remained at 3/0d. per day. 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	0	to	9	0	0	5	0
9	0	1	to	10	0	0	5	6
10	0	1	to	11	0	0	6	0
11	0	1	to	12	0	0	6	6
12	0	1	to	13	0	0	7	0
13	0	1	to	15	0	0	8	0
15	0	1	to	17	0	0	9	0
Exceeding				17	0	0	10	0

Where the net weekly earnings are less than £17, the charge for a second child is to be 1/0d. per day less than the assessed charge for the first child, subject to a minimum of 3/-d. per day for each child.

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

It has been found that the increased charges resulted in a drop in attendances at most of the nurseries, but this may be only a temporary reaction.

Medical Inspections.

Each Nursery is visited once each month by one of the Authority's Medical Officers. During these visits all new admissions are examined and any other children who have been under recent medical treatment or about whom the mother wishes special advice. Regular attenders are examined about once every six months. It is thus possible to detect defects in their early stages and with the co-operation of the general practitioner to secure early treatment. Special inspections are made in the case of infectious disease and the nurseries are also visited from time to time by Medical members of the Central Office staff and by the Superintendent Health Visitor.

Dental Inspections.

As in previous years, all the children resident in the Childrens Homes and Residential Nurseries received dental inspections. Except for a very small number, the dental conditions were very good. These children get care each year and as a result those long in residence who were found to need attention only required the minimum to keep their teeth sound. Oral hygiene was of a high standard and credit must be given to the foster parents for the inculcation of regular tooth cleaning habits.

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.

Matrons' Reports.

The following reports have been received from the Matrons of the Day Nurseries:—

Chaddesden Day Nursery.

"Number of children on the register on 31st December, 1959 40
Number of children admitted during 1959 35
Number of children who have attended in 1959 78
Average number of children on the register during 1959 43
Average daily attendance under two years 7.6
Average daily attendance two-five years 25.3

Attendances were very good during the first nine months of the year. A number of children were helped on compassionate grounds, that is, the mother was ill at home or in hospital or she was pregnant.

Nine children left the nursery at the end of September owing to the increased fees on 1st October. The attendances have dropped considerably since. There are still forty children on the register but the attendances fluctuate and very few children attend for a full week. This I feel is not good for the children: they seem to be unsettled. There is no waiting list; there are many enquiries, but few admissions. The mother usually wants to go out to work for financial reasons and they state there is very little financial gain out of the money they earn after paying nursery fees and 'bus fares.

The nursery has had a satisfactory year as regards infectious diseases. There were two cases of German Measles and one of Scarlet Fever. A child of three years brought to the notice of the visiting Medical Officer was found to be deaf and was fitted with a hearing aid.

Six formica-topped tables were supplied for the nursery rooms, a great improvement on the original supply of plywood-topped tables. A spin-dryer supplied in March has proved very useful in bad weather for drying and airing of linen. The new Dunlop-tiled floor layed in the kitchen is greatly appreciated: apart from making the kitchen brighter it has made work more pleasant. A large swing provided in May has been greatly enjoyed by the children.

I cannot speak too highly of my efficient and happy staff: they play a great part in the running of the nursery.

All nursery equipment is in good order, thanks to the Works Department for the prompt dealing with requested repairs.

We all appreciate the interest shown by all visiting members of the County Health Committee in the welfare of the children and staff and look forward to visits in 1960."

Whitfield Day Nursery, Glossop.

"Number of children on the register on 31st December, 1959	28
Number of children admitted during 1959	49
Number of children who have attended in 1959	90
Average number of children on the register during 1959	39
Average daily attendance under two years	9.7
Average daily attendance two-five years	16.5

Children have attended regularly: absent only when parents are away from work because of illness or changing jobs. We have no waiting list, except one or two names are recorded until the mother finds a suitable job.

There was a slight epidemic of Influenza when two of the staff were absent in February: no children were affected. A measles epidemic came in April when ten children were absent; not all were ill, and some had infection at home when mother had to stay home to nurse them. There have been less children with colds and coughs than in previous years: the nursery has been a much warmer place with a larger, central heating boiler.

The good summer also gave our children the chance of many more hours out of doors than previously, which made a great contribution to their general health. Every child got a beautiful sun-tan if only on his arms and legs. The children had most meals out of doors. In the heat wave, wearing swim suits, we had the sea-side here with zinc baths outside for paddling in!

The numbers of children attending are down since the increased fees in October. Assessment forms were issued by me with the most careful explanations regarding the confidential arrangements used by myself and County Officials.

These forms were not well received by parents. Some children were taken out (immediately) in September, not waiting until October. Mothers continue to work: we meet children that have left us, in the early mornings, being taken to someone's house for the day!

There are good numbers in the Education Committee's Classroom since our increased rate, (twenty or twenty-three) many of them only three years of age! There are not many people asking for admission, or, when they do come, already know about the increased daily rate.

Decorations have not been needed because so much work was done last year, except for paintwork in the corridor, milkroom and laundry ceilings, which were flaking; these have been corrected by painters.

Supplies of provisions and meat are very satisfactory and 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.

"In January 1959, my register stood at 30, and during the year the average on the register has been 29. On December 31st the number was 27.

This has been an unusual year, for although the fees have increased to a maximum of 10/0d. per day, my average daily attendance has gone up by 2.25. The figures for the year being:—under two years—9.6; over two years—11.4; total average attendance—21. I have admitted 44 children and discharged 47. In all 70 have attended the nursery during the year.

I feel that this increase in attendances is partly due to children who attend only on a part-time basis. At the moment I have six children who attend half days. Four of those children, their mother's only work half day, one of which is a trained nurse working at the hospital. Of the remaining two, one child came because his parents felt their child needed more association with other children, as he was very shy and would not talk very much. The other child was brought to us on the advice of a children's specialist at the hospital. This child at two-and-a-half years refused solid foods, and was frequently sick before meals. I may say there is a great deal of improvement in both these children. I have also helped two mothers by having their children in the nursery while they have kept hospital appointments.

Twelve children left as a result of the increase in fees, but I feel at the moment it is difficult to say whether this is going to have an effect on the attendances, as the increase came into force three months before Christmas, when we normally get more admissions, and mothers have less time off from work, so they make sure of extra money at that time of the year. I hope, however, that the position will not deteriorate.

We have had a low incidence of infection again this year, one Scarlet Fever, and two Measles, when the usual precautions were taken.

The common cold is still the main reason for irregular attendances, also relations looking after a child for one or two days.

During the year the nursery has had the sewing machine repaired, and the replacement of all the nursery curtains. An overhead gas fire has been installed in the laundry. The kitchen has been altered so that a sink unit and wash hand basin could be fitted, also some kitchen utensils have been replaced.

This year has seen staff changes: in May the sudden death of my Cook, who had been at the nursery some years; and the resignation of my Cleaner in September, who moved from the district, after seven years service. Both these changes have been felt by the staff with regret, although these vacancies are now filled. In July my Nursery Student sat her N.N.E.B. examination and was successful; she left at the end of August, and the vacancy has been filled.

The Museum Service has been very helpful with changes of pictures on loan and sending film strips for use with Health Department projectors. This has been enjoyed by the children very much, and has been of value to the students when they have taken story telling with the children. I hope to extend the student's scope next year with the use of a tape-recorder, so that the students can hear themselves when telling stories, and so help them to gain confidence and to improve in this part of their training.

I have been pleased to receive visits from members of the County Health Committee and look forward to future visits in 1960.

The past year has been in one respect a contradictory year inasmuch as the fees have increased, but my average attendance has not dropped as with previous fee increases. I hope, therefore, that the nursery will continue to play its part in child welfare in 1960."

Whitworth Road Day Nursery, Ilkeston.

"Number of children on register, 31st December, 1958	48
Number of children admitted 1959	46
Total number of children attending	94
Average number of children on register during 1959 (under two years—15; over two years—31).	46
Average daily attendance during 1959 (under two years—10; over two years—23).	33
Average daily attendance to October	34.5
Average daily attendance October 1st to December 31st	30.6
Children left during 1959	55
Number now on register, December 31st, 1959 (under two years—11; over two years—28).	39

In view of the increased charges operating from October, I think we have had a satisfactory year. Although fourteen children left owing to increased charges (two would have left at Christmas in any case), we have admitted eleven new children. A change-over with such a big increase will take at least six months to adjust itself.

Children are still admitted for the same reasons: mainly economic, but we are finding that the nursery is used for other reasons, for example, doctors recommend mothers who find difficulty in coping with children having feeding problems, and excretary worries; and one child (speaking) having deaf and dumb parents. The Nursery still serves a useful service in Ilkeston and co-operation exists between Health Visitors, Doctors and parents for the benefit of children.

The staff have worked splendidly during the year and the three students sitting their N.N.E.B. examination were successful. It is gratifying to find that of the eight students obtaining their N.N.E.B. during the past two years, three have commenced their general nursing training, two are in Premature Baby Units, one is at a Special School for Handicapped children and only one is in a Day Nursery. The scope is thus widening for these girls, as there is a need for their services outside Day and Residential Nursery work.

We have had no widespread infectious illness this year—although the following figures indicate the number of children absent for what might be termed 'sporadic illness':—

Scarlet fever	2
Chicken pox	6
Mumps	5
Measles	1
German measles	2

All children, except babies, have had their diphtheria injections and the polio injections are well in hand.

We are very thankful for improvements in the wash-house. It is really up-to-date for we now have a new Bendix washer, ventilator and heater. The staff room and office are most colourful with their new linoleum. A great help in hygiene has been effected by the provision of new children's washing bowls. We are looking forward to new flooring in the children's bathroom.

We have had five visits from members and we are always very pleased to see them; their continued interest in the children and nursery is very encouraging."

Long Eaton Day Nursery.

"Number of children on the register on 31st December, 1959 46
Number of children admitted during 1959 52
Number of children who have attended in 1959 127
Average number of children on the register during 1959 51
Average daily attendance of those under two years of age 10.7
Average daily attendance of those from two to five years of age 26.3

During the early part of the year attendances were rather low, due mostly to slight colds and coughs of children and sometimes parents. A very good attendance was maintained during April, May and the following summer months. As the fees were increased to 10/0d. per day on 1st October there was a fall in attendance, and eleven children left within the next few weeks. Attendances are still low, but I feel sure there will be a demand again, once the winter months are over.

There was an outbreak of Dysentry in the Nursery during the second week in February: eleven children and three staff were discovered to have the infection. All the necessary action and precautions were taken, and by the 20th March the infection was cleared from the Nursery. One isolated case of Scarlet Fever was the only other infectious disease.

New equipment comprised six rest beds, one swing, one ironing board and one clothes horse. Owing to dampness in the childrens' cloakroom electric tubular heating was installed, resulting in some slight improvement. A small wash-hand basin has been installed in the kitchen.

Three students sat for the N.N.E.B. examination and one was successful. These three resigned on 31st August and were replaced by only two students. One of our second year students got married and left the Nursery in November, thus leaving us two students short.

Members of the County Health Committee continued to visit us at intervals. These visitors are always very welcome.

I feel most grateful to the County Works Department for their prompt attention to my many calls for help, one way and another, during the past year.

Parents continue to appreciate the care and love given to their children while at the nursery. It is a great relief to them to know that their child is happy and contented while they do their job of work outside the home."

Reciprocal arrangements with other Authorities.

As a general principle the County Health Committee has decided that payment be made for all Derbyshire children who attend other Authorities' Day Nurseries or vice versa; that the home address be taken into account in deciding which nursery is appropriate; and that a charge be made in accordance with the Derbyshire scale of assessment.

Derbyshire children on the eastern border of the County may attend Nottinghamshire Day Nurseries and vice versa, the difference between the charge to the parent and the cost per child-day being met by the appropriate Authority. At the end of the year nine Derbyshire children were attending Nottinghamshire Day Nurseries, but no Nottinghamshire children attended Derbyshire Day Nurseries during the year.

Children living near to the northern border of Derbyshire may attend Sheffield Day Nurseries, the Derbyshire County Council being responsible for the difference between the actual cost and the charge made to the parent. No Derbyshire parent took advantage of this arrangement during 1959.

At the end of the year, twenty-six children from the County Council's area were attending Derby Borough Day Nurseries and one child from the Borough was attending a Derbyshire Day Nursery.

Training of Pupil Assistant Nurses.

The arrangement continued during the year whereby Pupil Assistant Nurses employed by the Derby Area No. 1 Hospital Management Committee 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.

Courses and Conferences.

The National Association of Nursery Matrons held its Annual Conference in Llandudno from 13th to 15th March, 1959, and the Matrons of the Long Eaton and Whitworth Road, Ilkeston, Day Nurseries, were allowed to attend.

The Matrons of Station Road Day Nursery, Ilkeston, and Whitworth Road Day Nursery, Ilkeston, attended a Study Day for Nursery Matrons which was held in London on 7th October.

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 Matlock, 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 positon for the period under review can be obtained from the following table:—

	Number of Midwives on the staff at the end of						
	1953	1954	1955	1956	1957	1958	1959
County Midwives ..	71	69	72	71	72	70	68
Home Nurse Midwives ..	35	32	30	30	29	29	28

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 sixty-eight and twenty-eight Home Nurse Midwives out of a total of twenty-eight 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 approxmately 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 mimimum of fourteen days during the lying-in period.

At the end of 1959 there were 181 Midwives on the County Roll—six were Midwives working in private Nursing Homes; seventy-nine were Midwives working in Regional Hospital Board Hospitals and Maternity Homes; sixty-eight were County Council Midwives; and twenty-eight were County Council Home Nurse/Midwives.

"Relief Duty".

The Minister of Health in circular 1/60 requested information concerning "the Authority's arrangements for relief duty, especially night rota systems." In this connection the following is a copy of an instruction addressed to County Midwives, Home Nurse Midwives and Home Nurses on the staff of the Department:—

"Commencing on 1st January, 1950, your off-duty periods will be as follows:—

(1) *Weekly day off duty:* Subject to the exigencies of the service, your weekly day off duty will be ..... in each week. The 'day' will extend from 9 p.m. on the preceding evening to 7 a.m. on the succeeding day.

(2) *Week-end off duty:* Subject to the exigencies of the service, you will have two free days and three free nights every sixth week, from 9 p.m. on a Friday evening until 9 a.m. on the following Tuesday morning. This period includes your weekly day off duty, but, if you prefer it, it can be taken separately, when the week-end period would be reduced by twenty-hours either at the beginning or at the end of the week-end.

It will, of course, be necessary for you to contact your Supervisor before taking your week-end (so that she will know the exact period of off-duty you have selected) and also on your return to duty.

Your relief is as follows:—

1st Relief .....

2nd Relief.....

Please adhere strictly to rule 6 concerning any holiday taken by you."

Rule 6 mentioned above reads as follows:—

"When a nurse or Midwife is out on her round of visits, a clear address at which she may be found should be left at her place of residence. Frequently valuable time is lost through lack of information as to whether a Nurse or Midwife is available or not.

The arrangement of which I most approve is for the Nurses or Midwives to leave a slate or a piece of paper with the address, or addresses, clearly written and placed in the window of their house in such a position that it can be read from outside.
For example:—

Nurse gone to Mrs. Smith, 10 Derby Road—9 a.m.
Mrs. Jones, 12 Station Road—approx. 10 a.m.

so that the messenger seeking the Nurse's or Midwife's assistance will know exactly where to find her.

When a Nurse or Midwife is absent from her area, for example, on her weekly or annual holiday, it will be her duty to see that her patients know which colleagues will be deputising for her. She must put a notice in her window giving the names and addresses and telephone numbers of her reliefs.

If any emergency arises and the Nurse or Midwife is available, although she may be technically off duty, she will be expected to deal with it without delay, on humanitarian grounds."

Having regard to the recruitment position and the geography of the County, with a varying population density, this is the best "off duty" system we have been able to evolve.

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 1953 to 1959:—

	1953	1954	1955	1956	1957	1958	1959
Numbers of cases attended by Midwives employed by the Authority:							
(i) As Midwives	2,938	3,047	3,039	3,349	3,430	3,500	3,548
(ii) As Maternity Nurses	1,510	1,385	1,352	1,402	1,351	1,248	1,304
Total	4,448	4,432	4,391	4,751	4,781	4,748	4,852
Number of cases in which Gas and Air was administered	2,501	2,667	2,611	2,651	639	374	411
Number of cases in which Pethidine was administered:							
(i) When acting as a Midwife ..	900	1,185	1,297	1,693	1,954	1,927	1,989
(ii) When acting as a Maternity Nurse	488	479	826	704	795	707	781
Number of cases in which Trilene was administered:							
(i) When acting as a Midwife ..	–	–	–	323	2,237	2,477	2,733
(ii) When acting as a Maternity Nurse	–	–	–	130	755	791	929

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	96
Employed in Homes and Hospitals in the National Health Service	71
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 year 1959 was 411.

Facilities are provided to enable domiciliary Midwives practising in the area to attend courses of instruction on 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.

Pethidine.

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	877
1952	1,190
1953	1,399
1954	1,665
1955	2,135
1956	2,397
1957	2,749
1958	2,634
1959	2,770

Trichloroethylene B.P. (Trilene).

All midwives employed by the County Council have been instructed in the use of, and provided with, Trilene Inhalers, as an alternative method of inhalational anlagesia to Gas and Air. 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 1959 was 3,662.

Relaxation.

Special courses in Mothercraft and Relaxation are held each year, and up to the end of the year under review twenty midwives have attended. Ten midwives are being sent each year until all the midwives have had an opportunity of attending this course.

Intra-Gastric Oxygen.

The pilot scheme in which twelve midwives were issued with intra-gastric oxygen equipment was continued during the current year. In conjunction with the other methods of resuscitation the apparatus was used fourteen times on severely asphyxiated babies. Nine babies responded satisfactorily within a short time. Of those who died three were extremely premature.

Refresher Courses.

Since 1st February, 1955 all midwives have attended a Refresher Course as laid down under Section "G" of the Rules of the Central Midwives Board. Under this arrangement midwives will continue to be sent at regular intervals. In addition, the Supervisors of Midwives attend in rotation the annual Post-Certificate Courses conducted by the Association of Supervisors of Midwives.

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) £3 3s. 0d. per week to the Midwife for providing board and lodging for each pupil; while the County Council pays £30 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 excerpts 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 ad-

minister 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."

"Cranbrook" Report on the Maternity Services.

The County Health Committee considered in September 1959, (*a*) Circular 21/59 from the Ministry of Health, as well as (*b*) the official summary of the conclusions and recommendations of the "Cranbrook" Report to the Minister of Health on the Maternity Services in England and Wales.

(*a*) Circular 21/59 reads as follows:—

"1. I am directed by the Minister of Health to refer to the Report of the Maternity Services Committee which was published on 18th February. The Minister has now given preliminary consideration to the recommendations contained in the Report and while there are many which he can at once accept, there are several matters on which consultation with the authorities and organisations concerned with the maternity services is required before final decisions can be taken.

2. The recommendations of particular concern to local health authorities which fall into the latter class and are therefore reserved for further consideration and consultation are as follows:—

(i) Reduction of the minimum lying-in period as prescribed by the Rules of the Central Midwives Board to ten days (para. 86).

(ii) Amendment of the Central Midwives Board's Rules regarding the definition of a "maternity nurse" (para. 198).

(iii) The gradual replacement of the local authority medical officer by the general practitioner obstetrician in ante-natal clinics (para. 147).

(iv) Reservation of the use of local health authority ante-natal clinics for doctors on the obstetric list (para. 149).

(v) Payment of medical aid fees (para. 207), and

(vi) Publication of clinical reports (para. 315).

3. There are other recommendations, some of which touch on the local health authority services, on which further consideration and consultation are needed, and these are set out in the accompanying documents—H.M. (59) 69 which has been issued to hospital authorities, and E.C.L. 44/59 and E.C.N. 304 which have been sent to Executive Councils and Local Medical Committees.

4. Subject to these reservations the Minister commends to local health authorities the recommendations in the Report relating to their services and asks all such authorities to give them their early consideration. He attaches special importance to the following matters.

5. In accepting the Committee's advice that the tripartite structure of the maternity service should be retained, the Minister is conscious of the difficulties inherent in the existing administrative structure. He is, however, satisfied that these difficulties can be overcome by willing co-operation between the authorities and individuals responsible for the provision of services in each of the three branches, and he commends to the careful attention of all concerned the advice on co-ordination contained in Chapter II and Appendix VIII of the Report.

6. In no part of this field is co-ordination of services more important than in the provision of good ante-natal care. The Minister accordingly invites special attention to the recommendations on this subject contained in paragraphs 60 and 131 of the Report, and to the advice contained in the Memorandum issued to all the authorities concerned in May, 1956, and now incorporated in Appendix II to the Report."

(*b*) The official summary of the conclusions and recommendations of Cranbrook Report reads as follows:—

"*SUMMARY OF THE CONCLUSIONS AND RECOMMENDATIONS OF THE 'CRANBROOK' REPORT.*

Chapter 5. *The Place of Confinement: Home or Hospital?*

325. The hospital maternity service should be expanded and a good domiciliary maternity service should continue to be maintained. (Paragraph 60).

326. A more uniformly high standard of ante-natal care is essential. (Paragraph 60).

327. A more careful selection of patients should be made for domiciliary confinements and for admission to hospital. (Paragraph 60).

328. The local health authority is the appropriate authority to determine whether social reasons made a home confinement undesirable and they should always be consulted by hospital authorities before a decision is made to book a patient solely on social grounds. (Paragraph 69).

329. Sufficient hospital maternity beds to provide for a national average of 70% of all confinements to take place in hospital should be adequate to meet the needs of all women in whose case the balance of advantage appears to favour confinement in hospital. (Paragraph 70).

330. Hospital authorities should, in addition to beds needed for confinement and lying-in, provide as a priority, ante-natal beds for 20% to 25% of all confinements in their areas. These beds should be reserved solely for ante-natal patients. (Paragraph 71).

331. Experience in this country justifies adherence to a period of ten days as the normal (not average) length of stay in hospital after delivery. (Paragraph 81).

332. In some areas additional hospital maternity beds will be required and it must be left to the hospital authorities to decide what provision will require to be made in the light of their own local needs. (Paragraph 83).

333. The local health authority and the patient's family doctor should, with the patient's consent, be informed by the hospital authority of the date on which she is to be discharged, irrespective of the time she has spent in hospital. (Paragraph 85).

334. The Central Midwives Board might consider amending their Rules to reduce the minimum of the lying-in period defined therein from fourteen to ten days. (Paragraph 86).

335. The amount of the home confinement grant should periodically be reviewed. (Paragraph 89).

Chapter 6. The Work of Midwives.

336. Any widespread attempt at present to compel domiciliary midwives to work in hospitals might disrupt the domiciliary nursing services. We believe that interchange between hospital and domiciliary midwives might become acceptable to midwives if it were made a normal condition of service on recruitment to a joint service. (Paragraph 103).

337. A midwife should be given every opportunity to participate in the maternity care of her patients to the fullest extent to which her skill and experience entitle her. (Paragraph 107).

338. The term 'maternity nurse', in as far as it is applied to a certified midwife, should be reserved for a midwife who has notified her intention to practise as a maternity nurse only. (Paragraphs 108 and 132).

339. The views of the Central Health Services Council regarding the status of the superintendent midwife, commended by the Minister of Health to hospital authorities in 1954, should be implemented. (Paragraph 110).

Chapter 7. Materniy Services provided by Local Health Authorities.

340. The respective responsibilities of all those involved in maternity care should be understood and proper records should be maintained to ensure that co-ordination is achieved. (Paragraph 131 and Chapter 11).

341. The general practitioner obstetrician should ultimately replace the local authority medical officer in providing maternity care in local authority ante-natal clinics. (Paragraph 147).

342. The use of local health authority ante-natal clinics should, as far as general practitioners are concerned, be reserved for doctors on the obstetric list. (Paragraph 149).

343. Local health authorities should continue to provide premises and facilities for ante-natal clinics without charge to general practitioner obstetricians and to hospital medical staff holding outlying hospital clinics. (Paragraph 150).

344. An appointment system should be instituted in all ante-natal clinics. (Paragraph 151).

345. Health education and mothercraft instruction should be available for all expectant mothers. Local Health authorities should, as necessary, provide instructors in health education in their own clinics, in the surgeries of general practitioner obstetricians and in hospital clinics. (Paragraphs 155 and 156).

346. The present priority dental service should continue to be provided. (Paragraph 163).

347. The home help service should be substantially increased but it should continue to be available for maternity cases on the same financial basis on which it is provided for other users. (Paragraphs 167 and 168).

348. A Maternity Aid service, similar to that in Holland, would be a valuable supplement to the home help service. (Paragraph 170).

Chapter 8. *Maternity Medical Services Provided by General Practitioners.*

349. The practice of obstetrics requires special skill and experience. There is not enough domiciliary maternity work available to enable every general practitioner to obtain and maintain the necessary standard of skill. (Paragraph 192).

350. The obstetric list should be continued. More uniform criteria should be applied for admission to and retention on it. (Paragraphs 193 to 197).

351. A six months' resident appointment in an obstetric unit under the control of a consultant obstetrician should be the normal criterion for admission to the obstetric list. (Paragraph 195).

352. In order to remain on the obstetric list, which should be reviewed every three years, a doctor should, over the preceding period of three years, have had at least sixty complete booked cases of which he should have attended deliveries of at least half. (Paragraph 196).

353. Local obstetric committees should continue. An appeals precedure should be adopted . (Paragraph 197).

354. There should be a periodical review of the criteria for admission to and retention on the obstetric list. These criteria should be made mandatory on local obstetric committees. (Paragraph 198).

355. The present obstetric list should be accepted and should be reviewed at the end of three years. (Paragraph 201).

356. Payment for maternity medical services should be for the exercise of special skill and experience as recognised by a doctor's inclusion in the obstetric list and such payment should be made only to doctors on the obstetric list. (Paragraph 202).

357. Except in the circumstances mentioned in paragraph 205 a general practitioner obstetrician who undertakes to provide maternity medical services should receive the full fee even if the patient is subsequently transferred to hospital. (Paragraph 204).

358. Medical aid fees, at present paid by local health authorities, should be paid by the authorities responsible for the payment of fees for maternity medical services. (Paragraph 207).

359. We accept the advice set out in the memorandum on "Ante-natal Care Related to Toxaemia". We consider that the general practitioner obstetrician should be present at the delivery whenever possible; that he should give any necessary care to the mother and child for a period of fourteen days after confinement; and that a post-natal examination should be carried out as near as may be to six weeks after delivery. (Paragraphs 211 to 213).

360. A general practitioner obstetrician and a midwife should be booked for every domiciliary confinement and there should be close co-operation between them . (Paragraphs 129 and 216).

Chapter 9. Maternity Services provided by Hospital Authorities.

361. After lying-in beds have been allocated to patients in the priority groups, including patients with social needs and those requiring emergency admission, any remaining beds might then be allocated on a 'first come, first served' basis. (Paragraph 224).

362. Although it is preferable for a patient to be referred to hospital by her doctor a hospital should be able to book a patient who applies directly to them for admission. (Paragraph 225).

363. An efficient appointment system should be adopted by all ante-natal clinics and prompt measures should be taken to follow up those who fail to attend. Hospitals should endeavour to make every use of both the local health authority staff and general practitioners to carry out this for them. (Paragraph 229).

364. Hospital authorities should provide, as a priority, ante-natal beds for some 20% to 25% of all confinements in the country as a whole. These beds should be reserved solely for ante-natal patients. (Paragraph 231).

365. Maternity hospitals should be organised in self-contained units of such a size that one sister can be in charge of both lying-in and labour wards and, if possible of ante-natal beds as well. (Paragraph 233).

366. Every attention should be paid in hospital to the mental and physical care and well-being of women during pregnancy and childbirth. (Paragraph 234).

367. Premature baby units, with adequate space and sufficient in number to cover the whole country, should be provided. (Paragraph 238).

368. There should be sufficient 'flying squads' to cover the country as a whole; they should be properly staffed and adequate transport should be available. Equipment for resuscitation should be kept in local hospitals and should be available to general practitioner obstetricians pending the arrival of the flying squads. (Paragraph 245).

369. Local health authorities and general practitioner obstetricians should do all they can to co-operate with teaching hospitals in maintaining and extending facilities for training medical students in domiciliary midwifery. (Paragraph 247).

370. The extra lying-in beds required to enable the hospital confinement rate to be raised to the suggested average of 70% of all confinements should, where possible, be general practitioner beds. (Paragraph 258).

371. General practitioner maternity beds are best situated within, or very close to, consultant maternity hospitals or general hospitals with maternity departments. A consultant obstetrician should have overall responsibility for supervision of general practitioner maternity beds. (Paragraph 258).

372. All general practitioner obstetricians should have access to general practitioner maternity beds. (Paragraph 258).

373. The use of general practitioner maternity beds should be limited to general practitioner obstetricians. (Paragraph 259).

374. General practitioner maternity beds should be reserved for normal cases. (Paragraph 260).

375. A representative panel should be set up for each general practitioner maternity unit to deal with all bookings. (Paragraph 261).

Chapter 10. *A Combined or Separate Maternity Service?*

376. At present the tripartite structure of the maternity service should be retained. It would not be practicable to transfer the maternity service alone to hospital control when all other health services remain under the tripartite structure. (Paragraph 293).

377. Measures need to be taken to improve the co-ordination and the co-operation between the three branches of the maternity service. (Paragraph 299).

378. There should be a firm link between the general practitioner obstetrician and the hospital. To strengthen this link fees for maternity medical services should be paid to general practitioner obstetricians by the hospital authorities. (Paragraph 299).

379. Those local authorities, to whom local health authority functions are delegated under the provisions of the Local Government Act, 1958, who find it difficult because of the small number of domiciliary confinements to maintain an economical domiciliary midwifery service, might make arrangements for this service to be provided by the local Hospital Management Committees. (Paragraphs 117 and 300).

Chapter 11. *Co-ordination Arrangements.*

380. Local maternity liaison committees with a professional membership should be formed to ensure that local provisions for maternity care are utilised to the best advantage. (Paragraphs 310 and 311).

381. Local clinical meetings should be encouraged so that all persons in an area responsible for carrying out maternity care can discuss the clinical aspects of maternity cases. (Paragraph 314).

382. The publication of clinical reports by the hospital authorities should be encouraged and, with the co-operation of the local authorities, extended to cover the domiciliary midwifery service. (Paragraph 315).

383. A standard co-operation card should be provided for use on a national basis. (Paragraph 316).

384. Arrangements for the exchange of information between the various individuals carrying out maternity care need to be strengthened and we have indicated in paragraphs 319 to 324 and in Appendix VIII the arrangements which should be adopted. (Paragraphs 319 to 324)."

APPENDIX VIII OF THE CRANBROOK REPORT:

"SUMMARY OF RECOMMENDED ARRANGEMENTS FOR THE EXCHANGE OF INFORMATION BETWEEN PERSONS CONCERNED WITH MATERNITY CARE.

A. In respect of patients booked for confinement in hospital—

1. Booking:
   (*a*) priority groups—the hospital will book these cases on its own initiative;
   (*b*) social cases. The hospital will refer to the local health authority for written assessment of social conditions.

   All information is supplied to the various bodies with the consent of the patient.

2. In all cases the hospital informs:

(i) the patient's family doctor of:

(*a*) her booking;
(*b*) any abnormalities which arise during pregnancy;
(*c*) her failure to attend clinic if they wish him to contact her;
(*d*) her emergency admission to hospital;
(*e*) her discharge from hospital;
(*f*) any abnormalities found at the post-natal clinic.

(ii) the local health authority of:

(*a*) her booking if they wish the local health authority to carry out health education;
(*b*) her failure to attend clinic;
(*c*) her discharge (if possible before she leaves).

In addition:

3. Where the hospital delegates their responsibility for ante-natal care to a general practitioner obstetrician—

(i) The hospital fills in the co-operation card stating clearly when they wish to see the patient again.

(ii) The hospital informs the general practitioner obstetrician of the:

(*a*) patient's booking;
(*b*) patient's discharge from hospital.

4. Where the hospital delegates their responsibility for ante-natal care to a local health authority—

(i) The hospital fills in the co-operation card stating clearly when they wish to see the patient again.

B. In respect of patients booked by a general practitioner obstetrician for confinement at home or in a general practitioner unit—

1. The general practitioner obstetrician informs:

(i) The patient's family doctor:

(*a*) when he books the patient;
(*b*) of any abnormalities which arise;
(*c*) if the patient is transferred to hospital;
(*d*) when the patient is discharged from his care.

(ii) the local health authority that he has booked the patient to ensure that she receives health education and, if she is to have her baby at home, that she books a domiciliary midwife.

2. The general practitioner obstetrician fills in the co-operation card. (If he is doing ante-natal care only for the hospital—he should fill in the co-operation card and inform the hospital of any abnormalities which may arise).

C. The procedure for the domiciliary midwife if the patient is booked for home confinement—

The domiciliary midwife:

(*a*) sends the patient to her family doctor to ensure that she books a general practitioner obstetrician;
(*b*) ensures that the patient receives ante-natal care;
(*c*) fills in the co-operation card;
(*d*) ensures that the patient receives the necessary health education and other local authority services.

D. Procedure for the local health authority—

Local health authority:

(*a*) notifies the hospital in writing of the reasons for admission to hospital of social cases;

(*b*) carries out any ante-natal care requested by the general practitione obstetrician or hospital—and fills in the co-operation card;

(*c*) follows up absentees from clinics for hospital, local authority or general practitioner obstetrician;

(*d*) ensures that a health visitor or midwife, where appropriate, attends the patient after discharge from hospital.

E. Procedure for family doctor—

The family doctor:

(*a*) if his patient attends him in the first instance he ensures that she books with the general practitioner obstetrician and midwife or attends hospital;

(*b*) if he is requested to do so follows-up absentees from clinic or sees that it is undertaken.

(*c*) informs the general practitioner obstetrician or hospital of any infectious disease in the family."

The Ministry of Health, in Circular 21/59 which has been set out above, referred to several matters on which consultation with the authorities and organisations was required. These were as follows:—

" (i) Reduction of the minimum lying-in period as prescribed by the Rules of the Central Midwives Board to ten days (para. 86).

(ii) Amendment of the Central Midwives Board's Rules regarding the definition of a 'maternity nurse' (para. 108).

(iii) The gradual replacement of the local authority medical officer by the general practitioner obstetrician in ante-natal clinics (para. 147).

(iv) Reservation of the use of local health authority ante-natal clinics for doctors on the obstetric list (para. 149).

(v) Payment of medical aid fees (para. 207), and

(vi) Publication of clinical reports (para. 315).

The County Health Committee agreed to the recommendations set out above with the exception of recommendation (i), (iii) and (iv).

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. 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 their work for the County Health Committee has already been referred to (under Section 22) as a substantial part of the care of mothers and young children is in their hands. Including the Superintendent Health Visitor and Deputy Superintendent Health Visitor, the establishment provides for the employment of seventy Health Visitors who also act as School Nurses.

The Health Visitor's duties are many and varied; in this County it includes school nursing, attendance at tuberculosis clinics, tuberculosis visiting, care of the aged, and the sub-normal and handicapped child. In this sphere much progress has been made, especially at Mothercraft and Relaxation Classes and in the schools. In all 332 talks have been given.

There is an acute shortage of Health Visitors, and at present there are eleven vacant areas in the County. Every effort is being made to recruit more staff.

Training of Health Visitors.

In view of the shortage of candidates to this 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 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.

One student commenced training under this scheme during the year under review.

In all there are thirteen Health Visitors in this County who were trained under this scheme since 1949, and only one has left the County Council's service since their contract expired.

Report of the Working Party on Health Visiting.

The Joint Medical Services Sub-Committee on 8th December, 1959 considered (1) a Circular issued jointly by the Ministry of Education and the Ministry of Health on the Health Visiting Services; (2) the "official summary" of the main conclusions and recommendations of the Report of the Working Party on Health Visiting ("Jameson Report"); and (3) certain comments of the County Councils Association on the need for co-operation in the field of social work, bearing in mind the recommendations not only of the "Jameson Report" but also the "Younghusband Report" on Social Workers employed in the Local Authority Health and Welfare Services. Miss Mindham, the Superintendent Health Visitor (who was to retire on 10th December, 1959) suggested that the efficiency of the Health Visiting Service could be improved by appointing (*a*) one Senior Health Visitor based on the County Offices (rather than a number of Area Group Advisors based on main clinics); and (*b*) an "Untrained Attendant" at each main clinic to assist the Health Visitors. The Sub-Committee, however, decided to consider the matters further after Miss Mindham's successor had taken up duty and bearing in mind the financial implications. The Joint Medical Services Sub-Committee on 12th April, 1960, considered a Report submitted by Miss E. Lloyd, the new Superintendent Health Visitor. The Sub-Committee decided (1) that the appointment of a Senior Health Visitor based on the County Offices be deferred until the position regarding the recruitment of further Health Visitors improves; and (2) to take no action regarding the appointment of a Clinic Assistant at each of the main clinics to assist the Health Visitors.

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 1).

Certain facts are extracted for use in the Department, but as they are likely to be of general interest they are set out in the Table on pages 96 and 97, 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).

MATERNAL AND CHILD WELFARE

1.	Ante-Natal Clinics—	
	Number of sessions	1,320
	New Cases	2,924
	Ante-Natal attendances	13,248
	Post-Natal attendances	555
2.	Visits to Homes—	
	Number of children under five years of age visited during year	39,726
	Expectant mothers:—	
	First visits	3,096
	Total visits	4,176
	Children under one year of age:—	
	First visits	11,099
	Total visits	31,964
	Children age one year and under two years:—	
	Total visits	18,086
	Children age two but under five years:—	
	Total visits	31,364
	Tuberculous Households:—	
	Total visits	2,616
	Other cases:—	
	Total visits	7,200
	Total number of families or households visited by Health Visitors	35,306
3.	Infant Welfare Centres—	
	Number of sessions	4,379
	Number of new cases:—	
	Under one year of age	8,949
	Number of children who attended during the year and who were born in:—	
	1959	7,089
	1958	5,724
	1957-54	4,745
	Total number of children who attended during the year	17,558
	Number of attendances made by children who, at the date of attendance were:—	
	Under one year	98,064
	One but under two	20,700
	Two but under five	11,921
	Total attendances during the year	130,685

	1953	1954	1955	1956	1957	1958	1959
NUMBER OF NOTIFIED BIRTHS:							
Live Births	11,039	10,122	10,130	10,769	10,946	10,991	12,532
Still Births	233	269	221	250	274	298	281
Total Births	11,272	10,391	10,351	11,019	11,220	11,289	12,813
DOMICILIARY MIDWIFERY:							
L.H.A. Midwives—Number of cases attended:							
as Midwives	2,938	3,047	3,039	3,349	3,430	3,500	3,548
as Maternity Nurses	1,510	1,385	1,352	1,402	1,351	1,228	1,304
Total	4,448	4,432	4,391	4,751	4,781	4,748	4,852
Midwives in private practice, number of cases attended:							
As Midwives	2	9	1	2	–	–	–
As Maternity Nurses	20	8	16	3	5	–	–
Total	22	17	17	5	5	–	–
Domiciliary Cases—Grand Total	4,470	4,449	4,408	4,756	4,786	4,748	4,852

Number of Domiciliary Cases attended as a percentage of all notified births	39.65	42.8	42.4	43.16	42.66	42.05	37.79
ANALGESIA.							
Number of cases in which inhalational analegsics were administered by L.H.A. Midwives in Domiciliary practice	2,501	2,667	2,611	3,104	3,631	3,642	4,073
Number of cases of Analgesia as a percentage of domiciliary births..	55.95	59.9	59.46	65.3	75.86	76.7	83.94
ANTE-NATAL CLINICS.							
Number of L.H.A. Clinics	22	22	23	23	24	24	24
Number of new cases attending during the year	4,183	3,976	3,777	3,837	3,349	3,149	2,924
Number of new ante-natal cases as a percentage of all notified births	37.1	38.3	36.5	34.8	29.85	27.89	24.38
POST-NATAL CLINICS:							
Number of cases attending during the yeat (including post-natal cases at Ante-natal Clinics)	394	487	514	559	506	485	473
Number of new post-natal cases as a percentage of all notified births	3.49	4.68	4.97	5.07	4.51	4.29	3.69
INFANT WELFARE CENTRES:							
Number of L.H.A. Centres	85	85	86	88	92	95	97
Number of Voluntary Centres	3	3	3	2	2	2	2
Number of children who first attended an Infant Welfare Centre during the year (under one year)	6,374	6,995	6,245	6,663	7,069	7,294	9,108
Number of first attendances of children under one year of age at I.W.C.'s as a percentage of notified live births	57.74	69.17	60.3	61.87	63.00	66.36	72.67

HOME NURSING SERVICE

(Section 25)

This service has been in operation for eleven years and its value to the community is now so well known and appreciated that little comment is necessary. The administration is very similar to that of the midwifery service which is described earlier in the report. The day to day running of the service in the Borough of Chesterfield is under the control of the Area Medical Officer assisted by a Superintendent of Home Nurses. In the remainder of the County the administration is from the County Offices in Matlock, and the County Medical Officer is assisted by his Deputy as well as by two Nursing Superintendents who are also Supervisors of Midwives. The service continued in 1959 much on the same general lines which were adopted when it came into operation in 1948.

When vacancies occur the circumstances in the area concerned are reviewed to see if in the interests of the service any changes are desirable.

It is the policy of the Council to separate wherever possible home nursing from midwifery because of the possible danger of spreading infection from general nursing cases to women in childbirth.

The following table shows the staffiing position at the end of each year since the inception of the service.

	1948	1949	1950	1951	1952	1953	1954	1955	1956	1957	1958	1959
Full-time—												
Home Nurse-Midwives	44	43	38	37	35	35	32	30	30	29	29	27
Home Nurses	81	91	104	99	99	99	103	108	112	112	114	115
Total	125	134	142	136	134	134	135	138	142	141	143	142
Part-time	2	–	2	3	2	–	–	–	–	–	–	1
TOTAL full-time and part-time	127	134	144	139	136	134	135	138	142	141	143	143

During 1959 the nurses attended 14,865 patients and the number of visits paid was 385,343, 39% of the patients attended were over sixty-five years of age at the time of the first visit, and 3% were under five years of age. Of all the patients visited 23% were paid more than twenty-four visits.

In Appendix I to this report a copy of the Annual Return to the Ministry of Health is set out, giving details of this services provided by the Authority, and in Part I, Section 6, is an analysis of the type of work the nurses are now called upon to carry out, showing the number of cases and visits made to medical, surgical, infectious diseases, tuberculosis, maternal complications and others.

The home nursing service does much to relieve the pressure on hospital beds. It has been reported that nursing in the home, when possible, is far more acceptable to the majority of patients than treatment in hospital, particularly in the cases of the elderly and young children, as they seem to progress more favourably in familar surroundings. Furthermore, it is often found possible to discharge patients from hospital sooner than might otherwise be the case as the home nurse is able to continue the treatment under the care of the patient's own doctor. The provision of nursing aids through the County Council's Care and After-Care service is also proving very helpful in this connection.

Chemotherapy is now widely used in domiciliary treatment and the home nurses are called upon to administer injections for a variety of diseases under the direction of the patient's own doctor. The number of patients visited for this purpose during the year was 5,601, involving 146,332 special visits.

The County Council has realised the advantage to all concerned of nurses using cars in connection with their duties, and it is their policy to grant car allowances to these Officers. The number using cars at the time of writing is 126 out of 142 nurses. Many nurses take advantage of the County Council's Scheme for granting loans towards the purchase of cars.

Local Housing Authorities have again been helpful in most instances in renting houses on their Housing Estates for occupation by home nurses, thus enabling the nurses to reside where there is a concentration of population.

The principle of enabling nurses to attend Post-certificate or Refresher Courses every five years has been continued, and in addition to this, for the third year in succession, a limited number of nurses have been allowed to attend Special Courses on Mental Health. This type of Course is felt to be important in view of the changing attitude towards mental illness. There can be no doubt that money spent on these Courses is well worth-while as the nurses are made aware of the latest advances in treatment.

VACCINATION AND IMMUNISATION
(Section 26)

Considerable advances have been made in recent years in the various forms of vaccination and immunisation. There is evidence to suggest that the general public are realising the value of these procedures and are becoming more willing to take advantage of the facilities now provided.

Diphtheria.

There can be little doubt that immunisation against diphtheria has played an important part in reducing the incidence and mortality from this disease in the country generally. As far as Derbyshire is concerned

it is very gratifying to report that for the fourth year in succession no notifications or deaths from diphtheria have been reported. Despite the fact that for the last few years considerable emphasis has been given to vaccination against poliomyelitis there has been a steady though slight increase in the number receiving primary courses of diphtheria immunisation. On the other hand, however, there has been a decrease in the number of persons given booster injections, but as these are usually given in the older age groups, it is probably due to parents thinking it is more important for their children to be vaccinated against poliomyelitis.

The following table gives the number of persons given primary and booster courses over the last few years:—

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
1957.. ..	8,577	6,570
1958.. ..	8,973	4,536
1959.. ..	9,552	4,492

The following tables give details of the children who completed a course on immunisation or received booster (re-inforcing) doses during 1959 in the form required by the Ministry of Health:—

DIPHTHERIA IMMUNISATION RETURN FOR THE YEAR ENDED 31st DECEMBER, 1959

	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	6,032	2,023	1,497	9,552
B. NUMBER OF CHILDREN WHO RECEIVED A SECONDARY (REINFORCING) INJECTION (i.e., subsequently to primary immunisation at an earlier age). TOTAL FOR THE YEAR	—	1,167	3,325	4,492

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, 1959.

IMMUNISATION IN RELATION TO CHILD POPULATION

Number of children at 31st December, 1959, who had completed a course of Immunisation at any time before that date (i.e. at any time between 1st January, 1945 and 31st December, 1959.)

Age at 31.12.59 i.e. Born in Year	Under 1 1959	1—4 1955–1958	5—9 1950–1954	10—14 1945–1949	Under 15 Total
Number of children whose last course (primary or booster) was completed in the period:					
A. 1955–1959 ..	6,032	23,536	24,343	13,902	67,833
B. 1954 or earlier ..	..	..	24,081	35,941	60,022
C. Estimated mid-year child population	11,400	43,900	116,400		171,700
Immunity Index 100A/C	52.9%	53.6%	32.9%		39.5%

The Immunity Index is rising steadily, particularly in the younger age groups.

The following extract from a letter dated the 5th November, 1959, from the Public Relations Officer of the Ministry of Health gives interesting information from the national standpoint:—

"1. *Diphtheria Immunisation.*

It is satisfactory to record that the number of children in the under one age group immunised in 1958 was 346,000 and that the immunity index in the under five group rose to 54% from 53.4 in 1957. It is less satisfactory to note that in 1958 the immunity index relating to the under fifteen age group fell from 47.9% to 46.7%, due to a substantial reduction in the number of reinforcing doses which fell from 452,000 to 384,000. Compared with the previous year notifications and deaths also rose in 1958 as a result of two sharp outbreaks. The comparative figures for England and Wales from 1953 onwards are as follows:—

Diphtheria, Corrected Notifications and Deaths.
(Excluding late Deaths).

Year	*Notifications*	*Deaths*
1953	266	20
1954	173	8
1955	155	12
1956	53	3
1957	37	4
1958	80	8

Whooping Cough; Tetanus.

Immunisation against these diseases was dealt with at some length in the Annual Report for 1958. Briefly, the scheme for making antigens available to General Practitioners came into operation in October of that year. The table on page 103 shows amongst other things the number of persons given Whooping Cough and Tetanus immunisation, either singly or combined with some other type of antigen.

Small Pox.

The same general remarks regarding Diphtheria immunisation apply in the case of Small Pox vaccination, and whilst no cases have been reported in the County, and no major outbreaks have occurred nationally, it is important that the vaccination rate should be high as otherwise there is a possibility that if the disease is introduced into the Country a major epidemic may occur.

As will be seen from the following table the number of both primary vaccinations and re-vaccinations has decreased slightly:—

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
1957.. ..	2,833	656
1958.. ..	3,541	715
1959.. ..	3,234	648

The following is a copy of the Annual Return for the year ended 31st December, 1959, 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	2,325	242	154	154	359	3,234
Number Re-vaccinated..	3	5	24	50	566	648

II. NUMBER OF CASES SPECIALLY REPORTED DURING PERIOD.

None.

The following are the number of persons immunised during 1959:—

	PRIMARY		*BOOSTER*	
	G.P's.	*M.O's. of D.C.C.*	*G.P's.*	*M.O's. of D.C.C.*
DIPHTHERIA				
0–4 years	1,503	407	331	453
5–14 years	122	818	502	1,750
Total	1,625	1,225	833	2,203
DIPHTHERIA-TETANUS-PERTUSSIS				
0–4 years	4,532	–	252	–
5–14 years	150	–	306	–
Total	4,682	–	558	–
DIPHTHERIA-PERTUSSIS				
0–4 years	1,079	–	105	–
5–14 years	40	–	83	–
Total	1,119	–	118	–
DIPHTHERIA-TETANUS				
0–4 years	19	–	13	–
5–14 years	21	–	15	–
Total	40	–	28	–
WHOOPING COUGH				
0-4 years	321	249	20	5
5–14 years	21	10	18	3
Total	342	259	38	8
PERTUSSIS-TETANUS				
0–4 years	7	–	–	–
5–14 years	8	–	–	–
Total	15	–	–	–
TETANUS				
0–4 years	12	2	2	–
5–14 years	30	–	1	–
15 years or over	38	–	5	–
Total	80	2	8	–
SMALLPOX				
Under 1 year	2,208	20	3	–
1 year	204	24	5	–
2–4 years	141	3	22	–
5–14 years	140	3	46	–
15 years or over	326	5	464	37
Total	3,019	55	540	37
Grand Total ..	10,922	1,541	2,193	2,248

Bacillus Calmette Guerin (B.C.G.) Vaccination against Tuberculosis.

Whilst the powers for providing and carrying out this form of vaccination are given under Section 28 of the National Health Service Act (Prevention of illness, Care and After-Care), for the purpose of this Report it is convenient to deal with it under the general section on Vaccination and Immunisation. This type of vaccination falls under two headings, namely: (1) the Contact Scheme; (2) the Schoolchildren's Scheme.

(1) *The Contact Scheme* is carried out by Chest Physicians who wish to use it on their own medical responsibility for contacts of cases of respiratory tuberculosis, and is generally confined to children. The scheme came into operation in 1950 when the Ministry of Health made available supplies of vaccine. The numbers of persons vaccinated under this scheme are as follows:—

1950	..	38	1955	..	387
1951	..	164	1956	..	339
1952	..	165	1957	..	530
1953	..	269	1958	..	694
1954	..	379	1959	..	586

(2) *The Schoolchildren's Scheme.* In the first place this scheme provided for the B.C.G. vaccination of children between their thirteenth and fourteenth birthdays (subject to parental consent). This age group was chosen by the Ministry of Health because it enables the majority of children to be vaccinated in what is their penultimate year at school, and to leave school with such protection as the vaccination affords. However, in April 1959 the Ministry of Health, in Circular 7/59 stated:—

"The Minister is now prepared to approve the extension of these arrangements as follows:—

(i) to children of fourteen years of age and upwards who are still at school and also students attending universities, teacher training colleges, technical colleges or other establishments of further education; and

(ii) it having been represented that it would be convenient if vaccination could be offered to whole school classes even though a few of the children are under thirteen years of age, the Minister is prepared to approve arrangements on these lines."

The County Council's existing proposals under the National Health Service Act 1946 cover all this extension so that the new provisions were applied without delay.

Briefly, the procedure is to skin test the pupils and the negative reactors are then vaccinated with B.C.G. The Ministry of Health supplies on request the material for skin testing and the actual B.C.G. The School Medical Officers carry out this work and as it is essential

that they should be trained in the technique of the procedure the County Health Committee has sanctioned them attending approved courses of instruction. The scheme came into operation to a limited extent towards the end of 1957 and is being extended gradually over the whole of the County as staff becomes available. However, Poliomyelitis vaccination has occupied much of the School Medical Officers' time, and consequently the scheme has not extended as much as one would like. Details of the work carried out from 1957 to 1959 are given below:—

Year	No. of schools at which skin testing and B.C.G. were carried out	NUMBER OF CHILDREN				
		Offered skin testing and B.C.G.	Skin tested	No. found positive	Tuberculin negative	Vaccinated with B.C.G.
1957	6	584	442	not available	330	329
1958	29	3,098	2,065		1,564	1,542
1959	68	9,694	6,405	1,394	4,891	4,725

Children who are tuberculin positive are, of course, not offered vaccination as they are already deemed to have a degree of immunity. Under these two schemes a total of 5,311 persons were given B.C.G. in 1959 as compared with 2,236 in 1958.

The following is a copy of a communication received from the Ministry of Health concerning the 2nd report of the Tuberculosis Vaccines Clinical Trials' Committee:—

"B.C.G. Vaccination.

1. The Second Report to the Medical Research Council by their Tuberculosis Vaccines Clinical Trials Committee was published in the British Medical Journal on 12th September, 1959, under the title 'B.C.G. and Vole Bacillus Vaccines in The Prevention of Tuberculosis in Adolescents.' There were 56,700 participants in the trial who at their entry to it were between fourteen and fifteen-and-a-half years. Those who were tuberculin negative were divided into four groups.

(1) B.C.G. vaccinated group in whom, during the five year period of follow-up the annual incidence of tuberculosis was 0.38 per 1,000.

(2) Concurrent tuberculin negative unvaccinated group: annual incidence 2.29 per 1,000.

(3) Vole bacillus vaccinated group: annual incidence 0.33 per 1,000.

(4) Concurrent tuberculin negative group: annual incidence 2.62 per 1,000.

2. The protective efficacy of each vaccine was thus substantial and moreover, the incomplete information beyond five years shows that similar high levels of protection have continued up to at least six and a half years after entry to the trial. The degree of protection was similar for pulmonary tuberculosis, for tuberculous pleural effusion and for hilar gland enlargement (in association with other lesions).

Further, there were no cases of tuberculous meningitis or miliary disease among the vaccinated compared with four of each among the unvaccinated and too there is a suggestion that the lesions which did occur among the vaccinated group were less severe than those among the unvaccinated.

3. This evidence therefore suggests that vaccination of children about the age of fourteen does confer a considerable degree of protection over a period of five years and probably for six and a half years.

4. Those who were positive to the tuberculin test on entry to the trial can be divided into two groups.

(1) Those strongly positive to 3 T.U. (15 mm. induration or more) had an annual incidence of 3.50 per 1,000 in the first two and a half years, 1.67 in the second two and a half years and 0.88 in the five to seven and a half year period.

(2) Those weakly positive to 3 T.U. or only positive to 100 T.U. There were annual incidences of 0.77 and 0.73 per 1,000 during the first two and a half years and subsequent periods.

5. The trial is to continue on a modified scale with the object of determining whether the degree of protection demonstrated over five years and almost six and a half years persists even longer.

6. In the meantime the trial has demonstrated:

(1) B.C.G. vaccination offers a substantial degree of protection.

(2) The risk of subsequent clinical tuberculosis in those strongly positive to 3 T.U. is appreciable.

(3) The risk of subsequent disease among those with a weak reaction to 3 T.U. or who are only positive to 100 T.U. is less, but still twice that of the B.C.G. vaccinated group.

7. The present B.C.G. programme is based on the tuberculin test at age thirteen. Those who are negative reactors to the test are offered B.C.G. vaccine, either the Danish liquid vaccine or the freeze-dried vaccine manufactured in this country. The conversion rate of the freeze-dried vaccine is comparable to that of the liquid one and the vaccine has the advantage that it can be stored under suitable conditions up to twelve months before use so that viability tests can be made before the vaccine is issued.

8. The value of tuberculin testing at age thirteen is not only to sort out those suitable for vaccination but also to bring to light those in whom there is a strong positive reaction and among whom an annual incidence of tuberculosis of the order of 3.50 per 1,000 may be expected in the next two and a half years. These strong positive reactors need supervision and there is a good case for arranging that they should be under the care of a chest physician so that both they and their contacts can be kept under supervision. For other positive reactors to the tuberculin test it should suffice to arrange an annual attendance for x-ray. In addition the general practitioner should be informed so that he can advise an x-ray at an earlier date if he considers it necessary.

9. The very considerable value to the community of a B.C.G. programme which advocates tuberculin testing of schoolchildren at thirteen and B.C.G. vaccination to tuberculin negatives before school leaving can only be achieved where the programme is vigorously pursued. At present less than half the schoolchildren who could benefit under the scheme do so. To increase the number of children tuberculin tested will mean that more children are given a measurable degree of protection, that more children already infected come under the direct care of the chest physician and that the opportunities of discovering sources of infection by contact tracing are considerably improved.

10. Because of the importance both to the individual and to the medical officer of health of the B.C.G. record card, medical officers of health are advised to retain cards for a period of ten years.

11. The M.R.C. Trial is to continue on a modified scale for a further period, the object being to determine whether and how far the manifest advantages of B.C.G. vaccination persist beyond the so far proven six and a half years of the trial. A scheme will be worked out under which it is hoped that chest physicians and medical officers of health will be able to inform the M.R.C. of any cases of tuberculosis which occur among the trial participants. The M.R.C. B.C.G. Trials Committee will be very grateful for any help that medical officers of health and chest physician, are able to give in this follow up, details of which will be sent to medical officers of health later."

This communication was circulated to the Authority's Senior Medical Officers and School Medical Officers with a covering letter which is given below:—

"*B.C.G. Vaccination.*

I enclose for your information a short note on the second report of the Medical Research Council's Tuberculosis Vaccines Clinical Trials Committee with some suggestions on the future prosecution of the B.C.G. vaccination scheme.

The note is self explanatory but I would stress the very favourable results of B.C.G. vaccination mentioned in paragraphs 1 to 3. I would also stress the value of tuberculin testing in the thirteen year age group. As mentioned in paragraph 8 of the note the incidence of tuberculosis in the strongly positive group is as high as 3.5 per thousand per annum.

I would, therefore, like to refer to the instruction which appears on the form of return which School Medical Officers make on the results of their vaccinations in the thirteen year old children which reads—

"Children who give only mild positive reactions to tuberculin are those least likely to develop tuberculosis. Children who are tuberculin tested in conjunction with the B.C.G. programme and are found to be severe reactors, e.g., degree 4 positive to the Heaf test, or give more than 15 mm reaction to 3 T.U. Mantoux should be X-rayed. It may be suggested that where serial tuberculin testing of schoolchildren is being carried out, only tuberculin hypersensitive children should be X-rayed."

One further point is that while we have not carried out controlled trials in Derbyshire, we can say that the amount of tuberculosis measured either by deaths from the disease or by notification is appreciably less than in the country as a whole. The tuberculosis death rate (all ages) was 7 per 100,000 of the population in the County as compared with 10 for England and Wales in 1958. The notifications in the ten-plus to twenty age group in the last few years have been:—

1951	..	71	1955	..	48
1952	..	85	1956	..	44
1953	..	67	1957	..	51
1954	..	65	1958	..	50

If the present figure of fifty is taken, then the annual incidence, assuming a population in the age group of 115,000, the children age ten-plus to twenty in 1958 would be born between 1939-1948 (the births 1939-1948 inclusive which are readily available total 115,688), is just under 0.44 per thousand. This compares with 0.38 per 1,000 in the B.C.G. vaccinated group in the national survey. The years, of course, do not exactly correspond, but from 1955 onwards I feel fifty is a fair figure to take for the County.

While this low incidence of tuberculosis in Derbyshire is reassuring, the Medical Research Council trials show that we have in B.C.G. vaccination a means of combating still further the disease in adolescents. We hope by its means to achieve even better results in the future."

It can now be said that the figures for 1959, which were, of course, not available when the above circular letter was written, show that the incidence during the year under review was not fifty but twenty-eight.

Poliomyelitis.

The poliomyelitis vaccination scheme was discussed at length in my Annual Report for 1958. During 1959 the scheme continued on the same lines, allowing the following groups to be vaccinated: (1) children aged six months and over and all other persons up to the age of twenty-six years; (2) expectant mothers; (3) General Medical Practitioners, hospital staff who come into contact with patients; medical students; ambulance staff; and the families of these groups.

During 1959, 103,820 Derbyshire patients received two injections against poliomyelitis and 76,558 received their third injections. From the inception of the scheme in 1956 up to 31st December, 1959, 170,051 Derbyshire patients received two injections, and of these, 76,941 received their third injections.

(NOTE: Since February, 1960, the following groups are eligible for vaccination against poliomyelitis: (1) children aged six months and over and all other persons who have not at the time of their application for vaccination reached the age of forty years; (2) expectant mothers; (3) General Medical Practitioners; medical students; hospital staff who come into contact with patients; practising Dental Surgeons; dental students; Dental Hygienists; student Hygienists; Dental Surgeons' Chair-side Assistants; practising Nurses; ambulance staff; and Public Health staff who might come into contact with poliomyelitis cases; and the families of all the persons mentioned in this group; (4) persons going to visit or reside in a country outside Europe other than Canada or the United States of America).

Yellow Fever.

Persons who propose to travel to certain countries are required to possess a certificate of vaccination against yellow fever as a condition of entry. This form of vaccination has hitherto been carried out at Regional Blood Transfusion Centres and certain hospital laboratories, because the type of vaccine in use until recently has required special storage facilities and techniques. Those requirements no longer apply, since the vaccine is now prepared in dried form and may be stored in an ordinary domestic refrigerator.

On 25th June, 1959, the Ministry of Health issued Circular 19/59 in which it was stated that it was now felt that the requisite protection to persons going abroad might be offered by Local Health Authorities as part of their functions under s.28 of the National Health Service Act. This type of vaccination is required by the International Sanitary Regulations to be performed at centres designated by the Ministry. The Ministry pointed out that there were nineteen existing centres in England and Wales, and it was thought desirable to increase this number, although it was not necessary to establish a centre in every large town. The centres would not need to be open each day, and travellers would be expected—as hitherto—to make an appointment for vaccination (except in an emergency).

The County Health Committee decided to inform the Ministry that they were agreeable to providing facilities for yellow fever vaccination at the County Council Clinics in Derby, Chesterfield and Buxton. As the Ministry had stated that it would be reasonable for authorities providing this service to recover the full cost, it was decided to make a charge of £1 1s. 0d. for each vaccination performed. The Circular also stated that the vaccine would be purchased by the Authority from the manufacturers, and the vaccinations would be performed under the authority of the County Council's Medical Officer of Health, who would be responsible for the issue of the relevant International Certificates of vaccination. The Authority are required to keep detailed records of each vaccination which is carried out.

The position at the end of 1959 was as described in the foregoing paragraphs. It may be added, however, that in March, 1960, the Ministry informed the County Council that it had been decided to designate some forty centres at which vaccination against yellow fever could be provided, and they included the Derbyshire County Council's Clinic in Cathedral Road, Derby, which is the only one in the geographical County. It was suggested that the new scheme might operate from 1st July, 1960, and at the time of writing these notes preparations are being made to put it into operation on that date.

AMBULANCE SERVICE

(Section 27)

Structure and Organisation.

During the year there was no change in the basic structure and organisation of the Ambulance Service, the County being served by four Main Stations manned throughout the twenty-four hours and ten Sub-Stations manned during the day-time only i.e., from 7 a.m. to 7 p.m. In respect of the latter, personnel were on stand-by duty at night with the exception of the Sub-Stations at Bolsover and Glossop where the stand-by cover was afforded respectively by the Chesterfield Ambulance Station, operated by the Derbyshire County Council, and the Stalybridge Ambulance Station, under the control of the Cheshire County Council.

At the time of writing this report, however, the Day Station at Bolsover has been dispensed with and a completely new Station, manned throughout the twenty-four hours, has been established at Eckington which, together with the Main Station at Chesterfield, now affords full cover for the North East of the County. Consequently it has been possible to dispense with the agency arrangements which existed with the Sheffield County Borough for transporting Derbyshire patients living in the "fringe" area to Hospitals in Sheffield.

In connection with the changeover, consultations took place with the Group Secretaries of the Hospitals concerned, who were most co-operative and anxious to render all the assistance they could in the interests of patients.

The system introduced whereby all requests for ambulance transport, whether urgent or non-urgent, arising in the North East of the County are received by the Main Station at Chesterfield, which is also a fixed station for radio-telephony, has resulted now in a fuller measure of co-ordination than hitherto existed.

Whilst this system has been operating only for a comparatively short period i.e., since the Eckington Station has been opened, it seems both from the standpoint of economy as well as of patients' interests that the arrangement has proved satisfactory; in the light of experience it may be considered expedient for this system, by which all requests for ambulance transport are received only by Main Stations, to be extended to other parts of the County.

Main Station Superintendents, supported by four Shift/Leaders working on a rota, have continued to supervise the Day Stations in their respective areas in the absence of the Day Station Superintendent.

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, when 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.

During the year the Council continued the arrangements with Cheshire County Council whereby the Derbyshire Ambulance Service gave full cover to the Disley area. The reciprocal arrangements with neighbouring authorities remained in force and every effort was made to co-ordinate ambulance journeys with other authorities, particularly those contiguous to the County. All long distance journeys outside the County were dealt with centrally and wherever possible our ambulances that were returning empty were utilised to convey patients on behalf of other authorities.

In order to reduce the amount of detailed accounting in respect of journeys undertaken on behalf of other authorities the arrangements with certain neighbouring authorities to waive charges were continued during the year.

Addresses and Telephone Numbers of Ambulance Stations.

Ambulance Station	*Telephone Number*		*Address*
	7 a.m. – 7 p.m.	7 p.m. – 7 a.m.	
Main Station			
*MICKLEOVER	Derby 53916		Station Road, Mickleover, Derby.
Sub-Stations			
Ashbourne ..	Ashbourne 441		Green Road, Ashbourne.
Ilkeston	Ilkeston 936	Derby 53916	Manners Avenue, Ilkeston.
Long Eaton ..	Long Eaton 1055		Old Hall Depot, The Green, Long Eaton.
Swadlincote ..	Swadlincote 7041		Civic Centre, Off Midland Road, Swadlincote
Main Station			
*RIPLEY ..	Ripley 75		Ivy Grove, Ripley.
Sub-Stations			
Heanor	Langley Mill 3141	Ripley 75	Wilmot Street, Heanor.
Matlock	Matlock 706		Town Hall, Bank Road, Matlock.
Main Station			
*BUXTON ..	Buxton 2012		Park Road, Buxton.
Sub-Stations			
New Mills ..	New Mills 3333		Park Road, New Mills.
Bakewell ..	Bakewell 393	Buxton 2012	Baslow Road, Bakewell.
Glossop	Glossop 3101		Talbot House, Talbot Road, Glossop.
Main Station			
*CHESTERFIELD	At all times		Ashgate, Chesterfield.
Sub-Station			
=Eckington** ..	Chesterfield 6282		Castle Hill, Eckington.

= Manned throughout the 24 hours.

* Manned throughout the 24 hours and equipped for radio control.

** Apart from the requisition of Ambulance transport, the Tel. No. of this Station is Eckington 691.

NOTES: (*a*) For all emergency cases, call the Telephone Exchange and ask operator for "AMBULANCE."

(*b*) In all cases of difficulty in contacting a Sub-Station manned only from 7 a.m.—7 p.m. daily, contact should be made, where necessary, with the appropriate Main Station indicated above.

Conveyance of Mental Patients.

As in the previous year, ambulance transport for conveying mental patients to the Pastures Hospital, Mickleover, who required specially trained attendants, was provided by the Mickleover Ambulance Station. The transportation of all other patients outside the scope of this arrangement was dealt with by vehicles from other Stations in the County.

The ambulance transport provided during the year for conveying mental defective patients to Training Centres in the County was somewhat less than the previous year; in all cases appropriate charges were made on the Mental Health Service.

Conveyance of Patients by Rail.

There is no doubt that the ambulance/rail/ambulance method of transporting patients over long distances has become recognised as generally more satisfactory than road transport. The number of rail journeys undertaken during the year under review was 303 compared with 304 the previous year. The Railway Undertaking as well as other Local Health Authorities have been most co-operative in connection with the transportation of patients under these arrangements. Similarly, the British Red Cross Society and the St. John Ambulance Brigade have been most helpful in providing escorts, sometimes unavoidably at short notice.

Infectious Diseases.

The arrangements which have been in force since the inception of the Service whereby all cases of infectious disease are transported by the general Ambulance Service were continued during the year. All personnel are familiar with the procedure for dealing with such patients and Station Superintendents have been instructed in the disinfection of vehicles, bedding and equipment.

Since 1951, biennial vaccination against smallpox of all operational ambulance personnel has been carried out in the Ambulance Service. The following table shows the number of personnel vaccinated during the past five years:—

Year	*Smallpox Vaccinations*
1955	81
1956	88
1957	94
1958	94
1959	101

Major Accidents.

The arrangement was continued for an emergency reserve of equipment to be located at each of the Main Stations for the purpose of dealing with any major accident. The procedure for dealing with a major accident is reviewed from time to time and amendments made in the light of changing circumstances.

Premises.

During the year work commenced on the building of new Ambulance Stations at Ilkeston, New Mills, Swadlincote and Eckington. Whilst good progress was made, none of the buildings was actually ready for occupation by the end of the year.

The Council has pursued the question of the acquisition of suitable sites in other areas where the Ambulance Stations fall below the standard required for a modern Ambulance Service.

Telecommunications.

The Council has continued its policy of equipping all ambulances, fitted with the 12 volt electrical system, with radio-telephony. As and when the older type vehicles with the 6 volt electrical system are passed out of service they are replaced by new ambulances with the 12 volt electrical system, and additional mobile units are introduced. Under this arrangement nine additional mobile sets were purchased during the year, although the delivery was not effected by the 31st December, 1959. These mobile units are, therefore, not included in the figures shown in the following table, which indicates the number of mobile equipments which were operating under the respective Fixed Stations on the 31st December, 1959.

Controlling Base Station	*Sub-Station*	*Number of Mobile Equipments*
Buxton	.. .. ..	8
	Bakewell	3
	Glossop	2
	New Mills ..	3
Chesterfield ..	.. .. ..	10
	Bolsover	2
Mickleover	.. .. ..	8
	Ashbourne ..	2
	Ilkeston	4
	Long Eaton ..	2
	Swadlincote ..	3
Ripley	.. .. ..	7
	Heanor	2
	Matlock	3
	Total ..	59

NOTE: Of the above fifty-nine Mobile Units fourteen sets conform to the specification laid down for the new 25 Kc/s channelling whilst the remainder are designed for the 50 Kc/s channelling and it is understood cannot be converted.

The question of interference at the Fixed Radio Stations at Mickleover and Ripley has not yet been definitely resolved. Reference was made in my report for 1958 to tests in connection with the operation of a remotely controlled Fixed Station at Alport Height, with reciprocal frequency working, and also the advisability of further tests for a longer trial period in order to confirm that the system was entirely satisfactory before introducing the scheme and incurring additional expenditure. These further tests, which were commenced on the 26th October, 1959 were still continuing at the end of the year under review.

Personnel.

Safe Driving Awards.

The following Table shows the results of the 1959 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*	*20 Year Brooch*	*21 Year Bar*	*Exemptions*
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	–	–	–
1957	171	7	44	76	3	28	1	1	1	2	–	–	8
1958	182	3	50	78	6	27	6	4	–	2	1	–	5
1959	192	7	21	100	9	24	9	8	2	1	1	1	9

The total number of accidents, in which ambulance service vehicles were involved during the year, was 138 compared with 173 for 1958 (i.e. a decrease of 20.2%). This is particularly gratifying having regard to the ever increasing traffic problems experienced on the roads today and the fact that the vehicles travelled an increased mileage of 3.1% over last year. As pointed out in previous years all accidents, no matter how trivial, are reported and investigated by the County Ambulance Officer, irrespective of whether they occur on the public highway or not. The high standard of finish to the modern ambulance bodywork may easily be damaged through the slightest accident and, therefore, the standard of driving and care of vehicles by crews must at all times be of the highest order.

Whilst over last year there was an increase of ten drivers entered for the Competition of the Royal Society for the Prevention of Accidents, the number disqualified was reduced from 50 to 21, i.e. a decrease of 58%.

An analysis revealed that of the 138 accidents, seventy-four were on the public highway, thirty-nine within the curtilage of Ambulance Stations, Hospitals and other premises, whilst in the remaining twenty-five cases the cause of the damage to our vehicles was unidentified.

Accidents when reversing occurred in nineteen instances, that is 13.76% of the total, but in ten of these cases the driver had no attendant to give assistance.

Ambulance Service drivers were considered blameworthy to some degree in connection with forty accidents, i.e. 28.98% of the total during the year; when comparing this figure with the twenty-one shown in the Table above as disqualified it must be borne in mind that some drivers were held to be blameworthy in respect of more than one accident.

Incidentally, it is interesting to note that at three Stations in the County, namely, one twenty-four-hour Station and two Day Stations, no driver was considered blameworthy for any accident during the year; the vehicles at these Stations travelled a total distance of 340,800 miles.

Establishment.

The following table shows the authorised establishment of ambulance personnel as at the 31st December, 1959:—

Ambulance Station	*Station Superintendent*	*Shift Leaders*	*Senior Drivers*	*Driver Attendants*	*Female Clerks*
Ashbourne	1	–	1	5	–
Bakewell	1	–	1	6	–
Bolsover	1	–	1	9	–
Buxton	1	4	–	24	–
Chesterfield ..	1	4	–	29	1
Glossop	1	–	1	6	–
Heanor	1	–	1	5	–
Ilkeston	1	–	1	7	–
Long Eaton ..	1	–	1	7	–
Matlock	1	–	1	7	–
Mickleover	1	4	–	24	–
New Mills	1	–	1	5	–
Ripley	1	4	–	28	–
Swadlincote ..	1	–	1	5	–
Totals ..	14	16	10	167	1

Vehicles.

During the year the following new replacement vehicles were ordered:—

Seven Bedford/Lomas Ambulances on the J type Chassis and Three Bedford/Lomas Light Ambulances on the CA Chassis.

The following vehicles were operational on the 31st December, 1959:—

Location	*Number of Ambulances*	*Number of Light Ambulances*	*Number of Cars*
Ashbourne	2	1	–
Bakewell	3	1	1
Bolsover	3	1	–
Buxton	6	3	1
Chesterfield	7	3	1
Glossop	2	1	1
Heanor	2	–	1
Ilkeston	3	1	–
Long Eaton ..	3	1	1
Matlock	3	1	–
Mickleover	6	2	1
New Mills	3	–	–
Ripley	6	2	1
Swadlincote	2	1	1
Pool	8	–	–
Totals ..	59	18	9

The following Table shows the average:—

(*a*) daily mileage travelled; (*b*) number of patients conveyed per day; and (*c*) mileage per patient.

compared with similar figures for the corresponding months of the previous four years:

Month	1955			1956			1957			1958			1959		
	Average Daily Mileage	*Average Daily Patients*	*Average Miles per Patient*	*Average Daily Mileage*	*Average Daily Patients*	*Average Miles per Patient*	*Average Daily Mileage*	*Average Daily Patients*	*Average Miles per Patient*	*Average Daily Mileage*	*Average Daily Patients*	*Average Miles per Patient*	*Average Daily Mileage*	*Average Daily Patients*	*Average Miles per Patient*
January ..	4,233	513	8.2	4,328	553	7.8	4,344	558	7.8	4,431	572	7.7	4,645	610	7.6
February ..	4,460	555	8.0	4,583	590	7.8	4,207	554	7.6	4,043	523	7.7	4,616	588	7.8
March ..	4,498	552	8.1	4,525	569	7.9	4,114	515	8.0	4,366	599	7.8	4,216	530	7.9
April ..	4,342	525	8.3	4,349	592	7.3	4,161	513	8.1	4,361	554	7.9	4,726	598	7.9
May ..	4,527	550	8.2	4,330	567	7.6	4,471	569	7.8	4,359	565	7.7	4,463	560	7.9
June ..	4,534	556	8.1	4,247	553	7.7	4,078	492	8.3	4,356	559	7.8	4,680	598	7.8
July ..	4,454	528	8.3	4,196	515	7.1	4,414	563	7.8	4,347	574	7.6	4,602	600	7.7
August ..	4,441	531	8.4	4,012	507	7.9	4,082	494	8.2	4,146	528	7.8	3,961	498	7.9
September	4,649	571	8.1	4,137	510	8.1	4,207	509	8.2	4,475	579	7.7	4,467	581	7.7
October ..	4,455	558	8.0	4,442	546	8.1	4,175	527	7.9	4,515	587	7.6	4,660	598	7.8
November	4,565	583	7.8	4,382	573	7.6	4,289	536	8.0	4,370	549	7.9	4,430	578	7.6
December	4,186	509	8.2	3,831	476	8.0	3,952	483	8.2	4,233	555	7.6	4,227	552	7.6
Averages for the year ..			8.2			7.8			8.0			7.8			7.8

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

1959	*Cars*			*Light Ambulances*			*Ambulances*			*Totals*		
	Accident or Emergency	*Total Cases*	*Mileage*	*Accident or Emergency*	*Total Coses*	*Mileage*	*Accident or Emergency*	*Total Cases*	*Mileage*	*Accident or Emergency*	*Total Cases*	*Mileage*
January	29	1,616	14,308	64	4,083	32,070	846	13,229	97,921	939	18,928	144,299
February	17	1,219	11,885	51	3,324	28,651	738	11,910	88,705	806	16,453	129,241
March	17	1,328	12,496	57	3,272	28,066	781	11,815	90,124	855	16,415	130,686
April	23	1,631	15,151	54	3,625	30,139	730	12,672	96,486	807	17,928	141,776
May	15	1,569	15,744	40	3,668	29,398	854	12,108	93,217	909	17,345	138,359
June..	15	1,789	16,293	64	4,055	32,686	779	12,110	91,436	858	17,954	140,415
July	8	987	9,893	46	4,363	36,722	845	13,252	96,062	899	18,602	142,677
August	10	1,034	10,047	57	3,441	29,821	773	10,973	82,922	840	15,448	122,790
September	18	1,423	13,399	48	3,987	32,380	731	12,016	88,239	797	17,426	134,018
October	13	1,753	15,551	38	4,025	34,024	737	12,774	94,893	788	18,552	144,468
November	25	1,582	13,566	46	3,832	32,438	692	11,925	85,906	763	17,339	131,910
December	16	1,172	10,640	42	3,632	31,556	714	12,308	88,838	772	17,112	131,034
Totals ..	206	17,103	158,973	607	45,307	377,951	9,220	147,092	1,094,749	10,033	209,502	1,631,673

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 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 hospital and specialist, and general practitioner 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 persons' 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, thus helping to relieve the pressure on hospital beds. Furthermore, patients are often happier at home amid familiar surroundings.

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 further stocks of all these articles are purchased from time to time to meet the increasing demand. There is every reason to believe that sick room equipment and articles mentioned above add to the comfort of patients and are much appreciated.

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.

Blindness and Partially-Sightedness.

The County Council is responsible for the welfare of the Blind and Partially Sighted, and the service is under the direct control of the County Welfare Committee.

All applicants for registration as Blind or Partially Sighted Persons are required to be medically examined, and for some years a standard form of medical report and certificate (Form B.D.8), which was introduced by the Ministry of Health, has been in general use throughout the country. Wherever possible Ophthalmologists of Consultant status are asked to examine applicants and complete the Form. As these Forms contain medical information which is of a confidential nature, the examinations are arranged through the County Health Department. With the written consent of the person concerned, particulars on broad lines are transmitted to the County Welfare Officer for registration, classification, and follow-up purposes.

During the year 264 Forms B.D.8. were received in respect of new applicants for registration; of this number 216 were registered Blind or Partially Sighted, and 48 were certified Not Blind or Partially Sighted. In a number of instances persons are re-examined at intervals of time or when treatment has been carried out; 37 such examinations were arranged and further Forms B.D.8 completed.

Analysis of the re-examinations reveal the following information:—

Category	Blind remaining Blind	2
„	Partially Sighted remaining Partially Sighted ..	14
„	Partially Sighted to Blind	12
„	Blind to Partially Sighted	1
„	Blind to Not Blind	1
„	Not Blind to Blind	4
„	Not Blind to Partially Sighted	–
„	Partially Sighted to Not Blind	–
„	Not Blind remaining Not Blind	3
		37

In the following table the newly registered Blind and Partially Sighted Persons are classified on broad lines and the number of persons recommended (*a*) no treatment, and (*b*) treatment, are indicated, together with the number which on "follow-up" action, have received treatment:—

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 ..	11	2	—	68	81
(*b*) Treatment (Medical, Surgical, or Optical)	59	14	—	66	139
(ii) Number of cases in (i) (*b*) above which on follow-up action have received treatment	32	12	—	55	99

B. OPHTHALMIA NEONATORUM

(i) Total number of cases notified during the year 3

(ii) Number of cases in which

(*a*) Vision lost .. .. –

(*b*) Vision impaired .. .. –

(*c*) Treatment continuing at end of year .. .. –

The incidence of this disease has in recent years been small, and modern methods of treatment usually prevent loss or impairment of vision.

C. CATARACT, GLAUCOMA AND RETROLENTAL FIBROPLASIA

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 1959 which clearly indicates that these diseases are more prevalent in the upper age groups.

		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
	1957	2	3	10	99	114
	1958	3	3	9	67	82
	1959	3	1	5	61	70
Glaucoma ..	1953	1	1	7	11	20
	1954	–	3	3	8	14
	1955	1	1	5	14	21
	1956	1	2	5	23	31
	1957	1	–	1	11	13
	1958	–	3	8	17	28
	1959	–	–	4	12	16

It is pleasing to see that the number of persons registered as Blind or Partially Sighted, due to cataract, is decreasing. 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, thus preventing blindness occurring. However it would seem that there is a natural reluctance for the elderly to undergo operative treatment.

With regard to retrolental fibroplasia, this is a condition which it has been suggested may be due to an excessive amount of oxygen being administered in cases of prematurity, which, most unfortunately results in blindness. In this County the incidence has been small, only six cases having been reported, three in 1952, two in 1955, one in 1956 and none since.

D. INCIDENCE OF BLINDNESS

The following table shows the incidence of blindness in age groups from 1943 to 1959. It will be seen that generally speaking blindness is an affliction of the more elderly and is much more prevalent in the females over sixty-five years of age than in the males of the corresponding age group. It must be realised, however, that women on the whole live longer than men.

Incidence of Blindness in Age Groups from 1943 to 1959

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	453	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
1957	2	4	6	17	9	26	243	207	450	364	647	1011	626	867	1,493
1958	–	2	2	20	9	29	245	197	442	380	666	1046	645	874	1,519
1959	2	3	5	20	11	31	246	204	450	387	700	1087	655	918	1,573

Mass Radiography.

The Regional Hospital Boards provide the Mass Radiography service, and whilst there is not a Unit based in the County, nevertheless the following four Mobile Mass Miniature Radiography Units operate in Derbyshire 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, District Medical Officers and my department. This is particularly the case when the Units carry out specific investigations with a view to tracing sources of infections e.g., in schools.

The following surveys were carried out in Derbyshire during the year:—

Unit.	*Number of Surveys.*
Nottingham Area No. 2	26
South Yorkshire Area	6
Sheffield Area	1
Stockport Area	2

There is no doubt that Mass Radiography brings to light many chest conditions at a much earlier stage than would otherwise be the case and when treatment can often be more effective.

Chiropody.

In April, 1959, the Ministry of Health issued the following Circular 11/59:—

"National Health Service Act, 1946

Section 28

Chiropody Services

1. I am directed by the Minister of Health to state that he is now prepared to approve proposals by local health authorities who wish to establish or, where one already exists, extend a chiropody service as part of their arrangements for the prevention of illness under Section 28 (1) of the National Health Service Act, 1946.

2. If the Council decide to provide or extend a chiropody service they should submit any necessary new proposals modifying their existing proposals accordingly. The new proposals should indicate the extent and method of providing the service intended at first but should allow for any later development or variation so as to avoid the need for a further formal amendment of the authority's proposals.

3. While it is not suggested that the new proposals should contain any formal limitation of the scope of the service, the Minister suggests that at least in the early stages priority should be given to the elderly, the physically handicapped and expectant mothers. He hopes that where it is proposed to provide a service in the authority's own premises it will generally be possible to make use of suitable existing buildings such as clinics at times when the necessary accommodation is not in use for other purposes. It would also be open to authorities to arrange for treatment to be provided at a chiropodist's own premises. Domiciliary visits by chiropodists to patients who are unfit on medical grounds to attend for treatment may be necessary, though no doubt the authority will consider whether in particular cases it would be more economical to provide transport for the patient concerned.

4. As the Minister considers that it would be appropriate for local health authorities providing a service to exercise their power under Section 28 (2) to make charges for it, he hereby gives his approval to the making of such charges, if any, as are considered reasonable, having regard to the means of the persons availing themselves of the service provided.

5. The authority is reminded that to qualify for employment chiropodists must satisfy one or other of the qualifications laid down in Section 3 of the National Health Service (Medical Auxiliaries) Regulations, 1954. (Statutory Instrument No. 55, 1954).

6. The authority will also be aware that as from 1st April, 1959, by virtue of paragraphs 19 and 35 of the Eighth Schedule and Part II of the Ninth Schedule to the Local Government Act, 1958, the Minister's approval is no longer required to contributions by local health authorities to the funds of voluntary organisations providing chiropody services. The Minister is aware of the valuable arrangements already made to provide chiropody services for elderly people by many local voluntary organisations at clubs and elsewhere. In some areas the authority may decide that a continuation of this provision with appropriate financial assistance may well be the most acceptable way of meeting the needs of this age group for some time to come.

7. A copy of this Circular is being sent to the Medical Officer of Health."

The County Council's Proposals under the National Health Service Act, 1946, to establish such a service were approved by the Minister on 26th October, 1959 and read as follows:—

"(*E*) *Chiropody Services.*

The Authority propose to establish gradually a Chiropody Service as part of their arrangements for the prevention of illness, care and after-care, under Section 28 of the National Health Service Act, 1946. It is intended that there should be no formal limitation of the scope of the service but that in the early stages priority should be given to the elderly, the physically handicapped and expectant mothers.

It is proposed that the service may be provided in any one or more of the following ways at the discretion of the Authority:—

(*a*) By the employment of Chiropodists (either full-time or part-time or on a case basis) who are eligible for employment by a Local Health Authority.

(*b*) So far as possible by the provision of treatment at suitable premises already in the possession of the Authority at times when the necessary accommodation is not in use for other purposes.

(*c*) By making arrangements for treatment to be provided at a Chiropodist's own premises in appropriate cases.

(*d*) By making arrangements for domiciliary visits by Chiropodists to patients who are unfit on medical grounds to attend for treatment.

(*e*) In suitable cases by providing transport to enable patients to attend for treatment.

(*f*) By giving financial assistance to suitable voluntary organisations for providing a Chiropody Service."

As a first step the question of appointing Chiropodists has received active consideration but difficulty is being experienced in ascertaining whether candidates are qualified in accordance with Section 3 of the National Health Service (Medical Auxiliaries) Regulations, 1954. It is hoped however, that this difficulty will be resolved when the "Professions Supplementary to Medicine" Bill, which is at present before Parliament, becomes law, as it is understood that a register of persons allowed to practise Chiropody will be established. It should be stated that in this county as a first instalment suitable equipment has been purchased for use at ten of the County Council's main Clinics, which are so geographically situated to provide a service for the major part of the County.

Occupational Therapy for Patients suffering from Tuberculosis

By agreement with the County Welfare Committee the Craft Instructors of the Welfare Department give instruction to tuberculosis 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.

Chest and Heart Association (formerly the 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 sixty years and has done good work in the campaign against the disease. In January 1959 the title of the Association was changed to correspond with the widening scope of their work in the field of chest and heart diseases.

Village Settlements.

The demand in this County for accommodation in these Settlements continues to be small. On the 31st December, 1959, there were two male patients in Sherwood Village Settlement, one of whom has the tenancy of a house in the Settlement; and one female patient in Papworth Village Settlement.

Chest Clinics.

This branch of the service is under the control of the Regional Hospital Boards, the Chest Physicians being officers of the Boards. Nevertheless the County Council pays a proportion of their salaries in respect of the Care and After Care work undertaken by these Officers.

Health Education.

During the year the Health Education of the County was reorganised and developed. The Senior School Medical Officer, as part of her conditions of service, was required to undertake the functions of a Health Education Officer. The main day-to-day work is to be carried out by the Health Department staff, i.e. Doctors, Dentists, Health Visitors and School Nurses. To do this each clinic has been equipped with a full range of visual aid material.

In order to make it easier for the local clinic staff to carry out a regular teaching programme a series of subjects is being prepared at the Central Office and will be sent to each clinic in turn. Each subject will be supported by all the necessary aids, i.e. posters, leaflets, filu (where necessary), film strips, flannelgraphs, a small exhibition, and a short talk (intended to act as a guide for speakers). Each of these is packed in a large box which we have purchased and will remain at a clinic for a month. The perishable material, i.e. posters, will be replaced before it is sent on to another clinic. We consider it better to treat only one subject at a time in a particular clinic. The Health Visitors are asked to display only posters connected with the subject of the month. Subjects covered are: nutrition, hygiene, food hygiene, hygiene as a whole, communicable diseases and immunisation, parentcraft, care of the teeth, foot health, mental health, care of the elderly, cancer, and home safety.

Most of the teaching is done at the clinics and in schools. When a request comes from outside organizations, i.e. Women's Institutes and Old People's Clubs, we try, where possible, to get a local Health Visitor to give the talk, or it may be given by the Central Office staff.

If a Health Visitor wishes to shew a film or film strip other than the subject being shewn at her clinic she specially requests the material necessary from the Central Office. A large library of film strips has been built up at the Central Office but only a few films have been bought as it is thought to be more economical to hire these at the present time.

Where a subject is being constantly dealt with as, for example, normal delivery and parent craft, at the relaxation classes, a permanent supply of film strips is kept at each clinic dealing with these programmes.

Material will be supplied to schools where the Head Teacher wishes his or her own staff to give the talks. The Public Health Inspector gives lectures on food hygiene. When a talk is being given at a clinic on nutrition a member of the Rural Domestic Economy Centre comes and gives a display and talk on the cooking of a well balanced meal. If the Home Safety Committee is putting on a "special" week or display the clinic and the local staff will make "Home Safety" their subject that week. The advantages of this system over one in which the work is done by a specialist staff is that the teaching is being done by the people who are in closest contact with the mothers and children and, furthermore, the necessary reading which has to be done by the staff before giving talks keeps them interested and up-to-date. The disadvantages are that all this takes a lot of time which might otherwise be used on routine health visiting work.

Each clinic has been supplied with a film strip projector and screen and the necessary amount of display boards. Many of the Health Visitors assist by making their own display and posters. There were two sound film projectors in the County and two more have now been purchased. These are sent to the Health Visitor when she requests or when a film is included in the subject sent out.

Home Safety Committee.

The Ministry of Health issued a circular in 1958 asking that Local Health Authorities should set up Home Safety Committees. At this time there was one Home Safety Committee in the County, at Heanor. During the year others were set up at Buxton, Glossop, Blackwell Rural, Chesterfield Rural and Swadlincote. They are set up by the Local Authority and have representatives from all the interested local organisations—Fire Brigade, Police, Gas and Electricity Boards, Welfare Committee, all the women's organisations, W.V.S., and W.I., also such bodies as the Red Cross, St. John's and Rotary. Each Committee has the local Health Visitor as a member and either the Senior School Medical Officer or the Deputy Superintendent Health Visitor attends. The Committees have shewn very great drive and enthusiasm, and

in addition to routine work such as the purchase and distribution of posters and leaflets each one has had one or two "special" weeks. Buxton week was held during "Well-dressing Week" and a specially decorated van took part in the procession. Glossop week included a very well equipped "Hazard" house, and newspaper competition. Blackwell Rural, during their week, gave a number of talks and film shows to Old People's Clubs. Chesterfield Rural had a number of activities which included a large exhibition at Barlow during Old People's Week which included daily talks by the County Council staff. There was also a Home Safety Quiz competition in the schools the final of which was held in the Civic Theatre at Chesterfield. It was a great success and included a manequin parade of clothes made of flame-proof material, put on by the girls of Killamarsh Secondary School.

Bodies Supplying Advice and Materials to wear: The Central Council for Health Education, The Rural Society for the Prevention of Accidents, The National Baby Welfare Council, Ministry of Health, Ministry of Agriculture, Ministry of Housing and Local Government, The National Association for Mental Health, Chest and Heart Association, B.M.A.

A list of the books in the County Library dealing with Health subjects has been sent on to all Health Visitors.

In-service Training was given to Health Visitors and School Nurses by the Central Office Staff on the use of visual aid material. Every Health Visitor was instructed in the use of film strip projectors and the film projector. In addition she was informed how to get a display ready. Some of the specially talented ones have made their own materials.

During the year talks were given at ante-natal clinics and relaxation classes and at child welfare clinics. These were mainly on the subjects outlined above. In schools, in addition to talks regularly given by Health Visitors to the school leavers there were two full courses in hygiene and health. There were films on dental health shewn in the junior schools, films on personal hygiene, personal care and cleanliness were shewn in the girls' Secondary Schools. One school only saw the smoking and cancer film. It is hoped to increase this this year. Talks were given to Parent-teacher Associations.

Voluntary Organizations—Lectures are mostly in the evenings and include talks on Personal Health Services, Cancer, Nutrition, First-Aid, Dental Health, Home Safety and Mental Health. The Food Hygiene film was shewn in the Day Nursery and to the Canteen Staff in the Central Offices.

HOME HELP SERVICE

(Section 29)

General Administrative Arrangements.

In accordance with a decision of the County Health Committee to expand this service, two further Area Home Help Organisers were appointed to assist the County Home Help Organiser namely, Miss D. M. Haythornthwaite and Mrs. B. M. Richards; they commenced duty on 8th June and 25th June, 1959, respectively. This led to the appointment of more Home Helps, and consequently the service has been made available to more people and for longer periods.

The progress of the scheme during recent years can be seen from the following figures:—

	1956	1957	1958	1959
Home Helps employed	118	151	204	260
Cases served	1,122	1,279	1,426	1,698
Home Help Organisers employed	2	2	4	6

It is interesting to see the gradually increasing number of elderly people who have benefited from the Home Help service in this county during recent years, as shown by the following figures:—

Year	*No. of Old Persons assisted*
1952	192
1953	297
1954	460
1955	580
1956	672
1957	796
1958	911
1959	1,329

Availability of Service

Particulars of the service are obtainable from the local Health Visitor (a map and names, telephone numbers and addresses of Health Visitors are given on page 27 of the County Council's Health Services Handbook), local County Council Clinic or Centre (these are listed under "Districts Separately" in the Handbook commencing on page 105), or from the County Medical Officer of Health, County Offices, Matlock (Telephone number Matlock 3411). Area Organisers can be contacted direct in any case of emergency at the following places:—

(1) *South of the County*—Miss Bracegirdle—Derby Clinic
Tel. Derby 45934—9 a.m. - 10 a.m. daily

(2) *North of the County*—Miss Priestley—County Offices
Tel. Matlock 3411—9 a.m. - 10 a.m. daily.

(3) *Centre of the County*—Mrs. Richards—Ripley Clinic
Tel. Ripley 872—9 a.m. - 10 a.m. daily.

(4) *North East of the County*—
Miss Haythornthwaite—Eckington Clinic
Tel. Eckington 591—9 a.m. - 10 a.m. daily.

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 persons 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 3/3d. per hour. Travelling expenses together with travelling time in excess of forty minutes each day at the normal rate of pay is also paid.

Home Helps are supplied with maroon nylon overalls.

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 Area Home Help Organiser should recommend the number of hours to be worked, which in any case should not exceed forty-four per week.

Laundry Facilities.

As mentioned in the last report, a survey had been carried out the previous year of the need for the provision of laundry facilities.

Following this a meeting was held during the year under review with representatives of certain district councils. As a result it was decided to go ahead with the scheme and the following amendments to the County Councils formal Proposals under sections 28 and 29 of the National Health Service Act 1946 were submitted to the Minister of Health and approved by him in November, 1959:—

"*Section* 28*: (F) Laundry Services:—*

The local health authority may as respects any person for whose care or after-care they have made arrangements under Section 28 of the Act, collect, cleanse, and return to him/her any bed linen and clothing; and acquire and maintain bed linen and clothing and lend them to any such person."

"*Section 29: Part III—Development Plan:—*

The local health authority may as respects any person qualifying for the provision of domestic help in accordance with the terms of Section 29 (1) of the Act, collect, cleanse, and return him/her any bed linen and clothing."

These Proposals had to be circulated to the District Councils and other bodies and consultations were in progress at the end of the year with a view to starting a pilot scheme.

Rules of Assessment.

Recovery of the cost (or part of the cost) of providing Home Helps, is made in accordance with a suitable scale of assessment.

MENTAL HEALTH SERVICE

(Sections 28 and 51)

I was asked to speak to the Matlock Rotary Club on 8th February as well as to the South Yorkshire and North Midlands Group of the Association of Public Health Lay Administrators on 9th July, 1960. I chose as the subject of my talk on each of these occasions "**The Mind—and how some of its problems have or are likely to be dealt with**". As the World Federation of Mental Health has designated 1960 as "Mental Health Year" it is thought that the following notes that I made for my talk might be regarded as topical and possibly interesting to the readers of this report :—

'First of all, I would make it clear that I am not an expert eductionist or a psychiatrist, yet I am frequently called upon to give advice on problems of the "mind" either in my capacity as County Medical Officer of Health or as Principal School Medical Officer to the Derbyshire County Council.

Intelligence varies from one individual to another, and it is not easy to assess it accurately. In 1938 when I attended a post graduate course in London University on mental testing we were told that probably the best all round method was that recommended by two American experts—Terman and Merrill—on Measuring Intelligence. I might say as soon as possible after appointment the Derbyshire Education Committee send their Medical Officers on these courses as the experience and knowledge they obtain on them is very useful in giving advice on educational subnormality. Incidentally these Medical Officers tell me that the Terman and Merrill Method is still regarded as the best all round test for Measuring Intelligence. An intelligence quotient is worked out after these tests have been applied, which is the child's mental age multiplied by a 100 and divided by his or her chronological age.

The average intelligence quotient is about 100. If you draw a graph for boys or girls it would be "bell-shaped". It would be a deeper bell in the case of girls, but more spread out in the case of boys.

Put in another way, while there are far more low-grade mental defectives and "brilliant" people among the males, there are far more girls who are about the average of 100.

A few years ago Sir John Charles the Chief Medical Officer of the Ministries of Health and Education reported on a survey that had been made relating to cerebral palsied children, in which he compared the intelligence of these children with controls, who were normal. He said the spread of intelligence was as follows among the normal :—

1%	had	an	I.Q.	of	130 or more
22%	„	„	„	„	110 — 129
52%	„	„	„	„	90 — 109
25%	„	„	„	„	under 90

It is most important that children should be educated according to their age, aptitude and ability, otherwise we shall be wasting their intelligence, but equally it would be wrong to force them to do things beyond their intelligence. There is no more unhappy person than the boy or girl who is compelled to study beyond his ability, whether it be at a primary school, secondary school, or university.

Much trouble is taken by the educationalists to guide children along the correct educational channels, but in spite of their efforts mistakes are occasionally made, but it must be admitted that some of these stem from temporary illness or varying rates of development. Unfortunately there are big gaps in our knowledge in the fields of education as well as health, but I feel much can be done by co-operation between the education and health experts. Mental health can be understood more easily if the difference between a mental defective and a person of unsound mind is appreciated.

Mental Deficiency has been well-defined as :—"A state of incomplete development of such a kind and degree that the individual is incapable of adapting himself to the normal environment of his fellows in such a way as to maintain existence independently of supervision, control or external support". Put in another way, a mental defective is a person suffering from arrested or incomplete development of mind arising before the age of eighteen years.

Persons of unsound mind, that is, those often referred to as psychotics, although suffering from mental illness, may have fully developed minds—their condition has been brought about by physical illness or other cause, and as a consequence they have "become persistently out of harmony with their surroundings".

Children who have a sub-normal intelligence may be divided into, roughly those who are *educable* and *ineducable*. Those who are *educable* are the responsibility of the *education committee* and may be taught in special classes in day schools or in special residential schools. *Ineducable*

children are reported by the education committee to the *health committee* and their care in the community then becomes the responsibility of the latter.

A number of mental defectives are able to lead happy and occasionally useful lives, especially where the home conditions are good; in fact some are able to work and earn their own living, particularly if they have the support of a favourable home background.

When mental defectives are cared for in their own homes they are supervised by the Mental Health Social Workers on the staff of the County Health Department and a number of them attend special training Centres provided by the County Council. Some of them also have craft instruction at clinics or other suitable buildings.

The lower grades or those with anti-social tendencies are admitted to institutions which it is the responsibility of the Regional Hospital Boards to provide. Unfortunately there is a considerable shortage of staff and/or beds throughout the country and consequently there is a waiting list for many urgent and deserving cases.

The new Mental Health Legislation has been drafted so that Mental Illness as far as possible can be treated like physical illness. Mental trouble is sometimes merely one symptom of ill-health. The provision of special hospitals for its treatment tends to stigmatise the condition. In the future I am inclined to believe that patients will increasingly be admitted to "blocks" within the cuctilage of the general hospitals rather than to special mental hospitals. Certification will only be invoked for the exceptional case where neither relatives nor the patient were agreeable to admission to hospital. It is to be hoped that the general public will have a more enlightened and sympathetic attitude to mental trouble. Relatives sometimes place obstacles in the way of the return of patients from hospital to their homes. After all it must be remembered that to segregate a patient from the community does not help him to live in it !

"W. H. Davies (1871-1940), the Tramp-Poet, of Newport, Monmouthshire, wrote the following lines :—

"What is life if, full of care,
You have no time to stand and stare?"

I feel that in those two lines an answer is suggested which would provide, if acted upon, greater happiness and efficiency and better mental and physical health. I have often said that "Speed has no merit unless you are going in the right direction!" If you "stand and stare" it provides an opportunity for reflection and for taking account of what is relevant in one's own experience before deciding on the line to be taken. Real satisfaction is obtained only if the best is performed or given.

Our present civilisation tends to make "a god of speed", but it is at a price! The incidence of coronary thrombosis, duodenal and

gastric ulceration, neurosis and mental trouble are a heavy toll to pay for increased speed (There are probably several factors concerned but excessive speed is regarded as a frequent contributor to their causation.)

"Although the people of this country have been smoking the leaf of the tobacco plant since Raleigh's time, I feel that larger numbers of our population have been turning latterly to it for solace—to soothe their harassed nerves caused by the speed of modern life. Unfortunately figures seem to suggest that it brings with it an increased incidence of respiratory and cardio-vascular complaints.

This is the age of "tranquillisers". While they help to quieten the person with frayed nerves they often produce undesirable "side effects". On reflection it would be better for our lives to be so adjusted that the conditions giving rise to their use were removed.

"A poor life this if, full of care,
We have no time to stand and stare".

A person who worked in the Mental Health field expressed the view recently that while E.C.T. was of value T.L.C. was often better. A friend of his said "I know E.T.C. is short for electro-convulsive therapy but what does T.L.C. mean?" He replied "Tender loving care!" I am sure this is true in many instances and it would be well to ponder over those words. It would be wrong, however, to oversimplify the requirements of treatment because I feel the causes of mental disorder are often complex.

More money is needed to be spent on research. It has to be conceded that some minds are more suitable for research than others, and that it is proceeding continuously in many aspects of diagnosis and treatment, and at many levels at the present time. But the greatest need in the future is for central direction with co-ordination, correlation and co-operation at all levels to tap the springs of ideas, knowledge and experience that are often flowing away to waste around us !

It is not easy to reconcile the freedom required for the individual patient, with the safety needed for the general public. It may be in this land of compromise the individual and the general public will each have to give up something in the interests of the other.

Our legal system has empowered the magistracy to enforce (custodial) care for patients who are regarded as mentally disordered either in the latter's interest or that of the community. The new legislation now proposes that this power be transferred to the medical profession but although an increasing number of patients have of recent years been admitted "*voluntarily*" and during recent months "*informally*" to mental hospitals, it does not have the protection from actions for damages that is granted to the magistracy. This is rather disturbing, because taking a wide view it will not be in the interest of the patients or the general public if the medical profession is continually conscious of the "Sword of Damocles" hanging over its head.

Some forms of mental disorders are likely to give rise to sexual or other forms of assault. Many members of the public often advise that the persons concerned be "fastened up," because of this possibility ; on the other hand, numerous patients do not deserve this harsh treatment. In fairness to an enlightened legislature the number sent to prison rather than to mental hospitals has dominished cinsiderably latterly. Probably there is no subject which causes people to "blow hot and cold" so frequently as mental health, and therefore we must be ever watchful to keep a sense of balance.

Due to specialisation there has been the tendency to divert psychiatry from the main stream of medicine. In the future there will be a move to integrate psychiatry more closely with general medicine. I believe that physical and mental illness will be merged not only in the training of personnel but also in the siting of hospitals. I think this advance will take place in phases. In fact, it is already being phased, for example, in the training of medical students, and psychiatrists now deal with case in out-patients 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 nurses now take the Certificate of the Royal Medico-Psychological Association prior to taking a general training to be a State Registered Nurse, but few in the reverse direction. 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 proclivity to regard mental symptoms as requiring treatment away from the main stream of ill-health. In my opinion we need to re-orientate 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 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 department 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 will be encouraged to go forward with their worth-while work.

Knowledge must precede legislation, but even so it is better that they both should walk forward hand-in-hand, for it is frustrating if one is lagging much behind the other. The knowledge available in the field of mental health is now ripe for application. The requirements of the Lunacy Act of 1890, however, are rather rigid, but they were eased by the Mental Treatment Act of 1930, which allowed of voluntary admissions and discharges from Mental Hospitals.

The legislation in the new Mental Health Act is even more flexible as it gives greater opportunities to experiment, which is the way advances in knowledge are made. Some time, however, must elapse before the minds of the professional staff as well as the general public will have been adjusted to take account of these opportunities.

Recently I heard a psychiatrist say that he had to be careful that his patients did not have treatment only by terminology ! If that is all the benefit they derived they would be better without it ! Put in another way, terminology, if not accompanied by effective treatment, may be more of a hindrance than a help !

Occasionally mental patients can derive benefit by discussing their symptoms together; a "recovered case" is sometimes able to give practical advice to another patient from his personal experience. Dr. Pentreath of the Pastures Hospital, with some of his enthusiastic colleagues, have established clubs in one or two areas in the County which, I believe, will be of advantage from this point of view. It is clear that a degree of selection for membership will have to be exercised, because an occasional patient might stimulate rather than resolve a difficult situation.

A new era is dawning for mental health, but much tolerance and understanding will be required from the general public, the judiciary and the health workers if the patient is to have a square deal".

Mental Health Act, 1959.

The following is an extract from Reports of Committees, which was approved by the County Council on November 4th, 1959 :—

> "4. *New legislation.*—(1) *Mental Health Act*, 1959.—The provisions of this Act follow in the main the recommendations of the Royal Commission on the Law relating to Mental Illness and Mental Deficiency which was appointed in 1954 and produced its report in 1957. The two main principles behind the Act are, first, that as much treatment as possible, both in hospitals and outside, should be given on a voluntary and informal

basis, and, second, that appropriate provision should be made for the residual category of cases where compulsion is necessary in the interests of society or in the interests of the patients themselves.

The Act repeals the Lunacy and Mental Treatment Acts, 1890-1930, and the Mental Deficiency Acts, 1913-1938, and provides one legal code to cover both mental illness and mental deficiency instead of the two codes previously existing. It introduces many changes of terminology in accordance with modern thought on the subject, thus the term "mental disorder" is used to cover all forms of mental illness or disability. In future mental health will be dealt with as an integral part of the National Health Service and any General Hospital will be legally empowered to receive patients suffering from any form of mental disorder. In seeking to promote the care of mentally disordered persons in the community the Act proposes the development of the functions of local health authorities in regard to such matters as the provision of hostels and other residential accommodation as well as occupation and training centres, the provision of home training and the establishment of social clubs and other activities. In addition, certain restrictions in the National Assistance Act, 1948, and the Children Act, 1948, are removed to give local authorities greater freedom to organise services for mentally disordered persons within the framework of their general health, welfare or child care services as appropriate. Informal treatment in hospital for mental disorders replaces the formalities previously applicable to voluntary treatment and compulsory powers of detention or guardianship provide a new system which will be exercisable only where no other appropriate methods are available. It also provides for offenders who are mentally disordered being sent to hospital or placed under guardianship as a result of criminal proceedings. The Act codifies the powers of the Judges and the Court of Protection to manage the property and affairs of persons who are incapable by reason of mental disorder of managing their property and affairs. It also revises the system of registration of nursing homes and residential homes for mentally disordered persons.

The provisions of the Mental Health Act, 1959, are to come into operation on such dates as the Minister of Health may, by Order, appoint and different dates will be appointed for different purposes of the Act. It is understood that it will be some months before the necessary preparatory work is completed to enable the Minister to bring into force the provisions relating to patients who are subject to detention in hospital. The Minister has now made the Mental Health Act (Commencement No. 1) Order, 1959 the effect of which is that from the 6th October, 1959, mental hospitals licensed houses and registered nursing homes may admit patients informally without using the powers of detention.

By Circular 22/59 dated 7th August, 1959, the Minister has directed local health authorities to make arrangements under Section 28 of the National Health Service Act, 1946, for the prevention of mental disorder and the care and after-care of persons suffering from mental disorder and accordingly the County Health Committee will be responsible for the submission and subsequent administration of the Council's scheme for the provision of all mental health services. It is recommended that the powers and duties of the County Council under the Mental Health Act, 1959, as local health authority, be delegated to the County Health Committee and that the minor consequential amendments of the National Assistance Act, 1948, the Children Act, 1948, and the Education Act 1944, be delegated to the County Welfare, Children's and Education Committees respectively.'

The Minister of Health issued Circular 27/59 on the 1st October, 1959, the following being a relevant excerpt :—

"*Informal Admission to Mental Hospitals*

1. I am directed by the Minister of Health to state that he has made an Order under the Mental Health Act, 1959, whereby with effect from 6th October, 1959, designated mental hospitals, registered hospitals, licensed houses and other hospitals, may admit patients without using the

procedures laid down in the Lunacy and Mental Treatment Acts. Any patient who is not unwilling to be admitted and can suitably be treated without powers of detention may be admitted informally in the same way as patients are admitted to general hospitals.

2. Until a further Order is made at some later date, the provisions of the Mental Treatment Act, 1930, for the admission of 'voluntary patients' will remain in force side by side with the new power to admit patients informally.

3. Informal admission to mental hospitals will, as in the case of general hospitals, usually be arranged by the patient's own doctor or by the hospital itself where the patient is attending the out-patient department. The local health authority's mental health staff may, however, often be associated with the arrangements for admission to hospital and will, therefore, wish to be aware of the new procedure for informal admission in suitable cases. Hospital authorities are also being informed that it should be standard practice to notify the discharge of patients to general practitioners and, in suitable cases and with the patient's consent, the local health authority."

The Minister issued Circular 14/60 on the 11th July, 1960 the following being a relevant excerpt :—

"1. I am directed by the Minister of Health to state that he has to-day made an Order under the Mental Health Act, 1959, bringing into effect from 15th July, 1960, Sections 4 and Sections 6 to 10 of the Act together with certain consequential sections. A copy of the Order (The Mental Health Act, 1959 (Commencement No. 2) Order, 1960) will be forwarded to you as soon as possible.

Definition of Mental Disorder.

2. Section 4 of the Act defines 'mental disorder' for the purposes of the Act and thus defines the various categories of mentally disordered persons for whom local authorities are responsible for providing appropriate services under the National Health Service and National Assistance Acts. The new terms defined in Section 4 of the Mental Health Act should from now on be used in relation to procedures under the sections of the Act which have been brought into force. It should be noted that, until the repeal of the Lunacy and Mental Treatment Acts and the Mental Deficiency Acts, it will be necessary to continue to use the terminology of those Acts in relation to procedures under them. It will probably, however, be convenient from now on to use the terminology of the Mental Health Act in all other contexts.

Functions of Local Health Authorities.

3. Section 6 sets out a number of services which, by virtue of the direction issued by the Minister in Circular 22/59, local health authorities have a duty to provide as part of their arrangements for prevention, care and after care under Section 28 of the National Health Service Act. These arrangements are described more fully in the proposals by individual authorities which were submitted to the Minister for approval in accordance with Circular 28/59.

4. Paragraph (*c*) of Section 6 (2) refers to the appointment of officers to act as mental welfare officers under other provisions of the Act. 'Mental welfare officer' is defined in Section 147 (1) as an officer of a local health authority appointed to act as mental welfare officer for the purposes of the Act. It will therefore be necessary for local health authorities to make formal appointments of those of their officers who are to exercise the functions given to mental welfare officers by Sections 22, 135 and 140 and Parts IV and V of the Act. The Minister has announced that these Parts and Sections of the Act will come into operation on 1st November, 1960, and further advice will be issued before then on these functions of mental welfare officers, which are in many ways comparable to those of

duly authorised officers and authorised officers under the present Lunacy and Mental Treatment Acts and Mental Deficiency Acts. It is essential that the appointment of these officers should be made in time for them to exercise their new functions from 1st November and it is open to authorities to make the necessary appointment at any time from now on.

5. Further advice will also be issued to authorities on their functions in relation to patients under guardianship before the parts of the Act dealing with guardianship are brought into operation.

6. Section 6 (3) of the Act removes the present prohibition on the payment of money to persons by an authority so far as this relates to payments to meet occasional personal expenses to persons under age 16 and resident in accommodation provided by the authority. This is intended to allow the payment of small sums as pocket money to children who are being provided with care in residential accommodation and whose parents or others responsible are unable to provide such sums. For those age 16 and over, the payment of remuneration by the authority for any work which may be done at a training centre remains unaffected.

Charges by Local Health Authorities.

7. The Minister indicated in paragraph 12 of Circular 9/59 the extent to which he was prepared to approve the making of charges for the provision of residential accommodation under Section 28 (2) of the National Health Service Act, as applied by Section 6 (2) of the Mental Health Act. The Minister accordingly hereby approves the making of charges to persons aged sixteen and over resident in such accommodation. As indicated in paragraph 11 of Circular 9/59, the residential accommodation provided may be in premises provided by the authority itself, in a home provided by a voluntary organisation or otherwise or by boarding out in a private household. It should be noted that the power to charge also relates to accommodation provided for 'short term' care on holidays arranged by the authority.

8. The Minister understands that the County Councils Association and the Association of Municipal Corporations, in consultation with the London County Council, have under consideration the issue of some guidance as to the charges for residential accommodation that may be appropriate.

9. Approval was given by the Minister in Circular 100/48, dated 10th June, 1948, to the making of charges for all articles of extra nourishment or clothing. This would include meals or refreshment provided for persons attending day training centres or social clubs. As indicated in Circular 12/56, dated 2nd July, 1956, the Minister would not expect a charge to be made for milk provided for children under age 16 attending training centres.

10. The information in paragraph 12 of Circular 9/59 about the payment of national assistance grants to persons not in employment for whom residential accommodation is provided requires some clarification. In the case of persons accommodated in the premises provided by the authority or in premises provided by a voluntary or other organisation, national assistance grants will be made on the same basis as for residents in accommodation under Part III of the National Assistance Act, 1948. Local health authorities should, however, consult the local manager of the National Assistance Board about the appropriate arrangements to be made in the case of each person boarded out in a private household.

Conduct of Premises of Local Health Authorities.

11. Section 7 of the Act empowers the Minister to make regulations as to the conduct of any premises in which residential accommodation or facilities for training or occupation are provided by local health authorities. The Minister has no present intention of making regulations on this subject and he relies on authorities to secure and maintain proper standards of accommodation and staffing in premises where residential accommodation or training are provided. To assist in this, authorities may wish to consider arranging for regular visits to be paid to each centre by a named member or officer (or, if on occasion the member or officer is unable to visit, by some other suitable person). The Minister's officers will always be glad to offer any help or advice to an individual authority.

12. Section 7 also empowers the Minister to make regulations conferring on his officers the power of inspection of premises provided by authorities. (Similar powers already exist in the case of residential accommodation provided and welfare arrangements made by local authorities under Part III of the National Assistance Act, 1948). The Minister is making regulations under this Section which are intended to provide a statutory basis on which visits can be made as part of the Minister's overall responsibility for the National Health Service. A copy of the regulations will be sent to you as soon as possible.

Functions of Welfare Authorities.

13. Section 8, as explained in paragraph 4 of Circular 28/59, removes prohibitions on the use of Sections 21 and 29 of the National Assistance Act, 1948, for the provision by local authorities of services for mentally disordered persons for whom they, as local health authorities, have a power or a duty to provide corresponding services under Section 28 of the National Health Service Act, 1946. It also extends the class of mentally disordered persons for whom services may be provided under Section 29 of the 1948 Act.

Child Care Services.

14. Sections 9 and 10 of the Act, although relating mainly to the functions of children authorities, are also of concern to local health authorities. A copy is enclosed of a Home Office circular to County Councils and County Borough Councils. It is not intended that the usual provision by a local authority for mentally disordered children in need of residential care should be in accommodation provided under the Children Act. Where, however, it is reasonable to make provision in this way in the circumstances of an individual case, Section 9 provides the necessary power to do so. The Section also makes clear that a local authority is empowered, as children authority, to receive into their care mentally disordered children who are eligible for care under Section 1 of the Children Act, 1948. While it may be appropriate in certain circumstances to place some of these children in accommodation for normal children in care, and for the local health authority to fulfil their duty by making arrangements with the children authority accordingly, the Minister hopes that in all cases where suitable care cannot be provided in this way, the local health authority will assume responsibility as quickly as possible for admitting the children to more appropriate accommodation provided under the mental health services.

Welfare of Certain Hospital Patients.

15. Section 10 imposes a duty on local authorities to arrange visits to certain hospital patients. The enclosed Home Office circular deals with the provisions relating to children in respect of whom the rights and powers of a parent are vested in the local authority. The duty to arrange visits applies also to patients in hospital or nursing homes who are subject to

the guardianship of the local health authority under the Mental Health Act (when the relevant Parts of the Act come into operation) and also to patients for whom the local health authority is acting in the place of the nearest relative by order of the court under Sections 52 and 53 of the Act. (These Sections are not yet in operation). This situation only arises when the patient requires to be detained for treatment in hospital or to be received into guardianship.

16. It is the intention that the local health authority which has any of these statutory responsibilities towards a patient should maintain its interest by visits or other suitable means while the patient is in hospital, whether he is in hospital for treatment for his mental disorder or for any other reason. It is open to authorities to arrange for visits to be made by their own officers, or by officers of another local authority, or by a voluntary organisation or by any other suitable person.

17. Apart from the statutory requirement to arrange visits on behalf of the authority in these particular cases, the Minister hopes that it will be the general practice of authorities to maintain appropriate contact with mentally disordered persons in hospital whose homes are in the authority's area. In co-operation with the hospital authority, patients in locally situated hospitals may for instance be visited by the local health authority's staff to discuss arrangements for after care on discharge from hospital, or be similarly visited to maintain contact with their home if they have no friends or relatives who can do this. In many areas persons in hospital who, because of additional handicaps such as blindness or deafness, are eligible to receive services under Section 29 of the National Assistance Act, 1948, are already visited by home teachers or welfare officers. The Minister hopes that all local authorities will, in appropriate cases, adopt this practice."

The Minister of Health gave the following reply on the 11th July, 1960, in answer to a question in Parliament :—

"As regards the bringing into effect of the Mental Health Act, Sections 1 and 149 have been operating since 6th October, 1959, to the extent necessary to permit informal admission to mental hospitals. I have made an order appointing 15th July, 1960, as the date of commencement of certain other sections, the chief of which are sections 6 to 10 which deal with local authority services. I intend to bring all the rest of the Act into operation on 1st November, 1960, the earliest practicable date."

Whilst the Mental Health Act, 1959 and Regulations made under the should be referred to as necessary, for the benefit of busy doctors and other health workers engaged in the care of patients, *particularly in the community*, an attempt has been made below to summarise some of the main features of the Act, which consists of 154 Sections and 8 Schedules. This Act repeals the Lunacy and Mental Treatment Acts of 1890—1930 and the Mental Deficiency Acts, 1913—1938, and makes fresh provisions with respect to (*a*) the treatment and care of mentally disordered persons and (*b*) their property and affairs. Owing to the large amount of re-organisation needed to implement its provisions, all parts of the Act will not come into operation on the same date, but powers will be conferred on the Minister of Health to decide by Order when the various sections shall come into operation.

(1) The Minister brought into operation an Order (Commencement No. 1) Statutory Instrument No. 1676(C.13), dealing with Sections 1 and 149 of the Mental Health Act, on the 6th October, 1959, which enables hospitals, licenced houses and nursing homes admitting mentally ill patients informally without powers of detention.

(2) The Minister issued an Order (Commencement No. 2.) Statutory Instrument No. 1159 (C.9), on the 11th July, 1960. This Order brings into operation inter alia (*a*) provisions for the setting up of Mental Health Review Tribunals; (*b*) defines and classifies the various forms of mental disorder; (*c*) deals with the powers of local health authorities to provide services for the care and after care of mentally disordered persons; and (*d*) the powers of welfare authorities and children authorities to provide accommodation and other services for such persons.

(3) The Minister has decided that the remaining Sections of the Act should come into operation on November, 1st, 1960.

The summary of the Mental Health Act, to which I referred earlier, is as follows:—

Mental Health Review Tribunals (Section 3)

For every area coming within the jurisdiction of a Regional Hospital Board there shall be constituted a Tribunal, to be called a Mental Health Review Tribunal, for the purpose of dealing with applications and references by and in respect of patients coming within the provisions of the Act.

Definition and classification of mental disorder (Section 4)

4.—(1) In this Act 'mental disorder' means mental illness, arrested or incomplete development of mind, psychopathic disorder, and any other disorder or disability of mind; and 'mentally disordered' shall be construed accordingly.

(2) In this Act, 'severe subnormality' means a state of arrested or incomplete development of mind which includes sub-normality of intelligence and is of such a nature or degree that the patient is incapable of living an independent life or guarding himself against serious exploitation, or will be so incapable when of an age to do so.

(3) In this Act 'subnormality' means a state of arrested or incomplete development of mind (not amounting to severe sub-normality) which includes subnormality of intelligence and is of a nature or degree which requires or is susceptible to medical treatment or other special care or training of the patient.

(4) In this Act 'psychopathic disorder' means a persistent disorder or disability of mind (whether or not including subnormality of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the patient, and requires or is susceptible to medical treatment.

(5) Nothing in this section shall be construed as implying that a person may be dealt with under this Act as suffering from mental disorder, or from any form of mental disorder described in this section, by reason only of promiscuity or other immoral conduct.

Informal admission of patients.

Informal admission of patients (Section 5)

5.—(1) Nothing in this Act shall be construed as preventing a patient who requires treatment for mental disorder from being admitted to any hospital or mental nursing home in pursuance of arrangements made in that behalf and without any application, order or direction rendering him liable to be detained under this Act, or from remaining in any hospital or mental nursing home in pursuance of such arrangements after he has ceased to be so liable to be detained.

(2) In the case of an infant who has attained the age of sixteen years and is capable of expressing his own wishes, any such arrangements as are mentioned in the foregoing subsection may be made, carried out and determined notwithstanding any right of custody or control vested by law in his parent or guardian."

Local Authority Services (under Part II of the Act)
General Provisions

Functions of local health authorities (Section 6)

Section 6 sets out the arrangements that a local health authority is authorised or may be required to do for the care or after-care of persons who are or have been suffering from mental disorder under Section 28 of the National Health Service Act, 1946, as follows:—

"(*a*) the provision, equipment and maintenance of residential accommodation and the care of persons for the time being resident in accommodation so provided;

(*b*) the provision of centres or other facilities for training or occupation, and the equipment and maintenance of such centres;

(*c*) the appointment of officers to act as mental welfare officers under the following provisions of this Act;

(*d*) the exercise by the local health authority of their functions under the following provisions of this Act in respect of persons placed under guardianship thereunder (whether so placed under the guardianship of the local health authority or of other persons); and

(*e*) the provision of any ancillary or supplementary services for or for the benefit of any such persons as are referred to in subsection (1) of this section."

Provision for care and training of children in lieu of education.

Examination and classification under Education Act, 1944 (Section 11)

"11.—The sections set out in the Second Schedule to this Act, and therein numbered fifty-seven, fifty-seven A, and fifty-seven B, shall be substituted for Section fifty-seven of the Education Act, 1944 . . ."

The Second Schedule reads as follows :—

Medical examination and classification of children unsuitable for education

"57.—(1) It shall be the duty of every local education authority to ascertain what children in their area are suffering from a disability of mind of such a nature or to such an extent as to make them unsuitable for education at school; and for the purpose of fulfilling that duty any officer of a local education authority authorised in that behalf by the authority may by notice in writing served upon the parent of any child who has attained the age of two years require him to submit the child for examination by a medical officer of the authority.

(2) If a parent upon whom such a notice is served fails without reasonable excuse to comply with the requirements of the notice, he shall be liable on summary conviction to a fine not exceeding five pounds.

(3) Before any child is medically examined as aforesaid, the local education authority shall cause notice to be given to the parent of the time and place at which the examination will be held, and the parent shall be entitled to be present at the examination if he so desires.

(4) If, after considering the advice given with respect to any child by a medical officer in consequence of a medical examination under this section, and any reports or information which the local education authority are able to obtain from teachers or other persons with respect to the ability and aptitude of the child, the authority decide that the child is suffering from such a disability of mind as aforesaid, they shall (subject to subsection (5) of this section) cause the decision to be recorded and furnish to the local health authority a report of the decision, together with a copy of any written advice, report or information which was taken into account for the purpose of the decision.

(5) Before recording a decision under this section with respect to any child, the local education authority shall give to the parent of the child not less than twenty-one days' notice in writing of their intention to do so, and if within that period the parent refers to the Minister of Education the question whether such a decision should be recorded the decision shall not be recorded except by direction of that Minister.

(6) Any notice under subsection (5) of this section shall contain a statement of the functions of the local health authority with respect to the making of arrangements for the treatment, care or training of the child in the event of the decision being recorded, and, if known to the local education authority, a statement of the arrangements proposed to be made by the local health authority in the discharge of those functions.

Review of classification.

57A.—(1) Where a decision has been recorded under section fifty-seven of this Act in the case of a child:—

(*a*) the parent of the child may, at any time (but not earlier than twelve months after the recording of the decision nor more often than once in any subsequent period of twelve months) by notice in writing request the local education authority to review the decision; and

(*b*) if at any time it appears to the local health authority, or to any authority or body responsible for the management of an institution in which the child is under care, that the decision ought to be reviewed, they shall give notice to that effect to the local education authority.

(2) Where any such notice is given to the local education authority, the local education authority shall cause to be served on the parent of the child the notice authorised by subsection (1) of section fifty-seven of this Act, and subsections (2) and (3) of that section shall apply accordingly; and if they decide, after considering the advice given by the medical officer and any reports or information available to them with respect to the child (including, in the case of a notice under paragraph (*b*) of subsection (1) of this section, any reports or information from the authority or body by whom the notice is given) that the child is no longer unsuitable to receive education at school, they shall cancel the original decision.

(3) Where a decision recorded under section fifty-seven of this Act is reviewed under this section, the local education authority shall serve on the parent of the child a notice stating whether they have decided that the child is still unsuitable to receive education at school; and where the notice states that the authority have so decided:—

(*a*) the parent may, before the expiration of the period of twenty-one days beginning with the day next following that on which the notice is served upon him, appeal to the Minister of Education against the decision of the authority; and

(*b*) if that Minister is of opinion that the authority ought to have decided that the child is no longer unsuitable to receive education at school, he may direct the authority to cancel the original decision recorded with respect to the child.

(4) Any notice under subsection (1) of this section shall be given to the local education authority who would be responsible for the education of the child if the decision were cancelled; and where a decision recorded in respect of a child by one local education authority is cancelled under this section by a different local education authority, the authority by whom the decision is cancelled shall give notice to that effect to the a ıthority by whom the decision was recorded.

Supplementary provisions as to classification.

57B.—(1) For the purposes of section fifty-seven of this Act a child for whom education is provided by one local education authority in the area of another local education authority shall be treated as if he were in the area of the first-mentioned authority; but any functions of the local education authority under that section may, in accordance with arrangements made between them, be performed on behalf of the first-mentioned authority by the other authority, and the reference in subsection (1) of that section to a medical or other officer of the authority shall be construed accordingly.

(2) If, after considering the advice given with respect to a child by a medical officer in consequence of a medical examination carried out under section thirty-four of this Act, the local education authority decide, not that the child requires special educational treatment, but that he is suffering from such a disability as is referred to in subsection (1) of section fifty-seven of this Act, the provisions of the said section fifty-seven shall apply as if the examination had been carried out and the decision made under that section.

(3) If, after considering the advice given with respect to a child by a medical officer in consequence of a medical examination carried out under section fifty-seven of this Act, or under the said section fifty-seven as applied by section fifty-seven A of this Act, and any such reports or information as are referred to in sub-section (4) of the said section fifty-seven or sub-section (2) of the said section fifty-seven A, the local education authority decide that the child is not suffering from such a disability as aforesaid, but that he requires special educational treatment, sub-sections (4) to (6) of the said section thirty-four shall apply as if the examination had been carried out and the decision made under that section."

Power to compel attendance at training centres.

Power to compel attendance at training centres. (Section 12)

"12.—(1) Where it appears to the local health authority to be appropriate that a child of compulsory school age who is the subject of a decision recorded under section fifty-seven of the Education Act, 1944, should receive training at a centre provided or made available under arrangements made by that authority under section twenty-eight of the National Health Service Act, 1946, the authority may give notice in writing to the parent of the child requiring him to cause the child to attend, either by the day or, if the notice so directs, as a resident, at such centre, being a centre provided or made available as aforesaid, as may be specified in the notice at such times or for such periods as may be so specified.

(2) Before giving a notice under this section, the local health authority shall satisfy themselves that the child is not receiving adequate training comparable with the training which he would receive at the centre; and if any person to whom such a notice is given is aggrieved by the notice on the ground that the child is receiving such training, he may require the local health authority to refer the question to the Minister of Health, and that Minister may either confirm the notice or direct that it be amended or withdrawn.

(3) Subject to subsection (2) of this section, if any person fails to comply with a notice given to him under sub-section (1) of this section, he shall, unless the child is receiving adequate training comparable with the training which he would receive at the centre, be guilty of an offence and shall be liable on summary conviction, in the case of a first offence, to a fine not exceeding one pound, in the case of a second offence to a fine not exceeding five pounds, and in the case of a third or subsequent offence to a fine not exceeding ten pounds or to imprisonment for a term not exceeding one month, or to both.

(4) It shall be the duty of the local health authority to institute proceedings for an offence under this section wherever, in their opinion, the institution of such proceedings is necessary, and no such proceedings shall be instituted except by or on behalf of a local health authority.

(5) For the purposes of this section a child shall be treated as of compulsory school age so long as, under the Education Act, 1944, he would be deemed to be of compulsory school age if he were a registered pupil at a special school, and 'parent' has the same meaning as in that Act.

Provisions as to regular attendance for training. (Section 13)

13.—(1) For the purposes of any proceedings under section twelve of this Act, the parent of a child of compulsory school age shall be deemed to have failed to cause the child to attend at a training centre on any occasion on which the child has failed without leave to attend at the centre, but the child shall not be deemed to have so failed:—

(*a*) at any time when prevented from attending by reason of sickness or any unavoidable cause;

(*b*) on any day exclusively set apart for religious observance by the religious body to which the parent belongs; or

(*c*) if it is not reasonably practicable for the child to make his own way, or to be taken by or on behalf of his parent, to and from the centre, and no suitable arrangements have been made by the local health authority either for his transport to and from the centre or for residential accommodation for him at or near the centre.

(2) If in any such proceedings it is proved that the child has no fixed abode, sub-section (1) of this section shall have effect as if paragraph (*c*) were omitted; but if the parent proves that he is engaged in a trade or business of such a nature as to require him to travel from place to place, and that the child has attended at the training centre as regularly as the nature of the trade or business of the parent permits, the parent shall be acquitted.

(3) For the purposes of any such proceedings as aforesaid in respect of a child who is residing at a training centre, the parent shall be deemed to have failed to cause the child to attend the centre if the child is absent without leave during any part of the period during which the training is given unless prevented from being present by reason of sickness or any unavoidable cause.

(4) In this section 'child of compulsory school age' and 'parent' have the same meaning as in section twelve of this Act, and 'leave', in relation to a training centre, means leave granted by any person authorised in that behalf by the local health authority by whom the training centre is provided."

Compulsory Admission to Hospital and Guardianship
(Part IV of the Act)

Procedure for hospital admission

Admission for observation. (Section 25)

"25.—(1) A patient may be admitted to a hospital, and there detained for the period allowed by this section, in pursuance of an application (in this Act referred to as an application for admission for observation) made in accordance with the following provisions of this section.

(2) An application for admission for observation may be made in respect of a patient on the grounds:—

(*a*) that he is suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital under observation (with or without other medical treatment) for at least a limited period; and

(*b*) that he ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons.

(3) An application for admission for observation shall be founded on the written recommendations in the prescribed form of two medical practitioners, including in each case a statement that in the opinion of the practitioner the conditions set out in paragraphs (*a*) and (*b*) of sub-section (2) of this section are complied with.

(4) Subject to the provisions of section fifty-two of this Act (in a case where an application is made under that section for transferring the functions of the nearest relative of the patient), a patient admitted to hospital in pursuance of an application for admission for observation may be detained for a period not exceeding twenty-eight days beginning with the day on which he is admitted, but shall not be detained thereafter unless, before the expiration of that period, he has become liable to be detained by virtue of a subsequent application, order or direction under any of the following provisions of this Act.

Admission for treatment. (Section 26)

26.—(1) A patient may be admitted to a hospital, and there detained for the period allowed by the following provisions of this Act, in pursuance of an application (in this Act referred to as an application for admission for treatment) made in accordance with the following provisions of this section.

(2) An application for admission for treatment may be made in respect of a patient on the grounds:—

(*a*) that he is suffering from mental disorder, being:—
(i) in the case of a patient of any age, mental illness or severe subnormality;

(ii) in the case of a patient under the age of twenty-one years, psychopathic disorder or subnormality;
and that the said disorder is of a nature or degree which warrants the detention of the patient in a hospital for medical treatment under this section; and

(*b*) that it is necessary in the interests of the patient's health or safety or for the protection of other persons that the patient should be so detained.

(3) An application for admission for treatment shall be founded on the written recommendations in the prescribed form of two medical practitioners, including in each case a statement that in the opinion of the practitioner the conditions set out in paragraphs (*a*) and (*b*) of sub-section (2) of this section are complied with; and each such recommendation shall include:—

(*a*) such particulars as may be prescribed of the grounds for that opinion so far as it relates to the conditions set out in the said paragraph (*a*); and

(*b*) a statement of the reasons for that opinion so far as it relates to the conditions set out in the said paragraph (*b*), specifying whether other methods of dealing with the patient are available, and if so why they are not appropriate.

(4) An application for admission for treatment, and any recommendation given for the purposes of such an application, may describe the patient as suffering from more than one of the forms of mental disorder referred to in sub-section (2) of this section; but the application shall be of no effect unless the patient is described in each of the recommendations as suffering from the same one of those forms of mental disorder, whether or not he is also described in either of those recommendations as suffering from another of those forms.

(5) An application for admission for treatment made on the ground that the patient is suffering from psychopathic disorder or subnormality, and no other form of mental disorder referred to in sub-section (2) of this section, shall state the age of the patient, or if his exact age is not known to the applicant, shall state (if it be the fact) that the patient is believed to be under the age of twenty-one years.

General provisions as to applications. (Section 27)

27.—(1) Subject to the provisions of this section, an application for the admission of a patient for observation or for treatment may be made either by the nearest relative of the patient or by a mental welfare officer; and every such application shall be addressed to the managers of the hospital to which admission is sought and shall specify the qualification of the applicant to make the application.

(2) An application for admission for treatment shall not be made by a mental welfare officer if the nearest relative of the patient has notified that officer, or the local health authority by whom that officer is appointed, that he objects to the application being made, and, without prejudice to the foregoing provision, shall not be made by such an officer except after consultation with the person (if any) appearing to be the nearest relative of the patient unless it appears to that officer that in the circumstances such consultation is not reasonably practicable or would involve unreasonable delay.

(3) No application for the admission of a patient shall be made by any person unless that person has personally seen the patient within the period of fourteen days ending with the date of the application.

(4) An application for the admission of a patient shall be sufficient if the recommendations on which it is founded are given either as separate recommendations, each signed by a medical practitioner, or as a joint recommendation signed by two such practitioners.

General provisions as to medical recommendations. (Section 28)

28.—(1) The recommendations required for the purposes of an application for the admission of a patient under this Part of this Act (in this Act referred to as 'medical recommendations') shall be signed on or before the date of the application, and shall be given by practitioners who have personally examined the patient either together or at an interval of not more than seven days.

(2) Of the medical recommendations given for the purposes of any such application, one shall be given by a practitioner approved for the purposes of this section by a local health authority as having special experience in the diagnosis or treatment of mental disorder; and unless that practitioner has previous acquaintance with the patient, the other such recommendation shall, if practicable, be given by a medical practitioner who has such previous acquaintance.

(3)Where the application is for the admission of the patient to a hospital not being a mental nursing home, one (but not more than one) of the medical recommendations may be given by a practitioner on the staff of that hospital, except where the patient is proposed to be accommodated under section five of the National Health Service Act, 1946, (which relates to accommodation for private patients)

(4) A medical recommendation for the purposes of an application for the admission of a patient under this Part of this Act shall not be given by any of the following persons, that is to say:—

(*a*) the applicant;

(*b*) a partner of the applicant or of a practitioner by whom another medical recommendation is given for the purposes of the same application;

(*c*) a person employed as an assistant by the applicant or by any such practitioner as aforesaid;

(*d*) a person who receives or has an interest in the receipt of any payments made on account of the maintenance of the patient; or

(*e*) except as provided by sub-section (3) of this section, a practitioner on the staff of the hospital to which the patient is to be admitted,

or by the husband, wife, father, father-in-law, mother, mother-in-law, son, son-in-law, daughter, daughter-in-law, brother, brother-in-law, sister or sister-in-law of the patient, or of any such person as aforesaid, or of a practitioner by whom another medical recommendation is given for the purposes of the same application.

Admission for observation in case of emergency. (Section 29)

29.—(1) In any case of urgent necessity, an application for admission for observation may be made in respect of a patient in accordance with the following provisions of this section, and any application so made is in this Act referred to as an emergency application.

(2) An emergency application may be made either by a mental welfare officer or by any relative of the patient; and every such application shall include a statement (to be verified by the medical recommendation first referred to in subsection (3) of this section) that it is of urgent necessity for the patient to be admitted and detained under section twenty-five of this Act, and that compliance with the foregoing provisions of this Part of this Act relating to applications for admission for observation would involve undesirable delay.

(3) An emergency application shall be sufficient in the first instance if founded on one of the medical recommendations required by section twenty-five of this Act, given, if practicable, by a practitioner who has previous acquaintance with the patient and otherwise complying with the requirements of section twenty-eight of this Act so far as applicable to a single recommendation, but shall cease to have effect on the expiration of a period of seventy-two hours from the time when the patient is admitted to the hospital unless:—

(*a*) the second medical recommendation required as aforesaid is given and received by the managers within that period; and

(*b*) that recommendation and the recommendation first referred to in this sub-section together comply with all the requirements of the said section twenty-eight (other than the requirement as to the time of signature of the second recommendation).

(4) In relation to an emergency application, section twenty-seven of this Act shall have effect as if in sub-section (3) of that section for the words 'fourteen days' there were substituted the words 'three days'."

Effect of application for admission (Section 31)

"31.—(1) An application for the admission of a patient to a hospital under this Part of this Act, duly completed in accordance with the foregoing provisions of this Part of this Act, shall be sufficient authority for the applicant, or any person authorised by the applicant, to take the patient and convey him to the hospital at any time within the following period, that is to say:—

(*a*) in the case of an application other than an emergency application, the period of fourteen days beginning with the date on which the patient was last examined by a medical practitioner before giving a medical recommendation for the purposes of the application;

(*b*) in the case of an emergency application, the period of three days beginning with the date on which the patient was examined by the practitioner giving the medical recommendation first referred to in sub-section (3) of section twenty-nine of this Act, or with the date of the application, whichever is the earlier.

(2) Where a patient is admitted within the said period to the hospital specified in such an application as aforesaid, or, being within that hospital, is treated by virtue of section thirty of this Act as if he had been so admitted the application shall be sufficient authority for the managers to detain the patient in the hospital in accordance with the provisions of this Act.

(3) Any application for the admission of a patient under this Part of this Act which appears to be duly made and to be founded on the necessary medical recommendations may be acted upon without further proof of the signature or qualification of the person by whom the application or any such medical recommendations, is made or given, or of any matter of fact or opinion stated therein.

(4) A patient who is admitted to a hospital in pursuance of an application for admission for treatment may apply to a Mental Health Review Tribunal within the period of six months beginning with the day on which he is so admitted, or with the day on which he attains the age of sixteen years, whichever is the later.

(5) Where a patient is admitted to a hospital in pursuance of an application for admission for treatment any previous application under this Part of this Act by virtue of which he was liable to be detained in a hospital or subject to guardianship shall cease to have effect."

Visiting and examination of patients. (Section 37)

"37.—(1) For the purpose of advising whether an application to a Mental Health Review Tribunal should be made by or in respect of a patient who is liable to be detained or subject to guardianship under this Part of this Act, or of furnishing information as to the condition of a patient for the purposes of such an application, or of advising as to the exercise by the nearest relative of any such patient of any power to order his discharge, any medical practitioner authorised by or on behalf of the patient or other person who is entitled to make or has made the application, or by the nearest relative of the patient, as the case may be, may, at any reasonable time, visit the patient and examine him in private.

(2) Where application is made to a registration authority or regional hospital board to exercise, in respect of a patient liable to be detained in a mental nursing home, any power to make an order for his discharge, the following persons, that is to say:—

(*a*) any medical practitioner authorised by that authority or board; and

(*b*) any other person (whether a medical practitioner or not) authorised under Part III of this Act to inspect the home,

may, at any reasonable time visit the patient and interview him in private.

(3) Any person authorised for the purpose of sub-section (2) of this section to visit a patient may require the production of and inspect any documents constituting or alleged to constitute the authority for the detention of the patient under this Part of this Act; and any person so authorised, being a medical practitioner, may examine the patient in private, and may require the production of and inspect any other medical records relating to the treatment of the patient in the home."

Duration of authority for detention or guardianship and discharge of patients.

Duration of authority. (Section 43)

"43.—(1) Subject to the following provisions of this Part of this Act, a patient admitted to hospital in pursuance of an application for admission for treatment, and a patient placed under guardianship in pursuance of a guardianship application, may be detained in a hospital or kept under guardianship for a period not exceeding one year beginning with the day on which he was so admitted, or the day on which the guardianship application was accepted, as the case may be, but shall not be so detained or kept for any longer period unless the authority for his detention or guardianship is renewed under the following provisions of this section.

(2) Authority for the detention or guardianship of a patient may, unless the patient has previously been discharged, be renewed under this section:—

(*a*) from the expiration of the period referred to in sub-section (1) of this section, for a further period of one year;

(*b*) from the expiration of any period of renewal under paragraph (*a*) of this sub-section, for a further period of two years.

and so on for periods of two years at a time.

(3) Within the period of two months ending on the day on which a patient who is liable to be detained in pursuance of an application for admission for treatment would cease under this section to be so liable in default of the renewal of the authority for his detention, it shall be the duty of the responsible medical officer to examine the patient; and if it appears to him that it is necessary in the interests of the patient's health or safety or for the protection of other persons that the patient should continue to be liable to be detained, he shall furnish to the managers of the hospital where the patient is liable to be detained a report to that effect in the prescribed form.

(4) Within the period of two months ending with the day on which a patient who is subject to guardianship under this Part of this Act would cease under this section to be so liable in default of the renewal of the authority for his guardianship, it shall be the duty :—

(*a*) where the patient is subject to the guardianship of a local health authority, of the responsible medical officer;

(*b*) in any other case, of the nominated medical attendant of the patient,

to examine the patient; and, if it appears to him that it is necessary in the interests of the patient or for the protection of other persons that the patient should remain under guardianship, he shall furnish to the guardian and, where the guardian is a person other than a local health authority, to the responsible local health authority a report to that effect in the prescribed form.

(5) Where a report is duly furnished under sub-section (3) or sub-section (4) of this section, the authority for the detention or guardianship of the patient shall be thereby renewed for the period prescribed in that case by sub-section (2) of this section.

(6) Where a report under this section is furnished in respect of a patient who has attained the age of sixteen years, the managers or the local health authority, as the case may be, shall, unless they discharge the patient, cause him to be informed, and the patient may, within the period for which the authority for his detention or guardianship is renewed by virtue of the report, apply to a Mental Health Review Tribunal.

Special provisions as to psychopathic and sub-normal patients (Section 44)

44.—(1) Notwithstanding anything in section forty-three of this Act, a patient who is subject to guardianship by virtue of a guardianship application as a psychopathic or subnormal patient shall cease to be so subject on attaining the age of twenty-five years; and a patient who is liable to be detained by virtue of an application for admission for treatment as a psychopathic or subnormal patient shall cease to be so liable on attaining that age unless the authority for his detention is renewed under the following provisions of this section.

(2) Within the period of two months ending on the day on which a patient would cease under this section to be liable to be detained in a hospital in default of the renewal of the authority for his detention, the responsible medical officer shall examine the patient, and if it appears to

him that the patient, if released from the hospital upon attaining the age of twenty-five years, would be likely to act in a manner dangerous to other persons or to himself, shall furnish to the managers a report to that effect in the prescribed form; and where a report is duly furnished under this sub-section the authority for the detention of the patient shall be thereby renewed, and shall continue in force accordingly after the patient attains the said age, but without prejudice to the application to the patient of the provisions of section forty-three of this Act.

(3) Where a report under sub-section (2) of this section is furnished in respect of a patient, the managers shall cause the patient and the nearest relative of the patient to be informed, and the patient and that relative may, at any time before the expiration of the period of twenty-eight days beginning with the day on which the patient attains the age of twenty-five years, apply to a Mental Health Review Tribunal."

Restrictions on discharge by nearest relative (Section 48)

"48.—(1) Where a report under sub-section (2) of section forty-four of this Act has been furnished in respect of a patient, an order for discharge shall not be made by the nearest relative of the patient during the period of six months beginning with the date of the report.

(2) An order for the discharge of a patient who is liable to be detained in a hospital shall not be made by his nearest relative except after giving not less than seventy-two hours' notice in writing to the managers of the hospital; and if, within seventy-two hours after such notice has been given, the responsible medical officer furnishes to the managers a report certifying that in the opinion of that officer the patient, if discharged, would be likely to act in a manner dangerous to other persons or to himself:—

(*a*) any order for the discharge of the patient made by that relative in pursuance of the notice shall be of no effect; and

(*b*) no further order for the discharge of the patient shall be made by that relative during the period of six months beginning with the date of the report.

(3) In any case where a report under sub-section (2) of this section is furnished in respect of a patient, the managers shall cause the nearest relative of the patient to be informed, and that relative may, within the period of twenty-eight days beginning with the day on which he is so informed, apply to a Mental Health Review Tribunal in respect of the patient."

Functions of relatives of patients.

Definition of relative and nearest relative. (Section 49)

'49.—(1) In this Part of this Act 'relative', means any of the following, that is to say:—

(*a*) husband or wife;
(*b*) son or daughter;
(*c*) father;
(*d*) mother;
(*e*) brother or sister;
(*f*) grandparent;
(*g*) grandchild;
(*h*) uncle or aunt;
(*i*) nephew or niece.

(2) In deducing relationships for the purposes of this section, an adopted person shall be treated as the child of the person or persons by whom he was adopted and not as the child of any other person; and subject as aforesaid, any relationship of the half-blood shall be treated as a relationship of the whole blood, and an illegitimate person shall be treated as the legitimate child of his mother.

(3) In this Part of this Act, subject to the provisions of this section and to the following provisions of this Part of this Act, the 'nearest relative' means the person first described in sub-section (1) of this section who is for the time being surviving, relatives of the whole blood being preferred to relatives of the same description of the half-blood and the elder or eldest of two or more relatives described in any paragraph of that sub-section being preferred to the other or others of those relatives, regardless of sex.

(4) Where the person who, under sub-section (3) of this section, would be the nearest relative of a patient:—

(*a*) is not ordinarily resident within the United Kingdom; or

(*b*) being the husband or wife of the patient, is permanently separated from the patient, either by agreement or under an order of a court, or has deserted or has been deserted by the patient for a period which has not come to an end; or

(*c*) not being the husband, wife, father or mother of the patient, is for the time being under twenty-one years of age; or

(*d*) is a man against whom an order divesting him of authority over the patient has been made under section thirty-eight of the Sexual Offences Act, 1956 (which relates to incest with a girl under twenty-one) and has not been rescinded,

the nearest relative of the patient shall be ascertained as if that person were dead.

(5) In this section 'adoption order' means an order for the adoption of any person made under Part I of the Adoption Act, 1958, or any previous enactment relating to the adoption of children, or any corresponding enactment of the Parliament of Northern Ireland, and 'court' includes a court in Scotland or Northern Ireland.

(6) In this section 'husband' and 'wife' include a person who is living with the patient as the patient's husband or wife, as the case may be (or, if the patient is for the time being an in-patient in a hospital, was so living until the patient was admitted), and has been or had been so living for a period of not less than six months; but a person shall not be treated by virtue of this sub-section as the nearest relative of a married patient unless the husband or wife of the patient is disregarded by virtue of paragraph (*b*) of sub-section (4) of this section."

Supplemental.

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"54.—(1) It shall be the duty of a mental welfare officer to make an application for admission to hospital or a guardianship application in respect of a patient within the area of the local authority by whom that officer is appointed in any case where he is satisfied that such an application ought to be made and is of opinion, having regard to any wishes expressed by relatives of the patient or any other relevant circumstances, that it is necessary or proper for the application to be made by him."

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"57.—The Minister may if he thinks fit, at any time refer to a Mental Health Review Tribunal the case of any patient who is liable to be detained or subject to guardianship . . ."

Admission of Patients concerned in Criminal Proceedings etc., and Transfer of Patients under sentence.

(Part V of the Act)

Provisions for compulsory admission or guardianship of patients convicted of criminal offences, etc.

Powers of courts to order hospital admission or guardianship. (Section 60)

"60.—(1) Where a person is convicted before a court of assize or quarter sessions of an offence other than an offence the sentence for which is fixed by law, or is convicted by a magistrates' court of an offence punishable on summary conviction with imprisonment, and the following conditions are satisfied, that is to say:—

(*a*) the court is satisfied, on the written or oral evidence of two medical practitioners (complying with the provisions of section sixty-two of this Act):—

(i) that the offender is suffering from mental illness, psychopathic disorder, subnormality or severe subnormality; and

(ii) that the mental disorder is of a nature or degree which warrants the detention of the patient in a hospital for medical treatment, or the reception of the patient into guardianship under this Act; and

(*b*) the court is of opinion, having regard to all the circumstances including the nature of the offence and the character and antecedents of the offender, and to the other available methods of dealing with him, that the most suitable method of disposing of the case is by means of an order under this section,

the court may by order authorise his admission to and detention in such hospital as may be specified in the order, or as the case may be, place him under the guardianship of a local health authority or of such other person approved by a local health authority as may be so specified.

(2) Where a person is charged before a magistrates' court with any act or omission as an offence and the court would have power, on convicting him of that offence, to make an order under sub-section (1) of this section in his case as being a person suffering from mental illness or severe subnormality, then, if the court is satisfied that the accused did the act or made the omission charged, the court may, if it thinks fit, make such an order without convicting him.

(3) An order for the admission of an offender to a hospital (in this Part of this Act referred to as a hospital order) shall not be made under this section unless the court is satisfied that arrangements have been made for the admission of the offender to that hospital in the event of such an order being made by the court, and for his admission thereto within a period of twenty-eight days beginning with the date of the making of such an order.

(4) An order placing an offender under the guardianship of a local health authority or of any other person (in this Part of this Act referred to as a guardianship order) shall not be made under this section unless the court is satisfied that the authority or person is willing to receive the offender into guardianship.

(5) A hospital order or guardianship order shall specify the form or forms of mental disorder referred to in paragraph (*a*) of sub-section (1) of this section from which, upon the evidence taken into account under that paragraph, the offender is found by the court to be suffering; and no such order shall be made unless the offender is described by each of the practitioners whose evidence is taken into account as aforesaid as

suffering from the same one of those forms of mental disorder, whether or not he is also described by either of them as suffering from another of those forms.

(6) Where an order is made under this section, the court shall not pass sentence of imprisonment or impose a fine or make a probation order in respect of the offence, but may make any other order which the court has power to make apart from this section; and for the purposes of this sub-section 'sentence of imprisonment' includes any sentence or order for detention, including an order sending an offender to an approved school."

Requirements as to medical evidence. (Section 62)

"62.—(1) Of the medical practitioners whose evidence is taken into account under paragraph (*a*) of sub-section (1) of section sixty of this Act, at least one shall be a practitioner approved for the purposes of section twenty-eight of this Act by a local health authority as having special experience in the diagnosis or treatment of mental disorders.

(2) For the purposes of the said paragraph (*a*) a report in writing purporting to be signed by a medical practitioner may, subject to the provisions of this section, be received in evidence without proof of the signature or qualifications of the practitioner; but the court may in any case require that the practitioner by whom such a report was signed be called to give oral evidence.

(3) Where, in pursuance of directions of the court, any such report as aforesaid is tendered in evidence otherwise than by or on behalf of the accused, then:—

(*a*) if the accused is represented by counsel or solicitor, a copy of the report shall be given to his counsel or solicitor;

(*b*) if the accused is not so represented, the substance of the report shall be disclosed to the accused or, where he is a child or young person, to his parent or guardian if present in court;

(*c*) in any case, the accused may require that the practitioner by whom the report was signed be called to give oral evidence, and evidence to rebut the evidence contained in the report may be called by or on behalf of the accused.

(4) In relation to a child or young person brought before a juvenile court under section sixty-two or section sixty-four of the Children and Young Persons Act, 1933, sub-section (3) of this section shall have effect as if for references to the accused there were substituted references to the child or young person; and in the case of a child or young person brought before the court under the said section sixty-four paragraphs (*a*) to (*c*) of that sub-section shall have effect as if those references included references to his parent or guardian, and as if in the said paragraph (*b*) the words from 'or, where' to the end of the paragraph were omitted."

Miscellaneous Provisions (Part IX of the Act)

Mentally disordered persons found in public places. (Section 136)

"136.—(1) If a constable finds in a place to which the public have access a person who appears to him to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so, in the interests of that person or for the protection of other persons, remove that person to a place of safety within the meaning of the last foregoing section.

(2) A person removed to a place of safety under this section may be detained there for a period not exceeding seventy-two hours for the purpose of enabling him to be examined by a medical practitioner and to be interviewed by a mental welfare officer and of making any necessary arrangements for his treatment or care."

PREVENTION OF ILLNESS, CARE AND AFTER CARE (SECTION 28 OF THE NATIONAL HEALTH SERVICE ACT, 1946)

MENTAL HEALTH SERVICE

Proposals approved by the Minister of Health on 25th August, 1960:—

Introduction:

The following information is, in general, divided into two parts, that is, A and B, of which part A is a statement of the services already being provided. This statement is not part of the submitted proposals but is supplied because it may be helpful to those who read the proposals. It is, therefore, excluded from the scope of consultation with, or recommendations by, the bodies mentioned in section 20 (2) of the National Health Service Act, 1946, upon which copies of the formal proposals are required to be served. Part B consists of the local health authority's new proposals which are submitted for the Minister's approval under section 20 of the Act of 1946 and contains a description of their plans for the period up to April, 1963, and a further general statement of their subsequent intentions.

1. *General:*

A. The proposals in sub-paragraph B are additional to the arrangements already approved by the Minister relating to the prevention of mental illness, the care of persons suffering from mental disorder, and the after-care of such persons under Section 28 of the National Health Service Act; existing arrangements for carrying out duties under the Lunacy and Mental Treatment Acts, 1890-1930, and the Mental Deficiency Acts, 1913-1938, continue in operation until the relevant sections of these Acts are repealed on dates appointed by the Minister by order under section 153 of the Mental Health Act, 1959; the proposals relating to duties under the repealed sections will then cease to have effect.

B. The Authority will make appropriate arrangements for the provision of services to meet the needs of the mentally disordered living in the community and will make the services known to and available to those who are in need of them. In particular, they will provide, or cause to be provided, junior training centres, adult training centres, home training, residential accommodation, social clubs, a home visiting service, and day centres, which include craft instruction group classes with social activities.

2. *Organisation and Staff of the Services:*

A. The following is, in outline, a description of the existing organisation and staffing arrangements:—

The County Medical Officer of Health is responsible for the organisation and control of the Mental Health Services' administration. A Senior Medical Officer for Mental Health has been appointed on his staff to advise on mental health matters and, under the County Medical Officer of Health, to undertake the medical direction of the Mental Welfare Officers, the supervision of Training Centres, and generally to deal with the work of the Mental Health Services of the County Council. In addition, the Authority employs Mental Welfare Officers, Craft Instructors, Training Centre staff, and makes use of the services of other medical, dental and nursing staff of the County Health Department as appropriate.

Staff Training:

At the present time arrangements are made (1) for the staff of Training Centres, including trainees, to attend for instruction at Technical Colleges and Schools of Art, and subsequently for training by the National Association for Mental Health; (2) for Mental

Welfare Officers to attend courses, including Residential Courses at Universities; and (3) for Annual Residential Refresher Courses for Training Centre Staff under the auspices of the National Association for Mental Health.

Liaison:

A number of Medical Superintendents of psychiatric hospitals receiving patients suffering from mental disorder, and a General Medical Practitioner, have been co-opted on the Mental Health Sub-Committee of the County Health Committee. The County Medical Officer of Health is a member of the Derbyshire Local Medical Committee; he may attend their meetings alone or be represented by his official Deputy, or be accompanied by the Senior Medical Officer for Medical Health if a mental health item is on the agenda. The Senior Mental Officer for Mental Health attends case conferences, etc., at the various appropriate Hospitals, and visits cases as requested by the General Medical Practitioners or Hospitals. It is the duty of all the Mental Welfare Officers to maintain close contact with the General Medical Practitioners in their areas. It is also part of their duty to attend Psychiatric Clinics and give reports on patients when required, and to carry out any other instructions as directed by the Doctors who run the Clinics. Further, they are encouraged to attend case conferences, and to visit patients in hospital so that they may be known to them prior to returning home.

Nurses from a local psychiatric hospital accompany the County Council's "field" Officers for a period of training whilst on their course. University Social Workers will also be given similar facilities.

Discussions have taken place with representatives of the Sheffield Regional Hospital Board and various Hospital Management Committees, and also with Officers of the Ministry of Health, on the implementation of the principles underlying the recent Mental Health legislation.

B. In addition to the existing arrangements, the Authority expect to increase their staff employed in the Mental Health Services, and in particular, intend to appoint a sufficient number of Officers to act as Mental Welfare Officers under the Mental Health Act, 1959, from such dates as the relevant provisions of the Act come into operation. The Authority will take whatever measures are necessary, including secondment and in-service training, to ensure that their staff of all grades are adequately trained and/or qualified.

The Authority may make arrangements for the provision of services through voluntary bodies, other authorities or otherwise.

3. *Junior Training Centres:*

A. At present 230 places are available in training centres for the under-sixteen age group. These have been provided as follows:—

(*a*) two modern purpose-built centres, at Chesterfield and Ilkeston;

(*b*) two whole-time centres in temporary premises, at Chinley and Spondon and a part-time centre at Matlock.

The following types of training are available at these centres:—

Mop making; woodwork; basket work; cane work; rug making; weaving; knitting, by hand and by machine; sewing, by hand and machine; embroidery; laundering and ironing; cookery; gardening; leather work; and toy making.

Ancillary Services:

(i) *Meals.* These are at present supplied by the School Meals Service of the Education Department of the Authority, but, as adult training centres may be erected near to the junior centres in the future, it is envisaged that the adult centres may provide the meals for those attending the junior centres in some instances.

(ii) *Dental inspection* is provided by Dental Officers on the staff of the Health Department of the Authority.

(iii) *Medical inspections* are carried out by Medical Officers on the staff of the Health Department of the Authority.

(iv) *Physiotherapy* is provided in appropriate cases by qualified staff on the Health Department of the Authority.

(*v*) *Transport.* Appropriate transport arrangements are made for the conveyance of pupils to the training centres.

B. In addition to the existing arrangements, the junior training centres are expected to develop on the following lines:—

(*a*) It is proposed to erect purpose-built centres at Chinley (forty places) and in South Derbyshire (sixty places), to replace the whole-time centres conducted in temporary premises at the present time at Chinley and Spondon, and to meet the further needs in these areas.

(*b*) It is proposed to erect a centre in Mid-Derbyshire (sixty places) to replace the part-time centre at Matlock, and to meet the needs of the Mid-Derbyshire area.

(*c*) The result of the above provision will be that a total number of 290 places will then be available in training centres for the under-sixteen age group. At a later stage in the development plan, consideration will be given to the need to provide a junior training centre in North-East Derbyshire.

The Authority's plans are expected to provide within the next five or six years places for most suitable cases, but any further provision which may be necessary will be considered according to the needs of the service.

4. *Adult Training Centres:*

A. No centres are at present available for the sixteen years and over age group. However, Craft Classes are held throughout the administrative County, and Craft Instructors visit patients in their homes (this relates both to junior and adult patients).

B. Adult training centres are expected to develop on the following lines:—

It is proposed to erect an adult training centre at Chinley with fifty places for which Ministerial approval has already been given. This has been designed in such a way as to provide room for expansion. Provision has been made for an adult training centre in Chesterfield with 120 places, with room for expansion. Adult training centres are also intended to be provided in the South and South-east of the Administrative County, as well as in Mid-Derbyshire (each for 120 places).

The result of the above provision will be that a total number of 530 places will then be available in training centres for the sixteen-years and over age group. Consideration will be given at a later date to the need to establish an adult centre in North-East Derbyshire.

It is proposed that the following types of work will then be undertaken:—

Mop making; woodwork; basket work; cane work; rug making; weaving; knitting, both by hand and by machine; sewing, by hand and by machine; embroidery; laundering and ironing; cookery;

gardening; leather work; toy making; lamp shade making and lamp assembly; marquetry; boot repairing; brush making; pottery; and other suitable forms of training when and as required.

The Authority's plans are expected to provide within the next five or six years places for most suitable cases, but any further provision which may be required will be considered according to the needs of the service.

Meals may be provided and transport will be provided if necessary.

5. *Residential Accommodation:*

A. No residential accommodation for the mentally disordered is provided at present.

B. In 1960-61 it is hoped to provide a hostel in North West Derbyshire for about twenty-three mentally subnormal persons and two hostels for the mentally ill in Chesterfield and South Derbyshire, each with accommodation for twenty, male and female.

These two hostels will be short-stay hostels to which the patients will be admitted, generally from psychiatric hospitals, for rehabilitation and placement in work. Arrangements may be made as appropriate for the residents to attend a training centre, or work in ordinary or sheltered employment.

It is proposed at a later stage in the development of the mental health services to provide further hostel accommodation as may be necessary, including hostels for the elderly mentally infirm and for the mentally sub-normal. It is intended that the residents in hostels for the mentally sub-normal may attend training centres or be engaged in suitable employment available to the population at large.

The Authority will, if necessary, use residential accommodation provided for the mentally disordered by other authorities or bodies or otherwise.

6. *Home Training:*

A. The Council employs trained Occupational Therapists who are referred to as Craft Instructors, who visit patients' homes, as well as conduct group classes for patients suffering from mental disorders.

B. It is proposed to continue and develop the home training facilities as necessary.

7. *Day Centres, Social Clubs and other activities:*

A. The Authority's existing arrangements provide for three Social Clubs at Chesterfield, Ilkeston and Derby, under joint arrangements with Regional Hospital Boards. The Authority's Mental Welfare Officers and the Hospital Psychiatrists regularly attend the Clubs. The premises are provided by the Authority.

B. Consideration will be given to the provision of additional facilities under this heading as and when required.

8. *Home Visiting Service:*

A. The following are the general arrangements for home visiting to provide care and after-care:—

The Mental Welfare Officers provide home visiting for mentally disordered patients. Each Officer has a district for which he is responsible and in case of need he can, at any time, call on Officers located in other districts for help.

9. *Guardianship:*

The Authority undertake to exercise their functions under the Mental Health Act, 1959, in respect of persons placed under Guardianship, whether under that of the Authority or of other persons when these replace the functions under existing legislation.

I asked Dr. Margaret Fynne, the Senior Medical Officer for Mental Health, to let me have a Report, suitable for inclusion in my Annual Report, on the Mental Health Section of the County Health Department, which she has submitted as follows :—

"This year has seen many further developments in the field of Mental Health. The new Mental Health Act, although not yet fully implemented, has offered a stimulus and challenge in the field of planning and development—a challenge which this Authority was not slow to accept, although to do so would require a great deal of expenditure. We were helped in our future building programme with its priorities by the advice of the Medical Superintendents of the various psychiatric hospitals, all of whom attended regularly the meettings of the Mental Health Sub-Committee. The Committee is ndeed well attended and is full of enthusiasm as to the future.

Personnel. More offices for field Officers were opened at strategic places in the County. From the 1st April, 1959, to the establishment was added :—nine Mental Health Officers; four Craft Instructors; four Trainee Students (for the Training Centres at Ashbrook and Stanton Vale); extra clerical staff.

The recruitment of suitable Mental Health Officers was difficult, due to the the shortage of man-power in this field, but it was decided to appoint suitable psychiatric qualified male nurses, with or without S.R.N. qualifications, and to give them in-service training in the work before they took responsibility for their own areas. This scheme proved successful, and altogether fifteen officers were appointed. By 1st January, 1960, all the Officers were assigned to areas for which they were responsible, and Welfare Officers who were Duly Authorised Officers ceased to assist. The Mental Health Officers combined the duties laid down by law under the Mental Definciency and Mental Treatment Acts and also regularly attended the Psychiatric Social Clubs, another of which was opened this year.

Procedure for Admission to Hospital.

The mode of entry to Hospitals this year has seen a great change. Fewer Orders are necessary and the majority go in as "informal patients". Many go in as "informal" having been seen in out-patients' psychiatric clinics and some go in as "informal" through the General Medical Practitioners without the help of a Mental Health Officer. Once the Mental Health Act of 1959 is fully implemented, the work of the Mental Health Officer will see yet more changes. Whether he will in the future play a more important role, I would not like to forecast. A great deal will depend on the close liaison between Regional Hospital Boards, Hospitals and the Local Authority.

Training Centres.

For the first time our trainee scheme for recruitment of Training Centre staff came into being and we were successful in appointing four

grammar school girls as trainees. These will in time, it is hoped, be accepted for the Diploma Course organised by the National Association for Mental Health.

All the Training Centre staff now attend evening classes at Tech-Colleges and Schools of Art, the courses being paid for by the County Council. Many, as a result, are sitting for the examinations of the City and Guilds Certificate in various subjects.

For the first time the County Council adopted a scheme for seaside holidays for children attending the Training Centres, and a party of the children and staff of the combined Centres spent a week's holiday at Skegness in the charge of a Mental Health Officer. It was a most successful venture and was much appreciated by the parents of these children. For many children this was their first seaside holiday and, for some, their first holiday, and the fact that they were apart from their parents gave some a feeling of independence and for the older ones a feeling of responsibility towards the younger.

Introduction of Group Classes and Domiciliary Occupational Therapy.

Our group classes and domiciliary classes are being introduced throughout the County and are now very well attended. We have a few small classes for pre-care and after-care patients, but many of these prefer to attend the group classes for the sub-normal. A great deal of domiciliary occupational therapy is to be carried out for the after-care patients and we find this serves as a useful check on the patients as the Occupational Therapists report to the Mental Health Officer any change in their patients.

As a result of our activities in group classes and training centres, we have been able to hold successful exhibitions of work which has awakened the public interest in this aspect of Health.

Conclusion.

To me, the future in the field of Mental Health under the new Act is one of hope and pioneer effort in the field of developments. Much will depend upon the tolerance and sympathy of the general public towards the mentally ill, and sub-normal patient, and even severely sub-normal patient.

So far as the officers are concerned with the treatment of these patients they are enthused with a desire to develop new thoughts and teaching; it is no longer accepted that a patient mentally ill will remain in a Mental Treatment Hospital for the rest of his days. Of those Hospitals it used to be said "Abandon hope all ye who enter here".

In the foreseeable future, due to the advance in medicine, treatment in a Mental Hospital will be for the few, as we shall have day hospitals, day psychiatric units to which patients can go every day from their homes, and once these are established the admission rate and length of stay in a Mental Treatment Hospital will decline".

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 Officers have continued to visit the mentally handicapped who were on licence or on holiday leave from hospitals. Periodical progress reports are forwarded to the Medical Superintendents concerned. Where necessary, suitable places of work are found by Mental Health Officers for a number of those on licence, 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 Mental Health Officers.

Under the National Health Service Act, the responsibility for mentally sub-normal patients on licence or on holiday leave from hospitals rests with the variousHospital Management Committees, but since many of the hospitals do not employ their own Social Workers, arrangements are made with the Medical Superintendents to have the the work done by officers of the Local Health Authority. Also on behalf of the Management Committees of the various hospitals, arrangements have been made for the Mental Health 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.

It also arranges for courses in connection with the obtaining of the Diploma of the Association, whereby suitable candidates who are interested in the work of Training Centres are selected to attend these courses which are held under its auspices. In addition, the Association arranges annual residential refresher courses for personnel who work in the Training Centres. Occasionally, it arranges conferences relating to matters dealing with Mental Health.

The County Council make an annual subscription of £30 to the Association.

Work undertaken in the Community.

(*a*) *Under Section* 28 *of the National Health Service Act*, 1946.

The work of the Mental Health Officers is chiefly concerned with the care and after-care of the mentally handicapped. 1,018 cases under statutory supervision and 627 cases under voluntary supervision were visited during 1959 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 Insurances officers and other public departments. A continuous record of each case is kept in the Central Office, compiled from the detailed reports of the Mental Health Officers on their visits.

(*b*) *Under the Lunacy and Mental Treatment Acts*, 1890—1930, *and the Mental Health Act*, 1959.

During the year 1959, as shown in the following tables, 2,115 patients were admitted to mental hospitals and in respect of 540 of these, Orders were obtained by the Mental Health 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 Act, or informally under the Mental Health Act. It is noteworthy that just over 74% of the cases were admitted either voluntarily under the Mental Treatment Act, 1930, or informally under the Mental Health Act, 1959, and it is encouraging that more and more people are realising that mental illness is similar to many other illnesses in that early treatment may bring about recovery.

During the period 1st January, 1959, to 31st December, 1959, the following number of patients were admitted to Mental Hospitals :—

	Males	*Females*	*Total*
Pastures Hospital, Mickleover	741	781	1,522
Kingsway Hospital, Derby	106	193	299
The Coppice Hospital, Nottingham	8	9	17
Parkside Hospital, Macclesfield	49	68	117
Scarsdale Hospital, Chesterfield	51	56	107
St. Matthew's Hospital, Burntwood	3	9	12
St. Thomas' Hospital, Stockport	11	8	19
Middlewood Hospital, Sheffield	3	3	6
Mapperley Hospital, Nottingham	5	–	5
Cheadle Royal Hospital, Cheadle	1	–	1
Ollersett View Hospital, New Mills	–	6	6
Claybury Hospital, Woodford Green	–	1	1
Springfield Hospital, Crumpsall, Manchester ..	–	1	1
Saxondale Hospital, Radcliffe-on-Trent	–	2	2
	978	1,137	2,115

These patients were admitted in the circumstances set out below:—

	Males	*Females*	*Total*
Lunacy Act, 1890			
Summary Reception Orders (Sec. 16)	34	39	73
Duly Authorised Officers 3-day Orders (Sec. 20)..	128	155	283
Justices' 14-day Orders (Sec. 21)	75	107	182
Mental Treatment Act, 1930			
Temporary Patients (Sec. 5)	–	2	2
Voluntary Patients	680	658	1,338
Criminal Lunatics Act, 1884			
Criminal Lunatics Order (Sec. 7)	1	–	1
Mental Health Act, 1959			
Informal Admissions	60	176	236
	978	1,137	2,115

(*c*) *Under the Mental Deficiency Acts*, 1913—1938, *Guardianship*,

The cases under Guardianship Orders are visited occasionally by a Medical Officer with special experience concerning those who are mentally handicapped, as well as regularly by Mental Health Officers.

Admissions to Hospitals for the mentally sub-normal.

The following Table shows the number of patients admitted during the year 1959 :—

Under age 16		*Over age 16*		*Total*		*Total cases*
M.	*F.*	*M.*	*F.*	*M.*	*F.*	
6	7	14	19	20	26	46

Cases urgently awaiting admission to Hospitals for the Mentally Sub-normal, at 31st December, 1959.

Area	*Under 16*		*Over 16*		*Total*		
	M.	*F.*	*M.*	*F.*	*M.*	*F.*	*T.*
Manchester Regional Hospital Board area (Popualation 69,000)	9	4	1	1	10	5	15
Sheffield Regional Hospital Board Area .. (Population 663,800)	18	23	22	26	40	49	89
Whole County	27	27	23	27	50	54	104

The urgent waiting list has been as follows during the last few years :—

1955	1956	1957	1958	1959
170	112	98	102	104

In addition to these cases on the urgent waiting list there are a number of mentally sub-normal patients 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 mentally sub-normal children who are awaiting admission to Hospitals, four beds have been reserved by the Sheffield Regional Hospital Board for short-term stay and during the year; 119 cases were admitted for periods of three to eight weeks. This as been greatly appreciated by the parents, who have been able to take a holiday or have a rest from the continual care of the child.

Cases dealt with during 1959.

The following Table gives details of the number of mentally subnormal patients reported and dealt with during the year 1959 and also shows the number "ascertained" in the County on the 1st January, 1960:—

MENTAL DEFICIENCY ACTS, 1913-1938

Name of Local Health Authority: Derbyshire.

	During 1959				*Total cases on Authority's registers as at 1st January*, 1960			
	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* 1959 :—								
(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	19	27	–	–	–	–	–	–
(2) On leaving special schools	–	–	13	11	–	–	–	–
(3) On leaving ordinary schools	1	3	–	–	–	–	–	–
(ii) Police or by Courts ..	–	–	7	2	–	–	–	–
(iii) Other Sources	2	5	8	10	–	–	–	–
(b) Cases reported but not regarded at 31st December as defectives "subject to be dealt with" on any ground.. ..	15	11	40	41	–	–	–	–
(c) Cases reported but not regarded as defectives by 31st December and thus excluded from (a) or (b)	5	1	15	4	–	–	–	–
(d) Cases reported in which action was incomplete at 31st December, 1959 and are thus excluded from (a) or (b) ..	1	1	4	1	–	–	–	–
Total number of cases reported during the year :—	43	48	87	69	--	–	–	–

	During 1959				*Total cases on Authority's registers as at 1st January, 1960*			
	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 ..	22	33	22	20	191	173	315	339
(ii) Placed under Guardianship	–	–	–	–	–	–	2	2
(iii) Taken to "Places of Safety"	–	–	–	–	1	–	–	–
(iv) Admitted to Hospitals ..	–	1	6	3	39	23	276	330
(b) Of the cases not ascertained to be defectives "subject to be dealt with" number :—								
(i) Placed under Voluntary Supervision ..	14	10	38	41	14	12	295	306
(ii) Action unnecessary ..	1	1	2	–	–	–	–	–
(c) Cases reported at 1(a) or (b) above who removed from the area or died before disposal was arranged	–	1	–	–	–	–	–	–
Total of item 2	37	46	68	64	245	208	888	977
3. *Classification of defectives in the Community on* 31.12.59								
(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	–	–	–	–	4	8	2	4
(ii) ambulant low grade cases	–	–	–	–	20	19	7	10
(iii) medium grade cases	–	–	–	–	2	–	8	9
(iv) high grade cases ..	–	–	–	–	1	–	6	4
(2) Not in urgent need of hospital care :—								
(i) "cot and chair" cases	–	–	–	–	3	2	1	2
(ii) ambulant low grade cases	–	–	–	–	16	6	19	16
(iii) medium grade cases	–	–	–	–	4	1	15	19
(iv) high grade cases ..	–	–	–	–	1	–	7	4
Total of item 3 (a) ..	–	–	–	–	51	36	65	68

	Under age 16		Aged 16 and over	
	M.	*F.*	*M.*	*F.*
3. *Classification of defectives in the Community on* 31.12.59 (*continued*)				
(b) Of the cases included in items 2 (a) (i) and (ii) and 2 (b) (i) overleaf, number considered suitable for :—				
(i) training centre	100	65	36	44
(ii) industrial centre..	–	–	84	81
(iii) home training (craft instruction) at home—not in groups..	5	9	56	78
(iv) Craft Instruction in groups	4	7	64	71
Total of item 3 (b)	109	81	240	274
(c) Of the cases included in item 3 (b) number receiving training on 31.12.59:—				
(i) in training centre (including Voluntary Centres)	87	60	34	40
(ii) in industrial centre	–	–	–	1
(iii) from a craft instructor in groups (craft instruction at various c asses in the county)	4	7	64	71
(iv) from a craft instructor at home (not in groups)	4	3	45	76
Total of item 3 (c)	95	70	143	188

4. Number of Mental Defectives who were in Institutions, under Community Care (including Voluntary Supervision) or in "Places of Safety" on 1st January, 1959, who have ceased to be under any of these forms of care during 1959.

	M.	*F.*	*T.*
(a) Ceased to be under care	4	2	6
(b) Died, removed from area, or lost sight of ..	25	25	50
Total	29	27	56

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 1959 1

	Males	*Females*
(*b*) Number who have married during 1959 ..	1	5

6. Number of mental defectives for whom short term care was arranged by the local health authority during 1959 and admitted to National Health Service Hospitals :—

Under age 16		*Age* 16 *and over*	
M.	*F.*	*M.*	*F.*
48	33	13	25

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 1959

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 ..	4,890	4,881	77	77	4,967	4,958
(b) Institutional ..	4,440	7,642	74	204	4,514	7,846

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 col. 5 enter in respect of ante-natal examinations women who had *not* previously attended any clinic of the Local Health Authority during current pregnancy, and in respect of post natal examinations women who had *not* previously attended any post-natal clinic of the Local Health Authority after last confinement.

(1)	Number of premises* in use at end of year (whether held at Child Welfare Centres or elsewhere) (2)	Average number of sessions held per month‡ during year‡ (3)		Number of women in attendance		Total number of attendances during the year (6)	
		Medical Officers Sessions	Mid-wives Sessions †	Number of women who attended during year (4)	Number of new cases included in col. (4) (5)	Medical Officers Sessions	Midwive Sessions†
L.H.A. Clinics:	24	110	—				
(*a*) For ante-natal examination	24	97	—	3,574	2,924	13,248	—
(*b*) For post-natal examination	—	—	—	519	473	555	—
Clinics provided by Vol. Org.:							
(*c*) For ante-natal examination	—	—	—	—	—	—	—
(*d*) For post-natal examination	—	—	—	—	—	—	—

†Where no Medical Officer is present or available.

*Premises used both for ante-natal and post-natal work, whether in the same or different clinic sessions. shou be counted as clinics for ante-natal examination, but their number should also be shown separately in the boxes.

‡Sessions in which both ante-natal and post-natal work is done should be counted as ante-natal sessions b their number should also be shown separately in the boxes.

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 :			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 :			Total attendan during t year (12)
				1959 (5)	1958 (6)	1957-54 (7)		Under 1 year (9)	1 but under 2 (10)	2 but under 5 (11)	
(*a*) L.H.A. ..	97	365	8,949	7,089	5,724	4,745	17,558	98,064	20,700	11,921	130,68
(*b*) Vol. Org. ..	2	6	159	151	84	59	294	1,569	304	64	1,93

Infant Welfare Centres opened during 1959.

1. Memorial Hall, Breadsall.
2. William Deacons Bank, Eyam.

4. Dental Care of Expectant and Nursing Mothers and Children under School Age.

1. (*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 0.1
   (2) Dental Officers 0.53

   (*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 .. .. Nil

   (*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* (Chesterfield Borough)

   (*e*) Number of dental technicians employed in the Local Health Authority's own laboratories at the end of the year .. .. Nil

* None specifically set aside in remainder of County for expectant and nursing mothers and pre-school children).

2. Dental Treatment Return.

A. NUMBERS PROVIDED WITH DENTAL CARE:

(1)	Examined (2)	Needing Treatment (3)	Treated (4)	Made Dentally Fit (5)
Expectant and Nursing Mothers	106	101	94	53
Children under Five	829	571	548	247

B. FORMS OF DENTAL TREATMENT PROVIDED:

(1)	Scalings and Gum Treatment (2)	Fillings (3)	Silver Nitrate Treatment (4)	Crowns or Inlays (5)	Extractions (6)	General Anaesthetics (7)	Dentures Provided: Full Upper or Lower (8)	Dentures Provided: Partial Upper or Lower (9)	Radiographs (10)
Expectant and Nursing Mothers	34	59	2	—	309	27	32	15	—
Children under five	—	35	276	—	888	379	—	—	—

3. Health Visiting and Tuberculosis Visiting.

A. 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)
(a) L.H.A	39,726	3,096	4,176	11,099	31,964	18,086	31,364	2,616	7,200	35,306	—
			740		3,235	1,750	2,787	468	499		—
(b) Vol. Org.	—	—	—	—	—	—	—	—	—	—	—

*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 shown in the boxes. They should be excluded from the totals which are to relate to effective visits only. In the case of a family containing more than one person with whom the health visitor is concerned, the number of effective visits to be recorded is the number of persons to whom the visitor gives effective consideration on the occasion of a visit to a household. The number of "no access" visits is the number of persons to whom a visit was intended but not made effectively owing to failure to contact the person or a responsible representative.

¶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	6,562
(*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 have had more than 24 visits during the year* (11)
Number of cases attended by Home Nurses during the year :— (*a*) L.H.A. ..	10,490	3,098	53	278	108	838	14,865	5,864	402	3,492
(*b*) Vol. Org. under arrangements with the Authority	—	—	—	—	—	—	—	—	—	—
Number of visits paid by Home Nurses during the year :— (*c*) L.H.A. ..	293,982	59,485	617	11,154	969	19,136	385,343	218,579	3,863	238,902
(*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 (including Assistant Organisers) employed at the end of the year:—

(*a*)	Whole-time	6
(*b*)	Part-time	Nil.
(*c*)	Whole-time equivalent of (*b*)	Nil.

(ii) Number of Domestic Helps employed at the end of the year :—

(*a*)	Whole-time	98
(*b*)	Part-time	162
(*c*)	Whole-time equivalent of (*b*)	95·5

(iii) Number of cases where domestic help was provided during the year*:—

	Total	Cases included in previous col. in which help began prior to 1959
(*a*) Maternity (including expectant mothers)	179	4
(*b*) Tuberculosis	2	—
(*c*) Chronic sick including aged and infirm	1,329	745
(*d*) Others	188	64

*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..	87
(*b*)	Others	65

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	59	121	48.24	103.07
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).

me and Address of Home or Hostel	Number of beds				Number of admissions (ignoring re-admissions after confinement) during the year	Number of admissions in col. (6) for which the authority was responsible	Average length of stay	
	Total beds (excluding maternity and labour and cots)	*Maternity (excluding labour and isolation)	Labour beds	Cots			Ante natal	Post natal
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Provided by the Authority :—		N	I	L				
Provided or used by Voluntary Organisations with which the Authority make arrangements under Section 22 (1) or to which the Authority make payment under Section 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	55
(2) Post-Natal Cases	54

*A separate form M.C.W. 96a, should be furnished for each institution with *maternity* beds included in the above table.

†Exclusive of the lying-in period.

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.

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	96	–	96
(*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	–	–	–
(ii) Otherwise	–	79	79
(*d*) Midwives in Private Practice (including Midwives employed in Nursing Homes)	–	6	6
Totals	96	85	181

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 confinement takes place.

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 ..	21	680	1,283	2,868	4,852	—
) 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 ..	—	—	—	—	—	3,908
) Midwives in Private Practice (including Midwives employed in Nursing Homes)..	—	—	—	—	—	347
TOTALS ..	21	680	1,283	2,863	4,852	4,255

(e) Number of cases delivered in institutions but attended by domiciliary midwives on discharge from institutions and before the fourteenth day, 2,084.

(f) **Breast Feeding.**

Number of domiciliary cases in which the infant was wholly breast fed at the fourteenth day, 3,841.

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 ..	301
(ii) Others	170
Total	471
(*b*) Cases in Institutions	345

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	71
(*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	96	94	94	122	929	289	2,733	781	1,989
(*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	—	—	—	—	—	—	—	—	—
Totals	96	94	94	122	929	289	2,733	781	1,989

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.

† *i.e.*, number of children to whom the registrations relate.

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 whose registrations were withdrawn during year..	—	—	—	—
Homes on the register at end of year	4	17	66	83
Homes exempt from registration at end of year	—	—	—	—

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	561
(*b*)	At home	234
*(*c*)	In private nursing homes	25
	Total	820

2. Number of Premature Still-Births Notified (as adjusted by any notifications transferred in or out of the area).

(*a*)	In hospital	110
(*b*)	At home	26
*(*c*)	In private nursing homes	5
	Total	141

*"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)	(1
(*a*) 3 lb. 4 oz. or less (1,500 gms. or less)	74	28	32	9	4	3	16	6	7	–	–	–	2	1	1	54	8	
(*b*) Over 3 lb. 4 oz. up to and including 4 lb. 6 oz. (1,500-2,000 gms.)	113	18	88	11	1	8	16	1	15	4	–	4	1	–	1	33	8	
(*c*) Over 4 lb. 6 oz. up to and including 4 lb. 15 oz. (2,000-2,250 gms.)	130	7	118	18	–	18	15	–	14	3	1	2	1	–	1	13	2	
(*d*) Over 4 lb. 15 oz. up to and including 5 lb. 8 oz. (2,250-2,500 gms.)	244	4	233	135	1	132	14	1	11	14	–	14	–	–	–	10	8	
Totals	561	57	471	173	6	161	61	8	47	21	1	20	4	1	3	110	26	

†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)
cal Health Authority ..	—	4	1·6	—	55	38.5	—	—	—	—	—	—
				—	—		—	—				
untary 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 in the boxes.

†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	68 / 3	28 / —	14
(b) Voluntary Organisations ..	— / —	— / —	—	— / —	— / —	—
(c) H.M.C. or B.G.				— / —	— / —	—

*Non-Medical Supervisors of Midwives should be included and also shown separately in the boxes.

†Midwives approved as teachers should be included and also shown separately in the boxes.

(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 .. .. .. —

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)	Equ Whc tim of(1 (1
(a) Local Health Authority ..	1	2	1	107	24	12	7	3	1·5	—	—	—
				—	—	—	—	—	—	—	—	—
(b) Voluntary Organisation ..	—	—	—	—	—	—	—	—	—	—	—	—
				—	—	—	—	—	—	—	—	—

*Male nurses should be included and also shown separately in the boxes.

4. Nurses Engaged on Combined Duties.

NOTE: A nurse should be counted once only in this section. If part of her duties relates to health visiting, home nursing, or midwifery, she will also have been counted in one or more of sections 1, 2 and 3 above.

Number of nurses engaged in:

(*a*)	Health visiting and school nursing only ..	57
(*b*)	Home nursing and midwifery only	26
(*c*)	Health visiting, home nursing and midwifery only	Nil
(*d*)	Health visiting, home nursing, school nursing and midwifery only	Nil
(*e*)	Other combinations (please specify)	Nil

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	5
(*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	273
(*b*)	Part-time	3

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	3	9	26
ol. rg.*	—	—	—	—	—	—	—	—	—	—	—

†The number of part-time Supervisors should be included and also shown in the boxes.

*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	11
(*b*)	Tuberculosis Visitors	—
(*c*)	Domiciliary Midwives	9
(*d*)	Home Nurses	3
(*e*)	Day Nursery Staff (specify grades).	1 Warden

COUNTY OF DERBY

APPENDIX II.

Table of Deaths during the year 1959 in each of the Sanitary Districts, Classified according to Diseases.

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	4	–	1	–	–	1	–	–	1	5	7	–	6	25	2	3	34	35	6	39	12	4	9	13	4	1	–	1	3	1	4	23	–	6	2	–	252
ASHBOURNE	–	–	–	–	–	–	–	–	–	2	3	4	–	4	1	–	14	12	3	10	5	–	1	1	–	1	–	–	–	–	1	1	1	–	–	64
BAKEWELL	–	–	–	–	–	–	–	–	–	3	1	1	–	4	2	–	19	9	–	19	8	–	4	2	–	1	–	–	–	–	–	6	–	–	–	79
BELPER	1	–	–	–	–	–	–	–	1	8	6	2	–	21	1	–	45	48	2	17	16	15	11	10	2	7	1	2	–	–	2	16	1	7	–	–	242
BOLSOVER	2	–	–	–	–	–	–	–	–	2	–	2	–	6	–	1	19	17	–	14	6	–	3	5	3	1	1	–	–	–	4	8	1	4	1	–	100
BUXTON (Borough) ..	1	–	–	–	–	–	–	–	–	8	12	6	–	20	1	1	45	43	5	50	5	3	4	10	2	2	1	1	–	–	–	14	11	3	5	–	253
CHESTERFIELD (Bor'gh)	1	2	–	–	–	–	–	–	2	24	34	16	5	73	3	5	105	123	13	139	41	4	66	69	8	12	4	5	3	–	7	57	6	20	5	2	853
CLAY CROSS	–	–	1	–	–	–	–	–	–	2	1	4	–	6	–	2	14	13	1	7	2	–	7	7	–	–	–	–	–	–	2	10	2	3	1	–	85
DRONFIELD	1	–	–	–	–	–	–	–	–	5	6	1	–	3	–	1	16	19	7	16	2	1	10	2	–	1	2	–	1	–	1	10	–	2	1	–	108
GLOSSOP (Borough)	1	–	–	–	–	1	–	–	–	3	7	4	3	12	1	1	41	55	1	45	8	2	6	10	–	1	2	8	–	–	4	23	–	4	6	–	249
HEANOR	1	1	–	–	–	–	–	–	–	8	11	3	–	18	1	3	27	42	7	22	20	1	5	16	10	1	2	–	2	–	5	12	2	8	3	–	231
ILKESTON (Borough) ..	1	–	–	–	–	–	–	–	–	9	12	7	5	39	–	–	58	38	3	50	10	5	9	21	4	2	1	2	1	1	2	21	4	11	1	–	317
LONG EATON	2	–	–	–	–	–	–	–	–	11	13	6	5	33	4	3	39	48	5	54	8	2	12	14	1	–	–	5	2	1	4	36	3	10	1	–	322
MATLOCK	1	–	–	–	–	–	–	–	–	2	1	2	–	20	1	–	35	42	–	28	8	3	8	17	2	2	–	–	1	–	3	19	1	4	2	1	203
NEW MILLS	1	–	–	–	–	–	–	–	1	2	4	1	–	13	–	1	26	16	6	11	17	1	1	9	–	–	–	–	–	–	10	1	2	1	–	124
RIPLEY	1	–	–	–	–	–	–	–	–	9	7	4	7	21	1	2	18	27	4	21	8	2	5	14	1	4	2	3	2	2	3	21	3	5	2	–	199
STAVELEY	–	–	1	–	–	–	–	–	1	6	10	1	–	13	2	1	29	21	2	15	9	–	10	9	1	–	–	1	1	–	3	18	2	5	1	–	162
SWADLINCOTE ..	2	–	–	–	–	–	–	–	–	6	2	3	1	25	–	1	28	27	8	29	13	3	7	19	5	1	1	2	1	–	6	19	1	4	4	–	218
WHALEY BRIDGE ..	–	–	–	–	–	–	–	1	–	1	7	1	–	6	–	1	11	7	–	8	3	–	–	4	–	1	1	–	–	–	2	7	1	1	–	–	63
WIRKSWORTH	–	–	–	–	–	–	–	–	1	1	1	–	1	5	–	1	7	11	–	13	6	2	2	1	–	–	–	–	–	–	1	3	1	1	–	–	58
URBAN DISTRICTS ..	20	3	3	–	–	2	–	1	7	117	145	68	33	367	20	27	630	652	73	607	207	48	180	253	43	38	18	30	17	5	53	334	41	101	36	3	4,182
(RURAL)																																			
ASHBOURNE	2	–	–	–	–	–	–	–	–	5	1	2	–	19	1	–	24	15	1	14	16	–	1	6	1	1	1	2	–	–	–	6	1	2	2	–	123
BAKEWELL	1	–	–	–	–	–	–	–	–	4	6	1	2	29	1	7	35	40	5	32	13	1	8	14	1	1	3	2	2	–	2	25	1	6	2	1	245
BELPER	–	–	1	–	–	2	–	–	1	16	11	3	1	32	4	2	50	58	3	42	27	5	14	12	2	3	–	4	6	–	4	15	6	9	4	–	337
BLACKWELL	–	–	–	–	–	–	–	–	2	12	9	5	1	30	2	4	65	54	4	65	17	2	14	33	4	1	1	6	2	–	10	62	7	10	7	–	429
CHAPEL-EN-LE-FRITH	–	–	–	–	–	–	–	–	1	4	11	6	2	18	2	4	44	27	2	39	17	6	3	15	3	2	2	3	1	–	–	25	3	7	–	–	247
CHESTERFIELD ..	5	2	3	–	–	–	–	–	1	15	30	17	7	81	3	6	127	129	14	124	46	4	38	51	13	9	5	5	3	–	8	70	11	16	7	1	851
CLOWNE	–	–	–	–	–	–	–	–	–	6	4	3	1	21	3	1	21	20	3	40	10	2	8	18	1	2	–	1	2	–	1	17	7	8	5	1	206
REPTON	2	–	–	–	–	1	–	–	–	8	7	4	1	42	2	3	55	62	10	63	33	1	20	25	1	2	3	7	4	–	5	42	8	5	4	–	420
S.E. DERBYSHIRE ..	4	–	1	–	–	1	–	–	2	19	26	14	10	75	6	1	108	133	11	144	36	15	36	39	8	4	3	5	5	–	8	63	9	19	11	–	816
RURAL DISTRICTS ..	14	2	5	–	–	4	–	–	7	89	105	55	25	347	24	28	529	538	53	563	215	36	142	213	34	25	18	35	25	–	38	325	53	82	42	3	3,674
URBAN DISTRICTS ..	20	3	3	–	–	2	–	1	7	117	145	68	33	367	20	27	630	652	73	607	207	48	180	253	43	38	18	30	17	5	53	334	41	101	36	3	4,182
WHOLE COUNTY ..	34	5	8	–	–	6	–	1	14	206	250	123	58	714	44	55	1,159	1,190	126	1,170	422	84	322	466	77	63	36	65	42	5	91	659	94	183	78	6	7,856

DERBYSHIRE EDUCATION COMMITTEE

REPORT

OF THE

Principal School Medical Officer

ON THE

Health & Well-being of School Children

FOR THE

Year ended 31st December, 1959

J. B. S. MORGAN,
B.Sc., M.B., B.Ch., L.R.C.P., M.R.C.S., D.P.H.,
Principal School Medical Officer.

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MRS. E. HARRISON
MRS. F. E. SHIPLEY
MRS. D. M. SUTTON
J. TURNER
REV. E. J. WASS

Councillors

H. G. BOOTH
F. R. BOTT
G. W. COCKER
C. E. FLETCHER
MRS. D. HARDMAN
J. HAWORTH
J. W. HETHERINGTON
C. D. LEWIS
D. PRINCE
G. A. SEYMOUR
J. J. SHEEHY
MISS A. V. STAFFORD
L. STONES
MRS. A. S. THICKETT
H. TURNER, J.P.
E. H. WRIGHT

Coopted Members

MRS. E. E. ARMSTRONG
MRS. M. G. C. SULLEY, M.A.
C. BEMROSE, ESQ., M.A.
PROFESSOR C. G. CHESTERS, M.Sc.
H. H. DAVIDSON, ESQ.
F. HEATH, ESQ.
REV. H. HODGKINS, M.A.
H. MILES, ESQ.
REV. DR. H. S. O'NEILL
H. PALFREMAN, ESQ.
MRS. J. PLATTS
F. R. ROLLINSON, ESQ.
VERY REV. CANON L. J. WILLIAMSON
W. A. STRETTON, ESQ.

SPECIAL SERVICES SUB-COMMITTEE OF THE DERBYSHIRE EDUCATION COMMITTEE
(1959-1960)

ALDERMAN F. A. GENT
(Chairman)

ALDERMAN J. B. HANCOCK
(Vice-Chairman)

Aldermen

J. W. ALLITT, M.B.E.
J. ANDERSON
MRS. A. M. BELFIELD
MRS. G. BUXTON, C.B.E., J.P.
MRS. O. EDEN, J.P.
C. FEAKIN, J.P.
R. FEWKES
MRS. E. HARRISON
MRS. F. E. SHIPLEY
MRS. D. M. SUTTON
J. TURNER

Councillors

F. R. BOTT
MRS. D. HARDMAN
G. A. SEYMOUR
J. J. SHEEHY
L. STONES
MRS. A. S. THICKETT
H. TURNER, J.P.

Co-opted Members

MRS. E. E. ARMSTRONG
H. H. DAVIDSON, ESQ.
F. P. HEATH, ESQ.
F. R. ROLLINSON, ESQ.

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, 1959, 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, C.B.E., J.P.
ALD. MRS. O. EDEN, J.P.
ALD. F. A. GENT
ALD. 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, 1959.

To the Chairman and Members of the Derbyshire Education Committee

Ladies and Gentlemen,

I have the honour to present my sixteenth Annual Report on the health and well-being of children attending schools maintained by the Derbyshire Education Authority.

I have continued to include in the Report, after a certain amount of editing by the Director of Education and myself, reports I have received from the school medical officers and some other staff. It may be thought that the incorporation of ideas from several sources would make for more interesting reading. In my view, different opinions on the same subject are often helpful in evaluating a problem, but it should be clearly understood that I cannot be expected to subscribe necessarily to every opinion expressed, particularly when they are opposed. Medical men in the course of their training are taught to be observant, reliant and responsible, but they sometimes disagree in their opinions. (Perhaps I should say at once that they are not peculiar in this respect!). If, therefore, I went meticulously through the Medical Officers' reports and expurgated everything that was contradictory or contentious and only included what was laudatory, the Report would have lost its "savour" and become insincere and dull. There is the further point that reports from different areas heighten interest in the work in various localities. In this connection it might be considered opportune to quote relevant extracts from a Ministry of Education circular dated 18th February, 1960:—

> "2. The report of the Principal School Medical Officer for 1959 is also required by the Ministry under Section 92 of the Education Act, 1944 . . . The Medical Inspection Returns should show figures for the whole of the Authority's area including Excepted Districts and Divisional Executives. The Reports of the Principal School Medical Officer might include reports from School Medical Officers of these districts."

I have agreed to a suggestion made by the Director of Education that it would be expedient that the following sentence should appear in this introductory letter: "It is right that medical officers, no less than other appropriate members of the County Council's staff, should be constantly on the look-out for improvements which need to be made, but it should be noted that the pace at which these improvements can be carried out depends mainly on the allocation of capital resources by central government."

"Education" and "Health" have much to contribute to one another—in fact neither blossoms to its full splendour without the help of the other. They are inextricably bound together, so that if one fails the other languishes. This may produce dire consequences in a child's scholastic career, notably when it coincides with special study for the "11-plus" examination or for University entrance. There are many factors operating in success or failure, including intelligence, work and teaching, but not least health.

While staffing difficulties in dentistry and speech therapy have continued, without hope of much improvement in the near future, the immediate prospect is brighter in the field of medical recruitment. More medical staff is necessary, not only to deal with the increased school population since the war, due to the birth rate and the raising of the school leaving age, but to carry out the various immunological procedures that informed medical opinion now advocates. In the latter connection I must pay tribute to the assistance received from the teachers in making known to parents and scholars the advantages to be gained from agreeing to these procedures.

Ably lead by its Chairman and Director, the Education Committee is taking an increasing interest in physical education, whether it be in a gymnasium, playing field, mountain top, or on or in the water! The right exercise, backed by sound nutrition, are important constituents in a successful education career:—

"*Mens sana in corpore sano.*"

Finally, I would like to thank Ald. F. A. Gent and Ald. Mrs. E. Harrison, the respective Chairmen of the Education Committee and the Joint Medical Services Sub-Committee, for their support in obtaining approval to expansions in the School Health Service during the year; Mr. J. L. Longland, the Director of Education, and his staff for their co-operation; and to the staff of my own Department for their assistance, but not least, Dr. Woodward, my Deputy, Mr. Gray, Principal Dental Officer, Dr. Julia Corrigan, the Senior Medical Officer for the School Health Service, and Mr. Dilks, the Chief Clerk.

I am,

Your obedient Servant,

J. B. S. MORGAN,

Principal School Medical Officer.

County Offices,
Matlock.

(*Telephone: Matlock* 3411).

4th April, 1960.

THE SCHOOL HEALTH SERVICE REGULATIONS, 1959

As a consequence of the passing of the Local Government Act, 1958, the Minister of Education has issued *The School Health Service Regulations*, 1959, which take the place of *The School Health Service and Handicapped Pupils Regulations*, 1953, with effect from 1st April, 1959.

An explanatory note appended to the Regulations indicates their general purport as follows:—

"These regulations replace Part II of the School Health Service and Handicapped Pupils Regulations, 1953, (revoked by the Special Schools and Establishments (Grant) Regulations, 1959 (S.I. 1959/366)) which prescribes the conditions for grant to local education authorities in respect of the medical inspection and treatment of pupils. The requirements imposed on the authorities by these regulations are no longer conditions of grant, but do not differ substantially from the existing conditions, except that specific requirements as to the occasions on which medical and dental inspection are to be carried out have been omitted.

The following extract includes the salient features of the new Regulations:—

"2. These regulations prescribe the requirements to be observed by local education authorities when performing their functions under the Education Acts, 1944 to 1953, in relation to the medical examination, inspection and treatment, and dental treatment, of pupils in schools, (including special schools), and other educational establishments maintained by them.

School Health Service.

3. (1) Every local education authority shall, for the purpose of performing the functions referred to in the preceding regulation, maintain a health service, to be called the 'school health service', and, as part of that service, a dental service, to be called the 'school dental service'.

(2) An authority shall appoint—

(*a*) a principal school medical officer, to be in general charge of the school health service, and responsible to the authority for the efficient conduct of the service in the interest of the health and well-being of the pupils for whom it is provided;

(*b*) a principal school dental officer, to be in charge of the school dental service, and responsible to the principal school medical officer for its efficient conduct; and

(*c*) such other medical and dental officers, nurses and other persons as may be necessary.

4. An authority shall, in making arrangements for its school health service, have regard to other health services in its area; and the authority's arrangements and the premises used for the service, shall be open to inspection by any person appointed for the purpose by the Minister.

Nurses.

5. A nurse employed by an authority for the purposes of the school health service shall possess the qualifications prescribed for a health visitor by the National Health Service (Qualifications of Health Visitors and Tuberculosis Visitors) Regulations, 1948 (b), unless—

(*a*) she is employed solely in a school clinic, or on duties of a specialist character, or was employed by a former local education authority before 1st April, 1945; or

(*b*) the authority is unable to comply with this regulation owing to a shortage of nurses possessing such qualifications.

Premises

6. Premises used for the school health service shall be kept in a proper state of repair, cleanliness and hygiene.

Medical and Dental Inspection

7. An authority shall, so far as is reasonable and practicable, give the parent of a day pupil the opportunity of being present at every medical inspection, and at the first dental inspection, of the pupil.

Records.

8. (1) An authority shall keep medical and dental records in a form approved by the Minister for every pupil attending a school maintained by it.

(2) If the pupil becomes a pupil at a school or other place of education or training maintained by another local education authority, the records shall be transferred to that other authority if so requested by it; and if he becomes

a pupil at a school or other place of education or training not maintained by a local education authority, reasonable medical information concerning him shall on request, be given to the person conducting that other school or place."

In a circular (No. 352 dated 24/3/59) which described the principal changes brought about by the new Regulations, the Ministry dealt with the following points:—

Medical and Dental Inspections. The frequency of medical and dental inspections has not been prescribed. The duty upon authorities to carry out these inspections at appropriate intervals is stated sufficiently clearly in s. 48(1) of the Education Act, 1944. Where this duty is carried out by means of *periodic general medical inspections*, they should take place during the first and last years of compulsory school attendance, and one other inspection either during the last year in the primary school, or the first year in the secondary school. It will also be desirable to inspect young chidlren under five years as soon as possible after they begin school, and also during their last year at school pupils who stay at school beyond the age of fifteen.

School dental inspections should, as far as practicable, be carried out at least once a year, and treatment offered promptly to those who are found to need it. The Ministry's circular states, however, that "this is unfortunately at present possible only in a few areas owing to the shortage of school dentists."

The circular goes on to say that "Medical and dental inspection should take place in school whenever this is possible. The Standards for School Premises Regulations include a requirement that suitable accommodation shall be immediately available at any time during school hours for the inspection and treatment of pupils by doctors, dentists, nurses and other professional workers in the School Health Service."

The circular—in my opinion very truly—points out that "the efficient conduct of the School Health Service depends above all on the close contact of doctors and nurses with the teachers, the parents and the children in the schools. They should be regular visitors, and the teachers should be encouraged to bring to their notice both those children who show particular defects and those whose general condition seems to indicate the need for an expert medical examination. There should also be close co-operation between the School Health Service staff and the children's general medical practitioners."

Reports. The circular states that "the Minister hereby requires that, as soon as possible after the end of each calendar year, the authority shall submit to him in respect of that year a report by their Principal School Medical Officer on the health and well-being of pupils in his care and on the work of himself and his staff in relation thereto, including a report on the School Dental Service by the Principal School Dental Officer."

In this County, three general medical inspections of the school children take place, generally 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. (Exceptionally, arrangements may be made for children to be examined in the last year at a junior school, instead of during the first year at a secondary school—this is to relieve some of the pressure on the larger secondary schools through which "the bulge" in the school population is passing).

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. As no routine general medical inspection is normally carried out in the "junior" departments or schools, School Medical Officers have been requested to make a point of getting in touch with the Headteachers of such departments or schools at least once a year to afford them an opportunity of bringing forward any children they require to be specially examined or cases in need of re-examination.

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-1959 ..	139,340	227,560	365,900	732,800

Primary and Secondary Schools.

Divisional Executive	Types of Schools and Numbers		Average No. on Registers	
North-west	Primary ..	80	8,317	13,938
	Secondary ..	16	5,621	
North-east	Primary ..	119	21,314	34,457
	Secondary ..	33	13,143	
Mid-Derbyshire ..	Primary ..	82	9,426	17,710
	Secondary ..	18	7,284	
South-east	Primary ..	63	10,660	18,719
	Secondary ..	16	8,059	
South	Primary ..	103	13,192	21,383
	Secondary ..	18	8,191	
Chesterfield ..	Primary ..	26	6,075	12,313
	Secondary ..	13	6,238	
Total — Whole Administrative County	Primary ..	473	69,984	118,520
	Secondary ..	114	48,536	

Nursery Schools and Nursery Classes.

Divisional Executive	Number of Schools or Classes		Approx. No. on Registers
North-west ..	Schools ..	1	42
	Classes ..	1	23
North-east ..	Schools ..	1	40
	Classes ..	6	136
South-east ..	Classes ..	2	61
Chesterfield ..	Classes ..	4	105

Special Schools. *Approx. No. on Registers*

Ashgate Croft (E.S.N. Mixed) Day Special School, Chesterfield (Opened 14 4 59) ..	160
Brambling House Open Air School and Children's Centre, Chesterfield	125
Bretby Orthopaedic Hospital Special School, Bretby	44
John Duncan (E.S.N. Girls') School, Buxton ..	45
Overseal Manor (E.S.N. Boys') School	43
Talbot House, Glossop (Cerebral Palsy) ..	21
The Brackenfield Day Special School (E.S.N., Mixed), Long Eaton	100

Boarding Homes for Maladjusted Pupils.

Holly House, Chesterfield	12
Stretton House, Stretton	24

New Schools.

The following new schools were opened during the year:—

North-West Division	*Date of Opening*
Buxton St. Thomas More R.C. Secondary	7th September.
North-East Division.	
Dronfield Holmsdale County Infants ..	6th January.
Mid-Derbyshire Division.	
Belper St. Elizabeth's R.C. Primary ..	7th September.
South Derbyshire Division.	
Swadlincote Eureka County Infants ..	5th January.
Breadsall The Darwin County Secondary	15th April.
Alvaston St. John Fisher R.C. Infants ..	1st September.

Schools closed during the Year.

North-East Division.	*Date of Closure.*
North Wingfield County Secondary Boys	13th April.
South-East Division.	
Heanor Langley Mill C.E. V.C. Boys ..	13th April.
Ilkeston Bennerley County Infants ..	31st August.
South Derbyshire Division.	
Swadlincote Church Gresley Hastings County Secondary	17th July.
Swadlincote Hastings County Infants ..	4th January.

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	1953 ..	109,099
1947 ..	87,107	1954 ..	112,021
1948 ..	91,875	1955 ..	114,744
1949 ..	95,595	1956 ..	116,699
1950 ..	97,511	1957 ..	118,761
1951 ..	100,973	1958 ..	119,792
1952 ..	106,323	1959 ..	118,520

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	1950	..	10,799
1941	..	10,078	1951	..	10,440
1942	..	11,032	1952	..	10,425
1943	..	11,724	1953	..	10,663
1944	..	13,149	1954	..	10,417
1945	..	11,393	1955	..	10,329
1946	..	12,710	1956	..	11,011
1947	..	13,714	1957	..	11,428
1948	..	12,152	1958	..	11,560
1949	..	11,534	1959	..	11,868

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 in 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, 1959, 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	29	14.6
(iii) General Practitioners working part-time in the School Health Service ..	—	—
(*b*) Physiotherapists, Speech Therapists, etc. (Specify)—		
(i) Orthopaedic Physiotherapists	3	1.50
(ii) Speech Therapists ..	3	2.54
(*c*) (i) School Nurses	57	19.90
(ii) No. of above who hold a Health Visitor's Certificate	52	
(*d*) Nursing Assistants	17	11.90

*—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	0.90	—	—
(ii) Dental Officers ..	8	5.83	—	—
(iii) Orthodontists (if not already included in (*e*) (i) or (*e*) (ii) above ..	—	—	—	—
Total ..	9	6.73	—	—

	Number of Officers	Numbers in terms of full-time officers employed in the School Dental Service
(iv) Dental Attendants ..	9	7.70

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 SCHOOL HEALTH—		
Julia M. D. Corrigan, M.B., B.Ch., B.A.O., D.P.H.	55%	45%
SENIOR MEDICAL OFFICER FOR MENTAL HEALTH—		
Margaret Fynne, B.A., M.B., B.Ch., B.A.O., L.M., D.P.H.	2½%	97½%
SCHOOL MEDICAL OFFICERS—		
Frances G. Brill, B.A., M.B., B.Ch., B.A.O.	70%	30%
Mary F. Cooney, M.B., B.Ch., B.A.O., D.C.H., D.P.H. (Left 20/3/59)	70%	30%
J. W. Crawshaw, M.B., Ch.B.	70%	30%
R. E. Dean, L.R.C.P.S., L.R.F.P.S.	75%	25%
J. Duthie, M.B., Ch.B.	70%	30%
Anna L. Frenkiel, M.R.C.S., L.R.C.P., D.R.C.O.G. (Left 23/1/59)	70%	30%
Winifred Gow, M.B., Ch.B.	70%	30%
Alison M. Hamilton, M.B., Ch.B., D.P.H. ..	70%	30%
Tonie F. Haynes, M.B., Ch.B. (Transferred from M.C.W. 8/9/59).	70%	30%
Emily B. John, M.B., B.S., M.R.C.S., L.R.C.P. (Commenced 5/1/59)	70%	30%
Dorothea Koffman, M.D., D.P.H. (Left 22/6/59)	70%	30%
Margarete Kuttner, M.D.	65%	35%
D. M. McCarthy, L.R.C.S.I., L.R.C.P.I. (Left 18/9/59)	70%	30%
D. R. McCaully, M.D., B.Ch., B.A.O., D.P.H. (Commenced 16/2/59)	70%	30%
Margaret J. Nettleship, M.B., B.Ch., D.P.H.	70%	30%
G. J. O'Connor, M.B., B.Ch., B.A.O.	70%	30%
G. Storey, B.Sc., M.B., B.S., L.R.C.P., M.R.C.S. (Commenced 22/6/59)	70%	30%
Teisi Urtson, Med-Dip., Univ. of Tartu ..	70%	30%
Mary T. Vass, L.R.C.P.I., L.R.C.S.I., L.M. .. (Five vacancies).	70%	30%
PART-TIME SCHOOL MEDICAL OFFICERS—		
M. Allan, M.B., Ch.B., D.P.H.	20%	80%
W. J. Morrissey, M.B., B.Ch., B.A.O., D.P.H. ..	33%	67%
A. R. Robertson, M.B., Ch.B., D.P.H.	20%	80%
F. D. F. Steede, M.B., B.Ch., D.P.H. ..	27%	73%
Mary Sutcliffe, M.A., M.B., B.Ch., D.P.H. ..	30%	70%
P. Weyman, L.R.C.P., L.R.C.S., L.R.F.P. & S., D.P.H.	20%	80%
C. G. Woolgrove, M.B., Ch.B., D.P.H.	27%	73%
BOROUGH SCHOOL MEDICAL OFFICER for Chesterfield Excepted District)—		
J. A. Stirling, D.S.C., M.B., Ch.B., D.P.H. ..	24%	76%

Staff	Proportion of whole time (expressed as a percentage) devoted to	
	School Health Service	Public Health
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., B.A.O., D.P.H. ..	28%	72%
CHILD GUIDANCE AND SPEECH THERAPY STAFF—		
CONSULTANT CHILDREN'S PSYCHIATRIST—		
D. J. Salfield, B.Sc., M.D., D.P.M. (9/11ths of Salary paid by Regional Hospital Board) .. (One vacancy).	80%	10%
EDUCATIONAL PSYCHOLOGISTS—		
J. R. Fish, B.Sc.	25%	—
Miriam S. Flint, B.A.	25%	—
Grace M. Hamer, M.A. (Chesterfield Excepted District)	50%	—
Jean Ingham, B.A. (Chesterfield Excepted District)	50%	—
Phyllis Lane, B.A. (Commenced 1/1/59).. .. (Two vacancies).	25%	—
PSYCHOTHERAPIST—		
Coral L. Tibbetts, B.Sc., Dip.Psych. (Commenced 20/10/59	90%	10%
PSYCHIATRIC SOCIAL WORKERS—		
Stella Hollingworth, B.A. (Left 30/11/59) .. (Two vacancies).	90%	10%
SOCIAL WORKERS—		
Ethel N. Ives, (Chesterfield Excepted District) .. (One-and-a-third vacancies).	50%	—
SPEECH THERAPISTS		
Edna Curry, L.C.S.T.	95%	5%
Margaret R. Marsh, L.C.S.T. (6/11ths)	50%	5%
Mary E. Smith, L.C.S.T. (4/11ths). (Left 23/7/59)	33%	3%
Sal y Go'dthorpe, L.C.S.T. (Chesterfield Excepted District). Commenced 1/9/59	100%	—
Helen Wright, L.C.S.T. (Chesterfield Excepted District). (Left 10/4/59) .. .. .. (Eight-and-a-half vacancies)	100%	—
DENTAL STAFF—		
PRINCIPAL SCHOOL DENTAL OFFICER—		
H. E. Gray, L.D.S.	90%	10%
DENTAL OFFICERS—		
G. H. Freeman (Dentist, 1921)	90%	10%
F. E. Welton, L.D.S.	90%	10%
PART-TIME DENTAL OFFICERS—		
Wilma Drury, L.D.S. (10/11ths)	80%	11%
Flora M. Jackson, L.D.S. (6/11ths)	50%	5%
Dorothy Littlar, L.D.S. (6/11ths)	50%	5%
Ilse B. Mann, L.D.S. (4/11ths) .. .. .. (7 and7/11ths vacancies).	33%	3%
Chesterfield Excepted District—		
A. R. Littlar, L.D.S. (Borough Senior Dental Officer)	91%	9%
Annie Kean, L.D.S. .. .. (One vacancy).	100%	—

At the end of 1953 we had the equivalent of 8.4 whole-time School Medical Officers; at 31.12.54 the figure was 9.3. In 1955 the County Council agreed to increase the establishment by seven Assistant Maternal and Child Welfare and School Medical Officers, in order to meet the growing needs for their services and to bring the ratio of staff up to a figure similar to the average for the country as a whole. At 31.12.55 the equivalent of 10.5 officers were engaged in school health work and at the end of 1956 the figure was 13.9. Steps were also being taken to arrange a scheme for carrying out B.C.G. vaccination of certain school children (which is designed to afford protection against tuberculosis), and the County Council therefore agreed that six additional Medical Officers be appointed (who will act as Maternal and Child Welfare as well as School Medical Officers), according to the need, to enable it to be implemented without detriment to the other schemes which have already been established. It will be seen from the foregoing schedules of staff that at the end of 1959 we had the equivalent of (approximately) 14.6 school medical officers, with five combined posts of Assistant Maternal and Child Welfare Medical Officers/School Medical Officer to be filled.

Each Medical Officer now has a "Medical Officer's Attendant." This scheme was introduced to relieve Health Visitors of some of the routine tasks, and has worked very well, the Attendant helping the Doctors not only in minor nursing work but also with the clerical work.

Regular meetings of the Medical Officers (about two each term) were held.

GENERAL CONDITION OF PUPILS

The number of pupils examined at routine medical inspections totalled 33,394. For 1955 and for each subsequent year the corresponding figure has been 29,982; 27,734; 28,385; and 30,520.

In the course of examining the 33,394 children at routine inspections, 5,915 children were found who required treatment for various conditions (17.7% of those examined). However, only 445 children were classed as being in an "unsatisfactory" physical condition (1.3% of the total number examined).

The percentage found to need treatment in 1959 (17.7%) may be compared with the following figures for successive years (starting with 1953):— 18.4; 17.3; 19.5; 18.1; 16.8; 18.9. The last published figure for England and Wales (year 1957) was 14.98%.

The percentages of those whose "physical condition" has been considered to be "unsatisfactory", since this classification was introduced in 1956, are as follows:—

Year	% *"unsatisfactory"*
1956	2.72
1957	3.88
1958	2.57
1959	1.33

(The last published average for the country as a whole was 1.72% for the year 1957).

The figures for 1959 have been "broken down" into Divisional areas, and are set out below. There are variations between the areas, but it must be borne in mind that the classification is a subjective one. It is not possible to say to what extent the variations are due to the personal element which must be present when the figures are the result of examinations carried out by different medical officers.

Divisional Executive	*Physical Condition*	
	Satisfactory	*Unsatisfactory*
North-west	98.6	1.4
North-east	99.0	1.0
Mid-Derbyshire	99.5	0.5
South-east	98.6	1.4
South	98.8	1.2
Chesterfield	96.8	3.2
Whole administrative County ..	98.7	1.3

There is, of course, a wide gap between the 17.7% of children who were found to need treatment and the 1.3% regarded as "unsatisfactory". As mentioned in previous Reports, this is due to the fact that the defects recorded as requiring treatment cover a wide range, and are of varying degrees of severity. The presence of a defect does not necessarily result, therefore, in a child being regarded as of "unsatisfactory physical condition".

Vision. I have referred in previous Reports to an upward trend in the incidence of defective vision. The figures since 1947 are as follows:—

Year	*Children referred for treatment of defective vision per* 1,000 *examined (excluding "entrants")*
1947	47.8
1948	49.0
1949	66.0
1950	69.9
1951	62.9
1952	69.9
1953	87.4
1954	84.5
1955	87.2
1956	88.7
1957	90.1
1958	96.9
1959	88.3

The wide variation between figures from different Education Authorities show that there is likely to be a marked personal factor in recording of visual defects.

Figures from neighbouring authorities in 1957 are as wide apart as approximately 95 and 25 per 1,000 examinations. This problem was discussed in the Ministry of Education's publication "Health of the School Child, 1958", relating to the years 1956 and 1957.

Squint. Prior to 1952 cases of squint were recorded in about 9 or 10 out of every 1,000 children examined. Since 1952 the figures are as follows:—

1952	13.3
1953	15.9
1954	16.6
1955	16.9
1956	10.9
1957	9.8
1958	13.6
1959	16.3

Comment has been made nationally that "a greater awareness of the significance of minor ocular imbalance has led to the more frequent reference of children for treatment of squint."

Nose and Throat Defects. The rate per 1,000 of pupils thought to require treatment for nose and throat defects has varied during the past few years from 28 to 49. The figure for 1957 was only 13.32, but in 1958 it was 21.6. The figure for 1959 was 17.9. During the examinations at schools the School Medical Officers have recorded the children seen at periodic medical inspections who have undergone tonsillectomy at any time previously. The figures in Derbyshire during 1959 were as follows:—

Groups Inspected	Numbers Inspected	Numbers and percentages found to have had tonsillectomy	
		No.	%
Entrants	12,000	468	3.9
Second age group	11,551	1,636	14.2
Leavers	9,843	1,654	16.8

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 to the rural schools. It should be noted however that the provision of water mains in the rural areas during the last ten years or so has resulted in wholesome water being brought to a number of schools, and as a consequence there are now very few not so connected. 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 (outside Chesterfield Excepted District) for which the Education Authority itself is responsible; this is the open air bath at Ashbourne.

This bath is provided with a modern treatment plant. Pupils from many schools in the area use it, and the facilities have been extended to youth and similar organiastions as well as to members of the public. In 1958, the attendance figure for school children was 27,392 out of a total attendance during the season of 37,836. Such a figure serves to emphasize the value of the bath to the schools able to make use of it.

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 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

Table "A" contains details of meals and milk provided on a day in September, 1959. In comparison with similar details for October, 1958, with almost the same number of pupils in attendance, there were increases in meals of 2% and in milk of .7%.

Training facilities for members of the Meals Service Staff have continued to be used at the Littleover Kitchen and there has been a good number of successful entrants.

The allocation of funds for kitchen and scullery modernisation has been fully spent and the programme of improvements continues.

Source and Quality of Supply to Milk under the Milk-in-Schools Scheme.

Sampling of school milk supplies was carried out by Mr. Rowley, the County Public Health Inspector. Pasteurised milks are submitted to the phosphatase test (for efficiency of pasteurisation), and raw milks to the biological test (for tubercle bacilli). Any pastuerised milk which fails to pass the phosphatase test is examined for tubercle bacilli as a matter of course. Canteen milk supplies are subjected to the same procedure.

Although there are fifty-eight suppliers of milk to schools there are only twenty-seven sources of supply, as many retailers buy their milk from the major pasteurising establishments. Nevertheless, all supplies of pasteurised milk are sampled at least yearly, whilst supplies of raw milk are sampled at least twice yearly for biological examination.

The following table combines figures of both school drinking milk and canteen milk supplies:—

	Phosphatase		Tubercle Bacilli		Total No. of samples submitted
	Satis-factory	Unsatis-factory	Satis-factory	Unsatis-factory	
Pasteurised ..	97	—	—	—	97
Tuberculin Tested..	—	—	21	—	21

TABLE A

MEALS and MILK PROVIDED on a day in September, 1959

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 ..	7,514	5,335	3,776	3,822	50.3	71.6	7,119	3,784	96.1	70.9
North-east ..	19,493	12,441	9,351	6,709	48.0	53.9	18,559	9,033	95.2	72.6
Mid-Derbyshire	9,801	6,921	3,405	3,951	34.7	57.1	8,829	4,694	90.1	67.6
South-east ..	9,974	7,509	2,865	2,423	28.7	32.3	9,418	4,908	94.4	65.3
South	12,303	7,675	5,088	4,253	41.4	55.4	11,390	5,192	92.6	67.6
Chesterfield ..	5,635	5,940	2,412	2,856	42.8	48.1	5,247	3,796	93.1	63.9
TOTALS—Whole Administrative County	64,720	45,821	26,897	24,014	41.6	52.4	60,562	31,407	93.7	68.5

The following Table shows the number of schools, including independent schools, supplied with milk on the 31st December, 1959. The Education Committee endeavour at all times to obtain the highest grades of milk and it is encouraging to know that of 648 establishments, 641 receive pasteurised milk, and the remaining seven are tuberculin tested.

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	105	98.13	164	100.0	107	99.07	86	100.0	133	97.08	46	100.0	641	98.92
Tuberculin Tested..	2	1.87	—	—	1	0.93	—	—	4	2.92	—	—	7	1.08
Totals ..	107	100.0	164	100.0	108	100.0	86	100.0	137	100.0	46	100.0	648	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; teachers entering service otherwise than from College are X-rayed as part of their medical examination on appointment; and the attention of the teachers on the staff of the Authority has been drawn to the advisability of their taking advantage of the facilities provided by mass radiography units from time to time.

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.

(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).

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 generally examined by the School Medical Officer of the area in which they live. 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 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, Departments of Universities and Approved Art Schools ..	320
Entrants to the teaching profession	128
X-ray examinations of entrants to the teaching profession and temporary teachers	150

INFESTATION WITH VERMIN

There were 231,844 examinations and re-examinations of Derbyshire school children during 1959, which revealed 3,052 individual children infested. This is just over 2% of the school enrolment, and approximately the same as for last two years. Ten years ago the Derbyshire figure was about 7%. The Health Visitors and Teachers continue to strive to bring about a reduction in this unpleasant and preventable condition. A new form of treatment for the eradication of head lice was commenced during the year, and appears to be showing good results. As the Chief Medical Officer of the Ministry has said, this is essentially a family problem, the children being infested and re-infested by adults, and "lice will be eradicated only when all families recognise that to be verminous is a cause for shame."

(The Authority's scheme for cleanliness inspections was last described in my Annual Report for 1953, and remains unchanged).

SCHOOL CLINICS

The Ministry of Education asked for a return showing the school clinic facilities as at 31st December, 1959; 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	26	—
B. Dental	23	—
C. Ophthalmic*	3	18
D. Ear, Nose and Throat ..	—	—
E. Orthopaedic	—	10
F. Paediatric†	—	—
G. Speech Therapy ..	23	—
H. Others (specify):— Sunray ..	2	—

*—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 CLINICS.

(1) Number of Child Guidance Clinics provided by the Authority—10.

(2) Staff of Clinics :—

	Number	Aggregate in terms of the equivalent number of whole-time officers
Children's Psychiatrists ..	1*	0.8
Educational Psychologists ..	5	1.75
Psychiatric Social Workers ..	—	—
Paediatricians, Play Therapists, Social Workers, etc. (excluding Clerks) (specify):—		
Psychotherapist	1	0.9
Social Worker	1	0.66

*—It is intended to appoint a second Children's Psychiatrist during 1960.

New Clinics.

In December, 1959, two new Clinic buildings—at Eckington and Ripley—were completed and will become operative early in 1960. Work is well advanced on a new Clinic at Chaddesden, and it is hoped to start work shortly on a new Clinic at Glossop. Further plans envisage replacing the existing Clinics at Matlock, Buxton and Swadlincote with modern premises. Major improvements have almost been completed at the Clinic in Brimington Road, Chesterfield, and extensions to existing Clinics at Bolsover and Staveley it is hoped will be carried out during 1960.

Minor Ailments.

Table 'B' shows the clinics at which facilities are provided for the treatment of minor ailments. Altogether, 893 children made 2,769 attendances (compared with 1,109 children who made 3,429 attendances in 1958). The decline has continued in the numbers attending for treatment of minor ailments. Most of the work took place in the four relatively compact municipal boroughs. Most of the sessions when treatment is available 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

Return of Minor Ailments treated at Clinics—Year ended 31st December, 1959

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.	90	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Ashbourne. St. Oswald's ..	2nd and 4th Wednesday, a.m.	19	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Belper. Field Lane ..	2nd and 4th Monday and 1st, 3rd and 5th Saturday, a.m.	30	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Bolsover. Welbeck Road ..	2nd and 4th Thursday, a.m. ..	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Buxton. Bridge Street ..	Daily	152	24	–	–	–	–	–	24	42	–	–	–	–	–	42
Chesterfield. Brimington Road	2nd and 4th Friday, a.m. ..	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Chesterfield Excepted District :— (*a*) Town Hall .. (*b*) Edmund Street, Newbold Moor	Daily, a.m. Monday and Thur.day p.m.	342	–	–	–	–	–	381	381	–	–	–	–	–	1361	1,361
Chinley. Lower Lane ..	1st, 3rd and 5th Saturday, a.m. ..	14	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Clay Cross High Street	Saturday, a.m.	38	–	–	–	–	–	–	–	–	–	–	–	–	–	–

Derby. Cathedral Road ..	Tuesday, p.m. and 2nd and 4th Saturday, a.m. ..	24	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Dronfield. The Grange ..	Saturday, a.m. ..	14	–	10	–	–	–	–	10	–	18	–	–	–	–	18	
Frecheville, Fox Lane	Saturday, a.m. ..	31	–	36	–	–	–	–	36	–	45	–	–	–	–	45	
Glossop. Municipal Bldgs.	Daily, a.m. ..	230	295	–	–	–	–	–	295	1105	–	–	–	–	–	1,105	
Hackenthorpe. Main Street ..	2nd and 4th Saturday, a.m.	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	
Heanor. Wilmot Street ..	1st, 3rd and 5th Saturday, a.m. ..	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	
Ilkeston, Albert Street	Daily, a.m. ..	96	–	–	–	114	–	–	114	–	–	–	152	–	–	152	
Long Eaton. 4, Nottingham Rd.	Saturday, a.m. ..	35	–	–	–	–	–	–	–	–	–	–	–	–	–	–	
Matlock. Causeway Lane ..	Saturday, a.m. ..	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	
Melbourne. Penn Lane ..	Wednesday, a.m. ..	45	–	–	–	–	1	–	1	–	–	–	–	2	–	2	
New Mills. High Lea Hall ..	2nd and 4th Saturday, a.m. ..	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	
Ripley. Infants' C. School	3rd Thursday, a.m.	7	–	–	–	–	–	–	–	–	–	–	–	–	–	–	
Shirebrook. Cliff House ..	Wednesday, a.m. ..	35	–	21	–	–	–	–	21	–	25	–	–	–	–	25	
Staveley. Lime Avenue ..	Monday a.m. and 4th Saturday, a.m.	16	–	–	–	–	–	–	–	–	–	–	–	–	–	–	
Swadlincote. Alexandra Road ..	2nd and 4th Wednesday	73	–	–	–	–	8	–	8	–	–	–	–	13	–	13	
Totals	.. .. ..	1,294	319	70	–	114	9	381	893	1147	94	–	152	15	1361	2,769	

Dental Work.

A statistical report appears in Part IV of the Appendix. Mr. H. E. Gray, the Principal School Dental Officer, has provided the following report:—

"The overall picture of the dental service for 1959 was pretty much the same as for the two previous years. One or two of the clinic areas were well served, several fairly well, but the great majority had no service at all. As before, the north-east was the most fortunate part of the County.

The Authority has the statutory obligation to provide comprehensive services for school children, nursing and expectant mothers and pre-school children, but three longstanding factors have continued to prevent this, viz., failure to recruit staff; the age factor of the existing staff; and the great increase in dental disease.

To achieve a complete service would require over thirty full-time staff whereas there was only about a quarter of this requirement. The hard core of five whole-time and four part-time officers, an equivalent of 7 4/11ths whole-time staff remained stable throughout the year and has been constant over the last three years. In the second half of the year, a part-time officer was engaged on a sessional basis of five half-days per week and installed at the Long Eaton Clinic, but the appointment lasted only four months and the amount of work done in the relatively short time could not be economically balanced with the expense involved. Such appointments are not satisfactory and have bad repercussions. School inspections are carried out, a scheme of treatment begun and in many instances cases left unfinished and in the area concerned a feeling of being let down results.

In the districts where there has been continuity of staff in the last three years, marked improvements have resulted. This is shown by the steady increase in the amount of conservative work done and a corresponding decrease in extraction work, especially of permanent teeth. This is more than gratifying for the officers are mostly elderly.

The majority of the clinics are good, conveniently situated, modern and well equipped with up-to-date apparatus. Services were provided at thirteen of them, including two in Chesterfield Borough which were staffed by whole-time officers.

Apart from the north east, there was only one whole-time officer available for the remainder of the County for the greater part of the year, and the service was given chiefly at the Derby Clinic. With over 20,000 children in the surrounding areas, this clinic was kept fully occupied without the need or the opportunity to carry out school dental inspections. A continuous flow of requests were made for appointments, among them a great many for six monthly check-ups, the latter from parents keen on ensuring regular dental care. A subtle change in the working of the service at this clinic has come about. The scheme of school inspections to ascertain those in need of attention, the offer of treatment and its

provision where accepted, does not work and the clinic is conducted on the lines of general practice. This may or may not be considered to be in the best interests of the school population as a whole, but in the circumstances of acute staff shortage the result has been that a greater number of children have been made and *maintained* dentally fit than would otherwise have been the case. Those who attended for regular check-ups required relatively little treatment, one visit in most cases sufficed, which permitted a greater number of this type of patient to be dealt with and more time for those children who required much more attention.

Inspection and Treatment. Just under 25% of the school population of approximately 118,000 received inspections, 22,000 were made at periodical school inspections and 5,700 were special inspections, made at the clinics, of children who attended for urgent treatment and check-ups. At the school inspections, 17,600 were found with defects and offers of treatment given to 13,900. Acceptance varied greatly from place to place, from as low as 22% to well over 80%, but the majority of the schools returned acceptance rates of between 50% and over 70%. The poorer acceptance rates came mostly from the senior and secondary schools. Offers of treatment were not given to children who attended the family dentist and it would appear that in many instances older children had considerable influence on the parents' refusal of the offer of treatment.

Over 12,400 children were treated, several hundred fewer than in the previous year, due to some seventy fewer treatment sessions and staff illness. Nevertheless, the amount of conservative work done amounted to over 9,300 fillings, a progressive increase for the 4th year in succession. On the other hand, extraction work, while still very heavy (over 13,000 temporary and 5,574 permanent teeth were extracted), showed a decrease for the 3rd successive year. This was mainly on account of the service in a few particular areas having been steady and uninterrupted for two to three years, with the result that there were shorter intervals between periodic school inspections and follow-up treatment.

The total attendances made were only ten short of 23,000.

General anaesthetics of "gas" continued to be used on a large scale and over 5,900 administrations were given by the school medical officers. In cases where heart conditions influenced treatment, arrangements were made for the patients to have 'penicillin cover' to minimise any risk.

Miscellaneous other operations included scalings, dressings, silver nitrate treatment and root fillings totalled 4,400.

Orthodontic and Denture Work. It was reported that in 1958 there had been a marked increase in the amount of orthodontic treatment. This was maintained in 1959. Eighty-seven cases completed courses of treatment compared with sixty-two the year before and 106 special corrective appliances were made and fitted,

while at the end of the year fifty-four cases were still under treatment. Much of this specialised treatment is long and often tedious and requires no little degree of skill and knowledge on the part of the dentist and the whole-hearted co-operation of the patient and the parent.

A hundred children had dentures fitted. The majority were partial dentures to replace the loss of about half the normal complement of teeth and in one instance the child required complete upper and lower dentures.

The following table shows the particulars of the orthodontic and denture work with the figures for the previous year in brackets:—

Orthodontic	*County*	*Chesterfield Borough*	*Total*
New cases	77(105)	6(12)	83(117)
Carried over from 1958 ..	40(17)	4(4)	44(21)
Discontinued treatment ..	4(10)	2(1)	6(11)
No. treated with appliances ..	84(74)	6(7)	90(81)
Removeable appliances fitted ..	100(78)	6(7)	106(85)
Attendances	675(498)	43(49)	718(547)
Dentures.			
No. pupils fitted with artificial teeth	68(63)	32(27)	100(90)

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.*

Eighteen 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, 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.

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.

Sunray Clinics.

During the year, 224 children made 1,852 attendances at the sunray clinics at the Town Hall, Chesterfield, and at Brambling House Open Air School, Chesterfield; thirty-eight sessions were held.

Orthopaedic and Postural Defects.

Orthopaedic sessions, attended by Orthopaedic Surgeons employed by Regional Hospital Boards, were held at ten of the County Council's clinics. Table 'D' indicates the attendances made by school children, 544 of whom made 1,583 attendances.

TABLE C

Annual Return of work at Eye Clinics—Year ended 31st December, 1959

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 ..	1st, 2nd, 3rd & 4th Wednesday, p.m. ..	34	–	–	427	–	–	–	427	–	–	427	–	–	–	427
Belper. Field Lane	4th Friday, a.m. ..	9	–	–	94	–	–	–	94	–	–	104	–	–	–	104
Bolsover. Welbeck Road ..	1st and 3rd Wednesday, a.m. ..	12	–	84	–	–	–	–	84	–	84	–	–	–	–	84
Buxton. Bridge Street ..	Each Monday a.m.	38	401	–	–	–	–	–	401	455	–	–	–	–	–	455
Chesterfield. Brimington Rd. ..	2nd and 4th Monday p.m. ..	12	–	157	–	–	–	–	157	–	178	–	–	–	–	178
Chesterfield Excepted District. Town Hall	Wednesday and Thursday, a.m. ..	71	–	–	–	–	–	753	753	–	–	–	–	–	1210	1,210
Clowne. Creswell Road ..	2nd and 4th Friday, a.m. ..	22	–	192	–	–	–	–	192	–	206	–	–	–	–	206
Derby. Cathedral Road ..	Each Monday, a.m.	41	–	–	–	3	490	–	493	–	–	–	3	588	–	591

Dronfield. The Grange ..	2nd and 4th Wednesday, a.m. ..	17	–	156	–	–	–	–	156	–	167	–	–	–	–	167
Frecheville. Fox Lane	2nd and 4th Wednesday, a.m. ..	20	–	195	–	–	–	–	195	–	216	–	–	–	–	216
Glossop. Municipal Bldgs. ..	1st, 3rd and 5th Saturday, a.m. ..	5	52	–	–	–	–	–	52	57	–	–	–	–	–	57
Hackenthorpe. Ma n Street .	3rd Monday, p.m. ..	11	–	151	–	–	–	–	151	–	157	–	–	–	–	157
Heanor. Wilmot Street ..	5th Wed. p.m. and 2nd Friday, a.m. ..	14	–	–	–	140	–	–	140	–	–	–	153	–	–	153
Ilkeston. Albert Street ..	1st and 3rd Friday, a.m. ..	20	–	–	–	235	–	–	235	–	–	–	271	–	–	271
Killamarsh. Sec. Mod. School ..	1st and 3rd F.iday, p.m.	12	–	79	–	–	–	–	79	–	87	–	–	–	–	87
Long Eaton. Grange School ..	2nd and 4th Tuesday, a.m. ..	19	–	–	–	212	–	–	212	–	–	–	257	–	–	257
Matlock. Dean Hill House, Causeway Lane ..	1st and 3rd Friday, a.m. ..	19	–	–	191	–	–	–	191	–	–	236	–	–	–	236
New Mills. High Lea Hall ..	4th Tuesday, a.m.	10	94	–	–	–	–	–	94	100	–	–	–	–	–	100
Shirebrook. Cliff House ..	1st and 3rd Friday, a.m. ..	18	–	166	–	–	–	–	166	–	191	–	–	–	–	191
Staveley. Lime Avenue ..	1st Monday, p.m. ..	10	–	111	–	–	–	–	111	–	140	–	–	–	–	140
Swadlincote. Alexandra Road ..	Alternate 2nd Thursday, p.m. .. every 4th Thursday	13	–	–	–	–	159	–	159	–	–	–	–	199	–	199
Totals	.. .. ..	427	547	1291	712	590	649	753	4,542	612	1426	767	684	787	1210	5,486

TABLE D

Annual Return of Orthopaedic Work—Year ended 31st December, 1959

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.	45	–	13	44	–	–	–	57	–	42	155	–	–	–	197
Buxton. Bridge Street ..	4th Friday, alt. months	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Derby. Cathedral Road ..	Thursday, a.m. and p.m.	56	–	–	–	–	150	–	150	–	–	–	–	387	–	387
Glossop. Municipal Buildings	2nd and 4th Tuesday, a.m. and p.m.	32	49	–	–	–	–	–	49	94	–	–	–	–	–	94

Heanor. Wilmot Street ..	Friday, p.m. ..	22	–	–	–	28	–	–	28	–	–	–	98	–	–	98
Ilkeston. Albert Street ..	Wednesday, a.m. and p.m.	58	–	–	–	86	–	–	86	–	–	–	269	–	–	269
Long Eaton. 4, Nottingham Rd.	Friday, a.m.	22	–	–	–	34	–	–	34	–	–	–	147	–	–	147
Matlock. Dean Hill House, Causeway Lane ..	Tuesday, a.m. and p.m.	45	5	–	36	–	5	–	46	21	–	107	–	7	–	135
New Mills. High Lea Hall ..	2nd and 4th Monday a.m. and p.m.	42	22	–	–	–	–	–	22	31	–	–	–	–	–	31
Swadlincote. Alexandra Road ..	1st and 3rd Tuesday, a.m. and p.m.	48	–	–	–	–	72	–	72	–	–	–	–	225	–	225
Totals	.. .. ..	370	76	13	80	148	227	–	544	146	42	262	514	619	–	1,583

HANDICAPPED PUPILS

The Handicapped Pupils and Special Schools Regulations, 1959.

As a consequence of the passing of the Local Government Act, 1958, the Minister of Education has made new Regulations—*The Handicapped Pupils and Special Schools Regulations*, 1959—which replace the *School Health Service and Handicapped Pupils Regulations*, 1953. The old Regulations defined the categories of pupils requiring special educational treatment and prescribed the requirements to be observed in respect of special schools. No alteration of substance has been made. The categories of "handicapped pupils" requiring special educational treatment are now defined as follows:—

(*a*) *blind pupils*, that is to say, pupils who have no sight or whose sight is or is likely to become so defective that they require education by methods not involving the use of sight;

(*b*) *partially sighted pupils*, that is to say, pupils who by reason of defective vision cannot follow the normal regime of ordinary schools without detriment to their sight or to their educational development, but can be educated by special methods involving the use of sight;

(*c*) *deaf pupils*, that is to say, pupils who have no hearing or whose hearing is so defective that they require education by methods used for deaf pupils without naturally acquired speech or language;

(*d*) *partially deaf pupils*, that is to say, pupils who have some naturally acquired speech and language but whose hearing is so defective that they require for their education special arrangements or facilities though not necessarily all the educational methods used for deaf pupils;

(*e*) *educationally sub-normal pupils*, that is to say, pupils who, by reason of limited ability or other conditions resulting in educational retardation, require some specialised form of education wholly or partly in substitution for the education normally given in ordinary schools;

(*f*) *epileptic pupils*, that is to say, pupils who by reason of epilepsy cannot be educated under the normal regime of ordinary schools without detriment to themselves or other pupils;

(*g*) *maladjusted pupils*, that is to say, pupils who show evidence of emotional instability or psychological disturbance and require special educational treatment in order to effect their personal, social or educational readjustment;

(*h*) *physically handicapped pupils*, that is to say, pupils not suffering solely from a defect of sight or hearing who by reason of disease or crippling defect cannot, without detriment to their health or educational development, be satisfactorily educated under the normal regime of ordinary schools;

(*i*) *pupils suffering from speech defect*, that is to say, pupils who on account of defect or lack of speech not due to deafness require special educational treatment; and

(*j*) *delicate pupils*, that is to say, pupils not falling under any other category in this regulation, who by reason of impaired physical condition need a change of environment or cannot, without risk to their health or educational development, be educated under the normal regime of ordinary schools."

The Medical Examinations (Sub-normal Children) Regulations, 1959.

These Regulations prescribe the qualifications required of medical officers undertaking the examination of pupils to ascertain whether they need attention in a special school for educationally subnormal pupils, or whether they are suffering from such a disability of mind as to make them unsuitable for education at school. They replace a provision contained in regulation 11 of the *School Health Service and Handicapped Pupils Regulations*, 1953, which required the Minister of Education to give his approval to the employment of each individual officer. Although the Minister's approval is no longer a requirement, it is prescribed that medical examinations for the foregoing purposes shall be conducted by a duly qualified medical practitioner possessing one of the following special qualifications:—

"(*a*) *he shall be a practitioner whose employment was approved by the Minister under regulation* 11 *of the School Health Service and Handicapped Pupils Regulations*, 1953(b); *or*

(*b*) *he shall be a psychiatrist working in a child guidance clinic; or*

(*c*) *he shall—*

(i) *have assisted for a period of at least six months in the conduct of medical examinations of the kind to which these regulations apply by a practitioner entitled to conduct them under these regulations; and*

(ii) *he shall have attended, at one of the following universities namely, Durham, Glasgow, Leeds, London or the Queen's Universities, Belfast, the post-graduate course of instruction in the ascertainment and treatment of children suffering from the disabilities described in regulation 2, or some equivalent course approved by the Minister for the purpose of these regulations.*"

HANDICAPPED PUPILS

The following is a copy of a return made to the Ministry of Education relating to Handicapped Children for the Whole Administrative County—Year 1959.

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 ..	4	4	10	1	46	8	183	49	4	309
B. Handicapped pupils newly assessed as needing special educational treatment at Special Schools or in Boarding Homes	3	9	13	5	49	20	255	51	4	409
On or about 22nd January, 1960 :—										
C. (i) Number of Handicapped Pupils on the registers of special schools :										
1. Maintained :										
(*a*) Day Pupils ..	–	3	9	1	78	7	262	56	–	416
(*b*) Boarding Pupils ..	9	10	9	6	9	20	83	1	2	149
2. Non-maintained :										
(*a*) Day Pupils ..	–	–	7	1	–	–	–	–	–	8
(*b*) Boarding Pupils ..	6	2	46	3	23	6	5	–	10	101
(ii) On the registers of Independent Schools under arrangements made by the Authority	–	–	–	–	1	7	22	10	–	40
(iii) boarded in Homes and not already included under (i) or (ii) ..	–	–	–	–	1	–	–	27	–	28
Total (C)	15	15	71	11	112	40	372	94	12	742
On or about 22nd January, 1960 :—										
D. Number of Handicapped Pupils receiving education under Section 56 of the Education Act, 1944:—										
(i) In hospitals	–	–	–	–	41	–	–	–	–	41
(ii) In other groups ..	–	–	–	–	–	–	–	–	–	–
(iii) At home	–	2	–	–	–	30	4	–	1	37
On or about 22nd January, 1960 :—										
E. Number of Handicapped Pupils who were requiring places in special schools—										
(i) Total—										
(*a*) Day	–	–	1	–	–	2	109	–	–	112
(*b*) Boarding	4	9	6	5	11	15	58	2	1	111

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)
(ii) Handicapped Pupils who had not reached the age of five—										
(*a*) awaiting day places	–	–	–	–	–	1	–	–	–	–
(*b*) awaiting boarding places	–	–	2	1	–	2	–	–	–	5
(iii) 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	–	–	–	–	–	–	10	–	–	10
(*b*) awaiting boarding places	2	1	–	–	–	–	4	–	–	7

The number of pupils on the registers of Hospital Special Schools on or about 22nd January, 1960 was 48.

RETURNS FOR DIVISIONAL EXECUTIVE AREAS

The following is an analysis of the preceding Table in 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	–	–	–	–	3	–	3	4	–	10
	B	1	1	1	1	3	2	11	4	–	24
	C (i) (1) (*a*) ..	–	–	–	–	–	1	2	1	–	4
	C (i) (1) (*b*) ..	2	–	2	1	–	1	11	–	1	18
	C (i) (2) (*a*) ..	–	–	–	–	–	–	–	–	–	–
	C (i) (2) (*b*) ..	1	1	2	–	6	–	1	–	1	12
	C (ii)	–	–	–	–	1	2	4	3	–	10
	C (iii) ..	–	–	–	–	–	–	–	3	–	3
	Total (C) ..	3	1	4	1	7	4	18	7	2	47
	D (i)	–	–	–	–	–	–	–	–	–	–
	D (ii)	–	–	–	–	–	–	–	–	–	–
	D (iii) ..	–	–	–	–	–	6	2	–	–	8
	E (i) (*a*) ..	–	–	–	–	–	1	4	–	–	5
	E (i) (*b*) ..	1	1	1	1	2	2	11	–	–	19
	E (ii) (*a*) ..	–	–	–	–	–	1	–	–	–	1
	E (ii) (*b*) ..	–	–	1	–	–	–	–	–	–	1
	E (iii) (*a*) ..	–	–	–	–	–	–	–	–	–	–
	E (iii) (*b*) ..	–	–	–	–	–	–	–	–	–	–
North-east	A	3	1	5	1	14	–	101	10	3	138
	B	2	3	5	2	15	1	131	11	3	173

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	C (i) (1) (*a*) ..	–	2	5	–	8	4	104	5	–	128
	C (i) (1) (*b*) ..	5	3	6	1	7	5	19	–	–	46
	C (i) (2) (*a*) ..	–	–	–	–	–	–	–	–	–	–
	C (i) (2) (*b*) ..	2	–	22	2	9	2	1	–	4	42
	C (ii)	–	–	–	–	–	–	4	–	–	4
	C (iii) ..	–	–	–	–	–	–	–	11	–	10
	Total (C) ..	7	5	33	3	24	11	128	16	4	231
	D (i)	–	–	–	–	12	–	–	–	–	12
	D (ii)	–	–	–	–	–	–	–	–	–	–
	D (iii) ..	–	–	–	–	–	10	1	–	–	11
	E (i) (*a*) ..	–	–	1	–	–	1	57	–	–	59
	E (i) (*b*) ..	1	2	1	2	6	2	9	1	1	25
	E (ii) (*a*) ..	–	–	–	–	–	–	–	–	–	–
	E (ii) (*b*) ..	–	–	1	–	–	–	–	–	–	1
	E (iii) (*a*) ..	–	–	–	–	–	–	10	–	–	10
	E (iii) (*b*) ..	1	1	–	–	–	–	–	–	–	2
Mid-Derbyshire	A	–	1	3	–	1	2	5	1	1	14
	B	–	1	4	–	–	3	12	1	1	22
	C (i) (1) (*a*) ..	–	–	1	–	–	–	20	–	–	21
	C (i) (1) (*b*) ..	–	2	1	–	–	5	26	–	–	34
	C (i) (2) (*a*) ..	–	–	–	1	–	–	–	–	–	1
	C (i) (2) (*b*) ..	1	–	10	–	3	–	1	–	1	16
	C (ii)	–	–	–	–	–	2	5	2	–	9
	C (iii) ..	–	–	–	–	–	–	–	3	–	3
	Total (C) ..	1	2	12	1	3	7	52	5	1	84
	D (i)	–	–	–	–	–	–	–	–	–	–
	D (ii)	–	–	–	–	–	–	–	–	–	–
	D (iii) ..	–	–	–	–	–	2	–	–	–	2
	E (i) (*a*) ..	–	–	–	–	–	–	8	–	–	8
	E (i) (*b*) ..	2	–	2	–	–	2	15	–	–	21
	E (ii) (*a*) ..	–	–	–	–	–	–	–	–	–	–
	E (ii) (*b*) ..	–	–	–	–	–	1	–	–	–	1
	E (iii) (*a*) ..	–	–	–	–	–	–	–	–	–	–
	E (iii) (*b*) ..	1	–	–	–	–	–	4	–	–	5
South-east	A	–	–	1	–	2	4	11	4	–	22
	B	–	1	2	–	3	6	21	5	–	38
	C (i) (1) (*a*) ..	–	–	2	1	1	1	61	–	–	66
	C (i) (1) (*b*) ..	–	2	–	–	–	1	11	–	–	14
	C (i) (2) (*a*) ..	–	–	2	–	–	–	–	–	–	2
	C (i) (2) (*b*) ..	1	–	1	–	2	3	–	–	1	8
	C (ii)	–	–	–	–	–	–	–	1	–	1
	C (iii) ..	–	–	–	–	–	–	–	6	–	6
	Total (C) ..	1	2	5	1	3	5	72	7	1	97

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)
outh-east	D (i)	–	–	–	–	10	–	–	–	–	10
	D (ii)	–	–	–	–	–	–	–	–	–	–
	D (iii) ..	–	–	–	–	–	2	–	–	1	3
	E (i) (*a*) ..	–	–	–	–	–	–	26	–	–	26
	E (i) (*b*) ..	–	4	2	–	1	3	2	1	–	13
	E (ii) (*a*) ..	–	–	–	–	–	–	–	–	–	–
	E (ii) (*b*) ..	–	–	–	–	–	–	–	–	–	–
	E (iii) (*a*) ..	–	–	–	–	–	–	–	–	–	–
	E (iii) (*b*) ..	–	–	–	–	–	–	–	–	–	–
outh	A	–	2	1	–	9	1	14	6	–	33
	B	–	3	1	2	11	5	29	6	–	57
	C (i) (1) (*a*) ..	–	1	1	–	3	1	27	–	–	33
	C (i) (1) (*b*) ..	1	3	–	3	2	6	15	1	–	31
	C (i) (2) (*a*) ..	–	–	5	–	–	–	–	–	–	5
	C (i) (2) (*b*) ..	1	–	9	1	3	1	1	–	–	16
	C (ii)	–	–	–	–	–	3	3	3	–	9
	C (iii) ..	–	–	–	–	1	–	–	4	–	5
	Total (C) ..	2	4	15	4	9	11	46	8	–	99
	D (i)	–	–	–	–	17	–	–	–	–	17
	D (ii)	–	–	–	–	–	–	–	–	–	–
	D (iii) ..	–	–	–	–	–	9	1	–	–	10
	E (i) (*a*) ..	–	–	–	–	–	–	11	–	–	11
	E (i) (*b*) ..	–	1	–	2	2	4	20	–	1	30
	E (ii) (*a*) ..	–	–	–	–	–	–	–	–	–	–
	E (ii) (*b*) ..	–	–	–	1	–	1	–	–	–	2
	E (iii) (*a*) ..	–	–	–	–	–	–	–	–	–	–
	E (iii) (*b*) ..	–	–	–	–	–	–	–	–	–	–
hesterfield	A	1	–	–	–	17	1	49	24	–	92
	B	–	–	–	–	17	3	51	24	–	95
	C (i) (1) (*a*) ..	–	–	–	–	66	–	48	50	–	164
	C (i) (1) (*b*) ..	1	–	–	1	–	2	1	–	1	6
	C (i) (2) (*a*) ..	–	–	–	–	–	–	–	–	–	–
	C (i) (2) (*b*) ..	–	1	2	–	–	–	1	–	3	7
	C (ii)	–	–	–	–	–	–	6	1	–	7
	C (iii) ..	–	–	–	–	–	–	–	–	–	–
	Total (C) ..	1	1	2	1	66	2	56	51	4	184
	D (i)	–	–	–	–	2	–	–	–	–	2
	D (ii)	–	–	–	–	–	–	–	–	–	–
	D (iii) ..	–	2	–	–	–	1	–	–	–	3
	E (i) (*a*) ..	–	–	–	–	–	–	3	–	–	3
	E (i) (*b*) ..	–	1	–	–	–	2	–	–	–	3
	E (ii) (*a*) ..	–	–	–	–	–	–	–	–	–	–
	E (ii) (*b*) ..	–	–	–	–	–	–	–	–	–	–
	E (iii) (*a*) ..	–	–	–	–	–	–	–	–	–	–
	E (iii) (*b*) ..	–	–	–	–	–	–	–	–	–	–

For the purpose of comparison the main figures for 1958 and 1959 are set out below:—

		1958		1959	
A.	Handicapped Pupils newly placed ..	139		309	
B.	Handicapped Pupils newly assessed as requiring education at Special Schools	167		409	
C.	(i) (*a*) Attending Special Day Schools	232		424	
	(*b*) Attending Special Boarding Schools	264		250	
	(ii) Attending Independent Schools	39		40	
	(iii) Boarded in Homes	11		28	
D.	Education under Section 56—hospitals	15		41	
	Education under Section 56—home tuition	50		37	
E.	Awaiting admission—day schools ..	164	254	112	223
	Awaiting admission—boarding schools	90		111	

I am indebted to Mr. J. L. Longland, the Director of Education, for the following comments on the figures relating to Handicapped Pupils:—

"The number of handicapped children placed in special schools during the year was 309 compared with 139 last year so that the number of children in day special schools has increased by 192. This is largely attributable to the opening of the Ashgate Croft School, Chesterfield which now has 151 educationally sub-normal pupils.

But 409 children were newly assessed as needing special education so that the net effect has been to reduce the waiting lists by only thirty. This is attributable to the continuing expansion of the service—particularly for educationally sub-normal children. The waiting list does not represent the total demand; many more children remain to be assessed. By the end of the year however work was in hand to provide 200 more places in special schools for educationally sub-normal children. These extra places should with the 340 places already provided, meet the demand as far as this handicap is concerned.

The provision for all other handicaps may be regarded as satisfactory. The waiting list represents the size of the 'turn-over' of cases and no one child is kept waiting very long for a suitable place although there is occasional difficulty with partially sighted children and the few very distressing cases of multiple handicaps."

Special Reports.

(1) *Overseal Manor (E.S.N. Boys') Special Residential School.*— The following report has been provided by Dr. Malcolm Allan who regularly visits this school:—

"The school was inspected each term and at other necessary times. From observations, the children improve mentally and physically, and the whole atmosphere of the school is delightfu.."

(2) *John Duncan (E.S.N. Girls) Special Residential School.*—Dr. Kuttner has commented as follows:—

"The school is visited regu ar y throughout the year. The atmosphere there is happy and harmonious, the work of the teaching staff and Matron is carried out with efficiency and very gratifying resu ts. It seems to me an excel'ent further deve'opment that the school will now begin to admit day pupils of both sexes, a step which will answer a great need."

(3) *Talbot House, Glossop.*—Dr. M. Sutcliffe, the School Medical Officer who maintains regular and frequent contact with this School for children suffering from cerebral palsy, has reported as follows:—

"Talbot House Special School has been visited frequently and two routine medical inspections have been carried out in 1959.

A few children suffered from laryngitis, coughs and colds in March, April, September and October. During the two latter months there was an outbreak of chickenpox which affected seven of the nineteen resident children and one of the two day pupils. There were no untoward complications . . . The children are well-cared for, cheerful and happy, and appear to enjoy every moment."

Miss Curry, the Speech Therapist, has made the following comments:—

"During 1959 the demand for Speech Therapy at Talbot House has gradually diminished and the number of sessions correspondingly reduced to 7/20. Children with milder speech defects are now able to overcome them and although minor individualisms are sometimes apparent, they do not unduly affect the child's intelligibility. By September only three of these were having occasional regular treatment. Of the remaining five receiving treatment, two have serious speech defects which fortunately are matched by the children's willingness to try to overcome them. Another child does not seem to realise his speech disability and even the use of a tape recorder does not fully convince him how indistinct his speech is during conversation. Until he is able to accept this, although he may be able to speak clearly, he will not make the effort required in doing so habitually. The other two children have worked well and should soon be able to manage satisfactorily without attending speech therapy sessions, provided they have the patient help of others. Throughout the year, the co-operation of those receiving speech therapy has been most encouraging."

(4) *Stretton House Hostel.*—Dr. Nettleship has made the following observations:—

"All the boys coming to this hostel settle down within a week or two despite occasional initial disturbances. They become less withdrawn and seem really to enjoy the many opportunities for outdoor pursuits that the hostel offers. 1959 was rather a poor year for physical health, however: there was one case of osteomyelitis, one of erysipelas, one case of pneumonia and one of otitis media. All the boys had influenza in March 1959; one child, who arrived very deaf and exceedingly withdrawn was much improved by a tonsillectomy during the year. All the boys have received poliomyelitis vaccination."

Cardiac Register

During 1957, a Medical Officer of the Ministry of Education suggested that in order to obtain a record of the incidence of cardiac defects over a number of years, a "cardiac register" should be established by the Authorities in the North Midlands Division, which is ideally suited to this purpose geographically because four of the counties have a hospital centre in the County Town which is in each instance the only County Borough, to which centres cardiac cases would naturally be referred for a consultant's opinion. If all the Authorities agreed to participate the investigation would cover some 550,000 school children and in size alone should be of major importance.

The investigation consists of the observation of organic heart disease (rheumatic and congenital) and should give useful evidence relating to the alleged decline of rheumatic heart disease and provide a pool of knowledge in regard to congenital heart disease which should prove useful as further developments appear in cardiac surgery. If a School Medical Officer discovers abnormal cardiac physical signs during his examination of a pupil he may decide that the signs are "innocent," in which case no further action is called for. He may, on the other hand, decide that the signs merit further investigation. In the majority of cases such children will ultimately obtain the opinion of a cardiologist or paediatrician as to the probable diagnosis. Where this opinion favours an organic cause (it cannot always be definite) the child's name is to be included in the cardiac register. Such children are to be subject to at least an annual special medical examination.

The Ministry feels that as regards rheumatic heart disease this investigation will afford an opportunity for studying the general incidence, relapse rate, ultimate state on school leaving, and the relationship of relapses to school streptococcal infections. As regards congenital heart disease, besides the usual data to be expected from a survey, there is the relationship to maternal infections, and their epidemiological features. An assessment will be made of the child on leaving school and the information will of course be useful in giving any necessary advice in relation to future employment.

At the end of 1959 there were thirty-seven children on this register, the diagnoses being as follows:—

1.	Patent ductus—ligated	3
	Mitral stenosis	1
2.	Pulmonary stenosis	1
3.	Pulmonary stenosis with ventricular septal defect	1
4.	Pulmonary stenosis with atrial septal defect	1
5.	Interventricular septal defect	8
6.	Atrial defect	1
	Patent Foramen ovale	1
7.	Interventricular septal defect with partial bundle branch block	1
8.	Co-arctation of aorta	1
9.	Fallot's tetralogy	1
10.	Mitral incompetence	1
	Rheumatic infection	1
	Others	15

Of the above thirty-seven children, thirty-six were attending ordinary schools, and one was receiving home tuition.

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	1	1	1	3
North-east	4	7	4	3
Mid-Derbyshire	1	3	—	1
South-east	5	5	7	5
South	5	8	—	1
Chesterfield	3	3	2	1
Totals ..	19	27	14	14

Maladjusted Pupils

In March, 1959, the Ministry of Education issued Circulars 347 and 348 concerning "Child Guidance" and "Special Educational Treatment for Maladjusted Children" respectively, and the Ministry of Health issued Circular 3/59 as well as a memorandum to hospital authorities on the subject of child guidance.

The circulars referred to the Report of the Committee on Maladjusted Children which was published in November, 1955 (the "Underwood Report") which contained a number of recommendations on Child Guidance and devoted four chapters to special educational treatment. The object of Circular 347 was "to lay a sound basis for the present organisation of the service and for the planning of future developments as and when it is possible for them to take place." In Circular 348 particular attention was directed to the following passage from the introduction to the Underwood Report:—

> "We recommend a number of measures, but we should like to emphasize that the making of formal recommendations which can be summarised in a few pages is not our main purpose. It has seemed to us more important to suggest throughout all we say, some of the attitudes of mind required for the prevention and treatment of maladjustment."

The Special Services Sub-Committee of the Education Committee, and the Joint Medical Services Sub-Committee (which consists of representatives of the Education Committee and the County Health Committee) gave careful consideration to a very full report by the Director of Education and the Principal School Medical Officer on the matters dealt with in the above mentioned Circulars. It was gratifying to note that the Authority were already carrying out or had made plans to carry out the recommendations made concerning child guidance.

During the year now being reviewed, our establishment authorised the appointment of a whole-time and a part-time Children's Psychiatrist, a Psychotherapist, four Psychiatric Social Workers, and seven Educational Psychologists. The last mentioned Officers serve part-time in the Child Guidance Service and the remainder in the Schools Psychological Service, the aggregate amount of time allocated to the Child Guidance Service being approximately equal to 2¼ whole-time staff.

Throughout the year Dr. D. J. Salfield was the Consultant Children's Psychiatrist in the part of the administrative County which lies in the area of the Sheffield Regional Hospital Board, his appointment having been made by the Board in consultation with the County Council; Dr. Salfield devotes most of his time to the treatment of maladjusted children. (During 1959 there was no similar arrangement covering the part of Derbyshire which lies within the area of the Manchester Regional Hospital Board, although negotiations have taken place as a result of which it is hoped it may be possible to remedy this deficiency during the next few months. In the meantime, children needing child guidance are referred to the Children's Psychiatrist for that Region to see if treatment can be arranged).

For many years it has proved impossible to secure the services of an adequate number of Psychiatric Social Workers. During 1959 we had the services of one qualified officer, as well as a Social Worker (half-time) at Chesterfield. The former, however, left on 30th November, 1959, and at the time of drafting this Report it has not been possible for her to be replaced.

On the other hand, it is pleasing to report that on the 20th October Miss Coral Tibbetts took up duty as a Psychotherapist.

We were also fortunate regarding Educational Psychologists, having the services of five Officers throughout the year; and appointments have been made to fill the two vacancies from 1st April, 1960.

Dr. Salfield has kindly provided the following report:—

"The scope and extent of Child Guidance Work has been maintained and the number of patients has increased.

The Authority's hostels and Special Schools have been visited as before and regular and increasing use has been made of the Bretby Recovery Unit which is attached to the Children's Hospital, for the investigation of problem cases.

It seems to be inevitable that the staffing position changes from time to time. We have lost our Psychiatric Social Worker and it seems difficult to replace her. On the credit side a non-medical Psychotherapist, Miss C. L. Tibbetts, B.Sc., Dip. Psych., has taken up work and the appointment of a second psychiatrist is imminent so that, psychiatrically, the care of the county will be more complete and the Buxton area, which up to now has fared badly from that point of view, will be properly served and more psychiatric time will be available in all clinics. The north-eastern (Hackenthorpe, Clowne) area of the county will also benefit considerably and it is hoped that some, as yet, fallow areas from the child psychiatric point of view, such as the southern part of the county and the Ashbourne area, will receive better service.

Close co-operation of the members of the clinic staff has continued and periodic meetings of all the Child Guidance Staff of the county have been arranged and also regular if infrequent meetings with the paediatricians in the area.

It is hoped in the coming year to interest even more than before, School Medical Officers in our specialised work. On the whole, co-operation between the Child Guidance Service and other services such as the Probation Service, Children's Officer's department etc. has been well maintained.

We continue to enjoy the interest and furtherance of the Principal School Medical Officer and his staff for which we are particularly grateful and of whose value we are very much aware."

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 1959 :—						
(i) Adjusted	1	2	5	3	4	15
(ii) Improving	–	1	2	8	2	13
(iii) Unadjusted	–	–	1	–	–	1
(iv) Miscellaneous	–	1	–	–	1	2
(v) Diagnostic and advice only	–	1	1	–	1	3
Totals	1	5	9	11	8	34
(2) Cases having regular Interviews for Psychiatric Treatment, Play-Therapy, or Remedial Teaching :—						
Psychiatrist—						
(i) Making satisfactory progress	–	3	2	2	3	10
(ii) Some improvement ..	–	2	1	2	1	6
(iii) No improvement	–	1	1	4	2	8
Totals	–	6	4	8	6	24
(3) Cases having only Occasional Interviews, or under Supervision :—						
(i) Making satisfactory progress	–	7	3	2	8	20
(ii) Some improvement ..	–	2	1	5	5	13
(iii) No improvement	–	3	6	8	7	24
(iv) Diagnostic and Other ..	3	3	11	7	13	37
Totals	3	15	21	22	33	94
(4) Cases Recently Opened ..	–	5	–	1	3	9
(5) SUMMARY :—						
(i) Number of "current cases"	12	50	65	82	96	305
(ii) Number of "closed cases"	1	4	9	10	7	31
Total Number of Cases dealt with during 1959 ..	13	54	74	92	103	336
(6) Number of Cases on Waiting List for first interview as at 31st December, 1959 ..	–	–	2	5	2	9

CHILD GUIDANCE WORK	Divisional Executive					Totals
	North-west	North-east	Mid-Derby-shire	South-east	South	
(7) Psychiatrist's Interviews with Patients	4	31	52	49	71	207
Psychiatrist's Interviews with Parents	4	37	78	57	97	273
Psychiatrists' Visits :—						
(i) to Schools	–	–	–	–	–	–
(ii) to Homes	–	–	–	–	–	–
(iii) to Institutions	1	–	21	–	15	37
Total number of siblings of patients seen	–	–	–	–	–	–
Number of Interviews with Probation Officers, Social Workers, etc.	–	–	–	–	–	–
Number of Reports to Magistrates	1	–	5	–	–	6
(8) Educational Psychologists' Visits :—						
(i) to Schools	35	3	86	8	13	145
(ii) to Homes	50	5	63	18	25	161
Number of Child Guidance Cases tested	45	5	43	12	76	181
(9) Psychiatric Social Worker :—						
(i) No. of home Visits ..	1	97	50	60	71	280
(ii) No. of clinical interviews..	–	23	40	14	50	127

The following Table indicates the sources from which patients were referred to the Child Guidance Service during the year :—

School Medical Officer	37
Private Doctors	27
Hospitals	8
Teachers	19
Courts and/or Probation Officers	3
Others	16

Speech Therapy.

The establishment permits the employment of eleven Speech Therapists (including one in Chesterfield Excepted District and one mainly at Talbot House Special School). I referred in my last Annual Report to a general shortage of Speech Therapists, when it was noted that at the beginning of 1958 we had the services of six whole- and two part-time Officers, but at the end of that year the numbers were only two whole- and two part-time Officers. It proved possible to recruit one Speech Therapist during 1959; but due to further resignations, at the end of the year we were reduced to two whole-time Officers and one who worked three days a week. (One of the whole-time Officers has, however, resigned to be married and leaves on 30th March, 1960). It may be recalled that in October, 1958, the Principal Medical Officer of the Ministry of Education wrote to Principal School Medical Officers seeking information about vacancies for Speech Therapists because a number of Authorities were unable to recruit them. He pointed out that there was no shortage of suitable candidates for training and that the training schools are always full, and added ". . . There is obviously a very high wastage. It looks as if many women are lost through marriage, either before or after starting professional work." There was some hope, however, that if the current rate of expansion continued, the national shortage might be made good in about four years.

At the time of writing this Report the only Speech Therapy Clinics in operation are at Derby on three days a week and a whole-time clinic in Chesterfield Excepted District.

The following reports have been received:—

Miss Curry:—

"During 1959 the Speech Therapy Service has continued at Glossop and New Mills and has been expanded to include a clinic and school at Buxton on the 2nd and 4th Thursdays.

The two Wednesday sessions now spent each week at New Mills enable treatment to be carried out without the overcrowding which previously existed. This has led to good results of treatment being achieved more speedily and in an increased number of cases. All patients referred for treatment have received appointments, but unfortunately these are not always followed by attendance and, after repeated appointments over the years, some cases have now been listed as discontinued. This observation also applies to Glossop clinic.

At Glossop work has been eased by an extra session on the 1st, 3rd and 5th Thursdays made possible by the decrease in the demand for speech therapy at Talbot House. Thus 6/20 sessions are devoted to the clinic and a waiting list is almost non-existent. Attendances at the clinics have been good on the whole except during school holidays, in particular the summer holidays.

These reports and figures cover the course of speech therapy as far as September when treatment was curtailed by the sudden illness

of the Speech Therapist. However, this period of four months without a therapist should not be altogether a disadvantage, as the majority of patients have ample material at their disposal for home practice and should have been able to persevere with this and assimilate it into their everyday behaviour, especially if they have been helped and encouraged by other members of the family—a factor which cannot be over-emphasised in obtaining favourable results.

It is the attitude of those in regular contact with the child—family, teachers and medical staff—which in many cases affects his response to the guidance provided by the Speech Therapist, and fortunately, in the majority of cases, we have this co-operation."

Mrs. Marsh:

"Clinics have been conducted at the Cathedral Road Clinic on Tuesdays, Wednesdays and Thursdays throughout the year. The results of treatment, particularly in the case of articulatory disorders, have been encouraging. Of thirty-six cases discharged during the year only two were discontinued without any improvement in their condition, compared with thirteen last year. One of these children failed to attend and the other was found to be already in the care of another specialist.

During the year the waiting list has risen from nineteen to thirty-nine, and now exceeds the annual intake for this Clinic. Severe cases are being referred from other areas, where at present there is no Speech Therapist in attendance, and as in general the time taken in treatment is prolonged by the severity of the disorder, there has been a slight drop in the number of new patients admitted. An effort, however, is being made to review waiting list cases from time to time so that advice can be given to the parents on how to proceed until treatment can be commenced."

SPEECH THERAPY	Divisional Executive			
	North-west	Mid.	South-east	South
(1) Number of Patients who received Treatment during the year :—				
New Cases—				
Stammerers	8	–	–	–
Articulation Defects ..	30	–	1	17
Other Speech Disorders ..	–	1	1	1
Old Cases—				
Stammerers	11	–	1	5
Articulation Defects ..	37	4	1	48
Other Speech Disorders ..	6	1	–	4
Total Number of Individual Patients	92	6	4	75
Total Attendances for Treatment	611	101	90	838
(2) Results of Treatment of Cases seen during 1959 :—				
Cases Closed :—				
Stammerers—				
Cured	–	–	1	–
Improved	4	–	–	1
Not improved	–	–	–	–
Discontinued for various reasons	–	–	–	1
Articulation Defects—				
Cured	19	1	–	25
Improved	1	–	–	3
Not improved	1	–	–	–
Discontinued for various reasons	5	–	–	–
Other Speech Disorders—				
Cured	1	–	–	1
Improved	–	2	–	–
Not improved	–	–	–	–
Discontinued for various reasons	1	–	–	1
Total number of Cases Closed	32	3	1	32
Cases Still Under Treatment—				
Stammerers	16	–	1	7
Articulation Defects ..	33	3	2	38
Other Speech Disorders ..	2	1	1	6
Cases seen once for initial examination and advice only.. ..	25	4	5	30
Total Number of Cases already seen, Carried Forward to 1960	76	8	9	81

SPEECH THERAPY	Divisional Executive			
	North-west	Mid	South-east	South
(3) Number of Patients Waiting to be seen for the first time, as at 31st December, 1959	4	–	3	2
(4) Visits :—				
To Schools	21	–	–	1
To Homes	–	–	–	–
(5) Number of Interviews with Parents	45	19	13	165
(6) Total Number of Sessions conducted at Clinics	153	–	–	278

HEALTH EDUCATION

Health Education advanced during the year; many talks were given, and film strips and films shewn by the Health Visitors in the schools. The very necessary teaching of the individual child during routine hygiene inspections continued. We are grateful to the Head teachers of the schools for their co-operation. A great disappointment was the poor response to the film and talk on "Relationship between smoking and cancer of the lung." Only one school had it in 1959.

"In-service" training on Health Education of members of the staff was organised by the Deputy Superintendent Health Visitor as a regular series. These classes were run in small groups at which all the techniques of visual presentation were taught. All the Health Visitors and School Nurses have taken part and many of the Medical Officers joined at their own request.

MEDICAL EXAMINATIONS OF CHILDREN FOR EMPLOYMENT

During the year the School Medical Officers examined 484 pupils desiring to undertake part-time employment. Certificates of fitness were given in 480 instances, and in only four cases was it decided that the suggested employment would be prejudicial to the health or physical development of the children.

PREVENTIVE INOCULATIONS

Details are given in my Annual Report as County Medical Officer of Health of various schemes for providing preventive inoculations against several diseases. These schemes come under the jurisdiction of the County Health Committee, as part of the services available under the National Health Service Act. However, since school children derive much benefit from them it is fitting to refer briefly to them here, particularly as the help and co-operation of Teachers is of great value to this aspect of the health services.

The arrangements for providing the inoculations continue on the lines which have been outlined in earlier Reports. The conditions against which protection is offered are as follows:— diphtheria, poliomyelitis, smallpox, tetanus, tuberculosis and whooping cough.

The numbers of children between five and fifteen years of age who were immunised against diphtheria, smallpox, tetanus or whooping cough were as follows:—

	Primary Immunisations	*"Booster" Doses*
Diphtheria only	940	2,252
Combined diphtheria, tetanus and whooping cough	150	306
Combined diphtheria and pertussis ..	40	83
Combined diphtheria and tetanus ..	21	15
Whooping Cough only	31	21
Combined pertussis-tetanus	8	—
Tetanus only	30	1
Smallpox	143	46

The polio' vaccination programme was introduced in this country in 1956, when vaccination was offered to children born between 1947 and 1954 inclusive, two injections being given. During 1959 the scheme provided for three injections being given to each patient, and the inoculations were available for children and young persons between the ages of six months and twenty-six years, expectant mothers, and a few special groups. During 1959 a total of 103,820 Derbyshire patients were given two injections, and 76,558 received their third injections. From the inception of the scheme up to 31st December, 1959, the total number in this County who had received two injections was 170,051 and 76,941 had received three injections.

Bearing in mind advice which had been given by the Ministry of Health, the County Health Committee agreed towards the end of 1956 to introduce a gradually expanding scheme for vaccinating children against tuberculosis (B.C.G. vaccination), between their thirteenth and fourteenth birthdays, as the necessary trained staff and equipment became available.

However, the Minister of Health issued Circular 7/59 dated 30th April, 1959, indicating that he was prepared to approve an extension of the arrangements as follows:—

(i) to children of fourteen years of age and upwards still at school, and students attending universities, teacher training colleges, technical colleges or other establishments of further education; and

(ii) it having been represented that it would be convenient if vaccination could be offered to whole school classes even though a few of the children are under thirteen years of age, the Minister was prepared to approve arrangements on those lines.

In the case of children or students at residential schools or establishments, it was suggested that vaccination could more conveniently be offered to them there than at home.

The County Council's Proposals under the National Health Service Act already allowed this extension to be carried out, and the County Health Committee agreed to implement this extended scheme.

Arrangements have been made for the School Medical Officers to be trained in the necessary techniques required for tuberculin testing and vaccination.

In 1957, 442 children in four schools were tuberculin tested, and of 330 children for whom vaccination was advised, 329 were vaccinated. In 1958, of 3,098 children at twenty-nine schools who were offered facilities for this type of prophylaxis, 1,542 were vaccinated with B.C.G.

The following are the figures for the year under review:—

Number of schools	68
Number of children offered facilities for B.C.G. vaccination	8,389
Number of children whose parents desired to take advantage of these facilities and who were Mantoux tested	5,465
Number of children found to be Mantoux positive ..	1,251
Number of children found to be Mantoux negative ..	4,139
Number of children vaccinated with B.C.G.	3,989

REPORTS RECEIVED FROM SCHOOL MEDICAL OFFICERS

The following are relevant extracts from reports which I have received from individual School Medical Officers:—

Dr. M. SUTCLIFFE (Part of N.W. Division):

"(1) *The general health and well-being of the children:* In this age of more even distribution of wealth and widespread prosperity the majority of the children are well-nourished, well clothed, happy and energetic. The few exceptions are usually the children of substandard, irresponsible parents who refuse to submit to the discipline of regular occupation and are maintained by the hard-working members of the community. To these unfortunate children school dinners and milk are an absolute necessity and prevent a marked deterioration in health.

(2) *The physical condition of the children:* The improvement in the general physical condition of the pupils noted during the past few years has been maintained, but the incidence of dental caries appears to increase. Very few children in each age group examined are free from dental disease. Of the other defects the largest numbers were found in the orthopaedic and visual groups.

The children were placed according to their physical condition into the two following categories:—

	1959	1958
	%	%
Satisfactory	98.63	98.6
Unsatisfactory ..	1.3	1.4

(3) *The cleanliness of the pupils.* A total of 191 school children were found to be verminous during 1959, a rate of 7.1%. The incidence varies considerably in the individual schools from nil in a grammar school to 17% in one of the primary schools.

The school children in certain families are constantly re-infested from older members who are, apparently, content to harbour head lice all their lives. It appears to be impossible to persuade the members of these families to make a determined effort to rid themselves of lice completely.

There was a marked decline in the number of cases of impetigo seen at the minor ailments clinic, a total of eight compared with twenty-seven in 1958. No cases of scabies were treated.

(4) *School Meals; the Milk-in-Schools scheme:* On a given day in October 43.94% of pupils in attendance at school had school dinners. The meals are well-cooked, varied, appetising and nutritious and, except by a few faddy children, very much enjoyed.

On a given day in October 86.59% of pupils participated in the milk-in-schools scheme. The milk is very popular in primary schools particularly with those children who refuse to eat an adequate breakfast. It provides the extra nourishment they need to sustain them until the midday meal is due.

(5) *The hygienic conditions of schools:* Improvements are being made each year in the hygienic conditions of schools. The last insanitary trough closets were replaced by modern types in August 1959. Disposable paper towels are in use in most of the schools, a useful measure in reducing the spread of gastro-intestinal infections. There are still three or four schools which have no supply of hot water in the cloakrooms, a provision which is essential if the principles of personal hygiene are to be instilled into children during their most receptive years.

(6) *Infectious diseases.* Measles was the epidemiological feature of the year, though there were minor outbreaks of chicken pox, rubella and mumps and many upper respiratory infections. All the seventy-three cases of measles were reported during the first three months of the year while the fifty-two chicken pox infections were scattered from the beginning of February until the end of October. One small primary school had twenty cases of mumps in November. No cases of infectious disease were notified from secondary schools.

(7) *Verrucae:* Towards the end of 1958 two school children developed verrucae. Since then, in an endeavour to assess the incidence of and to eradicate this painful and contagious foot ailment, the Health Visitors have carried out foot inspections at all the secondary modern and most of the junior schools. It was found that 1.6% of children were affected. Appropriate treatment was recommended and prophylactic measures instituted to prevent the spread of infection to others. Although plantar warts are by no means contracted solely at the local swimming baths the Borough Council very kindly resolved that the new flooring in the dressing cubicles at the baths should, if possible, be laid before the remainder of the modernisation scheme was implemented. The present rough concrete floors are to be replaced by easily cleansed, smooth, impermeable surfaces.

(8) *Immunisation procedures:*

(i) *Diphtheria immunisation:* Fewer children were immunised against diphtheria at the clinics though more appear to be having a combined or triple prophylactic from the family doctors. Many parents are neglecting to have their children's immunity maintained by a booster dose four years after the primary course. Although there have been no notifications in the area since 1950, parents are reminded that it is still necessary to maintain a high immunity rate or diphtheria could return in its former severity.

(ii) *Whooping cough vaccination:* Parents are becoming increasingly interested in protection against whooping cough but they prefer their children to have the combined prophylactic in order to reduce the number of injections.

(iii) *Poliomyelitis vaccination:* Poliomyelitis vaccination clinics were held regularly throughout 1959. The acceptance rate from the priority groups over fifteen years of age was poor at the beginning of the year but an increased response was noted in April, following the death of a well-known footballer from the paralytic form of the disease.

The poliomyelitis vaccination programme disorganised to a slight extent the ordinary routine work of the School Health Department, in that the number of examinations of entrants to secondary schools had to be curtailed.

(iv) *B.C.G. vaccination:* The preventive medical services have since October, included B.C.G. vaccination of school children aged thirteen years and upwards. The acceptance rate at the two schools completed was 64%.

(9) *'Medical stresses of examinations':* The few cases of 'examination stress' which were brought to my notice were caused by the attitude of the parents. Certain parents with high standards believe, rightly or wrongly, that a child who fails to obtain a Grammar School place will occupy a less important position throughout life. The parents anxiety was occasionally reflected in the over-sensitive child who suffered from habit spasms and poor appetite.

(10) *Inter-relationship between the National Health Service and the School Health Service.* The friendly relationship between the three branches of the Health Service continues. Information is obtained from the hospitals regarding school children who receive in-patient treatment, and handicapped children are referred to the School Health Service by hospital consultants and general practitioners for special educational treatment."

Dr. F. D. F. STEEDE (Part of N.W. Division):

"(1) *General health and well-being of the children:* The general health and well-being of the school population on the whole is very good indeed. Children are almost universally well clothed and cared for. The majority of parents go to considerable lengths to make sure they obtain the best possible advice in their children's upbringing and the attendance of parents at the five year old routine medical inspection is well over 90%.

(2) *Physical condition of the children:* The physical condition of the children is, with the exception of their dental state, excellent. Dental caries, generally on the increase, is now assuming serious proportions. It is a rarity at a routine school inspection to see a child free from caries at the five year old inspection and almost invariably when one does so, one finds that he or she is a member of the local Italian colony. At the older age groups it is commonplace to see extensive decay in the second dentition. While, undoubtedly the increased consumption of sweets, together with the lack of attention to oral hygiene is a major factor, in Buxton the position is aggravated by two other factors—the lack of a school dentist for a number of years past, and the natural low fluorine content of the town's water. Undoubtedly the time is coming, and in my opinion, the sooner the better, when in the future it will be routine procedure to add flourine to waters naturally deficient.

At the present time children waiting for operations for tonsils and adenoids in this district are placed on a comparatively long waiting list, which has been adversely affected, also, by the local poliomyelitis epidemic in 1958 when it was considered necessary

to suspend operations for some months. This is an unfortunate matter since it is a fact that many children do benefit considerably from this procedure provided the operation is performed after careful selection and as soon as possible following the decision to undertake it. During such waiting period the tonsil infection may well have done additional damage and one is left in the position of having bolted the stable door too late.

Children who present themselves with speech defects have had their hearing checked where this has been considered to be a potential factor. Adequate treatment for such speech defects at the present time is difficult in the absence of the availability of a speech therapist.

(3) *Cleanliness of pupils:* Satisfactory. Infestation with pediculosis capitis is rare, as also is impetigo, and I have seen no cases of scabies or tinea (ringworm).

(4) *School Meals; Milk-in-Schools scheme:* School meals are on the whole satisfactory though where meals are not prepared on the premises and have to be carried in containers some deterioration in quality, taste and appearance is inevitable. One would prefer, at any rate in the larger schools, to see school meals cooked in the school. Over the year it is estimated that 63% of school children partake of school meals.

All milk consumed is pasteurised and I have stressed continuously the importance on all concerned, and in particular in infant schools, of as large a take-up as possible. The co-operation of the teacher is readily obtained once one has explained the necessity for a high calcium intake as a vital factor in the production of sound dentition, together with the fact that milk is the sole normal constituent of the diet with a high calcium content. It is estimated that 73% are taking school milk—a figure which is still far too low.

(5) *Hygienic conditions of schools:* The opening of one new secondary school has helped to reduce overcrowding in an all-age school which now takes children only up to the age of eleven. Otherwise my remarks with regard to overcrowding of classrooms made last year apply, and it is still necessary in the case of three schools to carry out the routine medical examinations at the school clinic. I would again place emphasis on the need to bring the older schools up to a satisfactory standard with special reference to the necessity for adequate hand washing facilities to include hot water.

(6) *Infectious diseases:* The early part of the year was noteworthy for an outbreak of influenza, when at times attendance was very low (30% or less in the case of infant schools). The disease if widespread, was mild in character and individual absences were mostly under a week. In the autumn term to date the primary schools have had to contend with an outbreak of mumps which at times has resulted in a 50% attendance in the case of infant schools.

I am glad to say that poliomyelitis this year was absent, and while this could be, and indeed must be in some measure due to the immunity created by the epidemic of 1958, we hope also that it may be due in no little measure to the degree of immunity conferred by the systematic vaccination campaign which has been carried on vigorously.

(7) *Immunisation procedures:* Initial immunisation against diphtheria in this district is almost entirely in the hands of the general practitioners who are universally using the triple antigen. No case, so far as is known, of post inoculation poliomyelitis has occurred locally, and it may well be that the risk in using certain vaccines, notably those free from alum, carry less risk of such an occurrence than was originally calculated. Booster sessions have been held in schools and it is hoped that more of these will be possible next year now that the vast majority of children have been vaccinated against poliomyelitis and a large number have had a third booster.

Vaccination against tuberculosis was introduced in the summer term when efforts were concentrated initially on offering protection to those children about to leave. However, by the end of the year all children eligible had been offered vaccination with the exception of the students of the College of Further Education. Acceptance rate for skin testing was approximately 48% and the percentage of those giving a positive reaction was approximately 25%. Of the 75% giving a negative reaction almost all were duly vaccinated with B.C.G. A systematic scheme for following up those children, and their family contacts, giving a strong positive reaction is being evolved. No untoward complications have been reported.

(8) *Inter-relationship of the National Health Service and the School Health Service:* Co-operation with the general practitioners in this district is a close and happy one. With regard to the hospital services, arrangements have been made with the Ear, Nose and Throat Specialist to forward a copy of all reports of Buxton school children and this is most helpful and a practice which I should like to see extended to embrace other specialist departments."

DR. G. KUTTNER (Part of N.W. Division):

"(1) The general health and well-being of the school children continues to be very satisfactory throughout my area. Even children who lack affection and sound parental management are, almost without exception, well fed. If provided with school dinners this latter group of pupils receives at least a substantial hot midday-meal and a good supply of milk. Their physical condition is therefore equally satisfactory and increases with increasing age.

(2) The standard of cleanliness is on the whole very good. There remains the hard core—small in number—of constant offenders in certain areas who, in spite of tireless efforts of Health Visitors, become re-infested with pediculosis again and again. I have not seen a case of scabies for a number of years and only very few cases of impetigo and of tinea circinata.

(3) Very much has been done in the last few years to improve the hygienic conditions in old school buildings. Provision of running hot and cold water is now almost the rule in every school in my area. The brightly coloured classrooms create a pleasant background. The worst drawback, even in new school buildings are: over-crowding;

the lack of staff and medical rooms; in old buildings the all too frequent need to accommodate two classes in one room; and the failure to provide indoor lavatories.

(4) Early this year an epidemic of measles reduced school attendance very considerably. In the latter part of the year there was a widespread epidemic of whooping-cough, chickenpox and mumps, none of them serious.

(5) *Immunisation procedures:* The response to whooping-cough and diphtheria immunisations in schools is still far from what one would want it to be. Equally disappointing is the indifference towards the need of poliomyelitis vaccination of more senior pupils. B.C.G. vaccination on the other hand has been more widely accepted than I expected. This is entirely due to the excellent co-operation of Headteachers whose help and encouragement have been invaluable in spite of the difficulties of accommodation, interference with examinations, school activities, etc.

(6) '*Medical stress of examination:*' I have not seen any evidence of clinical or psychological ill-effects in connection with examination. It seems to me that symptoms of mental and physical strain together with a feeling of being unequal to educational demands appear increasingly during a pupils first year in a Grammar School when the curriculum and the amount of homework is so much more strenuous than a child has ever experienced before."

Dr. W. GOW (Parts of N.W. and N.E. Divisions):

(1) *General health and well-being of the children and physical well-being:* These alike are good, almost without exception, so much so that obese children are becoming more numerous and ones who might be under-nourished are very rare.

(2) *Cleanliness:* Excellent. No scabies seen, very little pediculosis and a few cases of impetigo.

Milk-in-schools: No-one can criticise the milk, but perhaps we should criticise the biscuits sold with it in many schools. If something must be sold, then would not apples be better?

(3) *Hygienic conditions of schools:* Mostly very satisfactory, a few are deficient as regards lighting and ventilation, and one still has no water supply.

(4) *Immunisation procedures:—*

(*a*) *against diphtheria:* It will be necessary to have a 'drive' in 1960, because many parents are neglecting diphtheria immunisation. For the last three years the polio injections have complicated the issue but now most children have received these.

(*b*) *against whooping-cough:* Few parents wish this separately and it is necessary constantly to explain that the combined prophylactic is not being used. This takes a lot of time.

(*c*) *against poliomyelitis:* This seems to be an accepted thing now and no longer attended with the hysteria of earlier

years. It does indeed curtail the time available for other duties, not only by reason of time taken for vaccination sessions but the incredible number of enquiries and amount of advice that has to be given every day.

(5) *Medical stresses of examinations:* None have been seen. In my opinion stress would be more likely in grammar school children approaching G.C.E. but I cannot say I have seen any examples.

(6) *National Health Service and School Health Service:* Inter-relationship has been very happy and in quite a few cases the combined efforts of N.H.S. and S.H.S. have succeeded where certainly the unaided S.H.S. would have failed. I think such co-operation is quite invaluable to the success of our work.

Dr. D. R. McCAULLY (Parts of N.W., N.E. and Mid. Divisions):

"Since I commenced duties in February, 1959, I have inspected the thirty-six schools in this area for the first time. I do not, therefore, know the parents, children and teaching staff as well as would otherwise be the case. However, I found excellent co-operation and friendliness amongst the teaching staff who took a great interest in the pupils' health and referred cases of suspected deafness, defective vision, etc., for special examination. I found this most helpful, especially in my own situation of having just appeared on the scene, and have tried to encourage it in whatever way possible. Parents, too, I found to be most interested in the medical inspection; in general they turned up in large numbers for the infants and, also for the middle age groups. Alas, however, there was a marked falling off of interest of the parents of the older children in the Secondary Schools, and one feels that the examination of children without their parents being present is rather an unsatisfactory and perfunctory business. However, the gaps in knowledge could often be filled in by the Health Visitors, whose knowledge and experience of the case in question I found to be invaluable.

In general, I have tried to limit the numbers for examination to about twenty for each morning or afternoon session, as I find adequate time to be a prime essential in order to talk to the parents in an unhurried atmosphere and try to gain their confidence.

(1) *The general health and well-being of the children* was very good and there appeared to be little loss of school time due to illness. Exceptionally, there were a few families whose standards of nutrition and cleanliness were below par and their children were frequently absent from school, not always for health reasons. I feel that to lecture these people is worse than useless and that the only chance of any success lies in a personal approach by the Health Visitor in visiting the home.

(2) *Cleanliness of the children:* This was, in general, most satisfactory but, exceptionally, left something to be desired in the final inspection in the Secondary Schools.

I saw very little skin infections apart from a few cases of impetigo, which was never wide-spread throughout a school. Apart

from this, there were a few isolated cases of epidermaphytosis, and, in all, I found only two or three cases of nits in the hair. Scabies, also, was conspicuous by its absence. Verruca of the hands and feet was seen from time to time and occasioned some worry to parents. I saw a few cases of tinea circinata.

(3) *Physical Condition:*

(*a*) *Visual defects:* Visual defects were fairly common and were brought to my notice by routine testing and, also, quite frequently, by teachers and parents. Glasses prescribed were usually but not always worn by the children. They were referred, if their parents were agreeable, to ophthalmic clinics in the first instance.

(*b*) *Strabismus:* This was not very uncommon in the younger age groups but most of the cases seen were already receiving treatment.

(*c*) *Enlarged tonsils:* This was quite frequent and occasioned much absence from school, although the majority tend to subside in time. There was, however, the occasional complication of otitis and perforated drum with resultant partial deafness. I found that out of a total of 2,100 children examined, 12% have had their tonsils removed.

(*d*) *Dental decay:* This was, in some areas, very wide-spread and a perfect set of teeth was, indeed something to be noted. It varied a great deal in incidence, and in some places it was quite evident that a great deal of care and attention had been given to the children's teeth by their private dentists. This was especially noticeable in one area. I ascribed much of the dental decay to the habit of eating biscuits and sweets, etc., at all times, but especially at night without any brushing of the teeth before going to bed.

(*e*) I encountered few speech defects of any seriousness. Most of these were in infants starting school, and who were experiencing emotional difficulties rather aggravated by their parents natural if undesirable anxiety. One felt that these children were better left alone and that they would, given time, and their parents being re-assured, imitate the speech of their fellows. A few of the older children with 'stammers' were either referred for speech therapy or were already receiving it.

(*f*) *Eneuresis:* This was not very common and usually had a background of emotional difficulty. My impression is that it is more common in only children and in children of small families. There was little one could do other than to re-assure the parents that, given time and patience, the problem would solve itself.

(*g*) *Obesity:* I saw an occasional case but feel that, in the absence of any glandular disfunction or other ascertainable cause, dieting may be harmful and should not be resorted to.

Allergic conditions: Asthma was by no means uncommon but appeared to be of a rather mild type which tends to subside as the child grows older, and should be rather minimised to the parents than over-emphasised. Various *eczematous conditions* were also seen but were usually not very severe.

Flat foot, this was fairly common, in various degrees, and advice was given regarding footwear and exercises. In general, the cases were not very severe, although a few of the school leavers had to be referred to Orthopaedic Clinics.

(4) *School Meals:* These were uniformly good and were well availed of. Unfortunately, the children who did not avail of them were frequently those of rather poor families who needed them most.

(5) *Milk-in-Schools:* I think that this scheme should be of great benefit to the children's health, and it appears to be well used.

(6) *Infectious Diseases:* There were minor outbreaks of measles and chickenpox which necessitated postponement of the Medical inspection in a few schools. There was, also, some mumps and an occasional case of scarlet fever.

(7) *Immunisation procedures:* I was very struck with the small number of children who were vaccinated against *smallpox*. I found that out of the 2,100 children examined only 594 were vaccinated, giving an overall figure of only 28.28%. There were wide variations, and in a few of the small county schools none of the children examined had been vaccinated. At the other end of the scale, 66% of the children had been vaccinated. Many school leavers, together with their parents, do not now understand even what is meant by the term 'vaccination' so much is it falling into disuse. I think that this is unfortunate in view of the small outbreaks of smallpox which keep recurring in various parts of the country with the ever increasing influx of immigrants from countries where the disease is prevalent.

Diphtheria immunisation: This was, on the whole, satisfactory and the great majority of the children had been immunised. Most of this work had been carried out by general practitioners. There is a tendency to neglect the 'booster' dose on school entry, and I have tried to repair this deficiency by giving this in the schools.

Poliomyelitis inoculation: This has been confined to clinics, where the response has been very good.

B.C.G. inoculation: I have commenced B.C.G. in November in two large secondary schools and the response, so far, has been good. I found the Multiple Puncture Method of tuberculin testing to be much less time-consuming and troublesome than the intradermal and, so far, it has proved to be just as reliable."

Dr. B. E. JOHN (Parts of N.E., S.E., and Mid-Divisions):

"(1) *The general health and well-being* of the children was very good. The vast majority of the children seen were happy and healthy throughout the areas served.

(2) *The physical condition of the children* was very good on the whole although there was a striking difference in physique in different areas. It is of note that in the areas where the physique was of a higher standard the general level of hygiene and cleanliness was also higher.

(3) *The cleanliness of the pupils* was good with the exception of one or two children from problem families. Here again a considerable variation in the standard of cleanliness was seen in different areas. No cases of scabies or impetigo were seen. Pediculosis did occur however both in problem families and also in children from very clean good homes who were unfortunate enough to be in contact with those infested.

The use of an insecticide appears to have been of value in this connection. This is as simple to use as an ordinary hair shampoo, it is non-offensive and parents have been very grateful for it. It is also very effective.

(4) *School Meals* have been of a generally high standard although those prepared on the premises seem to have more flavour and variety than those prepared in communal kitchens.

(5) *The Milk-in-Schools scheme* especially if connected with the sale of biscuits at break is a very mixed blessing. Some mothers appear to take the attitude that it does not matter if the child is late getting up and has no breakfast as it is possible to have milk and biscuits at school. The good done by the milk seems to be more or less negatived by the damage done to the teeth by biscuit crumbs. The children do not clean their teeth after having biscuits and spend all the latter part of the morning with a mouthful of crumbs.

(6) *The hygienic condition of schools:* The ventilation, heating and lighting has been satisfactory in the schools visited.

The majority of schools visited had outside lavatories and several of the rural schools had urinals with no water carriage which were very offensive especially during the hot dry summer which we had this year.

Considerable efforts have been made on the part of the authorities to provide hot water and wash handbasins together with disposable paper towels even in the smallest and most remote schools.

(7) *School canteen facilities* are adequate and hygienic although a number of schools find it necessary to have meals in the classrooms.

(8) *Infectious diseases:* Outbreaks of chickenpox and measles with a few cases of scarlet fever have occurred during the past term.

(9) *Attendance of parents at school medical inspection:* Nearly all the parents attended in the first age group and much useful information was obtained from them and I hope in some cases given. In all the other age groups parental attendance was much lower.

(10) *Immunisation. Diphtheria immunisation in school:* The need for this seems to vary in different localities. In some cases the general practitioner has evidently impressed on the mother that the child requires a booster injection before starting school and relatively few injections are given at school. In other areas more injections are needed. The mothers are grateful when the service is provided at school and the protection rate in the overall area is very high. I

have tried to make it a practice to perform diphtheria immunisation either on the same or the following day as school medical inspection. It is then possible to make enquiries concerning recent poliomyelitis inoculation, infections, etc. I have found the Attendant who accompanies me of great help in connection with these queries and completion of the inoculation records, etc.

Inoculation against poliomyelitis still continues in large numbers, the bulk of the children who are entering school seem in fact to have received injections.

B.C.G. inoculation: A start was made in this connection with inoculation of tuberculin negative thirteen-year-olds.

(11) *Evidence of medical stress due to examinations:* There is little evidence of this except isolated cases of 'tic' etc. at the eleven-plus stage which has been seen in the case of children of over-ambitious parents who try to 'push' the child.

(12) *Medical Practitioners* in the area have been very co-operative both in treating cases referred to them and in sending cases for a consultant opinion where this was indicated.

Dr. F. BRILL (Part of N.E. Division):

"(1) *The general health and well-being* of the school children remains satisfactory on the whole. In view of the potential seriousness of persistent obesity, I am now classifying all grossly obese children as unsatisfactory, about 4% of all children examined.

(2) *Physical condition:*

(*a*) *Dental caries* was again the most common defect found. Towards the end of the year, however, I have gained the general impression that persistent campaigning in favour of oral hygiene and conservative dentistry is slowly showing some effect. Several schools have co-operated and suspended the sale of biscuits, which when consumed during the mid-morning break with milk, encourage decay. It will be interesting to observe the long-term result of this step.

(*b*) *Enlarged tonsils* and adenoids were the next most common defect. The waiting list for operation in the Sheffield area is very long, averaging about eighteen months. There are still cases of scarlet fever and rheumatic fever occurring in children who have a previous history of repeated sore throats.

(*c*) *Defects of vision* accounted for about 10% of defects found. Most parents are prepared to purchase a better looking and better quality frame, but there are still children who persistently refuse to wear their glasses.

(*d*) *Nocturnal enuresis* was found commonly in infant entrants, and became progressively rarer in the older age groups. Since the opening of the Child Guidance Clinic I have referred a number of difficult cases exhibiting this sympton among others, but it is too early as yet to judge any results.

(*e*) *Emotional stability:* Here again I have found the newly opened Child Guidance Clinic of great help, and I would like to record my appreciation to Dr. Salfield for his help with problem cases.

(*f*) *Foot defects:* These were mainly confined to older girls, and in nearly all cases were the result of the wearing of unsuitable shoes. The present craze for so-called 'casual shoes,' which appear to me to ignore the basic anatomy of the foot entirely, and can only be kept on by flexing the toes, will eventually result in many girls developing unsightly and painful foot deformities, which may well affect them at work, especially if the job means standing for long hours, and also in the home, when these girls in turn become the mothers of young families. I am aware that there is a campaign throughout the country to try to influence both customer and manufacturer, but there appears to be marked apathy on both sides.

(*g*) Infantile eczema—ichthyosis—asthma syndrome was another defect cropping up in all schools inspected.

(3) *Cleanliness of pupils:* Good in all age groups. Pediculosis was found in only a handful of children, mostly members of 'problem families.' Two cases of scabies were seen during the year, and one case of impetigo.

(4) *The school meal service:* The meals sampled have been well prepared, but those served in schools without kitchens suffer by transportation.

(5) *The Milk-in-School scheme* functions well, and large numbers of children avail themselves of it. As I have mentioned above, however, the combination of milk and sweet biscuits is definitely harmful to the children's teeth, unless they could clean their mouths immediately. This is of course impossible for practical reasons.

(6) *B.C.G. vaccination:* All senior schools in this area, as well as two schools in an adjoining area, were offered B.C.G. vaccination. The acceptance rate varied from 90% to just over 50%, but as a result of intensive propaganda will I hope continue to improve. Among the tuberculin positive reactors sent for X-ray check up, six cases showed lesions requiring follow up. No active case of tuberculosis was discovered.

(7) *Poliomyelitis vaccination:* Following the death of a football star, there was a sudden rush, but the demand has slackened off again.

(8) *Diphtheria-Whooping cough-Tetanus Immunisation:* There is a fairly steady demand for this procedure, but many mothers prefer to attend their family doctors, who use the combined antigen injection.

(9) *Smallpox vaccination:* There is practically complete apathy on the part of the public to this measure. As there are now so many different injections given to children for various reasons, it is not surprising that many parents of large families fail to remember the

details. I have for some time thought that a possible solution would be a record book issued to each infant by the Registrar at the time the birth was registered, and that all vaccinations and immunisations could be entered into this. A method advocated by some is a tattoo mark, carried out at the time of the vaccination, etc.

(10) In conclusion, I would like to thank the Head Teachers of all the schools visited, and to their staff, for their patience, courtesy and co-operation. I would also like to express my appreciation to the Sheffield Chest Clinic, and to Dr. Townshend in particular, for all the help he has given me."

Dr. G. O'CONNER (Part of N.E. Division):

"(1) *The general health and well-being* of the children has continued to be satisfactory and with few exceptions they appear happy at school.

(2) On the whole their *physical condition* was excellent. Dental caries was still common in the younger age groups. Enlarged tonsils and adenoids was common in all age groups. Vision defects in leavers was the most common defect that required treatment.

(3) The standard of *cleanliness* of pupils was high due to constant attention of the School Nurses. The incidence of pediculosis has been kept down. I saw no case of scabies during my inspections.

(4) *School Meals:* The majority of the pupils avail themselves of School Milk and School Meals. The standard of School Meals continues to be very good.

(5) *The hygienic conditions of Schools:* Ventilation, heating and lighting were satisfactory in all schools.

(6) *Infectious diseases:* There were few cases of infectious disease—a few cases of whooping cough and some cases of measles.

(7) *Immunisation procedures:*

(i) *Diphtheria immunisation:* About 70% of the entrants had primary immunisation as babies and were given booster doses.

(ii) *Poliomyelitis vaccination:* Most parents are anxious to have their children protected. Smallpox vaccination has become very rare. Poliomyelitis vaccination has not interfered with my other duties."

Dr. A. R. ROBERTSON (Part of N.E. Division):

"As you are aware I am now Medical Officer for only one school. I give below the details you have asked for, for this one school.

(1) *General health and well-being* of the children is very good.

(2) The *physical condition* of the children is also very good.

(3) The *cleanliness* of the pupils reaches a very high standard indeed. For instance, at the last head inspection there were only two children who were not clear.

(4) *School meals* continue to be popular, the only disadvantage being that there is not sufficient room for all the children to have the meals at once. This means that there are different sittings and these give a tendency to rushing of meals.

(5) The *hygienic conditions of the school* are satisfactory on the whole."

Dr. J. NETTLESHIP (Part of N.E. Division):

"(1) *General health and well-being of the children:* This was generally good, especially in the two older age groups examined.

(2) *The physical condition of the children* was fairly good, only six pupils fell into the 'unsatisfactory category.'

Enlarged infected tonsils and cryptorchidism were the most common defects found in the first age group (apart from the universal dental caries). Visual defects were most common amongst the other age groups. Vision tests are now performed on five year olds (with with aid of a picture chart) and seven year olds as well as the older children; it is surprising how much visual defect, previously unsuspected, is discovered. This applies particularly to cases of unilateral amblyopia. There is frequently a family history of 'lazy-eyes' in these cases. Unfortunately little can be done for these children apart from advising the parents about suitable occupations, but one feels that this advice is not always followed.

(3) *The cleanliness of the pupils:* This is generally good. Only three cases of pediculosis have been seen.

(4) *Milk in school* remains generally popular, school meals generally satisfactory, but I personally find too great a difference in standard of the meals presented by often neighbouring schools.

(5) *Hygienic conditions in schools:* Good on the whole, apart from some of the outdoor toilet facilities which were in very poor condition.

Some schools were without screens for use in the medical inspections. In my opinion these are essential if the whole procedure is to be carried out in one room.

All the canteens that I have seen have been well planned and equipped.

(6) *Infectious diseases:* There was a mild outbreak of scarlet fever during the summer, while chickenpox has been endemic throughout the year.

(7) *Deafness* has interested me particularly this year. Four quite severely deaf children have been referred to consultants (through their general practitioners) and are now being investigated. Many more mild cases have been found and several audiograms have been performed. It is surprising how the intelligent child can conceal his deafness by lip-reading and intelligent guess-work. Parents have often been astonished on watching a deafness test by the degree of hearing loss discovered. Deaf aids remain very un-

popular with their owners and too much of my time is spent in persuading children to wear them. Parents' co-operation must be obtained in this matter since some deaf children seem willing to go to any lengths to avoid their aid. I feel that the formation of a proposed partially-deaf class in N.E. Derbyshire may help to reduce the isolation of these children.

(8) *Immunization procedures:* Poliomyelitis vaccination remains popular with a good attendance rate.

Most of the diphtheria booster doses in my area seem to be given by the general practitioners.

B.C.G. Vaccination has been carried out in one boys school so far.

(9) *Medical stresses of examinations:* I have not noted any evidence of these.

(10) *Inter-relationship between the N.H.S. and School Health Service:* The general practitioners in this area have been co-operative and helpful on the whole."

Dr. P. WEYMAN (Part of Mid-Division):

"The schools allocated to me have had full and complete medical inspections. The constant pressure of the last two years has eased considerably since the arrival of another school doctor in the area. Dr. Urtson has been most helpful and is much liked by the school staffs, parents and children.

The general health and well-being of the children was considered good. The physical condition was also considered good.

The dental situation remains much the same as last year—poor. Would more frequent visits by the school nurse or Health Visitor improve further the hygiene of the mouth? A number of children seen at medical inspection still do not clean their teeth at all.

Cleanliness: Maintained at a reasonable level. No cases of pediculosis, impetigo or scabies have been seen by me.

School Meals, and Milk-in-Schools Scheme: The situation seems to be generally satisfactory. There is no doubt that milk must be checked before distribution by a responsible person. A recent successful prosecution for supplying milk in a dirty bottle underlines this. I was glad to hear that remarks had been made recently on the subjects of sweets, iced-lollies and biscuits in school. As indicated in my last report this is a matter for some concern. Bad habits started at home and reinforced in school are set for life. As in health matters generally so in dental hygiene all those engaged in teaching must speak the same language.

Hygienic conditions in schools: Reports on the conditions in schools are sent in at intervals. The Copthorne Infants School is now closed and the children will move to a new school in Rodgers Lane in Alfreton next term. Classrooms remain too full. This is an excellent means of spreading infection, colds, sore throats, influenza.

Not only do these infections spread more easily but more time is spent out of school. Particularly in the first two years of school life, it means that consistent teaching is not possible for some children. Quite often children return to school too soon after illness with consequent further infection. This is easily caught by a debilitated child in an overcrowded classroom.

Immunisation procedures:

(*a*) *Diphtheria immunisation:* no real difficulty is experienced in increasing the number of children protected against diphtheria at school entrance age. In fact immunisation at school seems to be the easiest and most trouble free way of dealing with children.

(*b*) *Whooping cough vaccination:* more propaganda is required on this matter.

Tetanus: many children receive triple antigen from their own doctor.

(*c*) *Poliomyelitis vaccination:* there seems to be ready acceptance of this procedure but it does seem to need a personal approach by doctor or nurse.

(*d*) *B.C.G. vaccination* proceeds smoothly and without trouble.

Medical Stresses of examination: Are not these produced more by over-anxious parents than by the child?

The Headteachers and staff of the schools in my care have been interested and taken special care to see that arrangements are as satisfactory as can be in the premises at their disposal."

Dr. T. URTSON (Part of Mid-Division):

"(1) The *general health and well-being* of the children remains satisfactory. They are well nourished and their clothing is, on the whole, satisfactory. However, there is concern among the teachers in infant schools about the number of children looking tired and sleepy in the morning, due to lack of sleep and rest.

(2) The *physical condition* of the children is satisfactory. Upper respiratory tract infections are still prevalent in the first age group. There is high incidence of visual defects in the second age group. In the third age group foot defects are very common in girls. It is a rarity to see a 'leaver' wearing a well fitting pair of shoes. Large number of boys were found to have fungus infection of feet.

Routine vision tests are now carried out in all seven-year-olds.

(3) Marked improvement in *personal hygiene and cleanliness* was noted this year, thanks to the persistent efforts of the School Nurse and Health Visitors. Two cases of ringworm were seen and these were already under treatment. No cases of impetigo or scabies have been seen by me.

(4) *School meals* are on the whole well cooked and adequate in quantity. I should like to see, however, more fresh fruit served, instead of the starchy puddings.

(5) *Hygienic conditions of schools:* There is need for improvement in this area. Overcrowding remains a problem in many schools and medical examinations have to be carried out under difficult conditions.

Accommodation for the teaching staff is inadequate. None of the Infant Schools in my area have a common room for their staff.

(6) *Special interests:*

(*a*) *Attendance of parents* at the medical inspection in the first age group remains good—92% were present. In the second age group 66.5% and in the third age group 13.5% of parents attended.

(*b*) *Health education:* To-day the School Health Service has come to be regarded as one of the main avenues for the practice of preventive medicine. The periodic medical inspection provides us with a regular opportunity to teach health to a large part of the community. I started regular health education in a very small way—posters about oral hygiene, sleep and rest, eyesight and food were displayed in the examination-, waiting-, and classrooms. Leaflets about the care of hair, feet and teeth, and to older girls about personal hygiene, were distributed. On interview various subjects were discussed—mainly about importance of sleep, footwear, balanced diets, immunisation and vaccination. Owing to the lack of space available, the use of more interesting material, such as film strips, slides and models, is limited.

(7) (*a*) Investigating the state of *diphtheria immunisation*, I found that about 30% of the children in all three age groups have never been immunised against diphtheria. There was a better response to immunisation this year: seventy-three primary and 180 booster injections were given. Primary immunisation courses are very time-consuming, but in view of the 30% of children not being protected and the increasing number of cases of this disease registered in 1959 (Ministry of Health announcement), I think it is time well spent.

(*b*) *B.C.G. vaccination* commenced in my area for the first time this year. The high acceptance rate obtained was entirely due to the support of the Head Teachers.

(*c*) The '*polio*' *vaccination* scheme continues to work smoothly."

Dr. W. J. MORRISSEY (Part of Mid-Division):

"The *general state of health* of the children continued to be satisfactory in 1959. There were no cases of real malnutrition and a complete absence of children found to be inadequately clothed. The small core of *verminous and infested children* remains about the same, invariably coming from the same problem families, who are lacking in intelligence and parental care.

The percentage of children taking *school milk* has remained constant, varying from about 75—80. It is difficult to know why the uptake is not much higher because the number of children who are genuinely upset by drinking cows' milk must be very small. All milk is pasteurised and despite the warm summer there have been little or no complaints about keeping qualities.

Audiometric tests were carried out during the year at two of the biggest primary schools on all children who had speech defects, were backward, had a history of ear trouble, or were thought to be deaf by the teaching staff. A considerable amount of minor deafness was found but in only three cases was it considered necessary to have Consultant opinions, and one child was supplied with a hearing aid.

School Premises: All the schools in the town with one exception are old, but work is slowly proceeding in providing better facilities. Hot water for hand washing is now available in the majority and a start is being made with providing better toilet facilities. Washing up facilities in all premises for school meals is satisfactory and all have separate canteen staff; but two of the larger schools canteens are in halls outside school premises which are anything but ideal.

I have found no evidence of *medical stress caused by examination.*

Relationship with general practitioners is excellent, but this is of course facilitated because I also act as District Medical Officer for the area."

Dr. J. DUTHIE (Parts of Mid- and S. Divisions):

"Since the re-arrangement of areas, I have been dealing with an increased proportion of rural schools and in these there is a notable decrease in the amount of upper respiratory morbidity as compared with schools in built-up areas.

The state of care and well-being of children is good. Very few cases of head infestations are to be seen but the tendency of foot infections to occur amongst pupils in secondary schools will require watching.

In one group of school entrants born in 1954, the number showing vaccination against smallpox was only 11.2%.

The acceptance of B.C.G. testing and vaccination ranged from 54% to 84% between various schools. The higher figure was obtained in a grammar school."

Dr. T. HAYNES (Parts of S.E. and S. Divisions):

"Having only joined the School Health Service in September, 1959, this report is based on findings during 3½ months work only.

(1) *General health and well-being of the children:* On the whole the general health and well-being of the children is good. They are well-cared for and well dressed, although I would like to see all the children in the Modern Secondary Schools wearing the *school uniform.* I feel the '100% wearing' of school uniform should be encouraged for two main reasons. First it helps the children 'to care what they look like,' thus encouraging cleaness and tidiness. Secondly, I feel it would prevent one child from feeling conspicuous because it hasn't got uniform.

There appears to be a high incidence of functional nervous disorders amongst school children, e.g. nail biting, eneuresis, eczema, and asthma. The incidence of enuresis is marked not only in the five year old group, where one might expect it, but also in the eleven-plus and even older groups.

(2) *Physical condition:* The physical defects which I have met most commonly in the past three and a half months have been defective vision and to a less extent squints, very poor teeth, bad posture, bad speech, and chronic upper respiratory infection associated with chronic lower respiratory infections and asthma.

(3) *Cleanliness of pupils:* The children have a fairly high standard of cleanliness apart from a few problem cases. In three and a half months of school inspections I have seen one case of impetigo and four of pediculosis.

(4) *School Meals:* These are mostly very good, but there is rather a high proportion of carbohydrate sometimes.

They are of good value in persuading the child who is a 'picky' eater to eat properly simply because he is surrounded by a normal hungry mob which he copies. Another great benefit is that it ensures a child gets at least one well balanced meal a day and some milk.

(5) *Hygienic conditions:* In the new schools this is very good except that in one or two there is no hot and cold water in the medical room.

In some of the old schools conditions are not very good. In one the lavatories and wash basins are across a large playground away from the main building in outhouses.

(6) *Infectious diseases:* Apart from an outbreak of chicken pox the incidence of infectious diseases has been low during the last three months in my area.

(7) *Attendance of parents at school inspections* is good in the age groups five years and eleven-plus, but not so good in the school leavers group—probably because the children at this age discourage their parents from coming with them because they think it is 'babyish.'

Parents appear to appreciate routine notification for re-inspections, and I feel these are the very cases where the parent needs to be present. Judgment of improvement or otherwise is difficult without adequate history, and often the parents have difficulties which they are eager to discuss. This applies particularly to cases of eneuresis and other functional nervous disorders which appear to have a high incidence among school children, and which often cause much disturbance in the home.

(8) *Immunisation procedures:* While most parents go to the general practitioner for the primary course of immunisation, there is a great demand for booster injections by the School Medical Service.

(9) *Medical stresses of examinations:* Having only done 3/12 medical inspection I cannot produce any statistical evidence for or against the stress of examinations.

During this time, however, I have gained the impression that in children approaching the eleven-plus examination, and immediately afterwards in those children who do not pass, there is a higher incidence of symptoms due to functional nervous disorder, e.g. nail biting, eneuresis, tics, and behaviour problems. Asthmatics tend to relapse more, and eczema is more troublesome.

After talking to many of the parents of these children it seems that this examination stands as THE HURDLE which must be passed. Most parents are over-anxious naturally that the child should pass and this over-anxiousness is transmitted to the child.

(10) *Inter-relationship of National Health Service and School Health Service:* I am grateful for the very helpful co-operation of the general practitioners in my area. It is a pity there is not more opportunity for joint meetings between general practitioners and Local Authority medical staff so that common problems could be discussed."

Dr. A. M. HAMILTON (Part of S.E. Division):

"(1) *General health and well-being* of the children is good.

(2) *Physical condition* on the whole is good, but a fair number of bad postures in eleven year olds have been seen.

(3) *Cleanliness* is on the whole good. Nits in the hair have been encountered, however, and a few isolated cases of impetigo.

(4) *School Meals and Milk-in-Schools:* Both these services are utilised satisfactorily.

(5) *Hygienic conditions:* These remain as in previous years. Several old schools have been redecorated; no school building in Ilkeston is sub-standard. However, several are uncomfortably over-crowded in spite of new, temporary classrooms which have been added.

(6) *Infectious diseases:* No serious epidemic has appeared this year, but the hot summer seems to have been followed by a great crop of bad colds and coughs.

(7) *Attendance of parents at school medical inspections:* This seems to depend a good deal on the age of the child, but also on the interest taken in the medical inspections by the Head Teacher. Nearly all parents attend with children at the age of five. After this the attendance falls off unless the school authorities co-operate by persuading the parents to come. It cannot be too much emphasised that a medical examination in the absence of a responsible adult is not of the same value as one at which an adult is present with whom to discuss any defects discovered.

(8) *Immunisations: Diphtheria immunisation* has fallen off in the schools, partly because many parents wish for the combined immunisation against diphtheria and whooping-cough which can be obtained from their own doctor, and partly because propaganda has tended to fix attention on *poliomyelitis immunisation.* There is also a certain feeling that the children are getting too many 'pricks.'

The multiplicity of injections has certainly had the result of making the five year olds here much more difficult to examine in school, as their first reaction to a doctor is to expect a 'prick;' and often much reassurance is needed before physical examination is permitted. This psychological aspect of the case appears to be ignored by some enthusiastic immunologists, but it presents a very real problem to the School Medical Officer.

(9) *Medical stresses of examinations:* This effect has not been observed in children in this area."

Dr. G. STOREY (Parts of Mid. and S.E. Divisions):

"In the restricted period which I have spent in this district it has been impossible to gain more than a superficial impression of the whole. Comments must, therefore, of necessity be very general in their nature.

(1) *General health and well-being of children:* This seems to be remaining satisfactory in comparison with other years.

(2) *Physical condition* of pupils is, on the whole, satisfactory.

(3) *Cleanliness of pupils:* one case of scabies was seen only.

(4) *School Meals; Milk-in-School:* School meals seem to be of a high standard.

(5) *Hygienic condition of schools:* There seems to be a general trend towards improvement here, although many schools are out-dated. One school was scheduled for destruction no less than twenty-eight years ago but remains intact and even modernised.

(6) The number of *parents attending at school medical inspections* varies enormously with (*a*) the type of school, e.g. infant, junior, secondary modern, and (*b*) with the area. The majority of parents attend first examinations, about 50—60% attend eleven-plus entrants and very few, perhaps 5—10% attend "leavers" examinations. In the poorer class districts the attendance is generally lower.

(7) *Diphtheria immunisation:* there is usually a very fair response to this.

Poliomyelitis vaccination: the public have been very conscious of this and in general have attended very well until, perhaps, recently when there has been a palpable decline in interest. It occurred to me that in the same child, a 'polio' injection seemed to cause more distress than an identical diphtheria injection.

(8) *Medical stress of examinations:* I think it is difficult to reach any reasonable conclusions over a short period of time—this is a question which requires study over a period of years. It may be significant, however, that a Grammar School Headmaster has asked advice on two pupils, both girls, who showed signs of psychological upset as they approached the G.C.E. examination."

Dr. M. VASS (Part of S.E. Division):

"(1) *The general health and well-being* of the children continues to be of a high standard. The greatest number of defects was found in the entrant age-group. Vision defects were common amongst the 'leavers' but other defects were few in this group. Dental caries continues to be a problem amongst all groups.

(2) *Physical condition of the children:* Good on the whole. One rarely sees a child who appears to be undernourished.

(3) *Cleanliness of the Pupils:* Also of a high standard, though there are still a number of school leavers who are careless about dental and personal hygiene. I saw no cases of impetigo this year. Two cases of ringworm of the body were seen, these responded quickly to treatment.

(4) *School Meals:* Continue to be a valuable and satisfactory service.

(5) *Hygienic condition of schools:* Conditions at most of the schools in my area are satisfactory.

(6) *Infectious Diseases:* Only one case of Poliomyelitis was notified. None of the other fevers reached epidemic form. Cases of whooping-cough appeared to be less.

(7) It was noted at the medical inspections for "entrants" that the number of *children vaccinated against smallpox* had increased. The response to the Poliomyelitis Vaccination Scheme was very good this year. Attendances at the clinic sessions were high, with few defaulters.

Response to the *B.C.G. vaccination scheme* was also good, this being carried out in the senior schools.

(8) *'Medical Stresses of Examinations':* I have found no evidence of this.

(9) *Inter-relationship between the National Health Service and the School Health Service:* The General Practitioners in my area are, on the whole, very helpful."

Dr. R. DEAN (Parts of S. and Mid-Divisions):

(1) *The general health and well-being of the school children* in this area has been satisfactory during 1959.

(2) *The physical condition* of the children was of a high standard. However, an increased incidence of the following was noted: obesity; foot defects, mainly due to unsuitable shoes; dental caries with abscesses; infections of the nose and throat; mouth breathing and poor posture. One case of rheumatic heart disease has been recorded.

(3) *Cleanliness of pupils:* The number of dirty children remains at about one per cent in infant schools, but is higher in Junior and Senior Schools.

(4) *The School Meals Service* continues to improve with the establishment of new kitchens displacing transported container meals.

The milk-in-schools scheme appears to work well; however, the majority of pupils do not appear to need it.

(5) *Hygiene* is excellent in the modern schools and several of the older schools have been provided with modern washing facilities. The supply of paper towels should be universal.

(6) *Immunisation Procedures:*

Polio vaccination: There has been a gratifying increase in demand, and clinics have been supplemented by immunisation in factories.

B.C.G. vaccination: This has been a busy year mainly due to the extension of the age group from thirteen year olds to include all senior grades. All secondary and grammar schools in the area have been completed. In the age groups concerned 58% of the pupils attended for tuberculin testing. A positive result was seen in 34% of those tested. It was noted that there was a higher rate of acceptances of this service in grammar schools, and that there was a higher proportion of reactors in secondary modern schools.

Diphtheria Immunisation has increased in infant and junior schools."

Dr. J. W. CRAWSHAW (Part of South Division):

"*The general health and well-being of the children:* The children are generally very fit and lively and happy in their school life.

I think that a considerable number of children stay up too late at night. I do not think the parents like this to happen, but they do not make sufficient effort, to enforce regular hours of sleep for their children.

The standard of *cleanliness* is high and diseases due to dirty conditions are rare. I have seen no scabies for several years, and impetigo is quite rare. There are some cases of pediculosis which almost always seem to occur in the same families—of course odd cases appear in the cleanest families.

School Meals are of great importance especially when children come from a distance or the mother goes out to work.

The quality of the meals cooked on the premises varies considerably and seems to be dependent on the interest and inherent culinary ability of the cook.

Milk in schools is of great value but it should not be accompanied by sweet biscuits if teeth are to be healthy.

The parents of entrants make great efforts to attend the examinations of their children and discuss their problems with me. The older children seem to discourage their parents from attending their examinations, but of course a considerable number of parents still come to the examinations.

The *hygienic conditions* are quickly improving as new schools are built and older ones are being improved.

Immunisation: Diphtheria immunisation in infancy is frequently

neglected and the first injection is done in school if at all. Whooping cough and tetanus injections are generally done by the family doctor in combined injections with diphtheria prophylactic. It is a pity that a standard method of immunisation by family doctors and the public health service cannot be arranged. Poliomyelitis immunisation is very acceptable and objections are rare.

Poliomyelitis and B.C.G. tests and immunisation have taken about one day out of each week and this has certainly made it impossible to spend an adequate number of days in the schools.

Medical stresses of examinations: I have not observed these conditions but I have no doubt that some stupid parents do harm to their children by worrying them about examinations.

The inter-relationship between the National Health Service and the School Health: I find that family doctors are very co-operative when they are informed of defects found at periodic school examinations. A school M.O. has opportunities for finding defects in apparently normal children which are denied to the family doctor. My duty is to find these defects and inform the family doctor so that he can deal with them as he thinks fit."

Dr. C. G. WOOLGROVE (Part of South Division):

"(1) *General health and well-being of the children:* The general standard of health amongst school children has, on the whole, been satisfactory. The attendance of parents at routine examinations has continued to be good, especially with the entrants, and great interest is shown in their well-being. During the year, an innovation carried out at the Senior School in my area was to time my visit to the school inspections to coincide with that of the Youth Employment Officer. This ensured that the parents were available, not only for considering the future of their children with regard to employment, but also with regard to their medical condition on leaving school. It certainly seemed to be well worth-while and I shall endeavour to make these arrangements in the future.

(2) *Physical condition of the children:* This also appears to be generally satisfactory. Frequently, a small number of undersized children have, in fact, parents of similar stature. Only a very small percentage can be classified as unsatisfactory. During the year, junior schools were visited and special inspections carried out. These visits do fulfil a definite need, as otherwise the School Medical Officer would not normally examine any children in a junior school.

(3) *Cleanliness of the pupils:* This has been excellent, in spite of the exceedingly fine and dry summer which has been experienced.

(4) *School meals:* I have been impressed during the year with the excellent work carried out by the School Meals Services and the meals that they provide for the children. This is especially so when the food is prepared and eaten on the school premises. There is no doubt that the majority of children enjoy also the mid-morning milk which is of benefit to them.

(5) *Diphtheria immunisation:* The practice of offering primary immunisation and booster doses to children at school, particularly

to the entrants, has again been welcomed by the parents. There is no doubt that this service does prevent a great deal of wasted time and energy on the part of the parents as opposed to visiting the family practitioner.

(6) *Poliomyelitis:* There was one case of poliomyelitis during the year, which shows a considerable improvement compared with the twelve cases experienced in the previous year, nine of which were of the paralytic type. It has been most encouraging to note the good attendance at the poliomyelitis Vaccination Clinics throughout the year, and it is to be hoped that the acceptance rates for this procedure will continue to improve.

(7) *Inter-relationship between the National Health Service and the School Health Service:* The family practitioners in this Area have again been most co-operative with regard to School Health Services and appointments with Specialists in hospitals. Valuable information has also been received from hospitals.

(8) *B.C.G. Vaccination Scheme:* The B.C.G. Vaccination Scheme was extended during the year to include not only those children aged thirteen years of age, but those who were older. Response has again been excellent, reaching in some cases well over 70%. My thanks are again due to the Headteachers and their staff for their help in this very important campaign to eliminate tuberculosis."

Dr. M. ALLAN (Part of South Division):

"(1) *General health and well-being:* It is much better to see the children in their ordinary classrooms and play grounds or playing fields and on sports' days in order to assess their general health and well-being. When one collates these findings with the ordinary medical inspection there is no doubt that the children's health is very good.

(2) *Physical condition of the children:* As regards standards of nutrition and physical condition, only a very few fall into Category 'U' and these are usually due to some form of illness. The good health and high standard of nutrition is the result of wise parental care assisted by school meals and school milk.

(3) *Cleanliness of pupils:* The cleanliness generally is high, and throughout the year I have only seen a few cases of impetigo, a few children with nits and none with scabies. There are, of course, one or two problem families where the standard of cleanliness leaves much to be desired and despite the efforts of the Health Visitors, School Nurses, School Welfare Officers and Public Health Inspectors, little improvement takes place.

(4) *School meals:* I make a point of seeing the school meals regularly and it is a revelation to me to see the variety and attractiveness of the school meals, and this cannot be accomplished without a great deal of thought and care on the part of the kitchen staff.

I am pleased to see the family service being introduced into a number of the schools in my area. I have no doubt that the school meals and school milk prevent much disease, but what is more they improve the nutrition and promote the positive health of the school-

child, and in addition educate the child and through the child, the family in the choice of foods.

(5) *Hygienic conditions of schools:* Much repair and replacement work has been done in the schools, and on outside and inside decorations which have made a tremendous difference. Perhaps more attention could be paid to better accommodation, including toilets, for the teachers in some of the older type of schools.

(6) *Infectious disease:* Towards the end of the year there was an outbreak of Measles since this was an epidemic year, and also numerous cases of Chicken Pox were notified from the schools. These diseases were mild and nearly all the cases were nursed at home and the children were only absent for a short period from school.

(7) *Immunisation procedures:* The Diphtheria Immunisation numbers are falling because of the immediate and acute interest in Polio Vaccination and of course the parents have no experience whatsoever of the disease, diphtheria. For the boosting or reinforcing doses the best response is at the school medical inspection for entrants, and in this I have had the utmost assistance from the Head Teachers.

The parents have accepted the Polio Vaccination with enthusiasm and have given every possible assistance at the Clinics.

The Whooping Cough Vaccination continues to be popular and the numbers are increasing despite the difficulty for the mother to attend for the three injections.

(8) *Medical stresses of examination:* I have no evidence of this in any of the Schools in my area during the year.

(9) *Co-operation between National Health Service and School Health Service:* The co-operation continues steadily between the Local Authority Health Services and the General Practitioners of the area and the local Hospital letters are very valuable and save a lot of correspondence with General Practitioners and the Hospitals."

It is thought that the following letter dated 10th June, 1960, addressed to all the School Medical Officers employed in the Health Department, would be of interest, particularly as its writing was stimulated by the comments incorporated in the School Medical Officers' Reports quoted above:—

"SCHOOL MEALS

Several School Medical Officers have recently commented in their annual reports on lack of protein, excessive carbohydrate, and the need for more fruit in the school meal. The Director of Education thought it would be helpful for you to know more about the instructions under which the Schools Meals Service works. The Director has, therefore, forwarded to me a summary of the Ministry of Education's nutritional standards which reads as follows:—

"The Ministry say that the school meal should have an energy value of 650-1000 calories according to age and sex. Variation in the calorific value should be adjusted by increasing or decreasing the quantities of potato, flour, cereals, etc. and of fats. The rough guide we have been given is:—

Infants Schools	..	650 calories.
Junior Schools	..	750 calories.
Secondary Schools	..	850-950 calories.

The meal should include 25 to 30 grammes of fat, again adjusted according to age and sex.

The Ministry stipulates a content of 20 grammes of protein of animal origin as standard for children **of all ages.** They have refused to consider an increase in the cost allowance in order to provide older pupils with more meat. H.M. Inspectors consider that the cash allowance which we have worked out within the Ministry's overall costing as a guide to individual schools is adequate but that a few schools show room for improvement in their pattern of buying; this we are gradually remedying.

The other suggestion by the Ministry for increasing the protein content is to add dried milk to puddings, custards and sauces. (Their suggestion of ¾ oz. per head per meal is intended, with the allowance of fresh milk used for cooking, to provide 45% of the protein content recommended).

They state that 'fruit of some kind should be served at least once a a week when it is economic to do so.' Cooks are in fact instructed that meals must contain either fresh fruit or fresh vegetables and salads at least once a week in summer and every ten days in winter depending on the weather. We also suggest an allowance of fresh, bottled or tinned fruit of 5 oz. per meal.

We are also seeking to encourage the habit of providing a slice of apple or raw carrot in addition to the two course meal as one contribution to the prevention of tooth decay."

The Director of Education has suggested that 'Medical Officers who consider the meals at any kitchen to be wrongly balanced should get in touch direct with the School Meals Organiser, Miss Clifford'."

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:—

"During the year 1959, 3,759 pupils were examined in the prescribed groups. The general standard of health and well-being of the school pupils has been satisfactory.

The attendance of the parents at the periodic medical inspections was very good indeed, particularly in the case of "entrants" where there was practically 100% attendance and this is no doubt due to the revised invitation card sent to parents before children are examined. Increased attendance has also been shown in the intermediate age group although not so large as that of the first age group. Conversely, the attendance of parents at the examination of school leavers is practically nil and this is probably due to the independent outlook of the pupils themselves which, although commendable in almost every other direction, is not so in this connection as children will not discuss with the medical officer some points which might have been mentioned by a parent. The health and mental well-being of adolescents is receiving a great deal of attention at the present time and until children can be persuaded to bring parents with them, many problems could be missed which might have a great bearing on the child's future particularly with regard to the type of employment they may enter.

As regards defects found at medical inspections, it was found that visual defects as always, have proved to be the most frequent but is is pleasing to report that for the first time for many years, the number of children referred for a full ophthalmic examination has not increased. On the other hand, more frequent visual examination carried out amongst infants has resulted in an increase in the number of children which require observation.

Special note has been taken during the year of the condition of the children's tonsils. It is found that at the time of entrance 4.15% of boys and 1.93% of girls have had their tonsils removed; by the time of the second examination, these figures had risen to 20.30% and 18.11% respectively, while it is found at leaver examinations 23.28% of boys and 23.68% of girls have had their tonsils removed. It thus appears that the majority of tonsillectomies are carried out between the ages of six and ten. Roughly, a quarter of all children have their tonsils removed at the present time but it should be noted that in accordance with general medical opinion, the number has dropped over the last few years and is in fact 2% less than last year.

The establishment of the Educational Sub-normal School at Ashgate initially involved the staff of the School Health Service in considerable additional work but one feels that this has been well worth while as the school is working smoothly and efficiently.

Brambling House School, of which we have been justly proud over the last twenty-one years, has continued to bring back to health the delicate children of the Borough and also alleviated the stresses and disturbances of emotionally disturbed children. An innovation has been the appointment of a physiotherapist for one session per week at the School but as between thirty and forty children require physiotherapy weekly, it is likely that in 1960, it will be necessary for the physiotherapist to attend for two sessions a week.

Owing to the continued pressure on the medical and nursing staffs in connection with the scheme for Vaccination against Poliomyelitis, it has not yet been found possible to do general B.C.G. Vaccination for all children over the age of thirteen in accordance with the County Scheme, but it is hoped that a start will be made during the coming year.

Speech therapy was interrupted during the year owing to the resignation of Miss H. Wright the Speech Therapist. After a lapse of three months however, we were fortunate to secure the appointment of a successor and the work has been carried out on similar lines as in previous years.

The School Dental Service continued during 1959 on the usual lines including the treatment of school and pre-school children. Some dentures were supplied mainly to replace front teeth broken or lost through sport or accidents and also some orthodontic treatment was undertaken to improve irregularities of the teeth and mouth. The children at the special schools were all examined and received treatment.

The Medical Officers consultation clinics, the ophthalmic clinic, the sun-ray clinic and the minor ailments clinics continued as in previous years and were very well attended as also did the excellent work performed by the Home Teachers."

APPENDIX

TABLES OF THE MINISTRY OF EDUCATION

Medical Inspection and Treatment—Year ended 31st December, 1959—Local Education Authority, Derbyshire

Number of pupils on registers of maintained and assisted primary and secondary schools (including nursery and special schools) in January, 1960, 118,520

PART 1—**Medical Inspection of Pupils attending Maintained and Assisted Primary and Secondary Schools (including Nursery and Special Schools)**

TABLE A—**PERIODIC MEDICAL INSPECTIONS**

Age Groups Inspected (By years of Birth)	PHYSICAL CONDITION OF PUPILS INSPECTED																	
	TOTALS— Whole Administrative County					Divisional Executive												
						North-west		North-east		Mid-Derbyshire		South-east		South		Chesterfield		
	No. of Pupils Insp'd	Satisfactory		Unsatisfactory		No. Inspected	Satis. %	No. Inspected	Satis. %	No. Inspected	Satis. %	No. Inspected	Satis. %	No. Inspected	Satis. %	No. Inspected	Satis. %	
		No.	%	No.	%													
1955 and later ..	1,794	1,782	99.33	12	.67	242	100.0	450	99.1	263	99.7	355	99.1	341	99.1	143	99.30	
1954 ..	3,842	3,780	98.39	62	1.61	485	99.8	900	98.4	590	99.3	712	98.7	684	97.1	471	97.03	
1953 ..	3,885	3,841	98.86	44	1.14	718	99.5	1,293	98.5	526	99.8	323	98.7	725	98.9	300	97.67	
1952 ..	1,127	1,104	97.96	23	2.04	211	96.2	506	99.4	189	99.5	54	100.0	114	99.1	53	81.13	
1951 ..	479	461	96.24	18	3.76	126	96.0	178	97.2	99	97.9	13	100.0	28	96.4	35	85.71	
1950 ..	340	326	95.88	14	4.12	92	93.5	116	97.4	58	100.0	8	100.0	13	100.0	53	90.57	
1949 ..	533	522	97.93	11	2.07	77	92.1	97	97.9	238	99.6	4	100.0	9	100.0	108	98.15	
1948 ..	4,135	4,058	98.13	77	1.87	485	82.5	579	99.7	813	99.7	832	96.1	538	98.3	888	96.96	
1947 ..	5,222	5,155	98.71	67	1.29	885	98.3	1,388	99.2	767	99.5	890	98.2	877	99.1	415	96.87	
1946 ..	2,194	2,168	98.81	26	1.19	476	98.1	849	99.0	203	98.5	312	100.0	308	99.0	46	93.48	
1945 ..	2,654	2,608	98.26	46	1.74	305	98.4	450	98.9	276	99.3	229	99.6	209	99.1	1,185	97.38	
1944 and earlier ..	7,189	7,144	99.37	45	.63	828	99.0	2,081	99.6	1,102	99.6	1,553	99.3	1,563	99.4	62	95.16	
Totals ..	33,394	32,949	98.67	445	1.33	4,930	98.6	8,887	99.0	5,124	99.5	5,285	98.6	5,409	98.8	3,759	96.78	

TABLE B—PUPILS FOUND TO REQUIRE TREATMENT AT PERIODIC MEDICAL INSPECTIONS

(excluding Dental Diseases and Infestation with Vermin)

Age Groups Inspected (By Year of Birth)	Number of Pupils Found to Require Treatment						
	Total (Whole Admin. County)	Divisional Executive					
		North-West	North-east	Mid-Derby-shire	South-east	South	Chester-field
	FOR DEFECTIVE VISION (excluding Squint) :—						
1955 and later ..	16	4	5	1	2	2	2
1954	50	13	17	2	4	8	6
1953	79	24	31	10	4	7	3
1952	40	11	19	2	2	4	2
1951	23	9	11	2	—	—	1
1950	31	11	12	4	1	—	3
1949	31	10	11	8	1	—	1
1948	331	68	54	81	61	24	43
1947	514	134	132	71	81	79	17
1946	245	62	107	21	22	27	6
1945	199	49	50	30	26	15	29
1944 and earlier	889	153	235	136	195	168	2
Totals ..	2,448	548	684	368	399	334	115
	FOR ANY OF THE OTHER CONDITIONS RECORDED IN PART II :—						
1955 and later ..	176	18	42	25	20	40	31
1954	538	58	127	77	61	140	75
1953	529	77	170	60	40	134	48
1952	152	21	61	10	7	30	23
1951	84	21	28	9	1	4	21
1950	49	13	11	—	—	3	22
1949	79	12	12	14	2	5	34
1948	408	55	62	81	51	78	81
1947	576	62	148	87	66	177	36
1946	278	39	95	23	23	78	20
1945	247	31	32	17	18	38	111
1944 and earlier	790	121	128	111	85	325	20
Totals ..	3,906	528	916	514	374	1,052	522
	TOTAL INDIVIDUAL PUPILS :—						
1955 and later ..	186	20	46	26	20	42	32
1954	561	61	138	78	63	144	77
1953	573	88	192	68	41	134	50
1952	185	29	79	11	8	34	24
1951	101	25	38	11	1	4	22
1950	75	21	22	4	1	3	24
1949	104	19	23	21	2	5	34
1948	692	109	103	157	111	93	119
1947	1,003	180	262	151	139	219	52
1946	462	88	185	39	39	86	25
1945	415	64	78	47	40	49	137
1944 and earlier	1,558	241	348	233	266	448	22
Totals ..	5,915	945	1,514	846	731	1,261	618

TABLE C—OTHER INSPECTIONS

	Total (Whole Admin. County)	Divisional Executive					
		North-west	North-east	Mid-Derby-shire	South-east	South	Chester-field
Number of Special Inspections	3,358	318	1,065	198	198	603	976
Number of Re-Inspections ..	10,180	1,525	673	885	906	1,431	4,760
Totals	13,538	1,843	1,738	1,083	1,104	2,034	5,736

TABLE D—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 (*b*), (*c*) and (*d*) relate to individual pupils and not to instances of infestation.

	Total (Whole Admin. County)	Divisional Executive					
		North-west	North-east	Mid-Derby-shire	South-east	South	Chester-field
(*a*) Total number of individual examinations of pupils in schools by school nurses or other authorised persons ..	231,844	20,405	61,038	43,182	40,883	37,054	29,282
(*b*) Total number of individual pupils found to be infested	3,052	324	1,379	521	480	195	153
(*c*) Number of individual pupils in respect of whom cleansing notices were issued (Section 54 (2) Education Act, 1944)	—	—	—	—	—	—	—
(*d*) Number of individual pupils in respect of whom cleansing orders were issued (Section 54 (3) Education Act, 1944)	—	—	—	—	—	—	—

PART II—Defects found by Medical Inspection during the year

TABLE A—PERIODIC INSPECTIONS

Note—All defects, including defects of pupils at Nursery and Special Schools, noted at periodic medical inspection, are included in this Table, whether or not they were under treatment or observation at the time of the inspection. The Table includes separately the number of pupils found to require treatment (T) and the number of pupils found to require observation (O).

WHOLE COUNTY

Defect Code No. (1)	Defect or Disease (2)	Periodic Inspections							
		Entrants		Leavers		Others		Total	
		(T) (3)	(O) (4)	(T) (5)	(O) (6)	(T) (7)	(O) (8)	(T) (9)	(O) (10)
4	Skin	180	134	260	125	175	83	615	342
5	Eyes—*a.* Vision	463	343	1,079	606	906	596	2,448	1,545
	b. Squint	311	80	103	37	132	83	546	200
	c. Other	43	28	25	18	39	38	107	84
6	Ears—*a.* Hearing	38	85	26	45	31	52	95	182
	b. Otitis Media ..	73	110	55	48	44	53	172	211
	c. Other	18	110	12	69	17	80	47	259
7	Nose and Throat	391	823	71	157	136	339	598	1,319
8	Speech	51	110	16	39	78	57	145	206
9	Lymphatic Glands	17	379	8	43	10	169	35	591
10	Heart	20	157	6	92	16	76	42	325
11	Lungs	104	420	41	105	101	151	246	676
12	Developmental— *a.* Hernia	36	37	5	7	11	13	52	57
	b. Other	36	173	15	49	38	149	89	371
13	Orthopaedic— *a.* Posture	15	63	43	61	57	104	115	228
	b. Feet	109	202	129	239	126	166	364	607
	c. Other	80	280	57	98	123	115	260	493
14	Nervous System— *a.* Epilepsy	23	12	21	12	29	12	73	36
	b. Other	11	33	12	3	18	29	41	65
15	Psychological— *a.* Development ..	18	55	22	22	34	133	74	210
	b. Stability	38	173	16	127	96	136	150	436
16	Abdomen	21	41	10	7	21	27	52	75
17	Other	102	164	79	166	117	170	298	500

TABLE B.

SPECIAL INSPECTIONS

Defect Code No. (1)	Defect or Disease (2)	Special Inspections	
		Requiring treatment (3)	Requiring observation (4)
4	Skin	97	22
5	Eyes—*a.* Vision	410	432
	b. Squint	112	45
	c. Other	50	18
6	Ears—*a.* Hearing	25	50
	b. Otitis Media ..	36	30
	c. Other	28	15
7	Nose and Throat	79	127
8	Speech	53	40
9	Lymphatic Glands	12	46
10	Heart	7	55
11	Lungs	37	74
12	Developmental— *a.* Hernia	17	14
	b. Other	14	32
13	Orthopaedic— *a.* Posture	16	10
	b. Feet	41	33
	c. Other	32	32
14	Nervous System— *a.* Epilepsy	32	15
	b. Other	11	14
15	Psychological— *a.* Development ..	6	69
	b. Stability	59	48
16	Abdomen	17	12
17	Other	128	71

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	24	63	25	17	40	11	26	40	11	6	30	21	50	31	46	18	64	51	11	14	14	2	11	73
5	Eyes–*a.* Vision ..	130	262	25	12	22	12	104	108	12	1	73	45	182	266	180	247	173	31	30	115	16	39	28	378
	b. Squint ..	64	105	33	37	47	25	17	26	4	14	8	11	9	14	9	39	32	–	6	6	2	1	12	10
	c. Other ..	7	17	2	5	7	5	6	5	2	1	7	7	7	4	1	4	5	4	1	5	1	1	2	8
6	Ears–*a.* Hearing ..	2	8	2	1	24	1	12	28	11	9	15	10	1	4	5	–	14	2	9	10	2	10	4	10
	b. Otitis Media	2	25	15	4	21	6	22	35	16	10	18	9	4	14	10	8	12	7	10	12	9	8	5	4
	c. Other ..	–	5	–	3	8	2	3	12	4	7	19	65	–	1	–	2	6	3	2	–	–	2	3	62
7	Nose and Throat ..	46	189	25	26	64	41	192	233	78	95	134	91	1	18	9	6	30	7	18	47	13	22	20	37
8	Speech	10	19	6	3	12	1	20	23	14	17	18	18	–	4	2	2	3	5	1	9	6	–	19	4
9	Lymphatic Glands ..	–	1	2	7	5	2	61	43	40	77	108	50	1	2	–	–	5	–	4	4	6	3	16	10
10	Heart	1	6	3	–	4	6	23	51	12	25	35	11	1	1	–	2	2	–	7	13	7	26	16	23
11	Lungs	2	37	15	5	32	13	83	102	41	63	94	37	–	9	8	7	16	1	20	22	15	24	9	15
12	Developmental—																								
	a. Hernia ..	2	19	2	2	9	2	17	7	4	–	4	5	1	–	1	–	2	1	3	2	–	–	2	–
	b. Other ..	1	18	5	2	6	4	10	73	8	24	22	36	2	2	2	1	6	2	2	3	10	1	16	17
13	Orthopaedic—																								
	a. Posture ..	2	5	–	–	8	–	22	4	5	6	18	8	19	1	3	9	11	–	4	11	3	4	9	30
	b. Feet ..	16	32	15	4	35	7	80	28	24	24	24	22	15	8	13	5	81	7	75	22	25	1	29	87
	c. Other ..	9	26	13	6	20	6	36	30	21	110	47	36	9	4	9	8	24	3	17	17	23	9	21	11
14	Nervous System—																								
	a. Epilepsy ..	–	8	6	4	4	1	–	5	3	4	–	–	–	2	2	3	8	6	2	2	–	1	5	2
	b. Other ..	–	2	–	1	6	2	4	6	2	5	14	2	1	–	2	4	5	–	1	2	–	–	–	–
15	Psychological—																								
	a. Development	3	2	3	3	7	–	12	19	9	10	4	1	–	–	1	–	21	–	5	8	–	2	1	6
	b. Stability ..	–	14	3	–	15	6	14	46	19	15	17	62	–	2	2	–	1	11	1	8	2	2	4	110
16	Abdomen	–	10	3	–	5	3	19	13	2	–	5	2	1	4	1	2	2	–	4	–	–	–	1	2
17	Other..	3	28	15	9	19	28	40	48	12	16	13	35	5	12	10	9	34	9	14	12	3	3	16	118

Defects found by Medical Inspection in the Year ended 31st December, 1959

DIVISIONAL EXECUTIVES (*continued*)

Defect Code No.	Defect or Disease	Periodic Inspections																					
		Others												Totals									
		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	27	13	41	19	42	33	9	8	10	2	25	29	101	107	112	54	146	95	46	62	35	10	66	123
5	Eyes–*a.* Vision	236	156	163	140	139	72	83	53	63	54	46	297	548	684	368	399	334	115	217	276	91	94	147	720
	b. Squint	37	29	22	14	26	4	11	8	2	–	28	34	110	148	64	90	105	29	34	40	8	15	48	55
	c. Other	7	6	8	–	12	6	3	2	4	–	3	26	21	27	11	9	24	15	10	12	7	2	12	41
6	Ears–*a.* Hearing	1	8	1	4	13	4	14	7	9	5	4	13	4	20	8	5	51	7	35	45	22	24	23	33
	b. Otitis Media	5	14	4	6	5	10	9	7	11	5	7	14	11	53	29	18	38	23	41	54	36	23	30	27
	c. Other	1	–	–	1	11	4	2	1	–	3	6	68	1	6	–	6	25	9	7	13	4	12	28	195
7	Nose and Throat	14	31	26	12	35	18	84	58	27	22	50	98	61	238	60	44	129	66	294	338	118	139	204	226
8	Speech	34	3	3	2	13	23	9	9	2	2	25	10	44	26	11	7	28	29	30	41	22	19	62	32
9	Lymphatic Glands	1	1	–	1	4	3	28	18	35	15	27	46	2	4	2	8	14	5	93	65	81	95	151	106
10	Heart	–	4	2	1	1	8	11	14	6	8	17	20	2	11	5	3	7	14	41	78	25	59	68	54
11	Lungs	–	13	27	9	13	39	25	22	28	17	23	36	2	59	50	21	61	53	128	146	84	104	126	88
12	Developmental—																								
	a. Hernia	1	3	–	3	3	1	5	1	–	–	6	1	4	22	3	5	14	4	25	10	4	–	12	6
	b. Other	2	5	4	5	14	8	19	16	9	7	15	83	5	25	11	8	26	14	31	92	27	32	53	136
13	Orthopaedic—																								
	a. Posture	25	1	8	2	12	9	33	9	13	6	20	23	46	7	11	11	31	9	59	24	21	16	47	61
	b. Feet	23	12	23	15	43	10	31	13	10	14	35	63	54	52	51	24	159	24	186	63	59	39	88	172
	c. Other	66	5	8	4	26	14	23	11	20	7	23	31	84	35	30	18	70	23	76	58	64	126	91	78
14	Nervous System—																								
	a. Epilepsy	2	3	2	2	6	14	5	1	1	1	4	–	2	13	10	9	18	21	7	8	4	6	9	2
	b. Other	–	2	4	1	5	6	5	2	2	1	15	4	1	4	6	6	16	8	10	10	4	6	29	6
15	Psychological—																								
	a. Development	1	1	1	1	30	–	10	22	3	2	4	92	4	3	5	4	58	–	27	49	12	14	9	99
	b. Stability	–	4	7	–	6	79	14	5	11	6	8	92	–	20	12	–	22	96	29	59	32	23	29	264
16	Abdomen	–	3	4	1	9	4	7	1	4	1	8	8	1	17	8	3	16	7	30	13	6	–	14	12
17	Other	5	6	20	19	26	41	23	19	8	18	36	66	13	46	45	37	79	78	77	79	23	37	65	219

Defects found by Medical Inspection in the Year ended 31st December, 1959

DIVISIONAL EXECUTIVES (*continued*)

Defect Code No.	Defect or Disease	Special Inspections											
		Requiring Treatment						Requiring observation					
		Divisional Executive						Divisional Executive					
		North-west	North-east	Mid-Derbyshire	South-east	South	Chesterfield	North-west	North-east	Mid-Derbyshire	South-east	South	Chesterfield
4	Skin	2	16	2	2	5	70	1	13	1	1	2	4
5	Eyes–*a.* Vision	30	142	41	31	29	137	7	148	43	20	3	211
	b. Squint	1	29	3	10	56	13	4	12	3	3	17	6
	c. Other	–	5	1	1	9	34	–	5	1	1	1	10
6	Ears–*a.* Hearing	–	10	–	–	6	9	7	20	3	7	2	11
	b. Otitis Media	–	12	–	4	12	8	1	19	–	4	4	2
	c. Other	–	3	1	–	11	13	–	7	–	2	5	1
7	Nose and Throat	4	35	7	10	8	15	8	88	1	6	6	18
8	Speech	8	14	1	–	15	15	–	18	1	1	15	5
9	Lymphatic Glands	–	1	–	–	9	2	4	17	1	–	2	22
10	Heart	–	5	–	1	–	1	–	31	1	18	–	5
11	Lungs	–	14	–	7	2	14	2	52	2	10	6	2
12	Developmental—												
	a. Hernia	–	6	1	–	10	–	–	2	–	2	10	–
	b. Other	–	8	–	–	3	3	1	20	1	1	3	6
13	Orthopaedic—												
	a. Posture	–	1	1	1	9	4	–	1	1	3	1	4
	b. Feet	3	14	1	3	1	19	6	15	–	3	1	8
	c. Other	1	11	1	4	7	8	5	18	2	2	2	3
14	Nervous System—												
	a. Epilepsy	1	8	–	3	8	12	–	8	–	6	1	–
	b. Other	–	2	–	–	–	9	–	6	1	4	–	3
15	Psychological—												
	a. Development	–	4	1	–	1	–	1	17	3	4	–	44
	b. Stability	–	8	–	–	8	43	5	16	3	4	–	20
16	Abdomen	–	2	1	1	5	8	1	6	–	1	4	–
17	Other	1	9	5	4	13	96	3	28	3	6	4	27

PART III

Treatment of Pupils attending Maintained and Assisted Primary and Secondary Schools (including Nursery and Special Schools)

TABLE A—EYE DISEASES, DEFECTIVE VISION AND SQUINT

	Number of Cases known to have been dealt with						
	Divisional Executive						
	North-west	North-east	Mid-Derby-shire	South-east	South	Chester-field	Total
External and Other, excluding errors of refraction and Squint	5	40	8	62	56	45	216
Errors of refraction (including Squint)							8,013*
Totals							8,229*
Number of Pupils for whom Spectacles were Prescribed							5,166*

* (It is not possible to "Divisionalise" these figures).

TABLE B—DISEASES AND DEFECTS OF EAR, NOSE AND THROAT

Received Operative Treatment :—							
(*a*) for diseases of the ear ..	–	–	–	–	2	2	4
(*b*) for adenoids and chronic tonsilitis	56	276	4	9	33	168	546
(*c*) for other nose and throat conditions	–	1	–	–	3	5	9
Received other forms of treatment	12	1	–	5	4	70	92
Totals	68	278	4	14	42	245	651
Total number of pupils in schools who are known to have been provided with hearing aids :—							
(*a*) in 1959	3	1	3	1	1	–	9
(*b*) in previous years	7	8	4	–	6	8	33

TABLE C—ORTHOPAEDIC AND POSTURAL DEFECTS

(*a*) Pupils treated at Clinics or out-patients departments	76	26	81	165	411	54	813
(*b*) Pupils treated at School for postural defects ..	–	–	–	–	–	23	23
Total	76	26	81	165	411	77	836

TABLE D—DISEASES OF THE SKIN
(excluding uncleanliness, for which see Table D of Part I)

	Number of cases known to have been treated						
	Divisional Executive						
	North-west	North-east	Mid-Derby-shire	South-east	South	Chester-field	Totals
worm—(*a*) Scalp ..	–	–	–	–	–	–	–
(*b*) Body ..	–	–	–	–	–	2	2
ies	–	–	–	–	–	2	2
tigo	10	2	–	7	–	6	25
r Skin Diseases	70	15	–	–	–	195	280
Totals	80	17	–	7	–	205	309

TABLE E—CHILD GUIDANCE TREATMENT

s treated at Child idance Clinics	45	125	101	59	84	120	534

TABLE F—SPEECH THERAPY

s treated by Speech erapists	92	4	6	4	75	193	374

TABLE G—OTHER TREATMENT GIVEN

Pupils with minor ailments	381	172	8	162	40	266	1,029
Pupils who received convalescent treatment under School Health Service arrangements ..	–	–	–	–	–	–	–
Pupils who received B.C.G. vaccination ..	–	–	–	–	–	–	3,989
Other than (*a*), (*b*) and (*c*) above (specify) :— Sunray treatment ..	–	–	–	–	–	224	224

PART IV

Dental Inspection and Treatment carried out by the Authority

	North west	North east	Mid-Derby-shire	South east	South	Ches-ter-field	Totals
(1) Number of pupils inspected by the Authority's Dental Officers:—							
(*a*) at periodic inspections ..	170	15,383	82	2,704	750	2,825	21,914
(*b*) as specials	–	1,359	152	258	1,498	2,475	5,742
TOTAL (1)..	170	16,742	234	2,962	2,248	5,300	27,656
(2) Number found to require treatment	89	13,807	183	2,356	2,081	4,318	22,834
(3) Number offered treatment ..	77	11,070	154	1,918	1,890	3,866	18,975
(4) Number actually treated ..	1	6,497	147	791	1,786	3,214	12,436
(5) Number of attendances made by pupils for treatment, *including* those recorded at heading 11(h) below	1	13,312	255	975	2,852	5,595	22,990
(6) Half-days devoted to:							
Periodic (School) Inspection ..	2	125	2	18	5	26	178
Treatment	–	1,903	–	118	307	743	3,071
TOTAL (6)	2	2,028	2	136	312	769	3,249
(7) Fillings :—							
Permanent Teeth	–	6,032	124	384	923	1,237	8,700
Temporary Teeth	–	397	2	11	4	266	680
TOTAL (7)	–	6,429	126	395	927	1,503	9,380
(8) Number of teeth filled :—							
Permanent Teeth	–	5,330	100	323	723	1,190	7,666
Temporary Teeth	–	383	1	11	4	264	663
TOTAL (8)	–	5,713	101	334	727	1,454	8,329
(9) Extractions :—							
Permanent Teeth	–	2,488	64	224	1,073	1,725	5,574
Temporary Teeth	2	6,682	174	901	2,920	2,599	13,278
TOTAL (9)	2	9,170	238	1,125	3,993	4,324	18,852
(10) Administration of general anaesthetics for extraction	–	2,217	100	531	1,372	1,714	5,934
(11) Orthodontics :—							
(*a*) Cases commenced during the year	–	69	–	6	2	6	83
(*b*) Cases carried forward from previous year	–	32	1	2	6	3	44
(*c*) Cases completed during the year	–	75	–	3	8	1	87
(*d*) Cases discontinued during the year	–	3	–	1	–	2	6
(*e*) Pupils treated with appliances	–	77	–	6	1	6	90
(*f*) Removable appliances fitted	–	92	–	6	2	6	106
(*g*) Fixed appliances fitted ..	–	–	–	–	–	–	–
(*h*) Total attendances	–	619	–	19	37	43	718
(12) Number of pupils supplied with artificial dentures	–	56	–	2	10	32	100
(13) Other operations :—							
Permanent Teeth	–	2,344	14	42	74	263	2,737
Temporary Teeth	–	1,416	28	43	168	53	1,708
TOTAL (13)	–	3,760	42	85	142	316	4,445