[Report 1965] / Medical Officer of Health, Devon County Council.

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THE HEALTH of DEVON in 1965

The Annual Report of the
County Medical Officer and
Principal School Medical Officer

COUNTY COUNCIL OF DEVON

ANNUAL REPORT

of the

COUNTY MEDICAL OFFICER

and the

PRINCIPAL SCHOOL MEDICAL OFFICER

FOR THE YEAR 1965

DEVON HEALTH COMMITTEE

as at 31st December, 1965

Health Committee

Chairman : †Rev. J. W. Timms.

Vice-Chairman : ‡Mrs. M. Owen.

Chairman of the Council (*ex officio*)

Vice-Chairman of the Council (*ex officio*)

‖Mrs. Adams	Mr. Hillard	Mrs. Patt
Mr. Attenborough	Major Jackson	*Mrs. Perkin
Mr. Daymond	Mr. Kerr	Mrs. Phillips
Mr. Disney	Mr. Lee	Mr. Pollard
Mr. Franks	Mr. MacMullen	Mr. Prowse
Mrs. Gibbens	Mr. Marshall	Mrs. Ratcliffe
Sir G. C. Hayter-Hames	Mrs. Park	Rev. H. S. H. Read
	Capt. G. H. Roberts	

Nominated by the following bodies :

Community Council of Devon—Dr. A. Robinson Thomas.

Devon Branch, British Red Cross Society—Capt. G. T. Millett, C.B.E.

Devon Branch, St. John Ambulance Association—§Major T. W. Gracey.

Devon and Exeter Local Dental Association—Mr. G. Pendlebury.

Devon and Exeter Local Medical Committee—Dr. R. M. S. McConaghey, Dr. G. C. C. MacVicker.

Devon and Exeter Pharmaceutical Committee—Mr. H. Jarvis Graves.

Executive Council for Devon and Exeter—Mr. A. D. J. Harvey.

Women's Voluntary Service for Civil Defence—Mrs. N. Croft.

§ Chairman of Ambulance, † Appointments and General Purposes, ‡ Adult Health, ‖ Child Health and * Nursing sub-committees.

School Health Service Sub-Committee of the Education Committee

Chairman : Mrs. F. Hiley

Vice-Chairman : Mrs. A. S. Ratcliffe.

Chairman and Vice-Chairman of the Council (*ex-officio*)

Chairman and Vice-Chairman of the Education Committee (*ex-officio*)

Mr. Crook	Mr. Lee	Mr. Pridham
Major Edmonds	Mrs. Owen	Dr. Vanstone
Miss Hancock	Mrs. Perkin	Mr. Vinnicombe
	Prof. S. H. Watkins	

STANDING SUB-COMMITTEES OF THE DEVON HEALTH COMMITTEE

Adult Health Sub-Committee: To exercise and carry out the powers and duties conferred or imposed on the County Council in respect of the following services:—

Mental health (other than for children) and the care and after-care of mentally disordered adults, including provision of adult training centres.

Registration of mental nursing homes.

Care and after-care of persons suffering from physical illness (including provision for tuberculosis, occupational therapy, and home teaching services and the chiropody service).

To visit, inspect and manage adult training centres and workshops, including any hostel provided for such centres, and to deal with all matters connected therewith within the annual budget to be allocated by the Health Committee, provided that the Health Committee may, with the approval of the Finance Committee, modify such annual budget, as may be necessary from time to time in order to meet special items as they arise.

Ambulance Sub-Committee: To exercise and carry out the powers and duties conferred or imposed on the County Council in relation to the ambulance service.

Child Health Sub-Committee: To exercise and carry out the powers and duties conferred or imposed on the County Council in relation to the following services:—

Care of young children.

Vaccination and immunisation.

Registration of day nurseries and child minders.

Care and training of mentally subnormal children of school age.

Registration of homes for mentally disordered in relation to homes for subnormal children.

To visit, inspect and manage junior training centres, including any hostel provided for such centres.

Nursing Sub-Committee: To exercise and carry out the powers and duties conferred or imposed on the County Council in relation to the following services:—

Care of mothers and infants.

Midwifery.

Health visiting.

Home nursing.

Domestic help.

Registration of nursing homes, except mental nursing homes.

Appointments and General Purposes Sub-Committee: To exercise and carry out the powers and duties conferred or imposed on the County Council in relation to the following:—

Staffing matters (including the appointment of staff not delegated to the County Medical Officer).

Provision of clinics and their maintenance.

Health Education.

Supply of Water.

Disposal of Sewage.

Food and Drugs.

Milk and Dairies.

Any other functions of the Health Committee not specifically referred to any other sub-committee.

Basildon Sub-Committee: To visit, inspect and manage the County Council's home for delicate children. To present annual reports of their stewardship and to report special items to the Health Committee.

Table of Contents

PART IV

PART V

PART VI

PART VII

INTRODUCTION

Health Department,
County Hall,
Exeter.

July, 1966.

To: The Chairman, Aldermen and
Members of the Devon County Council.

Mr. Chairman, My Lord, Ladies and Gentlemen,

I have the pleasure of introducing the annual report for 1965, covering my second year of office as your county medical officer and principal school medical officer.

The report gives details of the vital statistics of the area and of the many services provided by the county council's health department for the prevention of illness, promotion of health and the care and after-care of patients in the community.

The vital statistics indicate that the improvement in infant and peri-natal mortality has been well maintained. The peri-natal mortality rate, which is a combination of still births and deaths of infants under one week, was 23.27 per thousand births as compared with 26.49 in the previous year and 26.9 for England and Wales. For the second year in succession the infant mortality rate was down at the extraordinarily low level of 14.9 per thousand live births compared with 19.0 for England and Wales. These statistics give cause for some satisfaction with the standard of ante-natal care provided by doctors, midwives and health visitors. There can, however, be no room for complacency, as further improvement is possible. A less satisfactory feature of the child health statistics is the rise in the number of illegitimate live births from 546 in 1964 to 616 in 1965. The moral and spiritual aspects of this trend are perhaps beyond the terms of reference of this report but I think it is salutary to note that it has public health significance too, since the infant mortality rate among the illegitimate infants proved in 1965 to be 2½ times that in the other infants. There are obvious difficulties in providing a high standard of ante-natal care to an unmarried expectant mother, especially if she is very young or immature. The difficulty is increased by the tendency of both the girl and her parents to keep the pregnancy secret for as long as possible.

Another noteworthy feature of the 1965 statistics is the number of deaths from cancer of lung which reached the record high figure of 302. In the light of our steadily increasing knowledge of the link between cancer of lung and cigarette smoking few doctors would quarrel with my contention that the majority of these 300 deaths could be attributed to cigarettes. The lung is now the commonest site of cancer, about one-third of all cancer deaths in men being caused in this way. Lung cancer is the only form of cancer which is rising appreciably at the present time and there is not the slightest sign that this rise is being halted except in one group of the community, viz. doctors, very many of whom have in recent years reduced or stopped their cigarette smoking or have turned to other less harmful forms of smoking. This is a slow, strangling epidemic, whose victims are by no means invariably senile. Indeed of the 302 deaths in 1965 in Devon no less than 141 were under the age of 65. The average age at death from this form of cancer is considerably lower

than in some other common cancers and very much lower than the average age at death of sufferers from coronary disease. Deaths in England and Wales from cancer of lung are now at the rate of a quarter of a million per decade and still the public goes on cheerfully smoking its health and money away!

The high average age of the population in Devon adds significance to any attempt made by the health department to prevent suffering and death. The introduction in 1965 of cervical cytology facilities at county council clinics was one such effort. Whilst this should be welcomed as the first in what may yet prove to be a series of simple diagnostic procedures, it is important not to exaggerate its contribution to the solution of the problem of cancer. Even if laboratory technicians were not in short supply and even if the entire adult female population volunteered for the tests, the maximum saving of life in Devon could be no more than 30 out of a total of nearly 1,700 cancer deaths per annum. The cigarette smoking public could achieve a far greater saving of life by a relatively modest reduction of their deplorable but socially acceptable habit.

Cancer is, of course, not the only disease where early diagnosis, advice and treatment can save life or prolong activity. There is a wide range of disorders prevalent in middle-aged and elderly people which can be effectively treated or controlled if diagnosed promptly. Examples are faulty hearing and sight, foot troubles, anæmia, nutritional disorders, obesity, diabetes, glaucoma, cataract, high blood pressure and coronary disease. Almost all these conditions can be effectively treated or ameliorated if diagnosed early. Most of them can be provisionally diagnosed by ordinary clinical examination with the addition of a few special tests, many of which can be done by nurses under medical supervision. Consideration has been given in the department to the practicability of arranging medical screening of this kind in our health centres, clinics or other suitable premises. The medical examinations could most appropriately be done by general practitioners assisted by health visitors, clinic nurses and clinic clerks, the health department being responsible for the organisation and administration of the service. The health visitor would have an important role in the educational and advisory part of this work and also in the follow-up of patients found to require treatment. The social and psychiatric aspects of health would of course be adequately covered. It is hoped that, subject to health committee approval, a start will be made with these "retirement" clinics in the autumn of 1966.

Retirement clinics represent just one further instance of the shifting emphasis in modern public health work towards meeting the needs of the aged and the handicapped. Further examples are provided by the growth of the health visiting, home help and chiropody services. In 1965 and for the first time the number of visits paid by health visitors to the aged exceeded those paid to the homes of school children. The increase over the previous year was of the order of 20%. This increase is likely to continue especially since the general practitioners are beginning to use the health visitors extensively for dealing with the social and medical problems of the elderly. The home help service, also largely devoted to the aged, has doubled its case-load in the past five years and the health department's chiropody service has increased the number of treatments provided from 10,000 to over 40,000 in only three years. It should be noted that in spite of this rapid growth there is still a waiting list for chiropody and further expansion is inevitable if hardship, isolation and suffering are to be prevented.

Good progress continues to be made in the implementation of the 1959 Mental Health Act. The aim of the mental health services provided by this department is to give advice, support and, where necessary, training for all children and adults who require it by reason of mental handicap or illness. In addition to our growing staff of mental health social workers and occupation therapists we now have a network of both junior and adult training centres with a total accommodation for approximately 650 persons. The facilities include three hostels for children and two for adults. A number of the premises used for adult training are temporary and unsuitable but it is hoped that these will be replaced by purpose-built centres within the next few years.

As explained in my report for 1964, the rapid growth of our nursing and other domiciliary services increases the need to work more closely than ever with family doctors. Close co-operation already existed in relation to home nursing and midwifery, but it was necessary to improve the co-ordination between the doctors and health visitors. Attachment of health visitors to practices is one method of dealing with this problem and over one-third of our health visitors were attached before the end of 1965. Our health centre programme will of course assist materially in our efforts to obtain some functional integration of general practice with the public health service. At the end of 1965 two health centres were in the course of construction, five were in an advanced stage of planning, and sites were obtained for a further six. Preliminary discussions were being held in relation to fourteen other centres, making a total in all of twenty-seven. As these health centres gradually come into operation over the next ten years or so the public will, I am confident, have reason to congratulate the health committee on its courage and vision.

It is with regret that I have to report that during 1965 the chairman of the health committee, Mrs. J. M. Phillips, O.B.E., J.P., found it necessary to resign her position because of failing health. Mrs. Phillips led the health committee wisely and well for nearly twenty years. We hope that her health will now improve so that she can enjoy a well-earned retirement from public life. We welcome our new chairman, the Rev. J. W. Timms, who I know will be happy to continue in the tradition set by Mrs. Phillips.

May I finally pay tribute to the loyalty, enthusiasm and energy of the staff of my department.

J. LYONS,

County Medical Officer and Principal School Medical Officer.

STAFF OF THE HEALTH DEPARTMENT

County Medical Officer and Principal School Medical Officer	J. Lyons, M.B., Ch.B., M.R.C.S., L.R.C.P., D.P.H.
Deputy County Medical Officer and Deputy Principal School Medical Officer	D. S. Parken, M.B., B.S., M.R.C.S., L.R.C.P., D.C.H., D.P.H.
Senior Medical Officer for Maternal Health and Nursing	F. Gloria Richards, M.R.C.S., L.R.C.P., D.(OBST.), R.C.O.G.
Senior Medical Officer for Child Health	A. D. Lepine, M.R.C.S., L.R.C.P., D.P.H. (resigned 9.5.65)
Senior Medical Officer for Child Health	D. O. McKnight, M.B., B.S., D.C.H., D.P.H. (from 9.8.65)
Senior Medical Officer for Adult Health	J. A. Theobald, M.B., B.S., M.R.C.S., L.R.C.P., D.P.H.
Senior Assistant County Medical Officer	D. Cullen, M.B., B.S., L.R.C.P., M.R.C.S., D.P.H. (from 18.10.65)
County Superintendent of Nursing and Supervisor of Midwives	Miss G. Heather, S.R.N., S.C.M., H.V.C.
Superintendent Health Visitor	Miss E. L. Hunter, S.R.N., C.M.B. (Pt. I), H.V.C.
Health Education Officer	Miss P. O. Davies, R.M., D.H.ED.
County Health Inspector	M. S. Powling, F.A.P.H.I.
Principal Administrative Officer ...	J. Cooke
Chief Clerk	H. T. Baldwyn
County Ambulance Officer	R. P. Selley, D.P.A., F.I.A.O.
Home Help Organiser	G. P. Brooks, D.P.A., D.S.A.
Principal Social Worker	L. H. Jenkins, D.S.S., M.H.CERT.
Senior Occupational Therapist ...	Miss M. M. Keily, M.A.O.T.
Chief Chiropodist	W. Beedle, M.Ch.S., R.M.A.
Senior Workshop Manager	T. O. Hughes, D.M.A.
Administrative Officers:	
Maternal Health & Nursing Section	K. G. Baker
Adult Health Section	R. H. G. Gibson
Child Health Section	W. H. Nickels
General Health Section	J. C. Wright, D.M.A.

Medical Officers

L. G. Anderson, M.D., Ch.B., D.P.H.
H. M. Davies, M.A., M.R.C.S., L.R.C.P., D.P.H.
R. C. MacLeod, M.D., D.P.H., D.T.M. & H.
M. McQuaid, L.R.C.P. & S.I., D.P.H.
D. K. MacTaggart, M.A., M.B., Ch.B., D.P.H.
H. M. Thomas, M.B., Ch.B., D.P.H., D.C.H. (resigned 30.4.65)
R. B. Walker, M.R.C.S., L.R.C.P., D.P.H.
J. H. Wildman, M.R.C.S., L.R.C.P., D.P.H.
E. Williams, M.R.C.S., L.R.C.P., D.P.H.

} "mixed" appointments

J. Allott, M.B., Ch.B., D.P.H.
N. E. R. Archer, M.A., D.M., B.Ch., D.P.H.
R. H. Browning, M.B., B.S.
M. E. Budding, B.Sc., M.B., Ch.B., D.P.H.
W. E. Denbow, B.Sc., M.R.C.S., L.R.C.P., D.P.H.
M. J. Dunn, M.B., Ch.B.
L. Solomon, B.A., M.B., B.Ch., B.A.O., L.M., D.P.H., D.C.H.
P. W. Tait, MB., Ch.B.
W. Burgess, L.R.C.P., M.R.C.S., M.B., B.S., D.C.H., M.R.C.P., M.D. (part-time).
S. C. Candler, M.B., Ch.B., M.R.C.S., L.R.C.P. (part-time).
E. A. Chalk, B.A., B.M., B.Ch. (part-time).
M. R. Epstein, L.R.C.P.I. & L.M., D.C.H., R.C.S.I. (part-time).
J. M. MacTaggart, M.B., Ch.B., D.P.H. (part-time).
E. A. Forsyth, M.B., Ch.B., D.P.H. (temporary, from 1.10.65).

School Ophthalmic Surgeons*

A. M. Barnett, M.A., B.A., M.R.C.S., L.R.C.P., D.O.
R. C. Chaturvedi, M.B., B.S., D.O.
A. J. A. McCormick, M.B., Ch.B., F.R.C.S., D.O.M.S.
G. Searle, M.R.C.S., L.R.C.P., D.O.

Chest Physicians*

G. E. Adkins, M.B., B.CHIR.
W. E. B. Lloyd, M.R.C.S., L.R.C.P., D.P.H.
B. R. Hillis, M.D., M.B., CH.B., F.R.F.P.S., M.R.C.P.
J. C. Mellor, M.B., B.Ch. (resigned 30.9.65)
J. J. Y. Dawson, M.C., M.D., M.R.C.P.

Psychiatrists, Child Guidance*

H. S. Gaussen, M.R.C.S., L.R.C.P.
W. Johnston, M.B., Ch.B., D.P.H.
C. J. Wardle, M.D., B.S., M.R.C.S., L.R.C.P., D.P.M.
D. A. Sime, M.B., Ch.B. (resigned 9.9.65).

* On staff of the Regional Hospital Board.

DENTAL SERVICE

Chief County Dental Officer and Principal School Dental Officer ... J. D. Sykes, L.D.S.

County Orthodontists ... ... A. S. Peacock, L.D.S., D.D.O., R.F.P.S. (part-time) (to 30.11.65)

Dental Officers :

G. H. S. Clarke, L.D.S.
G. J. Derbyshire, L.D.S.
J. L. Dickson, L.D.S., R.F.P.S.
H. W. Gibbs, L.D.S., R.C.S.
W. A. Humpherson, B.D.S., L.D.S., R.C.S. (to 17.12.65).
F. A. Pearse, O.B.E., L.D.S., R.C.S.
C. T. Pomeroy, L.D.S., R.C.S.
Barbara J. Shapland, L.D.S. (retired 15.9.65).
J. Smith, L.D.S.
K. P. Smith, L.D.S., R.C.S.
J. W. Steer, L.D.S., R.C.S.
C. N. Van Rijswijk, B.Ch.D.
J. K. Vowles, B.D.S.
F. M. Warren, B.D.S., L.D.S., R.C.S.
H. D. Williams, L.D.S.
J. A. R. Hemsted, L.D.S., R.C.S. (part-time) (to 26.2.65)
V. G. Holdsworth, L.D.S., R.C.S.
A. Shipley, B.D.S.
J. F. Hunt, L.D.S., R.C.S. (from 1.3.65)

Dental Auxiliaries :

Pauline Mitchell (to 31.3.65).
Miss M. I. Sowden (from 6.9.65).

Dental Hygienist :

Miss P. H. Turnage (from 16.8.65).

PART I

VITAL STATISTICS

Area and Population

Births

Deaths

VITAL STATISTICS

Devon is a predominantly rural county but has a concentration of almost 100,000 in the Torbay area, where almost one-fifth of the population reside. The remainder of the county, apart from relatively small urban areas, consists of rural districts which include two large areas of sparsely populated countryside, Dartmoor and the western part of Exmoor. The area and population of the aggregates of the municipal boroughs and urban districts and the rural districts and the administrative county are appended.

Area and Population

	Municipal Boroughs & Urban Districts	Rural Districts	Administrative County
Area (acres)	127,015	1,522,415	1,649,430
Population (estimated mid 1965)	285,570	278,230	563,800

Number of Municipal Boroughs, 10; Urban Districts, 19; Rural Districts, 17; Total, 46.

Statistics are detailed on pages 24 and 46 but the following is both a summary and an outline of the more interesting facts.

Births

Registered live births number 8,459 equivalent to a rate of 18.2 per 1,000 population. The number of still births registered was 137, corresponding to a rate of 15.9 per 1,000 total births.

Deaths

The total number of deaths allocated to the administrative county was 8,201 (compared with 7,898 in 1964).

Due to the age-sex distribution of the population differing from area to area throughout the country, crude rates, although based on actual occurrences, fail to provide a useful mortality index. To enable more realistic comparisons of the mortality between different areas to be made, compensating factors are applied to the crude rates. The death rates from all causes for the past six years, adjusted by the appropriate factors, for the aggregates of boroughs and urban districts, rural districts, the administrative county, also the rates for England and Wales are given below :

Year	Municipal Boroughs and Urban Districts	Rural Districts	Administrative County	England and Wales
1960	11.5	11.0	11.4	11.5
1961	12.0	11.2	11.6	11.9
1962	12.1	11.3	11.7	11.9
1963	11.6	11.5	11.7	12.2
1964	10.9	10.1	10.4	11.3
1965	10.3	10.2	10.2	

Perinatal Mortality

This term is used to describe stillbirths together with deaths during the first week of life and the resultant rate expressed per 1,000 total births. The 1965 rate of 23.27 is a reduction of 3.22 on the 1964 rate.

Infant Mortality

Deaths of infants in the first year of life numbered 126 representing a rate of 14.9 per 1,000 live births. This figure is identical to that for 1964.

Causes of Death

	1965	1964
Diseases of heart and circulatory system	3,414	3,107
Cancer and other malignant diseases	1,520	1,499
Vascular lesions of nervous system	1,307	1,270
Diseases of respiratory system (excluding tuberculosis)	691	770
Accidents, suicides, etc.	288	291
Diseases of stomach and digestive system	105	114
Diseases of genito and urinary system	105	80
Tuberculosis	25	35
Other infectious diseases	28	31
Maternal deaths	2	1
All other causes	716	700
Total deaths	8,201	7,898

Principal Causes of Death

The main causes of death remained, in descending order, as in recent years. It is interesting to note the increase in the number of deaths from cancer and the reduction in the number of deaths due to diseases of the heart and circulatory system and vascular lesions of the nervous system. These are the three major causes of death.

The relative contributions of the diseases, which accounted for 88.04% of the total mortality, is indicated below.

Percentage Contribution of Total Causes

Main Causes	1960	1961	1962	1963	1964	1965
Malignant Neoplasms	17.58	17.22	17.97	17.06	18.98	18.53
Vascular Lesions of Nervous System	15.79	15.78	16.53	16.09	16.08	15.94
Heart and Circulatory Diseases	41.39	40.88	40.32	39.57	39.34	41.63
Disease of Respiratory System	8.31	9.94	9.28	11.60	9.75	8.42
Accidents, Suicide and Violence	3.77	3.43	4.02	3.96	3.68	3.51

CAUSES OF DEATH AT DIFFERENT PERIODS OF LIFE IN THE ADMINISTRATIVE COUNTY OF DEVON 1965

Causes of Death	Sex	All ages	Under 4 weeks	4 weeks and under 1 year	1—	5—	15—	25—	35—	45—	55—	65—	75—
All Causes	M	4,090	49	30	12	10	63	31	73	206	641	1,246	1,729
	F	4,111	28	19	18	10	19	14	58	125	400	967	2,453
1. Tuberculosis—respiratory..	M	19	—	—	—	—	—	—	—	7	6	4	2
	F	1	—	—	—	—	—	—	—	—	—	—	1
2. Tuberculosis, other	M	2	—	—	—	—	—	—	—	—	—	1	1
	F	3	—	—	—	—	—	—	1	1	—	—	1
3. Syphilitic disease	M	10	—	—	—	—	—	—	—	—	2	4	4
	F	3	—	—	—	—	1	—	—	1	—	1	—
4. Diphtheria	M	—	—	—	—	—	—	—	—	—	—	—	—
	F	—	—	—	—	—	—	—	—	—	—	—	—
5. Whooping Cough	M	—	—	—	—	—	—	—	—	—	—	—	—
	F	—	—	—	—	—	—	—	—	—	—	—	—
6. Meningococcal infections	M	—	—	—	—	—	—	—	—	—	—	—	—
	F	—	—	—	—	—	—	—	—	—	—	—	—
7. Acute poliomyelitis	M	—	—	—	—	—	—	—	—	—	—	—	—
	F	—	—	—	—	—	—	—	—	—	—	—	—
8. Measles	M	1	—	1	—	—	—	—	—	—	—	—	—
	F	1	—	—	—	1	—	—	—	—	—	—	—
9. Other infective and parasitic diseases ..	M	7	—	1	—	1	—	—	—	2	—	1	2
	F	6	—	—	—	—	—	—	—	—	2	2	2
10. Malignant neoplasm, stomach	M	109	—	—	—	—	1	—	—	8	21	45	34
	F	70	—	—	—	—	—	—	1	3	11	19	36
11. Malignant neoplasm, lung, bronchus ..	M	247	—	—	—	—	—	1	7	22	85	99	33
	F	55	—	—	—	—	—	—	3	8	15	16	13
12. Malignant neoplasm, breast	M	1	—	—	—	—	—	—	—	—	—	—	1
	F	144	—	—	—	—	—	—	6	21	40	36	41
13. Malignant neoplasm, uterus	M	—	—	—	—	—	—	—	—	—	—	—	—
	F	54	—	—	—	—	—	—	3	10	17	13	11
14. Other malignant and lymphatic neoplasms	M	428	—	—	—	1	5	4	9	22	73	155	159
	F	377	—	—	—	2	3	1	10	28	70	119	144

15.	Leukaemia, Aleukaemia	M	15	—	—	1	—	2	3	1	—	3	1	4
		F	20	—	—	1	—	1	1	2	2	4	4	5
16.	Diabetes	M	21	—	—	—	—	—	—	—	1	—	13	7
		F	19	—	—	—	—	—	—	1	—	—	4	14
17.	Vascular lesions of nervous system ..	M	484	—	—	—	—	—	3	2	9	61	139	280
		F	823	—	—	—	—	—	1	6	9	60	194	553
18.	Coronary disease, angina	M	1035	—	—	—	—	—	1	21	64	229	359	361
		F	635	—	—	—	—	—	—	2	8	61	224	340
19.	Hypertension with heart disease ..	M	48	—	—	—	—	—	—	1	1	10	16	20
		F	87	—	—	—	—	—	—	—	2	6	18	61
20.	Other heart disease	M	461	—	—	—	—	1	1	1	14	31	98	315
		F	740	—	1	—	—	1	1	3	4	23	107	600
21.	Other circulatory disease	M	214	—	—	—	—	—	—	6	9	19	62	118
		F	194	—	—	—	—	—	—	—	2	13	45	134
22.	Influenza	M	3	—	—	—	—	—	—	—	—	1	—	2
		F	1	—	—	—	—	—	—	—	—	—	—	1
23.	Pneumonia	M	171	4	9	1	—	1	1	—	6	8	31	110
		F	190	2	4	2	—	—	—	1	2	20	34	125
24.	Bronchitis	M	195	—	1	1	—	—	—	—	6	32	88	67
		F	54	—	—	1	1	—	—	—	1	4	16	31
25.	Other diseases of respiratory system ..	M	45	—	—	—	1	—	—	1	3	9	18	13
		F	32	—	—	3	—	—	—	1	1	4	5	18
26.	Ulcer of stomach and duodenum ..	M	42	—	—	—	—	—	—	1	—	3	21	17
		F	25	—	—	—	—	—	—	—	—	3	3	19
27.	Gastritis, enteritis and diarrhoea ..	M	12	—	—	—	—	—	—	3	—	1	2	6
		F	26	—	1	—	—	—	—	—	1	1	8	15
28.	Nephritis and nephrosis	M	31	—	—	—	—	3	1	3	5	3	7	9
		F	26	—	—	—	—	—	1	2	—	3	4	16
29.	Hyperplasia of prostate	M	48	—	—	—	—	—	—	—	—	3	13	32
30.	Pregnancy, child birth, abortion ..	F	2	—	—	—	—	1	1	—	—	—	—	—
31.	Congenital malformations	M	29	11	11	1	2	—	—	1	1	—	1	1
		F	23	4	7	5	1	1	—	1	1	1	—	2
32.	Other defined and ill-defined diseases ..	M	255	32	3	1	2	9	5	4	10	29	53	107
		F	369	21	2	2	2	2	4	9	11	25	76	215
33.	Motor Vehicle Accidents	M	51	—	—	2	—	28	9	4	1	3	2	2
		F	33	—	1	2	2	8	1	1	—	7	7	4
34.	All other accidents	M	69	2	4	5	2	11	1	5	9	9	5	16
		F	73	—	3	2	1	—	1	1	2	4	8	51
35.	Suicide	M	35	—	—	—	—	2	1	3	6	9	8	6
		F	24	—	—	—	—	1	2	4	7	6	4	—
36.	Homicide and Operations of War ..	M	2	—	—	—	1	—	—	—	—	1	—	—
		F	1	1	—	—	—	—	—	—	—	—	—	—

Tuberculosis

Deaths From Tuberculosis

Classification	Age Group																Total		Grand Total
	0—		1—		5—		15—		25—		45—		65—		75—				
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
Respiratory	—	—	—	—	—	—	—	—	—	—	13	—	4	—	2	1	19	1	20
Non-Respiratory	—	—	—	—	—	—	—	—	—	1	—	1	1	—	1	1	2	3	5
Totals	—	—	—	—	—	—	—	—	—	1	13	1	5	—	3	2	21	4	25

There were four fewer deaths than in the preceding year. It is imperative that all preventive measures shall continue to be applied diligently, with the ultimate goal of complete eradication.

Infective and Parasitic Diseases (excluding tuberculosis)

There were 28 deaths in this group and once again diphtheria and poliomyelitis are conspicuous by their absence. This is due mainly to the acceptance by a large number of the population of immunisation.

Cancer

The total, including leukaemia, numbered 1,520 a higher figure than last year. Lung cancer deaths remain a particular cause of concern since all the available evidence points indisputably to cigarette smoking as the most important single factor in the causation of this disease.

The following table shows the relative contribution to mortality from the separately classified sites and indicates the greatest increase in the male lung and bronchus.

CANCER DEATHS

Year		Stomach	Lung, Bronchus	Breast	Uterus	Other Malignant and Lymphatic Neoplasms	Leukaemia, Aleukaemia	Total all sites
1960	M.	102	192	2	—	348	18	662
	F.	92	44	141	61	332	26	696
	T.	194	236	143	61	680	44	1,358
1961	M.	104	198	1	—	358	21	682
	F.	92	37	123	47	341	22	662
	T.	196	235	124	47	699	43	1,344
1962	M.	103	205	1	—	383	28	720
	F.	85	53	139	59	353	20	709
	T.	188	258	140	59	736	48	1,429
1963	M.	94	241	—	—	411	25	771
	F.	79	51	137	45	341	17	670
	T.	173	292	137	45	752	42	1,441
1964	M.	102	228	1	—	389	22	742
	F.	89	60	134	75	373	26	757
	T.	191	288	135	75	762	48	1,499
1965	M.	109	247	1	—	428	15	800
	F.	70	55	144	54	377	20	720
	T.	179	302	145	54	805	35	1,520

VASCULAR LESIONS OF THE NERVOUS SYSTEM

Assigned to this group were 1,307 deaths.

HEART AND CIRCULATORY DISEASES

Causing 3,414 deaths, this group carries year by year the highest mortality and accounts for approximately 42% of the total causes.

HEART AND OTHER CIRCULATORY DISEASE DEATHS

Year	Coronary disease, angina		Hypertension with heart disease		Other heart disease		Other circulatory disease		Total	
	No. of Deaths	Death Rate	No. of Deaths	Death Rate	No. of Deaths	Death Rate	No. of Deaths	Death Rate	No. of Deaths	Death Rate
1960	1,351	2.00	192	0.28	1,288	1.90	366	0.54	3,197	4.73
1961	1,333	1.99	180	0.27	1,282	1.91	395	0.59	3,190	4.76
1962	1,392	2.05	157	0.23	1.279	1.88	379	0.56	3.207	4.72
1963	1,569	2.17	180	0.25	1,254	1.73	339	0.47	3,342	4.61
1964	1,477	1.94	137	0.18	1,161	1.52	332	0.44	3,107	4.08
1965	1,670	1.83	135	0.17	1,201	1.49	408	0.50	3,414	4.24

DEATHS FROM ACCIDENTS, VIOLENT CAUSES, ETC.

The total number of deaths over the past six years has tended to fluctuate but this year's figure is the highest, due largely to an increase in fatal home accidents which make up the bulk of those classified as "all other accidents".

Year	Motor Vehicle Accidents	All other Accidents	Suicide	Homicide and Operations of War	Total Accidents, Suicide, Homicide
1960	64	150	74	3	291
1961	62	142	62	2	268
1962	56	175	79	10	320
1963	63	193	75	3	334
1964	70	141	75	5	291
1965	84	142	59	3	288

Fatalities on the road increased during 1965. Suicides were fewer.

DISEASES OF THE RESPIRATORY SYSTEM (excluding Tuberculosis and Lung Cancer) :

The 691 deaths assigned to this group excluded those due to bronchitis, pneumonia, and influenza, and involved chiefly the older age groups.

The national death-rate in what is widely known as the "English disease" remains among the highest in Europe. Much could be done to effect control, as smoking and air pollution are contributory factors.

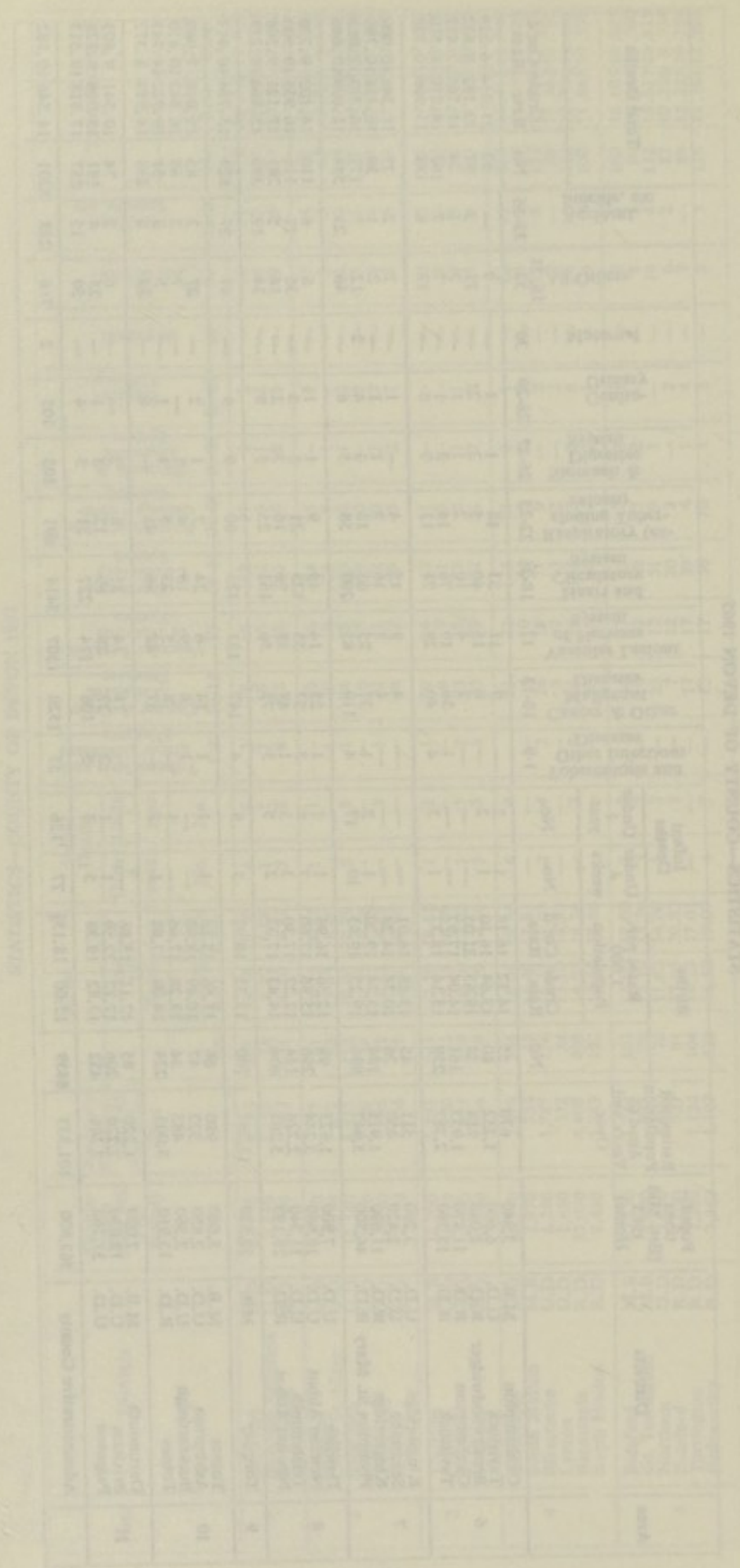
Suicides

		Totals	15-24	25-34	35-44	45-54	55-64	65-74	75 Plus	Incidence rate (Per 1,000 pop.)
Rural districts	M	22	2	—	—	6	6	7	1	
	F	6	—	1	2	2	—	1	—	
(pop. 278,230) Total		28	2	1	2	8	6	8	1	0.101
Urban districts	M	13	—	1	3	—	3	1	5	
	F	18	1	1	2	5	6	3	—	
(Pop. 285,570) Total		31	1	2	5	5	9	4	5	0.108
Admin. County Rural & urban districts (Pop. 563,800)	M	35	2	1	3	6	9	8	6	
	F	24	1	2	4	7	6	4	—	
Total		59	3	3	7	13	15	12	6	0.105

Area	Districts		Population (Est. Mid 1965 Home)	Estimated Population Aged 65 Years and Over	Births			Infant Deaths		Tuberculosis and Other Infectious Diseases	Cancer & Other Malignant Diseases	Vascular Lesions of Nervous System	Heart and Circulatory System	Respiratory (excluding Tuberculosis)	Stomach & Digestive System	Genito-Urinary	Maternal	All Others	Accident, Suicide, etc	Total Deaths		
						Rates per 1,000 Population		Under 4 weeks	Under 1 year													
					No.	Crude Rate	Cor'd Rate	No.	No.	1-9	10-15	17	18-21	22-25	26-27	28-29	30	16, 31 32	33-36	No	Crude Rate	Cor'd Rate
1	Exmouth	U.D.	21,190	4,783	303	14.30	18.30	4	7	2	78	68	162	37	4	2	—	46	11	410	19.349	11.029
	Budleigh Salterton	U.D.	3,810	1,159	34	8.92	16.06	1	1	2	19	15	42	9	1	2	—	8	3	101	26.509	12.724
	St. Thomas	R.D.	38,740	5,683	651	16.80	18.82	5	7	4	95	66	215	46	8	3	—	50	26	513	13.242	9.402
2	Honiton	M.B.	4,320	577	81	18.75	20.25	1	1	—	10	16	25	5	—	1	—	7	4	68	15.741	8.028
	Ottery St. Mary	U.D.	4,690	822	63	13.43	18.40	—	—	1	10	10	26	9	1	—	—	3	5	65	13.859	9.147
	Sidmouth	U.D.	11,140	3,813	112	10.05	17.79	3	3	1	34	35	103	20	1	2	—	12	6	214	19.210	7.876
	Seaton	U.D.	3,610	1 029	38	10.53	15.06	—	—	—	16	15	29	3	—	2	—	5	1	71	19.667	9.440
	Axminster	R.D.	14,970	2,695	171	11.42	14.85	—	3	1	42	31	62	10	2	3	—	8	4	163	10.888	8.166
	Honiton	R.D.	7,120	1,054	121	16.99	19.88	—	—	—	16	12	29	5	2	1	—	8	6	79	11.095	10.319
3	Tiverton	M.B.	13,700	1,893	241	17.59	18.65	1	1	1	29	34	42	11	—	—	—	10	5	132	9.635	7.130
	Crediton	U.D.	4,810	750	73	15.18	16.09	—	—	—	9	7	31	13	—	—	—	4	3	67	13.929	12.675
	Crediton	R.D.	9,800	1,417	149	15.20	17.02	3	5	2	23	18	33	8	1	1	—	9	3	98	10.000	9.400
	Tiverton	R.D.	20,840	3,034	329	15.79	17.84	5	5	3	35	39	102	21	7	2	—	25	9	243	11.660	10.377
4	Barnstaple	M.B.	16,330	2,498	295	18.06	18.96	4	9	—	53	22	135	21	2	1	—	22	13	269	16.473	12.849
	South Molton	M.B.	2,970	554	43	14.48	17.81	—	—	—	4	10	30	10	2	1	—	9	1	67	22.559	11.505
	Ilfracombe	U.D.	8,280	1,787	136	16.43	21.03	2	4	2	26	18	77	9	—	2	—	12	6	152	18.357	11.750
	Lynton	U.D.	1,680	332	24	13.10	14.93	—	—	—	3	7	13	2	—	2	—	2	—	29	17.262	10.702
	Barnstaple	R.D.	27,090	4,408	405	14.95	18.24	—	2	2	61	54	155	23	5	8	—	26	12	346	12.796	10.493
	South Molton	R.D.	8,430	1,249	132	15.66	18.66	—	—	—	25	16	40	7	2	1	—	6	3	100	11.862	10.558
5	Bideford	M.B.	10,830	1.712	163	15.05	17.00	2	2	1	36	27	82	13	3	1	—	5	1	169	15.605	10.923
	Gt. Torrington	M.B.	2,880	497	38	13.19	15.70	3	3	—	10	12	22	7	2	—	—	6	1	60	20.833	12.500
	Northam	U.D.	7,080	1,400	78	11.02	14.00	1	2	—	25	12	51	9	1	—	—	10	4	112	15.819	10.915
	Bideford	R.D.	5,070	707	91	17.95	20.82	—	1	—	7	12	20	3	—	2	—	6	2	52	10.256	9.734
	Torrington	R.D.	7,280	1,124	104	14.29	17.01	—	—	—	17	17	39	4	1	4	—	7	—	89	12.225	10.758
	Holsworthy	R.D.	7,360	1,107	122	16.58	19.07	4	7	—	15	17	56	10	1	3	—	9	5	116	15.761	12.293

STATISTICS—COUNTY OF DEVON 1965

Area	Districts		Populations (Est. Mid 1965 Home)	Estimated Population Aged 65 Years and Over	Births			Infant Deaths		Tuberculosis and Other Infectious Diseases	Cancer & Other Malignant Diseases	Vascular Lesions of Nervous System	Heart and Circulatory System	Respiratory (excluding Tuberculosis)	Stomach & Digestive System	Genito-Urinary	Maternal	All Others	Accident, Suicide, etc	Total Deaths		
						Rates per 1,000 Population		Under 4 weeks	Under 1 year													
					No.	Crude Rate	Cor'd Rate	No.	No.	1-9	10-15	17	18-21	22-25	26-27	28-29	30	16, 31 32	33-36	No	Crude Rate	Cor'd Rate
6	Okehampton	M.B.	3,840	670	55	14.32	16.18	1	2	—	9	11	33	18	1	3	—	7	—	82	21.354	16.229
	Tavistock	U.D.	6,600	1,252	80	13.64	16.10	1	2	—	8	15	40	5	3	2	—	11	3	87	13.182	8.832
	Broadwoodwidger	R.D.	2,040	214	38	18.63	21.05	—	—	—	2	4	10	2	1	1	—	3	1	24	11.765	13.412
	Okehampton	R.D.	11,470	1,953	161	14.04	17.97	—	—	1	36	19	76	14	2	1	—	7	7	163	14.210	11.510
	Tavistock	R.D.	15,790	2,387	239	15.14	18.77	1	3	4	40	29	71	13	7	5	—	13	6	188	11.906	10.358
7	Kingsbridge	U.D.	3,290	511	45	13.68	16.01	—	—	—	4	9	15	4	—	1	—	2	2	37	11.246	10.009
	Salcombe	U.D.	2,420	458	26	10.74	14.28	—	—	—	4	7	16	7	1	1	—	2	1	39	16.116	10.798
	Kingsbridge	R.D.	11,690	1,911	184	15.74	19.20	1	2	1	37	25	65	16	3	4	2	12	7	172	14.713	12.065
	Plympton St. Mary	R.D.	46,500	5,947	896	19.27	19.85	10	17	4	110	85	207	58	5	6	—	46	23	544	11.699	10.646
8	Dawlish	U.D.	7,800	1,623	98	12.56	16.96	1	1	1	25	14	45	9	1	1	—	8	6	110	14.102	9.730
	Newton Abbot	U.D.	18,660	3,244	296	15.86	17.60	7	8	3	57	55	125	21	5	3	—	35	12	316	16.935	10.500
	Teignmouth	U.D.	11,740	2,724	144	12.27	17.30	3	3	1	47	37	76	16	3	2	—	14	5	201	17.121	9.588
	Newton Abbot	R.D.	28,130	5,263	406	14.43	17.32	2	5	3	75	56	165	25	5	8	—	34	19	390	13.864	10.259
9	Torquay	MB.	52,520	11,281	700	13.33	16.93	3	8	4	147	133	373	60	9	9	—	67	27	829	15.784	10.417
10	Totnes	M.B.	5,660	980	66	11.66	13.88	1	1	1	14	6	24	7	1	2	—	27	3	85	15.018	7.960
	Ashburton	U.D.	2,850	522	47	16.49	18.96	—	—	1	8	9	16	4	1	—	—	7	2	48	16.842	10.610
	Buckfastleigh	U.D.	2,560	482	34	13.28	17.66	—	1	—	8	5	23	5	1	1	—	5	3	51	19.922	14.743
	Totnes	R.D.	15,910	3,003	224	14.08	17.88	1	2	—	37	42	86	41	—	6	—	20	6	238	14.959	8.377
11	Dartmouth	M.B.	7,020	1,220	85	12.11	15.86	—	—	—	11	14	31	8	2	—	—	6	2	74	10.541	9.803
	Brixham	U.D.	12,030	2,220	206	17.12	22.59	1	1	2	37	28	69	12	3	1	—	25	4	181	15.046	9.328
	Paignton	U.D.	31,260	7,384	432	13.82	18.38	5	7	5	106	114	227	31	5	4	—	50	15	557	17.818	10.513
	Administrative County		563,800	101,333	8459	15.00	18.15	77	126	53	1520	1307	3414	691	105	105	2	716	288	8201	14.546	10.182



PART II

DISTRICT MEDICAL OFFICERS OF HEALTH

DISTRICT MEDICAL OFFICERS OF HEALTH

Area	District Councils		District Medical Officers of Health
1	Budleigh Salterton	U.D.	L. G. Anderson, M.D., D.P.H. ("mixed" appointment)
	Exmouth	U.D.	
	St. Thomas	R.D.	
2	Ottery St. Mary	U.D.	R. C. MacLeod, M.D., D.P.H., D.T.M., & H. ("mixed" appointment)
	Sidmouth	U.D.	
	Honiton	M.B.	
	Seaton	U.D.	
	Axminster	R.D.	
	Honiton	R.D.	
3	Crediton	U.D.	N.F. Sawers, M.B., Ch.B.
	Crediton	R.D.	L. N. Jackson, B.A., D.M.
	Tiverton	M.B.	G. Nicholson, M.D., D.P.H., F.R.C.S. (combined appointment)
	Tiverton	R.D.	
4	Barnstaple	M.B.	E. Williams, M.R.C.S., L.R.C.P., D.P.H. ("mixed" appointment)
	Barnstaple	R.D.	
	South Molton	M.B.	
	South Molton	R.D.	
	Ilfracombe	U.D.	A. H. Morley, O.B.E., M.B., Ch. B., F.R.C.S., D.P.H. (retired 31.12.65)
	Lynton	U.D.	M. P. Nightingale, M.R.C.S., L.R.C.P.
5	Gt. Torrington	M.B.	C. F. R. Briggs, M.B., B.S., M.R.C.S., L.R.C.P.
	Bideford	R.D.	N. B. Betts, M.B., B.CHIR., F.R.C.S., L.R.C.P.
	Torrington	R.D.	H. MervynThomas, M.B., Ch.B., D.P.H., D.C.H. ("mixed" appointment) (resigned 30.4.65)
	Northam	U.D.	
	Bideford	M.B.	
	Holsworthy	R.D.	
6	Okehampton	M.B.	E. D. Allen-Price, M.D., D.P.H. (combined appointment)
	Tavistock	U.D.	
	Broadwoodwidger	R.D.	
	Okehampton	R.D.	
	Tavistock	R.D.	
7	Salcombe	U.D.	R. B. Walker, M.R.C.S., L.R.C.P., D.P.H. ("mixed" appointment)
	Kingsbridge	U.D.	
	Kingsbridge	R.D.	
	Plympton St. Mary	R.D.	
8	Dawlish	U.D.	H. M. Davies, M.A., M.R.C.S., L.R.C.P., D.P.H. ("mixed" appointment)
	Newton Abbot	U.D.	
	Teignmouth	U.D.	
	Newton Abbot	R.D.	
9	Torquay	M.B.	D. K. MacTaggart, M.A., M.B., Ch.B., D.P.H. ("mixed" appointment)
10	Totnes	M.B.	M. McQuaid, L.R.C.P. & S.I., D.P.H. ("mixed" appointment)
	Ashburton	U.D.	
	Buckfastleigh	U.D.	
	Totnes	R.D.	
11	Dartmouth	M.B.	J. H. Wildman, M.R.C.S., L.R.C.P., D.P.H. ("mixed" appointment)
	Brixham	U.D.	
	Paignton	U.D.	

DISTRICT MEDICAL OFFICERS OF HEALTH

In the greater part of Devon the district medical officer of health holds a "mixed" appointment. The effect of this is that the medical officer spends a proportion of his time, varying from 40% to 80%, undertaking public health duties for one or more district councils. The remaining proportion of his time is spent in duties for the county council which are mainly connected with the school health and child welfare services. With the mixed type of appointment a most valuable link is forged between the district medical officer of health and the county health department.

In two areas "combined" appointments were established several years ago In this type of appointment the district medical officer is responsible solely for the work of his district councils, and officially takes no part in the work of the county council. It should however be added that both the medical officers of health concerned take an interest in the work of the health department and have been most helpful in arranging and attending meetings with general practitioners in their areas when health centres and other county council services have been discussed.

The medical officer of health of six district councils is also a general practitioner practising in the area. Ilfracombe and Lynton are two such areas and in each of these towns plans are well advanced for the provision of a health centre.

Following the resignation of Dr. H. Mervyn Thomas discussions were commenced with representatives of all the district councils in areas 4 and 5, except those covered by general practitioner medical officers of health. By the end of the year agreement in principle was reached whereby Dr. Williams, based at Barnstaple, would become the medical officer of health, a "mixed" appointment for the whole area, and that a deputy would be appointed from one of the assistant county medical officers.

Later in the year, with the announcement of Dr. Morley's retirement, Ilfracombe were invited to participate in this scheme.

If final agreement is reached the population of this new area will be 95,900.

PART III

EPIDEMIOLOGY

Notification of Infectious Disease

Vaccination and Immunisation

TUBERCULOSIS

EPIDEMIOLOGY

Incidence and Notification of Infectious Disease

This table affords a comparison with the preceding five years :

	Number of corrected notifications					
	1960	1961	1962	1963	1964	1965
Measles	2,441	6,448	2,664	6,085	2,679	5,863
Whooping Cough ..	233	592	68	197	322	89
Diphtheria	—	1	—	—	1	—
Poliomyelitis ..	6	—	—	—	—	—
Scarlet Fever	289	121	99	152	142	145
Erysipelas	43	23	22	19	24	25
Pneumonia	171	198	127	178	121	81
Meningitis	—	2	1	6	8	4
Tuberculosis	181	158	156	117	110	131
Typhoid or paratyphoid	1	4	2	1	3	—
Dysentery	71	31	419	167	70	52
Food Poisoning ..	76	33	19	36	87	26
Ophthalmia Neonatorum	5	4	3	1	2	—
Puerperal Pyrexia ..	8	4	11	7	10	8

For the fourth year in succession, no cases of poliomyelitis were notified in Devon and, again, this is considered to be largely due to the successful vaccination campaign.

There was no notification of diphtheria.

Although there were fewer cases of dysentery again this year, this with the 26 cases of food poisoning shows an obvious need for more personal hygiene education, particularly of those handling food.

Venereal Diseases

	New Cases Treated					
	1960	1961	1962	1963	1964	1965
Syphilis	13	7	6	4	18	14
Gonorrhoea	50	38	49	50	106	102
Other conditions ..	187	220	300	306	279	374

Venereal diseases are not notifiable and the figures shown above are only in respect of cases treated at the special centres. It is obvious that these figures are an unknown fraction of the total cases of venereal disease occurring in this area.

Vaccination and Immunisation

DIPHTHERIA, WHOOPING COUGH AND TETANUS (Combined Immunisation)

The use of combined prophylactics involves fewer injections and is thus more acceptable to parents and infants, and there is a greater probability of a course being completed. Three injections are recommended; the first after two months but before six months, and the second a month afterwards and the third a month after the second dose. A booster dose is offered at approximately

eighteen months. Supplies of the vaccine can be obtained by doctors from the county health department together with the necessary record cards. Supplies of separate diphtheria, whooping cough or tetanus prophylactics are also available should these be required.

Diphtheria Immunisation (including combined immunisation)

The number of children who received immunisation since 1948 is shown in the following table :

Year	No. of children who completed a full course of immunisation			No. of children who were given a reinforcing injection
	Under 5	5-14	Total	
1948	2,379	209	2,388	1,030
1949	5,787	1,015	6,802	9,133
1950	4,460	572	5,032	5,288
1951	5,206	582	5,788	7,345
1952	4,838	574	5,412	8,798
1953	4,554	833	5,387	9,243
1954	4,865	959	5,824	8,329
1955	4,535	844	5,379	8,602
1956	4,914	690	5,604	7,564
1957	4,590	694	5,284	6,144
1958	4,058	473	4,531	4,048
1959	6,490	646	7,136	3,839
1960	5,799	561	6,360	4,247
1961	5,782	824	6,606	3,708
1962	6,394	1,107	7,501	3,866
1963	6,847	946	7,793	4,197
1964	6,857	703	7,560	6,883

	Under 1	1	2	3	4–7	Others under age 16	Totals	Booster
1965	2810	3085–	522	206	509	310	7442	7,500

Whooping Cough (including combined immunisation)

The number of children protected against whooping cough during 1965 is as follows :

	Year of Birth					Others under age 16	Total	Booster
	1965	1964	1963	1962	1958-61			
A.C.M.O's.	1332	175	45	15	46	11	1624	914
G.P's. ..	1464	2874	468	188	173	66	5233	1907
Total ..	2796	3049	513	203	219	77	6857	2821

Tetanus

Older children who did not have the opportunity to receive tetanus immunisation in infancy, have in some areas been offered a full course of 3 injections. This involves a great deal of extra work for the medical officers concerned, but is very worth while.

Tetanus (including combined immunisation)

	Year of Birth					Others under age 16	Total	Booster
	1965	1964	1963	1962	1958-61			
A.C.M.O's.	1346	187	50	16	343	1293	3235	4662
G.P's ..	1475	2902	481	198	238	1438	6732	3455
Total ..	2821	3089	531	214	581	2731	9967	8117

Poliomyelitis

Vaccination against poliomyelitis is now offered to all persons who have not at the time of their application for vaccination reached the age of forty, and also to special groups of personnel and their families who may come into contact with poliomyelitis cases. Oral vaccine is used but salk vaccine can be made available if required. Persons going to visit or reside in a country outside Europe other than Canada or the United States of America may also receive vaccination against polio.

In the autumn of 1965 the Ministry of Health gave permission for routine poliomyelitis vaccine to be administered at the same time as the "triple" immunisation and most medical officers have taken advantage of this. It reduces the number of the visits of the child to the clinic for these procedures by 3, and mothers much appreciate this. However, it means that the polio vaccination is commenced at an earlier age than before and the baby's response to the vaccination may be slightly less effective. To compensate for this possible deficiency, a booster poliomyelitis vaccination dose is therefore offered at eighteen months, as well as on school entry, in order to ensure a satisfactory response.

Salk Poliomyelitis Vaccinations

	Year of Birth					Others under age 16	Total	Booster
	1965	1964	1963	1962	1958-61			
A.C.M.O's.	37	49	12	4	2	38	142	325
G.P's ..	100	328	193	32	83	140	876	314
Total ..	137	377	205	36	85	178	1018	639

Sabin (Oral)

	Year of Birth					Other under age 16	Total	Booster
	1965	1964	1963	1962	1958-61			
A.C.M.O's.	1126	279	91	37	225	113	1871	2620
G.P's. ..	649	2807	637	283	270	513	5159	2493
Total ..	1775	3086	728	320	495	626	7030	5113

Smallpox

Smallpox vaccination should be carried out preferably sometime during the second year of life. Supplies of lymph vaccine can be obtained from the Public Health Laboratory, Church Lane, Heavitree, Exeter (tel. 77833). Record cards obtainable from the county health department, are completed by the doctors and returned to the county medical officer in respect of each vaccination carried out.

International certificates of vaccination (issued by the Ministry of Health), required before visitors are admitted to certain overseas countries, are submitted to the local district medical officer of health for the purpose of authenticating the doctor's signature.

The following table shows the number of vaccinations and re-vaccinations performed during the last five years.

	VACCINATIONS						RE-VACCINATIONS					
Year	Under 1	1	2-4	5-14	15 or over	Total	Under 1	1	2-4	5-14	15 or over	Total
1961	2105	2104	447	225	440	5321	20	13	88	325	1299	1745
1962	1839	3277	2339	8400	15404	31259	—	99	689	9380	32093	42261
1963	526	1430	348	389	791	3484	16	28	106	557	2180	2887
1964	463	2232	1012	106	363	4176	6	36	99	345	1672	2158
Year	Under 1	1	2-4	5-15	Total		Under 1	1	2.4	5-15	Total	
1965	42	2013	1761	223	4039		15	10	156	528	709	

Record Cards

Special personal record cards are issued to mothers attending welfare centres, and supplies are available to general practitioners on request. The importance of having these cards completed after each injection is stressed to the parents, who are also advised to produce it whenever a child attends a doctor or hospital following an accident. If the doctor has evidence of a satisfactory primary course of tetanus immunisation he will be able, under such circumstances, to give a booster dose of tetanus toxoid rather than A.T.S., and thus avoid the danger of serum sensitization.

Prophylactics can be obtained as follows:

Vaccine	*Centre*
Triple prophylactic Diph./Tetanus prophylactic T.A.F. Whooping cough Tetanus Oral polio vaccine Salk Polio Vaccine (if required)	County Health Department, County Hall, Topsham Road, Exeter (Tel. 77977, ext. 514) or *in small quantities* direct from Barnstaple—The Clinic, 19b, Alexandra Road (Tel. 3548)—Dr. Williams. Bideford — The Clinic, Coronation Road (Tel. 3163) — Dr. Candler. Brixham—The Clinic, Greenswood Road (Tel. 3374) — Dr. J. MacTaggart. Crediton—The Clinic, "Newcombes" (Tel. 2649)—Dr. Tait. Dartmouth—New Centre, Mayor's Avenue (Tel. 2845)—Dr. J. MacTaggart. Exmouth—The Clinic, 89 Withycombe Road (Tel. 2610) — Dr. Anderson. Honiton—Municipal Offices, New Street (Tel. 391) — Dr. MacLeod. Ilfracombe—The Clinic, 4 Market Street (Tel. 758)—Dr. Dunn. Kingsbridge—The Clinic, "Tresillian", Fore Street (Tel. 2606) —Dr. Browning. Newton Abbot—The Clinic, 21, Courtenay Park (Tel. 2445)—Dr. Davies. Paignton—The Clinic, 14 Midvale Road (Tel. 59131)—Dr. Wildman. Plympton—Council Offices (Tel. Plymouth 36644)—Dr. Walker. Plymstock—The Clinic, Horn Cross Road (Tel. Plymouth 42677)—Dr. Browning. Tavistock—The Clinic, Crowndale Road (Tel. 2617) — Dr. Budding. Tiverton—The Clinic, Rock Close, St. Andrew's Street (Tel. 3341)—Dr. Tait. Torquay—The Clinic, 15 Castle Road (Tel. 27963)—Dr. Solomon. Torquay—Health Dept., St. Marychurch Town Hall (Tel. 38204) —Dr. D. MacTaggart.
Smallpox Vaccine	Public Health Laboratory, Church Lane, Heavitree, Exeter (Tel. 77833).

B.C.G. (Anti-Tuberculosis)

Vaccination is undertaken by the chest physicians for infants and young children exposed to infection from a known case of tuberculosis. B.C.G. vaccination is offered to school children of over eleven years of age, and also young adults attending colleges, technical schools, etc. Parents have the opportunity of giving their consent to this procedure and the vaccination is carried out by specially trained medical officers.

	School Children	Students Attending Further Education Establishments
No. of Children on Roll	5,610	—
No. of children for whom parental consent received	5,041	15
No. tuberculin tested (Heaf tested 2 mm. puncture)	4,888	14
No. positive	623	8
No. negative	4,265	6
No. given freeze-dried B.C.G. vaccine	4,137	6

TUBERCULOSIS

This year 131 cases were notified, a rise of 21 over the 1964 figure. Until this year there has been a slow but steady fall in the number of new cases.

Age	Pulmonary		Non-Pulmonary		All forms T.B.		Totals				
	M	F	M	F	M	F	1965	1964	1963	1962	1961
Under 5	2	1	1	0	3	1	4	2	4	2	3
5—14	5	5	1	0	6	5	11	9	7	9	13
15—24	6	9	2	2	8	11	19	14	14	16	22
25—34	8	5	2	4	10	9	19	14	14	30	24
35—44	7	6	2	4	9	10	19	20	21	24	23
45—54	13	5	2	2	15	7	22	15	26	25	18
55—64	11	2	2	2	30	4	17	12	18	24	24
65+	6	5	4	4	10	9	19	23	13	25	31
Unknown	—	—	—	1	—	1	1	1	—	1	—
Totals	58	38	16	19	74	57	131	110	117	156	158
	96		35*		131						

*Includes 11 cases of T.B. glands, 3 abdominal, 10 genito-urinary system, 3 bones and joints, and 8 others.

Detection

How Picked Up	Pulmonary	Non-Pulmonary	Total
G.P. to Chest Clinic	41	6	47
G.P. to Mass X-Ray ..	6	—	6
Contacts of known cases ..	2	—	2
Hospitals	26	25	51
Public Sessions Mass X-Ray	10	—	10
Tests	8	—	8
No information available ..	3	4	7
Totals	96	35	131

Contacts

Contacts examined		No. of cases of T.B. found
Household — Spouse	42	0
Household — Children	86	8
Household — Other adults in the same house ..	56	1
Total household:	184	9
Neighbours, friends or relatives not living in household	124	4
Contacts at work, in school or elsewhere	9	0

Every case of tuberculosis must have a source and every contact runs a higher risk than the general population of either contracting tuberculosis or being its source. This is illustrated in the above table, which shows that the rate for tuberculosis contacts is almost 40 per 1,000.

Treatment

Chest Clinics. The work of the four chest clinics is summarised in the table below:

	Torquay	Barnstaple	Exeter	Plymouth	Total
Patients on Register 1.1.65 ..	849	510	1,346	364	3,069
New Notifications:					
(a) respiratory	37	17	35	17	106
(b) non-respiratory	9	6	14	1	30
Deaths	17	5	8	2	32
Patients on Register 31.12.65	699	469	1,349	366	2,883
First examination of suspects	967	142	940	1,166	3,215
Cases of T.B. found ..	50	20	25	16	111
Contacts examined ..	423	118	220	193	954
Cases of T.B. found in contacts	2	1	5	—	8
Contacts vaccinated with B.C.G.	96	66	164	64	390

Dr. Wyndham Lloyd (Torquay) states that this year the downward trend in the number of new cases of tuberculosis has not been continued. There were 50 new cases—41 of them pulmonary—compared with 39 in 1964 and 46 in 1963. All these figures compare very favourably with those of ten or fifteen years ago: but so long as forty or fifty new cases come to light each year, there can be no room for complacency.

The number of deaths of tuberculous patients on the register was 17, the lowest ever recorded: and of these it is fair to say that only two died directly from tuberculosis (that is to say, they had active tuberculosis at the time of death). The rest died from other causes, mainly heart disease, but there were two deaths from cerebral hæmorrhage and two from lung cancer. The average age at death has again risen, from 63 years in 1964 to 66 years in 1965. The youngest dying at 48 and the oldest at 90 years. The average interval between diagnosis and death was nine years. These figures show the life-prolonging effect of treatment with modern drugs.

The total number of tuberculous patients on the register has also declined to 699, the lowest so far recorded.

There were no notable minor epidemics among children, such as occurred in this area in two previous years. Tuberculosis among immigrants has presented no problem here.

Again it has to be reported that there were as many as 1,150 failures to keep appointments at the chest clinic, compared with a total attendance of 4,403, i.e. 19% of the total clinic appointments (5,453).

Dr. Adkins (East and Central Devon area) reports on the first full year's working of the joint Devon County Council and Exeter City Council chest clinics, and the benefits of such a system. One satisfactory feature of the year is that no new cases have been added to the drug resistant register, which has now declined from 13 to 3.

Heaf Testing

This is the fourth and final year of an investigation at the request of the Ministry of Education into the returns of natural tuberculin conversion at various ages in school children, with the purpose of observing whether a pattern emerges showing the most susceptible ages. The routine Heaf testing scheme, which has been conducted in the Tiverton area, includes all of the twelve-year-old children in the county secondary and grammar schools, so that in effect all children between five and twelve years of age have been tested. A consistently high percentage of acceptances was maintained, thus ensuring that the information was securely based. A steady decline in each age group over the years 1961 to 1965 showed well that the risk of exposure to any tuberculin infection was falling in a most satisfactory manner.

SERIAL SKIN TESTING
CREDITON—TIVERTON AREA, DEVON
YEARS 1962—65

AGE GROUPS	5—6	6—7	7—8	8—9	9—10	10—11	11—12	12—13	Total
1. No. of Children Tested	1656	2422	2482	2375	2355	2822	3375	2701	20188
2. Percentage of Acceptances ..	93.1	92.0	92.5	94.2	93.8	92.4	93.4	93.6	93.1
3. (a) No. of Positive Reactors:									
Grade I ..	14	34	34	55	71	136	208	243	795
Grades II—IV ..	16	29	30	33	36	68	113	141	466
Total ..	30	63	64	88	107	204	321	379	1256
(b) Percentage of Positive Reactors	1.8	2.2	2.6	3.7	4.5	7.25	9.5	14.0	6.2

The annual routine Heaf testing of all primary school children continues to show evidence of its value in picking up cases of tuberculosis which otherwise may not have been brought to light until much later, if at all.

The figures for the school year, September 1964 to August 1965, are as follows:

	Found Positive on first testing	Converted to Positive on subsequent test	Total
Found Positive	124	325	449
Positive Children X-rayed	77	160	237
Contacts X-rayed (Adults)	107	244	351
(Children)	20	19	39
Cases picked up: Positive Children	1	3	4
Adult Contacts	—	5	5
Child Contacts	—	5	5

No. of schools tested—358. No. of children tested (all ages)—37,365.

PART IV

LOCAL HEALTH SERVICES

Care of Mothers and Young Children

Midwifery

Home Nursing

Health Visiting

Home Help Service

Health Education

Ambulance

Adult Health

MATERNAL HEALTH AND NURSING

Maternity Services

There have been many changes in the maternity services since the introduction of the National Health Service Act in 1948, at which time the Devon County Council took over the administration and staff of the domiciliary service from the Devonshire Nursing Association. The County Council continued the progressive outlook of the D.N.A. and soon all midwives were trained in the giving of analgesia and the attending of refresher courses to keep them up to date in their practice. All were encouraged to become car drivers, and telephones were supplied to improve working facilities. Today the idea of a domiciliary midwife without a car or 'phone is unthinkable.

In the county 8,412 live births were notified during the year (as adjusted for transfers in and out).

Domiciliary	2,340
Institutional	6,072
	8,412

1965 was the first year to see a halt in the rising total of births that had been the picture for the preceding nine years. There is a drop both in the crude and the corrected birth rates but the greater difference in the crude rate for 1964 and 1965 emphasises the increasing proportion of older persons in the Devon population. For the fourth year in succession early discharge from hospital is more common and now is a feature of nearly one-third of all hospital deliveries. The domiciliary midwives are undertaking willingly this extra work but some are finding themselves very pressed. There is occasional anxiety over the hospital case who insists on discharging herself against advice to an unsuitable and unprepared home. So far, however, no harm to mother or child has been observed.

Ante-natal Clinics

In 1948 there were nine county clinics staffed by medical officers and midwives. As general practitioners rapidly took an increasing interest in the care of the expectant mother, the medical sessions ceased and are now entirely superseded by health education and relaxation classes conducted by the midwives and health visitors.

During the year new classes were started at Okehampton and Teignmouth and there are now 35 clinics in which the district midwives and health visitors together give courses on health education, exercise and relaxation. About 30% of the expectant mothers in the county attend these classes, most of these expecting their first baby. Two thousand six hundred and seventy-one mothers made a total of 11,616 attendances.

It is felt that the mothers at present attending are enthusiastic and appreciate the service, but there is obviously room for improvement in the attendance figures, particularly with those expecting their second and subsequent babies. In the busier centres staff are having difficulty in finding time to duplicate the sessions to meet the demand. Health Education sessions are more time-consuming than physical examinations as there is a considerable amount of preparation of talks and visual aids before each session.

The district midwife will always advise on the availability of an ante-natal clinic and if, in a rural area, one is not near, she will give health education individually in the patient's home, whether booked for home or hospital delivery.

Dental Care of Expectant and Nursing Mothers and Young Children

There was a further increase in the number of pre-school children seen and in the amount of work done. It is again gratifying to record that about 40% of those seen did not require treatment, indicating an enlightened attitude on the part of the mothers and also that the number of fillings done per child increased whilst the number of extractions per child diminished. This year for the first time in many years there has been an increase in the number of mothers seen and treated, but a reduction in the amount of work done, particularly in the number of teeth extracted and dentures fitted. No dental officers have commented on this; but some have expressed the feeling that the very young are not so welcome in the general dental service, which might account for the steady improvement of those figures.

Mr. Derbyshire says: "Cases are still referred from the Health Visitors and Midwives, with an increase in the number of mothers who have had treatment when eligible with a previous offspring returning for another course of treatment with their next." Cdr. Pearse comments: "With practice it is possible to do more for the under-fives than was previously thought and by so doing the need for emergency extractions is reduced. Mothers with older children attending the clinic appreciate the informal introduction to dentistry given to the little ones who like the formality of sitting in the chair and being inspected like their older brothers and sisters."

		Mothers	Children
A.	Numbers provided with dental care		
	Examined	210	780
	Treatment	185	448
	Treatment completed	128	307
B.	Forms of Treatment provided		
	Scaling and/or Gum Treatment	126	27
		Mothers	Children
	Fillings	247	844
	Silver Nitrate Treatment	7	188
	Crowns or Inlays	3	–
	Extractions	124	288
	General Anaesthetics	9	103
	Dentures		
	Full Upper or Lower	8	–
	Partial Upper or Lower	14	–
	Radiographs	26	4

Family Planning

A new centre was opened at Exmouth at the end of the year and the Exeter and District Women's Welfare Association have continued to hold evening sessions at many of the centres. These are greatly appreciated by the women attending. It is to be assumed that with earlier marriage advice will be sought more frequently in the coming years.

The health visitors are able to inform married women of the times of the sessions at the nearest available centre.

Grants, or rent-free premises, are made available to all family planning clinics giving advice to Devon mothers. Appreciation should be recorded of the ready way in which women in difficult financial circumstances are seen and advised free of charge.

Full use continues to be made of the facilities available.

	New Cases	*Continuation Cases*
Exeter Women's Welfare	186	605
Plymouth District :		
Honicknowle (previously St. Budeaux) ...	5	23
Plympton	197	216
Plymouth City	115	567
Torbay :		
Paignton	222	312
Dartmouth	46	161
Newton Abbot	152	174
Exmouth (commenced December, 1965)	22	–
Launceston and Bude	44	55

Cervical Cytology

The Minister of Health has approved a county council scheme for Devon. Under this scheme smears have been taken at convenient major county clinics and the cytological investigations carried out at the laboratories of the Regional Hospital Board. The clinics are staffed by women doctors and nurses. Appointments are only made after the general approval of the family doctor has been obtained for his patients to be seen.

A good start has been made during the latter half of the year and 1104 women between the ages of 30 and 60 had attended for smears to be taken by the end of the year. Three women had positive results and have had the appropriate further treatment necessary to prevent the actual onset of cancer. As more technicians become available the service will be extended so that there will be centres throughout the county within reasonable reach of all women of the appropriate age groups.

The following table gives details of attendances at the clinics from July to December, 1965 :—

Clinic	*Attendances*	*Positive result*
Barnstaple	174	2
Exmouth	566	Nil
Ilfracombe	79	Nil
Plymstock	119	1
South Molton	80	Nil
Tiverton	86	Nil

Care of Unmarried Mothers and their Children

The 616 illegitimate births show a sharp rise of 70 on those of the preceding year.

The social agencies are still finding that their work increases particularly in regard to girls who come to Devon late in pregnancy so as to keep their situation a secret from relatives and friends.

During the year 1 girl conceived under the age of fifteen, 11 under sixteen, and 14 under seventeen years.

The social workers are directly employed by the Exeter Diocesan Council for Family and Social Welfare. The County Council makes an annual grant towards the cost of the work carried out by its workers.

During the year the council was concerned with 476 cases. A hundred and fifty-six of these were referred by the health department. The number of cases admitted to mother and baby homes fell to 52. Twenty-five of these were admitted to St. Nicholas House, Exeter, where five places are reserved for Devon girls. In addition the county council accepted partial financial responsibility in respect of the maintenance of 27 girls in homes as follows :—

St. Olave's House, Exeter	11
Southview, Plymouth	9
Mayflower Home, Plymouth	6
Homes outside Devon	1
	27

Births

Registered live births numbered 8,459 compared with 8,458 in the previous year and an annual average of 7,797 in the quinquennium 1960-1964. The corresponding crude birth rates were 15.0, 15.2 and 14.5 respectively. With the exception of the current year the total number of births has increased each year since 1956.

The live birth rates for the past ten years adjusted by the factors applicable for the aggregates of boroughs and urban districts, rural districts, the administrative county, also the national rate, are given below :

	Boroughs and Urban Districts	Rural Districts	Administrative County	England & Wales
1956	13.7	15.9	14.8	15.7
1957	14.0	16.6	15.2	16.1
1958	13.7	16.7	15.1	16.4
1959	14.2	16.8	15.4	16.5
1960	14.2	16.9	15.5	17.1
1961	14.5	17.0	15.1	17.4
1962	14.8	17.8	16.1	18.0
1963	17.4	18.3	17.9	18.2
1964	18.3	18.4	18.3	18.4
1965	17.7	18.4	18.2	18.0

Infant Deaths

Total infant deaths are exactly the same number as in the preceding year but more survived the first month. Of these 49 children 13 suffered from a congenital heart defect, 13 died of a respiratory infection, 3 from congenital brain abnormalities, 8 from asphyxia, 2 from meningitis and 2 from multiple deformities. Toxaemia, epilepsy, intracranial haemorrhage and other respiratory infections each account for the death of one child.

Infant Welfare Services

The vital statistics for 1965, set out in the form requested by the Minister of Health, are :

	Adminstrative County	England and Wales
Live Births :		
Number	8,459	
Rate per 1,000 population	18.2	18.0
Illegitimate live births (616) per cent of total live births	7.28	
Stillbirths		
Number	137	
Rate per 1,000 total live and stillbirths	15.94	15.7
Total live and stillbirths	8,596	
Infant deaths (deaths under 1 year)	126	
Infant Mortality Rates :		
Total infant deaths per 1,000 live births	14.9	19.0
Legitimate infant deaths (106) per 1,000 legitimate live births	13.52	
Illegitimate infant deaths (20) per 1,000 illegitimate live births	32.47	
Neo-natal Mortality Rate (deaths under four weeks (77) per 1,000 total live births)	9.10	
Early Neo-natal Mortality Rate (deaths under one week (63) per 1,000 total live births	7.45	11.3
Perinatal Mortality Rate (stillbirths and deaths under one week combined (200) per 1,000 total live and stillbirths)	23.27	26.9
Maternal Mortality (including abortion) :		
Number of deaths	2	
Rate per 1,000 total live and stillbirths	0.23	

Stillbirths

A hundred and thirty-nine stillbirths were notified in the county during the year (as adjusted for transfers in and out).

Domiciliary	21	including	9	premature stillbirths
Institutional	118	including	73	premature stillbirths
Total	139		82	

There has been a small fall in the number of stillbirths and the Devon figure approximates to the average for England and Wales.

Each individual stillbirth is investigated and varied causes are found for the failure of the infant to survive. In some instances no apparent cause can be found. It is doubtful whether even a post-mortem would always disclose the cause.

The following table shows comparative stillbirth rate for the county and England and Wales over the years :

	1953	1954	1955	1956	1957	1958	1959	1960	1961	1962	1963	1964	1965
Devon	22.5	21.4	22.9	22.7	21.6	21.3	17.9	19.0	16.9	15.0	16.9	17.3	15.9
England and Wales	22.5	23.5	23.2	22.9	22.5	21.6	21.0	19.8	19.1	18.1	17.2	16.4	15.7

Neo-Natal Deaths

Neo-natal deaths fell again and there were 77 compared with 91 in 1964. Of the number who died forty-three were premature, the greater proportion being of a very low birth weight.

The following table shows comparative figures for the county and England and Wales from 1959 :

	1959	1960	1961	1962	1963	1964	1965
Devon	13.8	14.3	11.0	11.6	13.6	10.8	9.1
England and Wales ..	15.8	15.6	15.5	15.1	14.2	13.8	

Early Neo-Natal (1st week) Deaths

These number 63, of whom no less than 39 were premature.

The following table shows comparative rates for the county and England and Wales from 1959 :

	1959	1960	1961	1962	1963	1964	1965
Devon	12.8	13.2	9.6	9.5	11.9	9.3	7.5
England and Wales ..	13.8	13.4	13.4	13.0	12.3	12.1	11.3

Perinatal Mortality

The term perinatal mortality describes the combination of stillbirths and deaths in the first week of life which provides an indication of the loss of infant life due to conditions associated with pregnancy and events during labour and delivery.

The following table shows comparative rates for the county and England and Wales from 1959 :

	1959	1960	1961	1962	1963	1964	1965
Devon	30.5	32.0	26.3	24.4	28.5	26.5	23.3
England and Wales ..	34.2	32.9	32.2	30.8	29.3	28.2	26.9

Premature Births

Premature live births totalled 521 compared with 469 for the preceding year. Four hundred and seventy-eight of these survived the first twenty-eight days of life.

The previous reduction in premature stillbirths has not been maintained. The following table shows the birth weight, place of birth and number of premature babies surviving in each group at the end of twenty-eight days.

Weight at birth	Premature live births—Total notified 521												Premature Stillbirths	
	Born in hospital				Born at home or in a nursing home									
					Nursed, entirely at home or in a nursing home				Transferred to hospital on or before 28th day					
		Died				Died				Died			Born	
	Total births	within 24 hours of birth	in 1 and under 7 days	in 7 and under 28 days	Total births	within 24 hours of birth	in 1 and under 7 days	in 7 and under 28 days	Total births	within 24 hours of birth	in 1 and under 7 days	in 7 and under 28 days	in hospital	at home or in a nursing home
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)
1. 2 lb. 3 oz. or less ..	17	11	1	—	1	1	—	—	—	—	—	—	9	3
2. Over 2 lb. 3 oz. up to and including 3 lb. 4 oz. ..	28	4	2	—	—	—	—	—	3	2	1	—	21	—
3. Over 3 lb. 4 oz. up to and including 4 lb. 6 oz. ..	80	4	3	2	7	—	—	—	3	—	1	—	28	3
4. Over 4 lb. 6 oz. up to and including 4 lb. 15 oz. ..	114	2	1	—	6	—	1	—	1	—	—	—	9	1
5. Over 4 lb. 15 oz. up to and including 5 lb. 8 oz. ..	226	1	4	2	35	—	—	—	—	—	—	—	6	2
6. Total	465	22	11	4	49	1	1	—	7	2	2	—	73	9

Child Welfare Centres

There are now seventy-seven child welfare centre operating in the county, two centres having been closed during the year.

No. purpose built	10
No. adapted and in full-time use	12
No. used on sessional basis	55

Mothers continue to make full use of the facilities available, and 14,868 children made a total of 87,284 visits. Particular encouragement is given to the mothers of abnormal and handicapped children to make use of the clinic services regularly so as to receive all possible supervision and suitable counselling as to ensure the best possible development of the child concerned.

The following paragraphs are synopses of the views expressed by some of the medical officers of the child welfare centres :—

"Whether the cost in money and skilled manpower justifies the continuation of welfare clinics in their present form is difficult to assess. There is a case for the health visitors to take over all advisory and educational work. Medical Officers could then give more time to developmental progress in babies and toddlers. I feel that more should be attempted in the field of advisory services for the handicapped. Parents of backward or handicapped children need encouragement, understanding and supportive advice. In Devon a pattern is beginning to emerge since the start of the developmental clinic at Barnstaple, and this holds great promise. I would like to see small nursery units available for deaf and partially deaf children, children who won't talk and children with behaviour problems. These could also include places for "ordinary" children whose parents are having difficulty looking after them, e.g. because of ill health, coping with elderly relatives, loss of a parent. (Not, I think, to enable the mother to go out to work unless she has been left on her own). This would be to the mutual advantage of all groups, and would also be a useful starting point for the A.C.M.O. to attempt the care and follow-up of handicapped children. It would also save money that would otherwise be spent on residential care or fostering children. A lot of further work on normal child development must be learnt before slow or abnormal development can be picked up at an early stage. We will need education to achieve new and special skills, so that accurate advice will be readily available, and we shall not as it were, be an alternative opinion to the general practitioner, but used by them and their patients as a useful source of help, and an authority on normal and abnormal development."

"1965 has seen the setting up of clinics for routine screening for cervical cancer. This has been received with gratitude by Devon women, who are tremendously pleased that this service is now being provided. A frequent comment made is 'how wonderful that Devon is so far ahead in this field.' At present there are a number of volunteers, the people who have formed the forefront of the pressure group. There will come a time when it may become increasingly difficult to persuade the reluctant or disinterested to come forward and it will take a lot of hard work to encourage the high parity social class 5 to attend—the group probably at highest risk.

"Out of 328 visits to the end of December, 1965, we have had in the North Devon area 2 positive slides. These patients have been admitted to hospital with the good result of all the pre-invasive carcinomatous cells being removed."

"During the year periodic routine assessment of the children was introduced using the methods described in Illingworth's book 'The Development of the Infant and Young Child (Normal and Abnormal).' For the moment these assessments are carried out at the first visit, thereafter at 3, 6, 9, 12 and 18 months, 2, 3 and 4 years. The mothers welcome the routine assessment when the purpose has been explained. They are gradually being weaned from the idea that a child welfare centre is a baby clinic and that they only see the medical officer if the baby is unwell".

Phenylketonuria

Health visitors have been testing babies as a routine since 1st September, 1959. All mothers are advised of the reason for this test and almost all decide to have it performed for their own children. A few cases of doubtful positives have needed re-testing but there has not been any case of a confirmed positive.

Before routine re-testing was established there were three known cases in the county and the excellent results obtained by early diagnosis and subsequent special dieting justify continuing this preventive measure.

Congenital Dislocation of the Hip (Ortolani test)

In addition to many hospital staff the district midwives and health visitors have all been advised of the method of testing the hips of the new born infant. During the year four cases were detected and the children spared the prolonged treatment necessary for cases not detected until a child starts to walk.

"At Risk" Register

This continues to be kept in accordance with the returns required by the Ministry of Health. No less than 3106 out of 8412 births were placed on the register. Similar figures are being found in other authorities, but children are still found who develop handicaps and had not been on the "At Risk" register. Some of these had, in fact, histories previously undisclosed which showed clearly that they should have been on the register. This stresses the need to carry out a critical survey of *all* children in their early years.

Distribution of Welfare Foods

Issues of National Dried Milk, cod liver oil and vitamin tablets continue to fall, but it is interesting to note a small increase in issues of orange juice during the year. The following table shows comparable distribution figures for 1964 and 1965 :—

Period	National Dried Milk (Tins)		Cod Liver Oil (bottles)		Vitamin Tablets (packets)		Orange Juice (bottles)	
	1964	1965	1964	1965	1964	1965	1964	1965
January—March	17141	16828	1782	1660	2242	2086	19280	18733
April—June	17648	15546	1514	1336	1879	1756	22208	21896
July—September	18090	15380	1241	1329	1923	1697	22532	22843
October—December	17983	14728	1683	1407	1971	1720	19221	21155
Totals	70862	62482	6220	5732	8015	7259	83241	84627

Welfare Foods are issued from 63 child welfare centres, 8 W.V.S. centres and 155 shops and private houses. I should again like to express appreciation to the many voluntary workers who undertake the actual work of distribution at these 226 distribution centres and to officials of district councils and other departments of the county council who act as area depot officers.

Registration of Nursing Homes

During the year one new nursing home was registered and one nursing home re-registered on change of ownership. Three proprietors returned the certificate of registration on retirement or change of usage.

At the end of the year there were 23 registered nursing homes providing 23 maternity beds and 303 medical, convalescent and chronic beds.

Nurses' Act 1919-1945

Two applications for renewal of licences to carry on agencies for the supply of nurses under these Acts were received and approved during the year.

MIDWIFERY AND HOME NURSING

Staffing

There is a total establishment of 188 for home-nursing and midwifery. There is a superintendent nursing officer, a deputy and three assistant superintendents. An additional assistant superintendent was appointed for the Torbay area during the year.

The work is mainly combined nursing and midwifery but in some urban areas the work is separated and there are twenty-three full-time midwives and thirty-two full-time general nurses in addition to 124 undertaking combined work. Nine part-time nurses (equivalent of five full-time) are employed as home nurses. There were fourteen vacancies at the end of 1965.

The Group System

For convenience of administration the county is divided into groups, each with a county staff sister, who is responsible for bulk ordering of stores through the health department and the distribution of stores to the staff in her group. She is also responsible for arranging relief for holidays and sickness. During the year it was found necessary to form an additional group at Plymstock, making a total of 22 groups.

Dissemination of Information

County staff sisters attend meetings called by the superintendent nursing officer at least four times a year, when all changes and problems are fully discussed. These meetings are usually attended by one, or more senior medical officers, and occasionally by the county medical officer, or deputy county medical officer.

Notes are taken at the meetings and a copy sent to each member of staff. The county staff sisters call meetings of nurses in their groups as soon as convenient after the meeting at headquarters, when full details of all that was discussed at the meeting are given. The superintendent nursing officer or an assistant superintendent nursing officer, attend the group meetings and occasionally a medical officer.

Application for the Domiciliary Services

Home nurses and midwives are listed in the telephone directory under the entry for Devon County Council health department, according to the district in which they practise. All medical practitioners and hospital almoners also have lists of the nursing and midwifery staff in their areas.

In the areas of Barnstaple, Tiverton, and Newton Abbot, telephone calls are transferred when a nurse is off duty, and it is hoped to extend this service during the year, where telephone exchange facilities permit this arrangement.

A record-a-call service operates at Torquay.

MIDWIFERY

Miss Heather is the non-medical supervisor of midwives and is responsible for the code of practice by all midwives in the county including those in hospitals where there is no resident medical officer. She is assisted in these statutory duties by her deputy and three assistants, who act as assistant supervisors of midwives.

The work of the midwives is summarised in the following table:

Domiciliary deliveries attended	2,304
Nursing care of mothers discharged from hospital before tenth day ...	2,743
Attendances at G.P. ante-natal clinics	3,402
Attendances at county council ante-natal clinics	1,860
No. of cases in which gas and air was administered	1,896
No. of cases in which trilene was administered	135
No. of cases in which pethidine was administered	1,463
Total number of midwifery and ante-natal visits to home deliveries	69,407
Total number of ante-natal visits to hospital booked patients	17,206

Equipment

All midwives have the necessary equipment for their work and a gas/air machine each. There are eight Trilene apparatuses and each midwife has an oxygen apparatus. Pethidine is used by all midwives. During the year the Central Midwives Board approved a new gas and oxygen machine for the use of midwives. We were able to purchase sixteen and these are already in use in the county. A further sixteen will be purchased next year. Lectures and demonstrations on the use of these machines were given at the City Hospital, Exeter, and also following a county staff sisters meeting, at county hall.

Recruitment

There is considerable difficulty in filling vacancies combining midwifery and nursing in the rural areas but on the whole the staffing situation is satisfactory.

Retirements

Seven nurses/midwives who were over sixty years of age retired during the year.

Refresher Courses

The non-medical supervisors of midwives and all other midwives have to attend compulsory refresher courses every five years, and the county staff are all up to date in this respect.

Some difficulty is experienced in seeing that the midwives in the smaller institutions (not employed by the county council) observe this rule, especially those employed in a part-time capacity.

Liaison

Many of the midwives attend clinics in doctors' surgeries. They also visit those mothers booked for hospital confinement and who live at too great a distance to attend hospital for ante-natal care. Midwives are encouraged to visit the doctors' surgeries and co-operate with them in giving full and complete ante-natal care.

It is encouraging to note that many more ante-natal mothers are having their blood estimated for haemoglobin, but even so this is not nearly 100% of expectant mothers and we must persist in our efforts to get this done. Under the Midwives Act of 1951, the midwife has a responsibility to ensure that blood tests are done for all expectant mothers.

HOME NURSING

There are 32 full-time general nurses and 124 combining nursing and midwifery duties and 9 part-time general nurses.

Administration

Miss G. Heather, superintendent nursing officer, and her deputy and three assistants, are responsible for superintending the work of the nurses.

Recruitment

One additional assistant superintendent nursing officer was appointed during the year for the Torbay area.

There seems to be very little difficulty in recruiting for home nursing, particularly from newly qualified State Registered Nurses. Some of them come to us following an introduction to district nursing during their general training when they spend at least one day visiting with the district nurse.

Retirement

Seven nurses undertaking combined nursing and midwifery duties retired during the year.

Equipment

All hoists, lifting poles, wheel chairs, and walking aids have been in constant use during the year. Appliances are becoming more varied in type with newer rehabilitation methods, and increased stocks would appear to be necessary. There is a small waiting list for hoists.

Liaison

We continue to receive considerable help from voluntary agencies, and in particular, I should like to say how much benefit is derived from the welfare grant and night sitting-in service provided by the Marie Curie Memorial Foundation for patients suffering from cancer.

The home nursing service continues to give considerable help to the elderly and infirm and 90% of the work undertaken by the district nurses is in the care of the elderly. This service is greatly appreciated as it makes for

ease and comfort to the patients concerned and helps relatives looking after them. It also helps to keep people in their homes and relieves the pressure on geriatric hospitals. The caring for elderly people can be a most exhausting and wearisome task and relatives are grateful for the services of the home nurses.

The supply of incontinence pads has been a great success and well worth the additional expense involved. We have received several letters expressing satisfaction about them and the staff are pleased, both with the quality and the delivery service of these pads. There has been no difficulty in disposing of the soiled pads. In towns where there are cottage hospitals, they are taken to the hospital incinerators, in country areas they are burned or buried in the garden.

The additional help from voluntary organisations, especially the W.V.S. Meals on Wheels Service in providing hot meals is of inestimable value as one of the greatest needs is good nutrition. So many of the aged are unable to cook, or even shop, and church workers and other associations contribute greatly in the urban districts in helping these people in a voluntary capacity. In rural areas there is a considerable number of good neighbours who give a lot of unpaid help and who often give a Sunday dinner to lonely old persons.

It might not always be realised that in this county there are a great many old people in the favoured south living lonely lives in impersonal guest houses and bed-sitting-rooms. The home nurse by nursing the patient in illness and supervising and assisting in the care of the toilet is often a visitor looked forward to with pleasure, and one who can do much to improve the social conditions.

Lectures in Hospitals

These were given by the superintendent, or her deputy and assistants, to student nurses at the North Devon Infirmary, the Torbay Hospital, and the Royal Devon and Exeter Hospital.

The work of the district nurses is summarised in the following table :

No. of medical cases nursed	11,650	involving	262,934 Visits
No. of surgical cases nursed	2,522	involving	47,886 Visits
No. of infectious diseases cases nursed	9	involving	219 Visits
No. of tuberculosis cases nursed	41	involving	2,100 Visits
No. of maternal complications nursed	294	involving	1,695 Visits
No. of other cases nursed	667	involving	23,138 Visits

These figures include 9,655 patients over sixty-five years of age, who received a total of 199,386 visits; 446 children under five received 2,220 visits; and 2,440 patients who each received more than 24 visits in the year, the total number of visits involved to these patients 135,822.

HOME HELP SERVICE

Administration

Mr. G. P. Brooks, the County Organiser, is based at County Hall, Exeter, and is responsible for administering the service through the county through eleven area organisers. These are based at major clinics in each of the eleven M.O.H. areas. There are also 4 W.V.S. Organisers in urban areas. In six of the M.O.H. areas where there are very heavy case loads assistant organisers have been appointed. All the accounts relating to the service are raised in the health department and the county organiser is responsible for the supervision of the collection of accounts by full-time collectors.

Administration—The Service in 1965

During 1965 the demand for the service continued to increase on the lines anticipated, and details of the 4,916 cases dealt with in the twelve month period ending 31st December are given in the following table :

	Over 65	Under 65				Totals
		Chronic Sick inc. T.B.	Mentally dis-ordered	Maternity	Others	
D.C.C. Organisers	3,409	396	48	487	397	4,737
W.V.S. Organisers	146	16	1	10	6	179
Total Cases 1966	3,555	412	49	497	403	4,916
Total Cases 1964	3,096	391	43	493	328	4,351
Increases 1965	+459	+21	+6	+4	+75	+565

The increase of 565 cases is approximately 13.1% over the 1964 total. Individual increases are :

Over 65 (459)	15%
Chronic sick/T.B. (21)	5%
Mentally disordered (6)	14%
Maternity (4)	1%
Others (75)	23%

At December 31st there were 1,130 home helps employed—all part-time, compared with 1,059 the previous year. The full-time equivalent was 345 compared with 305—an increase of 13.2%. This is practically the same as the increase in the total number of cases dealt with during the year (13.1%) which means, in effect, that the level of service given to average individual cases has remained unchanged for a further year.

The daily case-load at 31st December was 2,954 compared with 2,498 in 1964—an increase of 456 or approximately 18%. Of this daily case-load total (2,954) there were 2,395 cases in the "over 65" group—81.5%. The following table shows how the service has expanded over the past five years and gives a clear indication of the trend in the future.

	Total cases dealt with (1)	Home Helps (part-time) (2)	Case-loads at Dec. 31st (3)	Aged over 65 (4)	% Aged over 65 (5)
1960	2,514	510	1,250	1,050	84.0
1961	2,870	686	1,536	1,313	83.5
1962	3,282	808	1,966	1,653	83.7
1963	3,827	950	2,194	1,816	82.8
1964	4,351	1,059	2,498	2,051	80.5
1965	4,916	1,130	2,954	2,395	81.5

From the above (col. 1) it will be seen that the total number of cases dealt with each year in the last five years has increased from 2,514 to 4,916—approximately 96%. The daily case-load (col. 3) has increased from 1,250 to 2,954—136%. The cases in the "over 65" group (col. 4) have grown from

1,050 to 2,395—130%. The correlation between cols. 3 and 4—where the proportion of the "over 65" group to the daily case-load is almost constant is illustrated by the percentage figures in col. 5. The very slight fall after 1963 is due to the fact that some of the "over 65" cases were re-classified by the Ministry and these now appear under different headings.

It will be seen that the daily case-load increases more in proportion than the total number of cases dealt with (136% against 96%). This is solely due to the influence of the increasing number in the "over 65" group, as cases in this category are, in the main, long term. There is, therefore, not the same "turn-over" of cases in this group and a much higher proportion remain for a long period.

There has been a slight increase in the "mentally disordered" group—the higher percentage figure is due to the small number involved. There was a noticeably higher increase in the "others" group—due mainly to general sickness and short-term cases.

Organisation in 1965

A review of the organisation in the field was carried out in September, particularly in connection with the cost of home help wages (dealt with later in this report) and organisers. Fifteen comparable local authorities were asked to give information on various costings. An analysis of the statistical data provided showed quite clearly that in order to run the service economically and efficiently an adequate number of full-time organisers was essential to control the service and the work of the home helps. Where this was not provided the total cost of the service increased considerably. From this point of view Devon was considered to be quite favourably placed.

In June, 1965, the Tavistock U.D. area was transferred from the W.V.S. to the County Service. Here, as in other areas previously, the service had grown beyond the capacity of voluntary effort. Miss de Blois Rowe, the retiring W.V.S. organiser, had completed 15 years' work with the service, and to mark the occasion she was presented with the W.V.S. long service medal by the chairman of Tavistock U.D.C. at a civic ceremony.

During the year two Devon county organisers left the county to take up senior appointments with other authorities. Miss Atkinson (Bideford) has moved to Luton as county borough organiser, and Mrs. Loveless (Exmouth/St. Thomas) was appointed divisional organiser at Hackney. In both cases we were able to transfer into the vacant areas organisers who had been trained as assistants in Devon. The recruitment and training of assistants in the county has progressed very well indeed. We now have a full-time county organiser in each of the eleven M.O.H. areas. The W.V.S. are still able to meet the day-to-day commitments of running the service in the four urban areas of Axminster, Dartmouth, Seaton, and Teignmouth.

Home Helps—Conditions of Service

In April, 1965, an interim J.I.C. award was made to home helps, as part of a general award to local authority manual workers. This was unexpected in view of the three-year agreement on wages rates operative at the time, and awarded an increase of 1½d. per hour. The last stage of the three year award became due in September, 1965—also 1½d. per hour. In November, 1965, we received advance notice that the working week of all workers in the group would be reduced from 42 hours to 40 hours—from 3rd January, 1966. This

meant, in effect, a further increase in the hourly rates. The new rates, which will operate from the 3rd January, 1966, are :

"A" Zones 4/6d. per hour. "B" Zones 4/5⅛d. per hour.

The Service in the future

The great majority of applications and recommendations for the service have been received from general practitioners and hospitals. The future success of the service will largely depend on our being able to meet this increasing demand, and without delay, as in the majority of cases there is some degree of urgency. Many patients are discharged from hospital in the knowledge that help will be available and we have a very good liaison with medical social workers in the hospitals.

We have always been fortunate in Devon in being able to recruit an adequate number of suitable part-time home helps to meet the requirements of an expanding service—even in the coastal resorts where female labour is very difficult to obtain during the holiday season. With the growing awareness of the role of the home help in domiciliary care a very good type of person is coming forward, who soon develops a real sense of vocation and we have not experienced any great difficulty in recruitment. The provision of help in some rural areas does present a problem at times, but the area organisers have been able to manage this and the attendant transport difficulties and there has been no delay in meeting the needs of cases. As some 80% of the day to day work is concerned with the care of the elderly in their own homes this aspect of the service will continue to be our chief concern. But as we have now a full county coverage by full-time county organisers and home helps I can foresee no difficulty in meeting the future requirements of the expanding service.

Collection of Accounts

Further progress has been made during the year in relieving education welfare officers of this work. At the end of the year only five were still responsible for this side of the service and arrangements are in hand for their accounts to be transferred to the health department in the very near future. The full-time collector of accounts has proved a very valuable asset to the service. In addition to keeping accounts up to date he has proved a valuable link between patient and organiser and has helped considerably towards the control and efficiency of the service.

Charges

The full charge for the service has remained at 4/6d. during 1965, but where required householders are assessed to pay according to means.

Appreciation and Thanks

I have already mentioned that W.V.S. organisers are still managing to cover four urban areas in the county, and I am aware of the great amount of time they are giving to this work. My sincere thanks to these organisers and to Miss de Blois Rowe who resigned in June. My thanks and appreciation also to all the officers of the National Assistance Board who have been so helpful to staff and patients during the year. Their advice and co-operation has been invaluable in dealing with some of the problems that arise in dealing with home help cases. And also to those education welfare officers who have

continued to collect accounts. Finally to all the home helps in the county for their service to the County Council and the way they have worked for those we are endeavouring to help.

Enquiries regarding the service

All general practitioners, medical social workers in hospitals and staff of the health department are informed of the address and telephone number of the home help organiser of the particular district in which a person requiring the service resides. Otherwise an enquiry addressed to the County Medical Officer, County Hall, Exeter, will be forwarded to the appropriate organiser. In urgent cases telephoned instructions will be given.

HEALTH VISITING

The Superintendent Health Visitor is based at the County Hall, Exeter. She is responsible for maintaining a high standard of health visiting including the organisation of the use and development of new ideas and procedures. She also has the important function of resolving the inevitable problems that arise from day to day with a large staff, and their personal happiness in their work.

The changing pattern of the health visitor's duties has led to an increase in administrative work and it became necessary to appoint a deputy superintendent health visitor. In July, 1965, Miss J. M. McGilvray was promoted from being the Group Adviser in the St. Thomas area to this new post.

At the end of 1965 there was an establishment of 85 health visitors including 4 vacancies—this gives a ratio of 1 health visitor to 6,632 population. Seven county sponsored student health visitors completed their training and started their work in Devon. The health visitors are divided into 10 groups, varying in size from 5 to 10 members to ensure good co-ordination of work in this large geographical area. In the more rural areas this arrangement also lessens any possible feeling of isolation. Each group has a group adviser who is herself a practising health visitor. She is responsible for co-ordinating the work of the group and for liaison with headquarters and other agencies. This includes arranging reliefs for absence due to holidays or sickness and for introducing new members of the staff to colleagues concerned with the health and welfare of the community in her area. She also ensures their knowledge of the particular methods of work in this authority. The group adviser has further responsibilities in arranging the practical training of the many students who come to Devon for their field work experience. All these aspects of their work include a large element of positive health education which is more and more recognised as being a most important part of the daily work of the health visitors.

All infants are visited as soon as possible after the 10th day, and further visits are made at intervals up to the age of 5 years. In the early weeks infants are examined for possible dislocation of the hips and the urine is tested for phenylketonuria. At six to eight months there is a simple hearing test; where there is any doubt a further visit is paid to retest and if necessary the child referred to the hearing assessment clinic. The health visitor is sometimes the first person to recognise that a child has a mental or physical handicap. She co-operates with the family doctor and other workers so that arrangements may be made to enable the child to make the best possible use of all its faculties, and to diminish, wherever possible, the effects of any handicap.

Health visitors and midwives together teach relaxation and mothercraft in the ante-natal clinics. In some parts of the county very successful classes for fathers have also been organised in the evening. In the child welfare centres the health visitor advises the mothers individually and also carries out group teaching when possible. She assists the medical officers by her knowledge of the home background. The prevention of the spread of infectious diseases is one of her most constant duties and by stressing the need for immunisation and vaccination she endeavours to see that as many children as possible are protected. For some years the health visitors have assisted the chest physicians to trace unknown cases of tuberculosis in the county by Heaf testing school children annually from the age of 5 to 11 years. The contacts of positive reactors are traced and endeavours made to persuade them to attend for X-ray. In the school year 1964-65 thirteen cases of tuberculosis were discovered by this method.

In the school medical service the health visitor is responsible for visiting the schools in her area; assisting in medical procedure such as school medical examinations, vision tests, hearing tests and hygiene surveys. She is also available to help teachers to understand the home background of children who present a problem. Home visits are paid to parents of school children when necessary, special support being given to the families of handicapped children. Junior training centres and the school for physically handicapped children are also visited. The homes of handicapped children at residential schools are visited during the school holidays so that any problems may be discussed.

There is in the county a hard core of problem families, and the health visitors use every means in their power to try to improve the conditions in which these families live. Good team work is an essential factor in the attempt to rehabilitate them, and there is close work at field level between the statutory and voluntary workers concerned with the differing facets that are shown in such cases.

The health visitors assist the Children's Officer by providing reports on prospective adopters and foster-parents.

Hospital consultants and almoners often request reports on home circumstances for patients with special problems who are ready for discharge. Over the years there has been a steady increase in the number of home visits paid to the aged. In some areas health visitors have carried out or taken part in surveys to discover the number of people over the age of 65 years who live alone. They have also assisted in the establishment of meals on wheels services in different areas. There still remains the need to extend this work because of the high number of aged in this county.

In some senior schools programmes of health education are carried out by health visitors. They co-operate with the current campaigns such as rescue breathing, smoking and lung cancer, etc., in schools, clubs and other organisations. Many assist with the Duke of Edinburgh's Award Courses. In a few senior schools the health visitor is available at a specified time—usually the lunch hour—so that any child may ask advice on personal problems. Talks are given to organisations when required.

Students from hospitals, health visitor training schools, universities and teacher training colleges accompany health visitors for varying periods for purposes of observation and practical work.

During the year a majority of the health visitors took part in one or more of the national surveys concerned with child development and dental health in the pre-school child. These surveys are important in that they provide useful

information that can lead to improvements in the health services. They are, however, very time-consuming and one is grateful to the field staff who devoted extra time to this work.

Additionally 8 health visitors (10% of the staff) took part in a survey showing the present range of their work in full detail. This was carried out during the four weeks of July. The health visitors concerned spent many hours of their own time compiling the detailed returns required.

With the exception of one health visitor, everyone is a car driver and so is able to get about her area with the minimum of travelling time. As each health visitor is on the telephone at home she can be contacted in emergency by members of the public, doctors or other workers.

Refresher courses are attended by health visitors every five years. In-service training is also given in the form of study days, attendance at lectures and visits to mental hospitals, etc.

Liaison with general practitioners has improved steadily over the years and generally there is a good working relationship. Fifty-two health visitors now have their case loads based on the families in group and single practices instead of geographical areas. They carry out their usual duties but there is also improved facilities for two-way communication between the family doctor and the health visitor working with the practice. This results in closer co-operation and mutual benefit in their work of family care. A number of doctors have expressed appreciation of the help given particularly in relation to the health and social problems of the older patients. There are difficulties in that health visitors have high case loads and some practices cover a wide territory. Health visitors also assist family doctors who have their own well baby clinics.

In areas where there is a county council clinic (Barnstaple, Bideford, Crediton, Dartmouth, Dawlish, Exmouth, Holsworthy, Honiton, Ilfracombe, Kingsbridge, Newton Abbot, Okehampton, Ottery St. Mary, Paignton, Plympton, Plymstock, South Molton, Tavistock, Tiverton and Torquay) health visitors may be contacted between 9 a.m. and 9.30 a.m. at the clinic. In the larger clinics where a clerk is employed, messages may be left to be dealt with by the health visitor. Each health visitor is issued with visiting cards which show her home as well as any official address and telephone number. One of these cards is given to a family at a first visit. A new health visitor visits general practitioners and social workers as soon as possible after taking up her duties.

A summary of the work undertaken by the health visitors during 1965 is given below :

Type of Visit	*No. of Visits*
Infants under one year	50,537
Children one to two years	18,707
Children two to five years	34,408
Schoolchildren	9,482
Age groups fifteen to sixty-five years	14,244
Expectant mothers	4,783
Tuberculosis	798
Aged	11,286
Mentally disordered persons	1,597
Under Children's Act	1,439
Patients discharged from hospital (not mental hospitals)	332
Attendances at centres, clinics, etc.	8,591

Households visited	27,174
"No Access" visits	17,112
Health Education :	
Group talks to mothers	640
Talks given in schools	126
All other talks	367
Visits to hospitals, G.P.'s and other workers	10,831

HEALTH EDUCATION

The task of the health education unit is to provide material, instruction and co-ordination for those engaged in health education in the field.

Materials are provided in the form of films, filmstrips, projectors, posters, pamphlets, books, etc.

Health education instruction is given on content and methods of teaching and presentation, and during the year a series of evening lectures were conducted for health visitors and midwives responsible for ante-natal discussions for mothers (and parent classes) in the Tavistock and Okehampton areas. This series was found to be very useful and it is hoped to complete similar courses next year in other areas.

Co-ordination is provided by a scheme of suggested area programmes. By this means the impact of a subject in an area is greater since most health educators will stress this subject.

A reference library is kept at County Hall so that any field worker is able to check facts easily.

Smoking and Health has remained one of the important topics. Unfortunately, little positive action has been achieved by the use of recent publicity material to back talks, etc. Any appeal for youth "to heed the dangers" is lost when such propaganda is compared with all forms of attractive, commercial advertising. Reprogramming the subject next year together with a newsletter to parents may help to arouse fresh interest and produce better results.

Venereal Disease is a topic which is being discussed in some secondary schools. Several medical officers and health visitors include this subject in their general talks to school leavers rather than dealing with it in isolation.

Dental Health. This programme has suffered from lack of continuity due to staff shortage.

A revised series of talks run as normal school lessons took place in the West of Devon and were well accepted. In these lessons the subject was dealt with widely and included relevant topics such as nutrition, and personal as well as oral hygiene.

This series has resulted in requests from schools for return visits and requests for similar talks to parent-teacher groups and ante-natal classes.

Rolle College, Exmouth (for women student teachers)

A set of three lectures was run for the students at Rolle College about the School Health Service, recognition of illness in children and the teacher's role in Health Education.

The lectures were followed-up with questionnaires to the students to provide information for the planning of future programmes.

Devon County Show

The title of the display at the Devon County Show was "Towards a Fuller Life". The display showed the various services available to the aged and the disabled both from the local and voluntary authorities.

Occupational Therapy Filmstrip

During the year a coloured filmstrip was made in conjunction with Camera Talks, Ltd. This shows how the occupational therapist deals with all types of disablement both in their own homes and in centres.

This filmstrip was necessary as there was no available material to use in talks on the domiciliary occupational therapy service. It is anticipated that this filmstrip which will be commercially available in April, 1966, will excite a wide interest.

Health Education Students

The health education unit is used as a field placing for students on the health education course of the University of London Institute of Education. The comprehensive programme which was arranged for them was very much appreciated and their comments were found to be most helpful by our unit.

Progress and General Operation

Single bookings and film hire (excluding number of showings)	292
Bookings of filmstrips, sound filmstrips, slides (excluding those used and based in 4 areas, and the number of showings)	152
Bookings of cine projectors (number of times used not indicated)	181
Bookings of 35mm. projectors (number of times used not indicated)	113

Accident Prevention

Everyone appreciates the number of road accidents deaths; but few people realise that the same number of people die accidentally in their homes each year. Accidents at work are also a cause of concern.

Information is issued on all these subjects to back up the work of the Royal Society for the Prevention of Accidents and the British Safety Council.

TALKS

General

It is evident that not all talks given by various members of the health staff are recorded. The following list excludes ante-natal and welfare sessions.

Headquarter staff	56
A.C.M.O.s	11
Health visitors	895
District nurses/midwives	17
Dental officers	4
Dental Auxiliary	158

Dental hygienists	69
Occupational therapists	5
Social workers in mental health	15
Chiropodists	5
Speech therapists	5
Adult workshop managers	7
Home help organisers	5
	1,252

Ante-Natal Classes

Of the 1,321 sessions conducted for the year, the total number of talks to expectant mothers were 1,470.

Health visitors gave 612 of these and the midwives 852. The other six talks were from commercial representatives.

A. Placement of trainee students, observational visits post graduate work and practical experience.

Medical Institute of Exeter, Post-graduate students	31 for 6 days
D.P.H. from London School of Hygiene and Tropical Medicine	1 for 3 days
Students in Social Work	7 for 2 days
Students (University) Diploma of Social Administration	5 for 22 days
Student nurses (District nursing)	33 for 4 days
Student nurses (Health visitors)—Trainees	19 for 3 days
Student health visitors	9 for 8 weeks (in all)
Occupational therapists	3 for 1 day each week
Students on Diploma Course	1 for 1 week
Health education students	4 for 2 weeks
Visits from	
Overseas Visitors	3 for 2 days
Local Government & Civil Service Officers	2 for 2 days
Sociology Post-Graduate Students	1 for 2 days
Northern Nigeria	3 for 1 day

THE AMBULANCE SERVICE

Section 27 of the National Health Service Act, 1946, places on local health authorities the responsibility of providing ambulances and others means of transport, where necessary, for the conveyance of persons suffering from illness, or expectant and nursing mothers, from places in their area to places outside their area. The words "where necessary" are generally interpreted as meaning the provision of transport to or from the nearest hospital at which the treatment required by the patient can be given assuming the patient is unfit by reason of mental or physical disability to travel by public transport. A further provision under section 27 allows local health authorities to delegate the provision of an ambulance service to the voluntary organisations.

The Devon County Council have taken advantage of this provision and have been very fortunate in being able to rely on the voluntary organisations of St. John, the British Red Cross Society and the hospital car service, to provide the service on their behalf.

The county council have entered into agreements with 32 local voluntary organisations in the county. Twenty-five of these organisations are St. John, five are Red Cross, one is a joint committee of St. John and the Red Cross and the other is an *ad hoc* committee made up of local people. This agreement provides for the local association to appoint and train such whole-time personnel as may be required to run the service in addition to the considerable number of voluntary members. All full-time personnel, therefore, are the employees of the local association, but the county council reimburse all running expenses of the ambulance service including staff salaries, provision of office equipment, the upkeep of vehicles, lighting, heating, rents and national and other approved insurances. The county council also provide the uniform for the full-time personnel. The number of vehicles owned by the associations has dropped from forty or so in 1948, to three at the present time, and it is the county council's policy to replace all locally owned ambulances by one provided by the county council. The county council now own sixty-three of the sixty-six ambulances used on ambulance work. A provision of the agreement is that officers of the county council can inspect vehicles, premises, and personnel at any time. It is part of the county ambulance officer's terms of appointment to be responsible for encouraging and fostering the voluntary effort as far as possible and to ensure that whatever aid is required by the local associations in order to carry out their duties under the agreement, is given. He is assisted in this task by the ambulance liaison officer, who is appointed by St. John and the Red Cross to look after their interests, and to liaise with the county ambulance officer. There is no doubt that this arrangement has resulted in Devon being able to rely on the voluntary organisations to run their own ambulance service much longer than has been possible in other authorities. Complaints concerning the service are reported both to the head of St. John or the Red Cross and the county medical officer, who between them decide what action to take to remedy any shortcomings. In this they are advised by the ambulance liaison officer and the county ambulance officer.

I do not think it is generally appreciated how much voluntary work comes into the provision of the ambulance service. Whilst a small call-out fee is paid to volunteers for the time they are actually working on the ambulance, no payment whatsoever is made for the enormous number of hours they stand by waiting for a call. There is also a large amount of voluntary work carried out by the officers of the voluntary organisations in arranging rosters, training, etc.

The majority of the sitting case work is carried out by the hospital car service. This consists of a number of private car owners who put their services at the disposal of the ambulance service. Nothing is paid to these drivers for the time they put into the service, but they do receive a small mileage allowance, which is agreed nationally, to cover cost of petrol, oil, and fair wear and tear.

Mention must also be made of the work put into the hospital car service by the area transport officers who receive all requests for sitting case transport, and who organise the journeys which are required. These persons spend a tremendous amount of time on this work and except for a very small clerical allowance do the work voluntarily.

The people of Devon should be grateful and proud of the fact that there are so many public spirited individuals available in the county to keep the ambulance and hospital car service working on these lines.

There are thirty-two ambulance stations in the county and they have been organised under four area controls at Barnstaple, Exeter, Plympton, and Torquay. These areas are more or less co-terminous with the catchment areas of the hospitals which they serve. By this means the majority of the ambulance journeys in one control area are made towards the focal point, namely the main hospital for the area. This lends itself to a better co-ordination of journeys. All ambulances and controls are equipped with two-way radio.

Emergency Calls

All emergency calls on the ambulance service are connected direct to the appropriate control office by the telephone service. It is important, therefore, that persons making an emergency ambulance call should carry out the instructions on the disc of the telephone upon which the call is made. In most parts of the county this means dialling 999.

Long Distance Journeys

British Rail provide excellent facilities for the transfer of stretcher and sitting cases. It is not generally appreciated that a stretcher case can travel much more quickly and comfortably by rail than by other means and that a special stretcher is available to ensure that the patient is able to travel the whole journey from door to door on one stretcher without being moved.

Infectious Diseases

Arrangements for the transport of patients suffering from infectious diseases are made from the following stations :

Torquay, Plympton, and Barnstaple,

and in the case of East Devon by the Exeter County Borough ambulance service.

Smallpox

As the only smallpox hospital in this area is at Liskeard, Plymouth County Borough has undertaken to deal with any smallpox cases which might arise in the county.

Premature Baby Incubators

Premature baby incubators are kept at Torquay, Plympton, Barnstaple, and Honiton ambulance stations, and can be obtained by telephoning the appropriate ambulance control office.

Emergency Flying Squad

An ambulance is placed at the disposal of the emergency flying squad at the Torbay Hospital as and when required.

Agency Arrangements with Exeter County Borough

The Devon County Council have entered into an agency arrangement with the Exeter County Borough Council whereby Exeter undertakes the provision of an ambulance service in those parts of Devon adjacent to Exeter and Devon undertakes the administration of the hospital car service within the City of Exeter. Appropriate financial adjustments are made.

Air Transport

The arrangement for the transport of patients by air is covered by a Ministry of Health circular on the subject. The Minister's views, with which the County Council agrees, is that air transport should be used only in those cases where the local authority, on the advice of the Medical Officer of Health, is satisfied, after consultation with the medical practitioner (normally the Consultant) in charge of the case, that it is essential on urgent medical grounds, and that all other forms of transport have been considered and found to be impracticable. It is not thought that such cases will often arise. The County Council have been quite firm in their decision that they will only meet the cost of transporting patients by air when the authority's prior approval has been obtained.

Statistics

	1964 (53 weeks)	1964 (Scaled down to 52 weeks)	1965 (52 weeks)
Ambulances			
Patients	75,489	74,065	78,443
Emergencies	9,542	9,362	9,229
Mileage	834,177	818,438	837,619
Hospital Car Service		**1964**	**1965**
Patients		246,577	273,429
Mileage		2,341,374	2,666,924
Hired Cars			
Patients		7,084	7,500
Mileage		25,789	28,697
Total			
Patients carried		327,726	359,372
Mileage		3,201,340	3,533,240

The changing pattern of hospital development and treatment and the increase in the services such as chiropody provided by the council, continue to show their effect on the work of the ambulance service in the continued increase in the number of patients carried and the miles run.

There is a small but nevertheless welcome reduction in the number of emergencies. Undoubtedly some of this reduction is due to the police motor patrols which operated on certain routes throughout the county between August and December of this year.

The continued increase in the work of the hospital car service has been discussed with the county organiser and her nine area transport officers. They have assured me that they can continue to cope with the increase in the number of sitting cases.

Tiverton Ambulance Station

It is with great regret that I have to report a fatal accident to one of our full-time ambulance drivers. On the 2nd August, an ambulance from the Tiverton ambulance station was in collision with an articulated lorry. As a result of this accident the driver, Mr. Norris, was killed instantly, and his attendant, Mr. Sanders, received serious injuries.

Costs

It is encouraging to be able to report that the cost of the ambulance service in Devon, which theoretically at any rate, with its long distances in the rural areas and its preponderance of elderly amongst the population, should be one of the most expensive ambulance services, is in fact well below the national average. This is undoubtedly due to the fact that we have so many volunteers available to man the ambulances and the wonderful work undertaken by the organisers and drivers of the hospital car service. The efficient organisation of ambulance journeys by the ambulance control staffs has also contributed in no small way to the economic running of the service.

Safety

During the year the ambulance sub-committee have considered three points which will contribute to the safety of our ambulance and their crews. It has been decided to issue fluorescent waistcoats for the crews and each ambulance is to be equipped with a fog lamp. The sub-committee have also authorised the inclusion of sufficient money in the estimates for 1966/67, for the provision of safety belts during that year.

Ministry of Health Circulars

Two circulars have been issued by the Ministry of Health this year which had been anticipated. One authorised the use of helicopters for the conveyance of patients and the other notifying the adoption of the two-tone horn as the standard audible warning in the three emergencies services. Helicopters have been used in this county for the transfer of patients for some years. The two-tone horn was introduced about two years ago.

Assistance to other Authorities

Assistance was given to the Dorset ambulance service at Lyme Regis when a lorry ran away on a hill, resulting in two deaths and 25 casualties.

New Ambulance Station

One new ambulance station was opened during the year at Bideford. This was a joint ambulance and fire station. As it was erected on the site of the previous station some inconvenience was experienced during the building, but thanks are due to the North Devon Hospital Management Committee who accommodated us at the Torridge Hospital.

Equipment

During the year Neil Robertson stretchers were acquired and each station now has at least one. This stretcher is extremely useful in dealing with casualties rescued from high places or confined spaces underground.

Civil Defence

Progress has been made with the implementation of Ministry of Health Circular 9/63, which provides for courses of instruction in first aid and home nursing to members of the public.

A first aid competition has been inaugurated for members of the ambulance and first aid section. This has been very well received by the volunteers and is a convenient method of combining training with competition.

An ambulance loading competition has also been started. This competition is a speed contest, requiring teams to load a dual purpose ambulance and first aid party vehicle with stretchers, blankets and other equipment which it carries. The introduction of first aid quizzes has also added interest to training.

The Regional Director in his remarks following the annual inspection of the corps suggested that more effort should be made in getting members of the voluntary aid societies into the civil defence corps. The assistant county ambulance officer has already spoken to a conference of St. John Ambulance Brigade Superintendents and officers and intends to speak at the British Red Cross annual conference next year. The St. John conference received him very well but the state of uncertainty in which civil defence found itself at that time did not in any way help to persuade members of St. John that the time was right to give it their support. I feel sure that once we know exactly what the new organisation of civil defence is we shall be able to make ground with the voluntary aid societies.

COMMUNITY CARE FOR THE ADULT HANDICAPPED

The growth of the adult health section continues. Some of the new developments over this period are as follows :—

1. **Occombe House, Marldon, Paignton**

   A hostel for adult subnormals of both sexes was opened in August. It is running most satisfactorily and caters for twenty-three persons.

2. **Hawley Training Centre, Rehabilitation Unit and Hostel** situated on the site of the old Hawley Hospital is nearly complete. The training centre has been designed to take 120 trainees and the hostel 29 adults of both sexes.

3. **Plympton Training Centre** moved in September from hired premises to County Council owned property—Ridgeway Lodge—an old house due to be demolished. Although the new building is more satisfactory it has a limited life and there is room in the grounds for a purpose built centre.

4. The Ministry has approved the building of the Exmouth Training Centre at Salterton Road, Exmouth, and work should commence early in January.

5. Plans have been submitted to the Ministry of Health in respect of the following capital building programme :
   (a) A new adult training centre at Tavistock to provide 50 places.
   (b) An extension of the adult training centre at Hollacombe, Paignton to provide 60 additional places.
   (c) A new training centre for adults and hostel for adult subnormals at Axminster.

6. Sites for future projects have been acquired as follows :
   (a) A halfway home at Hawley, Barnstaple, for 15 short stay residents who have been in-patients at a psychiatric hospital.
   (b) A site for an adult training centre and hostel at Kingsbridge.

Social Workers in Mental Health

A comprehensive community care service for all types of mentally disordered adults has been in existence for several years in the county, and the field staff this year has been increased to twenty-two area social workers

and two trainee social workers. The social workers are based on thirteen centres throughout the County which is now divided into four areas. These areas cover the catchment areas of a psychiatric hospital or of one of the proposed psychiatric units which are to be attached to the Barnstaple and Torbay Hospitals where outpatient clinics are already in existence. The four areas are :—

(1) East and Central Devon (Exe Vale Hospital with additional out-patient facilities at Exeter and Axminster).
Social workers based at Exeter, Honiton, Tiverton and Okehampton.

(2) North Devon (Barnstaple out-patient clinic with additional out-patient facilities at Bideford).
Social workers based at Barnstaple, Bideford and Ilfracombe.

(3) South-West Devon (Moorhaven Hospital and the associated Nuffield Centre at Plymouth).
Social workers based at Plymstock, Kingsbridge and Tavistock.

(4) South Devon (Exe Vale Hospital and Torbay Hospital out-patient clinic with additional out-patient facilities at Newton Abbot).
Social workers based at Paignton, Torquay and Newton Abbot.

Case Load (Mentally Disordered Persons)

	1962	1963	1964	1965
Social Workers' Total active case load ..	2,135	2,407	2,469	2543

The active individual case load of social workers continues to rise, and although the number of social workers employed is increasing annually, we have never been able so far to satisfy fully the demand for community care work.

Visiting and care of mentally retarded children is provided, in the first instance, by the health visitors in this county. The social worker is called in only where there are special problems or to arrange admission to a psychiatric hospital.

This arrangement is economical on manpower since the health visitor is often visiting the home of the subnormal child, either to see another child of the family or perhaps an older relative.

Analysis of Referrals to Social Workers

Sources of referral of all categories of new patients	1962	1963	1964	1965
General Practitioners ..	539	747	736	979
Hospitals, on discharge ..	291	380	626	539
Hospitals, Out-patients Dept.	276	386	449	437
Police and Courts	47	54	44	72
Other Sources	251	341	267	313
Total referrals ..	1,404	1,908	2,122	2,333

These figures have been compiled since 1962 only, but they give a very clear indication as to the growth of work in the community care service.

Moorhaven Hospital

Dr. F. E. Pilkington, Physician Superintendent of Moorhaven Hospital, in his annual report states :

"There have been considerable changes in the pattern of care for mental illness. The changes are characterised by a substantial increase in the number of admissions to psychiatric hospitals, a faster rise in the number of discharges leading to a reduction in the average length of stay and, since 1954, a fall in the total number of in-patients in hospitals treating the mentally ill. The rise of the first admissions and discharges, however, does not result in a corresponding increase in the number of patients receiving hospital care because the numbers of re-admissions are increasing still faster. In 1951 first admissions represented nearly two-thirds of the total admitted and second and third admissions under one-third. Less than one-tenth had more than three previous admissions. By 1960 the proportion of first admissions had dropped to just over half the total : second and third admissions accounted for one-third while one-fifth of those admitted in 1960 had more than three admissions."

Exe Vale Hospital Group

Dr. Lewis Couper, Medical Co-ordinator-Consultant Psychiatrist, Exe Vale Hospital Group has reported as follows :

"Co-operation of social workers in mental health with the three sections of Exe Vale Hospital has continued on the friendliest of bases. Once during the year the social workers in mental health had to be informed of the extreme shortage of beds at the Belvedere Clinic (Admission centre for the over-60's) and for a time only urgent cases could be accepted there. It was also requested that cases be admitted before mid-day, if they were routine, while there was a higher proportion of medical and nursing staff present in the Belvedere Clinic Unit.

"It is hoped that in the future we can introduce a combined-user establishment for social workers to cover all aspects of their work including supervision of patients in the community, admission to hospital, during treatment in hospital, arrangements for discharge from hospital and return to the community, so that all this is continually under the supervision of the local authority. Details of this are being worked out actively at the moment.

"Although the social worker in mental health numbers have been increased gradually the mental hospitals feel that a great many more social workers in mental health are necessary, in the big push in the return to community of the elderly. Due to the shortage of welfare accommodation, private homes are being used for this purpose and these will require constant and regular supervision by the social workers in mental health."

Mental Illness

No. of Social Workers Visits	1962	1963	1964	1965
Known Mentally Ill Adults in the community	1,286	1,480	1,560	1,673
Visits to patients	11,271	12,620	14,415	17,868

Social Worker Visits in respect of Hospital Admissions and Discharges of the Mentally Ill

Mental Health Act 1959	Exe Vale Hospital	Moorhaven Hospital	Out-County Hospitals	1962	1963	1964	1965
Informal Patients (Sect. 5)	1242	221	8	1279	1198	1537	1471
Observation (Sect. 25)	132	18	1	110	126	131	151
Treatment (Sect. 26)	15	2	—	11	25	19	17
Emergencies (Sect. 29)	277	32	3	322	283	294	312
Courts (Sect. 60)	17	2	—	4	14	12	19
Total Admissions	1673	275	12	1726	1646	1993	1070
Total Discharges	1328	275	1	1355	1514	1803	1604
*Re-admissions (included in the totals)				602	482	717	519
Visits by social workers in respect of admission				3247	3477	3706	4090

The de-centralisation of social work services took place during the year and has proved satisfactory. The senior area social workers are responsible for the day-to-day administration of the service in their particular areas and are co-ordinating the work of their social workers in order to provide economy of individual effort.

Social Work Training

The health committee encourages the further training of staff. During the year two officers were sent on Council of Social Work Training Courses and one on a psychiatric social worker attachment under the Psychiatric Social Workers' Association special scheme. One social worker returned from Southampton University having obtained his Certificate in Mental Health, and another completed his final year on a part-time course and obtained his Diploma in Social Administration at Exeter University. In addition, one social worker was accepted as a part-time student at Exeter University to read for his Diploma in Social Administration. This University uses officers of the department as placements for its graduate students and Moorhaven Hospital also uses these facilities in connection with social worker students. The section's services as a whole are used by Exeter University to give their students a general insight into the working of the social service. The trainee mental welfare officers appointed last year proved most satisfactory and one has been appointed a full mental welfare officer, taking up an establishment vacancy. This officer is now completing a part-time course of study at the Exeter University. St. Loyes School of Occupational Therapy sends occupational therapist students to the department for placement as part of their training.

Medical officers, social workers, occupational therapists and training centre staff continue to give lectures to various associations and societies who are interested in the work carried out within the department.

Voluntary Visitors

The Women's Voluntary Service offer their visiting service in association with the psychiatric hospitals and social workers in mental health. The members visit patients in hospital and, with the consent of the patient, at home after they have been discharged.

The Club run by the W.V.S. at Exminster Hospital maintains its popularity with the patients, and the service fulfils a most necessary function in operating a trolley club which visits about twenty wards on four afternoons each week.

The shop and canteen at the Royal Western Counties Hospital, Starcross, continue very successfully.

Hospital Care of the Mentally Subnormal

Dr. D. Prentice, medical superintendent and consultant psychiatrist, reports that the Royal Western Counties Hospital Group provides care and training under medical supervision for about 1700 mentally disordered patients most of whom suffer from some degree of subnormality as defined in the Mental Health Act, 1959.

The largest hospitals in the Group are the Royal Western Counties Hospital (553 beds) at Starcross, and Langdon Hospital (564 beds) near Dawlish. The patients and staff are engaged in a wide range of activities under the supervision of nursing, teaching, artisan, catering, occupational, agricultural and horticultural staff. Recreational activities include regular games and instruction, and matches are played on first class cricket, football and hockey pitches. Among the numerous forms of indoor entertainment provided are variety concerts, cinema, television, radio, billiards and snooker.

There are also eight smaller units in Devon and Cornwall, three with over 100 beds, being Box House Hospital, Axminster; Western Hospital, Crediton and The Retreat Hospital, St. Columb Major. Three of the hospitals are designed for the care of a particular category of patient: Franklyn Hospital, Exeter, mostly for cot and chair children, Stoke Lyne Hospital, near Exmouth, for ambulant boys and the Elizabeth Barclay Hospital, Bodmin, for elderly patients. In addition, there is one hostel for female patients who are nearing return to outside community life, two hostels for male patients being trained for agricultural employment, a holiday home for female patients and a summer holiday camp for males.

The Hospital Group has always regarded hospital and community care as complementary to each other, and while individual patients may be adequately trained in one or the other, many require benefit from their combined services in enabling them to develop their full potential. Thus a close integration of the activities of both is essential if efficiency is to be achieved in the best interests of the patients concerned. This is effected by regular liaison and co-operation between the Hospital Group, the County Health Department, and other local health authorities in the catchment areas. Co-ordination meetings are attended by Medical Officers of Health, Senior Mental Health Officers and Medical and Administrative Officers of the Hospital Group and Regional Hospital Board. The Medical Officers of Health are represented by their inclusion in membership of the Hospital Management and the Medical Superintendent of the Hospital Group, a Consultant Psychiatrist, serves as a member of the County Adult Health Sub-Committee. Weekly case conferences are held at which the hospital staff meet mental health, probation and other

officers for discussion of difficult cases and the most suitable form of care or treatment for particular patients. From time to time local authority social workers accompany the hospital consultants on domiciliary visits, and the after-care which is so essential in making the discharged patient socially viable, is undertaken by the county mental health officers directed by the senior medical officer in the psychiatric social service.

Maintenance of close and friendly contacts between the Royal Western Counties Hospital Group and the County Health Department have for many years enabled each to be aware of the others plans for development and to promote a unified service avoiding overlap and dispersion of effort.

The Care of the Mentally Subnormal in the Community

The social workers in mental health are responsible for the care of all mentally subnormal adults in the community. Assessment panels are held at which those cases of young subnormal persons who have been discharged from special schools or junior training centres are discussed with a view to arranging for future care and training as soon as possible. Medical Officers, social workers, school teachers, educational psychologists, youth employment officers and workers from other agencies are invited to these panels to decide what is best in the interests of the individual. Apart from employment, the Ministry of Labour Rehabilitation Units can offer courses where these young people can learn a basic trade, or we can offer our own training centres or domiciliary occupational therapy outwork.

Mentally Subnormal School-Leavers

	1962	1963	1964	1965
Number of special school and junior training centre leavers placed under community care	31	42	59	30
Number of children classified as educationally subnormal leaving secondary modern schools and placed under community care	30	34	46	20
TOTALS	61	76	105	50

Mentally Subnormal Adults

	1962	1963	1964	1965
Discharged from hospital to community care	72	67	38	89
Guardianship cases	2	1	1	1
Discharged from community care ..	63	39	65	76
Total visits by social workers ..	3,864	4,178	4,232	4,562
Total active case load	849	927	909	922

Hospital Admissions and Discharges of the Mentally Subnormal

Mental Health Act 1959	R.W.C. Hospital	Special Hospitals	Out-County Hospitals	1962	1963	1964	1965
Admissions: Informal Patients (Sect. 5)	22	0	3	82	54	48	25
Observation (Sect. 25)	1	0	0	0	1	0	1
Treatment (Sect. 26)	0	0	0	6	4	2	0
Emergencies (Sect. 29)	1	0	1	0	0	0	2
Courts (Sect. 60)	8	0	0	4	11	9	8
Total admissions	32	0	4	92	70	59	36
Total discharges				*60	*41	*55	*46
Temporary hospital admissions (not exceeding two months)				25	29	27	19
Visits by social workers in respect of admissions				203	124	141	130

*Includes 18 (1962), 11 (1963) and 10 (1964) persons technically discharged but remaining resident informally in hospital.

Hospital Waiting List

	Boys	Girls	Men	Women	Total
Patients awaiting admission 1962	4	3	9	3	19
Patients awaiting admission 1963	12	7	11	3	33
Patients awaiting admission 1964	14	9	10	4	37
Patients awaiting admission 1965	18	12	14	5	49

Adult Training Centres

There are now nine adult training centres in the county and all except three—Newton Abbot, Tavistock and Kingsbridge—are open on five days a week. The number of handicapped persons who attended regularly was four hundred and thirty, and the total income for the year from the sale of products was £20,249.

Training Centre/ Unit	Physically Handicapped	Mentally Ill	Mentally Subnormal	Total
Axminster	6	6	12	24
Barnstaple	20	18	46	84
Exmouth	18	6	38	62
*Kingsbridge ..	0	2	6	6
Newton Abbot ..	17	1	19	37
Crediton	9	8	27	44
Paignton	18	16	68	102
Plympton	2	2	20	34
Tavistock	9	11	17	37
Totals ..	109	68	253	430
			Total 1964	394
			Total 1963	286

*Financed by the Torbay Society for Mentally Handicapped Children.

Income from Sale of Products

	1963	1964	1965
	£	£	£
Barnstaple	974	3,033	9,760
Axminster (grouped with Exmouth)	—	153	215
Crediton	—	54	1,703
Exmouth	1,550	2,351	2,058
Kingsbridge (under auspices of Torbay Soc. for M.H.)	—	—	—
Newton Abbot	—	—	367
Paignton	3,421	3,317	5,104
Plympton	—	424	666
Tavistock (grouped with Plympton)	50	94	276
Totals	5,995	9,426	20,249

Late in the year a most interesting experiment took place within the East Devon group of training centres. A local firm for whom the training centres had been doing a large volume of packing wished to introduce more modern methods of packaging. The firm was prepared to install the necessary machine in the new training centre at Exmouth when ready for occupation. In the meantime, however, a machine became available and as it was just before the Smithfield Show the managing director decided that his components, used largely in agriculture all over the world, should be on show in the new pack at Smithfield. As we had no suitable accommodation the firm offered us the free use of a small building they were not using.

The process consists of loading the components to be packed on large sheets of cardboard. This sheet is passed under a unit which heats a sheet of polythene large enough to cover the whole cardboard sheet. When the polythene has reached a desirable state of plasticity it is dropped on to the components and the cardboard. A vacuum pump extracts the air from between the polythene sheet and the cardboard so that the polythene forms a "skin" which closely follows the contours of the components and adheres firmly to the cardboard. The cardboard sheet is then guillotined into the appropriate sizes for the components which are then packed in display boxes and an outer protective carton ready for despatch.

This very close approximation to normal industrial working with a "man sized" piece of machinery has had a good effect on the trainees engaged on the project.

With the ingenuity of the staff in devising suitable jigs to enable the trainees to load the components on the cardboard sheets accurately, and the enthusiasm of the trainees themselves, the processing has outstripped the production from the factory.

The way in which training centres are being developed in Devon lends itself to a reconciliation of the apparently opposing needs of "production" and the other important aim of the centres viz: to rehabilitate and train the handicapped so that they may live as full a life as their disabilities allow.

East Devon Group (Exmouth, Crediton and Axminster)

The most interesting development in the Exmouth centre has been mentioned earlier, while the Crediton centre, where cardboard boxes and cartons are made, is a good example of demand outstripping improvised means of production. Adequate machinery is being installed as quickly as possible. Largely by reason of its geographical position, Crediton has become the distribution centre for a rapidly growing "disposables" industry. This consists of gowns, caps, bag linings and similar items manufactured in paper for use in hospitals and nursing services generally.

At the end of the year Axminster moved to larger, though still rented, temporary accommodation at Colyton Church Hall.

Paignton (Hollacombe)

Polystyrene has continued to be the mainstay of production here with perhaps a greater emphasis on the packaging side rather than domestic insulation and decoration. A fire in a polystyrene moulding factory has resulted in the firm placing its packaging requirements with the Hollacombe centre.

Newton Abbot

This centre continues to run on only two days a week because of accommodation difficulties. It is now administered by the Hollacombe centre because the increased pressure of work on the occupational therapists has necessitated their withdrawal. They did excellent work in establishing this training centre.

Barnstaple (Hawley)

The growth in the demand for incontinence pads has resulted in the machine working continuously at full pressure and in spite of difficulties through working in widely scattered premises, the centre has continued to make good progress. The new building has been completed and will be occupied early in 1966.

West Devon Group (Kingsbridge, Plympton and Tavistock)

Kingsbridge: The supervisor employed by the Torbay Society for the Mentally Handicapped became ill towards the end of the year and the Society was unable to find a successor. They requested the County Council to assume direct responsibility for this small centre. Except for appointing a supervisor no change has, as yet, taken place in its organisation.

Plympton: During the year this centre moved into its own accommodation at Ridgeway Lodge. This accommodation is not ideal by any means but, at least, the noise level need not now be unduly restricted and the baby pants packing has been supplemented by outwork from a local cardboard box manufacturer.

Tavistock: Three days a week is still the most that can be arranged here. In spite of hired premises the staff have designed most ingenious tools capable of being packed away each night. There is a good variety of work including polystyrene packaging for firms in the Plymouth area. An increase in the work available to Exmouth enabled this packaging to be transferred to Tavistock which is a much more convenient arrangement.

Social Club Activities

All the centres, other than Plympton, carry out some form of social activities. Unfortunately, because of transport and/or accommodation difficulties, these activities are carried on during the afternoon except at Hollacombe and Crediton. In the case of Hollacombe, Crediton, Barnstaple and Exmouth the activities are organised by the staff themselves with some assistance from the local branches of the Societies for Mentally Handicapped. In the case of the other centres local voluntary bodies provide a "tea party" followed by games organised by the staff.

Various outings are held during the year and special parties at Christmastide. A great deal of very helpful support is given to the centres by the various voluntary societies. We are very grateful for their efforts.

Therapeutic Social Clubs

The Therapeutic Social Clubs in Devon continue to flourish, although the club at Tiverton has been temporarily suspended while the social worker attends a course. At each club a committee of former patients is formed and, guided by the social workers, decides the club's affairs and manages all financial arrangements. The club meet one evening each week and various forms of entertainment are arranged. The social workers in attendance are able to offer advice and guidance to those members who require it, and other helpers include the section's occupational therapists, health visitors and home help organisers.

The Barnstaple Club, known as the Brownlees Social Club, continues to meet on Tuesdays in the Trinity Hall, Trinity Street, Barnstaple, from 7.30 p.m. to 9.30 p.m. The present membership totals fifty-four. There has been a gradual increase in membership during the year, though some members who commenced did not continue more than a few months. This emphasises one of the functions of the club in that it has helped those members to re-adjust themselves in the community to the point where they no longer need the services of this type of club.

Club activities are as varied as possible and include social evenings, indoor games, groups of entertainers, film shows and talks, and there have also been visits to local theatres and pantomimes. During the year the club had two day outings — one to Bristol Zoo, another to Minehead. Both were well attended and very successful. In addition to these activities, several members asked during the year if they could undertake some handcraft and this was arranged. At present the types of handcraft being undertaken are knitting dishcloths for themselves and their friends. A group of older women are

knitting cotton blankets. Some members have taken an interest in rug-making, basket work, pottery and lamp-shade making. These activities are helpful in that they enable the membership to split up into small groups doing similar tasks and within these groups conversation and discussion maintain a lively interest. It is hoped that with the move to better premises at the Hawley Adult Training Centre this year the activities of the club will be even more varied; that the membership will increase and that the club will function on more than one night a week.

The Bideford Club, known as the Torridge Friendship Club, continues to hold weekly meetings at the local Moose Hall with an average attendance of twenty members and a steady introduction of new members and occasionally older members discontinuing as their needs decrease. A very active committee, including both co-opted members and members, has met at six-weekly intervals to map out a varied programme as well as stimulate action for new ventures. A great feature during last summer was a full day's outing to Bicton Gardens on August Bank Holiday bringing in people as far away as Halwill and generally adding a boost to conversation for many weeks afterwards. Mr. Prince, the Chairman, who is himself a keen amateur photographer, gave an excellent talk on this subject, the outcome of which was to purchase a camera for the club which is available for any member to borrow with a view to holding some kind of exhibition with the photographs taken. Unfortunately, the rather wet summer did not give a lot of encouragement, but it will be pursued again. The Autumn Fayre held in November realised a profit of £54 and the major benefit was the amount of work put into it by the members and the feeling of comradeship and satisfaction at the success of the event.

One or both of the social workers attend each weekly meeting and opportunity for contact is always available, but their main objective is to be on the touch line and allow the members themselves to organise and take a full part in the activities.

A suggested scheme to meet other clubs in Devon at a rendezvous or mutual exchange basis has been received with enthusiasm by the committee and it is hoped to arrange activities in the summer months. We are indebted to the Women's Voluntary Service and the British Red Cross for their excellent support given to the club by way of transport facilities, and also to our co-opted members who attend and help regularly, in spite of other commitments.

The Paignton Social Club held at the Midvale Road Clinic, has had another successful year, and members have gained much in friendship and pleasures shared. The average attendance of thirty-three was slightly down, but it is gratifying to report that this decline was mainly due to members voluntarily moving on to other activities in the community. The highest percentage of membership falls in the psychoneurotic category and the group is maintaining a good recovery. There are also several chronic psychotics Recent new members have included some subnormal patients who have been accepted wholeheartedly by other members. General activities on Tuesday evenings have followed the pattern of past years and the club is still favoured periodically by outside entertainers. Two regular features, namely the New Year supper party and summer coach outing, were very much enjoyed. Here again we are indebted to the health visitors and home help organisers for the support they have given.

The Torquay Social Club, held at Owendene, Albert Road, meets every Tuesday from 7 p.m. to 9 p.m. Entertainment varies but it has been found

that discussions and talks are not as popular as films and competitive games. A smaller meeting takes place every Monday evening when about a dozen members attend a local theatre.

During the year the club held two coach outings and over a hundred members and guests attended the annual dinner and dance. At Christmas, club members visited twelve long-stay patients in Exe Vale Hospital who would not otherwise have received visitors. All these events were financed by members' own fund-raising activities.

People who suffer mental breakdown tend to become over-preoccupied with themselves and their symptoms; and because of this many of them experience difficulty in meeting and mixing with others. Besides giving members the opportunity to mix and meet in a sheltered environment the club stresses the value of an "outward" interest in life. This manifests itself in the coach and theatre outings—"helping others"—and the insistence that members run the club themselves—the Torquay club has a very active and efficient members' committee.

In assessing priorities, account has had to be taken of the needs of about a hundred people returned to the community during the past two years who had spent an average of over twenty years in Exe Vale Hospital. The present day world for these people is very bewildering and they do need special assistance in adjusting to it. The social club has proved helpful in this respect but the club's age structure has been changed so that it has now taken on the appearance of an old people's club and this has discouraged the attendance of younger persons. The answer is another club for the younger age group but the social workers' duties are too extended at present to organise another club.

Group Therapy

A group commenced in March on an experimental basis. It seeks to provide group therapy as supportive treatment to patients attending psychiatric out-patient clinics. All members are referred by the psychiatrist, and the membership is limited to a maximum of ten. The group meets every Wednesday evening at the Castle Road Clinic, Torquay, from 7.15 p.m. to 9.15 p.m. and the social worker in mental health acts as leader and tries to provide a situation which enables patients to express their feelings and discuss their problems. Many people who are mentally ill have no awareness that others have similar feelings. To be able to talk in a group diminishes their feelings of isolation. Additionally mental illness tends to be a taboo subject in our normal society and to be able to talk about it freely and frankly can be a relief in itself. Many patients lack insight into how their own behaviour may be responsible for their problems and objective advice and criticism from other group members can be more effective than similar advice and criticism from relatives and friends. Psycho-analytical type of group therapy is not attempted as it is recognised that this can only be carried out by a psychiatrist or psycho-therapist.

One or two persons failed to benefit from group attendance but many more gained real and obvious benefit, and in July the consultant psychiatrists gave the group their full support so that it has now passed from the experimental stage and become a permanent part of the community mental health services.

Occupational Therapy

During the year the volume of work done for patients at home has increased. For the first time since 1961 the therapists were entirely relieved of training centre duties, but there was not enough staff or time to cover all needs. Owing to a national shortage many posts remained vacant and there has, therefore, been little increase in staffing.

Aids

From March 1st the welfare department occupational therapy service merged with the health department service and this has meant a comprehensive and unified scheme for the county. The occupational therapists took over the assessment for and provision of all portable aids and gadgets for the handicapped and provided a consultant service to the welfare department on household adaptations. This service not only provides the actual articles or alterations required and a training in their use, but also continued surveillance to see that the items remain the best possible for the patient in the event of further deterioration. Maintenance of the aid is also provided as it is felt that an aid badly used and ill maintained is a danger and not a help. Although the items provided are too numerous to list, those in greatest demand are : aids to dressing, eating, toileting; hydraulic hoists and wheel chairs and other aids to mobility. It is pleasing to realise that those needing these aids can obtain them free and that aids are also available to a wider range of patients than before — e.g. children. Many aids have been individually designed and manufactured by the therapists for patients who cannot be fitted with off-the-peg aids. Some of the aids such as bath seats, benches and trolleys are made at the adult training centres.

Rehabilitation Units

Rehabilitation units are to be placed at every major adult training centre eventually. Their function is to assess and provide training for all types of handicapped persons and to provide occupation for those who are not acceptable in the training centre. Here again through lack of staff we were not able to expand and, in fact, had to diminish the service offered.

Axminster

The occupational therapist was able to extend his half day to a full day a week, but was very restricted in activities as he had no separate room.

Exmouth

The two occupational therapists continued to use the unit twice weekly, and this is beginning to take shape. It has the benefit of now being housed in a separate room, but even so the facilities are poor. However, individual tuition can be given in cleanliness, road and street discipline, hand-eye co-ordination, etc.

Barnstaple

The two occupational therapists continued to run this unit with the help of a training centre attender. Here the class was some distance from the centre and this created difficulties. However, despite this and the fact that it was held only twice a week many trainees have commenced there and graduated to the training centre.

Plympton

This is a twice-weekly unit run by two occupational therapists in almost impossible surroundings until the removal to Ridgeway Lodge. Here they have had to deal first with real basics—cleanliness, grooming, clothes care, shopping, money sense, etc.

Tavistock

Run by an occupational therapist once a week, this unit has hardly expanded at all, but efforts have been made to help individuals overcome both personal and workshop problems.

Crediton

An occupational therapist ran this unit four days a week but later this had to be reduced to three to cover home cases. Although the unit is much too small and ill situated it has been a great success. The further facilities of a kitchen and washing machine have made it possible to provide training in domestic work and offer a wider range of activities.

Unfortunately due to lack of space and staff Newton Abbot and Hollacombe have remained without a unit.

Often the staff are depressed at their results, but this is only because they are "too near" to the patient. Outsiders are often amazed by the maturity gained and general improvement of the trainees, not least the trainees themselves.

One girl graduating from a junior training centre had to be constantly reminded about her routine work with the washing machine. Now, a year later, although not able to tell the time, she reminds the therapist when she should do the washing, and if helped unnecessarily resents the interference in *her* job.

Another girl came to the unit on leaving an E.S.N. school. She wore calipers and "carried" a useless arm—the result of poliomyelitis. She was difficult and when asked to try to use both hands became sulky. Now she has a special job winding bobbins and if a sewing machine is held up for one she realises this is her fault. She also works hard on a machine designed to help her useless arm and is learning to use an electric sewing machine. She is learning to use both hands and is no longer ashamed of her disability but accepts it as a challenge. She happily reports "I nearly turned the door knob at home with my bad hand!"

All the unit staff have a chance to see the other units at work and to spend time at the nearest junior training centre.

Language and "communication" are two of the priorities of the units and although the speech therapist cannot treat all our trainees they have been most generous in seeing some of them and giving guidance and advice to the occupational therapists.

It is interesting that each unit has a character of its own, and although we may not be progressing rapidly at present we are gaining knowledge of what is needed and how to deal with it.

Steps Cross School for delicate Children

An occupational therapist continued to spend a half-day a week at the school giving advice on individual handicaps and running a small class.

St. Loyes College

Four students from the occupational therapy training school attend the Exmouth adult training centre each Wednesday for the social club in order to gain experience in physical and recreational activities. An occupational therapist is able to give on-the-spot instruction and guidance, as well as explaining the handicaps and limitations of the trainees. These students are in their first year and the Exmouth training centre is their first contact with "live" patients.

Domiciliary Occupational Therapy

The work in this field grows steadily, not only in numbers but also in content. One may be teaching a mongol child to sew, and next an old lady who has to learn to walk and sit in safety; then lessons in painting, dressmaking, advice on reorganising a kitchen, provision of reading material, devising a sling in which a disabled mother may carry her baby; or meeting with a builder and the area welfare officer about positioning a gradient ramp; arranging a correspondence course for a convalescent mentally ill patient; organising a rota for an electric typewriter provided for the use of multiple sclerosis patients, etc.

A student from Exeter University reporting on a day spent with an occupational therapist remarked "when we weren't fixing aids to lavatories we were giving old ladies a 'dry run through' in the bath to see if they could manage with aids provided".

The provision of paid outwork is a tremendous help to the occupational therapist and the patient. It may mean more work in delivery and checking, but its therapeutic aspect cannot be over-stressed. The craft work side is still in full swing for those who require it, many patients making their own sales, others being paid for their work by the county, and the work sold later.

Staff

At 1st January there were nine therapists in post. On March 1st two therapists from the welfare department joined the health department and there were also two vacancies (13). The establishment for the year was increased to 22 therapists. During the year one therapist transferred to the Hawley training centre and two left to take other posts. These full-time posts were filled. We were able to make a further full-time appointment, and two part-time appointments.

Chiropody

The chiropody service continued to grow during the past year. It is available for the elderly, the handicapped, expectant mothers and schoolchildren. No charge is made to those in receipt of National Assistance, but for all others the charge is 2/6 per treatment and 4/- for a domiciliary visit. During the year two chiropodists were appointed and one resigned, bringing the total number employed to fourteen full-time senior chiropodists in addition to the chief chiropodist. Nineteen new clinics were opened, making the total number in the county one hundred and twenty-six. The waiting lists at the various clinics continue to rise and because of this it has not been possible to extend the domiciliary service which continues only in a very limited way in

the Torquay and Paignton area.

The main object of this service is to keep as many elderly persons mobile and fit enough to reside in their own homes, instead of allowing them to become housebound and eventually in need of residential care. The hospital car service continues to offer transport to the clinics for those patients medically recommended. In many instances this service is only needed for initial treatment and these patients are then able to make their own way for further treatments. The chief chiropodist continues to work in clinics in the area around Exeter, and the staff of senior chiropodists are based at each of the following towns: Barnstaple, Bideford, Exeter, Exmouth, Honiton, Kingsbridge, Newton Abbot, Okehampton, Paignton, Plympton, Plymstock, Tiverton, Torquay and Totnes.

Schoolchildren

The chiropody service at the moment is available only to children in the Torbay area, and one whole day each week is allocated for this purpose. In other areas in the county schoolchildren have been offered the service in a limited way in view of the very large waiting lists for treatment of the elderly and handicapped.

Appliances

Again because of the number of people awaiting treatment, appliance making has been kept to a minimum, but it is hoped in future to do more of this work.

Voluntary Organisation

The British Red Cross Society continues to operate one chiropody clinic at Chulmleigh and receives an annual grant from the County Council for this purpose.

COUNTY CHIROPODY CLINICS

	1962	1963	1964	1965
Number of chiropody clinics operating	52	63	96	126
Old Peoples Homes visited(Welfare and Private) ..	4	9	15	21
Treatments at Welfare Homes	229	397	888	1851
Treatments to school children	0	363	1542	916
Treatments to adults at clinics	9599	17270	26530	38550
Domiciliary visits to give treatment..	0	0	329	737
Total treatments provided	10040	18131	29289	41317
Waiting List at 31st December	151	432	498	762

Towns and villages in which County Chiropody Clinics are held:

Alphington
Ashburton
Ashburton Kenwyn Welfare Home
Axminster
Bampton
Barnstaple
Barnstaple Pilton Private Home
Barnstaple Rosebank Welfare Home
Beer
Bere Alston
Bideford
Bideford East Club
Bideford West Club
Bovey Tracey
Bow
Bradworthy
Branscombe
Bratton Clovelly
Braunton
*Brixham
*Brixham Laywell Private Home
Broadclyst
Buckfastleigh
Budleigh Salterton
*Burlescombe
Chagford
Cheriton Bishop
Chudleigh
Colyton
Combe Martin
Croyde
Cullompton
Dartmouth
Dawlish
Exminster
Exmouth Kincraig Welfare Home
*Exmouth Kingsdon Welfare Home
*Georgeham
Hartland
Hatherleigh
*Hemyock
Holsworthy
Honiton
*Honiton St. Michael's Welfare Home
Ilfracombe
Instow
Ipplepen
Ivybridge
*Kenton
Kingsbridge
Kingsbridge Combe Royal Welfare Home
Kingskerswell
Kingsteignton
*Lewdown
Lustleigh
*Lydford
Lynton
*Marldon
*Marldon Occombe House Hostel
Modbury
Morchard Bishop
Moretonhampstead
Newton Abbot
*Newton Abbot Broadlands Welfare Home
Newton Poppleford
Northam Over Sixties Club
Northam Fairlea Welfare Home
*North Tawton
Noss Mayo
*Okehampton
*Okehampton Wardhayes Welfare Home
Ottery St. Mary
Paignton (2)
Paignton Fernham Welfare Home
Pinhoe
Plympton
Plympton Hillside Welfare Home
Plympton St. Vincents Private Home
Plymstock
Princetown
St. Giles in the Heath
Salcombe
Seaton
Seaton Whitecliff Welfare Home
Shebbear
Sidmouth
South Brent
South Molton
Spreyton
Starcross
*Sticklepath
Stoke Canon
Stoke Fleming
Stoke Gabriel
Stokenham
Tavistock
Teignmouth
Thorverton
Throwleigh
Thurlestone
Tiverton

Tiverton Alexandra Welfare Home
Topsham
Torquay (3)
Torquay Luscombe Welfare Home
Torquay Grosvenor Private Home
Torquay Reddenhill Private Home
Torquay Seaway Private Home
Torrington
Totnes
*Totnes Pomeroy Welfare Home
Uffculme
Westward Ho! Chalet Private Home
Winkleigh
Witheridge
Woodbury
Woolacombe
Yealmpton
Yelverton

* Commenced in 1965.

Dental Inspection and Treatment of Trainees attending Adult Training Centres:

This scheme was initiated in 1962. Further progress has been made and the amount of treatments carried out are as follows :—

Number examined	177
Number needing treatment	110
Number treated	104
Number made dentally fit	52
Attendances	192
Scaling and/or Gum Treatment	50
Fillings	165
Silver Nitrate Treatment	10
Crown Inlays	5
Extractions	143
General Anaesthetics	89
Local Anaesthetics	83
Dentures	19
Radiographs	9

It will be noted that the acceptance rate is very high, which would seem to indicate that these people do not endeavour to obtain treatment elsewhere. It is expected that as the service becomes more widely known more trainees will ask for treatment but the amount of extra work involved cannot be calculated as those who remain in the centres indefinitely will require little attention on subsequent occasions whilst others who stay for only a limited training period will be replaced with new-comers needing treatment for the correction of several years of neglect.

PART V

Environmental Hygiene

Food and Milk

Water Supplies

Sewerage and Sewage Disposal

FOOD AND MILK

Food hygiene is supervised by district medical officers of health and the public health inspectors, but, with the exception of Torquay, sampling of foods under the Food and Drugs Act, 1955, is undertaken by this department.

There are five sampling officers in the county, whose function it is to procure samples of any food which is sold for human consumption and they are supervised by the county health inspector. Food and Drugs Act samples, other than milk, are sent to the Public Analyst for examination, but the majority of milks are subjected to the gerber test in this department and only the suspicious samples are submitted to the Public Analyst.

During the year, 2556 formal and informal samples were taken. 138 milk and 807 other commodities were submitted to the Public Analyst and the remaining 1611 (all milks) were examined by the gerber test in the laboratory attached to this department.

The samples submitted to the Public Analyst represented a wide range of foodstuffs and medicines, including ice cream, sausages, spirits and various proprietary medicines, drugs and vitamin preparations.

The Public Analyst reported that of the 945 samples he received 77 were either adulterated or gave rise to some other irregularity. 55 of the samples were of milk and 41 of these were ones in which the non-fatty solids and/or butter fat was below the normally accepted figure, but investigation in each case showed that the milk was being sold in the same condition as it came from the cow and that no offence under the Food and Drugs Act was being committed. The remaining 14 samples of milk were found to contain added water in varying amounts and one vendor was prosecuted.

The remaining 22 samples other than milk reported on by the Public Analyst included corn oil margarine which consisted of hydrogenated corn oil, pork sausages deficient in meat, a portion of fish containing a filariform worm, a bottle of milk containing dead pupae of the fruit fly, a bottle of limeade which was contaminated with cresol, a bottle of milk containing a curved piece of glass, bread containing part of the thorax of a cockroach, a milk loaf in which whole milk solids were absent, a swiss roll containing extraneous mineral debris, bread spread with rancid butter, a loaf containing a piece of paper, a bottle of milk containing a garden snail, dried peas containing a poppy capsule case, a stick of rock containing a steel nut, cake containing a piece of glass, bacon which had suffered spoilage by a growth of mould, a fruit pie which had suffered spoilage by a growth of mould, a chocolate cake containing a piece of metal, a pasty containing a fragment of rag, a can of pears containing a beetle, a loaf containing burnt dough, a tin of liver, bacon and onion containing a nail. Four of these cases resulted in prosecution and similar action was recommended in other instances; warning letters were sent in three other cases.

The Sampling Officers take their samples with very considerable care and selectivity. Apart from the help given in this department, they are assisted and advised in their choice of samples by consultation with the Public Analyst and by a close study of the reports issued by the Public Analysts of other counties and published accounts of the legal action taken by other Food and Drugs authorities.

All complaints of alleged infringements of the principal Acts or the many Regulations, etc., made under it are very carefully examined. The co-operation of the public and of other local authorities is welcomed and I hope that this assistance will increase in the future.

Milk

The Divisional Milk Officer of the Ministry of Agriculture, Fisheries and Food informs me that, at the end of 1965, there were 7659 registered milk producers, a decline of 187 on the previous year; 625 licences permitting the sale of Untreated milk by producer-retailers were also in operation.

The Divisional Veterinary Officer of the Ministry of Agriculture, Fisheries and Food reports as follows :—

"Without a doubt the year 1965 can be considered to have been a most successful one in Devon as far as animal health division is concerned. 299,680 cattle were tested and revealed 58 reactors, 39 of which showed lesions on post mortem. This number of reactors represents 0.019% of animals tested and shows a very gratifying drop. In 1964 there were 78 reactors; this figure being 0.02% of the total tested. In previous years there were 98 reactors in 1963 and 556 reactors in 1962.

Swine fever and fowl pest have been almost non-existent and we have been most grateful for another year without foot and mouth disease. Nevertheless, complacency must be the last thing to enter one's thoughts or actions as there has been an increase in non-scheduled diseases, such as brucellosis and salmonellosis.

As far as the free calfhood vaccination service is concerned, we were able to report a 25% increased uptake in the vaccine and in 1965 41,420 doses were used compared with 31,496 in 1964. Every effort has been made and will be made to increase this latest figure even more.

Although there were 28 confirmed cases of anthrax in the county during 1965, this is not causing undue worry. 20 of them occurred in January, February and March of 1965 and then tailed off towards the end of the year. We would like to record our thanks to the public health department for their excellent co-operation."

It will be noted that there is still a significant percentage of heifers unprotected against brucellosis and this, together with the small amount of tuberculosis in cows, only emphasises the need for pasteurisation of milk and its products. The native of Devon will be at small risk since such milk will have been drunk from infancy. The visitors are, however, much more susceptible since they have not usually had the doubtful privilege of drinking unpasteurised milk before and are not, therefore, immune to the diseases carried in milk.

Brucella Abortus

Towards the end of 1963, a sampling programme was initiated to determine the degree of infection by this organism in the milk sold for human consumption, and sampling continued through 1964 and 1965. The results of the sampling carried out during the year under review were as follows :—

Total number of samples submitted	1,109
Number positive on the Ring Test but negative on culture	128
Number positive on culture	50

Immediately a positive culture was known, the medical officer of health for the district was informed and steps were taken to prohibit the sale of the infected milk and to trace the offending animal or animals. Normally, two consecutive negative results are required before the raw milk is allowed to be consumed again and the number of samples taken is increased.

Biological Examination of Milk for the Presence of Tuberculosis

During the year a total of 964 samples was submitted, special attention being paid to milk to be sold unpasteurised. There were no positive results.

The figures for the preceding 13 years are as follows :—

Year	No. of Samples	Positive Results
1952	781	11
1953	475	3
1954	1028	12
1955	1941	5
1956	959	0
1957	831	4
1958	1107	2
1959	905	2
1960	679	0
1961	697	0
1962	666	0
1963	721	0
1964	865	0

The Milk (Special Designation) Regulations, 1963

These Regulations, which came into force on September 29th, 1963, gave to the County Council the duty of licensing every dealer in designated milk; this work had previously been carried out by the public health departments of 47 district councils. The task of supervision and control by one authority was, therefore, a formidable one.

It has meant the annual inspection and general approval of the premises and milk handling facilities of 1,102 dealers and a comprehensive sampling programme is now in being.

During the year the following samples were submitted :—

Pasteurised	*TOTAL*	*No. failing phosphatase test*
	1143	1
Untreated	*TOTAL*	*No. failing methylene blue test*
	547	30
Sterilised	*TOTAL*	*No. failing turbidity test*
	35	nil

When a sample fails to pass the prescribed test, an immediate inspection of the dealer's premises is made and repeat samples are taken where necessary. If it is thought that the failure, in the case of untreated milk, is the fault of the producer, the Ministry of Agriculture, Fisheries and Food's Divisional Milk Officer is informed.

The Milk (Special Designation) (Pasteurised and Sterilised Milk) Regulations, 1949

The County Council issued licences to the six pasteurising plant operators remaining in the county and a very careful watch is kept on both the plants and the processed milk. This involves regular inspections and samples are submitted for laboratory examination at very frequent intervals.

342 samples were taken from these plants during the year, all of which passed the phosphatase test.

Additional checks on the quality of the processed milk are afforded by the routine sampling of milk supplied to the schools in the county, as a very large proportion of school milk is derived from these plants.

SCHOOLS

Milk in Schools Scheme

The tendering and three-year contract system of supplying the schools with milk which commenced in 1955 has worked with great success as far as this department is concerned. 535 schools in the county receive milk, including private schools; only 4 of this number are receiving raw milk, the remainder being supplied with pasteurised milk. Every effort was made to find a supply of pasteurised milk for the schools in question, but largely on the grounds of distance and excessive cost it proved impossible to arrange.

School Swimming Pools

I welcome the rapid progress which is now being made with the provision of swimming pools for schools throughout the county. Most of them are of the learner type but a few, particularly in the larger secondary modern schools, are large enough for the advanced swimmer. At the end of the year 103 pools had been completed and at least another 25 are contemplated for the following summer.

The Education Committee are prepared to consider grants of £250 for primary school pools and £500 for secondary schools, or half the cost—whichever is the smaller. In most instances the Head Teacher has been able to raise the balance from voluntary sources, e.g. parent-teacher organisations.

This rapid increase in the number of school swimming pools has meant a considerable extension of the work of the department. The sampling officers visit every school once a week and obtain a sample of water for bacteriological examination. If this sample is the subject of an adverse report, the County Health Inspector visits the school immediately and offers the appropriate advice. The all-important consideration is to maintain a satisfactory level of residual chlorine in the pool at times of peak load, and our experience has been that this can only be achieved in the hand-dosed pool by continual checking and the repeated use of booster doses of hypochlorite solution throughout the day. This supervision will undoubtedly occupy a certain amount of the time of an already busy Head Teacher, but it is a responsibility which cannot be shirked if the pool is to remain an asset rather than a danger to the health of the children.

On a number of occasions the samples from a minority of pools (which, of necessity have to be collected before lunch) gave unsatisfactory bacteriological results and if samples were to have been taken in the afternoon when the peak bathing load, allied to higher water temperature, was exerting its full effect on the available chlorine, then undoubtedly the picture would have been worse. Spot checks on the chlorine residual in pools were frequently carried out by the County Health Inspector and these only confirmed the truth of this statement.

It is clear that some Head Teachers do not realise how rapidly chlorine can be dissipated from pool water under the influence of warmth and bright sunshine, even when the pool is not in use : this action is immensely accelerated when the pool is being used, as each child contributes organic impurities which lock up and neutralise chlorine which would otherwise be available for killing germs.

My advice to Head Teachers is that it is a mistake to economise with chlorine; if they are hand-dosing, then the initial application of the day may well require hypochlorite solution at the rate of 3-pints per 10,000 gallons of

pool water, with booster doses, whenever necessary, throughout the day of 1½ to 2 pints; these figures are given as a guide, and will vary under individual circumstances. Testing need not be a time-consuming operation: the orthotolidine test can be carried out in ten seconds and there is no excuse for children using a pool without a chlorine residual of at least .5 parts per million.

WATER SUPPLIES

Water Boards in the county have all been active during the year and all have substantial schemes, either in course of construction or awaiting the consent of the Ministry of Housing and Local Government. This progress is emphasised by the amount of precept which each Board makes on the county council.

Comparative figures are as follows :—

	1963/64	1964/65	1965/66
	Actual Cost	*Actual Cost*	*Probable Cost*
North Devon Water Board	£147,580	£223,355	£253,875
South-West Devon Water Board	£ 79,513	£ 43,342	£ 42,850
East Devon Water Board	£ 73,399	£ 92,738	£ 27,000

The North Devon Water Board now covers an area of 1,646 square miles; approximately 1,180 miles of mains have been laid and the average quantity of water supplied is over 8.6 million gallons per day. The total capital expenditure incurred by the Board up to March, 1965, was £6,777,600.

As from the 1st April, 1965, the Boroughs of Bideford, Okehampton and South Molton and the Urban District of Crediton were added to the Board's area of supply.

The Board have made application to the Ministry of Housing and Local Government for an Order to construct an impounding reservoir at Meldon and a public inquiry into the Board's application was held in March, 1965. The decision of the Minister is still awaited.

The South-West Devon Water Board was formed under Ministerial Order to operate from 1st October, 1963, and it took over the water undertakings of the South Devon Water Board and of the Boroughs of Torquay and Totnes; the Urban Districts of Ashburton, Brixham, Buckfastleigh, Dawlish, Paignton and Teignmouth; the Rural District of Newton Abbot and part of the Rural District of St. Thomas lying to the south of the River Exe. The statutory area is approximately 500 square miles and the total amount of water produced in 1965 was 4,215 million gallons. The total capital expenditure to the 31st March, 1965, was £6,333,062, including the book value of assets transferred under the Order. The outstanding debt at the 31st March, 1965, was £4,078,086. Up to the 31st December, 1965, the new Board had laid 64 miles of mains.

The East Devon Water Board was reconstituted on the 1st October, 1964, and now comprises the authorities of the original Board, together with the County Borough of Exeter, Budleigh Salterton, Exmouth, Seaton and Sidmouth, the whole of the St. Thomas Rural District area east of the River Exe and the Water Undertaking of the Colyton Feoffees. The total capital expenditure of the Authorities included in the Board amounted to £4,223,750 at the 31st March, 1965; of this figure £1,581,831 was incurred by the Board itself and £2,641,919 represented the debt of transferred undertakings.

The East Devon Water Board covers an area of 371 square miles; 865 miles of mains have been laid and the output during the year was 3,326 million gallons.

During the year grants under the Rural Water Supplies Acts were agreed to in principle on the following schemes :—

Local Authority	*Parishes or Areas Affected*	*Estimated Cost*
South-West Devon Water Board	Churchstow	£600
,,	Chudleigh, Ideford, Luton and Olchard	£75,000
,,	Staverton	£1,100
,,	Torbryan	£5,700
,,	Waterhead and Goodshelter	£4,100

Sewerage and Sewage Disposal

The following schemes submitted to the County Council for financial assistance were examined by the County Health Inspector, and recommendations in each case were made to the Appointments and General Purposes Committee :—

Local Authority	*Parishes or Areas Affected*	*Estimated Cost*
Axminster R.D.C.	Colyford	£6,500
Barnstaple R.D.C.	Landkey, Swimbridge and Bishopstawton	£160,600
Bideford B.C.	East-the-Water	£35,000
Broadwoodwidger R.D.C.	Broadwoodwidger	£9,800
	Grinacombe Moor	£5,400
	St. Giles-on-the-Heath	£18,500
Crediton R.D.C.	Zeal Monachorum	£33,800
Crediton U.D.C.	Sewage Disposal Scheme	£343,000
Dawlish U.D.C.	Northern Area	£167,365
Holsworthy R.D.C.	Halwill	£15,500
	Halwill Junction	£44,800
Kingsbridge R.D.C.	South Pool	£25,400
	Chillington and Frogmore	£75,000
	Loddiswell	£48,000
Newton Abbot R.D.C.	North Whilborough	£4,000
Newton Abbot U.D.C.	Sewers and Forde Road Pumping Station	£666,400
Northam U.D.C.	Sewage Disposal Scheme	£190,000
Okehampton R.D.C.	Meeth	£16,120
	Throwleigh	£29,457
	Belstone and Sticklepath	£58,906
Okehampton B.C.	Sewage Disposal Works	£68,655
Ottery St. Mary U.D.C.	Westhill	£187,128
St. Thomas R.D.C.	Tedburn St. Mary	£95,700
	Kenton and Starcross	£340,000
Salcombe U.D.C.	Sewage Disposal	£205,000
South Molton R.D.C.	Burrington	£8,697
Tiverton R.D.C.	Huntsham	£11,775
	Ashill	£28,600

Tiverton B.C.	Sewage Disposal Scheme	£746,000
Torrington R.D.C.	Weare Gifford	£46,200
	Hollacombe	£12,600
Totnes R.D.C.	Galmpton	£30,000
	Higher and Lower Dean	£8,643
	Marldon and Compton	£75,000

PART VI

MISCELLANEOUS SERVICES

Capital Building Programme

Health Centres

Clinics

Ambulance Stations

Junior Training Centres

Hostel Accommodation—Children

Adult Training Centres

Hostel Accommodation—Adults

Accommodation for District Nurse/Midwives

CAPITAL BUILDING PROGRAMME

HEALTH CENTRES

A health centre is a building in which family doctors have their consulting rooms, where the local health authority has its clinic and where officers of Health and other departments may be based or have interview facilities. There is thus a drawing together of those engaged in the community health and welfare service which can only be of benefit to all concerned.

A great deal has been written about the family doctor, the waste of valuable medical time, poor accommodation, inadequate equipment and lack of clerical and ancillary help. The doctors "charter" will almost certainly be of assistance but it remains a matter of importance that unsatisfactory accommodation, together with clerical and other ancillary help, should be provided in the most economical manner possible. It is surely preferable for the doctors and the local health authority to share accommodation, equipment and clerical help rather than for individual practitioners and the authority each to provide their own premises. When accommodation, etc., is shared in this manner the premises become very fully used, i.e. general practitioner's main surgeries are in the mornings and evenings, the local health authority's child welfare and ante-natal clinics take place in the afternoons. Furthermore, the policy of attaching or closely connecting to the general practitioner such ancillary staff as health visitors, nurses, midwives, mental welfare officers, etc., will be of even greater value in a health centre where liaison can be effected easily without time-consuming journeys.

The premises to be provided by the county council will be let in the first instance to the Executive Council, who will re-let to the general practitioners. The Executive Council remains responsible for rent and thus ensures permanency of letting. The rent charged, which is inclusive of all repairs, is assessed by the county land agent and the county treasurer on a basis of 8% of capital cost of the rooms of which the doctors have exclusive or shared use. In addition, the Executive Council pays a proportion, again according to use, for equipment and running expenses, including rates, heating, lighting, cleaning, telephone, etc.

Arrangements are made for the sharing of clerical staff, and an appropriate proportion of salaries, etc., are payable by the Executive Council. Thus both the county council and the doctors, by sharing the premises, are able to use very satisfactory accommodation at a cost to each which is considerably less than it would be for buildings erected for independent use. At some of the smaller places a clinic purely for local health authority purposes would be exactly the same size as that now being erected for shared use with the general practitioners.

Health centres are being planned in various towns and villages in Devon, the minimum criteria generally being as follows :—

(i) Approval of the general practitioner(s) already practising in the area.

(ii) The need for new maternity and child welfare clinic facilities : this is dependent upon existing accommodation, overall population, the annual number of births, and the number of children under the age of 16 years.

Although these figures are not hard and fast, the following is an estimated guide :—

Overall population	2,500
Annual number of births	40
Number of children under 16 years	600

Progress

Throughout 1965 steady progress was maintained with the planning of health centres in many parts of the county. The earlier enthusiasm of general practitioners showed no signs of abating and by the end of the year two centres were in the course of construction, and twenty-seven more were being planned.

Buckfastleigh

Site problems had delayed the commencement of building and further set-backs resulted in a half finished centre by the end of the year, although November had originally been given as the completion date. The building is not now likely to be finished until April/May, 1966.

Ottery St. Mary

The county council purchased the purpose-built premises of the general practitioners and work commenced during the year to adapt and extend the former dental wing vacated when the dentist left the district and could not be replaced. Excellent progress has been made on this project, which is likely to become the first operational centre in the county.

Okehampton

By the end of the year a tender had been accepted to extend the new Okehampton clinic to afford accommodation for the four local doctors. Minor adaptations were also carried out during the year to make the clinic suitable for use by the Regional Hospital Board as an orthopaedic out-patient department.

Lynton

A tender was accepted for this health centre in December and building should commence early in the New Year.

Ilfracombe

Working drawings are in an advanced stage, and tenders should be invited early in the New Year.

Seaton

At working drawing stage and tenders should be invited at about the same time as Ilfracombe.

Ipplepen

Although ready to invite tenders for this health centre, difficulties arose over the site acquisition, and these were not resolved at the end of 1965.

Site Acquisition

During the year sites were obtained for health centres at Colyton, Combe Martin, Cullompton, Great Torrington, Plympton, and South Molton.

Future Programme

Following discussions with the general practitioners and the Executive Council, plans are now in hand to provide health centres at the following additional places :—

Ashburton, Axminster, Budleigh Salterton, Chudleigh, Dawlish, Exmouth, Ivybridge, Kingsteignton, Northam, Paignton, Salcombe, Sidmouth, and possibly Teignmouth.

CLINICS

If health centres cannot be erected then clinics should be provided containing not only health department services but also those of the welfare, children's, education and perhaps probation departments. This is essential to help effect liaison between the services of these departments which can overlap in the fields of the elderly, children's welfare, handicapped persons, problem families, and the unmarried mother, etc.

A social services sub-committee of the establishment committee, meeting to discuss administrative arrangements in the children's, health, education and welfare departments, resolved that all social workers in these departments should be based wherever possible in the same offices. An extension to Bideford clinic is likely to provide the first of such bases.

All future clinics in Devon are being planned so that it will be possible to add an extension to provide accommodation for general practitioners if they should elect later to join in a health centre.

A survey of existing hired accommodation showed that although some places are tolerable, conditions in others are quite deplorable. Some of the conditions found are as follows :—

(1) Several premises were very dirty and, because of age and dilapidations, impossible to keep clean.
(2) Water closets often out of action and frozen in cold weather.
(3) Buildings so poorly heated that babies and toddlers could not be examined except in warm weather.
(4) Complete lack of privacy and sound-proofing so that no matters of a confidential nature could be discussed.
(5) Dangerous stairs and steps which were hazardous to mothers carrying babies, elderly persons, expectant mothers and toddlers.
(6) Inadequate means to provide hot water.
(7) Cramped conditions. In one instance the doctor has to sit in a wash-room immediately outside the lavatory which is used by the public attending the clinic.
(8) In one place, which is also used as a club, evidence of the previous night's revelry may still be found.

Clinics Completed

During the year the clinics at Exmouth and Okehampton were completed.

At Bideford the second stage extension to provide a new dental suite and a surgery for the chiropodist and office accommodation for the occupational therapist was commenced and completed.

At Paignton the extensions which were completed, consisted of re-modelling the existing clinic and an adjacent house.

Bovey Tracey

By the end of the year the architect's plans for a clinic at Bovey Tracey were well advanced. This building has been so designed as to allow easy extension should the local doctors wish to have accommodation later.

Totnes

This clinic, designed to house also the children's, welfare and education departments, could not be commenced during 1965 owing to the credit squeeze. It is hoped that a start may be made some time in 1966.

Site Acquisition

A site was purchased for a clinic at Kingskerswell and a building similar to that at Bovey Tracey will be erected later.

AMBULANCE STATIONS

Bideford ambulance station was completed in 1965.

In the post-war period, ambulance stations have been provided at Crediton (1963) and at Plympton (1960). In addition a further nine ambulance stations have been provided by voluntary organisations at Ashburton, Axminster, Combe Martin, Dartmouth, Honiton, Okehampton, Sidmouth, South Molton, and Torquay.

JUNIOR TRAINING CENTRES

These have been provided since the war at :—

	Day Pupil Places	*Residential Places*
Abbeyfield, Barnstaple	60	30
Oaklands Park, Dawlish	48	43
Mayfield, Paignton	48	–
Downham, Plymstock	48	21

During the year plans were drawn up to provide at Paignton a manual instruction room and an additional 12 places, together with a special care unit, the capital cost of which is being generously donated by the Spastics Society. Towards the end of the year tenders were being invited for this work.

Working drawings were almost completed for the Plymstock extensions which will provide an additional 12 places, a kitchen, new dining room/hall and manual instruction room.

HOSTEL ACCOMMODATION FOR CHILDREN

During the year 6 additional places were provided at Barnstaple and an additional 6 places in Plymstock. This brings the total number of places provided to 30 at Barnstaple and 21 at Plymstock.

ADULT TRAINING CENTRES

Barnstaple

The new purpose-built 120-place adult training centre was virtually completed by the end of the financial year.

Exmouth

The urgent need for a new adult training centre at Exmouth was recognised by the Ministry of Health and this building received loan sanction in spite of the restriction on capital expenditure. A tender was accepted in December and the contractor was due to start building operations early in the New Year.

Tavistock

Plans were drawn up for a 50-place adult training centre at Tavistock and these have been submitted to the Ministry of Health.

Axminster

Site problems, in addition to the credit squeeze, held up further developments in this part of the county.

HOSTEL ACCOMMODATION FOR ADULTS

Marldon, near Paignton

This 23-place hostel for men and women was brought into use during the year. The male side filled almost immediately and, although the female side was a little slower, by the end of the year the building was full.

Barnstaple

A 29-place hostel, adjacent to the new adult training centre and occupying the converted former tuberculosis hospital, was almost completed by the end of the year.

ACCOMMODATION FOR DISTRICT NURSE/MIDWIVES

An experimental enlarged district room, together with lavatory and waiting accommodation, is being provided in certain bungalows, so as to give the county chiropodists satisfactory working conditions in small villages where other clinic facilities are not justified. Thus, at a cost probably no greater than that of hiring a hall, the chiropodist can work in clean, pleasant surroundings, without interference to the privacy of the nurse.

The first of these bungalows, with large district room, were brought into use during the year at Kenton and Landkey, and have proved very successful. Others are planned at Bratton Fleming, Winkleigh, Bampton and Uffculme. The following additional building construction was started in 1965 :—

Bideford—2 bungalows.
Okehampton—1 bungalow.

The following were purchased in 1965 :—

Sidmouth bungalow.
Northam (transferred from Police).
Honiton bungalow.

PART VII

Child Health Services

The Health of the School Child

The Annual Report of the Principal School Medical Officer, including

The Report of the Principal School Dental Officer

CHILD HEALTH SECTION

SCHOOL HEALTH SERVICE
HANDICAPPED CHILDREN
JUNIOR TRAINING CENTRES AND HOSTELS
DAY NURSERIES AND CHILD MINDERS
SPECIAL FAMILIES
LIAISON WITH OTHER DEPARTMENTS

The child health section was introduced in 1961 and covers all local authority health services available to children between the age of two years and school-leaving age. There is, of course, no hiatus at the extremes, liaison with the maternity and infant welfare and adult health sections being close and continuous. This administrative division is unusual in that it includes the community care of mentally handicapped children, a service more often included in the mental health sections of health departments. Here in Devon, by having a more comprehensive child health section, we ensure that these handicapped children receive continuity of care and are dealt with by the same professional and administrative staff between the ages of two and sixteen, thus emphasizing our belief that these children should not be cut off from the main stream of community child care.

In the field, the care of all children from birth to sixteen is the special responsibility of both assistant county medical officers and health visitors, and while help and supervision are still available through them after this age, this is supplemented in the case of handicapped children by social workers from the adult health section who assist in effecting liaison with youth employment officers, disablement resettlement officers and others operative in the adult working world.

On the central staff there is a senior medical officer responsible under the county medical officer for the administration of the section, assisted by the superintendent health visitor, a health visitor experienced in the care of special families and clerical staff dealing with detailed administration of the separate sub-sections. We are fortunate in having an excellent clerical staff who give unstinted hard work and loyalty to the section.

SCHOOL HEALTH SERVICE

The work of the school health service has continued smoothly throughout the year. The work which the school medical officer is called upon to do becomes more diverse. Ascertainment of handicapped pupils becomes an increasingly important and time consuming task—it demands the most careful and thorough work to ensure that a child has been thoroughly assessed and correctly placed. Further the school medical officer must do medical examinations for teachers and teaching candidates, special examinations, health education talks, confer with head teachers, attend case conferences, examine school buildings, quite apart from investigation of any infectious disease outbreaks. All these tasks tend to erode away the time needed for routine medical inspection and immunisation procedures. As a result some school medical officers have had difficulty in completing their programme for the year.

Apart from their visiting work and attendance at medical inspections the health visitors and clinic nurses do much routine work in the schools. School children have an annual vision test and an annual hearing test. In some schools a termly hygiene examination is also considered necessary.

Further, in one area (Tiverton-Crediton) for the last 4 years about 5,000 (over 90%) of school population for the area between the ages of 5 and 12 years have been Heaf tested for tuberculosis each year following a request in 1962 from the (then) Ministry of Education (see report page 39).

This work also gives the nursing staff a useful opportunity to talk to and appraise every child.

In few schools is it possible to have a medical inspection room, which is the ideal, and visits to the schools by the many and various members of the school health service must at times cause difficulties and disruption, especially in the smaller ones. The goodwill and co-operation of head teachers, which is invariably found, is much appreciated.

Administration

The numbers of children on the school registers are as follows :—

Primary Schools	42,841
Secondary Schools, Grammar Schools, and Comprehensive Schools	28,693
Special Schools	407
Total	71,941

Direct control of this service is vested in the school health sub-committee of the education committee, and we are particularly fortunate in this county in the friendly and effective liaison between education and health departments.

There are twenty-two school medical officers in the field, fourteen of whom are part-time and nine of these hold mixed appointments as assistant county medical officer and district medical officer of health. They arrange their own school programmes and are responsible for advising head teachers of impending school medical inspections. Needs vary widely in a county of such size and diverse nature as Devon and a delegate function such as this has much to commend it. All school medical officers have a degree of independence which encourages interest and responsibility and allows the development of varied skills.

To enable us all to benefit from such individual experience and to guard against isolation as well as to discuss matters of general interest, the county medical officer holds a central meeting of all medical staff three times a year. It is planned that these meetings shall be held in different areas of the county; and followed by a talk by an invited speaker, or a visit to a place of interest. As a further means of exchanging ideas, the senior school medical officers of Plymouth, Exeter, Cornwall and Devon, also meet three times a year and it is most useful to discuss problems and compare experiences.

School Medical Inspections

The compulsory school medical examination of school entrants remains the keystone on which the school health service is built. It may be the first complete medical examination the child had had and its value is heightened by the opportunity afforded to the parents to discuss with the school medical officer any problems which they have concerning the child. Some medical officers use the selective system for examination of intermediate age groups, others continue with the examination of all pupils at this age. This is a decision for the individual preference of the medical officer concerned and is still a matter of some controversy. Those who use the selective system find it rewarding in that they are able to spend more time with children having a definite symptom; those who examine all children routinely feel that defects may be missed if selection for examination is made on the basis of a complete questionnaire, or the recommendation of the school nurse or teacher. All children have a third medical inspection before leaving school. The general trend of less physical defects and more emotional problems is especially noticeable at this medical inspection; with a need to spend more time with each child. Several medical officers report emotional problems following admission to either the primary or the secondary school. This change in a child's life can result in such difficulties as poor school work, bed wetting, school phobia, etc. It usually settles down with time, but plea has been made that children should be able to visit the primary or secondary school before admission so that they do not feel it is quite so strange when they are admitted. The frequency of visits to each school varies. Some medical officers are arranging with head teachers to divide up the year's work so that the medical officer visits the schools each term routinely and is thus able to establish a much closer liaison with both pupils and staff.

School Medical Records

Anxiety has been expressed by many medical officers and school nurses concerning the present arrangement of filing school medical records in schools. These records are confidential documents, and include letters and copy letters from doctors concerning school children which are sent to the local authority medical officer on the understanding that the usual medical ethics of confidentiality are observed.

Medical officers are so concerned about this lack of confidentiality that many keep a separate file of confidential documents in their clinics and take these with them to the schools when performing medical inspections. This arrangement is most unsatisfactory, and there is a danger of important documents being lost if a child removes from the area.

The filing of records in the school results in records being accessible only during school hours and in term times. It is to be hoped that it will be possible for all records to be kept in the area clinic or health centre, with appropriate clerical assistance for filing, so that they are cared for by the school health service staffs and accessible to them at all times.

A—Periodic Medical Inspections

The number of children classified unsatisfactory will depend very much on the medical officer doing the examination. Different standards are held by different medical officers, and therefore these figures do not give a reliable guide to the standard of health of the children examined.

Age Groups Inspected (By year of birth)	*No. of Pupils inspected*	*Pyhsical Condition of Pupils Inspected*	
		Satisfactory	*Unsatisfactory*
		No.	*No.*
(1)	(2)	(3)	(4)
1961 and later	116	113	3
1960	3,955	3,941	14
1959	2,458	2,451	7
1958	567	563	4
1957	1,963	1,961	2
1956	1,684	1,650	4
1955	613	609	4
1954	1,387	1,385	2
1953	1,734	1,731	3
1952	749	747	2
1951	829	829	—
1950 and earlier	4,061	4,051	10
Totals	20,116	22,061	55

B—Other inspections

Number of Special Inspections	644
Number of Re-inspections	4,993
Total	5,637

C—Pupils found to require Treatment at Periodic Medical Inspections
(excluding Dental Diseases and Infestation with Vermin)

Notes: Pupils found at Periodic Inspections to require treatment for a defect are not excluded from Table C by reason of the fact that they were already under treatment for that defect. Table C relates to individual pupils and not to defects. Consequently, the total in column (4) will not necessarily be the same as the sum of columns (2) and (3).

Age Groups Inspected (By year of birth) (1)	*For defective vision (excluding squint)* (2)	*For any of the other conditions recorded in Part II* (3)	*Total individual pupils* (4)
1961 and later	1	23	18
1960	42	230	253
1959	28	153	127
1958	10	65	52
1957	29	118	114
1956	37	127	153
1955	13	62	61
1954	32	136	116
1953	67	130	157
1952	44	140	122
1951	51	158	130
1950 and earlier	194	337	376
Totals	556	1,682	1,661

Return of Defects by Medical Inspection in the Year ended 31st Dec., 1965

Note: All defects noted at medical inspection as requiring treatment are included in this return, whether or not this treatment was begun before the date of the inspection.

Defect Code No.	Defect or Disease	Periodic Inspections — No. of defects		Special Inspections — No. of defects	
		Requiring treatment	*Requiring to be kept under observation but not requiring treatment*	*Requiring treatment*	*Requiring to be kept under observation but not requiring treatment*
	(1)	(2)	(3)	(4)	(5)
4	Skin	214	238	6	12
5	Eyes—*a.* Vision	556	667	16	6
	b. Squint	102	198	2	2
	c. Other	35	114	5	3
6	Ears—*a.* Hearing	60	357	8	6
	b. Otitis Media	26	422	6	9
	c. Other	23	45	—	2
7	Nose or Throat	139	1,091	8	18
8	Speech	58	368	5	11
9	Lymphatic Glands	7	433	1	7
10	Heart	21	223	5	2
11	Lungs	86	475	45	9
12	Developmental—				
	a. Hernia	7	48	—	—
	b. Other	34	314	7	3
13	Orthopaedic—				
	a. Posture	33	222	11	11
	b. Feet	148	432	9	11
	c. Other	132	481	19	12
14	Nervous system—				
	a. Epilepsy	24	85	1	6
	b. Other	23	104	7	—
15	Psychological—				
	a. Development	208	414	9	6
	b. Stability	218	531	6	19
16	Abdomen	25	114	2	1
17	Other	8	110	3	—

Infestation with Vermin (head-lice)

Neither cleansing notices nor cleansing orders were issued during the year, the policy being that a friendly approach to the parents is more effective in the long run.

The schools in most areas are completely free from infestation, in others it is a constantly recurring problem. A determined and energetic school nurse can do much to reduce the incidence, and it is to be hoped that with the easy, pleasant modern treatment, infestation will soon become a thing of the past.

Infestation with Vermin

(i)	Total number of examinations in the schools by the school nurses or other authorized persons	99,089
(ii)	Total number of individual pupils found to be infested ...	311
(iii)	Number of individual pupils in respect of whom cleansing notices were issued (Section 54 (2), Education Act, 1944)	–
(iv)	Number of individual pupils in respect of whom cleansing orders were issued (Section 54 (3), Education Act, 1944) ...	–

Nocturnal Enuresis

The electric alarm apparatus was out on loan during the year and continues to be of valuable service. If it does not actually produce 100% cures in all cases it does demonstrate to the child concerned that he is capable of having dry nights. This realisation makes the child and the parents much happier and in one or two cases an improvement in the child's school work has also resulted. The family doctor is consulted in all cases before treatment is commenced. This group of children needs our help but unfortunately parents are often reluctant to bring them forward for treatment. There is no doubt, however, that the success obtained with the alarm has brought many mothers to the Clinic to enquire about it and ask for help.

We are using the alarm for five- and six-year-old children now, as well as for older children. It is just as effective with the younger children and usually the time required to establish control is much shorter than with older children.

Relationship with G.P.s

On the whole this is excellent, and medical officers are encouraged when they first take up their duties to visit all G.P.s in their area, making themselves known to facilitate later contacts. Any child found at a school medical inspection to require treatment is referred to the G.P. by letter or 'phone, and where specialist advice is necessary a consultation form is completed and sent to central office: notice of this is sent to the G.P. with a proviso "If you have any objection to this course of action, please inform me within seven days. If I do not hear from you I shall assume that you have no objection, but if you have any further details of the child's medical history which you think may be of help perhaps you will be kind enough to send these to me or direct to the consultant. A copy of the consultant's report will be forwarded to you," which gives an opportunity to object but saves the G.P. any trouble in replying if he is agreeable.

ANCILLARY SERVICES

There are many services which, whilst disciplines in their own right, also provide ancillary help essential to the proper functioning of the school health service.

Child Guidance

There are three clinics in the county situated at Barnstaple, Torquay, and Exeter, the latter being a joint clinic with Exeter City. The teams are headed by psychiatrists who give varying amounts of time on a sessional basis. Children from the south-west of the county are referred to the Nuffield Clinic at Plymouth where Dr. Weeks sees them for us.

In addition to their ordinary work, the psychiatrists give much valuable time to meetings with health visitors and school medical officers to discuss cases of mutual concern and to advise on child guidance in general. This in-service training is of incalculable benefit and we are most appreciative of such constructive help. Dr. Johnston also gives much guidance over problems of mentally handicapped children and is available for consultation with parents and staff.

Dr. Johnston reports :—

"New referrals to the clinic and the numbers of those undergoing treatment have been maintained during the past year. Sources of referral have remained more or less the same, though there is increasing evidence that more children are being referred by general practitioners, and that the latter are becoming increasingly aware of the services offered. It is generally felt that the family doctor should be fully in the picture to a greater extent than has been manifest in the past, though there may be still a few who doubt the value of what can be done in a clinic of this kind. I, personally, would feel happier that each family doctor should have a report on any child who has attended, similar to that sent to the school medical officer. In most instances parents themselves would be agreeable to this.

"Most of these reports are of a highly confidential nature, and their content is mainly of a medical nature. I am a little perturbed that the contents of these reports have, in some instances, been passed on to non-medical officials, and I know also that my colleagues have very strong views about this.

"The past year has seen several changes in clinic staff. Unfortunately Dr. D. A. Sime left the service, and his valued clinical judgement and co-operation, in all fields, have been greatly missed. There has been great delay in appointing a successor, though I understand that one extra session will be granted to the person appointed.

"With the arrival of Dr. C. J. Wardle, I was permitted, by the Regional Hospital Board, to devote the two sessions per week to Torquay, instead of Barnstaple, and there is a possibility that a further full session may be allowed, once the new establishment has been given final approval.

"The opening of the adolescent unit at Wonford has been of great help in the adequate care and treatment of the disturbed adolescent.

"At the present time the clinic has some little difficulty because of the lack of a full-time psychologist. Both Mr. H. H. Hillman and Mr. A. D. Bate departed to take up better posts elsewhere. The clinic has therefore been deprived of their wide experience and clinical ability, as well as their personal qualities as members of a team.

"Fortunately we have retained the services of our two fully trained and able psychiatric social workers, Miss Jean Williams and Miss M. Rossall, who have provided excellent social histories, as well as supportive help to the families of those children for whom advice has been sought.

"Miss E. Yeo has remained with us and has been of inestimable value with her psychotherapeutic work, with young children in particular.

"There have been changes, too, in the remedial teaching staff. When Mr. A. Tutcher left, he was replaced by Mr. C. C. Coxon. I am indebted to both of them for their untiring efforts and skill with those children who have reading and other educational difficulties.

"A great burden has been thrown on the secretarial and clinical staff because of the increasing number of reports, case histories, etc., which are building up continually. It is hoped, therefore, that further help may be available in these departments in the not-too-distant future.

"Crichel hostel has been working to full capacity during the whole of the year, and the demand for places there has been ever increasing. Both Mr. and Mrs. A. O. Broughall and their assistant, have done good work with a number of problem boys and families."

Dr. Wardle reports that his sessions during the last year have been more than fully taken up and feels there is little doubt that there is sufficient work for at least 2 full days per week in the area. He is hoping to obtain the assistance of a registrar in child psychiatry to work with him at his present sessions.

It is interesting to note the increase in cases seen at the clinic over the last five years :—

1961	56
1962	57
1963	84
1964	67
1965	130

The number of cases seen in 1965 is double that of previous years. It is not surprising, therefore, that the secretarial and social work staff have found their work increasing beyond what they can manage.

Number of pupils treated at child guidance clinics under arrangements made by the authority	1,049
Total No. being treated 1st January, 1965	454
Residential	35
No. on waiting list 1st January, 1965	65
No. referred during 1965	525
No. discharged during 1965	481
No. being treated 31st December, 1965	500
Residential	38
No. on waiting list 31st December, 1965	60

Educational Psychologists

There are six educational psychologists including the senior, Dr. Star (who resigned in July, since when Miss B. Edwardson, has been acting senior) who work closely with the school medical officers. Where it is necessary to complete form 2 H.P. the educational psychologist completes the first part and the medical officer the remainder, the examination including an audiogram. The final recommendation is made by the senior school medical officer, after consultation with the senior psychologist, and a suitable placement arranged.

HEARING ASSESSMENT CLINICS

Four of the school medical officers have received special training in the assessment of deaf children and 4 hearing assessment clinics have been established to date for North Devon, East Devon, and the Torbay area, and West Devon. Some children from the south and west are referred to Plymouth hearing assessment clinic.

All children receive an annual hearing test in school and those in whom there is reason to doubt aural acuity including pre-school children, are referred to the hearing clinic run by these school medical officers. If found to be deaf they are passed to the hearing assessment clinic at which an E.N.T. consultant attends as well as the medical officer and other interested workers, e.g. peripatetic teacher for the partially hearing, audiometrician, speech therapist, health visitor. A decision is made there as to the best medical treatment and education for the child.

Torbay Area

The medical officer in charge of the Torbay hearing assessment clinic, Dr. L. Solomon, reports :—

"So much progress has been made locally in the ascertainment and education of children with severe hearing defects that one can now concentrate on the child with the slight or even temporary defect. Optimum health may be necessary for the adult wage earner because the maternal well-being and comfort of the family depends on him, but optimum health is just as important during the formative learning years at school in preparation for a full adult life. This applies specially to hearing, where minor defects can slow a child's educational progress, and by missing essential steps, lead often to psychological and behaviour problems unless recognised by teacher or others. The interplay of one system with another makes it essential to consider "the child as a whole" and not just concentrate on one defect.

From a school population of 24,000 and a pre-school population of 12,000, suspected hearing defects were referred for investigation for the first time in 137 cases. So much interest has been taken in the early ascertainment of partially hearing children that the Hospital Consultants referred 20 cases and General Practitioners referred 13 cases to the hearing assessment clinics for investigation and advice during the year. One was particularly interested to have 27 children of pre-school age referred, many under one year of age. Of the new cases 40 were referred to the Joint Hospital Hearing Assessment Clinic, where 16 of them were issued with Hearing Aids and 5 were recommended for operation, and at least 10 others will be seen again regularly.

Besides these new cases, many others have been seen for review, and all the 78 children wearing hearing aids were called up, at least once, during the year. Some hearing aids have been withdrawn as no longer necessary."

SEVENTH YEAR OF SOUTH DEVON HEARING ASSESSMENT SCHEME (1965)

(New Cases Only)

(1) School Population of Area 24,000

Pre-School Population of Area .. 12,000

(2) No. of children referred for investigation in 1965 — 137 (110 school) (27 pre-school)

(3) Children were referred by:—

A.C.M.O. ..	(5 pre-school)		88
H.V./School Nurse	(3 pre-school)	..	7
Consultant ..	(12 pre-school)	..	20
G.P.	(13 pre-school)	..	5
School Psychological	(2 pre-school)	..	2
Parents ..		..	2
Other H.A. Clinics		..	5
			—
			137

(4) Of the cases referred **Dr. Solomon's Hearing Clinic :—**

No further action needed		.. ..	19
For re-check		.. ..	62
Referred to Hospital Clinic		.. ..	40
Refused		.. ..	2
Left area		.. ..	2
Not yet seen		.. ..	12
			—
			137

Number of Sessions	87	(59 school children) (28 pre-school)
Total No. of examinations	349	(261 school children) (88 pre-school)
Appointments not kept	124	(105 school children) (19 pre-school)

(7) **Hospital Assessment Clinic :—**

No further action advised		.. ..	4	
Advised operative treatment		.. ..	3	
Advised Hearing Aid ..		.. ..	14	(2 High frequency)
Advised operation and Hearing Aid		..	2	
Further observation	..	.. ..	10	
Refused		.. ..	0	
Not yet seen		.. ..	7	
			—	
			40	

Number of sessions	31	(17 school children) (14 pre-school)
Total no. of examinations	218	(192 school children) (26 pre-school)
Appointments not kept	55	(52 school) (3 pre-school)

East Devon Area

Dr. Archer, the medical officer in charge of the East Devon hearing assessment clinic, reports :—

"Routine screening for hearing loss is carried out by Health Visitors and School Nurses at selected ages in pre-school and school children and children are brought forward by the Health Visitor for a second screening in Child Welfare Clinics and School Medical Inspections where necessary. When the tests are again unsatisfactory full assessment at a Hearing Assessment Clinic is arranged. The skill and promptness with which Health Visitors and School Nurses now identify children with hearing loss in schools is impressive. A parent told me recently that for several years he had been expressing concern about the poor speech and unsatisfactory progress in school of his nine year old son. Within a few weeks of his arrival in a Devon school routine testing in school had discovered that he had a hearing loss, he had been seen by a Consultant and provided with a hearing aid which was helping him very much. While the children who need hearing aids are, fortunately, very few, there are many others with slight or intermittent hearing loss who need medical and educational treatment suited to their own particular requirements."

1965 — *Exeter and Exmouth Hearing Assessment Clinics*

Appointments given	168
Attendances	141
Patients not requiring further appointments	60
Referred for speech therapy	11
Prescribed hearing aids by Consultant	4

Among 50 children who have been using hearing aids in this area conductive deafness is present in 10 and nerve deafness in 40. The aetiological groups into which these 40 children divide are :—

1.	Familial	15
2.	Low birth weight and prematurity	8
3.	Neonatal	4
4.	Maternal rubella	3 (one of these included in 1.)
5.	Meningitis	3
6.	Rh. incompatibility	1
7.	Measles	1
8.	Unknown	6

Tavistock/Holsworthy Area

The first report of the newly formed Tavistock/Holsworthy area hearing assessment clinic, is reported by the medical officer in charge, Dr. M. E. Budding :—

"At last after appointment of an audiometrician, and peripatetic teacher of the deaf in this area, the local E.N.T. consultant was approached regarding the setting up of clinics in his very rural area where a day's expedition to either Plymouth or Barnstaple was well nigh impossible for many parents. Mr. Hadley (the E.N.T. consultant concerned) was delighted to assist, and emphasised that he himself had hitherto been unable to follow-up

any child whom he considered needed an aid as the child was automatically seen elsewhere at that point. Consequently, after suitable arrangements could be made, clinics were set up in Tavistock and Holsworthy clinics, the consultant preferring to also attend at the D.C.C. clinics for the joint sessions rather than use the hospitals. This does mean that these at present have to be held in the early evening and lunch hour respectively, but staff and patients appear to be adaptable! Clinics were started at the end of July, then after a gap for holidays, restarted in September.

Holsworthy H.A.C.

Total No. Seen	Under 5	School Children	By whom Referred	Result
10 (3 sessions)	4	6	A.C.M.O	1 discharged 2 annual audiogram 7 T.C.A.
Tavistock H.A.C.				
13 (3 sessions)	5	8	2 by G.Ps. 1 transfer 2 using Aids 8 A.C.M.O.	1 discharged 7 to Joint H.A.C. 5 T.C.A.
Tavistock Joint H.A.C.				
7 (3 sessions)	1	6 (one from private school)	H.A.C.	2 using Aids 2 given Aids 1 T.C.A. 2 treatment in hospital

"Although so far the numbers are small, the work involved in arrangements, transport, etc., and the satisfactory results have made it worth while, and undoubtedly the work will grow now that a start has been made."

AUDIOMETRY

Work in the field of hearing and speech increases every year. This service includes three essential parts :—

1. Screening in appropriate age groups to demonstrate normal hearing and language development.
2. Investigating children who fail these screening tests.
3. Treating the children shown by investigation to be defective in hearing or speech.

Hearing tests for infants are carried out routinely according to the methods recommended by Manchester University by health visitors before the first birthday. There is close supervision and testing of all babies known to be at risk. Health visitors also carry out vocabulary tests for hearing when a child enters school and subsequently each year. Any child suspected of a degree of deafness is referred to the hearing clinic and an audiogram is requested by the medical officer. The audiometricians have also carried out a number of sweep tests in schools throughout the area. They attend at hearing assessment clinics and do a great deal of work in the testing and care of hearing aids.

Total number of audiograms	2,490
Number of children "Sweep" Tested	1,542
Number of hearing aids issued (all areas)	31
Hearing aids tested	187
Sent for repair	93

The county paid for 16 commercial A.V.C. Hearing Aids for special cases during the year.

SPEECH THERAPY

The comparatively modest salary offered to speech therapists has resulted in a nation wide shortage and in spite of its attractions Devon has not been able to employ a full establishment. Some areas of the county have only a skeleton coverage and children must be taken on for treatment on a strict priority system. For many children there is a long waiting list.

All children are seen by a medical officer for a medical examination which includes an audiogram prior to his recommending treatment.

In one area the speech therapist attends the hearing clinics whenever possible. These meetings are interesting to her in themselves and also bring her into contact with other field workers. Speech therapists can have a lonely professional life unless an effort is made by other field workers and the speech therapists themselves to link up and discuss cases.

At Tiverton a group of pre-school children with speech difficulties meet at the clinic; this is proving most successful. This need for handicapped children to mix with others in the pre-school years is being found by speech therapists as well as workers in other disciplines.

Three speech therapists are also employed part-time by the Regional Hospital Board to treat adults. This work is particularly interesting and rewarding to the therapists but has to be restricted to one session per week because of the demand of the school health service.

Statistics relating to work in the different areas are given below:

Speech Therapy Clinics—Annual Returns of Work for 1965

Area and Officer	No. of clinics operating	Cases discharged during year	Under treatment at end of year	Under observation	Awaiting treatment	Totals
E. Devon	16	26	132	47	43	348
W. Devon	7	31	216	27	70	190
N. Devon	10	35	64	48	42	189
S. Devon	14	30	52	83	29	194
Totals	47	222	310	205	184	921

Speech Therapy—Diagnostic Categories of Cases—treatment completed

Delayed Speech	66
Cleft Palate	10
Cerebral Palsy	3
Articulation Defects	75
Dysphonia	6
Hearing loss	2
Stammer	25
Others	35
	222

SCHOOL OPHTHALMIC SERVICE

Every child received an annual vision test in school and those whose acuity is less than 6/9 in one or both eyes are referred to one of our part-time ophthalmic specialists.

The geography of the county and availability of suitable clinic space have, between them, dictated the development of the school ophthalmic service as one primarily operated in schools rather than clinics. Basically this is likely to remain the pattern for the future except in larger centres of population where good clinic facilities are available: in such cases the latter will be used, subject always to the convenience of schools and parents and to facility of attendance.

The difficulty of arranging transport to the clinics is becoming more acute in some rural areas and it may be necessary to arrange our own transport system to ensure that children do not default from their appointments.

EYE DISEASES, DEFECTIVE VISION AND SQUINT

	Number of cases dealt with
External and other, excluding errors of refraction and squint	2,795
Errors of refraction (including squint) ..	8,526
Total	11,321
Number of pupils for whom spectacles were prescribed	3,858
Total number of sessions held at schools ..	318
Total number of sessions held at clinics ..	417
Total number of school children seen ..	9,091
Total number of pre-school children seen ..	3,331

TEN YEAR RECORD OF ABOVE TABLE

	No. of cases dealt with	*No. prescribed glasses*
1956	11,454	2,769
1957	12,108	3,180
1958	11,261	2,269
1959	9,225	2,861
1960	9,890	1,771
1961	11,071	2,072
1962	11,063	1,179
1963	10,648	3,101
1964	11,575	3,434
1965	11,321	3,858

HANDICAPPED CHILDREN

Ascertainment of handicapped pupils remains an important and time consuming task of the medical officers of the school health service.

In many cases, before ascertainment can be made, many opinions must be sought from workers specialising in one aspect of the problem of handicapped pupils, e.g. G.P., paediatrician, speech therapist, peripatetic teacher of partially hearing, educational psychologist, etc. The medical officer having received these opinions must co-ordinate them and assess the child as a whole, before making his recommendations to the parent and the education authority. Even in cases where formal ascertainment is no longer required (e.g. prior to admission to day-schools for the E.S.N.) it is still the duty of the school medical officer to assess the child comprehensively. Without this careful evaluation mistakes in diagnosis and placement will occur.

Handicapped children may not leave special schools until they are 16 years old, but a scheme for continued care up to 18 years is being developed. The education authority's residential special schools have for some time been implementing schemes for ensuring appropriate placement and follow-up, teachers being especially allocated time for this work. This type of work is also carried out by the social workers in mental health in appropriate cases.

One medical officer reports :

"The community as a whole is becoming more understanding about physical and mental handicap and, as a result, parents of handicapped children seem able to accept the facts and the help offered them more readily now than a few years ago. This is least often true of the parents of educationally subnormal children. One still meets parents to whom the suggestion that their child is unlikely to fulfil his educational and social potential in the ordinary class with ordinary methods of teaching comes as a bomb shell. These children are often superficially articulate and converse readily about everyday affairs; it is only when they meet with the demands of formal education that they are unable to make progress and their parents lack the standards by which to judge this. The best way to help these families is to persuade them to go to see one of our special schools for educationally subnormal children and to talk with the staff. When they actually see what can be offered by special teaching facilities very few fail to appreciate the benefit they can expect for their child.

"It is still extremely difficult to get help for parents with pre-school handicapped children. This essential side of the work seems to be developing so much more slowly than work with the children over five years old, and yet it is the most important time in life from the development point of view. There is an enormous need for skilled practical help in the day to day management of young handicapped children in the home and for local arrangements that will enable the handicapped child to spend a few hours several times a week with other children under expert supervision in stimulating surroundings so that his experience can be extended and his mother given some time free from caring for him."

Development Clinic in Barnstaple

The Medical Officer, Dr. Burgess, reports :—

"In February, 1965, the Development and Advice Clinic was started in North Devon at the Infant Welfare Clinic, Barnstaple, the idea being that the clinic would and should become one for children of any age with problems

in development and in particular for those under school age. In this way handicaps could be found early and treated before school entry. A great number of different problems presented themselves particularly the diagnosis of mental retardation at an early age and advising and supporting the parents through the early years. A number of children were already diagnosed and under a paediatrician but were sent for a level of retardation to be established and so that the parents would discuss future management and schooling. Those found to have organic diseases were sent to a paediatrician.

"Another group of referrals were babies with abnormal birth histories who were not already attending a premature baby clinic or a paediatrician.

"Ideally a development clinic should consist of a panel with a paediatrician, A.C.M.O., psychiatrist, educational psychologist, speech therapist, physiotherapist, hearing assessment mental officer, etc., etc. In place of this a good liaison has been established with all these specialists and several children have been referred and much personal advice given to myself.

"The attendance at Dr. Haas' paediatric clinic at the hospital in Barnstaple once a fortnight has meant that mutual patients could be discussed and has led to the referral of two patients for assessment. It has proved a most helpful attachment."

Number of patients attending until middle of Jan., 1966 ... 44

Number thought to have problems 35 (79.5%)

Of these 35 children considered to have problems :—

7 genuine severely subnormal (4 mongol)
(1 spastic) a new case.

10 subnormal (roughly E.S.N.)

6 low average

9 level normal intelligence

3 babies subnormality not finally assessed.

Handicapped Register

A register of handicapped children is kept in the central office and is compiled from reports sent in by medical officers, health visitors and others. A card is made out and sent to the medical officer of the area in which the child lives, a duplicate card is retained so that before the child is due to start school notice may be sent to the medical officer concerned, to enquire whether special educational provision will be necessary if not already in hand, the whole purpose of a register being to ensure appropriate and continuing care for each child.

The number of handicapped children registered in the department at 31st December, 1965, were 1,092 children of school age and 303 aged two to five years. They fall into the following categories :

	Ages 5 to 16	Ages 2 to 5
Blind	9	1
Partially Sighted	16	17
Deaf	13	3
Partially Hearing	47	10
Epileptic	9	17
Delicate	98	76
Physically Handicapped	116	105
Educationally Subnormal	455	–
Maladjusted	69	–
Mentally Handicapped (unsuitable for education at school)		
Subnormal	218	74
Severely Subnormal	42	–

Handicapped pupils requiring education at special schools approved under Section 9(5) of the Education Act, 1944, or boarding homes are shown on page 119.

Handicapped Pupils Requiring Education at Special Schools

During the calendar year ended 31st December, 1965	(1) *Blind* (2) *Partially signted* (1)	(2)	(3) *Deaf* (4) *Partially deaf* (3)	(4)	(5) *Pyhsically Handicapped* (6) *Delicate* (5)	(6)	(7) *Mal-adjusted* (8) *E.S. N.* (7)	(8)	(9) *Epileptic* (10) *Speech Defects* (9)	(10)	*Total Cols.* 1-10 (11)
A. How many handicapped pupils were newly assessed as needing special educational treatment at special schools or in boarding homes?		1	1	7	11	15	29	174	1	1	240
B. (i) of the children inc uded at A, how many were newly placed in special schools (other than hospital special schools) or boarding homes?	—	1	1	4	10	7	18	117	1	—	159
(ii) of the chi dren assessed prior to 1st January, 1964 how many were newly placed in special schools (other than hospital special schools) or boarding homes?	1	1	1	3	14	3	3	32	—	—	58
Total B(i) and B(ii)	1	2	2	7	24	10	21	149	1	—	217
On or about 21st January, 1965, how many handicapped pupils from the Authority's area											
C. (i) were requiring places in special schools—TOTAL (a) day	—	—	—	3	—	—	—	9	—	—	12
(b) boarding	—	1	—	—	1	4	6	168	1	1	182
(ii) included at (i) had not reached the age of 5 and were awaiting (a) day places	—	—	—	—	—	—	—	—	—	—	—
(b) boarding places	—	—	—	—	—	—	—	—	—	—	1
(iii) included at (i) who had reached the age of 5, but whose parents had refused consent to their admission to a special school, were awaiting— (a) day places	—	—	—	—	—	—	—	—	—	—	—
(b) boarding places	—	—	—	—	—	—	1	110	1	—	112
D. (i) were on the registers of (1) maintained special schools as (a) day pupils	—	—	1	8	50	35	—	111	—	—	205
(b) boarding pupils	—	1	—	2	1	—	—	185	—	—	189
(2) non-maintained special schools as (a) day pupils	—	—	1	5	1	—	—	—	—	—	7
(b) boarding pupils	9	13	10	13	32	2	1	4	4	—	88
TOTAL	9	14	12	28	91	49	14	308	4	—	489
(ii) were on the registers of independent schools under arrangements made by the Authority	—	—	—	—	7	12	13	8	—	—	40
TOTAL (D (i) and D (ii))	9	14	12	28	91	49	14	308	4	—	529
(iii) were boarded in homes and not already included under (i) and (ii) above	—	—	—	1	2	—	24	—	—	—	27
TOTAL (D (i), (ii) and (iii))	9	14	12	29	93	49	38	308	4	—	556
E. On or about 21st January, 1965, how many handicapped pupils (irrespective of the areas to which they belong) were being educated under arrangements made by the authority in accordance with Section 56 of the Education Act, 1944											
(i) in hospitals	—	—	—	—	2	12	—	—	—	—	14
(ii) in other groups (e.g. units for spastics, convalescent homes)	—	—	—	3	3	11	3	—	—	—	20
(iii) at home	—	—	—	1	14	6	—	4	—	1	26

Partially Hearing Children

The great majority of hearing aids wearers manages very well in ordinary school with help from the peripatetic teacher of the partially hearing.

There are units for 8 partially hearing children each, attached to a primary and a secondary school in Torquay.

Many visitors have seen over these units at Westhill County Secondary School and St. Margaret's County Primary School.

Week-end Residential Course for Parents of Partially Hearing Children

In October, 1965, a course for the parents of pre-school partially hearing children was held at Dartington Hall. This course was organised by the education department in consultation with the school health service and proved very successful. The parents lived at Dartington Hall over the week-end and were able to discuss problems informally with members of the staff of both the education department and school health service, and had an opportunity to meet each other. A further course is planned for parents of partially hearing children of school age when the school health service will contribute more on the important medical aspects of case finding, diagnosis, ascertainment and supervision of the deaf and partially hearing child.

Delicate and Physically Handicapped Children

The Medical Officer reports that Steps Cross School at Torquay, a day school of 90 places, now has its full complement of physically handicapped pupils, but since an orderly has been appointed it has been possible to take chair cases and other children needing more personal attention than previously. Several muscular dystrophy cases and partially incontinent children have now been admitted whereas previously only home tuition was available to them. Children with asthma or bronchiectasis constitute the majority of the pupils, and regular daily physiotherapy has improved or maintained their health so that regular school attendance has been possible. The psychological attitude of the "chest cases" to school and life generally is very variable and makes their management particularly difficult. Three protein meals a day are an important part of treatment as is an after lunch rest. Such is the enthusiasm of the headmaster for widening the horizon of education that many pupils know much about human biology and disease processes, about river navigation and slide rule calculations, about typing and chromosomes. The teachers, the meals staff, the physiotherapist, the remedial occupational therapist, the taxi drivers and the pupils have such a close community spirit, inside and outside the school, that the well-being and educational progress of the child is their main concern. The full ordinary school curriculum is taught and a high proportion of children are selected for grammar school places.

Many children with physical handicaps cope in the ordinary schools or training centres available to others of comparable intelligence. Some children are remarkable in the way they overcome severe handicaps. Dame Hannah Rogers School at Ivybridge caters for severely spastic children of at least average intelligence; this is an independent school which many Devon children attend.

Educationally Subnormal Children

There are three residential schools in the county for these children :—

Maristow, near Plymouth	89 pupils (Girls)
Bradfield School, Willand	75 pupils (Boys)
Withycombe House School, Exmouth	45 pupils (Girls)

There are also five full-time special classes in ordinary schools, and many part-time classes held by the peripatetic remedial teachers.

At all of the special schools a member of staff has special responsibility for job placement and follow-up of the children, and the results are most encouraging.

Epileptic Children

Epileptic children are in the main contained within schools for other children of comparable ability. A few are at special schools for epileptic children, but, as medical control of this disability has advanced, it becomes increasingly possible to integrate the epileptic child into the normal school community.

Maladjusted Children

Maladjusted children can be received into Crichel hostel at Totnes or The Gables at Willand. Those who are unsuitable for either, insofar as they are too disturbed to go out daily from the hostels to normal schools, are placed in residential special schools.

Special Schools

During 1965 Handicapped children from Devon have been placed in the following special schools :—

PHYSICALLY HANDICAPPED
*Steps Cross Special Day School, Torquay

EDUCATIONALLY SUBNORMAL
*Maristow House School, Roborough
*Withycombe House School, Exmouth
*Bradfield School, Willand

BLIND AND PARTIALLY SIGHTED
Royal School of Industry for the Blind, Bristol
Dorton House, Sevenoaks, Kent
Rushton Hall, Kettering, Northants.
Condover Hall, Shrewsbury, Salop.
Sunshine House School, Northwood, Middlesex
West of England School for the Partially Sighted, Exeter, Devon

DEAF AND PARTIALLY DEAF
Royal West of England Residential School for the Deaf, Exeter, Devon
Hartley House School for the Deaf, Plymouth, Devon
Mary Hare Grammar School for the Deaf, Newbury, Bucks.
Needwood School for the Partially Deaf, Burton-on-Trent, Staffs.
St. John's School for the Deaf, Boston Spa, Lincs.

EPILEPTICS
Lingfield Hospital School, Surrey

DELICATE AND PHYSICALLY HANDICAPPED
St. Elizabeth's R.C. School, Much Hadham, Herts.
Heathercombe Brake School, Manaton, Devon
Heathlands Rise School, Teignmouth, Devon
Oxton House School, Kenton, Devon
Victoria Home and School, Poole, Dorset
St. John's Open Air School, Woodford, Essex
Coney Hill Home School, Kent
Halliwick School, Bush Hill Road, Winchmore Hill, London

SPASTICS
Trengweath School and Centre for Spastics, Plymouth
Dame Hannah Rogers School for Spastics, Ivybridge, Devon
Chailey Heritage Craft School & Hospital, Sussex.
Craig-y-Parc School for Spastics, Pentyrch, Cardiff, Wales
* Devon County L.E.A. School.

IMPROVEMENTS TO SCHOOL PREMISES

Lastly, but by no means least, is appended a list of improvements to school premises during the year. Devon is a rural area with many small schools. The condition of lavatories in many primary schools remains unsatisfactory in spite of valiant efforts by caretakers; and seems worthy of a higher priority for improvement than given to it at present.

Improvements to Sanitation, etc. at Schools

1965/6

School	*Improvements*
Ashwater C.P.	Convert existing W.C. to suitable accommodation with wash basin and water heater for lady teacher.
Boasley Cross C.P.	Electric lighting in toilets and electric heaters in cloakrooms and toilets. Automatic flushing system for boys' urinals.
Braunton C.P.	New toilet block for infants and improvements to juniors' toilets.
Brixham C. of E. Infants	Hot water supply to staff cloakroom.
Chulmleigh County Secondary	Roof to Girls' toilets. Improvement to Male Staff cloakroom and toilet. Hot water supply in Headmaster's cloakroom.
Clovelly C.P.	Drinking fountain.
Cockwood C.P.	Hot water supply to basins.
Clyst Hydon C.P.	Partitions in Girls' lavatories.
Dartmouth C.P.	Water heater to basins.
East Anstey C.P.	Wash basin with hot water supply, Staff toilet and washbasin.
Halberton C.P.	Additional basins and hot water supply to basins.
Holsworthy County Secondary	7 W.C.'s, 13ft. urinal, 7 basins with water heater and drinking fountain.

Ideford C. of E.	3 additional basins and hot water supply to all basins.
Kenton C.P.	Drinking fountains in playground.
Kingsnympton C.P.	Drinking fountain.
Kingsbridge Secondary School	Lavatories for playing fields.
Landkey C.P.	Hot water to staff washbasins.
Newton Poppleford C.P.	Additional toilet accommodation.
Ottery St. Mary. The Kings Grammar	Improvement to ventilation in Boys' and Girls' toilets.
Ottery St. Mary County Junior	2 additional W.C.'s for boys and 6ft. urinal. 2 staff W.C.'s.
Plymstock Hooe Junior	Renewal of basins and water heaters.
Princetown C.P.	New toilet for girls and staff.
Starcross C.P.	Drinking fountain.
Stoke Fleming C.P.	Conversion to provide Office/M.I. room.
Talaton C. of E. (A)	Additional drains to connect school to main school.

APPENDIX

"LETTUCE INTAKE AND LEAD INGESTION"

An Investigation in the Tamar Valley

By Dr. MARY BUDDING, Senior Assistant County Medical Officer

The Survey was started in 1964 as the result of the late Dr. E. D. Allen-Price passing the information on to me that, arising out of his cancer research work involving estimations of trace elements (this work is unpublished as yet), lettuces grown in various districts of the Tamar Valley showed an astoundingly high percentage of lead. The lead content was so high in fact that the analysis was suspect until repeated samples showed the same result. Consequently, I wondered whether there was in fact any danger of lead poisoning resulting from ingestion of lettuces and fresh vegetables from this area (a market garden area).

It was decided, for administrative convenience, to investigate the children in the local primary school (Bere Alston) in the West Devon side of the Tamar Valley, which is also a large commercial market garden area. As the mineral content of the soil was known to be high, an area with a low mineral content with a similar sized primary school in mid-Devon (Hatherleigh) was chosen as a control.

Questionnaires were prepared, introducing all possible pointers to early overdosage of lead and eliminating other factors such as lead water pipes and low ingestion of fresh garden or local vegetables. Letters were sent to all parents inviting them to complete these and explaining the reason. It is interesting, by the way, to remember that the condition of "Dartmoor Colic" was recognised and named over 40 years ago by Dr. Budd of North Tawton and was due to lead poisoning.

The response to the questionnaires was remarkably good. After consultations with the bio-chemist and public analyst, it was decided that for the purposes of this investigation, urine tests would be sufficient in the first instance. The blood tests would have been impracticable in this rural area;

also time and finance were limited as the examinations were almost all done in spare time, i.e. weekends, early mornings and evenings. 500 cc colourless polythene containers were used and cleansed with distilled water and acid sterilisation, and 24-hour specimens were required.

Unfortunately, by the time the questionnaires had been returned and containers obtained, it was well into August, and as the ingestion of fresh lettuces, etc., would be less, it was decided that a more accurate estimation could be done the next year in early summer. Meantime, the questionnaires were studied and, as the cost of estimations for every child was prohibitive, those showing no ticks in the "Symptoms" (Yes) boxes, were eliminated from the survey and parents sent a letter confirming this, and those chosen for further investigation later on were informed. As will be seen from the table at the end, there was a good response. Meantime a few had left the district before completing the tests in 1965.

Early in July the parents of the children chosen for urine examinations were given letters and containers with each child's name firmly written on it. This was all done by the A.C.M.O. but with invaluable help given by health visitors in directing her to outlandish farms. The specimens were collected within a few hours of completion by A.C.M.O., 24 hour amounts carefully measured, and stored in the refrigerator until analysed.

At the end of the survey all the parents were sent the result and thanked for taking part in what was after all quite a chore in that, keeping all urine passed for 24 hours, sometimes with several in a family, was not without its pitfalls, e.g. the sailor father home on leave who knew nothing of this and emptied all the containers helpfully for the mother! Two families even took the containers to the seaside for the day.

Summary

It would appear that there was no danger of overdosage of lead from ingesting lettuce containing exceptionally high proportion of it absorbed from the soil, and moreover that there was no difference at all in the lead content of urine output of the children "at risk" and those in the control area. Therefore, even in an area of high lead soil content, or even as suggested recently with absorption of lead from motor traffic passing, by lettuces, there appears to be no danger to health, particularly of children. Chelating agents would of course have demonstrated whether in fact the bones were storing up the lead, but this does not seem to be probable. Only one child had excreted above average (0.132 mg per litre) taking the accepted normal maximum as 0.08—0.10 mg/1. In this case no cause could be found and the two other members of her family were well below the maximum, it was therefore decided with the G.P. to re-test her at a later date.

I was most grateful to all the participants in the survey, and also to the two family doctors concerned who encouraged their patients to co-operate. The willing and active co-operation was undoubtedly partly due to the fact that the G.P.s, M.O.H. and S.M.O. concerned were all well known to most of the parents, having lived and worked in the district for between 16-30 years.

THE SCHOOL DENTAL SERVICE

Mr. J. D. Sykes, the Principal School Dental Officer, reports :

Staff

The year started with the orthodontic appointment vacant and no prospect of filling it, but with a promise from Mr. A. S. Peacock who had retired from the post in 1963 that he would come back to part-time service on his return from Africa if required; and he did — working about four sessions a week from April until he left again for Nairobi to take up permanent residence there in December. There was also a vacancy in the Plympton-Tavistock Area, but Mr. J. F. Hunt had been appointed and started work in March. In the meantime Cdr. J. A. R. Hemsted was working part-time at Plympton and Rear Admiral F. R. P. Williams, who had retired from the Paignton appointment the previous March was working part-time at Tavistock. Both ceased duty on 24th February. Admiral Williams entered hospital the next day for an operation from which he did not recover and he died on May 18th. We mourn the loss of a distinguished colleague and a delightful friend. Miss B. J. Shapland was appointed to the staff on 1st July, 1935 and retired in September, 1965, leaving shortly afterwards for a ten month trip round the world.

Between 1st March when Mr. Hunt started and 15th September when Miss Shapland left the dental officer staff was up to full approved establishment, a state the writer had never experienced since first being appointed a chief dental officer in 1942. A candidate had been appointed to succeed Miss Shapland in the Crediton Area from 1st November. Unfortunately he was unable to come and the post had to be advertised again, being still vacant at the end of the year. Mr. W. A. Humpherson left in December to take up a Divisional Dental Officer's appointment in Wiltshire. Miss Mitchell, the Dental Auxiliary resigned on her marriage in March and was succeeded by Miss Sowden when she completed her training course in September. We welcomed the arrival of Miss P. H. Turnage to fill the vacant Dental Hygienist appointment in August.

Clinics and Equipment

Okehampton Clinic opened in August, but only after a long succession of postponements, the first date promised being February 1st. Because of this delay Mr. Shipley, who had nowhere else to work, had to be given continuous use of a Mobile Dental Clinic and this completely disrupted the M.D.C. allotment programme which in turn disorganised the planned programme for several other dental officers. I would like to record here my gratitude for their forbearance and acceptance of the difficulties so created. Of the clinic Mr. Shipley says : "The dental suite consists of main surgery, dark room and recovery room. The surgery is very light and airy and a delight to work in." This clinic which is the base for the Okehampton Area is unfortunately able to serve adequately only the local Primary and Secondary Schools. The nearest schools to Okehampton are Bridestowe 6 miles and Sticklepath 5 miles, but the bus services are so poor that to expect children to attend the Okehampton Clinic for routine treatment is not possible. Seven schools in the Area are situated 20 miles or more from the base clinic". Mr. Shipley goes on to point out that in his widely dispersed rural area, parents are concerned because once the Mobile Clinic has left the village school, the dental service

is no longer available until it returns to the neighbourhood a year later. He has suggested a scheme whereby his area is divided into regions each of three schools. These schools will be visited singly and successively in three separate tours during the course of the year, which means that the clinic will appear in each region three times instead of once each year. This is an interesting and ingenious suggestion. It is hoped that the availability of Mobile dental clinics will allow it to be given a trial.

The new dental suite at Bideford came into use in September. Major alterations and enlargement of the dental suite at Paignton were completed in May. The surgery was re-equipped and some of the old equipment used to furnish a second surgery. Whilst these alterations were in progress Mr. Holdsworth, the dental officer was accommodated in a mobile clinic. Unfortunately the alterations which were to have been completed in about three weeks took ten weeks, thus aggravating the disturbance caused by delays at Okehampton. All dental officers now have high speed air turbine equipment for use wherever they may be working, but four are still without X-ray equipment. On this subject Mr. H. D. Williams who acquired an X-ray unit with the Mobile Dental Clinic Devon IV delivered in May writes: "The newspaper publicity attending the introduction of Devon IV had a surprising effect, in that so many people were now found to be aware of its existence. It would seem that any publicity of this nature that the service receives is something that is well worth having. The X-ray equipment is proving to be an asset which I would not like now to be without. I often had the feeling that when asking parents to bring children to Newton Abbot Clinic for X-rays, that I could almost see them thinking that it would be easier to get treatment locally. From my own point of view it is a great time saver." The Devon lanes limit the size of our mobile clinics and there is not room for X-ray dark room and processing equipment. In the majority of cases a picture is not required immediately and processing can be done at a base clinic. In the few cases where an immediate picture is needed there are now "self developing and fixing" films which can be processed without any dark room or equipment at all in the same way that "Polaroid" photographs are produced.

The programme for replacement of obsolete equipment in existing clinics continued, and of the Castle Road Clinic Mr. Derbyshire writes: "I would like to report how pleased I was to receive the new surgery equipment comprising chair, unit, and cabinet trolley at the beginning of the autumn term. The stimulus that it has given to my work I find most helpful. Patients and their parents are not slow to notice the vast improvement in the appearance of the surgery. It is a very good thing, for the image of the School Dental Service must always stand comparison with that of general practice; and not imagined to be a place where poor dentistry is practised in indifferent surroundings—a vestigial image still invoked in some people's minds by the words 'school clinic'."

With no prospect of a new clinic at Barnstaple the spittoon unit had to be replaced and a new pedestal type with instrument bracket table was installed.

This has been the best year's progress yet reported under this heading, but Totnes and Crediton clinics still remain to stifle complacency on this score. With general standards improving year by year and these clinics and their outdated equipment deteriorating steadily the gap between what they are and what they should be gets ever greater; and little can be done about it. It would be folly to put new equipment into these buildings.

The progress of replacing the use of portable equipment by treatment in a mobile clinic is determined by the rate of increase in the number of clinics.

Inevitably the number of moves each year has been increasing—to a total of 154 in 1965. The time will shortly come when another vehicle has to be made available for towing. Already dental officers are being embarrassed because the towing vehicle is booked when a move is required.

Treatment

Although the staff was at full strength for half the year the actual number of sessions worked was less than in the previous year, and is reflected in reductions under most headings in the statistical table. This, it may be noted, is in a new form and is in accordance with new requirements of the Department of Education. Whilst basically the items on the return are the same, some of them have been sub-divided and others amalgamated or eliminated; direct comparison with many of the previous years figures would be somewhat complicated. The graph shows little change in the pattern of work done as compared with 1965. The increased proportion of fillings done in the temporary teeth has been maintained. Other forms of conservative treatment of these teeth such as cutting down to produce self cleansing areas for reduction of food stagnation and treatment with silver nitrate were previously submerged under a general heading "other operations". They now receive recognition, accounting for almost the whole of "teeth otherwise conserved", in the statistical table.

Most of the dental officers get round their areas in a year or under. To enable all to do so, a realignment of area boundaries is long overdue. It has been held up pending the outcome of the Boundary Commission recommendations which will necessitate major changes in the dental areas adjacent to Plymouth and Torbay with compensating adjustments further afield. Mr. Derbyshire writes: "Over the past year or two there has been a notable increase in the number of parents phoning and making appointments and not waiting for the school inspection, i.e. they are coming to view the service much the same as general practice in this respect. This means, however, that while some children of the more conscientious parents are getting 3, 4 or 6 monthly checks and treatment it does tend to increase the period between inspections at school."

The number of general anaesthetics given continues much the same but an increasing proportion of them are now given by medical anaesthetists. Only one Walton anaesthetic machine now remains. As machines have become unserviceable they have been replaced by McKesson Simplor Units. Mr. Smith writes: "I cannot stress enough what a valuable adjunct "Halothane" has been in general anaesthesia. Induction and recovery are so uneventful that one rarely finds a child who has had halothane opposed to it on a future occasion—surely the acid test." Mr. Derbyshire has also been using Halothane and Vinesthene to compare the two, but has not yet preferred one to the other.

Several members record unusual and interesting cases which they have dealt with themselves. There were in addition several which were considered unsuitable for treatment at the clinic and they were referred for in-patient or out-patient treatment at hospital. I would like to thank Mr. P. A. Bramley and Mr. P. H. D. Lewars, the consultant dental surgeons at Plymouth and Exeter, for their ready acceptance and treatment of these cases and for the prompt and informative reports received.

Survey of the Dental Condition of 15-year-old Pupils

The aim of the school dental service is to ensure that every child leaves school dentally fit and the Select Committee on Estimates recommended that statistics should be produced to show to what extent the dental needs of children are being met. Accordingly the Department of Education and Science invited authorities in parts of the country representative of the varying concentrations of dental man-power to carry out a survey during the Spring Term of the dental condition of 15-year-old children. Devon was one of the authorities invited to participate.

A random sample of about 10% was taken by examining all those whose birthday fell on the 5th, 15th or 25th of any month during the school year. High standards of accuracy for the inspection and charting were laid down. Out of 5,770 of this age in the county 534 were examined. Of this number only one was found to have perfectly sound teeth with none decayed, missing or filled; 151 were found to have sound teeth by reasons of dental treatment, and the remaining 382 had decayed teeth. There were only 52 who had not lost a tooth. Each child had an average 17.8 teeth sound. 1.9 teeth missing. 6.1 teeth filled and 3.0 teeth requiring filling. These figures total 28.7 whereas the normal dentition is 28. This excess is due to the fact that some teeth already filled showed further decay.

Orthodontics

Many dental officers have pointed out the difficulties arising from having to take back the cases originally referred to the orthodontist for treatment and all officers affirm the necessity of having an orthodontist on the staff. The dental officer in the rural area is most affected. Mr. Dickson writes : "I just cannot find time to carry out this work as I should like to. I previously referred any orthodontic cases living within reasonable travelling distance of Exeter to the County Orthodontist. Now I have to see these cases in addition to those in remote rural areas. It is really very difficult and I must again stress my previous observations regarding the urgent necessity for an orthodontist on the County Staff." This is reiterated by Mr. Clarke, who goes on to say : "The appointment of a County orthodontic specialist to give a really complete child dental service . . . it would leave so much more time for routine inspection and treatment which must always be the essence of the service". A few of the staff record that in their areas orthodontic treatment is not easily got elsewhere and the demands on the school service become more pressing. Mr. Derbyshire writes : "Parents are generally much more enthusiastic about orthodontics than conservation. I suppose this is natural when they can see the need for straightening a child's teeth, whereas the need to conserve deciduous teeth where they are only temporary can to some people sound not very convincing." Mr. Vowles mentions a problem which plagues every dental officer. "A problem I find almost insoluble is assessing the amount of co-operation forthcoming from patients and parents. So very often people who request orthodontic treatment fail to co-operate in a proper manner in spite of a full outline of proposed treatment; on the other hand some very unlikely children have proved to be first class patients". When orthodontic treatment is offered a letter is sent to the parent explaining that treatment may take a long time and will demand patience and perseverance. In giving written acceptance the parent agrees to ensure the necessary co-operation. That some do not is probably due to the fact that what is "free" is lightly valued. If we continue to accept the principle that people should have "free"

health services we may sometime come to the conclusion that they should be subject to penalty for abusing them.

During the year with no prospect of making an appointment an approach was made to the S.W. Regional Hospital Board for assistance. This it was unable to give, which is not surprising. The Wessex Region with a population of 2,000,000 has four Consultant Orthodontists. The S.W. Region with a more widely scattered population of 2,900,000 has but one full-time and one part-time consultant orthodontist. In the absence of any prospect of help from the R.H.B. and recognising the importance of this work a new salary scale for the County Orthodontist was agreed and at the time of writing, an appointment has been made. Mr. M. A. Burley the R.H.B. Consultant has not in the past refused any case referred, and we are most grateful to him for his help and co-operation. It is considered, however, that a more generous Consultant cover should be provided by the Board.

Dental Health Education

At the beginning of the year the dental hygienist appointment was still vacant but Miss Mitchell, the dental auxiliary at Torquay who showed a real flair and enthusiasm for this aspect of her work was devoting half her time to dental health education, in Torquay. Mr. Derbyshire reports: "The good work in this field commenced by Miss Mitchell has been ably continued by Miss Sowden. Nearly all the primary schools have been visited and talks and films given according to age groups. These have all been well received in the schools. The benefit derived from dental health education is naturally difficult to assess, but if questioning some of the young patients in the chair when they attend for treatment subsequent to a D.H.E. visit can give some lead I would say they have learned their lessons well. Whether they proceed to practise what we teach is even more difficult to find out, but I feel that we must still show them the correct way for dental health if we are to fulfil our role". Mr. Gibbs says: "The posters issued by the Health Education Officer are much appreciated in the schools and we often receive requests for additional copies." Stocks of most of the available posters and pamphlets are kept and issued as required either through the dental staff or direct to school or other interested organisation.

Mention must be drawn to the work of Mrs. W. F. N. Turnbull the D.S.A. working with Mr. Vowles in the Kingsbridge Area. She gave a very successful series of six lectures to the local St. John Ambulance Cadets using posters and lecture notes of her own creation. The course finished with a film show and presentation of certificates for work done by the children. She also gave a lecture to the local Mothers' Union and has been asked to give one to the Young Wives' Club. Mr. Vowles writes: "At the conclusion of treatment at the Newton Ferrers Primary School I was asked by the Head Master to have a talk to her class. I made use of disclosing tablets and found this a very effective means of showing the children how dirty their teeth were." Like Mr. Derbyshire he recognises the difficulty in assessing the effect of the work and feels that isolated attempts at instruction may not have a very lasting effect but looks forward to the day when oral hygiene instruction becomes a regular feature of school life.

With the appointment of Miss Turnage in August this is again becoming a reality in those parts of the county that she can reach. The schools are visited and classes or age groups taken for what is in effect just another lesson or teaching period given by a different teacher using new teaching aids.

Much of Miss Turnage's time has been spent on equipping herself with these visual aids. All who are engaged in this work appear to find that made up material, be it model, poster or display is more compelling of attention than mass produced material. Mr. Vowles says: "The posters used are again products of Mrs. Turnbull's conjecture using cut outs of advertisements and pictures in an attempt to be in tune with today's children and teenagers".

The dental hygienist in addition to her school work visits Parent Teacher Associations, Women's organisations and various clinic groups. 74 of these were visited whilst 223 teaching sessions were given in 71 schools to a child audience of 7,650.

Fluoridation

Early in the year the ratepayer in Watford who had instituted proceedings to restrain the Corporation from adding fluoride to the water supply withdrew the action—as had been done at Andover on an earlier and similar occasion—influenced no doubt by the Privy Council decision on an appeal from the Courts in New Zealand where a comparable case had been heard. Devon C.C., like many other councils, had left the matter in abeyance pending the outcome of the Watford case. It was, therefore, revived by Appointments and General Purposes Committee whose report was approved by Health Committee on 7th of December and went forward to County Council on 20th January, 1966. During this period the efforts of and published statements by the opponents of this measure aroused in the general public a degree of interest in the activity of the County Council which is probably without precedent. The one surprising feature of this is that in view of the evidence in favour of this measure the enthusiasm was not for it but against it.

The dental aspects of the case tend to have been forgotten during the controversy and it is of interest to look at the figures produced by the 15-year-old survey noted above. The natural fluoride content of the water in Devon is low, nowhere exceeding 0.1 parts per million (p.p.m.). Sarnia, Brantford, and Stratford are places in Canada which did a survey of the dental condition of their 16- and 17-year-olds and the figures are shown below for comparison.

	Number Examined	Percentage Caries Free	Mean D.M.F.	Average teeth lost per individual
DEVON Low F.	530	0.19%	10.25	1.96
SARNIA Low F.	482	0.41%	10.44	1.31
STRATFORD				
Natural F. 1.5 p.p.m. ...	227	12.78%	4.19	0.42
BRANTFORD, Artificial F. 1.0 p.p.m.				
for past 17½ years	356	11.80%	4.74	0.38

The mean D.M.F. is the average number of decayed, missing or filled teeth and is the usual index of the incidence of decay. The figures need no comment other than to draw attention to the usual 50%—60% reduction in the incidence of dental caries in fluoridated areas.

School Tuck Shops

Heads of schools are advised from time to time by various means about the undesirability of selling caries-producing foods in school. Dental officers

were getting the impression that these reminders were having some small effect. It was not possible to conduct a full-scale survey by questionnaire but dental officers were asked to get information when visiting schools. So far reports are in for 86 schools which may be accepted as representative of all. Apart from provided meals no food is sold in 45 schools. In 6 only of the other 41 are sales confined to non-decay producing foods such as nuts, dried fruit or crisps. The following commodities are retailed, the number of schools doing so being shown after each item :—

Biscuits 31; Chocolate 17; Sweets 6; Ice Cream 2; Iced Lollies 3; Nuts 13; Dried Fruit 34; Crisps 24. Only one school is recorded as selling fresh fruit, but 20 serve a portion of apple or carrot at the end of, and as part of the school meal. The "Tuck-shops" vary from a tin or carton from which biscuits are dispensed to what must be a considerable establishment in one particular school which sells coca-cola and orange drinks in addition to all items listed above except fruit.

Refresher Courses

Mr. Vowles and Mr. Pomeroy attended a Refresher Course in Children's Dentistry at the Eastman Dental Hospital in November and write respectively : "This proved to be of great value both in content of the course and in contacts and discussions. It was extremely pleasant to get back into the atmosphere of a teaching hospital and I found on returning that I could view my work with a more objective eye" and "It is impossible to keep abreast of improvements in dental practice without clinical instruction which was carried out in an admirable manner. If the school dental service is to take its place in the vanguard of children's dentistry the value of these courses cannot be over-estimated."

Mr. Williams writes at length on this subject : "I do feel, however, that there is an isolation from the stimulation of any professional academic activity . . . because of Devon's remoteness from the teaching hospitals . . . for the school dental service to play its full lively part, enthusiasm wanes if those engaged are allowed to stagnate technically." He goes on to suggest the possibility of running our own courses within the county. Whilst such could not offer all the advantages of a residential course, such as contact with staff or other authorities, it could be a most valuable supplement and could be arranged at no very great cost.

Research

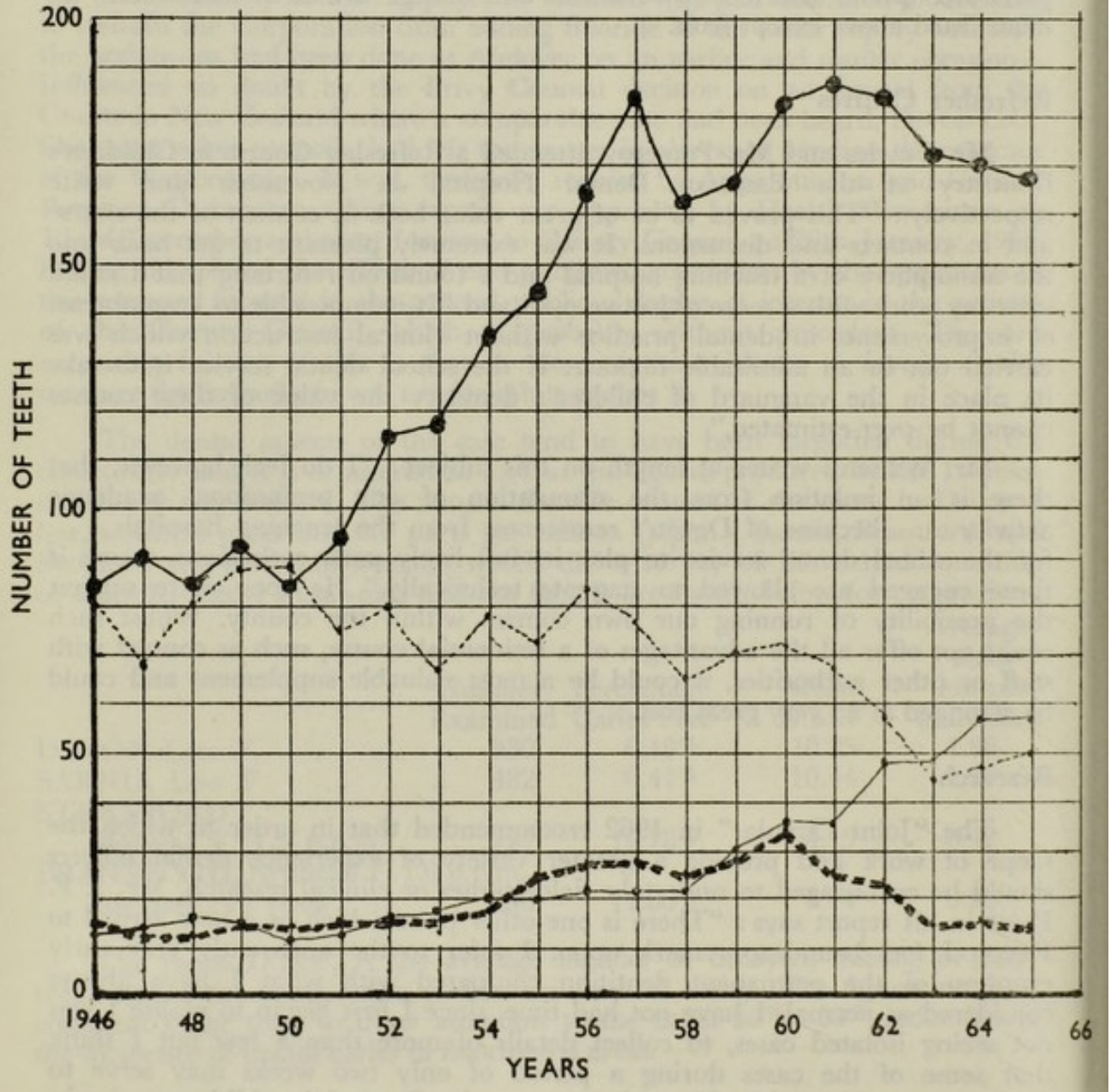
The "Joint Circular" in 1962 recommended that in order to widen the scope of work and provide a greater variety of experience dental officers should be encouraged to undertake field studies or clinical research. Mr. J. F. Hunt in his report says : "There is one other point which as a new arrival to Devon I feel bound to remark upon. I refer to the apparently very early eruption of the permanent dentition compared with what I have always considered as normal. I have not had time, since I first began to realise I was not seeing isolated cases, to collect details of more than a few but I think that some of the cases during a period of only two weeks may serve to illustrate my point." Mr. Hunt then quotes details of eight children and asks if any other members of staff has noted similar conditions. In view of the earlier physical maturation of boys and girls it would seem reasonable to expect earlier eruption. School routine inspections offer the opportunity to

confirm or refute, without calling for an undue loss of clinical time. Perhaps some member of staff may care to do a field survey on this subject.

Conclusion

I have been asked to express appreciation of the services and help of a large number of people. We are grateful to the Heads, teaching staff and secretaries in the schools, to our anaesthetists, to our surgery assistants, to the towing vehicle crew who move and site the mobile clinics and to the clerical staff at County Hall. The fact that these are listed does not in anyway detract from the sincerity of our thanks.

Details of Dental Treatment per 100 Children Treated



Key :—Permanent Teeth Filled—Heavy Continuous Line
Permanent Teeth Extracted—Heavy Pecked Line
Temporary Teeth Filled—Light Continuous Line
Temporary Teeth Extracted—Light Pecked Line

2. Number of Pupils on the Register of Maintained Primary and Secondary Schools including Nursery and Special Schools in January 1966 as in Forms 7, 7m and 11 schools, 71,941.

3. ATTENDANCES AND TREATMENT

	Ages 5 to 9	Ages 10 to 14	Ages 15 and over	Total
First Visit	7685	6003	1342	15030
Subsequent visits	9422	10270	1944	21636
Total visits	17107	16273	3286	36666
Additional courses of treatment commenced	887	1167	175	2229
Fillings in permanent teath	5971	13751	3275	22997
Fillings in deciduous teeth	10088	909	—	10997
Permanent teeth filled	5162	12252	2827	20241
Deciduous teeth filled	9300	831	—	10131
Permanent teeth extracted	393	1341	334	2068
Deciduous teeth extracted	5566	1780	—	7346
General anaesthetics	1379	613	57	2049
Emergencies	508	287	89	884

Number of Pupils X-rayed	422
Prophylaxis	4874
Teeth otherwise conserved	3265
Number of teeth root filled	43
Inlays	24
Crowns	25
Course of treatment completed	14373

4. ORTHODONTICS

Cases remaining from previous year	420
New cases commenced during year	303
Cases completed during year	264
Cases discontinued during year	45
No. of removable appliances fitted	447
No. of fixed appliances fitted	29
Pupils referred to Hospital Consultant	34

5. PROSTHETICS

	5 to 9	10 to 14	15 and over	Total
Pupils supplied with F.U. or F.L. (first time)	—	1	1	2
Pupils supplied with other dentures (first time)	—	29	16	45
Number of dentures supplied	1	26	31	58

6. ANAESTHETICS. General Anaesthetics administered by Dental Officers 1797

7. INSPECTIONS

(a) First inspection at school. Number of Pupils	51190
(b) First inspection at clinic. Number of Pupils	4382
Number of (a) + (b) found to require treatment	27840
Number of (a) + (b) offered treatment	19875
(c) Pupils re-inspected at school clinic	5694
Number of (c) found to require treatment	3338

8. SESSIONS

Sessions devoted to treatment	6644
Sessions devoted to inspection	797
Sessions devoted to Dental Health Education	29

MENTALLY HANDICAPPED CHILDREN

We now have over 200 children attending training centres in the county, two centres being officially overcrowded and the numbers requiring places will increase. There are less than 30 mentally handicapped children between 5 and 16 years who do not attend any centre or other institution. These children may be too severely handicapped for them to be admitted to the training centres, or their parents may be reluctant for them to attend. A few parents would allow their children to attend daily, but refuse a boarding place. However, the distance would be too great for daily travel. Powers given under the 1959 mental health act to compel parents to allow their child's attendance have not yet been used.

Ascertainment

Formal ascertainment of the children as unsuitable for education in school can cause great distress to parents of mentally handicapped children. Many feel that this ascertainment is final and irrevocable in spite of careful explanations to the contrary, and therefore, informal placement with later review is being used more frequently to allay anxieties. Educational psychologists visit the centres regularly and the review of children is undertaken to see whether a child can profit from education in school. It is imperative that the interchange of children between school and centre be facilitated.

JUNIOR TRAINING CENTRES

There are four of these in the county :

Day Pupil Places		Residential Places	
60	(58)	30	(*25)
48	(53)	21	(*20)
45	(43)	–	
48	(51)	43	(42)

Figures in brackets represent number of places filled at December, 1965.

* Weekly hostels.

From this it can be seen the provision is made for 201 places, forty-three of which are fully residential and fifty-one for weekly boarders.

Staff

The staff/pupil ratio remains at 1 : 12 children.

The admission of children of 5 or under to the Centres means that many are not yet toilet trained.

The policy of sending any untrained staff for the invaluable N.A.M.H. training continues. Untrained teaching staff are recruited only on the understanding that they are prepared to do the N.A.M.H. course; and we hope ultimately that all staff will be trained.

Accommodation

With increasing numbers, the centres are becoming overcrowded and extensions are planned at Downham and Mayfield. Besides extra classrooms, more space is needed for dining and teaching crafts.

Plans are also advanced for a special care unit at Mayfield for which the Spastics Society has most generously donated the capital cost.

The number of hostel places has been increased at Downham from 14 to 21, and at Abbeyfields from 24 to 30 but in spite of this few vacancies now remain.

Curriculum

Great advances are being made in the understanding of the learning processes and abilities of the mentally handicapped child. The staff of the 4 training centres are all keen to try any method which will help the children, in this rapidly developing field of child care.

The help which has been given by the education department advisers (in particular Miss Clarke—Infant Teaching Adviser) has been valuable and much appreciated.

The children are being taught (albeit slowly) along the lines of the nursery and infant schools' curriculum—each one encouraged to use his abilities to the limit; to experiment and to create.

Some older children after completing a pre-reading course, are able to read a little. All children are trained to recognize words important to daily living, e.g. "Danger," "Bus-Stop," "Ladies," "Gentlemen."

Social training is given emphasis, being recognised as the most important factor in community acceptance. Many children are socially almost as well developed as the normal child, in spite of their low intellectual development. Children are encouraged to widen their general knowledge and interests, and to become as independent and self assured as possible.

Health

The general health of children remains excellent, apart from the usual childish ailments. Daily attending children have up to an hour's journey twice a day to attend the centre—which makes a long day for them—yet they thrive. Many children at the Training Centres have other handicaps besides mental subnormality, but are quickly accepted and absorbed into the community. It is rare for a child not to "settle" at the centres or the hostels. If he comes from a home where he is loved and accepted for what he is, there are few difficulties.

School medical officers visit the centres regularly for medical inspections and take a great interest in the children and the centres.

Parent Teacher Associations

All the centres have an active P.T.A. and a wide circle of friends who contribute most generously to provide amenities for the children which are outside the scope of a local authority budget. By their efforts the three centres with hostel places have been provided with swimming pools and at Mayfield daily centre a paddling pool is planned.

Dental Inspection and Treatment

Regular visits for inspection and treatment were made to all centres and there was a considerable increase in the amount of treatment carried out. This is undoubtedly due to the growth of the rewarding relationships between pupils and staff. Whilst it can be expected that the amount of work that can

be done for these children will increase there will still be those for whom conservative treatment, or indeed any treatment except under a general anaesthetic, will always be impossible. Such cases will be referred to hospital as before.

Number inspected	234	Scaling and/or Gum Treatment	57
Number needing treatment ...	142	Fillings	171
Number Treated	111	Silver Nitrate Treatment ...	7
Number made dentally fit ...	76	Crown Inlays	1
Attendances	168	Extractions	64
		General Anaesthetics	13

DAY NURSERIES AND CHILD MINDERS

	Nurseries on Register on 31st December	Child Minders on Register on 31st December
1964		
Number registered	25	30
Permitted No. of children	552	305
1965		
Number registered	36	40
Permitted No. of children	796	370
New registrations	17	14
Cancellations	6	4

It can be seen that this type of care is becoming more popular and it is to be regretted that the local authority cannot itself provide Day Nurseries.

Before registration is granted by the Child Health Committee the applicant and the proposed premises are visited by one of the medical staff, and, in the case of a Day Nursery, by a fire prevention officer. Advice is given as required. After registration the assistant medical officer and the health visitor for the district are notified.

The majority of applications for registration of Day Nurseries and Child Minders in 1965 have been in order to form playgroups. Only a very small proportion of the children who are looked after in this way attend because their mothers go out to work. They mainly attend because their parents are aware of the need for them to meet other children and to learn to adjust to different surroundings in order that they may be prepared for school. In rural areas of Devon where homes are scattered the playgroups are sometimes the only means of children meeting each other.

Attenders are mainly from middle class families, but there are a few playgroups where a special effort is made to attract children from the poorer type of family for whom playgroups are of particular value. In some cases mothers are encouraged to attend as it is felt that they will be given ideas on how to play with their children.

Handicapped children also benefit greatly by meeting and playing with other children. Their attendance at playgroups can in certain cases be financed by the education authority.

At a few child welfare clinics there are playgroups where children are entertained while their mothers have talks on health topics. This is also a useful opportunity for giving mothers ideas on how to play with their children.

In April, 1965, the Ministry of Health issued a circular on the Day Care of Children. It emphasised the need for registration of Nurseries and Child Minders to safeguard the health and welfare of the children, and mentioned that extra training for people who look after children is useful.

Many playgroup staff have expressed a wish to learn more about their job. As a start a Day's Refresher Course is being arranged for Spring, 1966, at County Hall. It is hoped to arrange longer courses at four centres in Devon later.

It is pleasing to find that those people who are running playgroups are so anxious to raise their standards.

BASILDON CHILDREN'S HOME, EXMOUTH

This is a local health authority children's home for convalescent children admitted on the recommendation of G.P.s and medical officers. In 1965 it was decided to also admit socially and emotionally deprived children, and as a result the home has been filled to capacity with a waiting list for admission. Admissions for 1965 totalled 96.

There is no doubt of the value of a recuperative holiday for the children; they quickly respond to the regular hours, good food, and fresh air. There is a large garden, and each season Basildon has its own hut on the beach nearby.

The children usually stay from 1—3 months. Girls are admitted from the age of 2—15 years, boys from 2—11 years. Basildon has occasionally been used for the care of a physically or mentally handicapped child with excellent results.

SPECIAL FAMILIES

The key worker with these families is of course the health visitor, but par excellence this is the field in which she needs to have a good working relationship with her colleagues. Last year we endorsed our faith in the effectiveness of this in the county by decentralising the bulk of co-ordinating committee work to the field officers, and we have been more than justified by the excellent way in which they have handled matters. Whoever convenes the local meeting takes the chair, and is responsible for submitting reports to central office. Members of other services, for example Probation, N.S.P.C.C., may be invited as appropriate.

Any health visitor who wishes to have further guidance about a family can contact Miss McGilvray, a group adviser with special responsibility for these families throughout the county: she goes out to the health visitor and usually visits the family also. The senior medical officer is kept informed by Miss McGilvray and, if any officer feels a co-ordinating meeting should take place at central level, request is made to a member of the education department, who convenes these, and he is informed of the circumstances.

The attached figures give the measure of the work. The "others" in the first group are those on whom a close watch is kept but who are, for the moment, keeping their heads above water: in the second, potential, group the "current" one are those recently reported as possible breakdowns should some outside factor upset the equilibrium, and on whom we therefore keep a watchful eye and try to reinforce weak points: the "others" are one place removed again, and least likely of all to break down, but as this service aims at prevention as well as alleviation, we ask for all such families to be reported.

Basildon, our convalescent home at Exmouth, has proved an effective

means of preventing a family break-up, as well as providing the children with a chance to build up their low resistance.

SPECIAL FAMILIES 1965

Current	92
Others	235
Total	327

POTENTIAL SPECIAL FAMILIES 1965

Current	143
Others	139
Total	282

CO-ORDINATING MEETINGS 1965
27

CHILDREN FROM SPECIAL FAMILIES IN BASILDON
1965 ... 18 families, 39 children

LIAISON WITH OTHER DEPARTMENTS

The senior medical officer for the child health section is the official liaison officer, but co-operation is close at all levels, and the development of the local co-ordinating meetings as described in the section on special families has made this even more effective.

In addition, Miss McGilvray attends the children's department case conference at Villa Languard once a month. This is a reception home and the conference occasion is most valuable both from the point of view of getting to know the child care staff who attend to report on progress in planning for children from their areas, and because many of the children are already known to the health department as members of a special family. The link is extremely important when a child is discharged from the home, as the health visitor can be alerted in the receiving area. One of our school doctors, Dr. Epstein, is medical officer to Villa Languard and she gives expert advice on health matters both in the particular and in the broadest social sense of health education.

The children's officer keeps the health department up to date on children's department matters by sending us copies of relevant minutes and, in particular we are most grateful for the copies of the minutes of area children's officers meetings.

Liaison with the Welfare Department is mainly at field level but Miss McGilvray and Miss Williams, Deputy Welfare Officer, have developed an excellent understanding in relation to the care of problem families and also in the training of new staff who are given an insight into the work of the Health Department. This is extremely important because it is ignorance of one another's distinctive functions which causes difficulties among field workers, particularly when areas of responsibility overlap as much as they do between health and welfare departments.

The understanding and co-operation invariably offered by the administrative staff of the education department is very much appreciated. This team work is vital if the school health service is to run smoothly.