[Report 1952] / Medical Officer of Health, Barnsley County Borough.

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THE HEALTH OF BARNSLEY

1952

The Annual Report of the Medical Officer of Health

The Annual Report of the Schools Medical Officer

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FOREWORD

And no one shall work for money and no one shall work for fame,
But each for the joy of working, and each in his separate star
Shall draw the Thing as he sees It for the God of Things as They Are.
—" L'envoi ", R. Kipling.

It has been necessary to prepare this report in a manner which diverges somewhat from the established practice. In presenting it, therefore, the hope is expressed that the unavoidable breaks in continuity which occur in it will not detract from any interest it may contain or have the effect of rendering it less readable. The method usually adopted in preparing the Annual Report is to study in some detail the vital statistics for the County Borough and to comment on them and on the occurrence of communicable disease during the year. In this way a measure of the success of the various services is obtained and in reporting on them the statistical information is referred to on numerous occasions. In this way a form of Annual Report has been developed which deals with each subject in its logical order, and this order has been adhered to in the preparation of the 1952 report despite the fact that parts III and V were required to be written before the receipt of the Vital Statistics from the Registrar General.

The Minister of Health requested that the Report for 1952 covering the Local Authority's part in the National Health Service should be a survey of the Services and a review of their relationships with the other partners in the National Scheme. He further requested an advance copy of this part of the report early in the year at a date long before the Registrar General's figures could be expected. Compliance with these requests demanded that the whole of Part III be written in advance of the remainder of the report. It will be noted therefore, that observations on infantile mortality and still-births which have until now been regarded as belonging to the section on " Care of Mothers and Young Children " are now made in Part I of the report—the statistical part.

Similarly, the Minister of Education during the past two years has required the report on School Health to be delivered in advance copy form at a date prior to the receipt of the Registrar General's figures. Again a report prepared in compliance with this direction can not really be complete as the Principal School Medical Officer is denied the opportunity of relating School Health figures to corrected Vital Statistics. It is in this case, difficult to understand why the Minister of Education should be so anxious to obtain the detailed report so early, particularly in view of the fact that all the statistical material dealing with School Medical inspections is submitted to the appropriate department in the first six weeks of the year. Study of parliamentary questions some time ago offers a possible explanation for this.

Now every Medical Officer of Health who works " for the joy of working " takes a considerable pride in ensuring that his Annual Report gives an adequate picture of the health of his area and the measures adopted

to maintain it. Furthermore, the report used to offer him an opportunity of making recommendations supported by facts in regard to possible improvements. If future reports are to be prepared piecemeal by reason of one department of the Central Government requiring advance copies of parts of the report before another department releases information essential for their adequate preparation, much of the pleasure and pride that has been derived by the Medical Officer of Health from his work will be lost. In part III of this report, mention is made in several places of need for vigorous leadership in the National Health Service and the suggestion is made that the Ministry could do much to assert this leadership. It is submitted that this matter of annual reports is one aspect where leadership and co-ordination would be much appreciated by those responsible for the day to day running of one part of the service.

Some of the Vital Statistics set out in the first part of the report might well be more encouraging. Full comment is made on these, particularly the infantile mortality figure and the stillbirth rate. Once again emphasis must be placed on the falacy of trying to compare the statistics of a relatively small population group over the period of a single year with accepted standards. A true comparison can be obtained only by the observation of statistical trends over a period of years. In order to facilitate this, the practice has been continued of including a series of Tables showing Vital Statistics for past years. Study of these would indicate that the statistical trends in Barnsley are not altogether unsatisfactory.

The incidence of infectious disease in the County Borough as described in Part II of the report calls for little comment. It is pleasing to note that the number of cases of poliomyelitis was the smallest recorded since 1947. The occurrence of cases of dysentery and Salmonella infection (this latter is popularly referred to as food poisoning) is discussed in some detail and mention is made of special investigations which are proceeding with special reference to any relationship that may exist between these two diseases in Barnsley.

The third part of the report deals with the Local Authorities' activities in discharging the obligations imposed by the National Health Service Act. This part comprises the Review and Survey requested by the Minister of Health. On reading it and re-reading it with its criticisms and suggestions it is difficult to escape the feeling that this is the story of a splendid ideal which is slowly but surely failing in realisation by reason of some of the less desirable attributes of human nature. How this has come about it is difficult to determine. Was it due to someone overestimating the essential honesty of the community or have temptations too strong to resist, been placed within the reach of weak humanity? Be the causes of potential failure what they may, the sooner they are faced and eradicated, the better. There seems little doubt that a quality which is often described as Cupidity is playing an important part in preventing the development of the ideal. This quality has shown itself to occur in the professions which operate the Service as well as in the public for whom the Service exists. Then there is hypocrisy, this tends to exhibit many manifestations in the community, but it seems to be particularly prevalent amongst the professional element in the Service. In addition other forms of intellectual dishonesty appear from time to time such as malingering and lax certification.

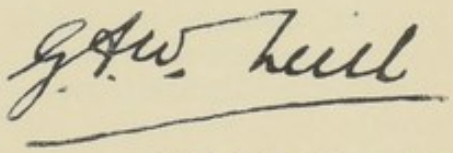
It is recognised that it would be futile in a relatively small area such as Barnsley to try " to put the world to rights." Nevertheless the writer of a report such as this must either conform with the prevalent deterioration in standards of intellectual integrity or " draw the Thing as he sees It for the God of Things as They Are."

Apart altogether from idealism, the review and survey of the National Health Service in Barnsley does indicate that there is room for strong leadership and an attempt has been made to suggest from whence this might be forthcoming, and where it might with profit be applied.

In the sphere of Environmental Hygiene, the report contains nothing that is spectacular, simply the record of unremitting routine which has proved successful in maintaining a reasonable level of health. The health of the school child in Barnsley is dealt with in some detail in the fifth part of the report and some considerable attention is paid to the place of the school in Health Education.

The whole of the report is prepared in accordance with the relevant statutory instruments (The Sanitary Officers' (Outside London) Regulations, 1935, Article 17(5) insofar as the first four parts are concerned and the Handicapped Pupils and School Health Regulations, 1945, as regards part V). In addition every effort has been expended to comply with the desires of the Minister of Health as expressed in Circulars No. 2/53, 29/52 and 42/51.

Finally it is desired to tender thanks to those many people who by hard work and goodwill have contributed to a year of successful work for the Barnsley Local Health Authority. At the same time, the opportunity is taken to express appreciation of an enthusiastic and loyal staff and to acknowledge the courtesy and kindness extended by the Mayor, Aldermen, Councillors and Heads of other Corporation Departments during the year.



Medical Officer of Health and
Schools' Medical Officer.

BARNSLEY. 13th August, 1953.

Part I

SOCIAL AND STATISTICAL INFORMATION

1. Geographical Situation: Latitude 53° 33" N.
   Longitude 1° 29" W.
2. Elevation: 125 ft. to 575 ft.
3. Area of County Borough: 7,811 acres
4. Population: (a) Census 1951..... 75,625
   (b) Registrar General's estimate for 1952 74,730
5. Density of Population: 9.56 per acre
6. Number of inhabited houses: 20,952
7. Rateable value at 31st December, 1952: £417,636
8. Sum represented by a penny rate: £1,645

Social Conditions

The National demand for coal continued through 1952. So long as it does the prosperity of Barnsley will be assured. In addition the other industries in the Borough have been fully occupied with the result that for another year the medico-social problems arising from unemployment have been virtually non-existent. The figures supplied by the Manager of the Barnsley Employment Exchange are as follows:—

	Men 18 and over	Women 18 and over	Total
As at 1/1/52:			
Wholly unemployed	342	147	489
Temporarily unemployed	15	138	153
As at 31/12/52:			
Wholly unemployed	317	171	488
Temporarily unemployed	14	30	44

In last year's Report mention was made of some of the rather unexpected effects of full employment which tend to have an adverse influence on the well-being of the community. These effects operate more especially in the field of mental hygiene and the two principal ones arise from housing difficulties and the employment of married female labour.

During 1952 there was little marked diminution in the number of housing problems referred to the Health Department despite the appreciable number of new houses built in the Borough. Most of the difficult cases encountered have arisen where married couples with little claim to priority

have been living with "in-laws." By the nature of things it is unavoidable that these families should be a considerable time on the waiting list. In most cases the longer the period of waiting the more acute becomes the mental strain when living unwanted in the "in-laws" home. For this reason for some time to come perhaps an increase rather than a decrease in this type of case is to be expected.

As regards the other social problem—the mother who goes out to work —this has never been a serious one in Barnsley and it certainly caused little difficulty during 1952.

Perhaps the most difficult and important medico-social problem which faces Health Authorities today is the care of the elderly. This problem is less directly related to full employment but it arises immediately from the establishment of the present system for Social Security. In Barnsley much has been done to meet the immediate needs of the aged section of the community. This will be evident from the repeated references to old people which will be found in those parts of this Report which deal with the more personal services provided by the Health Authority. Most of these measures must be regarded as palliative as they tend to reduce hardship which already exists rather than to prevent its occurrence.

In a surprising number of these cases old people have been found to be suffering varying degrees of privation and it would seem that any review of social conditions would be incomplete without reference to the existence of this. Indeed so far as Barnsley is concerned it is probable that the only really serious hardship in the Borough exists amongst the elderly. Cases of this kind are a reproach on the system of social security and as such call for examination in an effort to ascertain the underlying causes. The principal one appears to be the difficulty of the old people's adaptation to social security—a conception accepted by the community since they grew up. Contributing to this is the great difficulty which must be encountered by any scheme conforming with the theory of social security in providing for the old person's point of view. This latter is based on certain outlooks that social security must regard as outmoded and wrong in principle. Yet it is probably not too much to say that these views form part of the foundation of many elderly individuals' personality. It is therefore unrealistic if not unreasonable to ask them to reorientate themselves at this stage.

Many of the cases of difficulty that come to the notice of the Health Department arise through the attitude adopted by those old people with a commendable desire for personal independence who have attempted themselves to provide for their old age. This has been done either by saving and investment or by the foundation of a family. Let it be said here and now that a report of this kind is not the place to consider the ethics involved in these methods of provision. The fact is that many people have tried to adopt these means of arranging for their care when they are old and the problems arising from this have to be met. Some of the most difficult problems in the mitigation of hardship arise among those whose provision by saving and investment has proved inadequate owing to lowered rates of interest, increased taxation and rising cost of living. For the whole of their lives many of these people have believed that they must have a "nest egg" behind them. This is their sheet anchor and to spend it on the ordinary daily needs would be to them the height of profligacy. They are

utterly incapable of doing so. When the time comes to provide assistance of any kind where an assessment of means is required this "nest egg" is included in the assessment. The result of this is that less than adequate assistance is provided and so hardship supervenes. It is appreciated that it would be wrong for such people to be enabled to bequeath money to relatives and others by reason of having had assistance; nevertheless it should not be beyond the powers of human ingenuity to devise a means whereby the maintenance intact of the "nest egg" could be effected for the old person's life without involving privation as it does now and without it passing to heirs or being available for frivolous purposes. This is an example of the need for a greater understanding of human nature by social security.

Then there are those who have consciously or unconsciously provided for the evening of their days by the foundation of a family. They regard their children as having a moral obligation to ensure their care when they become unable fully to care for themselves. By reason of the differing outlooks of two generations the children often value this obligation differently from their parents. The parents expect the children to honour these obligations at their standard; thus it is considered that the children should keep themselves informed as to the needs of the parents. If they do not do so the old people, anxious to believe the best of the family, will struggle on in silence until their hardship comes to the notice of the agencies of social security. Attempts to rectify matters by such agencies are often rebuffed and hardship continues until it is possible to get some member of the family to advise and to help the old people. In most cases this help need not be of a material kind. Human nature is such that many of these old people will, when carefully handled by their own flesh and blood, do things for their well-being that they will steadfastly refuse to do for social agencies. It is difficult to see how social security can provide an answer to this problem other than by continuing to promote a strong feeling of loyalty in the family units which constitute the community.

The instances quoted above exemplify in outline only two of the many socio-medical problems that are being encountered with increasing frequency in a modern socially secured community such as Barnsley. This suggests that attention should now be focussed on the older portion of that community. There is little doubt that it is amongst elderly people that the more serious social difficulties will arise in the future. The importance of this will be appreciated when it is remembered that the population as a whole is an ageing one. As time goes on, therefore, it must be expected that the number of old people will increase and, unless solutions are found in advance, so will their social problems.

Vital Statistics

As in previous Reports, the story of the health of Barnsley in 1952 is written in the briefest possible form in the vital statistics. In some other years a few of the figures for the County Borough have shown a more favourable comparison with those for other areas and perhaps with those for the nation as a whole. This is always a possibility but annual variations in vital statistics for an area with a relatively small population group such as Barnsley are not of very great significance. Rather must the trend of the statistics over periods of five years or more be consulted to obtain a comparison of value.

In the pages which follow, an attempt will be made to interpret the figures for 1952, each under its appropriate heading, and to ascertain the trend indicated by these figures together with those of the immediately preceding years. In the Appendix to this part of the Report will be found the various comparative tables relating to Barnsley in previous years. Comparisons between Barnsley and various other population groups are shown in Table I. As regards this table, it should be noted that the column relating to the great towns now shows averages for 160 instead of 126 as for many years past, whilst 160 smaller towns are quoted in place of 148.

POPULATION

The Registrar General's estimate for the mid-year population of the County Borough of Barnsley was 74,730. This compares with the figure of 74,890 which was estimated for 1951 and the actual 1951 census figure of 75,625. This estimate is reached by taking into account a great many factors and not by simply applying the figures of crude death rate and uncorrected birth rate to the existing population figure.

BIRTHS

There was a total of 1,374 live births in the Borough. The details of these were as follows:—

LIVE BIRTHS

	Males	Females	Total
Legitimate	694	627	1,321
Illegitimate	34	19	53
Total	728	646	1,374

Birth rate per 1,000 population = 18.38.
Birth rate adjusted by application of comparability factor of 1.04 = 19.11.

The unadjusted figure of 18.38 is markedly higher than the average for England and Wales—15.3—and also for the 160 County Boroughs and Great Towns—16.9 (Table I). Reference to Table II will show that whilst the average birth rate for the country showed a small decrease when compared with 1951, that for Barnsley showed an appreciable increase. It will also be noted from this table how the birth rate for Barnsley has over the past 20 years remained higher than the average for the country as a whole. This increase is at first sight gratifying but the fact that it represents only a single year must not be overlooked. The general trend of the birth rate both locally and nationally has been downwards since 1947.

STILL BIRTHS

	Males	Females	Total
Legitimate	14	12	26
Illegitimate	2	2	4
Total	16	14	30

Rate per 1,000 total births (live and still) = 21.36.
Rate per 1,000 population = 0.40.

The still birth rate for Barnsley at 0.40 per 1,000 population is once again above that for England and Wales—0.35—but is below that for the 160 Great Towns—0.43 (Table I). It represents a fractional decrease on the figure for Barnsley for 1951. In view of the relatively high still birth rate recorded in Barnsley last year, an investigation was carried out into each still birth reported in order to ascertain if there was any cause which occurred with undue frequency. In addition it was felt that the place of confinement might be recorded with a view to ascertaining how far failure to take advantage of ante-natal and other facilities was a factor contributing to still birth. This would not appear to be the case. 19 out of the 30 reported still births occurred to mothers who had booked for hospital confinement. These women had presumably made full use of hospital ante-natal facilities.

The causes of the 30 still births recorded may be set out as follows. It is interesting to note that of these 30, 18 were premature births and 12 were at full term :—

Toxæmia of pregnancy		3	(1 prem.)
Concealed accidental hæmorrhage		2	
Malformed fœtus		5	(4 prem.)
Intrauterine death of fœtus :			
No cause found, bad social conditions	2		
No cause found	5		
Hydramnios	1		
Premature twin, other child born alive	1		
Acute intercurrent maternal infection	2		
	——	11	(10 prem.)
Severe maternal anæmia, bad social conditions		1	(1 prem.)
Subarachnoid hæmorrhage (twin)		1	(1 prem.)
Insufficient information		1	
Obstetric casualties :			
Prolonged labour	2		
Breech	1		
Occlusion of cord	1		
P.O.P. forceps delivery	1		
Precipitate labour	1		
	——	6	(1 prem.)
		——	
		30	(18 prem.)
		——	

It would seem that there was an unusually large number of fœtal deaths in utero. This was accompanied by a larger than usual number of malformed still born fœtus. Consideration will be given to fœtal malformation later in the report when infantile mortality is considered.

Place of Birth—Still Births :

St. Helen Hospital booked cases	19
St. Helen Hospital referred cases	1
St. Helen Hospital emergencies	2
Pindar Oaks Maternity Home	3
Jessop Hospital referred case	1
Home confinement, doctor booked	4
	30

DEATHS

Males ..... 488. Females ..... 388. Total ..... 876.
Crude death rate : 11.72 per 1,000 estimated population.

This figure for Barnsley is shown alongside that for England and Wales and other comparable areas in Table I.

When compared with last year, there is a decrease in the total number of deaths of seven. This is represented by the fractional decrease in the crude death rate—11.72 for 1952, 11.79 for 1951. When the area comparability figure is used the rate so obtained is 13.82 per 1,000 which it will be seen is in excess of the country taken as a whole.

It is disappointing that the death rate is not lower and does not approximate more to the figure for 1950. However, reference to Table III will show that the figure for 1952 is little above the average for the past 10 years.

A detailed statement of the number of deaths attributable to each of the causes on the abbreviated list is shown in Table IV. In addition this table shows the distribution of the deaths of Barnsley residents occurring in the several Wards of the County Borough and in various institutions. The age groups most affected by the principal causes of death are shown in Table V.

The common infectious diseases accounted for four deaths in 1952. Tuberculosis of the respiratory system showed an increase in the number of its victims over last year with 23 deaths as compared with 18. Non-pulmonary tuberculosis again accounted for three deaths. Whilst these figures are slightly higher than those for 1951 they are far from unsatisfactory and show no evidence that the decline in the number of deaths from infectious causes has been arrested. Again the numbers involved are small and the trend over the years is more significant than one annual group of figures. Syphilitic disease accounted for three deaths, one less than in 1951.

In comparing the figures for commoner causes of death with those for previous years, the most striking increase is in the case of cancer which now occupies a place second only to heart disease as the most frequent killing malady. Examination of Table V will show, however, that unlike heart disease which was more fatal to the age groups over 65 years, cancer has claimed most of its victims before that age. There is little comment to be made at present as regards the incidence of cancer in Barnsley though these figures are such as to call for careful observation in the future.

To the group of diseases affecting the heart and circulatory system including coronary disease, hypertension and other circulatory diseases were attributed 351 deaths. This compares with 375 for the previous year and represents a satisfactory decrease in numbers.

Vascular lesions of the nervous system are quoted as the cause of death in 106 cases, six more than last year.

Pneumonia and bronchitis are credited with the fatal issue in 82 cases and influenza in four. Both of these figures are below those for 1951.

Once again, examination of the causes of death and the age groups affected shows much that is expected in an ageing population. Attention must for the next few years be paid to the figures relative to cancer, particularly if they continue to rise.

In commenting on the figures obtained from medical certificates of the cause of death, the thought often occurs, " How often are these certificates supported by a complete post-mortem examination carried out by a Pathologist?" It would be most interesting to know this proportion. Much could be learned if it were only possible for a single year to have every person who dies in a small community such as Barnsley subjected to an examination of this kind. The figures resulting might then be examined alongside those relative to a series of communities of comparable size where no such special arrangements are in existence. It is appreciated, of course, that at present such a scheme is hardly practicable; nevertheless, if possible, there is little doubt that it would be most informative.

Suicides were fewer than in either of the previous two years, numbering five in all, and the figure for road traffic deaths was seven.

A survey of the causes of deaths found at inquests in Barnsley is appended (Table VI).

MATERNAL MORTALITY

One death was attributed to pregnancy, child birth or abortion. The resultant maternal mortality figure is 0.71 per 1,000 total (live and still) births. This compares favourably with the National figure of 0.72. The figure may also be said to be an improvement on that for Barnsley in 1951 which was 0.73. In both years one death occurred but the total number of births in 1952 was higher, thus giving a lower maternal mortality figure. It is hardly necessary once again to comment on the effect of a single maternal death on the statistics for a relatively small community like Barnsley. At the same time emphasis may be placed on the value of a five-year figure rather than an annual one if this figure continues to be regarded as a measure of the effectiveness of the maternal health services provided for such communities.

A short resumé of the facts concerned in the maternal death mentioned above is given in order that any lessons that might possibly be learned from it may be available to those interested in midwifery.

Place of death.	*Details.*
Hospital.	Patient aged 39. First pregnancy after 14 years of marriage. Booked for hospital at 16th week. Full out-patient ante-natal care. Admitted to hospital on onset of labour. Long

labour with little progress — Classical Cæsarian section. Living infant delivered — temperature rose shortly after operation. Transfusion and antibiotics given at once. A dynamic ileus was diagnosed and later peritonitis. Appropriate and active treatment was instituted. In spite of this patient died three days after delivery.

This would seem to be an example of a case where the fatal issue was inevitable despite the fact that all the resources of modern obstetrical science were made available to safeguard the lives of both mother and child.

Comparative figures for the recognised causes of maternal mortality for England and Wales and for Barnsley are shown in Table VII.

INFANTILE MORTALITY

A total of 53 children died in Barnsley during 1952 before attaining the age of one year. The corresponding figure in 1951 was 43. When reduced to an infant mortality figure of deaths under one year per 1,000 live births, this gives a figure of 38.57. That for England and Wales is 27.6.

It is somewhat disappointing to find that the infantile mortality figure for the County Borough thus shows a rise over that for the two previous years—32.04 in 1951 and 34.6 in 1950, the more so as the National figure continues to decline. It was felt that there must be some reason for this and arrangements were made to review all the information available regarding the 53 infants who died during the year. The review was carried out in two groups—deaths of children under four weeks of age (referred to as neo-natal deaths) and deaths of children aged from one month to one year (infant deaths). The results of this review are most interesting and suggest a reason for the higher figure though they do not explain that reason fully.

I. Neo-natal Deaths

				Whole term	Pre-mature
Causes :	Prematurity		6	—	6
	Prematurity and atelectasis		8	—	8
	Prematurity due to toxæmia		1	—	1
	Congenital deformities		9	5	4
	Obstetric casualties		4	3	1
	These consisted of :				
	Cerebral hæmorrhage (1 breech, 1 forceps)	2			
	Birth injury, forceps delivery	1			
	Atelectasis, post maturity, forceps	1			
	Neo-natal infections		4	3	1
	These consisted of :				
	Broncho pneumonia	3			
	Pneumococcal meningitis	1			
	Totals		32	11	21

Of the 21 premature babies, five were under 2lbs. in weight.

Place of birth—neo-natal deaths:

St. Helen Hospital—booked cases	11
St. Helen Hospital—referred cases	3
St. Helen Hospital—emergencies	7
Pindar Oaks Maternity Home	2
Jessop Hospital	2
Home confinement, doctor booked	3
Home confinement, midwife booked	4
	32

II. INFANT DEATHS FROM ONE MONTH TO ONE YEAR

			Total	Breast fed
Causes:	Congenital deformity		2	1
	Acute respiratory diseases		15	3
	These consisted of:			
	Broncho pneumonia	8		
	Broncho pneumonia & prematurity	1		
	Broncho pneumonia & pericarditis	1		
	Broncho pneumonia & mongolism	1		
	Broncho pneumonia & cretinism	1		
	Bronchitis	2		
	Bronchitis & otitis media	1		
	Whooping cough		1	—
	Influenzal meningitis		1	1
	Gastro-enteritis		1	—
	Asphyxia from inhaled vomit		1	—
		Total	21	5

Of the total of 53 deaths amongst children under one year of age in Barnsley during 1952, no fewer than eight were investigated by the Coroner.

Review of these figures is most interesting. To begin with, the number of infant deaths in children aged between one month and one year was 21. This is exactly the same number as in the previous year; therefore the increase over last year's figure was due entirely to deaths occurring in the first month of life.

Deaths due to congenital malformation amounted to 11. This compares with five for 1951. In addition there were five stillborn malformed children in 1952 and none in 1951. This is of great interest and every effort has been made to ascertain how far these cases were related to colds, influenza and other more serious virus infections. Unfortunately the results of these enquiries made so long after the event were so inconclusive as to preclude their consideration here. There is no doubt at all that this excessive proportion of fœtal malformations has played a big part in the increase of the infantile mortality figure. As mentioned above, when still births were under consideration, there appears also to have been an inordinate number of deaths of the fœtus in utero. So far there is little to connect this with the excessive number of malformations but their occurrence together is interesting. Another point of interest is the number of cases where

prematurity is mentioned as an actual cause of death. It appears on 15 occasions in the list of neo-natal deaths and once in the list of infant deaths. This factor was mentioned in connection with only five of the neo-natal deaths accorded in 1951. It is also to be noted that in five cases the premature baby weighed less than 2lbs. The question might be asked, "Has this increase in prematurity any relationship with the other two factors already mentioned?"

Again, in regard to deaths of infants aged from one month to one year, it is interesting to note that breast feeding was practised in only five out of the 21 cases. This compares with three last year.

This review of infant deaths would indicate that the increase in the numbers in Barnsley during 1952 was due to some factor or group of factors beyond the control of traditional socio-medical methods. The cause in the majority of cases would appear to have arisen in utero as a result of something reacting on the mother's health during pregnancy. This offers a very interesting and attractive line of research which it is intended should be followed up. The usual or classical causes of infant death are still present in the community and it is pleasing to see that the Coroner has been informed in so high a proportion of these cases. Enquiry indicates that broncho-pneumonia in the infant is a condition calling for very great respect from parents and medical practitioners. On the other hand, gastro-enteritis has once again failed to claim more than a single victim from the infants of Barnsley. In view of this, though the figures for 1952 are disappointing, they cannot be taken as indicating any falling off in the Health Authority's efforts towards the care of Mothers and Young Children. Rather do they suggest a field of fresh endeavour which might be explored with advantage in the future.

A detailed analysis of the various causes of death in infants under one year of age is shown in Table VIII along with the age at which death occurred.

Table IX gives a detailed ten-year comparison of the four principal causes of infantile mortality.

PART I APPENDIX

TABLE I.

Birth-rates, Death-rates, Analysis of Mortality and Case rates for certain Infectious Diseases in the year 1953 (Provisional Figures based on Quarterly Returns) for England and Wales, 160 County Boroughs and Great Towns, 160 Smaller Towns, London Administrative County and Barnsley County Borough.

	England and Wales	160 County Boro's and Great Towns	160 Smaller Towns (Resident Populations 25,000 to 50,000 at 1951 Census)	London Administrative County	Barnsley County Borough
BIRTHS—	Rates per 1000 Home Population				
Live	15.3	16.9	15.5	17.6	18.38
Still	0.35	0.43	0.36	0.34	0.40
DEATHS—					
All Causes ...	11.3	12.1	11.2	12.6	11.72
Typhoid and Paratyphoid ...	0.00	0.00	0.00	0.00	0.00
Whooping Cough ...	0.00	0.00	0.00	0.00	0.03
Diphtheria ...	0.00	0.00	0.00	0.00	0.00
Tuberculosis ...	0.24	0.28	0.22	0.31	0.34
Influenza ...	0.04	0.04	0.04	0.05	0.05
Smallpox ...	0.00	0.00	0.00	0.00	0.00
Acute Poliomyelitis (including Polioencephalitis) ...	0.01	0.01	0.00	0.01	0.00
Pneumonia ...	0.47	0.52	0.43	0.58	0.50
NOTIFICATIONS—					
Typhoid Fever ...	0.00	0.00	0.00	0.00	0.00
Paratyphoid Eever ...	0.02	0.02	0.03	0.01	0.00
Meningococcal Infection ...	0.03	0.03	0.03	0.02	0.15
Scarlet Fever ...	1.53	1.75	1.58	1.56	2.62
Whooping Cough ...	2.61	2.74	2.57	1.66	4.53
Diphtheria ...	0.01	0.01	0.03	0.01	0.02
Erysipelas ...	0.14	0.15	0.12	0.14	0.26
Smallpox ...	0.00	0.00	0.00	0.00	0.00
Measles	8.86	10.11	8.49	9.23	13.79
Pneumonia ...	0.72	0.80	0.62	0.57	2.82
Acute Poliomyelitis (including Polioencephalitis) :					
Paralytic ...	0.06	0.06	0.06	0.06	0.06
Non-Paralytic ...	0.03	0.03	0.02	0.03	0.02
Food Poisoning ...	0.13	0.16	0.11	0.18	0.17
Deaths under 1 yr. of age	Rates per 1000 Live Births				
All Causes ...	27.6	31.2	25.8	23.8	38.57
Enteritis and Diarrhoea under 2 yrs. of age	1.1	1.3	0.5	0.7	0.04
NOTIFICATIONS—	Rates per 1000 Total (Live & Still) Births.				
Puerperal Pyrexia ...	17.87	23.94	10.22	30.77	5.00

TABLE II.

Vital Statistics of Barnsley for 20 years, compared with those of England and Wales.

Year	Live Births per 1,000 Total Population.		Deaths per 1,000 living.		Deaths under One year per 1,000 Live Births.		Maternal Mortality Rate per 1,000 Births Live&Still	
	England and Wales,	Barnsley.	England and Wales.	Barnsley.	England and Wales.	Barnsley	England and Wales	Barnsley
1933	14.4	17.31	12.3	13.28	64	89	4.23	3.75
1934	14.8	19.20	11.8	11.35	59	64	4.41	3.47
1935	14.7	17.88	11.7	11.36	57	58	3.93	3.00
1936	14.8	17.44	12.1	12.27	59	61	3.65	1.54
1937	14.9	16.59	12.4	12.85	58	55	3.11	4.92
1938	15.1	17.80	11·6	13.27	53	59	2.97	2.24
1939	15.0	16.80	12.1	*13.75	50	58	2.82	6.19
1940	14.6	16.83	14.3	*15.59	55	60	2.16	1.64
1941	14.2	17.30	12.9	*13.12	59	66	2.23	4.03
1942	15.8	18.88	11.6	11.48	49	61	2.01	1.51
1943	16.5	20.26	12.1	11.97	49	66	2.29	2.84
1944	17.6	22.50	11.6	11.75	46	40	1.93	1.89
1945	16.1	19.90	11.4	12.22	46	56	1.79	1.42
1946	19.1	21.47	11.5	11.76	43	39	1.43	0.63
1947	20.5	22.59	12.0	11.88	41	43	1.01	1.17
1948	17.9	20.87	10.8	10.75	34	46	1·02	2.50
1949	16.7	19.08	11.7	10.67	32	41	0.82	0.00
1950	15.8	19.06	11.6	10.74	29	34	0.86	2.03
1951	15.5	17.92	12.5	11.79	29	32	0.79	0.73
1952	15.3	18.38	11.3	11.72	27	38	0.72	0.71

*Adjusted Death Rate.

TABLE III.

Vital Statistics of the County Borough of Barnsley during 1952 compared with those for the preceding Ten Years

Year	Total Civil Population Estimated to the middle of the year	Nett Births (Live)		Nett Deaths at all ages		Nett Deaths under 1 year of age		Nett deaths under 1 year	Nett deaths under 5 years
		Number	Rate	Number	Rate	Number	Rate	Per cent. of Total Nett Deaths	
1942	67670	1278	18.88	777	11.48	78	61	10.00	14.54
1943	67070	1359	20.26	803	11.97	90	66	11.20	13.07
1944	68260	1540	22.50	802	11.75	62	40	7.73	18.36
1945	69170	1377	19.90	845	12.22	78	56	9.22	11.36
1946	72430	1555	21.47	852	11.76	61	39	7.16	8.8
1947	73600	1663	22.59	875	11.88	72	43	8.23	10.36
1948	74730	1560	20.87	804	10.75	73	46	8.95	11.44
1949	75250	1436	19.08	803	10.67	59	41	7.34	9.59
1950	75780	1444	19.06	814	10.74	50	34	6.13	7.86
1951	74890	1342	17.92	883	11.79	43	32	5.21	5.66
Average for 10 yrs 1942-51	71885	1455	20.25	825	11.50	66	45	8.11	11.10
1952	74730	1374	18.38	876	11.72	53	38	6.05	7.64

TABLE IV.

Deaths Allocated to Wards, Hospitals, Institutions, etc. 1952.

Causes of Death	Sex	North	South	East	West	South East	South West	Central	Ardsley	Monk Bretton	Carlton	St. Helen Hospital	Beckett Hospital	Lisson Hostel	Kendray Hospital	Mount Vernon Hospital	Faith House, Leicester	Wath Wood Hospital	Brompton, Chelsea	Sheffield Children's Hosp.	St. Catherine's Institution Don.	Stanley Royd Hospital	Sheffield Royal Infirmary	Storthes Hall Hospital	Queen's Park Hosp., Blackburn	Private Residence Outside Borough	Sheffield Royal Hospital	Sheffield Home for the Aged
1 Tuberculosis, Respiratory	M	1			1	1			4	1	2	1	1	1			1	3	1									
	F			1						1						3												
2 Tuberculosis, Other	M																											
	F														1					1	1							
3 Syphilitic Disease	M		1		1																							
	F										1																	
4 Whooping Cough	M														1													
	F														1													
5 Meningococcal Infections	M														2													
	F																											
6 Other Infective and Parasitic Diseases	M					1																						
	F						1								1							1						
7 Malignant Neoplasm—Stomach	M			2	2	1	3	2	2				1										1	1	1			
	F				2	3		1				3	1													1		
8 Malignant Neoplasm—Lung, Bronchus	M	2			3	3	1			2	1	2	1									1					1	1
	F		1																				2					
9 Malignant Neoplasm—Breast	M																											
	F				1	2	1		1	2	1	4		1									1					
10 Malignant Neoplasm—Uterus	M																											
	F				1	1		1	1			1														1		
11 Other Malignant and Lymphatic Neoplasms	M	1		4	7	2	3	2	3	2	2	3	4	3									1				1	1
	F	1				5	2		8	4	3	4	5															
12 Leukæmia, Aleukæmia	M																											
	F						1								1													
13 Diabetes	M																											
	F	1		2			2				1	1	1															
14 Vascular Lesions of Nervous System	M	2	4	1	3	5		1	5	3	4	10	1	1														3
	F	4	3	3	3	5	5	3	5	5		13	4	2												1	1	1
15 Coronary Disease, Angina	M	6	3	2	1	6	6	1	3	3	5		6											3		1		
	F	2	1	4	1	4	4	1	2	3	2		2															
16 Hypertension with Heart Diseases	M	2			2							1																1
	F	1					1	1					1													1		
17 Other Heart Disease	M	13	6	11	10	11	6	3	12	6	2	14	3	9	1													
	F	7	3	7	7	12	6	5	8	6	2	21	7	1	2							1				1		
18 Other Circulatory Diseases	M		1	1	1	2	2		1	1		1	5	2														
	F	1	1	1	3	1		2	1				2	1										1				1
19 Influenza	M			1					1																			
	F				1						1																	
20 Pneumonia	M	3		1	2	3			1		1	3	3		7													
	F	2		1	1	1			2		1				3													
21 Bronchitis	M	4	3	2		2	1	1	3	6	1		1	1	1													
	F	1		1	1	4		3	3			1	1		1													
22 Other Diseases of Respiratory System	M						1																					
	F																											
23 Ulcer of Stomach and Duodenum	M					1			1				4															
	F											1																
24 Gastritis, Enteritis and Diarrhœa	M				2								1															
	F						1				1		1		1													
25 Nephritis and Nephrosis	M								1	1			2															
	F	1				1				1			1										1					
26 Hyperplasia of Prostate	M			1						2		2	3	1														
	F																											
27 Pregnancy, Childbirth, Abortion	M																											
	F											1																
28 Congenital Malformations	M										1	3	1															
	F		1						1	1	1	1																
29 Other Defined and Ill-Defined Diseases	M	3	2		6	3	2	3		4	2	14	5	1	4													
	F	3	2		4	4			2	4		12	3															
30 Motor Vehicle Accidents	M	1									1		1		1													
	F					1							1															
31 All other Accidents	M		1										4															
	F			1						1			1															
32 Suicide	M	1									1																	
	F																											
Totals		63	33	47	66	85	49	30	71	59	37	117	78	24	28	3	1	3	1	1	1	3	6	5	1	6	3	8

Causes of Death	Sex	Rotherham General Hospital	Chester-le-Street General Hospital	Lundwood Hospital	Sheffield City General Hospital	New Lodge Residential Home	Expanse Hotel, Bridlington	Barnsley Omnibus Station	Textiles Factory, Barnsley	Salford Railway Station	Sutton Coldfield Hospital	Mitchell Laithes Hospital Annexe, Earlsheaton	Yorkshire Traction Depot, Barnsley	Birk House Residential Home	Evelyn Nursing Home, Cambridge	Middlewood Hospital, Sheffield	Western Hospital, Doncaster	Pinderfields Hosp., Wakefield	Southmoor House, Hemsworth	Wharncliffe Woodmoor Colliery	General Hospital, Altrincham	Pindar Oaks Maternity Home, Barnsley	Sheffield Women's Hospital	Infirmary Annexe, Sheffield	Swanee Pond, Measborough Dike, Barnsley	Old Silkstone Colliery, Dodworth	Carlton Road Hotel, Barnsley	British Railways, Wilthorpe, Barnsley	Aire & Calder Canal, Carlton	Totals
1 Tuberculosis, Respiratory	M																													18
	F																													5
2 Tuberculosis, Other	M																													...
	F																													3
3 Syphilitic Disease	M																													2
	F																													1
4 Whooping Cough	M																													1
	F																													1
5 Meningococcal Infections	M																													2
	F																													...
6 Other Infective and Parasitic Diseases	M																													1
	F																													3
7 Malignant Neoplasm—Stomach	M																													16
	F																													11
8 Malignant Neoplasm—Lung, Bronchus	M																													18
	F																													3
9 Malignant Neoplasm—Breast	M																													...
	F																													14
10 Malignant Neoplasm—Uterus	M																													...
	F																													6
11 Other Malignant and Lymphatic Neoplasms	M	1	1	1																										42
	F																													32
12 Leukæmia, Aleukæmia	M																													...
	F				1																									3
13 Diabetes	M																													...
	F																													8
14 Vascular Lesions of Nervous System	M			2																										45
	F					2	1																							61
15 Coronary Disease, Angina	M			1				1	1																					49
	F							1		1	1																			29
16 Hypertension with Heart Diseases	M																													6
	F																													5
17 Other Heart Disease	M			8								1	1	2																119
	F	1		1																										98
18 Other Circulatory Diseases	M														1															18
	F															1														16
19 Influenza	M																													2
	F																													2
20 Pneumonia	M																1	1												26
	F																		1											12
21 Bronchitis	M																			1										27
	F																													16
22 Other Diseases of Respiratory System	M																													1
	F																													...
23 Ulcer of Stomach and Duodenum	M																													6
	F																													1
24 Gastritis, Enteritis and Diarrhœa	M																													3
	F																													4
25 Nephritis and Nephrosis	M																													4
	F																				1									6
26 Hyperplasia of Prostate	M																													9
	F																													...
27 Pregnancy, Childbirth, Abortion	M																													...
	F																													1
28 Congenital Malformations	M																													5
	F																													5
29 Other Defined and Ill-Defined Diseases	M																					1	2	1						53
	F	1																	1											36
30 Motor Vehicle Accidents	M																													4
	F																													2
31 All other Accidents	M																								1	1				7
	F																													3
32 Suicide	M																										1	1		4
	F																												1	1
Totals		3	1	13	1	2	1	2	1	1	1	1	1	2	1	1	1	1	2	1	1	1	2	1	1	1	1	1	1	876

TABLE V.

CAUSES OF DEATH.

The following Table gives the principle causes of death in order of frequency, arranged in age groups to facilitate more detailed examination.

Cause of Death	Total	0-1 yrs.	1-5 yrs.	5-15 yrs.	15-25 yrs.	25-45 yrs.	45-65 years	Over 65 years
Heart Diseases ...	228	...	...	...	2	10	36	180
Cancer (all forms) ...	142	...	1	1	...	11	64	65
Respiratory (Pneumonia and Bronchitis) ...	82	14	1	1	...	2	20	44
Vascular Lesions of Nervous System	106	...	...	...	1	23	39	43
Coronary Diseases Angina ...	78	...	...	...	...	1	27	50
Accidents ...	16	1	...	2	...	3	6	4
Tuberculosis ...	26	...	...	2	4	6	8	6
TOTALS ...	678	15	2	6	7	56	200	392

TABLE VI.

Inquests held by Coroner during 1952 on Barnsley Residents.

		Male	Female
1.	Deaths certified from Natural Causes	35	9
2.	" as Road Traffic Accidents	4	3
3.	" as Occupational Accidents	5	1
4.	" as Home and Other Accidents	5	3
5.	" as Suicide	4	1
6.	" from Miscellaneous Causes	—	—
		53	17

TABLE VII.

Maternal Mortality in England and Wales and Barnsley County Borough in the year 1952.

Rate per 1000 Total (Live and Still) Births.

	England and Wales	Barnsley
Sepsis of Pregnancy, Childbirth & the Puerperium	0.09	0.00
Abortion with Toxaemia	0.02	0.00
Other Toxaemias of Pregnacy and Puerperium ...	0.21	0.00
Haemorhage of Pregnancy and Childbirth ...	0.09	0.00
Abortion without mention of Sepsis or Toxaemia...	0·04	0.00
Abortion with Sepsis ...	0.07	0.00
Other complications of Pregnancy, Childbirth and the Puerperium ...	0.20	0.71

TABLE VIII

INFANT MORTALITY 1952

Causes of Death	Under 1 week	1—2 weeks	2—3 weeks	3—4 weeks	Total under 4 weeks	4 weeks & under 3 months	3 months and under 6 months	6 months and under 9 months	9 months and under 12 months	Total 1 month to 12 months	Total Deaths 1952
Whooping Cough ...	...	...	...	...	...	...	...	...	1	1	1
Pneumonia ...	...	...	2	...	2	5	6	...	...	11	13
Bronchitis ...	...	...	...	...	...	...	1	...	...	1	1
Gastritis, enteritis & diarrhoea ...	...	...	...	...	...	...	2	...	...	2	2
Congenital Malformations ...	7	...	2	...	9	...	2	...	...	2	11
Other defined or ill-defined	19	2	...	...	21	1	2	...	...	3	24
All other Accidents ...	...	...	...	...	...	1	...	...	...	1	1
Totals ...	26	2	4	...	32	7	13	...	1	21	53

TABLE IX.

INFANT MORTALITY

DEATHS FROM BRONCHITIS, PNEUMONIA, DIARRHŒA AND PREMATURITY, DEFORMITY, ETC. DURING THE LAST TEN YEARS.

Year	Neo-natal.								1—12 Months.							
	Bronchitis		Pneumonia		Diarrhœa		Prematurity Deformity, etc.		Bronchitis		Pneumonia		Diarrhœa		Prematurity Deformity, etc.	
	No.	Rate per 1000 Live Births	No.	Rate per 1000 Live Births	No.	Rate per 1000 Live Births	No.	Rate per 1000 Live Births	No.	Rate per 1000 Live Births	No.	Rate per 1000 Live Births	No.	Rate per 1000 Live Births	No.	Rate per 1000 Live Births
1943	1	0.73	8	5.88	2	1.46	37	27.96	8	5.88	14	10.30	2	1.46	10	7.36
1944	—	—	6	3.89	3	1.94	27	17.53	2	1.29	9	5.84	3	1.94	8	5.19
1945	—	—	6	4.35	1	0.72	12	8.70	4	2.90	18	13.06	6	4.35	7	5.08
1946	1	0.64	2	1.28	2	1.28	31	19.89	1	0.64	3	1.93	4	2.57	7	4.05
1947	—	—	3	1.80	2	1.20	27	16.23	5	3.01	13	7.82	8	4.81	6	3.61
1948	—	—	2	1.28	—	—	27	17.31	2	1.28	6	3.84	16	10.25	5	3.20
1949	1	0.70	2	1.40	—	—	25	17.40	1	0.70	9	6.26	6	4.20	10	7.00
1950	—	—	2	1.38	2	1.38	17	11.77	1	0.69	9	6.23	7	4.85	12	8.31
1951	—	—	2	1.49	1	0.75	18	13.41	1	0.75	6	4.47	2	1.49	13	9.68
1952	—	—	2	1.45	—	—	9	6.53	1	0.72	11	8.00	2	1.45	2	1.45

Part II

EPIDEMIOLOGY

During 1952 a total of 1,903 cases of infectious disease were notified under various enactments. This compares with 1,427 notifications in 1951. The increase of 476 is largely accounted for by the prevalence of measles during the first three months of the year. The numbers of cases notified of each of the infectious diseases, their incidence in the several Wards of the County Borough and their distribution through the various age groups of the community is shown in the Appendix to this Part (Table I). Figures for monthly incidence appear in Table II. These tables provide material for study and interest and may be regarded as recording an extremely satisfactory position. There was no outbreak of serious communicable disease during the year, the only epidemiological event of interest being the occurrence towards the end of the year of a number of cases of diarrhœal disease which has become the subject of a lengthy investigation. Details of this investigation will be described under the appropriate headings. No administrative change took place during the year and there are some indications that the medical profession is somewhat more ready to notify such conditions as measles and food poisoning than they were in previous years.

Scarlet Fever

There were in all 196 cases of Scarlet Fever notified, most of them occurring in the first half of the year. They may nearly all be regarded as sporadic in nature, no large groups of related cases being reported. The disease continues to be mild. As is usual, a number of cases were related to those of tonsillitis which is, of course, not notifiable.

Diphtheria

As in 1951, only two cases of Diphtheria were notified in the County Borough. It is a pity that it has not yet been possible in Barnsley as in so many other Boroughs to report that the year was entirely free of notifications of this disease. The graphic picture of Diphtheria in Barnsley during the past thirty years is again reproduced and brought up to date (Figure 1).

It is impossible to consider the incidence of Diphtheria in 1952 without making reference to the successes achieved by the process of immunisation against the disease. The fruits of this success will only be enjoyed by the community so long as a high immunisation level is maintained amongst the child population. It is necessary, therefore, for every individual—teacher, officer of the Health Service and parent—to appreciate this and to co-operate in ensuring that each and every child is immunised at the earliest possible moment. In addition they must not stop at this but be eternally vigilant in reinforcing immunity at the appropriate intervals.

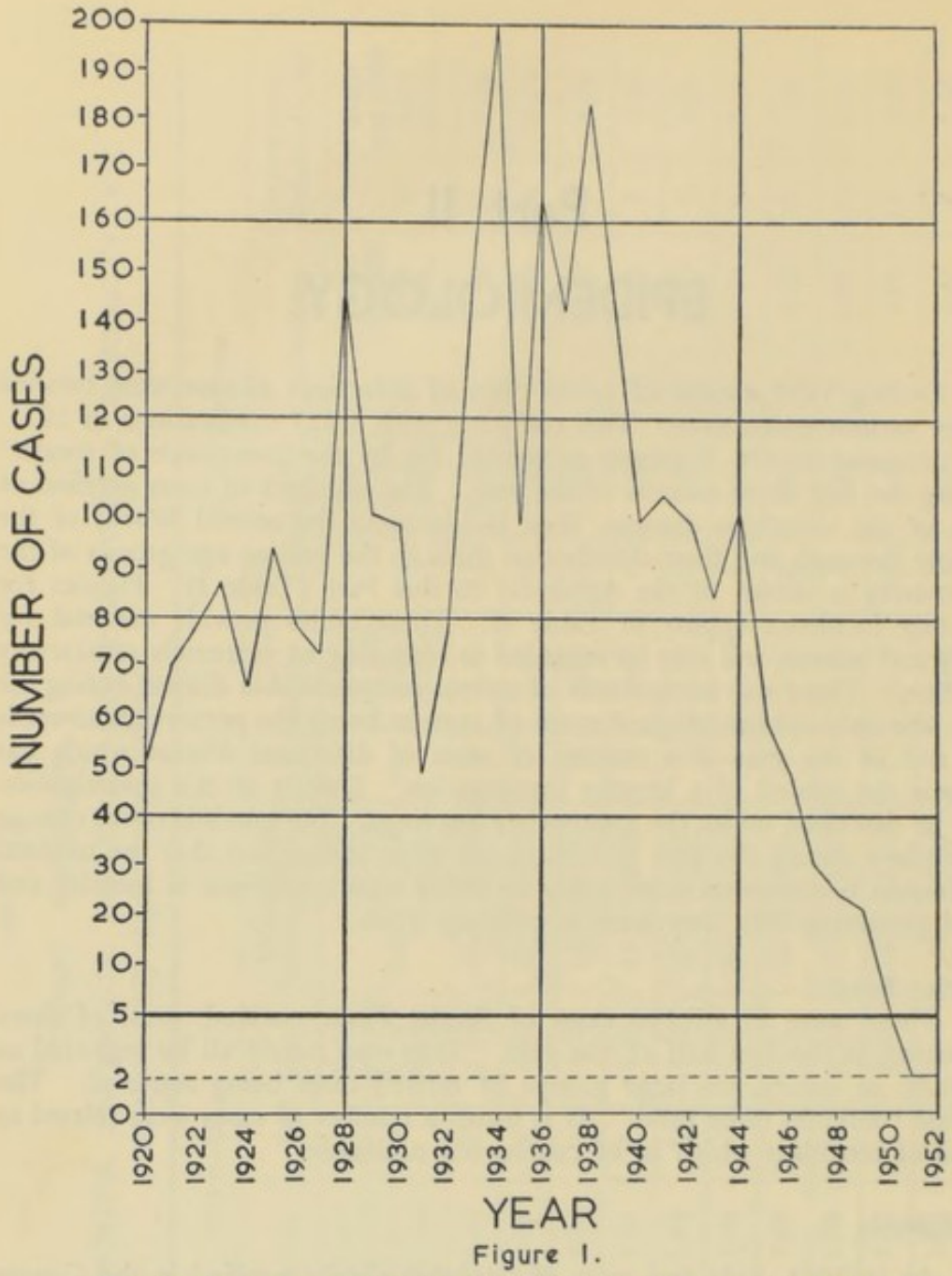


Figure 1.

Graph showing Incidence of Diphtheria in Barnsley since 1920.

Pneumonia

211 cases of Pneumonia were notified during 1952. This represents a decrease of 74 when compared with the previous year. Reference to Table II will show that more than one quarter of the total occurred in the month of February. This corresponds with the incidence of a pyrexial condition during that month which may have been a manifestation of virus influenza.

Meningococcal Infection

Eleven cases of Meningococcal Infection were notified in 1952, four less than the previous year. Two of these were fatal. In November circumstances suggested that the three cases notified for that month (vide Table II) were interrelated and were in some way connected with the overcrowded

conditions prevailing in a certain house. With the help of the Public Health Laboratory Service a very extensive investigation was carried out but no bacteriological evidence was found to support either contention. Once again attention must be drawn to the low case mortality rate now accepted as normal for this disease. This fortunate state of affairs as far as it affects Barnsley is due not only to modern therapeutic measures but also to the prompt and effective manner in which they are applied at Kendray Hospital.

Measles

Notifications of measles for 1952 amounted to 972, an increase of 288 over the previous year. It is unlikely that the notifications represent any more than a moderate percentage of the actual cases of the disease. It is surprising how many parents attempt to pilot their children through this relatively serious illness without the assistance of the family doctor, with the result that no notification is received in respect of those who succeed in doing this. In addition to this the tendency amongst practitioners to laxity in notifying infectious disease is probably more pronounced in relation to measles than to the other diseases on the list.

Figure 2 illustrates the incidence of Measles in Barnsley during the past 12 years. Comment has been passed on the " pattern " of this incidence in two previous reports. Again the picture shows divergence from the examples shown in textbooks on epidemiology though this is less marked than heretofore.

In the past Measles figured frequently on certificates issued in respect of deaths amongst young children. In a high proportion of cases it was the complications rather than the disease itself which decided the fatal issue. In recent years, however, there has been a considerable falling off in the number of Measles deaths. In this connection it is interesting to note that not a single death in Barnsley in 1952 was reported showing Measles as a principal or contributory cause. This is most satisfactory and is probably the result of several separate and distinct causes. In the first place parents are beginning more and more to appreciate the seriousness of the disease in a young child. As a consequence of this they are seeking medical advice earlier and more frequently. The National Health Service has in turn made medical assistance more readily available in those homes where it is most needed. When the doctor sees the Measles patient early in the illness he is able to take active steps to lessen the chance of complications. The taking of these steps has been revolutionised by the discovery of the new therapeutic agents—the antibiotics and the " sulpha " drugs. It will be seen then that all these circumstances together have been combined to reduce the power of Measles as a killing disease.

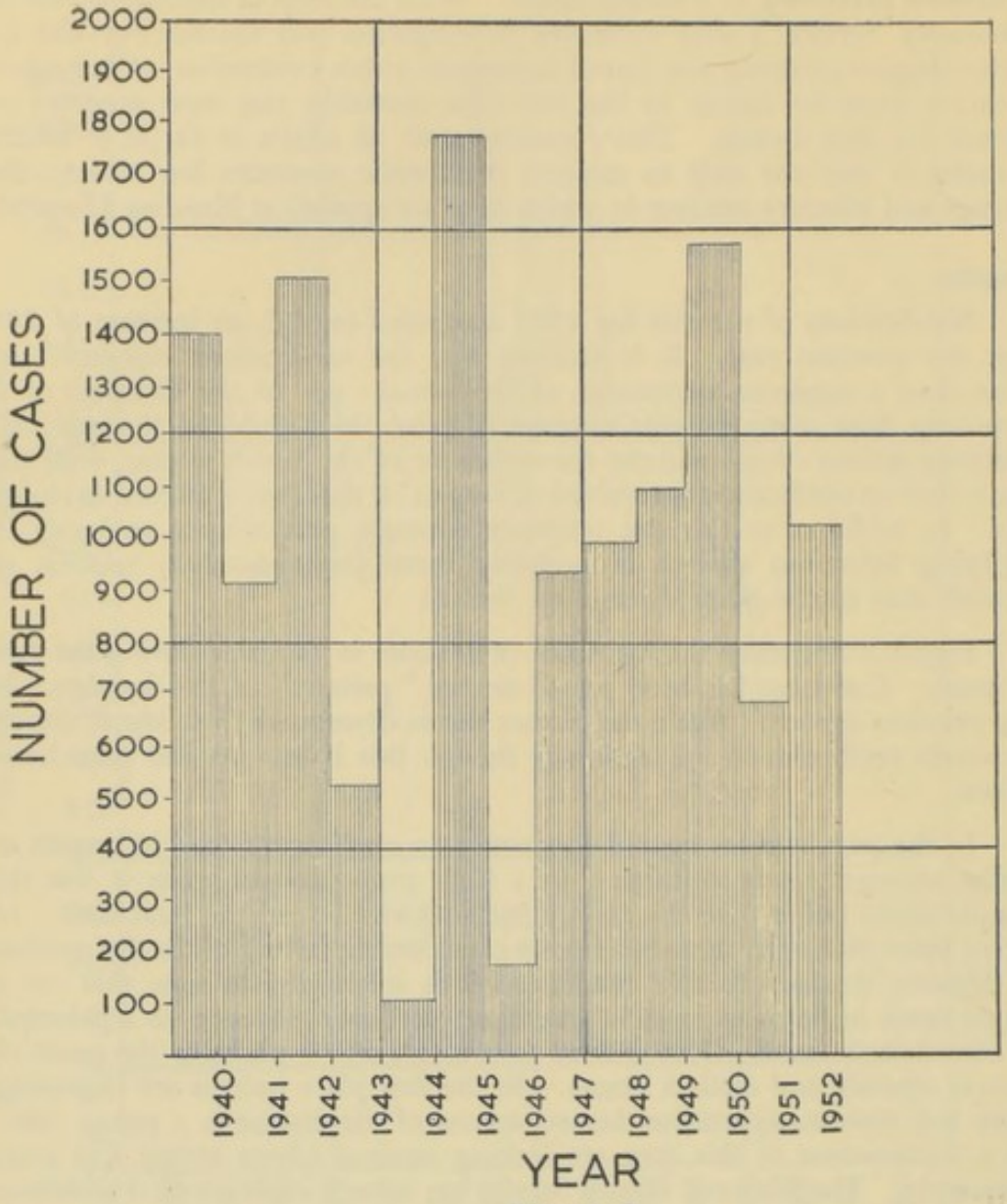


Figure 2.

Graph showing Incidence of Measles in Barnsley during the past eleven years.

Whooping Cough

339 cases of Whooping Cough were notified. This shows an increase over the previous year. Once again two deaths were attributed to this disease. Whooping Cough continues as a difficult epidemiological problem. It tends to be regarded as an illness of minor importance, yet in Barnsley it accounted in 1952 for as many deaths as Meningococcal Infection—a disease recognised as one of the most dangerous. Pædiatricians are finding that more and more of the chronic respiratory disease encountered amongst children has its foundations laid in an attack of Whooping Cough.

Many parents regard Whooping Cough as an inevitable accompaniment to childhood and consider medical advice to be unnecessary. It is essential that this idea be dispelled and that the importance of the disease be appreciated by the community. Immunisation against Whooping Cough is now

available and a considerable body of reliable evidence is to hand as to its efficacy. Parents have only to make contact with the Health Department or with their family doctor in order to have their children immunised, yet as shown later in this report relatively few take advantage of this.

Puerperal Pyrexia

In all seven cases of Puerperal Pyrexia were notified during the year. A higher number might have been expected in view of the standards required by the Puerperal Pyrexia Regulations, 1951. The question arises as to whether the medical profession is complying with these Regulations to the full.

Poliomyelitis

Seven cases of Poliomyelitis were notified in 1952. This is the lowest figure recorded since 1947. Reference to Table II will show that there was little relationship between these cases though it is interesting to note that three of them occurred in June, a time of year when the weather was noticeably hot and dry.

Again, as in previous years, there was a fairly wide geographical "scatter" of the cases over the Borough area and little to associate any of them with any particular environmental factor. None of the cases was fatal. In five of them there was evidence of paralysis and two were non-paralytic. In no case had any immunising antigen been given during the preceding twelve months and none was associated with tonsillectomy.

Food Poisoning and Dysentery

These two conditions were during 1952 found to be closely associated in Barnsley. Thirteen cases of infection with organisms of the Salmonella or so-called food poisoning group were reported. Two of these were fatal. In addition 65 cases of Dysentery were notified. All of these were attributed to Shigella sonnei. Reference to Table II in the Appendix will show the incidence of these cases during the year. In previous reports emphasis has been placed on the great need for investigating cases of diarrhœa of even moderate severity occurring in the community. Little was, however, done until the end of the year when cases of severe sonnei dysentery began to appear amongst children. Up to that time some four cases of severe diarrhœa had occurred sporadically and the cause of two of these has been ascertained as Salmonella dublin—and in one S. typhimurium. This latter is the common food poisoning organism in Barnsley. In none of the cases was the illness severe and the late stage at which the organism was identified rendered it impossible to ascertain the means by which it had been carried to the patient. Extensive investigation of the contacts of these cases failed to reveal any carriers or any potential source of infected food.

In October and November, however, cases of " Dysentery " began to be brought to the notice of the Health Department. Most of these were due to Shigella sonnei but in several cases the causal organism proved to be Salmonella typhimurium. One such case in an elderly adult, which was initially notified as Dysentery, proved fatal. On the occurrence of this death it was felt that a very extensive investigation into Diarrhœa in Barnsley must be undertaken. A statement of the facts involved, in the form of a circular

letter, was made to all the general practitioners practising in the Borough. This urged them to report cases of Diarrhœa to the Medical Officer of Health for investigation. All such cases were investigated by a Health Visitor and, where necessary, by a Medical Officer. Specimens of fæces were forwarded to the Public Health Laboratory at Wakefield and when these were found to contain a pathological organism specimens from all other members of the household were examined. In all cases an extensive questionnaire regarding food eaten and contacts outside the home was prepared.

Where any person who was a food handler was found to be infected with either dysentery or food poisoning organisms, the provisions of Section 38 of the Barnsley Corporation Act, 1949, were applied and the person was thus requested to desist from following his employment and, in appropriate cases, compensation was paid by the Corporation. This undoubtedly contributed towards limiting the spread of both diseases. In this connection a tribute must be paid here and now to all those individuals who at great inconvenience to themselves have so willingly co-operated both in this investigation and by remaining away from work till clear of infection.

Very extensive enquiries were instituted regarding the spread of the S. typhimurium infection and many samples of food were submitted for examination without a positive result being obtained. The enquiries instituted to demonstrate relationship between the families infected with typhimurium likewise failed to produce any results.

In four of the cases of infection with Salmonella typhimurium, which occurred during the latter two months of the year, other members of the patient's household were found to be symptomless excretors of the organism. The histories of these individuals were carefully examined and some had had gastric upsets of indeterminate character days or weeks previously. The facts in each case were very indefinite and it is quite possible that the case which came to notification was due to an infection acquired in the home from someone who had picked up the organism some time previously. The family doctors were advised and asked to institute treatment. At the same time everyone in whose fæces Salmonella organisms had been found was kept under bacteriological observation until a minimum of three successive negative results had been obtained.

A second fatal case occurred in December. Again this was in an elderly person and again the initial notification was of Dysentery. Investigation revealed no demonstrable source of infection amongst home contacts or food recently obtained in Barnsley. It was known that the patient had been out of the Borough for meals shortly before the onset of his illness.

As regards the 65 cases of Dysentery, several groups of these occurred in households which were closely associated with each other. None of the cases was very severe and investigation showed that 40 of them occurred in children under 10 years of age. (Table I). In practically every case there were one or more symptomless excretors of the organism in the household and it was often quite impossible to say which member of the family had introduced the infection.

It appears that many factors as yet unascertained are involved in the incidence of these alimentary infections in Barnsley. Little conclusion could be drawn from the findings in 1952. It was therefore decided to continue

throughout 1953 with the investigation of every case of diarrhœa reported to the Medical Officer of Health by practitioners. Apart from this, and perhaps more important, it might well prove to be a valuable preventive measure. Such an investigation could well detect food handlers who had picked up either infection and would enable action to be taken to prevent a serious outbreak of food-borne disease. There is every reason to hope that it will be possible to report further in this matter when the Annual Report for 1953 comes to be written.

Tuberculosis

During 1952 there were 67 notifications of pulmonary tuberculosis amongst inhabitants of the County Borough. Reference to Table III in the appendix will show that this compares very favourably with the two previous years and indeed is the best figure shown in the table. The figures for 1938 and 1939 were perhaps more favourable but before comparisons are made with the pre-war years the "telescoping" effect of mass miniature radiography on the notification rate of pulmonary tuberculosis must be borne in mind.

In last year's Report this effect was fully discussed and it certainly appears to have accounted for the relatively high figure in 1950 and 1951. In looking at the satisfactory figure for the year under review there is still another aspect of mass miniature radiography to be considered. This is the notification of those cases which would have passed undetected without it. Sir William Osler has described pulmonary tuberculosis as the most curable of diseases and without doubt a large number of cases undergo spontaneous cure without even the patient himself suspecting the existence of the disease. There may be several months of indefinite malaise and feeling of being generally " run down " and this in turn disappears after a holiday or change of air. Such cases are now being diagnosed as active pulmonary tuberculosis by mass radiography and are being treated and notified. There is no doubt at all that this is good for the community. It reduces the economic drag of people who are below standard in health and are unable to pull their full weight. It reduces the risk of such cases progressing to advanced disease and of infection of others. However, it must be borne in mind that though the notification rate for pulmonary tuberculosis is increased by these measures the true incidence of the disease in the community is unaffected.

Full details of the results of the survey carried out by the Sheffield Regional Hospital Board's Mass Miniature Radiography Unit in Barnsley during 1952 are contained in Part III of this Report under the heading of " Prevention of Illness." It is, however, of interest to note here that a total of 41 persons suspected as suffering from pulmonary tuberculosis were referred to the Chest Physician following the survey. It is reasonable to assume that some at least of these contributed to the final notification figures and that some would not have been notified in 1952 if it had not been for the survey. This must be an assumption pure and simple as full information is not available. This problem and the difficulties arising from it have been stressed in previous reports and there seems to be little point in repeating it here.

Once again attention must be drawn to the effects of the shortage of housing and hospital accommodation on the spread of Tuberculosis. Here again, it is unnecessary to repeat the points raised in last year's report. At

the same time the need for isolation of infective cases who call for little or no treatment must be repeatedly emphasised. Somehow or other provision must be made for such patients as the most important single step in controlling the spread of tuberculous infection. Suggestions such as "Night Sanatoria," special Settlements and specially designed houses have been considered from time to time. Experiments on these lines have been tried in different places with varying degrees of success. The great obstacle encountered has been the attitude of the community to the tuberculous patient. From this it would seem that until considerable reorientation in this direction has been achieved the simplest solution to the problem is re-housing of tuberculous families in ordinary houses of adequate size as quickly as possible coupled with Health Visitor and after-care supervision.

Deaths from pulmonary tuberculosis numbered 23. This figure, with the exception of that of 18 recorded for 1951 is the lowest on record. This is the ultimate measure of the success of measures against tuberculosis. Examination of the figures in Table III shows a steady and sustained decrease in the mortality from the disease over the past 12 years. This is an excellent example of "trends" in vital statistics. Comparison with earlier tables shows this trend to have continued for some 20 years. Although each year has not itself shown a decrease over the previous one, the average for the last three years of the period shows a marked improvement over that of the first three.

The age groups in which deaths from tuberculosis occurred along with the ages at which a diagnosis of the disease was made in new cases are shown in Table IV. This table illustrates a number of interesting points. The fact that 10 of the deaths occurred in males over 55 years of age suggests that it is no longer correct to look upon tuberculosis as a young person's disease. This is supported by the fact that no fewer than 19 of new notifications related to persons over 45 years of age.

Tables V and VI show the returns submitted to the Ministry of Health in accordance with the Public Health (Tuberculosis) Regulations, 1952.

Table VII shows the interval which occurred between notification and death in the various fatal cases of tuberculosis, pulmonary and non-pulmonary, during 1952.

In the case of non-pulmonary tuberculosis the incidence still continues to decrease. Notifications of tuberculous disease were received involving the following sites :—

	Cases	
	Males	Females
Meninges	–	1
Spine	1	1
Gland of neck	–	2
Knee	1	–
	2	4

Total notifications : 6.

This compares with a total of 12 notifications for 1951. It is satisfactory to note that there was only a single notification of tuberculous meningitis. All the three deaths from non-pulmonary tuberculosis on the other hand were from meningeal infection. This is very interesting as it would seem that two at least of these represent cases notified in previous years who have responded to modern treatment for a short period. Such a figure 10 years ago for an area the size of Barnsley—one notification and three deaths from tuberculous meningitis in a given year—would have been a rarity if not an impossibility. Prior to the use of streptomycin in the treatment of tuberculous meningitis, death followed notification in every case by an interval which could be counted in days. Now whilst streptomycin is not wholly successful in every case it prolongs life sometimes for many months so that it is possible for the disease to be notified in one year and to prove fatal in a subsequent one.

Venereal Diseases

Once again the incidence of venereal disease in Barnsley is not a matter to cause any great concern, having due regard to all the various factors involved. It must be remembered, however, that the figures quoted here are based on returns from the treatment centres and not on statutory notifications as in the case of other illnesses described in this part of the Report. In regard to this it is well to bear in mind the great reticence exhibited by some patients when attending Treatment Centres. Patients often travel to centres in distant towns and give fictitious names and addresses.

Returns in respect of first attendances of Barnsley residents during 1952 may be summarised thus :—

Special Treatment Centre	Syphilis	Gonorrhœa	Other conditions
Barnsley	10	34	105
Leeds	–	1	–
Royal Hospital, Sheffield	–	1	1
Jessop Hospital, Sheffield	–	–	1
Royal Infirmary, Doncaster.....	–	–	1
	10	36	108

The figures for Syphilis show a substantial decrease since last year when the number was 24. In view of the seriousness of this disease and its tenacity once entry to the body has been obtained, this is most gratifying. Gonorrhœa, on the other hand, shows an increase of 24 cases. This is not so satisfactory. " Other conditions " again show an increase. A high figure under this heading is always satisfactory. In indicates that those who have incurred the risk of venereal disease have sought advice on experiencing suspicious symptoms. It would seem that Health Education in this direction continues to be effective and that the community appreciates the value of early diagnosis and treatment of venereal disease.

Scabies

11 cases of Scabies (4 adults, 11 children) were treated during the year at New Street Clinic. This condition, it would seem, is no longer a serious problem in Barnsley.

TABLE I.

NOTIFIABLE INFECTIOUS DISEASES (excluding Tuberculosis).

AGE AND WARD DISTRIBUTION, AS CORRECTED

Notifiable Disease.	Number of cases notified in Barnsley during 1952								Total cases in each Ward.										Removed to Hospital.				
	At all Ages.	Under 1 yr.	1 yr. and under 3 yrs.	3 yrs. and under 5 yrs.	5 yrs. and under 10 yrs.	10 yrs. and under 15 yrs.	15 yrs. and under 25 yrs.	25 yrs. and over.	North Ward.	South Ward.	East Ward.	West Ward.	S. East Ward.	S. West Ward.	Central Ward.	Ardsley Ward.	Monk Bretton Ward	Carlton Ward.	Kendray Hospital.	Beckett Hospital	St. Helen Hospital	Pindar Oaks M. Home	Home Cases
Scarlet Fever	196	—	14	37	93	40	7	5	15	14	11	15	35	17	26	15	14	34	192	—	—	—	4
Diphtheria	2	—	—	—	—	2	—	—	—	—	—	—	1	—	—	—	1	—	2	—	—	—	—
Pneumonia	211	24	33	25	29	7	6	87	18	8	10	20	21	7	5	6	40	22	61	1	11	—	138
Meningoccal Infection	11	2	3	2	1	2	—	1	—	—	2	2	—	1	—	2	2	2	9	—	2	—	—
Measles	1031	62	228	333	384	10	9	4	79	33	86	52	158	39	163	40	225	156	56	—	2	—	972
Whooping Cough ...	339	43	85	112	93	4	1	1	10	10	43	22	56	11	5	100	35	47	34	—	—	—	305
Erysipelas	20	—	—	—	—	—	1	19	2	—	3	—	3	1	—	7	4	—	7	—	—	—	13
Puerperal Pyrexia ...	7	—	—	—	—	—	1	6	—	—	1	1	3	1	—	1	—	—	1	—	1	1	4
Poliomyelitis	7	—	3	1	—	2	1	—	—	1	1	—	—	—	—	2	1	2	7	—	—	—	—
Dysentery	65	4	10	12	14	5	4	16	4	3	1	1	—	—	13	4	28	11	7	—	—	—	58
Food Poisoning ...	13	2	4	3	2	—	—	2	—	—	—	3	2	—	1	5	1	1	1	1	1	—	10
Oph. Neonatorum ...	1	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	1	—	—	—	—
Totals	1903	138	380	525	616	72	30	141	128	69	158	116	279	77	213	236	352	275	379	2	17	1	1504

TABLE II.

Notifiable Infectious Diseases (excluding Tuberculosis). Table shewing monthly prevalence during 1952.

Notifiable Disease.	Jan.	Feb.	March	April	May	June	July	Aug.	Sep.	Oct.	Nov.	Dec.	Totals
Scarlet Fever ...	16	25	27	14	30	22	18	10	8	11	6	9	196
Diphtheria ...	1	—	—	1	—	—	—	—	—	—	—	—	2
Pneumonia ...	31	57	20	16	9	17	10	5	5	6	12	23	211
Meningococcal Inf. ...	1	2	—	2	—	—	—	1	—	1	3	1	11
Measles ...	141	99	138	175	75	70	99	32	26	29	44	103	1031
Whooping-Cough ...	112	103	54	25	11	3	5	6	4	1	4	11	339
Erysipelas	3	2	3	—	—	—	1	2	1	1	4	3	20
Puerperal Pyrexia ...	1	—	1	—	—	1	1	—	1	2	—	—	7
Poliomyelitis ...	1	1	—	—	—	3	1	1	—	—	—	—	7
Dysentery ...	—	—	—	—	—	1	—	—	—	4	12	48	65
Food Poisoning ...	—	—	—	1	2	—	1	—	—	—	5	4	13
Oph. Neonatorum ...	—	—	—	—	—	—	—	—	1	—	—	—	1
TOTALS ...	307	289	243	234	127	117	136	57	46	55	90	202	1903

TABLE III.

TUBERCULOSIS—NOTIFICATIONS AND DEATHS

For 12 Years.

Year.	Pulmonary.			Other Forms of Tuberculosis.			Total Tuberculosis Death Rate.
	Notified	Died.	Death Rate per 1000 living.	Notified.	Died.	Death Rate per 1000 living.	
1941	72	34	0·49	43	9	0·13	0·62
1942	84	29	0·43	44	10	0 14	0·57
1943	101	35	0·52	30	6	0·09	0·61
1944	108	30	0·44	35	4	0·06	0·50
1945	76	45	0·65	25	6	0·08	0·73
1946	102	31	0·43	22	5	0·07	0·50
1947	91	30	0·40	14	8	0·11	0·51
1948	166	37	0·41	16	8	0·10	0·51
1949	71	29	0·38	15	8	0·10	0·48
1950	118	26	0·34	16	1	0·03	0·35
1951	114	18	0·25	12	3	0·04	0·29
1952	67	23	0·30	6	3	0 04	0 34

TABLE IV

TUBERCULOSIS.

New Cases and Deaths.

CLASSIFIED INTO AGE GROUPS.

Age Periods.	New Cases.				Deaths.			
	Pulmonary.		Non-Pulmonary.		Pulmonary.		Non-Pulmonary.	
	M.	F.	M.	F.	M.	F.	M.	F.
0—1 years	...	1	...	...	...	...	...	...
1—2 ...	...	...	...	...	...	..	...	...
2—5 ...	1	2	1	...	...	...	...	...
5—10 ...	...	4	...	2	...	...	...	1
10—15 ...	2	1	...	1	...	...	...	...
15—20 ..	3	7	1	1	1	...	...	...
20—25 ...	6	5	..	...	2	2	...	1
25—35 ...	5	8	...	...	...	3	...	1
35—45 ...	1	2	...	...	1	...	...	...
45—55 ...	5	2	...	...	4	...	...	...
55—65 ..	9	2	...	...	5	...	...	...
65—75 ...	1	...	...	...	5	...	...	...
75 and over	...	...	...	...	...	...	...	...
Totals ...	33	34	2	4	18	5	...	3

TABLE V

PUBLIC HEALTH (TUBERCULOSIS) REGULATIONS, 1952.

Summary of notifications of Tuberculosis during Year 1952.

AGE PERIODS	Formal Notifications													
	Number of Primary Notifications of new cases of tuberculosis													
	0—	1—	2—	5—	10—	15—	20—	25—	35—	45—	55—	65—	75—	Total (all ages)
Respiratory, Males	—	—	1	—	2	3	6	5	1	5	9	1	—	33
Respiratory, Females	1	—	2	4	1	7	5	8	2	2	2	—	—	34
Non-Respiratory, Males	—	—	1	—	—	1	—	—	—	—	—	—	—	2
Non-Respiratory, Females	—	—	—	2	1	1	—	—	—	—	—	—	—	4

TABLE VI.

New cases of Tuberculosis coming to the knowledge of the Medical Officer of Health during the period 1st January, 1952 to the 31st December, 1952, otherwise than by formal notification.

Source of Information		Number of cases in Age Groups													
		0—	1—	2—	5—	10—	15—	20—	25—	35—	45—	55—	65—	75—	Total
Death Returns from Local Registrars	Respiratory M	...	....	....	....	....	....	....	....	....	....	1	3	....	4
	Non-Respiratory M	...	....	....	....	....	....	....	....	....	....	1	....	....	1
Death returns from Registrar-General (Transferable deaths)	Respiratory M	....	....	....	....	....	....	....	....	1	....	....	....	....	1
	Non-Respiratory F	....	....	....	....	....	....	1	....	....	....	....	....	....	1
Posthumous Notifications	Respiratory M	....	....	....	....	....	....	....	1	....	....	....	1	....	2

TABLE VII.

TUBERCULOSIS DEATHS.

PERIODS BETWEEN NOTIFICATION AND DEATH.

1 case died within 2 weeks of notification
1 case died within 2 months ,, ,,
1 case died within 6 months ,, ,,
1 case died within 7 months ,, ,,
3 cases died within 1 year ,, ,,
5 cases died within 2 years ,, ,,
3 cases died within 3 years ,, ,,
1 case died within 4 years ,, ,,
2 cases died within 5 years ,, ,,
1 case died within 7 years ,, ,,
1 case died within 10 years ,, ,,
4 cases died without notification
2 cases were posthumously notified.

26 cases

Part III

THE NATIONAL HEALTH SERVICE

The Minister of Health in Circular 29/52 has requested that Annual Reports for 1952 should contain, in addition to an account of the work done during the year, a special survey of the Health Authority's Services and a review of the relationship between them and those operated by the other bodies in the National Health Service. In spite of this it is unlikely that this part of the report will be found to differ greatly from those prepared for the years 1950 and 1951. It has long been felt that a series of reports containing such a survey and review presents a much more complete picture of the development of the Health Service, than " Survey Reports " prepared at intervals of five years or so with but little comment contained in those dealing with the intervening years. It is hoped, however, that the Minister's having designated the 1952 report as a " Survey Report " will result in its being more widely read and perhaps also a little more attention will be paid to its contents than has been the case with the preceding "ordinary reports."

Administration of the Health Authority's Services

The County Borough Council has charged the Health Committee with exercising the powers and functions of a Health Authority under the National Health Service Act, 1946. To deal with the detail work involved three Sub-Committees have been formed—they are as follows :—

1. The Handicapped Persons Sub-Committee.
   This is concerned with the welfare of the blind and the deaf and other physically handicapped persons (National Assistance Act, 1948) as well as with the Authority's duties in relation to Mental Health under the National Health Service Act, 1946. This Sub-Committee deals with all matters relating to lunacy, domiciliary care of the mentally ill and defective and controls the Occupation Centre for mental defectives.

2. The Centres and Clinics Sub-Committee.
   This Sub-Committee deals with the Immunization and Vaccination schemes, arrangements for Care and After-care and the Ambulance Service, in addition to matters relating to centres and clinics. It will become extremely busy when a full scheme for the erection and running of Health Centres becomes operative.

3. The Home Services Sub-Committee.
   This administers matters pertaining to the Care of Mothers and Young Children (the Day Nursery, dental services, supply of dried milk), the Midwifery, Home Nursing and Health Visiting Services, and the provision of Domestic Help in the Home.

The Chairman and Vice-Chairman of the Health Committee hold the same offices in the Sub-Committees which consist entirely of members of the Council and do not include either of the two co-opted members of the Health Committee.

Matters relating to medical and administrative staff, estimates and communications from the Minister and other bodies are dealt with by the full Health Committee whose meetings take place each month.

The day-to-day overall direction and administration of the Health Department is the responsibility of the Medical Officer of Health (who is also Schools Medical Officer and Superintendent of the Blind). The Deputy Medical Officer of Health carries out a wide range of clinical duties and acts as supervisor of Health Visitors. (In this latter duty she is assisted by an Assistant Superintendent who also undertakes a small district as a Health Visitor). She assumes the general supervision of the Department in the absence of the Medical Officer of Health. The Administrative Assistant and Chief Clerk supervises the clerical arrangements. In this he is assisted by two Senior Clerks, one of whom deals with wages, accounts and payments whilst the other, who is in effect a record officer, is responsible for the collection and tabulation of statistical material of all kinds.

The Midwives and Home Nursing staff are supervised by the Non-medical Supervisor of Midwives and Superintendent Home Nurse and her Assistants the latter also undertakes some practical Home Nursing duties. Both Superintendent and Assistant Superintendent are Queen's Nurses and are approved by the Queen's Institute of District Nursing for their present appointments.

The dental services are arranged by the Senior Dental Officer who directs the work of the Assistant Dental Officers and their ancillary staff.

The Ambulance Service is operated by the Chief Fire and Ambulance Officer.

For the Home Help Service there is an Organiser and Assistant Organiser and a panel of some 80 part-time Home Helps.

The Occupation Centre staff is controlled by the Supervisor and that of the Day Nursery by the Matron of that establishment.

Additional services are provided by the three Duly Authorised Officers and the Social Worker.

Liaison between the various Services mentioned above is maintained by the Medical Officer of Health to whom each officer responsible for the detailed working of a service has easy and ready access. The Medical Officer of Health conducts all correspondence relating to the services and steps are taken by the Administrative Assistant to see that everyone concerned is kept in the picture. Conferences of officers are called when occasion demands discussion of any major problem. Such conferences are extended, when it is considered desirable, to include every individual person engaged in providing the particular service under discussion.

The Medical Officer of Health is also Superintendent of the Blind and in the duties involved is provided with the services of an Assistant Superintendent.

Certain premises, for example the Central Health Services Clinic in New Street, are shared with the Education Authority for School Health Service use. Close liaison is maintained between the School Health Services Sub-Committee of the Education Committee and the Health Committee. The Chairman and as many members as possible are common to both. At officer level there is day-to-day consultation between the Medical Officer of Health and the Director of Education.

The Medical Officer of Health has been appointed by the Children's Committee Co-ordinating Officer for children neglected or illtreated in their own homes. This provides a useful and satisfactory basis of liaison with the Children's Department and indeed with all Corporation Departments and welfare agencies on matters affecting the health of young children.

Relationship at officer level with neighbouring Health Authorities is maintained by the Medical Officer of Health through his membership of the Sheffield Regional Hospital Board's Liaison Committee and through his membership of the Yorkshire Branch of the Society of Medical Officers of Health.

A joint arrangement has been made with the West Riding County Council in respect of attendance at the Barnsley Corporation's Occupation Centre for mental defectives of patients from the County Council's area, while arrangements for reciprocity in the use of the Ambulance Services are in every day operation.

From time to time ad hoc arrangements are made with regard to individual problems as they arise.

The administrative structure described above has proved itself to be efficient, a sound basis for future development and capable of expansion in any direction to meet growing demand or emergency. Being part and parcel of the well tried machine of English Local Government is without doubt a tremendous advantage. The Local Authority's health service has behind it a legal department specially versed in the problems of corporate bodies, an Engineering department with a wide experience of Public Works of all kinds and an accountancy department whose knowledge of finance extends to almost every aspect of community spending. With such resources it is possible to provide almost any kind of health service rapidly and economically without burdening it with an array of specially appointed officials. At the same time, in Barnsley the Corporation's building department makes it possible to get new premises provided and structural alterations carried out without resorting to the delays and difficulties of seeking the services of outside contractors.

Perhaps, however, the greatest advantage that the Local Health Authority's services reap from being part and parcel of English Local Government is that the governing body consists of representatives of the people chosen by the community by exercise of the franchise. With such a body the tendency to lose the human touch is less and the relationship with the community as a whole is closer than is the case where the governing body is nominated and tends to represent sectional interests.

In surveying the road travelled by the internal administrative structure of the Local Authority's health services since 1948, Barnsley has good ground for satisfaction. Despite the many changes that have taken place during the years in question, a machine is now available which could undertake efficiently and with great economy the administration of a very much larger share of the National Health Service than that which is granted to it at present.

Co-ordination and co-operation between the Parts of the National Health Service in Barnsley

In each of the Annual Reports on the health of Barnsley which has been written since 1948, reference has been made to the need for co-ordination and co-operation between the three partners in the National Health Service and the steps which have been taken to secure it. The Report for 1949 contained a detailed description of the relationship which exists between each individual hospital and the Local Health Authority's services and of the need for a closer relationship with the bodies concerned in their administration. Little change has taken place since then. In the Report for 1950 reference was made to the feeling of need for a closer understanding between the three parts of the service and to the efforts then being made to achieve this. In the Report for 1951 it appeared that while co-operation and co-ordination were possible in the cases of individual patients, this depended to a very great extent on the personality and goodwill of the officials immediately concerned with the well-being of the case in question rather than on any concerted policy of the governing bodies. That comment on these lines is to be found in each of the Reports since the inception of the National Health Service tends to suggest that little progress has been made towards the required objectives. It is not desirable nor is it necessary to mention in detail in a survey such as this the many misunderstandings that have arisen and the difficulties that have grown out of them. Rather should the steps which have been taken to achieve a closer working be enumerated and examined critically with a view to improving upon them in the future. In this respect it would be well to consider first the relationship between the Local Health Authority and the Hospital Specialist Services.

A relationship between the governing bodies is provided, in the case of the Sheffield Regional Hospital Board, of membership of two Barnsley Aldermen. In the case of the Barnsley Hospital Management Committee the Health Authority has two members and one on each of the two House Committees. In 1952 the Barnsley Hospital Management Committee saw fit to reduce the Local Authority representation on the House Committees. This would seem to be a retrograde step as it substantially reduced the representation of the Health Authority in hospital affairs. In addition it called for the broadest vision on the part of the individuals who were dropped from the Committees to prevent themselves from regarding this action as a calculated affront to both the Health Authority and to them personally. Unfortunate incidents of this kind give rise to an atmosphere that is, to say the least, unfavourable to the promotion of co-operation between either bodies or individuals the one with the other.

The Sheffield Regional Hospital Board has on its part shown every consideration in the making of Specialist appointments where the Specialist

concerned conducts clinic sessions on the Local Health Authority's premises. Representatives from the Health Authority have been invited to be present with the Selection Committee when such appointments have been made.

In addition to this an attempt was made during 1950 and 1951 to form a local informal liaison committee consisting of the Chairmen of the Barnsley Hospital Management Committee, the Health Committee of Barnsley Corporation and the Barnsley Executive Council and the chief officers of each of these bodies. This ad hoc committee met on two or three occasions and the atmosphere at its meetings was good. It is interesting to note that the Management Committee has not during 1952 asked for a meeting or provided matter for discussion.

In the case of the General Practitioner service the relationship between the Executive Council and the Health Committee is much more satisfactory and free exchange of information of one kind or another takes place all the time. It would be interesting if it were possible to assess the extent to which this is due to the fact that the Chairman of the Health Committee is also Chairman of the Executive Council and that in all eight members of the Borough Council are members of the Executive Council.

So much for co-ordination and co-operation at "Representative" or "Member" level.

Consideration must now be given to what, for want of a better phrase, has been termed "co-ordination and co-operation at officer level."

With the Sheffield Regional Hospital Board opportunities are afforded for discussion through the Liaison Committee which is attended by the Medical Officer of Health. In this way it is possible for matters of policy to be discussed not only with the Chief Administrative Medical Officer but also with Medical Officers of Health of adjoining Health Authorities.

Apart from the informal ad hoc committee already mentioned, there was no mechanism for liaison or co-operation between the Medical Officer of Health and the officers—medical and otherwise—of the Barnsley Hospital Management Committee until October, 1952, when the Medical Officer of Health was made a member of the Barnsley Group Medical Advisory Committee. Despite this there was rarely, if ever, any difficulty when the Medical Officer of Health approached the individual officers of the Committee in regard to specific matters or cases; in fact relations of this kind have always been both cordial and mutually helpful.

As regards the general practitioners and other officers of the Executive Council, liaison has been maintained through the Medical Officer of Health having membership of the Local Medical Committee and, as in the case of the officers of the hospitals, by individual contact for specific cases.

In 1951 the Sheffield Regional Hospital Board established Group Medical Co-ordinating Committees attended by medical staff of the Hospitals, Medical Officers of Health and representatives of the general practitioners from the various Local Medical Committees. This body was concerned with discussing current problems affecting all three parts of the Service in the area covered by the members of the Committee. In the Report for 1951 comment was made to the effect that in the absence of executive members of the

parent bodies it was difficult to see how this Committee could be more than an advisory body. So far nothing has transpired from the proceedings which would suggest that this comment should be altered.

In the course of the four years or so since the inception of the National Health Service there has been an increasing tendency to establish committees and to call ad hoc meetings of officials who are employed in each of the three parts of the National Health Service with a view to promoting liaison and co-operation amongst them. Attendance at these committees and meetings has become a major portion of the duties of the Medical Officer of Health of a Local Health Authority. In a survey report such as this, therefore, it would seem that some attempt should be made to record observations made and impressions received and to assess the value to the community of the time spent in this way.

Reflection and thought given to the observations and impressions resulting from meetings of various kinds on co-operation and co-ordination within the Health Service would indicate that there is one fundamental cause for all the difficulties that are encountered under these headings. This cause would seem to be the lack of strong leadership not only at a National level but to a greater or lesser extent throughout the Service. As a result of this there is a mutual lack of confidence and trust between groups and individuals. Much of this is caused by real or imagined inequality of treatment from a higher level, a situation that inspired leadership would dispel at the earliest opportunity. For example, an obvious inequality of treatment between the three partners in the Service has been present right from the commencement. In the National Health Service Act, 1946, itself Local Health Authorities are required by Section 20 to prepare "proposals" of their intended arrangements for discharging the obligations placed upon them by the Act. They are required to submit these to both Regional Hospital Boards and Executive Councils so that either or both of these bodies may make recommendations for modification of the proposals. Neither Regional Hospital Boards nor Executive Councils are obliged by statute to disclose their intentions to Local Health Authorities. The latter are at times faced with *faits accomplis* of hospital administration which might well prove obstructive to their officers in discharging duties imposed under other legislation. There is no statutory right for Health Authorities to recommend alterations or modifications in the plans of Regional Hospital Boards or Executive Councils despite their long experience in health administration. Then many of the circulars received on matters of mutual concern are couched in terms which are suggestive rather than imperative. Such circulars must be acted upon by Local Health Authorities who have a long experience of Ministerial methods of direction and whose expenditure is subject to scrutiny by the District Auditor. In addition the actions of Local Authorities are liable to the sanction of the electorate. Regional Hospital Boards, on the other hand, by reason perhaps of the absences of the conditions which apply to Local Authorities, tend to regard such circulars as permissive. This often results in much fruitless discussion between bodies. Again this tendency to leadership by tentative suggestion rather than positive direction has led, particularly with the technical aspects, to much of the development of the National Health Service being delegated to paid officials instead of a more detailed consideration of it being undertaken by the elected representatives of the people. In view of the involved technical nature of

some aspects of the Service, there might be a very great deal to be said in favour of the people who are actually doing the job, accepting some of the responsibility for forming policy. Unfortunately however there are great divergences of interest amongst the qualified medical officials of the three partners of the Service and it would seem that these divergences are one of the principal obstacles to co-operation. It may well be said, and has indeed often been inferred, that the ideals of medicine override all personal considerations and provide a community of interest. To accept this view unreservedly is to overlook the fact that doctors are human beings and subject to the human frailty of liking to obtain the best prizes possible in the particular field of endeavour which they happen to have chosen.

The Medical Officer employed by a Health Authority depends for his advancement and for increase in his monetary rewards on the efficiency of the services he provides. This is judged by the value measured statistically he gives the community in relation to the amount of public money he recommends to be spent. His principal preoccupation is therefore with the purely scientific aspects of preventive medicine.

The General Practitioner, on the other hand, due to the present system of "free choice of doctor" combined with capitation fee remuneration is largely dependent for increasing his reward on his popularity with his patients or potential patients. Now many members of the community regard their doctor solely as a machine for the production of the certificates and prescriptions which they themselves desire and readily discard this machine for another more accommodating one when, as a result of professional conscience, the desired piece of paper is not forthcoming. It will be seen then that the general practitioner works in an atmosphere of continual internal conflict between his professional conscience and the very natural desire for at least maintaining if not increasing his material position in the world. The Hospital Specialist who is employed on a part-time basis has interests in many ways similar to both his colleagues. In his salaried service with the hospitals he is able to practice scientific medicine or surgery secure in the knowledge that by his work he will be judged. His success in private practice, however, calls for popularity with the general practitioners and here he is exposed to a whole mass of conflicts which makes him very chary of expressing an opinion publicly on any matter of professional policy. These divergences of interest are fundamental under the present conception of the National Health Service and are without doubt one of the principal causes of the difficulties encountered in welding the three parts of it into an efficient and harmoniously working instrument.

When any projected development of the Service which remotely affects more than one of the three partners is considered it becomes necessary to give each of these interests a hearing. Often the resulting meetings are protracted as few of those present are prepared to concede the smallest point that might possibly be prejudicial to the interests they represent. Furthermore the position is further complicated and befogged by reason of the reluctance of many members of the medical profession to admit that the stand they take is motivated by anything but their moral responsibilities to the patient who entrusts himself to them. This must on many occasions call for much rationalization of their thoughts. With a little more forthrightness as to personal and sectional interests and under-

standing of each other's points of view, agreement might be reached more readily with consequent benefit to the Service as a whole. As it is, the final result of these discussions often depends on the views and the personality of the representative who is endowed with the greatest degree of "Committee meeting endurance." In this way it is not impossible that the Health Services in any area may develop in accordance with the outlook of the member of the local ad hoc co-ordinating committees who has the strongest will. Again the question arises as to whether the time spent at these discussions is justified. Would not all the doctors who spend all these hours talking, each to try to justify further reward or prestige for himself or his little group, be better engaged in practising their profession ?

It is appreciated that these observations have so far made little or no constructive suggestion regarding the improvement of the National Health Service. It is extremely difficult to make suggestions which will not be taken either as an attempt to forward some personal interest of the person making them or as a direct attack on someone else or their interest. It is indeed sad that it should call for moral courage to express a sincere opinion. Nevertheless the Minister of Health has indicated in his circular letter that he desires such suggestions and the ones that follow are made in response to that request.

First it would appear that it is essential to provide strong leadership for the Health Services at both National and local level. At National level this leadership rightly belongs to the Ministry of Health and it only remains now for it to be asserted in a really inspired manner. Leadership at local level might well be through a new body, the majority at least of whose members are subject to the sanction of the electorate. This body should be responsible for the working of the whole of the National Health Service for a manageable unit of population, say 100,000 to 500,000. It need not necessarily control, say, the distribution of specialist manpower nor need it co-ordinate the distribution of hospital accommodation over the territories of the present Regional Hospital Boards which should retain these and other functions as advisory bodies. It would, however, undertake the management of hospitals, the general practitioner services and the domiciliary services. It might appoint an experienced administrative medical officer who would be responsible to the elected body for leading the medical profession in the area and for the administration of the services. The suggested body would be vested with considerable powers of direction and itself be subject to some degree of direction and supervision from a National level. Financial control should be by means of audit conducted by the District Auditor and all accounts should be available each year for scrutiny by any member of the electorate.

This is merely a suggestion based to a small extent on the experience gained from the well-tried methods of administration used for the health and medical arrangements in Her Majesty's Forces. It is put forward as an example of one of the many possible ways in which strong and disinterested leadership might be introduced into the National Health Service. There is little doubt that such a change would, to begin with, be strongly opposed by many sectional interests. If, however, strong leadership of the right kind could once be established in the National Health Service all the present difficulties of co-ordination and co-operation would soon disappear.

It should be stressed, however, that this leadership must be of the right kind. By this is meant a leadership which ascertains those factors which are necessary for a truly efficient Health Service for the community and aims continually at attaining these factors irrespective of sectional interests. Such leadership would readily gain the trust and confidence both of the community and of the officers of the Service.

The formal mechanism for general co-ordination has now been described and commented upon. The Minister, in his circular, has also asked for a statement of the ways in which the various officers of the Local Health Authority are co-operating in the care of patients under treatment at the hospitals by general practitioners.

At the hospitals several arrangements are in existence. These are all of an informal nature and are based entirely on the goodwill of the individuals operating them. As such they work well but it would be much more satisfactory if they were all the subject of formal agreement between the hospital authorities and the Corporation. This kind of thing, while it has a good effect on the relationship between the two branches of the service concerned in it, has two marked disadvantages. The first is that the benefit derived by patients from such arrangements is entirely dependent on the personality of those making them. Alterations in personnel then could easily have the effect of materially altering both the quality and character of the services available to the public. The second is the possibility of an appalling legal tangle that could well occur if some patient were to bring an action for negligence against some of the personnel involved in such arrangements. For instance, what is the position of the employing bodies and who is liable to whom if a Local Health Authority nurse working by courtesy in a hospital out-patients is found to have been negligent in respect of a patient in the care of the Management Committee? How is this position affected when the Management Committee does not officially either know of or give approval to the Health Authority nurse being invited there by a member of the consultant staff who is anxious to co-ordinate the three parts of the Service?

It is in problems of this sort that the leadership mentioned above is so very necessary.

Actual examples of this kind of arrangement which were in operation in Barnsley during 1952 are as follows:—

One Assistant Medical Officer with mental health experience assists the Consultant Psychiatrist at the Beckett Hospital. The Duly Authorised Officers are also in attendance there to give assistance with knowledge of the home and social conditions of patients.

A nurse employed by the Health and Education Authorities in the Authorities' orthopædic clinic also attends at the orthopædic out-patients at Beckett Hospital.

A nurse employed by the Health Authority with special experience in audiometric methods assists in carrying out tests in the hospitals from time to time.

In order to ensure that uniform methods are employed in the home nursing of ear, nose and throat cases, arrangements were made that each Home Nurse should attend and assist at the Ear, Nose and Throat out-patient sessions held at Beckett Hospital for a period of one month. This arrangement lapsed during the Winter months owing to pressure of district work.

The Social Worker employed by the Health Authority attends at the Special Treatment (Venereal Disease) Clinic and at the Chest Clinic. These arrangements are on a more formal basis than the others mentioned and some written records of them are available. The Social Worker also visits patients in the Chest and other hospitals and maintains close consultation with the Almoner at Beckett Hospital.

Co-operation with the general practitioners in the care of patients is much closer and operates principally through the Home Nursing and Midwifery Services where it is extremely close. As regards the Health Visiting Service, reference has been made in great detail in previous reports to the fact that few general practitioners take advantage of the services of the Health Visitors. In certain specific cases the Health Visitors get in touch with the family doctor where it is felt that this is in the patient's interests. Experience has shown that while many doctors appreciate this, others exhibit a deep-rooted hostility to this Service.

There is little doubt that until a part at least of each general practitioner's work is done in a Health Centre the community will not be able to reap the fullest benefit of the domiciliary services provided by the Health Authority. This is particularly the case with the Health Visiting Service. At present general practitioners tend to work in watertight compartments, only coming into contact with such workers as Health Visitors when the circumstances of a particular case throw them together. Working in the Health Centre at which all those concerned in the well-being of the individual in his own home come together and have an opportunity of exchanging points of view, there is little doubt that the doctor would come to appreciate the valuable assistance he could obtain from the Health Visitors.

Liaison on matters of interest and on any alteration in the services available to the general practitioners is maintained by circular letters sent to each doctor practising in the County Borough. The Medical Officer of Health also maintains contact with the profession through the Local Medical Committee and attends and addresses, when necessary, any meetings of the profession held to discuss the facilities for practice available in the County Borough.

The public has been kept informed of the services available by notices in the local press, by a leaflet which was produced in the early days of the Service in 1948 and by advertisements and announcements in the current Official Guide to Barnsley. It has proved to be difficult to keep the Guide leaflet to the Services up-to-date as their development has been fraught with such frequent changes. Each time a fresh edition has been considered its issue has been postponed to include details of some new development. When this is substantially completed still further changes have loomed on the horizon and publication has been postponed to include these. This process has been repeated several times.

Joint use of staff

Under present arrangements the Health Authority does not employ general practitioners on a part-time or sessional basis. The Regional Hospital Board provides the services of Specialists in orthopædics, dermatology, oto-rhino-laryngology, ophthalmology, pædiatrics and obstetrics to attend at the Health Authority's clinics to provide consultant sessions for mothers, young children and school children referred by the Assistant Medical Officers of Health.

The Local Authority accepts responsibility fer two-elevenths of the salary of the Chest Physician employed by the Regional Hospital Board in respect of work done in connection with the prevention of tuberculosis. Reference has already been made to the informal arrangement whereby an Assistant Medical Officer of Health attends at the Psychiatric Out-patients at Beckett Hospital.

Voluntary organisations

It is the policy of the Health Authority, where a service is necessary, to provide it directly and not on an agency basis. For this reason then, apart from the Central Council for Health Education and the Queen's Institute of District Nursing (if these may rightly be included under this heading) the Health Authority has no standing arrangements with voluntary bodies. From time to time ad hoc arrangements are made generally in respect of finding suitable hostel accommodation for unmarried mothers or to satisfy some other special non-recurring need.

HEALTH CENTRES

National Health Service Act, 1946, S.21.

During the period since the inception of the National Health Service a very considerable amount of work has been expended in planning the provision of Health Centres. Building restrictions prohibited anything more than planning until 1951. Perhaps this was as well as experience of the service has to some extent altered the original conception of the Health Centre. The preparation of the Development Plan for Barnsley under the Town and Country Planning Act, 1947, gave a considerable stimulus to the planning of Health Centres and the development of Health Centre policy as it was necessary for this purpose to earmark the sites on which Health Centres may ultimately be established. Details relating to these sites were mentioned in the Annual Report for 1951.

In October 1952 a maternity and child welfare centre and school clinic was opened in converted existing buildings known as Hunningley Villa, which at present occupy part of the site acquired for Health Centre purposes by the Corporation in the Ardsley-Kendray area. This follows the policy of using sites already designated for health purposes in the development of Health Centres.

In the Athersley district, as mentioned in last year's report, there is a great need for clinic facilities. The Health Authority has therefore decided to provide a building for this purpose. Having full regard for all aspects of the developments that will take place in this area, it was felt that this building should be designed in such a way that it will be possible to extend it to provide accommodation for general practitioners of both medicine and dentistry should this be required.

There are at present few precedents for development along these lines and it seemed possible if needs were to be met as they arise that a Health Centre might ultimately come into being by the undesirable process of haphazard additions to the proposed clinic. In view of this it seemed there was a need for advice from a source having experience in experiments with Health Centres and approach was therefore made by the Corporation to the Nuffield Provincial Hospitals Trust, inviting that body to be associated with the Corporation in experimental work on a Health Centre to serve Athersley Estate. The Trust accepted the invitation and during the year its representatives visited Barnsley on two occasions. On the first of these contact was made with the members and officers of the Health Authority and other statutory bodies concerned, the proposed site was viewed and the various existing clinics belonging to the Corporation were inspected. On the second occasion contact was made by the Trust with the representatives of the medical profession and the various implications of the provision of a Health Centre were discussed in some considerable detail.

In the latter part of the year discussions have taken place between the Trust's Architects and the technical officers of the Corporation, and the necessary machinery has been set in motion to ensure the acquisition of a suitable site in Laithes Lane by the Corporation. At the same time approval for the building of a clinic to serve this area has been obtained from the Ministry of Health. Thus by the end of 1952 several important preliminary steps had been taken towards the provision of the first Health Centre in Barnsley.

CARE OF MOTHERS AND YOUNG CHILDREN

National Health Service Act, 1946, S.22.

The Barnsley Health Authority provides ante- and post-natal clinics at three centres. The principal of these is in the main Health Authority clinic situated in New Street. Sessions are also held weekly at St. Mary Magdalene Church Hall, Lundwood. The Ardsley and Kendray districts were served by weekly clinics held in the Ebenezer Wesleyan Reform Church, Hunningley Lane, Stairfoot, until October. The Authority's own premises, already mentioned in this report, some 50 yards distant at Hunningley Villa, were then taken into use and the weekly ante- and post-natal clinics are now held in them. Infant Welfare Centres are also held at the places mentioned above and in addition at the Authority's premises at Carlton, in the Wesleyan Church Hall at Smithies and in the Old Council Offices, Monk Bretton.

It would seem that the tendency to drift away from the Health Authority's clinics is at last showing signs of a check. In the case of the ante-natal clinics the numbers show a fractional increase over 1951 (1,009 patients in 1951 and 1,051 in 1952) although the figures for 1950 (1,069) were not attained. It is interesting to observe that the trend noted in last year's report for the attendances to fall in the outlying clinics and those at New Street to increase has not continued. It was suggested also in last year's report that the improvement in clinic facilities at Ardsley might be accompanied by an increase in attendance. There has been a marked increase at Ardsley but it would appear that the provision of new facilities occurred too late in the year to affect this.

In previous reports it has been stated that the fall in attendance at ante-natal clinics is undoubtedly due to women availing themselves of the maternity medical service provided by the Executive Council and receiving their ante-natal care from the general practitioner of their choice. Reference has also been made to the fact that no figures are available of either the number of women who have received ante-natal care in this way or the number of consultations which take place between expectant mothers and doctors each year. For several years there has been a tendency for the still birth rate to rise and full figures—together with some indication of the stage of pregnancy at which mothers receive their first ante-natal examination—would be most helpful in taking steps to check this tendency.

It is appreciated that much controversial discussion has arisen over this question of who should carry out ante-natal care—the "clinic" or the general practitioner. It is most desirable that there should be continuity of medical care by the practitioner actually attending the confinement. Almost every Health Authority in the country would advocate this were it possible to have reasonable assurance that general practitioners as a whole would be prepared to provide ante-natal supervision of the same quality as that which has been and is being afforded by the Health Authorities themselves. By this is meant, amongst other things, team work and co-operation between the Midwife, Health Visitor, Consultant Obstetrician and the doctor, the keeping of records as fully and as carefully as this is done by the Assistant Medical Officers of Health, and the provision of surgery accommodation where facilities exist for proper and thorough examination. It would seem that the Health Centre would make all this a reality. Until it is a reality, however, the Health Authorities will be obliged, in order to discharge their statutory duties relating to the Care of Mothers and Young Children, to provide ante-natal clinics and to encourage mothers to attend them. It is in the rapid solution of problems of this kind that really inspired leadership at a National level is so necessary.

In the case of the post-natal clinics the decrease noted in previous years has continued. This is probably due to the fact that the post-natal examination is included in the service provided by the maternity medical services of the Executive Council. Reference has been made in the reports of previous years to the fact that although these examinations are being paid for from funds contributed by the community, the findings of the examinations are not available to those whose job it is to prepare statistics of health and sickness for that community. The total number of mothers examined post-natally at the Local Authority clinics in 1952 was 48 as compared with 69 in 1951 and 118 in 1950.

Since 1949 there has been a small but steady decline in the number of attendances at the Infant Welfare Centres. It would seem, however that there has been during 1952 a tendency for this decline to be checked when compared with 1951. It is interesting also to note that while the total number of individual children was fewer—2,291 in 1952 as against 2,375 in 1951—the total number of attendances was higher in 1952. It is also significant that the numbers attending both Smithies and Carlton Clinics are rising, whilst those attending the Central, Ardsley and Lundwood Clinics are falling. This is probably due to the extensive housing development taking place in the North-Western part of the Borough and emphasises the great need for a new clinic at Athersley.

Some part of the decline in numbers attending the clinics since the inception of the National Health Service is accounted for by parents taking sick or ailing children to the family doctor direct instead of using the clinic as a means of ascertaining whether or not the child was ill enough to justify the expense of a doctor's bill. A decline in numbers from this cause is to be welcomed as it tends to ensure more rapid treatment for the sick child and reduces the number of children incubating infectious disease who are brought into the clinic waiting rooms. Furthermore it leaves the clinics more time to perform their proper job of giving advice to prevent illness. These advantages probably offset the introduction to the Health Authority's services that the circumstances outlined above afforded to some families who would otherwise have failed to take advantage of the preventive services available.

Consideration has been given to the preparation of complicated tables of comparatives figures covering all the clinics in the Borough for the years since 8th July, 1948. It appeared, however, that little, if anything, would be gained by this. Many inferences might be drawn and a great deal of comment might be made as to factors thought to cause alteration in attendance figures at each clinic. The only facts, however, emerging from all this would seem to be that for the first year or two of the National Health Service there has been a decline in the number of children taken to the clinics. This decline is gradually becoming less marked and there is a tendency amongst those on the clinic register to attend more frequently.

At the sessions held by the Consultant Pædiatrician at New Street Clinic the number of children attending—100—was exactly the same as in 1951 though less than in 1950 (123). The number of attendances showed a slight increase—433 in 1952 as against 412 in 1951. This clinic is of extreme value and allows of parents receiving specialist advice on children who are showing early defects in development or nutrition without them having to attend a hospital. It thus allows of the preventive approach to be made in some difficult cases and may well avoid the children concerned acquiring an invalid's outlook on life.

The statistical data relating to clinics and centres during 1952 may be summarised in the following tabular form :—

Ante Natal and Infant Welfare Centres.
Summary of Attendances in 1952.

Centre.	Barnsley New St.	Lund-wood	Ardsley	Monk Bretton	Smithies	Carlton	Total
Infant Welfare—							
1. Number of children who attended centres during the year	1272	176	246	137	214	246	2291
2. Number of children who first attended during the year (excluding children known to have attended a clinic in another town) and who on their first attendance were							
under 1 year ...	571	113	148	49	113	131	1125
1— 5 years ...	80	6	9	1	23	27	146
3. Number of children in attendance at the end of the year, who were then							
under 1 year ...	325	33	60	27	38	49	532
1—5 years ...	326	17	33	39	25	47	487
4. Number of attendances made by cases during the year under 1 year ...	6813	1007	1542	822	1241	1306	12731
1—5 years ...	2388	166	364	240	465	402	4025

Paediatric Clinic—

100 cases attended the paediatric clinic at New Street Clinic during 1952, and the number of attendances made was 433.

	Barnsley	Lundwood	Ardsley	Total
Ante-Natal Clinic—				
Number of women who attended during the year ...	751	149	151	1051
Number of attendances made ...	2347	430	512	3289
Post-Natal Clinic—				
Number of women who attended during the year ...	48	...	...	48
Number of attendances made ...	70	...	...	70

NOTE :— Of Barnsley's 751 Ante-Natal cases, 60 also attended the Consultant Ante-Natal Clinic and made a total of 96 attendances.

Of Barnsley's 48 Post-Natal cases 11 also attended the Consultant Post-Natal Clinic and made a total of 11 attendances.

Of Barnsley's 751 Ante-Natal cases 255 were later transferred to St. Helen Hospital.

Of Lundwood's 149 Ante-Natal cases, 61 were later transferred to St. Helen Hospital.

Of Ardsley's 151 Ante-Natal cases, 37 were later transferred to St. Helen Hospital.

Care of premature babies

The number of premature live births at home (births where the baby weighs less than 5½ lbs.) irrespective of the period of gestation) was 25 during 1952. This compares with 28 in 1951 and 32 in 1950. In 1949 there were 20 such babies.

Of the 25 premature babies, 8 were transferred to hospital. Of the 17 who remained at home, all survived the first 28 days.

The care of premature babies in Barnsley does not offer a very great problem. St. Helen Hospital is always ready to receive any case requiring special care. The Ambulance Service is particularly prompt in such cases and is provided with a special heated oxygen tent for handling them. Arrangements have also been made through the Midwifery Service for the provision on loan of any special equipment that may be required for the care of premature babies at home.

During 1952 a recommendation from the Home Services Sub-Committee was accepted whereby all midwives in the service of Barnsley Corporation would, within the next two years, receive a special post-graduate course in Birmingham in the care of premature babies.

Supply of dried milk and other nutrients

The arrangements made with the Ministry of Food whereby a representative attends at each session held at each clinic for the purpose of dealing with the distribution of welfare foods continues. It has proved to be most helpful and is the most effective method of ensuring that these foods are available to all mothers attending the clinic. In addition the Health Authority provides a wide range of other dried milks and nutrients which may be purchased at a reduced cost at clinics when ordered by one of the Health Authority's Medical Officers. Quite considerable use is made of this service. The total turnover involved in 1952 was £5,148 11s. 6d. and £5,082 8s. 1d. in 1951.

Dental Care of Mothers and Children.

(a) MOTHERS.

At the commencement of 1952, 69 nursing and expectant mothers were awaiting dental treatment at the New Street Dental Clinic. With the appointment of a new Dental Officer early in January, followed by the appointment in March of a Senior Dental Officer, it was possible to reduce this waiting list and to re-commence the routine examination of expectant

mothers on their first visit to the ante-natal clinic. It is worthy of note, however, that of the 1,099 ante-natal and post-natal cases attending maternity clinics in the Borough, only 216 were inspected by the Dental Officer. Cases are referred by the Medical Officer at these clinics either to private dental practioners or to the Health Authority's Dental Officer. In every case the mother was handed a Dental Reference Card with the instruction to present it to the Dental Officer or a private practitioner; it is assumed that several patients did not trouble to do so. Unfortunately no arrangements exist for returns from private practitioners regarding such referred patients. Complete records of routine dental inspections of mothers-to-be will be possible only when the clinics have the full complement of Dental Officers.

Of the 216 cases inspected, 209 were found to require treatment—a percentage of 96.7, compared with 77.5% in 1951 and 71.1% in 1950. This is explained by the Medical Officer referring only those cases which were obviously in need of dental treatment. The ratio of Extractions to Fillings is higher in 1952 because of the back-log of patients requiring dental extractions in January 1952.

A comparison with recent years is as follows :—

Year :—	1949	1950	1951	1952
EXTRACTIONS } FILLINGS }	0.55	0.24	0.78	2.08

56 complete dentures and 23 partial dentures were supplied to expectant and nursing mothers during the year, a higher figure than in previous years owing to the fact that dentures are supplied free at the clinic, whereas a charge for dentures is made by the private practitioner under the provisions of a recent instruction by the Ministry of Health.

The condition of the mouth of the expectant mother is again the subject of comment. Marked pocketing of the gingivæ and accumulations of calculus necessitated the operation of scaling and gum treatment in 102 cases of the 209 cases treated—almost half! This figures does not include pre-extraction scaling. When the Carlton Mothers' Group asked the Senior Dental Officer to lecture to their group at their weekly meeting, an opportunity presented itself to inform the mothers of the need for oral hygiene not only during pregnancy but at all times.

It will be noted that dentures for the clinic are constructed by a firm in Huddersfield who provide satisfactory service and the fees charged compare favourably with those of other Dental Laboratories. The Dental Surgeon, however, is faced with the task of casting models in the surgery from impressions taken, as these latter would otherwise deteriorate in transit by post from the clinic to the laboratory. The casting of models in Plaster of Paris or model cement is a time-devouring process and is but one of the indications for the establishment of a Dental Laboratory in the precincts of the clinic. The occasion arises often where the Dental Surgeon should have a Dental Technician in the surgery for consultation on the requirements for an individual case, in order that the completed denture may be sound both æsthetically and functionally.

It is considered most essential that the amenities of future Dental Clinics in the Borough should incorporate a Dental Laboratory and the employment of Dental Technicians.

(b) CHILDREN UNDER 5 YEARS.

The Saturday morning of each week is usually observed as an occasion when the Dental Officer is "At Home" to all parents who wish to bring their children along for dental advice, inspection and treatment. The majority of the 186 "toddlers" examined by the Dental Officer during 1952 emanated from the Saturday morning session, the remainder being inspected and treated prior to tonsillectomy, having been referred by the E.N.T. Specialist. 147 were found to require treatment, and extraction under general anæsthesia was necessary in a large number of cases.

The local anæsthetic referred to on the appended summary of treatment provided did not consist of the injection of a local anæsthetic solution into the area surrounding the tooth. It is the established practice in the Dental Clinic that the child's horror of having a needle stuck into him is appreciated and no hypodermic injection is given to any child of impressionable years. The application of a surface anæsthetic solution on a pledget of cotton wool around the loose deciduous tooth, followed by a tweak with the fingers or forceps is painless to the child who sits waiting for the tooth to take home. A local tradition persists that if a tooth is placed under an egg cup or the pillow before going to bed at night, the fairies remove it before dawn, leaving behind a sum of money, varying in these parts from a halfpenny to a sixpence! The value of this tradition is that the visit of the toddler to the dentist loses some of that aura of gloom with which parents are apt to surround the journey.

Silver nitrate treatment of a carious deciduous tooth, followed by a filling, was reduced to a minimum. This form of treatment is very desirable in a number of cases, but the shortage of Dental Officers and the large number of cases of oral sepsis in other children which necessitated priority treatment made it a virtually impossible procedure.

A summary of this work completed during 1952 is appended.

(a) NUMBERS PROVIDED WITH DENTAL CARE.

	Examined	Needing Treatment	Treated	Made Dentally Fit
Expectant and Nursing Mothers	216	209	143	110
Children under Five years of age	186	147	147	147

(b) FORMS OF DENTAL TREATMENT PROVIDED.

	Extractions	Anæsthetics		Fillings	Scalings or Scaling and Gum Treatment	Silver Nit. Treatment	Dressings	Radiographs	Dentures Provided	
		Local	General						Complete	Partial
Expectant and Nursing Mothers	353	62	98	313	102	—	21	1	56	23
Children under Five years of age	212	7	120	1	—	2	28	—	—	—

Children in Nursery Schools included in School Reports.

Patients who require X-ray examinations are referred to the Radiographer at the St. Helen Hospital.

Contract for the supply of dentures with Metrodent Ltd., 78, John William Street, Huddersfield.

SUMMARY OF WORK DONE FOR MATERNITY AND CHILD WELFARE PATIENTS DURING JANUARY — DECEMBER, 1952.

Number of Patients Inspected and Treated	402
Number of Visits made by Patients	1091
Number of Treatment Sessions	98½
Number of Anaesthetic Sessions	18½
Number of Fillings	314
Number of Scalings	102
Number of Extractions	865
Number of Other Operations	464
Number of Dentures Supplied	79
Number of Patients Provided with Dentures	44
Number of Prosthetic Operations	254

New Street Day Nursery

This Nursery—which came into being as a war-time nursery—has places for 36 children, nominally 18 under two years of age and 18 over two.

Children are admitted to the Nursery between the ages of six months and two years. Those over two years will be transferred later to a nursery school but are allowed to remain at the Nursery until three years of age.

The waiting list for this Nursery gave rise in the past to some difficulty, particularly regarding the choice of criteria for priority of admission. During 1951 the Health Committee gave consideration to these

difficulties and to their underlying causes. With a view to ensuring that the greatest possible benefit was derived from the Nursery by the community as a whole it was decided that admissions be limited to the following types of case:—

(a) Children of widowed mothers
(b) Children of deserted mothers
(c) Children of unmarried mothers
(d) Children in need of nursery care recommended by the Medical Officer of Health.

The application of these criteria has to all intents and purposes solved the problem of the waiting list. It would appear from the year's working that the Nursery provides ample accommodation for such cases of the above categories as occur within the County Borough.

STAFF

The staff of the Nursery during the year was as follows:—

1 Matron
1 Deputy Matron
1 Warden
3 Nursery Assistants
1 Nursery Student.

As mentioned in the report for 1951, teaching difficulties and alterations in the syllabus for the examination of the National Nursery Examination Board Certificate have resulted in the Nursery becoming a non-teaching Nursery with the result that no further students have been accepted and arrangements are now in train to employ a full staff of Nursery Assistants.

ADMISSIONS AND TRANSFERS

26 children of 0—2 year age group were admitted during the year. 16 children were transferred to various nursery classes on attaining the age of three years. 17 children were withdrawn by their parents.

HEALTH

Six cases of measles occurred amongst children in attendance during the year. In December seven cases of dysentery due to shigella sonnei were found amongst children in attendance. These cases occurred at the time when cases were occurring in the town as a whole and they must be regarded not as a nursery outbreak but as part of the more generalised one mentioned in Part II of this report.

Orthopædic Clinic

The report of the work done at the Orthopædic Clinic for children under school age is as follows:—

INSPECTIONS AT CLINIC

Visits of the Orthopædic Surgeon	11 sessions.

NUMBER OF CASES SEEN

New Cases	33
Re-Examinations	104

NUMBER TREATED IN THE ORTHOPÆDIC CLINIC

67 pre-school children have been treated during the year.
163 attendances have been made for Observation, Splinting, and Postural defects.

ADMISSIONS TO HOSPITAL

No pre-school child was admitted to hospital in 1952.

Ultra Violet Light

There was no change in the arrangements for affording Ultra Violet Light Treatment to mothers and children under school age at New Street Clinic. Arrangements have been made for a portable lamp to be available at Littleworth School Clinic and this has been used by several children under five years of age.

The numbers attending were as follows:—

	No. Treated	No. of Attendances
CENTRAL CLINIC, NEW STREET.		
Children 0—5 years	70	732
Expectant and nursing mothers	3	17
Other adults	—	—
LITTLEWORTH CLINIC (from 2/10/52 to 31/12/52)		
Children 0—5 years	3	17

Nursing Homes

Following the closure of St. Margaret's Nursing Home in 1951, there is now no Nursing Home in the County Borough.

Homes for Mothers and Babies

In the Report for 1951 mention was made of the project to provide a Mothers' and Babies' Hostel within easy reach of Barnsley. The search for premises suitable for conversion for this purpose was described and the ultimate suggestion to make use of "Rose Hill," Dodworth, was noted. Considerable attention was paid to this scheme and plans for conversion of the premises were prepared and submitted to the Minister for approval. Unfortunately legal difficulties were encountered in completing purchase and the scheme was abandoned. The search for suitable premises has been commenced once again. There is no doubt that it would be of great value to have available a hostel where expectant mothers might be admitted for rest and quiet or where nursing mothers and their babies might go to recuperate from the effects of a difficult confinement.

During the year the Health Authority accepted responsibility for the admission of two unmarried mothers to hostels provided by other bodies.

MIDWIFERY

National Health Service Act, 1946, S.23.

In discharge of the obligation imposed by this section of the Act, the Barnsley Local Health Authority employ nine full-time Midwives. These Midwives are supervised by the Medical Officer of Health and by the

Non-Medical Supervisor of Midwives who is also Superintendent of Home Nurses. Arrangements were made during 1952 for the creation of the appointment of an Assistant Non-Medical Supervisor of Midwives and Assistant Superintendent Nurse; however, this was not filled until January 1953.

Staff

The staff remained constant at nine throughout the year. Two Midwives resigned for family reasons and two new members of the staff commenced duties.

Gas and Air Analgesia

All Midwives are now in possession of the Certificate for the Administration of Gas and Air Analgesia and they are now each equipped with the necessary apparatus.

Gas and air analgesia was administered in 217 cases, in 22 of which the Midwife was acting as a maternity nurse. This compares with 192 cases in 1951, 138 in 1950 and 88 in 1949.

Pethedine was administered in 25 cases, in six of which the Midwife was acting as a maternity nurse.

The scheme for the provision of sterilized maternity packs was continued during the year and the contents of the pack have been revised in 1951 in accordance with the recommendations contained in the circular letter from the Ministry of Health on this subject.

Medical Aid

Medical aid was summoned in accordance with the provisions of Section 14 (1) of the Midwives' Act, 1918, as follows:—

(a)	Domiciliary cases:	
	(i) Where the medical practitioner had arranged to provide the patient with maternity medical services under the National Health Service	77
	(ii) Other	54
		131
(b)	Institutional cases	8

Teaching of Midwifery

The number of Midwives recognised as teachers remained during the year at four. During 1952 five pupil midwives received practical instruction from Teacher Midwives as well as a course of lectures at the Corporation Health Department. All five were successful in obtaining the Certificate of the Central Midwives Board.

Domiciliary Midwifery and Institutional Confinements

During 1952 in Barnsley—

336 confinements were conducted at home by Municipal Domiciliary Midwives;

43 women confined at home had the services of a Municipal Midwife acting as a Maternity Nurse;

260 women were confined in institutions and were attended by Midwives acting as Midwives;

1525 women confined in hospital had Midwives in attendance as Maternity Nurses;

816 women who were confined in hospital were discharged before the 14th day of the puerperium. They were attended between the times of discharge and the 14th day by Domiciliary Midwives provided by the Health Authority;

5369 visits were paid by Midwives during the puerperium (up to the 14th day) to patients delivered at home;

198 post-natal visits were paid by Midwives (after 14th day);

1701 ante-natal visits were paid to women in their own homes by the Authority's Midwives;

2213 visits were paid by Midwives to women who were delivered in hospital or maternity home and who were discharged before the 14th day.

The difference between the 1,775 institutional confinements and the 1,404 notified births for the County Borough is accounted for by the fact that the institutions in Barnsley serve a wider area than the County Borough itself. There is, therefore, a very considerable adjustment in respect of transferred notifications.

Of the 1404 total births notified belonging to the County Borough after adjustment, 1,018 occurred in institutions and 386 at the home of the patient. Comparison of these figures with those for previous years shows that as far as residents of Barnsley are concerned the tendency to have the confinement in an institution continues to increase. During 1952 0.27 of all confinements took place in hospital. In 1951 the figure was 0.29 and in 1950 0.32.

The Annual Reports for the past two years have each contained detailed comment on this trend and the various arguments for and against it have been considered at some length. However, in a survey such as this a short re-capitulation of the position will not be out of place.

For a considerable period before the inception of the National Health Service the economic circumstances of a large part of the population of Barnsley were far from satisfactory. As a result of this, conditions in many homes made them unsuitable places for confinements whilst financial stringency was often a limiting factor on medical attention. To overcome these difficulties the Local Authority developed an institutional maternity service and encouraged as many women as possible to take advantage of it. There is no doubt at all that at that time this was the best means of combatting the maternal mortality figures then prevailing.

Since the end of World War II, however, the picture has changed greatly. The community in Barnsley as a whole is much more prosperous. The National Health Service Act and other welfare legislation provides every possible facility to make confinements safe at home. In addition, the dangers of sepsis have been minimised to vanishing point by the

discovery of the sulphonamides and the antibiotics. Slowly but surely more and more potential mothers are being moved into modern hygienic council houses well adapted for home confinements, in cases where ante-natal care has shown that complications are unlikely. At the same time the National Health Service and a number of economic factors which accompany it have greatly increased the demand for hospital beds for all purposes. The result of this is that for some urgent surgical treatment there is often a long waiting list. This causes delays in treatment which have an extremely adverse effect on the health of the community as a whole. At the same time modern methods for the care of the aged calls for an increasing number of beds which at present are not available. It would seem, therefore, that the tendency to permit an increase in the number of beds devoted to normal maternity cases is not in the best interests of the community—until hospital accommodation is available to satisfy these other more pressing needs. Investigation shows that in spite of the rising numbers of babies born in hospital there is not an increase in the number of maternity beds available. A more rapid turnover is being effected by discharging patients sooner after their confinements than the fourteen days recognised as the end of the lying-in period. This is far from satisfactory and suggests an attempt to cater for the popular demand for hospital confinement at the expense of the welfare of both mother and baby.

When a patient is discharged on the tenth day of the puerperium or earlier it is necessary for the Health Authority to arrange for a midwife to attend the woman until at least the end of the 14th day. This arrangement cannot but be condemned. The patient is confined and spends the first few days of her convalescence in hospital surroundings, cared for by one team of midwives and doctors. Half-way through this convalescence she is turned out and comes under the care of another group of workers. She is sent to her own home where she sees things needing her attention without having had an adequate chance to make preparations for coping with the situation or with the new baby, having in most cases entered hospital in the belief that she will be allowed to remain there for the whole of the puerperium.

It is interesting to note that during 1952 816 women were discharged to homes in the County Borough of Barnsley. This placed a considerable burden on the Domiciliary Midwives for which they receive little appreciation or professional satisfaction.

It would be much more satisfactory if fewer normal cases were booked for institutional confinement and those whose booking is accepted were allowed to have the whole of the lying-in period in hospital. There were signs towards the end of the year that an informal arrangement might be reached whereby the Medical Officer of Health would arrange for reports on the social and home conditions of women whose ante-natal history suggested they would be safe for home confinement. Such an arrangement will be most welcome.

Apart altogether from the mother, the effects of home confinement as against institutional birth on the child are worthy of consideration. From the child's point of view, if the home is a good one it is better to be born at home. From the physical point of view the risk of infection, particularly the infections peculiar to the new-born, are very much reduced at home.

Then there is the psychological effect in moving the very young infant. This may well re-act on that feeling of security which is so very essential in the early part of life if a psychopathic background is to be avoided.

All the points mentioned above have been discussed in each of the last two reports. It is appreciated that to some extent the tendency towards institutional confinement is more marked in Barnsley than in some other centres and attention has been drawn to the factors which have contributed to this. Were adequate hospital accommodation available for every case whose claim to it is no stronger than that of average healthy multipara, with a good council house home then these arguments might be re-considered. In the meantime, however, it will be essential not only to continue to maintain and if possible to improve the Domiciliary Midwifery Service, but in the overall interests of the health of the community to encourage its use in every possible suitable case.

HEALTH VISITING SERVICE

National Health Service Act, 1946, S.24.

The figures showing visiting done by Health Visitors in Barnsley during 1952, compared with that done during the two previous years, are as follows :—

	1952	1951	1950
Expectant mothers :			
First visits	1127	966	918
Total visits	2176	1651	1487
Children under one year of age :			
First visits	1326	1302	1463
Total visits	9349	9515	8990
Children between one and five years of age	17459	16120	14303
Other cases :			
First visits	2233	2534	2449
Total visits	4178	3829	3455
Ineffective visits	3497	3320	2779

These figures show a steady increase in the number of visits. In fact the only decreases which occur are due to falls in the birth rate. Unfortunately little statistical evidence can be adduced to show the amount of real work done by the Health Visitors in the community. Plain numbers of visits convey very little. A visit may be simply a momentary enquiry at the door or may entail advising on matters pertaining to each and every member of the household and may occupy as long as an hour. The proper valuation of the work done by any group of Health Visitors can only be arrived at by a long period of observation. The principal " yard-stick " to be employed in such an observation should be an increasing level of " Health Education " in the community they serve. In addition an improvement in the manner of employment of the socio-health services available to that community would also be a useful measure of Health Visiting efficiency.

At present, however, the accepted method of assessing the activities of a Health Visiting Service is to record numbers of visits under selected headings and, in doing so above, this report conforms to custom. It is well,

however, to bear in mind that Health Visitors serving a community such as Barnsley undertake many other duties in addition to home visiting. They are both Health Visitors and School Nurses, and their activities in the field of school nursing call for attendance at school medical inspections, school inspections for cleanliness, following-up of children with defects and, to some extent, teaching Health subjects in the schools. In addition to this they attend sessions at the ante-natal clinics and infant welfare centres which cater for the districts allocated to them.

During the past year considerable attention has been paid to the work done by Health Visitors and two important reports have been prepared on the subject. Each of them is concerned with the allocation of Health Visitors to the community and both stress the importance of relating the establishment to the whole of the community rather than to the number of young children in that community. There is a great deal in favour of this and examination of the establishment provided for Barnsley shows that it is ample for allocation of Health Visitors to population groups on the ultimate scale suggested in the Report on the Function and Case Load of Health Visitors prepared by the Women Public Health Officers' Association. In the meantime, by making full use of the Health Visitors immediately available, it is possible to conform to the recommendation for the interim period contained in the same report of one Health Visitor to every 6,000 of the population.

In another report suggestions are repeated along the lines that the work of a Health Visitor might well be related to the group of families under the care of one or more general practitioners. This is, of course, the goal to be aimed at as it carries into practice the basic ideal of the National Health Service scheme and is a fundamental necessity for the integration of the preventive and curative services. Unfortunately there are at present many practical difficulies. Despite the fact that Health Visitors have been available for many years, few general practitioners have tried to develop the potential assistance available from the Health Visitor. On the other hand, with present arrangements it is extremely difficult for Health Visitors to contact some general practitioners, many of whom have a number of overcrowded and over-busy surgeries in several parts of the Borough. When they do succeed in seeing the doctors their offers of assistance are often ignored and their suggestions treated as interference. Nevertheless, where it seems that the individual will best be served by doing so, an approach is made on his behalf to his general practitioner and every effort is made to arouse interest in that particular case.

Earlier in this report reference was made to the need for co-ordination between the Health Visiting Service and the general practitioner. It is unfortunately true to say that in this need the barrier between the curative medicine of the family doctor and the preventive practice of the Health Authority is perhaps more apparent than anywhere else. Until this barrier is destroyed the community is being deprived of much of the possible benefit of the National Health Service. The great difficulty seems to be the reluctance of the average doctor to associate himself with the officers of a body he suspects of attempting to control his freedom to practise medicine in his own particular way. It is a thousand pities that this unfounded prejudice is poisoning the relationship between the two agencies which are charged with the domiciliary care and the health of the community. It has made difficult of realisation the simplest solution to this problem, namely

the Health Centre. Here the Doctors and Health Visitors would be able to meet each day. They would be able to discuss with one another the problems of the families who are their mutual concern. If this were possible the Doctors would quickly appreciate the very great assistance that is available for them.

Having regard for the number of patients whose care the average Doctor undertakes through the National Health Service, it is idle for him to pretend that some kind of social information service is unnecessary to him. It it quite impossible for any ordinary human being to retain in his brain the technical knowledge demanded by modern medical diagnosis and treatment *plus* the intimate social and environmental details required to use that knowledge for the individual patient with a reasonable degree of efficiency. The Health Visitor can at any time provide to the Doctor on request environmental and social details relative to any of the families allocated to her.

Appreciation and utilization of these facts by the general practitioner would go a very long way to the complete integration of the curative and preventive aspects of medicine. This is more and more essential to the achievement of a really comprehensive National Health Service. Here is a situation which offers a still further opportunity for inspired leadership. This would help to allay the suspicions and to dispel the prejudices which are at present preventing the Health Visiting Service from operating to the fullest advantage possible.

Staff

During the year three Health Visitor trainees obtained their qualification and took their places on the staff. One nurse was accepted as a trainee. One Health Visitor resigned at the end of the year on taking an appointment with another Authority. The total trained Health Visitors available on December 31st, 1952, was 16.

As previously mentioned, each Health Visitor also holds the appointment of School Nurse to the Education Authority.

HOME NURSING SERVICE

National Health Service Act, 1946, S.25.

During 1952 the demand on the Home Nursing Service showed once again an increase though not so great as in the previous years. In a survey report such as this it is of interest to compare figures of work done and staff employed in this Service for each of the four full years since the National Health Service came into being:—

	1949	1950	1951	1952
Cases	1061	1610	1834	2001
Visits	25851	40150	41702	45482
Whole-time Nurses	9	10	10	12
Part-time Nurses	1	3	3	1
Part-time Nursing Orderlies	2	—	—	—

When considering the figures for 1952 it is of interest to analyse the *types* of case dealt with and the age groups of the patients nursed:—

Types of Cases Nursed	No. of Cases Nursed	No. of Visits paid to these Cases
Pneumonia	123	1193
Tuberculosis	5	394
Infectious diseases	12	98
Maternal complications, including miscarriages	22	196
Carcinoma and neoplasms	97	3925
Burns and scalds	56	1171
Post-operative	139	1805
Others	1547	36700
Totals	2001	45482

Age Groups Nursed	No. of Cases Nursed	No. of Visits paid to these Cases
1—5 years	209	1360
5—15 years	138	1395
15—65 years	945	15676
Over 65 years	709	27051
Totals	2001	45482

It will be noted that there has been little material change in number of staff employed since 1950. Increasing demands during the past two years resulted in the part-time nurses then employed working longer and longer hours until in 1952 it was decided to employ them as whole-time officers although this in fact made little alteration in the amount of time they put in for the Authority.

The ever-increasing demand is a matter of great satisfaction and encouragement to all concerned in organising and operating the service. At times when there is an increase in sickness this demand places a considerable strain on the nursing staff but the continued appreciation that is shown more than compensates for this. There is little doubt that prior to the inception of the National Health Service there was a large unsatisfied demand for home nursing.

At the end of 1951 it appeared that this need was very nearly satisfied and that stabilization of the Home Nursing Service was in sight. The figures collected during 1952 combined with certain problem cases which have been encountered indicate that in fact this point is as far away as ever. Furthermore the experience of the past year suggests several lines of thought to which consideration might well be given here.

The Home Nursing Service is capable of providing and actually does provide care which enables a proportion of patients who would otherwise be in hospital to be looked after at home. The more highly developed the Home Nursing Service in any given area, the greater the proportion of patients in that area who can be treated at home. Development of a Home

Nursing Service costs money—the more highly developed the Service, the greater the cost. The cost of the Home Nursing Service is borne half and half between the local ratepayers and the Exchequer. The entire cost of hospital treatment falls on the Exchequer. Therefore in an area where a highly developed Home Nursing Service succeeds in keeping patients out of hospital, sickness costs the local ratepayers more than in an area where the Local Authority has taken less trouble with its Service. In the under-developed district the cost of sickness is spread over the whole country and this cost is higher because it is more expensive to treat a patient in hospital than at home. In the area, on the other hand, where the community through its elected representatives interests itself in caring for its own sick in their own homes by developing a good home nursing service, the financial burden for this is placed on the ratepayers who comprise that community. In other words, the community who tries to do an efficient job as regards home nursing penalises itself.

Apart from all this the argument quoted above takes no account of the human angle. Newspaper publicity gives great prominence to old persons who for the want of proper care are forced into costly institutions when with fully developed home services many of these old people could end their days at home in their own surroundings. They would be much happier and the ultimate cost to the country as a whole would be a very great deal less. Under present arrangements such fully developed services constitute a local burden that few elected representatives can be expected to advocate.

It may well be said that this discussion of the financial policy in relation to Home Nursing is out of place in a report of this nature. This point of view is appreciated. However, in this report mention must be made of factors adversely affecting the Health Authority's services and this question of finance is bound sooner or later to be an overriding factor in the development of Home Nursing Services. It therefore seems proper that attention should be drawn to it here.

A scheme might be introduced whereby a Local Health Authority whose Home Nursing Service reduced the hospital expenditure in its area could receive a payment of the money so saved in hospital expenditure to be set off against the General Rate Fund. It is appreciated that such a scheme would be rather crude and perhaps a little too simple. Nevertheless it should not be beyond the capabilities of those concerned in National finance to devise a means whereby communities who concern themselves with caring for their sick in the most economical and at the same time the most human way receive financial benefits of their efforts. At least they should not be discouraged in their efforts as they are at present.

Combined with the financial aspect there is that concerned with the most advantageous employment of accommodation available in any given area. Here again there is need for strong National leadership and perhaps direction. In Barnsley, for example, there is no mechanism whereby it is possible for the hospitals and the Home Services to get together to decide in a period of pressure on hospital accommodation how best to make use of the beds that are available. There is no attempt whatsoever to co-ordinate the facilities for care in hospital with those for care at home. Family doctors for a variety of reasons recommend patients for hospital and, unless a case

can be made out for emergency admission, the patient's name is handed to an impersonal organisation devoid of humanity known as the Bed Bureau. Thereafter it is difficult to ascertain what may happen—a bed may be available or the patient may appear to be forgotten for as long as six weeks. All this is so utterly unnecessary. The hospitals or even the Bed Bureau have only to ask the Health Authority who is actually caring for these patients at home to say which of them is presenting most difficulties in home care to get an immediate answer. The Health Authority would be glad to receive a statutory direction to co-ordinate services in this way. Its officers cannot, however, be expected to accept rebuffs on each occasion they try to arrange something on what is referred to in the fighting services as the "old boy level."

It has been argued in reply to this that the person responsible for the treatment of a patient in hospital has a fundamental right to accept or refuse that patient's admission. This may, in certain circumstances, well be true of an individual or specialised hospital. This must surely be on the broadest interpretation of the National Health Service Act a false assumption. The Regional Hospital Board has by this enactment an absolute and unqualified duty to provide a reasonable amount of hospital accommodation for those who need it within the Board's area. There is little doubt that the High Court would make an Order enforcing this duty were an application made to it by way of a Writ in the nature of mandamus. As to who should decide priority of admission where there is a shortage of accommodation, it would appear that this decision should be with the persons responsible for the provision of care of the patient in his own home, namely the Medical Officer of Health and the family doctor. Statutory recognition of a kind is given to this in the National Assistance Act, 1948, Section 47, and in the National Assistance (Amendment) Act, 1951. By use of this legislation it is possible to apply to a Court of Summary Jurisdiction for an Order requiring the admission of a specified patient to a specified hospital. The procedure is fairly simple and has on occasion proved to be effective although it has been felt that the Court proceedings have to some extent marred relations between the Health Authority and the Hospital Management Committee. It would seem that for this there is sufficient precedent and justification for a National directive clarifying the position and making it possible for the Medical Officer of Health to secure admission to a suitable institution of cases whose care at home by Home Services is impracticable.

Nursing and Loans Centre

Mention was made in the report for 1951 of the opening of the Home Nursing and Report Centre at the Occupation Centre premises in Pitt Street. This Centre has proved to be an unqualified success and is rapidly outgrowing its quarters. There is little doubt that the problem of re-housing it is one which must be faced within the near future.

The Centre provides a starting point from which the Home Nurses work, where they can clean and sterilize their equipment and exchange washable articles, such as towels, overalls, etc. They are seen here each morning by the Superintendent Home Nurse and are briefed by her for the day's work. During office hours, the Nursing Centre Orderly is on duty to take messages from doctors and to hand them over to the nurses. In addition she cares for the nursing and loan equipment, issuing it and receiving it on return.

The following figures relating to the loan of sick room and invalid requisites to those nursed at home is of some interest :—

Articles Loaned	No. of times loaned to Patients
Air rings	266
Chairs (invalid)	36
Mackintosh sheets	276
Bed cradles	15
Crutches	16
Urinals	167
Bed pans	256
Bed rests	107
Sorbo beds	49
Air and water beds	4
Bedstead	1
Pulleys and fittings	2
Feeding cups	3
Fracture boards	5
Total number of loans for year	1203

Staff

At the end of the year the staff consisted of the Superintendent Home Nurse, 12 whole-time nurses and one part-time nurse. The 12 whole-time nurses included four Queen's Nurses S.R.N. (one of whom is a male nurse), three Nurses S.R.N., two Nurses S.R.F.N. and three Nurses S.E.A.N. The part-time nurse holds the S.E.A.N. Certificate.

During the year there were five resignations from the staff. These nurses were duly replaced by new appointments.

VACCINATION AND IMMUNISATION

National Health Service Act, 1946, S.26.

Vaccination against Smallpox

The vaccination statistics for Barnsley are shown in tabular form as follows :—

I. *Number of persons vaccinated (or re-vaccinated) during 1952*

Age at date of Vaccination	Under 1	1	2 to 4	5 to 14	15 or over	Total
Number vaccinated	263	15	12	4	9	303
Number re-vaccinated	21	1	—	1	76	99

II. NUMBER OF CASES SPECIALLY REPORTED DURING PERIOD (AGE GROUPS AS ABOVE)

(a) Generalised Vaccinia	—	—	—	—	—	—
(b) Post-vaccinal Encephalomyelitis	—	—	—	—	—	—
(c) Death from complications of vaccination other than (a) and (b)	—	—	—	—	—	—

The figure of 303 primary vaccinations compares unfavourably with 331 in 1951 and 407 in 1950. Whilst re-vaccinations show an increase during the year (99 as compared with 45 last year and 59 the year before), they include the "key personnel" members of the various Health Service staffs who are re-vaccinated at frequent intervals and it so happened that a larger than usual number of them was due during the year.

In each Annual Report since the "appointed day" comment has been necessary on the small number of children whose parents have thought it worth while to protect them against Smallpox. Similarly, attention has been drawn to the view that vaccination in the early weeks of infancy is not only a prophylactic against Smallpox but is also a prophylactic against the effects of vaccination itself in later life. Nearly all the tragedies that have been recorded with vaccination have occurred in adolescents or adults who have undergone primary vaccination. Complications of re-vaccination are so rare as to be almost unknown.

If an individual who has been vaccinated in infancy comes into contact or is likely to come into contact with the disease either abroad or in this country, he can be protected by this process of re-vaccination which is a trivial matter utterly devoid of risks. Should he not be vaccinated in infancy his protection is a much more serious question. It is felt that this view must be kept constantly before the public. Every effort is made to stress to the people of Barnsley that vaccination is available at each and every one of the Health Authority's clinics. In addition it is possible for vaccination to be carried out by the family doctor in his own surgery under the National Health Service scheme.

Immunisation against Diphtheria

Immunisation against diphtheria was carried out for children in the following age groups:—

Aged 1 year	Aged from 1—4 years	Aged from 5—14 years	Total
271	321	73	665

Reinforcing injections of antigen were given to 595 children.

The immunisation state of children in the County Borough may be shown as follows:—

Number of children at 31st December, 1952, who had completed a course of immunisation *at any time before that date* (i.e. at any time since 1st January, 1938):—

Age at 31/12/52 i.e. Born in year:	Under 1 1952	1 1951	2 1950	3 1949	4 1948	5 to 9 1943-47	10 to 14 1938-42	Total under 15
No. immunised	500	791	833	894	956	5668	5689	15331

	Children under 5	Children 5–14	Total
Estimated mid-year child population, 1952	6700	12100	18800

These figures show a marked decrease when compared with those for the two preceding years. In 1950 835 children received primary immunisation and in 1951 the figure was 834. The figures for boosting doses have remained fairly constant.

The situation revealed by these figures is not one that can be viewed with anything but disquiet. The steady decrease in the number of immunisations performed each year means that the percentage of protected children in the population is gradually falling and that sooner or later the incidence of diphtheria and the number of deaths from diphtheria will commence to rise again.

Much difficulty has been experienced during the past three years in arranging the immunisation campaign so that it does not in any way coincide with the prevalence of acute anterior poliomyelitis in the Borough. The relationship between immunisation and this disease has been discussed at length in the last three Annual Reports and the view has been re-affirmed that immunisation does not cause or predispose to acute anterior poliomyelitis. If, however, by coincidence a child should develop the disease shortly after immunisation it is just possible that the slight trauma of the injection might cause the paresis arising from the attack to be localised in the limb used as the site of immunisation.

During the past three years considerable publicity has been given in the lay press to this relationship and it has been felt that were several coincidental cases to occur in a neighbourhood it might do lasting harm to the cause of immunisation in the Borough; therefore, during those months when poliomyelitis is likely to be prevalent, instructions have been issued that the immunisation campaign is not to be pressed. This means that at this time immunisation has been done at the request of parents but no strenuous efforts have been made to induce them to consent to it.

At the same time considerable attention has been given to reducing to a minimum the amount of trauma caused by immunisation. In this way the risk of localising paresis is reduced should by unfortunate coincidence a child contract poliomyelitis shortly after immunisation.

It is satisfactory to report that none of the seven cases of poliomyelitis reported in the Borough during 1952 occurred in patients who had been immunised during the preceding twelve months. Thus there can be no question of the unfounded rumours that immunisation causes the disease being attached to any of these cases.

The policy of limiting the immunisation campaign to certain seasons of the year has raised a considerable number of administrative difficulties. To overcome these and others, a scheme has been adopted for the conversion of a redundant ambulance vehicle into a small mobile clinic which will be used for immunisation. It is intended that immunisation sessions will be held in this vehicle at various points in the new housing estates and other parts of the Borough at present remote from the existing clinics. It is felt that this scheme will have a material effect on increasing the immunisation figures for 1953.

Immunisation against Whooping Cough

702 children received complete courses of Immunisation against Whooping Cough. 641 of these courses were carried out by the Medical Staff of the Health Authority and 61 by family doctors.

AMBULANCE SERVICE

National Health Service Act, 1946, S.27.

During 1952 the Barnsley Ambulance Service continued to operate with the high degree of efficiency that has come to be expected of it As in each of the years since 1948, there has been an increasing demand for the service. This increase has been met and every effort has been strained, by consultation with the Doctors and the officials of the various hospitals, to " prune " to a minimum the number of journeys performed by the ambulances. In spite of this, both the number of patients carried and the number of miles travelled were greater in 1952 than in any previous year.

The Ambulance Service in Barnsley is run in conjunction with the Fire Service; the Chief Fire Officer being also Chief Ambulance Officer. In this way the ambulance vehicles are maintained and manned in the traditions of readiness that have always been associated with the Fire Service. This has also ensured a very high degree of efficiency which would be difficult to attain without the background of urgency that comes with the fireman's training. The high reputation enjoyed by the Barnsley Service is undoubtedly due to this.

Apart from the problems of day-to-day maintenance and staffing, all qestions relating to the relationship between the Ambulance Service and other Health Services are dealt with by consultation between the Chief Ambulance Officer and the Medical Officer of Health.

The following report of the year's work of the Ambulance Service has been prepared by the Chief Ambulance Offier.

Arrangements with other Authorities

West Riding County Council.

This Authority still continues to work amicably with the West Riding County Council and by arrangement we undertake to deal with infectious Diseases, Emergency and Maternity Calls from certain parts of their territory into the County Borough Hospitals and also with a good proportion of their discharges from the County Borough Hospitals back into the West Riding.

The new Agreement for financial settlement entered into last year between the respective Authorities is working extremely well and seems to provide a reasonable and satisfactory arrangement with the minimum of administrative work.

OTHER AUTHORITIES.

With all other authorities except the West Riding—with whom we have a special agreement—an approved scale of charges is laid down for ambulance transport by one authority on behalf of another. The charges are reviewed and revised from time to time and the last amendment was made some few months ago to apply as from the 1st April, 1952, as follows :—

3s. 0d. per mile for ambulance journeys.

1s. 6d. per mile for sitting-car journeys.

he mileage for each journey to count from the ambulance or sitting-car leaving to returning to the Station.

Authority to order Ambulances

Formal requests for ambulance conveyances are not, in the normal way, accepted from members of the public, but only as follows :—

From—Doctors.
Hospitals.
Institutions
Other Authorised Persons.

Emergency Calls, including Maternity Cases, however, are accepted from any source whatever.

Return of Ambulance Calls

The return is shown on a monthly basis and is sub-divided into ordinary calls undertaken for patients within the County Borough and similarly for calls undertaken on behalf of other authorities.

Figures for 1951 are also given for comparison purposes.

Details of Journey	Jan	Feb	Mar	Apl	May	Jne	July	Aug	Sep	Oct	Nov	Dec	Total
Brought Forward	1024	997	1116	967	1158	993	1040	959	987	1069	1019	1028	12356
To Hospitals outside of Borough—continued													
Little Houghton	0	1	0	0	0	0	0	0	0	0	0	0	1
Acton	0	1	1	0	0	0	0	0	0	0	0	0	2
Hemsworth	0	1	0	0	0	0	0	0	0	0	0	0	1
York	0	1	0	0	0	0	0	0	0	0	0	0	1
Kirkburton	3	0	9	3	2	4	4	3	0	0	1	2	31
Rotherham	2	0	2	0	4	3	7	3	4	1	0	2	28
Manchester	1	0	0	1	1	1	0	0	0	0	0	0	4
Harrogate	1	0	0	1	0	0	0	0	0	0	0	2	4
Skegness	0	0	1	0	0	0	0	0	0	0	0	0	1
Ilkley	0	0	1	0	2	0	1	0	0	0	0	0	4
Oswestry	0	0	0	0	0	1	0	0	1	0	0	0	2
Southport	0	0	0	0	0	1	0	0	1	0	0	0	2
Wath	0	0	0	0	0	0	10	5	3	6	5	7	36
Firbeck	0	0	0	0	0	0	0	1	0	0	0	0	1
Cottingham	0	0	0	0	0	0	0	0	1	0	0	0	1
Huddersfield	0	0	0	0	0	0	0	0	0	0	1	0	1
To Home Addresses Within the Borough From :													
Beckett Hospital	347	388	384	387	424	315	449	462	389	451	427	468	4891
St. Helen Hospital	68	76	81	88	82	89	111	51	58	60	65	75	904
Beckett Annexe	36	35	32	48	45	25	32	30	25	34	35	42	419
Pindar Oaks	0	3	0	0	0	0	0	0	0	0	0	0	3
Kendray Hospital	61	80	70	66	74	56	54	45	18	42	52	55	673
New St. Clinic	2	0	3	3	2	0	1	0	1	2	1	5	20
Queens Rd. Clinic	101	82	122	108	116	98	115	129	152	144	189	142	1498
Penistone Annexe	2	12	4	8	7	2	8	7	6	9	11	10	86
House to House Removals	8	10	6	6	3	7	14	6	8	13	7	7	95
Lundwood Hospital	0	0	0	0	2	1	1	0	0	0	0	1	5
To Home Addresses out of the Borough													
West Riding	213	218	240	189	241	183	233	170	173	192	226	202	2480
Bradford	2	1	0	0	0	0	1	0	0	0	0	0	4
Leeds	1	0	0	1	0	0	0	0	0	3	1	1	7
Wakefield	1	0	0	0	0	0	0	0	0	1	0	0	2
Sheffield	0	1	0	4	1	3	0	0	4	3	0	1	17
Doncaster	0	0	1	0	1	1	1	1	0	0	1	0	6
Manchester	0	0	0	0	1	0	3	0	0	0	0	0	4
Cleethorpes	0	0	0	0	0	2	0	0	0	0	0	0	2
Bridlington	0	0	0	0	0	0	2	0	0	0	0	0	2
Huddersfield	0	0	0	0	0	0	0	1	1	0	0	0	2
Uttoxeter	0	0	0	0	0	0	0	0	1	0	0	0	1
Rotherham	0	0	0	0	0	0	0	0	2	0	0	2	4
Stockport	0	0	0	0	0	0	0	0	0	1	0	0	1
Cheshire	0	0	0	0	0	0	0	0	0	0	1	0	1
Kearsley	0	0	0	0	0	0	0	0	0	0	0	1	1
Journeys made, patient not conveyed	83	92	61	57	78	69	78	61	65	86	107	88	925
Journeys made by ambulance stationed at Kendray Hospital	135	184	139	121	136	109	134	65	76	10 9	118	133	1459
TOTALS	2091	2183	2273	2058	2380	1961	2299	1999	1976	2226	2267	2274	25987

	County Borough						West Riding County Council							
onth	Ordinary		Emergency		Total		Ordinary		Emergency		Total		Grand Total	
	1951	1952	1951	1952	1951	1952	1951	1952	1951	1952	1951	1952	1951	1952
n.	1733	1813	84	61	1817	1874	205	210	7	7	212	217	2029	2091
b.	1725	1895	71	68	1796	1963	248	208	7	12	255	220	2051	2183
ar.	1676	1958	61	74	1737	2032	193	231	5	10	198	241	1935	2273
ril	1716	1785	76	79	1792	1864	216	185	11	9	227	194	2019	2058
ay	1713	2067	91	69	1804	2136	173	227	10	17	183	244	1987	2380
ne	1779	1672	66	100	1845	1772	226	182	12	7	238	189	2083	1961
ly	2035	1964	61	95	2096	2059	167	228	25	12	192	240	2288	2299
ıg.	1535	1716	71	111	1606	1827	167	156	16	16	183	172	1789	1999
pt.	1445	1708	82	87	1527	1795	168	169	14	12	182	181	1709	1976
ct.	1759	1939	74	87	1833	2026	188	188	13	12	201	200	2034	2226
ov.	1706	1945	72	93	1778	2038	222	222	21	7	243	229	2021	2267
ec.	1510	1961	98	106	1608	2067	223	185	11	22	234	207	1842	2274
otal	20332	22423	907	1030	21239	23453	2396	2391	152	143	2548	2534	23787	25987

Details of Calls.

The figure of 25,987 calls represents an increase of approximately 2,000 on the previous year which increase can be attributed in the main to greater demands for conveyance to and from Beckett Hospital and Queens Road Clinic. The full details of the above number of calls are given below.

Details of Journey	Jan	Feb	Mar	Apl	May	Jne	July	Aug	Sep	Oct	Nov	Dec	Total
To Hospitals, etc., Within the Borough													
Beckett Hospital	360	413	411	380	428	340	475	448	390	440	434	486	5005
St. Helen Hospital	191	175	198	147	163	161	133	112	138	173	125	166	1882
Beckett Annexe	107	66	87	86	100	57	76	79	70	95	95	82	1000
Pindar Oaks	5	10	10	6	7	11	6	6	6	8	15	7	97
Kendray Hospital	12	9	5	16	16	12	3	17	14	0	5	2	111
New St. Clinic	2	0	3	2	0	1	0	0	1	1	1	4	15
Limes Hostel	0	10	1	5	2	13	11	8	16	9	3	5	83
Queens Rd. Clinic	113	88	125	112	128	103	112	137	171	163	214	158	1624
Schools	79	49	71	32	72	46	30	0	45	35	10	13	482
Lundwood Hospital	1	1	1	4	30	7	6	7	6	1	0	0	64
West Riding Chest Clinic	0	1	1	0	0	0	0	0	0	0	0	1	3
Borough Mortuary	0	1	0	0	0	0	0	1	0	1	0	1	4
To Hospitals Etc., out of the Borough													
Mount Vernon Sanatorium	21	26	18	25	31	18	34	0	0	0	0	0	173
Penistone Annexe	16	29	25	17	23	17	21	19	18	27	23	18	253
Sheffield	92	95	137	113	138	184	111	111	91	97	76	68	1313
Wakefield	17	18	18	17	12	10	14	1	0	1	0	1	109
Leeds	7	2	5	4	3	4	7	9	21	15	15	14	106
Doncaster	1	2	0	1	4	3	1	2	0	3	3	2	22
Mexboro'	0	2	0	0	1	4	0	2	0	0	0	0	9
Carried forward	1024	997	1116	967	1158	993	1040	959	987	1069	1019	1028	12356

Mental Defectives

The two Ambulance Coaches are employed in transporting mentally defective children to and from the Occupational Centre on each day the Centre is open. The number of children conveyed and the journeys undertaken are not included in the general figures previously given but are counted as a separate service.

Altogether 11,976 passengers have been conveyed whilst undertaking 1,248 journeys and it is a matter of fair comment that without the two Ambulance Coaches this service could not have been satisfactorily maintained.

One point worth noting is that although there has been a substantial increase in the number of passengers transported, the actual number of journeys have decreased, due obviously to the aquisition and use of the 18-seater Coach.

Vehicles

One new ambulance has been received into the Service during the year to replace the 1938 Vauxhall Ambulance HE 8469 which has been transferred to the Medical Officer of Health's Department.

This new ambulance whilst similar in appearance to the other ambulances purchased since 1948 is nevertheless an improved design and contains a number of additional internal improvements.

Of the eight ambulances now in the Fleet only one ambulance is pre-war and all but two have been acquired since the inception of the National Health Act in 1948.

The maintenance staff have contrived to keep the Fleet on the road with the minimum of delays and the absence of any breakdown whatever during the year is a tribute to their efficiency and the attention given to regular routine maintenance.

It is pleasing to report a year without any major accident and it is considered that with increased mileage and increased calls and therefore increased demands upon both men and machines, the absence of any notable accident and the remarkably small number of very minor accidents encountered, reflects great credit upon the efficiency and watchfulness of all drivers and attendants.

At the 31st December, 1952, the Fleet consisted of :—

Make	Reg. No.	Year	H.P.	Type
Morris	CHE 138	1949	24.8	Ambulance
Morris	CHE 469	1949	24.8	Ambulance
Morris	CHE 652	1949	24.8	Ambulance
Morris	CHE 745	1949	24.8	Ambulance
Morris	DHE 730	1951	24.8	Ambulance
Morris	CHE 567	1949	15.9	Ten-seater Ambulance Coach
Morris	EHE 207	1951	24.8	Eighteen-seater Ambulance Coach
Austin	HE 7711	1936	23	Ambulance stationed at Kendray Hospital
Austin	AHE 41	1945	26.9	Ambulance
Vauxhall	DPX 181	1938	25.0	Sitting-Car
Wolseley	BVH 397	1939	25	Sitting-Car
Morris-Oxford	EHE 192	1951	14	Sitting-Car
Morris	EHE 874	1952	28.9	Ambulance

Mileage

During the year the Fleet covered 144,796 miles on ambulance work made up as follows :—

AMBULANCES :			
CHE 138	11,274		
CHE 469	14,015		
CHE 652	12,434		
CHE 745	14,052		
DHE 730	2,960		
HE 8469	2,871		
HE 7711	4,755		
AHE 41	2,963		
EHE 874	234		
		65,558	
AMBULANCE COACHES :			
CHE 567	13,438		
EHE 207	8,894		
		22,332	
SITTING-CARS :			
BVH 397	22,151		
DPX 181	15,703		
EHE 192	19,052		
		56,906	
TOTAL ...		144,796	

For comparison purposes the total mileage covered during the preceding years were :

1949 ...	107,927
1950 ...	125,296
1951 ...	135,286

A close scrutiny of the comparable figures reveals that the greater proportion by far of the increased mileage this last 12 months over the preceding year is with the Ambulance Coaches and Sitting-Cars. In other words with Sitting-Car patients.

Without any doubt the Ambulance Coaches are proving a great acquisition to the Service and they are consistently used for hospital discharges and transfers when not employed on journeying to and from the Occupational Centre.

The small coach has many advan ages over a Sitting-Car and considerable thought is being given to the desirability of recommending to the Committee that when the next Sitting-Car is ready for disposal it be replaced with another small Ambulance Coach.

Equipment

No new type of equipment has been added to ambulances during this period but two further ambulances have been equipped with Resuscitation Apparatus.

The Maternity Packs first brought into use in 1950 have proved their value on a number of occasions during the year and without doubt they have become a necessary and vital ambulance accessory.

The Oxygen Baby Tent which was purchased during the preceding year is still under the care of St. Helen Hospital and is constantly available for use in case of premature births. This Tent is specially constructed to fit into an ambulance and if it is urgently required arrangements are made for an ambulance to collect a nurse and the Tent before proceeding to a call. The baby can then be placed in the Tent which is in the form of a Cot specially pre-heated and receive treatment whilst in transit to the Hospital.

First Aid Training

As recorded in the Fire Service Report 52 members of the Brigade are competent to render First Aid and hold current Certificates. Only men so qualified are used on ambulance work and a number of these men have reached competition standard.

Communications

Ambulance calls from Doctors, Members of the Public, and Authorised persons, continue in the majority to be received via telephone either on Barnsley 3366 or in the case of emergency 999.

Direct lines are also in existence between the Station Control Room and both Beckett and Kendray Hospitals and these lines are used to full advantage, the former being almost in continuous use during certain periods of the day.

One other method of communication with the public is by Police Call Boxes, whereby any member of the public, by opening the outside door in a Police Call Box, can speak through the grill to Police Headquarters who in turn can connect the speaker direct to the Ambulance Control Room. This method is only to be used in an emergency and can be extremely useful.

Short-Wave Radio

The installation of short-wave radio will be completed in the very near future and the experience of other authorities with this form of communication between the Control Room and ambulance vehicles is very favourable. A substantial speeding up of ambulance conveyance by a subsequent reduction of wasted time is anticipated.

Accommodation

The Ambulance garage in Westgate continues to house the ambulance vehicles when not in use and a direct telephone line between the Station Control Room and the Ambulance Garage is sufficiently near to the Fire Station as to be almost in the same curtilage.

Conveyance of Midwives

The Service continues to place a sitting-car and driver at the disposal of the Medical Officer of Health for conveyance of midwives during non-working hours.

i.e. Monday to Friday, from 5-30 p.m. to 9 a.m. the following morning.

Saturday from 12 noon until 9 a.m. on Monday morning.

Public and Bank Holidays.

345 requests were received and responded to during the year, which is an increase of 34 over the previous year, when 311 such requests were dealt with.

Infectious Diseases

An ambulance still continues to be housed at Kendray Hospital to respond to infectious Diseases cases requiring transport into the hospital. The ambulance is manned by Hospital Porter / Drivers.

Considerable assistance however has to be given by the Ambulance Service who quite often provide an attendant to assist the Porter / Driver and on other occasions particularly during sickness and holiday periods the Service has to provide entire cover. In addition all Kendray discharges are undertaken by us.

However the arrangement with Kendray Hospital is quite good, the liaison is at high level and in normal times the Hospital maintains an efficient response to Infectious Diseases Calls.

Civil Defence—Ambulance Section

The lack of facilities in the form of accommodation for both practical and lecture purposes continues to hamper the progress of Civil Defence — Ambulance Section. Despite this great handicap however certain advancement has been made during the year and plans have been made for more rapid progress in the New Year.

Mr. A. Hammond has been appointed as Chief Clerk to the Fire and Ambulance Department, and also assumes command as Deputy Ambulance Officer for Civil Defence purposes.

Arrangements are in hand for advanced training to all members who have passed their Basic Training to commence in the New Year under the auspices of Doctor Bird and the St. Johns Ambulance Brigade. The Course will take place in the Civil Defence Room at the Public Hall.

Enrolments in the Ambulance Section are as follows :—

Male	...	26
Female	...	34
TOTAL	...	60

and of the above 6 males and 14 females have completed their Basic Training. A proportion of these have actually received uniform.

Interest in the Civil Defence Ambulance Section seems to be quite pronounced as is evidenced by the fact that 60 recruits have been obtained which means that the establishment of the Civil Defence Ambulance Section of 56 has been exceeded, and every effort will be made to hold the interest of these volunteers.

PREVENTION OF ILLNESS, CARE AND AFTER-CARE

National Health Service Act, 1946, S.28.

In order to appreciate the full significance of the inclusion of this Section in the National Health Service Act it is necessary to look behind legislation and regulation to the intentions and ideals which statutes merely translate into practical instruments to benefit the community.

In the first place there is a tendency to forget that the National Health Service was never intended to be more than a part, though quite an important part, of a much larger design for the removal of fear due to social insecurity. It was intended to banish such social insecurity as arises from illness and disease. The obvious way to do this is by the promotion of positive health; therefore in the original conception of the National Health Service the emphasis was on prevention of illness rather than on its treatment. When the time came to provide for the consideration of the practical working of the scheme it was clear that whilst the preventive outlook must be the ultimate aim there was a vast amount of sickness occurring to which preventive medicine has not yet found an adequate answer. Human nature being what it is there was also a not inconsiderable amount of preventable sickness. This undoubtedly arose from the failure of individuals to take full advantage of available medical knowledge. Now, the principal object of the scheme being to reduce the effects of the impact of sickness on the community, it became necessary to provide for the treatment of sickness and injury for which prevention had not as yet found the answer and also for those cases where preventive measures have failed by reason of neglect or other causes. Adherence to the original conception means that every possible opportunity must be taken by those operating the Health Service to replace the treatment of illness by its prevention and to regard as their object the limitation of the effects of disease and injury rather than simply the cure of a given pathological condition in the individual.

In order to provide this treatment it was neccessary to assimilate into the Health Service the then existing agencies of curative medicine. The task of doing this involved much detail work and negotiation with those interests which have been traditionally vested in illness. As a result of the upheaval so caused, the original conception of a service progressing toward prevention has been almost completely overshadowed by the immediate need to provide treatment. Thus the means is fast establishing itself as the end. This is largely due to the swamping of the service by those trained in the tradition of curative medicine rather than that of preventive medicine. Curative medicine in the past has been an art practised by individualists for individuals and has had little if any relationship with the community as a whole. Preventive medicine on the other hand has grown from a community science concerned with population groups ever lessening in size until the point has been reached where it also must now concern itself with the individual.

Unfortunately this swamping of the Health Service by the agencies of curative medicine has led more and more to the original conception being pushed into the background. Still more unfortunately, by reason of the individualistic approach of these agencies, the idea has been spread through the community that the Service is primarily concerned with the

sickness of the individual and that prevention is only of secondary importance. The fostering of such an outlook will serve most admirably the sectional interests of the agents of curative medicine. If, however, such an approach were to be carried to its logical conclusion it would result in the Service becoming simply an instrument for the treatment of disease that in many cases need never have occurred at all.

It is obvious that those who planned the National Health Service foresaw that there would be these two approaches towards the individual and foresaw that it would be necessary to provide a common ground upon which those using both of them could meet. To provide this, Section 28 was included in the Act, giving the Health Authority, with its long tradition of prevention, powers to assist those concerned with the treatment of the individual. In doing this the Section showed appreciation of the preventive value to the community of rehabilitation of the individual after illness or injury, both from the "human angle" and the economic point of view. Section 28, therefore, may well be regarded as the key section to the attainment of the Comprehensive Health Service which is envisaged as a principal part of the British System of Social Security.

This survey report now offers an opportunity to review how far it has been possible to make use of this common ground in Barnsley. Purely preventive medicine as applied to the community as a whole has continued on the lines originally developed by the Public Health Service prior to 1948. The structure has perforce undergone some alteration due to the change brought about by the fever hospital and the tuberculosis hospital coming under an administration purely curative in outlook. So far by reason of continuity of staff and the personal relationship existing between them and the Public Health Department no practical evidence of the theoretical unsoundness of such a structure has been encountered in Barnsley. By the establishment of a joint appointment with the Sheffield Regional Hospital Board in the case of the Chest Physician, steps have been taken in relation to tuberculosis to minimise as far as possible any effects this change may have.

The newer aspects of preventive medicine—those concerned with the prevention of illness in the individual and the limitation of its effects on the individual—have, however, not made the advances in Barnsley that might have been anticipated. The Health Authority, in preparing its proposals and in putting them into effect, had in mind the vital necessity for team work in this, particularly between the elements generally regarded as preventive and those regarded as curative. Thus there are available the services already described in this report. On the preventive side there is the Health Visiting Service, the Care of Mothers and Young Children and the means of immunisation and vaccination, whilst for the limitation of the effects of illness and rehabilitation there is the Home Nursing Service, the Domestic Help Service and the Appliance Loans Service. In addition to these a Social Worker has been appointed whose duty it is to deal with social problems which have a direct bearing on health and sickness, whilst the administrative machinery of the Corporation's Health Department is available to weld all these services into a single team and to direct their development in the most beneficial manner.

To be of the fullest possible value this team now requires representatives from the Hospital Services and the General Practitioner Service. Without them it is incomplete. It is impossible for this team to reduce the effects of illness in the individual and difficult to prevent it in other members of his family unless those directing its activities know something of the nature of the illness from which the individual is suffering.

In each annual report since 1948 reference has in one way or another been made to the need for team work between the three partners in the National Health Service. Suggestions have been put forward that this might first take the form of a free exchange of information regarding individuals whose health might be benefited by the full development of all available resources. Despite this, however, no official approach has yet been made to the Health Authority by the other two partners in the service with a view to discussing these suggestions. It would seem that despite the efforts of the Health Authority the community in Barnsley is being denied the fullest benefit from the National Health Service. Furthermore it would appear that this would continue to be so until some means can be found of organising a team to work on common ground on the lines which Section 28 envisages. This is perhaps the outstanding example of the need for strong leadership and direction at a National level in the National Health Service.

Although for the reasons outlined above, which would appear to be beyond the control of the Health Authority, it has not been possible to develop a service for Prevention of Illness, Care and After-care in accordance with the spirit of the Act, much has been done. A Social Worker has been appointed and has established herself in those spheres where her expert knowledge is specially appropriate—tuberculosis, venereal diseases, the care of the aged and after-care of those discharged from hospital.

At the same time considerable experience has been gained in the organisation and administration of all the other services in relation to care and after-care as well as to rehabilitation and other medico-social work. This experience would confirm that "care and after-care" must not be regarded as a separate entity but in fact constitute the great mass of the work to be done by a Health Authority—the other Services would in fact appear to be integral parts of this mass. Indeed it might not be incorrect to describe the whole of this part of the Annual Report as a report on the care of the people of Barnsley.

Work done by the Social Worker.

It is usually considered appropriate to include under the heading of Care and After-care details of the work done by the Social Worker. Reference has already been made to the spheres in which she is particularly concerned. It should also be noted that by the nature of her work the Social Worker has wide opportunities of making those ad hoc personal arrangements in relation to the individual patient which have become for good or for evil such a feature of the National Health Service. For this reason it is very difficult for the reader of her report to judge the amount of work involved. Numbers of visits and statistics of interviews give little index of the results achieved. Much time is often spent in overcoming prejudices and in eliciting the patient's objection to certain courses of action. There is no means yet available for recording the amount of patience and tact that is expended in this way.

The Social Worker reports as follows :—

The Social Worker now has her own office in the Town Hall where it is possible to interview members of the public in privacy and where articles of clothing, magazines, etc. intended for purposes of almoning, can be stored. A system of keeping records from which valuable data can be gleaned has also been established and from these is noted the increase of After-care work passed on by other sources. There is also the foundation of an After-care Service for the aged sick, or those without immediate family to accept responsibility for their welfare. On a quick general survey it appears to have been a year of some progress in the further development of the After-care Service.

Total visits for the year : 1,285.

The number of visits recorded cannot be regarded as an indication of efficiency or success, since case work may often require detailed attention and, for its completion, contact with organisations outside the town. As an extension of this statement, it is to be remembered that a cursory visit to a home produces little or no result. The Social Worker's aim is in many ways an effort to rehabilitate the patient and his or her co-operation is therefore necessary.

OLD-AGE CARE : NO. OF VISITS 272.

Verbal acknowledgment and genuine gratitude suggests that the enlargement of this section of the work is both desirable and desired. On record there are some sixty-odd cases. There have been several deaths of old people and cases transferred to Local Authority hostels but it is gratifying to realise that their comfort has been considered before decease.

As examples of case-work undertaken, the following can be quoted.

Elderly man of 77 had recently undergone operation for removal of cancer in the bowel; found to have a wife of same age in delicate health. Nearest daughter, living six or seven miles outside the Borough, willing to help with the washing. Total income £3 18s. 6d. per week which included National Assistance. Grant of 7/6 per week obtained through the Cancer Relief Fund, to be paid until further notice; bedding and towels also obtained through the same source.

Elderly man of 76, slowly dying with cancer, had a young married couple living with him who were willing to co-operate in his care. Bedding a source of great financial worry—this obtained through the Cancer Relief Fund; also Housing and Welfare Department contacted with a view to the patient's daughter exchanging her house with that of her father so that the lodgers who have recently had another baby will not have the responsibility.

Regular visits of a purely social nature are so much appreciated by old ladies living alone that failure to call is often cause for anxiety on the part of the old person. Home Helps in these cases have proved a great boon for not only has the old lady assistance for household chores she is unable to accomplish but companionship too.

V.D. Visits to Defaulters from Treatment and Contact Cases: No. of Visits 407.

There are 81 cases of defaulters on record, receiving either periodic or frequent visits. A survey of the year's work shows that where defaulters have been encouraged to return to the Centre, it may only be for one or two visits before reversion to default. It is very difficult to convince these patients that observation is essential to their personal health and that of the community. Several young girls have been under surveillance this year and as close a supervision as possible kept upon contacts in the town. The function of the Social Worker also includes incidental welfare under which the whole of the patient's family comes under review. In this way problems which may have contributed to the contraction of the original infection can be discussed without embarrassment. Again, to achieve any degree of success, the co-operation of the patient must be obtained. One of the most heart-warming cases on record this year is quoted as an example of this work.

A mother of five children (two of whom, aged 15 and 13 respectively, are in a home at Bradford) has been visited once or twice a week during the last six months whilst her husband has been imprisoned for stealing coal. This woman has a history of 17 years unhappily married life with periods of real destitution when she has been compelled by her husband's laziness to live the life of a vagrant. The entire family occupies one small back-kitchen room, approx. 12ft. x 13ft. There is no floor covering and the walls are in a thoroughly wretched condition, yet the place is cleanly kept and the children neat and tidy. The youngest, aged 18 months, has all the physical characteristics of a mongol and the mother is to be commended for her care of this baby under such circumstances. A special grant was obtained for this mother at Christmas, with which food was bought; also toys were received for the children. The mother has also been encouraged to pay off debts incurred by her husband at two or three shillings a week after necessities have been bought. The Housing and Welfare Department has been contacted re this family.

Two clinic sessions a week are attended and this provides a personal contact with all members of the clinic staff. It also offers an opportunity of gaining an idea of the social problems involved in each individual's treatment. A room has now been placed at the disposal of the Social Worker, should she wish to interview a patient privately. Of the cases visited or re-visited, this year's best results are to be found where defaulters have completed treatment and been discharged, of which there are five cases on record.

T.B. After-care: No. on Visit. 81.

On record 29 cases referred directly by the Chest Clinic or through the Health Visitors. Of these cases, two or three only receive regular visits since, when application has been made to the Social Worker, it has generally been for the purpose of almoning, viz., obtaining special grants or need for bedding. By special arrangement with the Chest Consultant, patients from the Barnsley area have been visited at Wath Wood Sanatorium fortnightly. Magazines are taken for the patients' pleasure and personal problems discussed.

As an example of satisfactory case-work can be quoted the following: Family of three, mother, father and daughter in middle twenties. Father on compensation for silicosis contracted in the pit, mother history of T.B. spine for which treatment has proved satisfactory, daughter suspected early pulmonary tuberculosis for which sanatorium care has been successful. When first requested to visit there was a need for financial assistance. In this case there has been full co-operation, the husband had started to keep pigs and occupy himself with a greenhouse and the daughter by sheer hard work had been admitted to a local Training College. The total sum obtained for this family was £15 0s. 0d. paid out in the form of weekly grocery. The daughter is now a fully-fledged teacher and the income adequate to meet current demands.

HOSPITAL AND OTHER AFTER-CARE: NO. OF VISITS 525.

The hospital After-care is not only statutory but an essential service —survey of the patient's reaction to visits may perhaps be taken as proof of this. The Almoner has become a colleague in the accepted sense of that word and through her intercession it is possible to effect contact with a patient before leaving the hospital. This has occurred in several cases this year and the value of actually visiting a patient in the ward cannot be too greatly stressed. This is not to be an argument for indiscriminate visiting of all patients but those cases where problems of after-care are likely to prove more complicated than the straight-forward after-care warrants. Since there has only been an Almoning service here for four years the Local Health Authority development of this service is closely linked with that of the hospital. Work undertaken follows the accepted pattern of visiting, investigation of social background, discussion with the Almoner of any immediate requirement for convalescence, financial grant or transfer of case to another department, i.e., intercession of Child Care Officer or National Assistance Officer. Often families which are likely to require constant supervision are passed on, i.e., a problem family with a history of poor adjustment to organised society demands. As an example of the latter can be quoted the following:—

Man of some forty years, admitted to hospital as an emergency case, found to be in filthy condition. Sister reported this to Almoner. After investigation of home, discovered that there were two children aged 14 and 12 respectively, the elder a girl who had been under the ægis of the Children's Officer, boy found to roam the streets at night. Provision made for their care through the School Welfare Service. Father subsequently took his own discharge from the hospital and was described as a very difficult patient.

To facilitate the satisfactory care of problem families, a small group of officers meets about once every three weeks and questions are raised re more satisfactory methods of effecting the care of outstanding family case-work.

Other After-care includes cases referred by the Probation Officer, Domestic Help Organiser, Health Visitors and, rarely, a general practitioner. This often comprises work of a purely Almoning nature where the intervention of the National Assistance Board is not feasible. The Superintendent of District Nurses frequently approaches the Social Worker with a

request to visit a home where she feels that there may be some problem demanding more specialised attention. A recent example has been :—

Case of girl aged 20, recently confined with baby. Home already known by Social Worker since hospital after-care undertaken for the grandmother aged 73. A pram was obtained and relatives approached for help with clothing. The putative father is known to the uncle who also lives in the household and an affiliation order will be filed in due course.

Looking back over the work this last year, there is little doubt that with further zeal and enthusiasm, greater co-operation from all departments which should be concerned, the After-care service will develop into an efficient service. The Social Worker, to be efficient, requires contacts of as wide and varied a nature as possible.

Prevention of Illness

TUBERCULOSIS

The epidemiological factors concerned with the spread of tuberculosis in Barnsley are described in Part II of this Report and attention has been drawn there to some of the ætiological factors involved.

Reference to the statistical tables in Part II shows that the inception of the National Health Service has not been marked by a notable decrease in the number of cases of this disease notified. However, there has been a steady fall in the mortality during the period under survey. There is perhaps no disease which is more readily affected by social circumstances than tuberculosis and this fall in death rate is most gratifying to those whose interest lies in the relationship between social welfare and illness. It would be more gratifying still if it were accompanied by a corresponding fall in the number of notifications. However, it is much too early yet to draw any conclusion from this discrepancy between these two figures.

In previous reports the position caused by placing the treatment of tuberculosis in the hands of a body other than that responsible for its prevention has been discussed in some detail. There is no doubt at all that even under the most satisfactory local arrangements for the correlation of these two the administration of counter measures against the disease has been rendered more complicated. At the Appointed Day the Assistant Medical Officer of Health for tuberculosis (who was also Medical Superintendent of Mount Vernon Sanatorium) joined the staff of the Sheffield Regional Hospital Board as Chest Physician and has continued in this position since. The Barnsley Chest Clinic has therefore enjoyed continuity of direction and has been developed considerably during the past four years. At the same time an arrangement was negotiated with the Regional Board whereby the Barnsley Health Authority contributes a sum toward the salary and expenses of the Chest Physician. In consideration for this the Chest Physician undertakes preventive duties on behalf of the Health Authority.

These duties include the follow-up of contacts, environmental investigations and immunisation against tuberculosis using B.C.G. vaccine. The number of these immunisations has been increasing each year, 49 being done in 1952 as compared with 35 in 1951.

Each year since 1950 Barnsley has received a visit from the Mass Miniature Radiography Unit of the Sheffield Regional Hospital Board.

On each occasion an attempt has been made to secure the examination of a maximum number of a group chosen as having a raised tuberculosis incidence as compared with the community as a whole. Efforts in this direction have resulted in the examination of a great part of the adolescent population during the past two years.

On the first two occasions on which the Unit visited the town a high degree of co-operation was obtained from all employers of labour in that time off was given to workers to attend for radiography. This privilege was withdrawn during 1952 by some firms and it had a direct effect on the numbers of persons presenting themselves for examination. An attempt to overcome this difficulty was made by arranging " open " evening sessions. This, however, did not have the same effect of encouraging young people to attend as a mass visit to the Unit of a " factory group." There is something to be said for the point of view that holds that individuals should use their own time to care for their own health. Many community groups are not yet sufficiently health conscious to appreciate this. It is therefore a pity that all employers cannot see their way to assist in this very useful measure to improve both Health Education and the Public Health.

In all 5,275 persons were examined during the period of the visit of the Unit from 1st September till 8th October. This compares with 8,067 examined in 1952. More than half of this number (2,678) attended on their own initiative at open sessions as opposed to attendance in organised parties. This is a matter for some satisfaction. The results of the Mass Radiography Survey were extremely interesting—41 persons (23 male and 18 female) were referred to the Barnsley Chest Clinic with suspected tuberculosis. This compares with 120 in 1951. 66 persons were referred to their own doctors on account of non-tuberculosis lung conditions detected in the course of the Survey. In many ways this side of the work—the detection of non-tuberculous conditions—is of considerable value and importance and ought to be borne in mind each time mass radiography is considered. The possibility that soon another Unit will be available in the Sheffield area is most welcome. The task of choosing community groups to whom mass miniature radiography may be offered is an extremely difficult one. Even the best compromise arising from the choice cannot be regarded as entirely satisfactory. It is to be hoped, therefore, that the additional Unit will result in more frequent and more prolonged visits to Barnsley with a correspondingly wider section of the community receiving examination.

The ideal situation, of course, would be the permanent establishment of a Unit in Barnsley. With this it would be possible not only to subject the whole population of the town to examination at regular annual intervals but also to ensure that even more frequent examinations were carried out on selected groups. It must always be borne in mind that because an individual has a clear X-ray on one occasion this does not preclude the development of tuberculosis at a later date, which may well be as soon as three months after the X-ray.

Regret has been expressed in previous Annual Reports that the duty of providing mass miniature radiography was placed on Regional Hospital Boards rather than on Health Authorities. Experience has shown that such regret is founded on reasonable argument. At the same time it is appreciated

that in the immediate post-war years Regional operation of these Units ensured the widest distribution of the limited amount of equipment then available. There is, however, prospect that the equipment situation will be greatly eased and that more and more Units will become available. Perhaps in such circumstances the Minister of Health might consider returning this essentially preventive service to the Health Authority. Such a step would do much to assist the Health Authorities not only with the discharge of their obligations in relation to tuberculosis but also in the development of a wider preventive service for all diseases of the chest including those of occupational origin.

Health Education

Since the Appointed Day in 1948 and indeed before it, a great deal of attention has been given to the problem of instructing the community at large in matters concerned with health. Prior to 1948 this was usually aimed at achieving a single object; for example, popularising immunisation against diphtheria or encouraging early medical examination when tuberculosis might be a possibility. In those years the methods of instruction developed along stereotyped lines which were basically borrowed from advertising practice. There is little doubt that under the conditions then prevailing this kind of mass instruction produced some quite useful results. It is characteristic of the whole arrangement that the term "Health Education" was coined to describe it.

With the inception of the National Health Service in 1948 it became obvious that instruction of the community in the maintenance of health would become one of the most important factors in achieving the ultimate ends of the Service as set out earlier in this section of the report. This is purely preventive work, consequently the duties connected with it were placed upon the Local Health Authorities in Section 28 of the Act. In Barnsley, as in most other areas, the methods of Health Education which had produced results before 1948 were continued in an intensified form during that period of re-organisation which marked the first two years or so of the Service.

As the pattern of the National Health Service develops it becomes more and more obvious that only with the fullest co-operation of the community can it hope ever to achieve its ultimate objective as part of the design for social security. Co-operation with any community is only obtainable on a basis of trust and understanding. Understanding in its turn only comes with knowledge. It is therefore essential that knowledge of health matters should be propagated in the community—then, with an honest service, understanding and trust will follow.

It is most necessary that this position should be appreciated as to a very great extent it provides the key to results which have been obtained from use of those Health Education methods which till now have been regarded as conventional. Any critical examination of these results which is detached and honest cannot but reveal them as disappointing. The methods used, for example posters and leaflets, can have but little effect on a population which since World War II has been over-exhorted by officialdom to do all kinds of disagreeable things. The community is probably by now heartily tired of such advice just as it is of advertising

measures which do not appear to give away something for nothing. In fact much of this kind of propaganda, consciously or unconsciously, arouses a suspicion that it is trying to get people to do things for some motive ulterior to that declared on its face.

Then there is the lecture and study group method of approach. This is somewhat more successful but it tends to preach to the converted and does not reach those elements in the community such as "problem families" where it is particularly essential that understanding and trust should be established. Exhibitions and displays may attract some transient attention but it is extremely doubtful if they make any lasting impression at all.

The need for a new approach to Health Education was mentioned in the Annual Report for 1951. Here the theory was propounded that Health Education must be governed by a long-term policy and that the proper place for teaching health is in the school. During 1952 a pilot experiment on these lines was carried out at Kendray Junior School and is described in that part of this report which deals with School Health. The impression made by this was that it is easy to stimulate the interest of children in health and that thought must be given sooner or later to devising a suitable means of ensuring that all children receive instruction of this kind at school. This would appear to be the ideal solution to the problem but its usefulness will be greatly reduced unless steps are taken to ensure the existence of a unified policy of Health Education throughout the whole of the Health Service. The need for such a policy exists and there is little point in quoting instances to prove this need in a report such as this. The formulation of such a policy calls for strong leadership which should preferably come from the Ministry of Health. Its inception would involve a complete re-orientation of outlook on the part of the general practitioner and also to some extent on the part of certain hospital workers. There is no doubt, however, that the individual member of the community is more receptive to advice and will learn about health more readily when he himself has sought advice rather than when it is thrust upon him. On such occasions the agent of curative medicine frequently prescribes the bottle of medicine which is at its best a palliative, or writes the much sought after certificate and hopes that these will effect the cure. If they do not they are not particularly likely to cause the patient to seek another medical attendant. So no great harm is done from his point of view. By this practice countless golden opportunities for Health Education are lost and the real object of the National Health Service is forgotten. It is, of course, appreciated that many practitioners rationalize their thoughts (or, in other words, salve their consciences) with lengthy discussions on the psychological effect of the bottle of medicine or of a few days away from work. There are also some practitioners who make full use of their opportunities in Health Education and so ~~fulfil~~ their proper function in the Service, but it would seem they are few in number. How far it will be possible to overcome the undermining effects of curative medicine on true Health Education remains to be seen. Will the child who has been taught the rudiments of physiology and hygiene at school break down to the enjoyment of ill-health under the inducement of the too-easily granted certificate? Probably so if the standard of certification at present made available to excuse school attendance is allowed to continue. How can a proper respect for the Health Service be inculcated into children when they announce to the general public in the

'bus that an afternoon at the pictures costs one shilling and sixpence? (A shilling for a certificate from Dr. . . . . , and sixpence for admission).

How can the community respect the medical certificate when instances occur where the attendance officer actually sees a doctor issuing a certificate to excuse a child from school when the child is in fact away from home? These instances which are quoted refer to school children but it is difficult to believe that when the individual passes school leaving age he finds it more difficult to induce the practitioner to produce the magic piece of paper.

A further example of the need for the fostering of a preventive approach amongst the general practitioners is to be found by studying the diphtheria immunisation figures for Barnsley for 1947 and comparing them with those for 1952. In 1947 the only arrangement for free immunisation that existed was immunisation at the Health Authority's clinics. In that year 1,254 children were immunised. In 1952 when every general practitioner has had for over three years the opportunity of immunising every child we place in his care whose parents consent, only 565 immunisations were known to be carried out, this despite the fact that the Health Authority is ready to pay a fee for the record of immunisation and to provide the antigen free of cost. It would seem that immunisation has offered an opportunity for the general practitioner to enter the field of preventive medicine, where he would be most welcome. These figures, to say the least, would suggest that he has not availed himself of the opportunity. They also show very clearly that the agencies of curative medicine require considerable instruction in Health Education.

Apart from experiments in the education of children, supplies of leaflets have been provided for distribution at the Clinics and those community groups in the County Borough who have asked for it have been given lectures by members of the Health Department staff. Mothers' discussion groups have been started at certain of the Clinics. One such group at Carlton Clinic is in a particularly healthy condition. In addition various posters are exhibited at the Clinics and a display is shown in the foyer of the Town Hall. On this side of the work useful assistance is provided by the Central Council for Health Education to which the Corporation continues to subscribe.

DOMESTIC HELP SERVICE

National Health Service Act, 1946, S.29.

Each year sees an increasing demand for this Service although, unlike the other Services such as Home Nursing, it is not free of charge. The Corporation has adopted the scale of charges suggested by the Association of Municipal Corporations but has applied certain modifications to this in the case of old age pensioners. The effect of this is that everyone who applies for domestic help is assessed according to their means and in no case where domestic help is necessary on medical grounds is it refused simply because the patient lacks the means to pay for it. Each application for help in the home must, of course, be supported by a medical certificate from the family Doctor.

Probably the best method of gauging the demand is to examine the number of cases for whom the provision of Domestic Help was continued from one year to the next. The figures foy the last three years are illumating :—

Number of cases for whom help was continued from 1950 into 1951	90
Comparable number carried forward from 1951 into 1952	138
At the end of 1952 the number of cases to be carried forward into 1953 was	163

A number of the cases, old persons for example, who are crippled in some way and unable to do all their household work have been receiving help in the home under the scheme for as long as three years. This has not in every case been continuous. The patients often try to carry on themselves but they catch a cold or suffer some minor injury and have in the end to make a fresh application for assistance.

As with the Home Nursing Service, the Domestic Help Service performs a very useful function in enabling people to live at home who would otherwise have to be admitted to hospitals of one kind or another. This is most desirable in many ways. Of first importance is the fact that most of these people are infinitely happier in their own homes. Then the general cost to the state is much less than that of maintaining them in expensive institutions. Against this, however, is the situation that the expansion of the Service, as shown below, is putting a heavy burden on the local rates. It must, of course, be appreciated that there is a 50% grant in respect of expenditure on Domestic Help in the home; nevertheless much of the money spent on it has the effect of reducing the burden on the hospitals. Now since the hospitals are paid for by the Exchequer, it would seem that the grant to the Local Health Authority might with justice be increased. Unless it is, sooner or later local financial conditions will impose a ceiling on further development of this very useful service.

The cost of the Service in Barnsley during the years under survey has been as follows:—

Year ended	Gross Cost £ s. d.	Income (Fees) £ s. d.
31st March, 1949	383 12 10	188 2 11
" " 1950	1,996 1 8	143 5 10
" " 1951	6,198 14 10	487 7 6
" " 1952	8,129 1 11	418 4 3
" " 1953	10,405 9 0	588 0 0

Despite the fact that the Domestic Help Service was not intended to be a free Service, each year sees the deficit beween income and expenditure increasing. This, as will be seen from the report of the Organiser set out below, is due to the high proportion of cases where old age is a factor contributing to the need for help in the home. As noted above, old age pensioners are in most cases exempt from contributing to the cost of the help provided for them. It is also interesting to note how few women make use of the service during the lying-in period. The Ministry of National Insurance makes a special grant of attendance allowance and the Health Authority is ready to provide help on request at the appropriate fees; nevertheless it will be seen that little use is made of these facilities. Probably the attendance allowance is spent on assistance in the home made under private arrangements.

The Domestic Help Organiser reports as follows :—

Number of enquiries during the past year	213
Number of cases given help during the year	278
Number of cases rejected during the year	75

Classification and number of cases to which help has been given :—

	1949	1950	1951	1952
Age and illness		106	181	222
Age		18	18	18
Maternity		14	10	9
Illness		38	32	29
Total cases	71	176	241	278
Number of Domestic Helps employed	22	50	64	73

Age and illness

In this section the demand and increase in demand has been the greatest. Some of these cases cause a tremendous amount of anxiety and worry, as many are absolutely alone in the world or have relatives who refuse to accept their responsibilities. It is surprising how these persons become dependent on the Service and soon realise, if the Domestic Help is unable to overcome their obstacles, that the Organisers are ready to give advice and assistance or to try to smooth out their difficulties.

The following are some of the problems which are frequently cropping up.

The circumstances of a case change either through sickness or hardship. If a Domestic Help is unable to cope, she contacts the Domestic Help Organiser. Then other services are tapped to give benefit to the patient, such as :—

National Assistance Board—
for extra pension—for nourishment
—for replacement of bedding
—for new clothes
—for increase of supplementary pension to combat increased cost of living (e.g. rents).

Nursing Centre—for the services of the District Nurse and appliances for the comfort of the patient.

Ambulance Service—for transporting patient from own residence to relatives or to more suitable accommodation.

The most distasteful duty is attempting to convince relatives there are certain duties which it is their moral duty to perform. Many times neighbours are more willing and can be a great help when approached.

Maternity

There has been a steady increase of enquiries in this connection but here the cost of the service hinders any noticeable progress, despite the grant of attendance allowance provided by the Ministry of National Insurance.

Illness

Once again, it is very surprising how people can manage on learning that the Service is not entirely free.

Tuberculosis

There have been several enquiries but, on visiting, the patients refused on the grounds of cost.

Domestic Helps

All the women employed in the Service, a total of 73, work on a part-time basis. The morale of these workers continues to be very high and it is surprising the lengths to which these women will go to gain extra comfort for their patients. One lady has loaned a smaller bed to enable an elderly couple to be more comfortable whilst they are seriously ill. Husbands have frequently been pressed into performing small jobs of shaving, joinery and decorating.

During the year the Corporation adopted new conditions of service and increased wages as set out by the Joint Industrial Council. These now apply and have been much appreciated by all members of the Service.

Staff

The steady increase of demand on the Service made necessary the creation of the appointment of Assistant Domestic Help Organiser. The post was advertised in October, 1952, and Miss D. Smith was appointed and took up duty in November.

Acknowledgment

It is felt that reference should be made in this report to the co-operation and assistance in the administration of the Domestic Help Service received from the Barnsley Area Officer of the National Assistance Board.

MENTAL HEALTH SERVICE

National Health Service Act, 1946, S.51.

The provisions of Section 51 have extended the field of activity in preventive medicine open to Local Health Authorities to an extent that is perhaps not yet fully appreciated. Combined with those of Section 28 they have put at the disposal of the Authorities a very full armamentarium to practise the wider art of social medicine in the broadest application of that term.

Major Local Authorities such as Barnsley Corporation have had a long association with the care of those threatened with or suffering from mental illness. In this field as well as in others the summary division between curative and preventive services and domiciliary and institutional services which took place on 5th July, 1948, caused considerable concern and perhaps not a little confusion at first. The necessity for maintaining a service which would continue to deal with the more severe crises of mental illness actually occurring in the community during this period of change overshadowed for several years the more purely preventive side of the work. Many of the difficulties encountered during this period have arisen from shortage of institutional accommodation.

The building situation has been the fundamental cause of this and by its effects on mental health has contributed to this shortage in a number of differing ways, the ramifications of which are not immediately apparent. In the first place difficulties in obtaining houses have caused overcrowding in the home: this makes it necessary to institutionalise patients who, given reasonable living space, might receive out-patient treatment and domiciliary supervision. Again overcrowding itself is a potent social ætiological factor in the causation of mental disease. The social changes which have their roots in housing problems (e.g. families paying high rents as lodgers in inadequate accommodation) have resulted in fewer female relatives being available to care for the member of the family who is suffering from transient mental upset. These ladies must for financial reasons go out to work and simply cannot afford to stay at home to look after the mentally sick. Again, overcrowded conditions give rise to a feeling of strain which in itself makes the care of even the mildest mental patient an intolerable burden. In addition to all this there is, of course, the simple direct effect on the mental hospitals themselves—the need for more bricks and mortar which can only be satisfied at the expense of some other competing interest.

Then there has been the shortage of accommodation for old persons whose mental condition makes them difficult to care for at home. All the social factors mentioned above apply to these old people who are merely senile and who, if they cannot be cared for at home, should have special provision made for them. Granted they suffer in most cases from some defect in reasoning power. This, however, cannot be said to be due to mental illness; nevertheless a number of such old people find their way to mental hospitals where they occupy beds which should be used for other purposes.

These difficulties with accommodation looked at one stage like giving rise to an acute crisis in Barnsley. They were, in addition, aggravated by the fact that the mental hospital which, previous to 1948, served the County Borough was taken over by Leeds Regional Hospital Board, whilst all other local hospital services were provided by the Sheffield Board. However, by consultation with the Regional Psychiatrists of both Boards, these difficulties were ultimately overcome and arrangements were made which work in a highly satisfactory manner. It should be said here that sympathetic co-operation and understanding of this kind would be greatly welcomed in other parts of the National Health Service.

In the case of persons suffering from mental deficiency, a similar difficulty exists in obtaining institutional accommodation and for certain types of case this is even more acute than with mental illness.

Although the provision of institutional accommodation is the responsibility of the Regional Hospital Board, the shortage of it has had a direct effect on the development of the preventive Mental Health Services of the Local Health Authorities. The retention at home of cases which should be in institutions calls for increasing supervision and this supervision must necessarily be done by staff which should be otherwise engaged on more purely preventive work. In addition, the placing of a violent patient in an institution during a period of acute mental bed shortage can be a time-consuming occupation. It would seem, therefore, that provision of more accommodation for mental patients would be a first step towards developing the preventive Mental Health Service.

In addition to accommodation there is also a need for trained staff. Until the end of 1952 theS heffield Regional Hospital Board, owing to this need, had been unable to offer the Barnsley Health Authority the services of a Consultant Psychiatrist to lead a Mental Health Service team. It is essential that a Psychiatrist should be available as much mental disease can be prevented by early recognition of slight deviations from normality. It is particularly important that these should be recognised in the pre-school child and that steps should be taken to recognise the presence of these deviations and to eradicate their causes before the child enters school. To achieve this there must necessarily be a re-orientation in outlook on child guidance. The tendency to regard this entirely as an educational service is unfortunate as it results in its isolation from the Mental Health Service where it might well form the keystone of preventive mental medicine. This tendency would seem to have either arisen from or given rise to a confusion of thought as to what the words "Child Guidance" really mean.

Pleas for a closer relationship between the Child Guidance Centre operated in Barnsley by the Educational Psychologist on behalf of the Education Authority and the Mental Health Service have been made in those parts of the last three Annual Reports which are devoted to School Health. Unfortunately, owing to the difficulty experienced by the Regional Hospital Board in obtaining the services of a suitably experienced and qualified Psychiatrist, it has not been possible to effect this.

With a suitable child psychiatric clinic available it would be possible for the Mental Health Service to take, in suitable cases, advantage of the facilities offered by the Educational Psychologist. At the same time a properly organised system of exchange of information through the School Health Service would ensure that a medical psychiatricopinion of consultant status would be available where the suspicion of psychopathic personality arose in cases attending the Educational Psychologist.

With such an arrangement many cases of potential mental disease would be recognised before they develop and appropriate steps could be taken to eradicate their cause both by action in the home and in the school. This would call for the inclusion of a Psychiatric Social Worker in the Mental Health Service team. Such a Worker would be available to do the field work for the Psychiatrist and would act as a link between the ordinary social and educational services and the Mental Health Service. The suggestion received from the Sheffield Regional Hospital Board that the services of a Consultant Psychiatrist may be available in the none too distant future offers hope for an early realisation of a truly comprehensive Mental Health Service to operate on those lines.

Having thus reviewed the difficulties and problems which affect the Mental Health Service in Barnsley, it now remains to describe the existing arrangements in accordance with the requirements of the Minister's Circular No. 29/52 dated 19th August, 1952.

(1) Administration

(a) The duties of a Mental Health Sub-Committee are carried out by the Handicapped Persons' Sub-Committee of the Health Committee. This Sub-Committee, on which no co-opted members sit, contains 11 members, one of whom is a lady. The Sub-Committee meets monthly.

(b) Number and qualification of the staff :—

The Medical Officer of Health,

The Deputy Medical Officer of Health, the Senior Assistant Medical Officer of Health and one Assistant Medical Officer of Health are certifying officers for mental defect.

One Assistant Medical Officer of Health has had special experience in mental diseases.

The Authority employs three Duly Authorised Officers, one of whom is a State Registered Nurse and acts as Mental Health Visitor. The other two are male.

The Occupation Centre, which was supervised by the Duly Authorised Officers and was worked on a part-time basis until September 1951, was available for persons suffering from mental defect as a whole-time Centre (for those aged under 16) throughout 1952. The Supervisor is in possession of the Diploma qualification of the National Association for Mental Health, and one Assistant Supervisor also had this qualification. There are in addition three untrained Assistants. The internal administration of the Centre is carried out by the Supervisor under the direction of the Medical Officer of Health.

(c) A Consulting Psychiatrist employed by the Regional Hospital Board holds an out-patient clinic at the Beckett Hospital. One Assistant Medical Officer of Health and the Duly Authorised Officers attend with patients at this Psychiatric Clinic as occasion demands.

There are no officers jointly employed by the Local Authority and the Regional Hospital Board.

Supervision of patients on trial or on licence from mental hospitals or institutions is carried out when required by the Medical Officers of these institutions and by the Duly Authorised Officers.

(d) No duties are delegated to Voluntary Associations.

(e) The three Duly Authorised Officers have all within the last three years received a course of training in Mental Health—two at the Sheffield University and one at Manchester.

One Medical Officer completed a Course on the Ascertainment of Mentally Defective Children at London University.

(2) Work undertaken in the Community

(a) Under Section 28 of the National Health Service Act, 1946—Prevention of Illness, Care and After-care.

This was done by visitation by the Duly Authorised Officers and also by the Authority's Health Visitors and Social Workers. By this means it is possible to persuade patients to attend the Psychiatric Out-patients' Clinic held by the Regional Hospital Board. The Duly Authorised Officers usually go with them and ascertain the nature of the advice. In this way it is possible to ensure that adequate supervision and assistance is available in cases

where preventive measures are likely to be of value. One of the Authority's Assistant Medical Officers attended the Psychiatric Clinic to study problems relating to out-patients as a field worker in co-operation with the Consultant Psychiatrist.

(b) Under the Lunacy and Mental Treatment Acts, 1890-1930, by Duly Authorised Officers.

The number of cases dealt with and the numbers of patients in mental hospitals is shown in tabular form on page 60. In addition to the work involved in arranging admission to mental hospitals the Duly Authorised Officers made 115 visits to reported cases which were not removed to a mental hospital. They also made 211 visits to patients who had been discharged from mental hospitals.

ANALYSIS OF CASES INVESTIGATED AND DEALT WITH BY DULY AUTHORISED OFFICERS DURING 1952

	Males	Females	Total	Over 70 years of age	Death prior to further action	Discharges prior to further action	Certified under Section 16	Other Disposals	
								Section 1 Voluntary	Section 5 Temporary
(a) Lunacy Act, 1890. Order of Duly Authorised Officers (3 day order, Section 20)	9	6	15	—	—	1	12	2	—
Order of Judicial Authority (14 day order, Section 21)	—	—	—	—	—	—	—	—	—
Summary Reception Orders (Section 16) Direct to Mental Hospital	5	2	7	1	—	—	7	—	—
Transfers	—	1	1	1	—	—	1	—	—
	14	9	23	2	—	1	20	2	—
(b) Mental Treatment Act, 1930. Voluntary Cases—Section 1	11	7	18	—	—	—	—	18	—
Temporary Cases—Section 5	—	—	—	—	—	—	—	—	—
	11	7	18	—	—	—	—	18	—
Grand Total, Lunacy and Mental Treatment Acts	25	16	41	2	—	1	20	20	—

POSITION REGARDING PATIENTS IN MENTAL HOSPITALS.

NUMBERS OF PATIENTS IN MENTAL HOSPITALS ON THE 1ST JANUARY, 1952.

	Males	Females
Storthes Hall Hospital	88	71
Stanley Royd Hospital	2	7
Middlewood Hospital	1	2
Menston Hospital	2	1
	93	81

ADMISSIONS DURING THE 12 MONTHS ENDED 31ST DECEMBER, 1952.

	Males	Females
Storthes Hall Hospital	2	15
Stanley Royd Hospital	—	1
Middlewood Hospital	—	—
Menston Hospital	—	—
	24	16

DISCHARGES DURING THE 12 MONTHS ENDED THE 31ST DECEMBER, 1952.

	Males	Females
Storthes Hall Hospital	18	17
Stanley Royd Hospital	—	—
Middlewood Hospital	—	1
Menston Hospital	—	—
	18	18

DEATHS IN MENTAL HOSPITALS DURING THE 12 MONTHS ENDED THE 31ST DECEMBER, 1952.

	Males	Females
Storthes Hall Hospital	4	3
Stanley Royd Hospital	1	1
Middlewood Hospital	—	—
Menston Hospital	—	—
	5	4

NUMBER OF PATIENTS IN MENTAL HOSPITALS ON THE 1ST JANUARY, 1953.

	Males	Females
Storthes Hall Hospital	90	66
Stanley Royd Hospital	1	7
Middlewood Hospital	1	1
Menston Hospital	2	1
	94	75

Number of visits made to cases reported but not removed to a Mental Hospital	115
Number of visits made to patients discharged from Mental Hospitals	211

(c) Under the Mental Deficiency Act, 1913-1918.

(i) ASCERTAINMENT AND CERTIFICATION proceeded during the year as cases came to the notice of the Authority through the School Health Service and otherwise. Details are shown in tabular form on page 60.

(ii) GUARDIANSHIP AND SUPERVISION. There are no cases under guardianship in the County Borough.

The welfare of Mental Defectives on licence and those placed under statutory supervision is followed up by the Mental Health Visitor (female Duly Authorised Officer) and the two male Duly Authorised Officers. The three certifying Medical Officers on the Authority's staff dealt with such cases as were from time to time referred to them.

(iii) TRAINING—THE OCCUPATION CENTRE. The Authority maintains an Occupation Centre in Pitt Street. This Centre is open daily from 9-30 a.m. till 3-30 p.m. for children under 16 years of age. Arrangements have been made for the provision of dinners in exactly the same manner in which they are provided for children attending the Barnsley Education Authority's schools. In addition the children receive ⅓-pint of milk daily.

Arrangements exist for making the facilities of the Centre available on a part-time basis to defectives over 16 years of age on several afternoons a week.

The negotiations with the West Riding County Council mentioned in the Report for 1951 for the admission of defectives domiciled in that Authority's area were successfully concluded during 1952. It was agreed that ultimately 25 places would be provided for Defectives from the County Council's area, admissions in the first instance to be arranged in groups of six, the first six being admitted on 1st September, 1952. This has necessitated the appointment of an additional Assistant Supervisor in the Centre.

Sitting-case coaches belonging to the Ambulance Service bring defectives resident in outlying places in the Borough to the Centre each morning and take them home again in the afternoon. Defectives from the West Riding area reach the Centre under arrangements made by their own Health Authority.

	MALES		FEMALES		TOTAL	
	Under 16	Over 16	Under 16	Over 16	Under 16	Over 16
No. of defectives on register :						
BARNSLEY	14	8	7	15	21	23
W.R.C.C.	3	—	7	2	10	2

ATTENDANCE

Average full-time attendance of children :	
Boys under 16 years of age	10.89
Girls under 16 years of age	7.00
Girls over 16 years of age	2.49
Average part-time attendance :	
Boys over 16 years of age	6.74
Girls over 16 years of age	9.00

DINNERS

No. of defectives receiving and paying for dinners	36
,, ,, ,, free dinners	5
Total number having dinners	41
No. of dinners provided for defectives—paid	4,115
,, ,, ,, ,, ,, —free	685
,, ,, ,, ,, staff—paid	155
,, ,, ,, ,, ,, —free	244
Total number of dinners provided	5,199
,, ⅓-pint bottles of milk delivered for children	4,778

The Centre is fully equipped with modern furniture and desks as well as rest beds, blankets, crockery and other necessities. The premises themselves are satisfactory enough for their purpose but at present are becoming crowded. One room of the building is occupied by the Home Nursing Loan and Report Centre. If a new home could be found for this the additional space available for the Centre would be most welcome.

The daily programme includes habit training, sense training, physical training, speech training, handwork, music and movement, story-telling, training in simple domestic tasks and table manners. Provision is made for periods of free play as well as for rest and relaxation.

Progress in all subjects taught at the Centre continued to be satisfactory in 1952. Lack of concentration is the principal difficulty to be overcome in this work and emphasis is therefore placed on constructive rather than intellectual activities. Much is achieved in holding interest by constant repetition with some variety and this has become a feature of most of the lessons given at the Centre. Every effort is strained to teach each individual child every subject his or her intellect is capable of assimilating.

The handwork classes for older male and female defectives continued during 1952. £4 5s. 2d. was realised from the sale of handicraft products.

Social activities are also an important feature of the Centre. Those held in 1952 included an outing to Cleethorpes in July for 36 of those in attendance. An open day was arranged in November and this gave the parents and relatives an opportunity of seeing the work done. Finally a Christmas Party was arranged in December.

The children are medically examined by an Assistant Medical Officer of Health at frequent intervals.

Mental Deficiency Acts, 1913 to 1938

	Under age 16		Aged 16 and over	
1. *Particulars of cases reported during 1952.*	M.	F	M.	F.
(a) Cases at 31st December ascertained to be defectives "subject to be dealt with." Action taken on reports by—				
(i) Local Education Authorities on children				
(1) While at school or liable to attend school	2	2	—	—
(2) On leaving special schools	—	—	—	—
(3) On leaving ordinary schools	4	—	—	—
(ii) Police or by Courts	—	—	—	—
(iii) Other sources	—	1	—	—
(b) Cases reported but not regarded at 31st December as defectives "subject to be dealt with" on any ground	7	2	1	2
(c) Cases reported but not confirmed as defectives by 31st December and thus excluded from (a) or (b)	—	—	—	—
Total number of cases reported during the year	13	5	1	2
2. *Disposal of cases during the year.*				
(a) Of the cases ascertained to be defectives "subject to be dealt with,"				
(i) Placed under Statutory Supervision	6	3	—	—
(ii) Placed under Guardianship	—	—	—	—
(iii) Taken to "Places of Safety"	—	—	—	—
(iv) Admitted to Institutions	—	—	—	—
(b) Of the cases not ascertained to be defectives "subject to be dealt with,"				
(i) Placed under Voluntary Supervision	7	2	1	2
(ii) Action unnecessary	—	—	—	—
Total of Item 2	13	5	1	2

	Under age 16		Aged 16 and over	
3. *Total cases on Authority's registers as at 31st December, 1952.*	M.	F.	M.	F.
(a) Of the cases ascertained to be defectives "subject to be dealt with,"				
(i) Placed under Statutory Supervision	20	8	46	47
(ii) Placed under Guardianship	—	—	—	—
(iii) Taken to "Places of Safety"	—	—	—	—
(iv) Admitted to Institutions	5	4	31	37
(b) Of the cases not ascertained to be defectives "subject to be dealt with,"				
(i) Placed under Voluntary Supervision	32	15	25	23
(ii) Action unnecessary	—	—	—	—
Total of Item 3	57	27	102	107

4. *Classification of defectives in the community on 31st December, 1952.*

(a) Cases included in items 2 (a) (i) to (iii) above in need of institutional care:—				
(1) In urgent need of institutional care:				
(i) "cot and chair" cases	1	—	—	1
(ii) ambulant low grade cases	1	1	1	1
(iii) medium grade cases.....	—	—	3	1
(iv) high grade cases	1	—	—	—
(2) Not in urgent need of institutional care:				
(i) "cot and chair" cases	2	—	2	3
(ii) ambulant low grade cases	3	2	9	9
(iii) medium grade cases	6	1	10	14
(iv) high grade cases	6	4	21	18
Total of Item 4 (a)	20	8	46	47

	Under age 16		Aged 16 and over	
(b) Of the cases included in items 2 (a) (i) and (ii) and 2 (b) (i) above, number considered suitable for:	M.	F.	M.	F.
(i) occupation centre	15	9	12	15
(ii) industrial centre	—	—	4	5
(iii) home training	2	—	—	—
Total of Item 4 (b)	17	9	16	20
(c) Of the cases included in Item 4 (b), number receiving training on 31st December, 1952:				
(i) in occupation centre	13	7	8	15
(ii) in industrial centre	—	—	—	—
(iii) at home	—	—	—	—
Total of Item 4 (c)	13	7	8	15

5. Number of Mental Defectives who were in Institutions, under Community Care (including Voluntary Supervision) or in "Places of Safety" on 1st January, 1952, who have ceased to be under any of these forms of care during 1952:

	M.	F.	T.
(a) Ceased to be under care	6	6	12
(b) Died, removed from area, or lost sight of	5	10	15
Total	11	16	27

6. Of the total number of mental defectives under Supervision or Guardianship or no longer under care:

(a) Number who have given birth to children while unmarried during 1952		1
	M.	F.
(b) Number who have married during 1952	1	1

CARE OF THE DEAF

National Assistance Act, 1948, S.29.

The Barnsley and District Mission for the Deaf have for many years interested themselves in the welfare of the deaf. The Corporation has subscribed to the funds of the Mission and is represented on its Executive Committee. In addition to this the Medical Officer of Health, the Director of Education and the Director of Social Welfare are ex-officio members of the Committee.

The Corporation has also appointed an Advisory Committee for the Welfare of the Deaf which includes three representatives of the Mission.

The Mission is situated at St. Augustine's Hall, Racecommon Road. There is a Club for the deaf which meets during the week, and on Sundays a service is held and the premises are open for quiet recreation. Special facilities have been made available here for the hard-of-hearing as well as for the deaf.

The Mission employs a whole-time Missioner and has recently succeeded in making a new appointment. The Missioner acts as interpreter for deaf persons where this is necessary. He is also available to help them to deal with those problems of life rendered particularly difficult by their handicap.

The Barnsley Corporation is empowered by various statutes to contribute to a voluntary society promoting the care and welfare of the deaf. In this way the voluntary society to some extent becomes the agent of the Health Authority. Alternatively, power exists for the provision of all necessary welfare services for the deaf by the Corporation. So far this power has not been exercised.

The Mission caters for some 90 persons in the area covered by it and appears to do so efficiently.

WELFARE OF THE BLIND

National Assistance Act, 1948, S.29.

The Barnsley Corporation, in addition to providing Blind Welfare Services for the County Borough, also, by arrangement with the County Council for the West Riding of Yorkshire, provides these services for the surrounding districts of Cudworth, Royston, Staincross, Darton, Cawthorne, Dodworth, Silkstone, Stainborough, Worsborough, Chapeltown, Elsecar, Platts Common, Hoyland, Thurnscoe, Darfield and Wombwell. The Medical Officer of Health for the County Borough is the Superintendent of the Blind. The day-to-day work of the Blind Welfare Department is supervised by the Assistant Superintendent, Mr. A. Henshaw. A Workshops Supervisor and three Home Teachers (two of whom are themselves blind) are employed.

Blind Population

The number of blind persons under the care of the Department and a comparison with previous years is as follows:—

	1952	1951	1950	1949	1948
Barnsley County Borough cases	156	159	163	155	159
West Riding County Council cases	320	330	353	348	318

The number of cases in the Barnsley area continues at a fairly consistent figure. Over a period of 10 years there has been an average increase of one person per year. The number of cases in the West Riding shows marked fluctuations over the past 10 years. For a number of years applicants for registration in this area were examined largely in their own homes where the Surgeon had not the same facilities for carrying out the examination as are provided at a clinic or hospital, and the patient would receive the benefit of any doubts. However, during recent years, arrangements have been improved, and all applicants, with the exception of those confined to their homes through additional physical disabilities, are now examined either at hospital or the Surgeon's consulting rooms. Over a period of 10 years the register of blind persons in this area shows a decrease of 25 persons.

In the Barnsley area 18 new cases were registered as blind and two cases removed into the area during the year ending 31st December, 1952, 18 deaths occurred during the year amongst those previously registered, two persons were de-certified, and three persons removed out of the area, making a net decrease of three.

In that area of the West Riding subject to supervision by arrangement, 27 persons were registered as blind and six removed into the area, 34 deaths occurred, one person was de-certified and eight removed out of the area, making a net decrease for the year of 10.

Causes of Blindness—newly registered persons

	Barnsley	West Riding
Congenital and hereditary	—	3
Glaucoma	1	1
Cataract—primary	3	12
Infectious diseases	4	1
Trauma, non-industrial	—	1
General diseases	10	9
Total	18	27

It is pleasing to note in the causes of blindness that no new cases have arisen through retrolental fibroplasia among premature infants; the three cases of congenital diseases referred to above are adult persons.

Prevention of Blindness

It is important to note that since the Corporation prepared a scheme of Welfare Services under the Blind Persons Act, 1920, prevention of blindness has been a prominent and useful service. The number of registered blind persons would no doubt be greater than that shown at present but for this service. This feature has been further emphasised by a new scheme prepared under the National Assistance Act, 1948, and the Ministry of Health has from time to time circularised Local Authorities with regulations and advice for their guidance in dealing with this matter. One recent circular is concerned with the causes of eye defects, particularly those caused by retrolental fibroplasia, and also the follow-up action to be taken in cases where the Surgeon has recommended medical, surgical or optical treatment as a means of preserving sight or prevention of worsening vision. Arrangements are now made for such persons who are " substantially and permanently handicapped by defective vision " to be included on a

special register under the classification of "Register for Partially-sighted Persons," and also for them to be provided with the same welfare services which the Authority are empowered to provide for blind persons.

At the 31st December there were 34 persons on this register in the Barnsley area and 38 persons on the West Riding register. In addition the Department maintains a record of 77 persons in Barnsley and 125 in the West Riding with defective vision, but not sufficiently defective to be classified either as "blind" or "partially-sighted." These have been examined by an Ophthalmic Surgeon on one occasion or more and are kept in review for re-examination and when appropriate.

Out of the 18 cases registered "blind" in the Barnsley area, treatment and follow-up action was recommended in six of these, and out of eight cases registered as "partially-sighted" three were recommended for treatment by the examining Surgeon.

In the West Riding, out of 27 persons registered "blind," 13 persons were recommended for follow-up treatment. The treatment recommended —surgical—in four cases was however ultimately considered to be inadvisable on grounds of age and heart trouble. In addition one person refused to undergo surgical treatment, thus leaving eight cases to be followed up. 14 persons were registered "partially-sighted" and five of these are follow-up cases.

The Minister of Health has directed that Medical Officers of Health include information in relation to this subject in their Annual Reports for 1953. The Barnsley Corporation has long been aware of the value of this service and consequently has been keeping records for a number of years past. The information is therefore available and on this account the Minister's direction is anticipated by including it in the Report for 1952.

Follow-up of Registered Blind and Partially-sighted Persons

BARNSLEY AREA

	Causes of Disability				
	Cataract	Glaucoma	Retrolental Fibroplasia	Others	Totals
(i) Number of new cases registered which para. 7(c) of Form B.D.8 recommends:					
(a) No treatment	5	1	—	11	17
(b) Treatment, medical, surgical or optical.....	2	—	—	7	9
(ii) Number of cases at 1(b) above which on follow-up action have received treatment	2	—	—	6	8

(i) Number of new cases registered which para. 7(c) of Form B.D.8 recommends :					
(a) No treatment	8	1	—	19	28
(b) Treatment, medical, surgical or optical.....	5	1	—	7	13
(ii) Number of cases at 1(b) above which on follow-up action have received treatment	3	1	—	7	11

No new cases of Ophthalmia Neonatorum notifiable under the Public Health (Ophthalmia Neonatorum) Regulations, 1926-1937, have occurred during the year.

AGE GROUPS

	Barnsley		West Riding	
	M.	F.	M.	F.
Under 5 years	2	—	—	1
5–16 years	1	3	1	6
16–40 years	7	7	14	13
40–60 years	18	14	21	29
60–70 years	24	14	30	39
Over 70 years	32	34	71	95
Totals	84	72	137	183

CATEGORIES

	Barnsley		West Riding	
	M.	F.	M.	F.
Unemployable	65	59	108	164
Unemployed but employable	1	1	11	1
Employed	9	5	12	2
In Blind Homes	—	1	1	2
In training	—	—	1	—
In Welfare Institutions	3	3	1	6
In Mental Hospitals.....	3	—	2	1
In Schools for the Blind	1	1	—	4
Not at school	2	2	1	3
Totals	84	72	137	183

EMPLOYMENT

	Barnsley		West Riding	
	M.	F.	M.	F.
Hosiery knitwear	—	3	—	1
Newsvendor	1	—	1	—
Basket Maker	1	—	—	—
Commercial Traveller	—	—	1	—
Home Teachers	2	—	—	—
Switchboard Operator	—	—	1	—
Boot and Shoe Repairer	1	—	2	—
Typist	—	1	—	1
Piano Tuners	—	—	3	—
Factory Worker	2	—	3	—
Masseur	1	—	—	—
Shop Keeper	—	1	1	—
Share Broker	1	—	—	—
Totals	9	5	12	2
Employment 1951	8	4	11	2

Close co-operation is maintained with the Ministry of Labour and National Service in an endeavour to place suitable and employable blind persons in employment, and the above table shows a slight improvement on the previous year. The last table shows that only two cases are awaiting employment in the Barnsley area. One of these, a young woman, has some reasonable prospects of employment or training in the near future, but the male person is over 60 years of age and consequently in his case the prospects are not so hopeful. In the West Riding area there are 14 persons awaiting employment. A number of these are resident in country areas where the opportunities for suitable employment are extremely limited.

Some difficulties have been experienced during the year in disposing of saleable knitwear made in the Corporation's Workshop. Enquiries for goods are, however, improving and it is not unreasonable to expect that full employment will be maintained in the future. Apart altogether from financial consideration this is most important. From close contact with the Workshop it seems that a happy blind person is an "employed" blind person. The happy atmosphere in the Barnsley Workshops is a feature that cannot escape notice from all those who visit it.

The Barnsley Corporation has continuously shown an active interest in the rehabilitation and placement of blind persons in employment, and in addition to the provision of a workshop, two out of three Home Teachers to the Blind are registered blind persons.

Home Visiting and Teaching Services

Three trained Home Teachers are employed for the purpose of visiting blind persons in their homes, teaching Braille, organising social activities, arranging classes in pastime handicrafts and undertaking those other services which the blind are unable to do for themselves. Over 4,000 visits were made to individual homes and these visits have been very much appreciated, especially by those living alone.

Social activities

It will be appreciated that one of the problems associated with the loss of sight is the intolerable tedium of having "nothing to do" and therefore one of the essential features of Blind Welfare Service is the provision of arrangements to meet this need. For this purpose Social Clubs or Centres are provided at Barnsley, Wombwell, Hoyland and Thurnscoe. The women enjoy the cups of tea provided, handicrafts and social intercourse while domino and card playing are the games which appeal most to the men. There is little doubt that members of the blind community look forward enthusiastically to the sessions when they can match their skill against suitable "opponents."

When the weather permits, outings in the country are arranged. These usually consist of long walks over the moorlands and are followed by adequate refreshments.

A concert party is also organised amongst those with musical talent and many pleasant hours are spent in rehearsals and in entertaining other handicapped persons, particularly the old age pensioners at their "Darby and Joan" Clubs. This is done without charge as those concerned say, "We like to return something to somebody for the many kindnesses shown to us."

In conclusion the opportunity is taken to acknowledge the provision of free wireless sets by the British Wireless for the Blind Fund, also the services of the Barnsley and District Joint Blind Welfare Committee in meeting the cost of wireless repairs. Thanks are also due to the latter body for providing annual outings to the seaside and for the annual re-unions held at the Christmas season.

REMOVAL TO SUITABLE PREMISES OF PERSONS IN NEED OF CARE AND ATTENTION

National Assistance Act, 1948, S.47.

As in 1951, no formal action was taken under this Section. The Medical Officer of Health visited three old persons regarding whom from one source or another information had been received that proper care was not available at home. Persuasion and advice solved the problem in two of the cases. In another a frank discussion with the old person's relatives in which moral if not legal obligations were pointed out resulted in proper care being forthcoming from his own family.

As in 1951, General Practitioners from time to time enlisted the assistance of the Medical Officer of Health in finding accommodation for persons to whom this Section might have applied. In these cases, however, the persons concerned were willing to go to hospital but some difficulty had been experienced in obtaining beds for them. These cases were less frequent than in 1951, probably owing to additional accommodation being available in Lundwood Hospital. When they arose they were investigated and where there was evidence confirming the existence of a medico-social emergency the local representative of the Sheffield Regional Hospital Board was advised. As far as the year under report is concerned, no difficulty was experienced in placing any of these cases in hospital without unreasonable delay.

CARE OF OLD PEOPLE

National Assistance Act, 1948, S.21.
National Health Service Act, 1946, S.28.

The care of healthy old people in residential homes continues to be the responsibility of the Housing and Welfare Committee which administers these homes. The care of old persons in their own homes when sickness supervenes becomes a matter for the Local Health Authority. To deal with this situation close co-operation is maintained between the Health and Welfare Departments.

The care of the fit aged person presents little difficulty. Similarly hospital treatment for the aged person with an acute illness can usually be arranged. The difficulty arises where the old person is not fit to get around and at the same time cannot be said to be acutely ill. Such patients require nursing care and domestic help if kept at home, whilst if admitted to hospital they occupy and immobilise hospital beds for a very considerable period. This problem has been exhaustively examined by the Geriatric Advisory Committee of the Sheffield Regional Hospital Board and consultations have taken place between the Board's representatives and those of Local Authorities, the Executive Councils in the Region and also with the newly established Medical Co-ordinating Committees. The full results of these consultations were not available at the end of the year. It appears, however, that all these bodies are greatly concerned with this problem and that each is ready to do everything within its powers to find a solution to it. Unfortunately this may take some considerable time.

It is impossible for the Health Authority to regard the care of the aged as a separate commitment. It is rather part of the job of caring for the health of the family at home. Thus it is largely part and parcel of the Health Visiting Service, the Home Nursing Service and the Domestic Help Service. As regards the Prevention of Illness, Care and After-care, much of this Service is concerned with the aged, as will be appreciated by reference to the section of this report devoted to this subject. On this account much of the Social Worker's time is devoted to work done by her on behalf of the ageing portion of the population.

The Social Services make a fairly generous provision for this section of the community. It is not, however, always easy for them to claim the fullest advantage from everything that is available. It is in this direction that the Social Worker can afford great assistance. She knows what is available and cannot only pass this information on to her patients but can advise them of the best and most expeditious way of obtaining the provision made for them.

CHILDREN NEGLECTED OR ILL-TREATED IN THEIR OWN HOMES

In accordance with Circular 78/50 of the Ministry of Health, the Medical Officer of Health has been designated by the Corporation as the officer responsible for securing full co-operation amongst all the local services, statutory and voluntary, which are concerned with the welfare of children in their own homes. Contact has accordingly been made with all the agencies concerned and a system of notification of cases which appear to call for co-ordination of resources has been instituted. The Co-ordinating Officer now maintains a register of all cases investigated and calling for observation.

At first, regular monthly meetings were instituted to consider any cases specially referred and to discuss minor ones in which the various departments were concerned. This has, however, been discontinued in place of case conferences called to deal with serious cases as and when they arise. This arrangement is combined with a meeting at the end of the year to review the work done on less outstanding cases and it appears to be very satisfactory. In this way departments and agencies are free to get on with the problems involved in minor cases themselves and to obtain assistance from every possible source in cases of any special difficulty, whilst at the end of the year, by exchange of results in the minor cases, it is possible for the Co-ordinating Officer to obtain a clear overall picture of what has been happening in the County Borough and to draw up a list for future observation. In all this work the N.S.P.C.C. has proved to be most helpful and co-operative. The opportunity is taken here and now to record appreciation of the work done by the Local Inspector, Mr. W. A. Rawlings.

During 1952 six specially reported cases were investigated and were added to the Co-ordinating Officer's register.

MEDICAL EXAMINATIONS

In addition to the work done under the National Health Service, an important part of the duties of the Corporation's Medical Officers consists of carrying out medical examinations for various purposes. These fall at present into two categories—examinations carried out on behalf of the Children's Committee and those carried out to ascertain whether an applicant for some office under the Corporation is physically fit for that office or is in a suitable state of health to be admitted to a Superannuation Scheme.

The work on behalf of the Children's Committee involves the medical examination in their homes of boarded-out children, visits to the Children's Homes and medical examination of alleged child delinquents prior to their being brought before the Magistrates. These latter examinations are extremely important, particularly in view of the psychological background to many cases of delinquency; consequently they must consume a great deal of time if they are to be done in the detail necessary to make them of value.

Medical examinations of candidates for Corporation appointments also provide the Medical Officers with a considerable amount of work. It is, however, usually possible to fit these examinations in to the time-table without disturbing fixed clinic or school inspection appointments. It is from these medical examinations that an industrial medical service for the Corporation's employees might be developed.

Medical examinations were carried out during 1952 as follows:—

Child Delinquents	111
Boarded-out children (prior to boarding-out)	9
Superannuation	48
Retirements	24
Candidates for Training Colleges	22
Police Force	26
Fire Service	14
Total	254

Part IV

ENVIRONMENTAL HYGIENE

In recent years, particularly since 1948, there has been a very great deal of discussion on the subject of Health Services and a marked tendency has arisen to regard these as an entirely new feature of English National life. This is erroneous and results largely from the attention that certain personal forms of Health Service based on curative medicine have attracted to themselves. On no account should it be overlooked that these services are only made possible by the maintenance of a high standard of environmental hygiene.

It is therefore well to bear in mind that public services to preserve the health of the whole community came into being well over a century ago and that in the first instance these operated impersonally and almost entirely by improving the sanitary circumstances under which the people lived. This early approach to Public Health was met with a degree of success which surprised its instigators and during the latter part of the 19th century it developed very rapidly.

As a result of this success development turned, imperceptibly at first, towards the more personal aspects of the prevention of illness. It may therefore be said that the National Health Service of to-day is established on a foundation of Environmental Hygiene. Recognition of this fact is most important as neglect of the foundation could shake, if not endanger, the whole edifice. For example, Typhoid Fever is to-day a rare disease. This is due entirely to the activities of Sanitary Authorities in ensuring that food and water are free from infection by the causal organisms. Relaxation of these efforts would sooner or later result in a widespread outbreak of Typhoid. The hospitals, it is true, are now perhaps in a better position than ever before to cope with the situation which could arise from this; nevertheless there is little doubt that the explosive occurrence of a large number of cases of serious illness in any area would greatly tax the resources of curative medicine there and would almost certainly for a greater or lesser period cause some dislocation of the services available to the less acutely sick. That the hospitals are not frequently confronted with incidents of this kind is entirely due to the unremitting watchfulness of those engaged in the maintenance of environmental hygiene. Thus it has been possible for curative medicine to take for granted the success of their vigilance to the extent of planning future hospital development on the assumption that any failure on their part is not only unlikely but improbable. This carries with it a heavy responsibility.

For this reason the pages of this part of the report are worthy of consideration and attention. They tell by figure, by table and by sentence of systematic work done thoroughly and quietly away from the limelight of public approbation. It was this work which provided a sound foundation for the personal health services in Barnsley throughout 1952.

Reference has been made in previous Reports to the changing nature of the work of the Sanitary Department and how the Department is becoming more and more advisory in function rather than inspectorial. Mention has also been made of the shifting of the emphasis from drains and wells to care of food in the course of preparation. Proceedings for the abatement of statutory nuisances are becoming less frequent whilst those for the sale of food unfit for human consumption are becoming more so. These changes indicate an ever-increasing vigilance on the part of the Sanitary Authority and its officers in the preservation of environmental hygiene. An unfortunate but not altogether unexpected feature of this kind of vigilance is that the more successful it is the less attention it attracts. This in turn results in failure on the part of the community to appreciate its value. In such circumstances there is a real danger that this lack of appreciation may tend to limit co-operation with the service. On this account it is essential in each Annual Report on the health of Barnsley to emphasise and re-emphasise the important part played by the Environmental Health Service.

In last year's Report reference was made to the difficulty in giving in a report of this kind the account of the work of the Sanitary Department that it deserves and of presenting such an account in a readable form. This problem continues to exist and until there is a change in the statistical approach to this work it will not be possible to do full justice to the efforts of the Sanitary Authority. The story of the year's work is well set out in the material provided by the Senior Sanitary Inspector. This reveals an ever-widening field of activity, particularly in relation to food hygiene, whilst considerable attention is being paid to the improvement of the houses in which people are living. This at present raises many difficult and controversial points which are perhaps best summarised by the statement that the most important single health task before Local Authorities is the provision of houses, more houses and yet more houses. This should be coupled with a campaign of demolition of the many unhealthy hovels which only owe their continued existence to the occurrence of the Second World War.

Having thus considered the broader issues of environmental hygiene, attention may now be directed towards particular matters arising from the year's work.

Provision of new houses

(1) Number of houses built since re-building commenced at the end of the War :

(a) Privately owned	94
(b) Council	1872

(2) Number of houses built during 1952 :

(a) Privately owned	13
(b) Council	181

Four more private houses were built than in the previous year.

Water Supply

The following information is supplied in accordance with the requirements of Ministry of Health Circular letter No. 42/51.

(i) The water supply to the County Borough was entirely satisfactory throughout 1952 in both quality and quantity.

(ii) Bacteriological control is maintained of both the raw water and the treated water going into supply. The results of this control are as follows :—

	No. of Samples taken during year	No. of Samples showing positive presumptive B Coli Test	Highest Coli count during year
RAW WATER			
Midhope Reservoir	52	11	5
Ingbirchworth Reservoir	52	35	90
Royd Moor Reservoir	52	14	3
Hunshelf Bore Hole	31	3	9
Coffin Field Bore Hole	47	2	3
Green Lane Bore Hole	5	Nil	Nil
Coffin Field and Green Lane Bore Hole.....	15	Nil	Nil
TREATED WATER			
All sources	228	Nil	Nil

These results may be considered highly satisfactory.

Chemical analyses are frequently made on raw water from all sources and water going into supply at the Water Department Laboratory. Quarterly chemical analyses are carried out in addition by the Public Analyst. All results have been found to be satisfactory.

(iii) Lime is added to the water after filtration as a precaution against any possible plumbo solvency.

(iv) There has been no evidence of active contamination occurring during the year. Adequate precautions are taken during repairs to mains and for their sterilization. Special attention is given to air valves on trunk mains.

(v) There is no change in the position regarding the number of premises in the Borough without a piped water supply. Only one or two lack this commodity.

During 1952 rainfall was recorded as follows :—

Jordan Hill, Barnsley	Midhope Reservoir
19.93 inches.	40.76 inches.

Sewage Disposal Works

No alterations have been carried out at any of the Sewage Works during 1952.

Food and Food Poisoning

Details of inspection of premises concerned in the preparation and sale of food and of the various articles of food and drink themselves are contained in the pages that follow. Observation of the operation of the new Byelaws made under the Food and Drugs Act, 1938, S.15, continues but it still appears to be early to make comment on their effectiveness.

In Part II of this Report—the part devoted to epidemiology—the incidence of 13 cases of food poisoning in the County Borough during the year received detailed attention. Mention was made there of the problems involved in dealing with mild cases of food poisoning due to organisms of the Salmonella group in view of the recent prevalance in the Borough of dysentery caused by organisms of the Shigella sonnei group. Attention was drawn to this latter condition which is also a food-borne disease and reference was made to the investigation commenced during 1952 into all reported cases of Diarrhœa occurring in Barnsley.

Further on in this part of the report a record will be found of the foodstuffs investigated and the other steps taken to obtain bacteriological evidence of the source of infection in certain cases. No positive finding was, however, obtained, thus confirming the view that much further work remains to be done on diarrhœal diseases in Barnsley, and stressing the very great importance of food hygiene not only in the shop but also in the home.

SANITARY INSPECTION OF THE AREA

In accordance with the Sanitary Officers' (Outside London) Regulations, 1935, Article 27(18) (S.R. & O. 1935, No. 1110), the following tables and information have been submitted by the Senior Sanitary Inspector.

TABLE 1
INSPECTION WORK

Total number of Inspections made	8,649
Total number of Re-inspections made	6,338
Total number of Defects found	4,576
Total number of Defects remedied	4,442
Total number of Informal Notices served	1,175
Total number of Formal Notices served	301
Total number of Informal Notices complied with	1,004
Total number of Formal Notices complied with	277

TABLE 2
SUMMARY OF INSPECTIONS MADE

Date from : 1st January, 1952. Date to : 31st December, 1952.

	Inspections	Re-Inspections
Dwellinghouses:		
No. Inspected.		
Re Infectious Disease	2	—
Re Filthy Condition	12	8
Re Verminous Condition	162	118
Re other conditions	2,952	5,693
Houses-let-in-Lodgings	32	8
Common Lodging Houses	28	20
Tents, Vans and Sheds	352	1
No. of Drains Tested	211	87
Inspection of:		
Dairy	123	—
Ice Cream Premises	469	3

	Inspections	Re-Inspections
Slaughterhouse	175	—
Knackers Yard	54	2
Food Preparing Premises	611	20
Hotels and Public Houses	64	2
Markets	475	—
Food Shops	699	65
Pet Animals Shops	18	—
Factories with power	346	63
Factories without power	34	9
Workplaces	12	2
Outworkers' Premises	7	4
Bakehouses	116	10
Hawkers' Premises	262	—
Hairdressers' Premises	132	17
Shops—re sanitary conditions	58	27
Cinemas and Theatres	59	10
Premises re rats	73	26
Offensive Trades	43	2
Smoke Observations made	132	—
Smoke Visits to plant	19	3
Other premises—visits and interviews	1,015	133
TOTAL NO. OF DEFECTS FOUND	4,198	378
TOTAL NO. OF HOUSES AFFECTED	2,216	139
TOTAL NO. OF OTHER PREMISES AFFECTED	279	10

TABLE 3

Date from : 1st January, 1952. Date to : 31st December, 1952.

SUMMARY OF NUISANCES ABATED AND IMPROVEMENTS EFFECTED

Dwellinghouses

Internal.

Floors repaired or renewed	81
Walls repaired or renewed	281
Ceilings repaired or renewed	170
Fireplaces repaired or renewed	196
Flues repaired or renewed	30
Windows repaired or renewed	222
Doors repaired or renewed	81
Staircases repaired or renewed	14
Sinks repaired or renewed	105
Waste Pipes repaired or renewed	77
Coppers repaired or renewed	14
Foodstores provided or improved	6
Coal Stores provided or improved	27
Cleansed or limewashed	6
Freed from vermin	13
Damp conditions abated	255

External.

Roofs repaired	201
Eaves spouts repaired or provided	158

Eaves spouts cleansed	19
Downspouts repaired or provided	84
Downspouts disconnected from drain	7
Downspouts cleansed	6
Walls repaired or repointed	246
Chimney stacks repaired or repointed	42
Doors repaired or renewed	44
Steps repaired or renewed	8
Yard paved	1
Yard paving repaired	18
Yard cleansed	1

Common Lodging Houses

Nuisances abated	10
Limewashed	3
Closed	2

Tents, Vans, Sheds

Removed	1
Sites licensed	7
Dwellings licensed	12

Drains

Cleansed	253
Repaired	87
Reconstructed	45
New provided	24
Disconnected from sewer	2
Self-cleansing gullies provided	53

Inspection Chambers

Built	24
Repaired or improved	18

Cesspools

Abolished	1

Water Closets

Provided for houses—additional	13
Provided in substitution of privies	5
Provided in substitution of pail closets	5
Provided in substitution of waste water closets	19
Limewashed and cleansed	3
Structure repaired or improved	81
Fittings repaired or improved	124

Waste Water Closets

Abolished	2
Repaired	63
Cleansed or limewashed	3
Converted to water closets	19

Midden Privies

Converted to water closets	5

Pail Closets

Converted to water closets	5
New pails provided	11

Ashpits

Repaired	12
Abolished (dry)	1
Abolished (wet)	2

Ashbins

Provided in substitution of ashpits	3
Renewed for houses	798
Renewed for other premises	17
Shelters repaired	6

Bakehouses

Cleansed or limewashed	13
Premises improved	9

Hairdressers Premises

Premises improved	2

Hawkers Premises

Premises improved	11

Dairies

Cleansed or limewashed	5

Ice Cream Premises

Cleansed and limewashed	19
Premises improved	3

Slaughterhouse or Knackers Yard

Cleansed and limewashed	3
Premises improved	2

Offensive Trades

Premises cleansed and limewashed	10
Premises improved	4

Food Preparing Premises

Cleansed and limewashed	44
Premises improved	43
Discontinued	4

Smoke Observations

Nuisance from burning spoilbanks	1

Offensive Accumulations

Removed	6

Rat Infested Premises

Premises rat proofed	1

Shops-Re Shops Act

Suitable and sufficient sanitary convenience provided	2
Suitable and sufficient washing facilities provided	7

Factories

Cleansed and limewashed	1
Overcrowding abated	1

Sanitary Conveniences

Cleansed and limewashed	21
Additional provided	10
Intervening ventilated space provided	2
Separate accommodation for sexes	2

Screened	1
Notice of indication provided	12
Artificial light provided	4
Doors and fastenings repaired or renewed	12
Fittings repaired or renewed	15
Cinemas and Theatres	
Defects remedied	39
Stable Premises	
Cleansed or limewashed	1
Drains cleansed	1
Manure pits covered	2
Other Premises	
Nuisances abated	34
TOTAL DEFECTS REMEDIED	4,442
TOTAL HOUSES AFFECTED	2,511
TOTAL OTHER PREMISES AFFECTED	248

Common Lodging Houses

During the year the number of registered Common Lodging Houses was reduced from three to one. This step had been under consideration for some time as two of the premises situated in Doncaster Road were considered to be totally unsuitable for use as lodging houses; finally it was decided to recommend that future registration should be refused and to this recommendation the Sanitary Committee agreed.

At the end of the year these two lodging houses were empty and were in process of demolition; when this is completed not only will a sanitary improvement have been effected but if the owner of the land is allowed to develop it as he desires, a definite improvement will take place on one of the main roads into and out of the town.

The one remaining lodging house is 24a Doncaster Road, which has accommodation for 117 lodgers.

Tents, Vans, and Sheds

The same seven sites and 12 caravans were licensed as in previous years. One new application for a licence was received in respect of one caravan but was refused.

Reference was made in the Report for 1951 to proposed improvements at the Council's Caravan Site in Grange Lane, Stairfoot, and these improvements, consisting of another water supply pipe, two blocks of pail closets and an ashpit, were completed during 1952. Unfortunately, many of the temporary residents on the site do not appreciate the need for cleanliness and do not respond to requests to improve their habits, it seems therefore that the only course to effect better conditions on the site is to prohibit the 'pulling on' of travelling caravans, many of which are horse drawn. Loose horses from the site have been a source of great annoyance to neighbouring farmers whose crops have been damaged by the animals which are often turned out at night to find their own food.

Factories

Table IV below gives the details of factory inspections as required by the Ministry of Labour and National Service. The number of inspections of factories has increased by nearly 200, otherwise there is nothing in the table calling for comment.

TABLE IV

FACTORIES ACTS, 1937 and 1948.

Part 1 of the Act.

1. INSPECTIONS for purposes of provisions as to health.

Premises	No. on Register	Number of		
		Inspections	Written Notices	Occupiers Prosecuted
(1) Factories in which Sections 1, 2, 3, 4 & 6. are to be enforced by Local Authorities	50	68	1	—
(ii) Factories not included in (i) in which Section 7 is enforced by the Local Authority	269	535	20	—
(iii) Other Premises in which Section 7 is enforced by the Local Authority (excluding out-workers premises) ...	—	—	—	—
Total ...	319	603	21	—

2. CASES IN WHICH DEFECTS WERE FOUND.

Particulars	Number of cases in which defects were found				No. of cases prosecuted
	Found	Remed.	Referrred To H.M.I.	By H.M.I.	
Want of Cleanliness ...	1	1	—	—	—
Overcrowding ...	—	1	—	—	—
Unreasonable temperature	—	—	—	—	—
Inadequate ventilation. ...	—	—	—	—	—
Ineffective drainage of floors	—	—	—	—	—
Sanitary Conveniences. ...					
(a) Insufficient	8	7	—	1	—
(b) Unsuitable or defective	39	29	—	3	—
(c) Not separate for sexes ...	2	2	—	—	—
Other Offences	—	—	—	—	—
Total ...	50	40	—	4	—

Cinemas and Theatres

An increased number of visits has been made with a correspondingly greater number of defects found and remedied. The 39 defects remedied consist of water closet and urinal compartments cleansed, flushing cisterns repaired, new bolts provided on the inside of doors, pedestal seats repaired or renewed, and electric light fittings renewed. Unfortunately, the need for these repairs is due in many instances to the rough treatment which the sanitary conveniences receive from the public, and is a matter difficult to control.

Offensive Trades

The Offensive Trades in operation during 1952 consisted of five Tripe Boilers, one Fellmonger, one Rag and Bone Dealer, one Bone Boiler and Fat Extractor.

The Bone Boiling and Fat Extracting which forms part of the operations carried on at the Knackers Yard, Old Mill, was again responsible for creating a nuisance by the emission of objectionable odours. Reference was made in the 1951 Report to the insufficiency of the water supply to the condenser, this insufficiency was remedied during 1952 by the installation of a pump to draw water from the adjoining river from which it is possible to take all the water required to ensure proper condensing of the vapour given off from the digestors. It is essential, however, if complaints are to be eliminated, that the machines should be operated at all times by a competent staff and that the owners of the business should constantly exercise strict supervision of the various processes.

Atmospheric Pollution and Smoke Abatement

The abatement of atmospheric pollution does not progress as speedily as desired and although contraventions of the Council's Byelaws have not markedly increased, there is still far too much smoke emitted from factory chimneys. The sooner owners of factory premises realise that by emitting smoke they are wasting money and coal, the sooner positive action will be taken to eliminate smoke; it must, however, be admitted that factory owners are not entirely free agents in the choice of the coal they use or the source from which it is obtained and, as is well known, the type of coal in use has a distinct bearing on the amount of smoke leaving the chimney top.

The problem of eliminating smoke from domestic chimneys, is a rather more difficult matter. The old fashioned open range is wasteful of coal and energy besides being a great smoke producer. The remedy seems to be the installation, wherever possible, of a firegrate specially designed to burn smokeless fuel, but in a mining district like Barnsley where a large percentage of householders receive 'home coal' other factors besides smoke prevention have to be taken into consideration and these factors are not capable of being easily resolved.

The sulphur dioxide recording stations at Kendray Hospital, Mount Vernon Sanitorium and the Abattoir, continued to function during the year, comparative figures are given below.

Average daily figure in milligrams of sulphur dioxide per 100 square centimetres.

	1952	1951	1950
Kendray Hospital	2.179	2.0515	2.3948
Mount Vernon Sanatorium	1.682	1.5805	1.9848
Abattoir	2.180	1.8590	2.4640

The Council were again represented on the Executive Committee of the West Riding of Yorkshire Regional Smoke Abatement Committee, by the Senior Sanitary Inspector.

Hairdressers and Barbers

On the 1st January, 1952, the Council's Byelaws, made under Section 44 of the Barnsley Corporation Act, 1949, became operative and every person carrying on the trade of Hairdresser or Barber within the Borough was required to comply with the Byelaws.

71 applications for registration were dealt with and 149 visits were made to Hairdressers' and Barbers' Premises. In the main the standard of cleanliness was satisfactory and the impression received by the inspecting officers was that the persons concerned realise the need for a high standard of hygiene in the carrying on of their business.

Disinfestation

During the year 53 Council houses and 14 privately owned houses were sprayed with liquid insecticide to eradicate bugs. In addition furniture and bedding was removed for treatment from 15 houses known to be bug infested, prior to being taken into new Council houses; the furniture was treated with Hydrogen Cyanide Gas and the bedding put through the steam disinfector.

An unusual type of infestation, at least unusual in Barnsley, was revealed when the complaint of the tenants in new Council houses in Hardwick Crescent was investigated. The complaint was regarding numbers of tiny reddish coloured insects which were particularly infesting the bottom of the windows and the front entrance doorway on the ground floor. These insects were identified as the Clover Mite (Bryobia prætiosa) which affects fruit trees, clover and annual plants; it seems therefore, that the infestation may have originated in the clover and other herbage which covered the ground when it was agricultural land before the houses were built. Spraying with Kerosene was carried out but it remains to be seen whether or not this was entirely successful, and if the mite will appear again during 1953.

Disinfection

The following premises were sprayed with formalin :—

750 Rooms in 360 Dwellinghouses
4 Hospital Wards
2 Rooms in one Children's Home
1 Common Lodging House.

In addition 1,028 articles of bedding and clothing were treated in the steam disinfector.

Most of this work was done in connection with cases of infectious disease.

Rodent Control

Two rodent operators are employed, who carried out a baiting and poisoning programme in 1,261 sewer manholes and who also dealt with rat or mouse infestation in 271 buildings.

A copy of the annual report, on the prescribed form, as submitted to the Ministry of Agriculture and Fisheries is given below. It will be noted that 181 dwellinghouses were found to be infested with rats, in many instances rats are attracted to a house and its vicinity by the practice of

putting out bread for the birds or by throwing waste food into an open dry ashpit. However desirable the former practice may be, there can be nothing but objection to the latter on other hygienic grounds besides rodent control—waste food should be burnt.

TABLE V

PREVENTION OF DAMAGE BY PESTS ACT, 1949
REPORT FOR YEAR ENDED 31st DECEMBER, 1952

	Type of Property				
	Local Authority (1)	Dwelling Houses (2)	Agricultural (3)	All other (including business) premises (4)	Total (5)
Total number of properties in Local Authority's District	65	20,829	31	2,628	23,553
No. of properties inspected by the Local Authority during 1952 as a result of (a) notification	(a) 10	226	3	26	265
(b) survey or otherwise	(b) 5			1	6
No. of properties inspected which were found to be infested by rats	Major 1			2	3
	Minor 10	181	3	16	210
No. of properties inspected which were found to be seriously infested by mice				1	1
No of infested properties treated by local authority	15	226	3	27	271
No. of notices served under Section 4 : (1) Treatment				1	1
(2) Structural Works (i.e. proofing)					
No. of cases in which default action was taken by the Local Authority following the issue of a notice under Section 4					
Legal Proceedings					
Number of " block " control schemes carried out	1				

Swimming Baths

26 samples of water from swimming baths were taken for examination to determine the amount of chlorine they contained and the presence of objectionable organisms. 16 samples were from the Public Baths, Race Street

—three were unsatisfactory as they had a relatively high B.Coli content, the remaining 10 samples were taken at Raley School Baths and of this number three contained a small number of the organism B.Coli.

Rag Flock and Other Filling Materials

At the end of the year two firms were registered under the provisions of Section 2 of the Rag Flock and Other Filling Materials Act, 1951.

Samples of the following filling materials were taken and submitted to the prescribed analyst, all were found to be satisfactory.

Woollen Flock	1
Cotton Felt	2
Down	1
Cotton Millpuffs	1
Hair	1
Willowed Fibre	1

Fertilisers and Feeding Stuffs

The following samples of fertilisers and feeding stuffs were obtained and submitted to the Agricultural Analyst.

Fertilisers.

1 Sample of Hoof and Horn Meal
2 Samples of Steamed Bone Meal
1 Sample of Nitrate of Soda
2 Samples of Growmore Fertiliser
2 Samples of Sulphate of Ammonia

8 Samples all satisfactory.

Feeding Stuffs.

3 Samples of Poultry Balancer Meal—2 were slightly deficient in oil
7 Samples of Pig Meal—2 were slightly deficient in oil
1 Sample of Dried Meat Meal for Poultry—No Statutory Statement available
1 Sample of Laying Pellets with Cod Liver Oil

12

Appropriate action was taken in each of the unsatisfactory samples.

The Exchange of Toys for Rags

Only one instance was found where toys were being exchanged for rags contrary to Section 154 of the Public Health Act, 1936. The person concerned was brought before the magistrates and was fined 10/-.

Pet Animals Act 1951

This Act came into operation on the 1st April, 1952, and is for the purpose of regulating the sale of pet animals. Briefly, it requires the licensing, and authorises the inspection of pet shops, it prohibits the selling of pets in streets (except at a stall or barrow in a market) or to children under 12 years of age. At the end of the year eight premises had been

licensed, this figure includes a number of stalls in the Market. The conditions attached to each licence are as follows:—

1. No animal shall be displayed in a cage, hutch, box or other receptacle in such position as to expose it to interference or annoyance by persons or animals.
2. Animals shall at all times be kept in accommodation suitable as respects size, temperature, lighting, ventilation and cleanliness.
3. Animals shall be adequately supplied with suitable food and drink and (so far as necessary) visited at suitable intervals.
4. No animal which is suffering from or could reasonably be suspected of having come into contact with any other animals suffering from any infectious disease shall be brought or kept on the premises, unless it is properly isolated from the other animals therein.
5. Animals shall not be handed to customers in unsuitable containers.
6. No mammal shall be sold unweaned, or if weaned, at an age at which it should not have been weaned.
7. Where animals are kept in cages, hutches, boxes or other receptacles placed on top of other cages, hutches, boxes or other receptacles, effective means shall be provided for preventing water, food or other droppings falling on to or contaminating the animals or other surroundings which are underneath.

In addition where the premises concerned is a shop, further conditions are imposed after consultation with the Chief Fire Officer; generally these are (1) the provision of at least one two-gallon soda-acid fire extinguisher, (2) the provision of a small automatic fire alarm system with a suitable alarm gong outside the premises, (3) the displaying of a notice inside the shop door giving the location of the nearest available key for the premises, the position of the nearest available telephone and the method to be adopted in calling the Fire Brigade from that telephone, (4) in certain cases requiring the electrical installation and wiring to be examined and reported upon by a competent electrical engineer.

Housing

The urgent problem of dealing with houses which were condemned as unfit for human habitation prior to 1939, and which are still occupied, has again been under consideration and with the co-operation of the Housing and Welfare Services Committee, who rehoused the tenants, it has been possible to demolish 36 houses and to close one—details are as follows.

Clearance Area No. 51.	
19a, 21, Copper Street.....	2 houses demolished
Clearance Area No. 61.	
1, 3, 5 & 7 Court 8, Dodworth Road	4 houses demolished
Clearance Area No. 67.	
3 & 5, Prospect Street, and 1 & 2 Court 1, Prospect Street.....	4 houses demolished
Clearance Area No. 72.	
1, 3, 5, 7, 2, 4, 6, 8, Slackhills	8 houses demolished

INDIVIDUAL HOUSES.

1, Wood View, Smithies	1 house demolished
57, Shambles Street	1 house closed

HOUSES DEMOLISHED BY AGREEMENT WITH OWNERS.

11, Wilson Street	1 house demolished
22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, Days Croft, Monk Bretton	16 houses demolished

The demolition of unfit houses and the repair and re-conditioning of other houses is a matter of vital importance; unfortunately, the matter is overshadowed by the need to build new houses, with the result that unfit houses continue to be occupied and houses which, with normal repair and maintenance, would provide satisfactory accommodation for many years, are falling into a state of disrepair which will, if not checked, eventually lead to demolition as being the only way to deal with them. The high cost of labour and materials acts as a deterrent to property owners doing any but absolutely necessary repairs and great difficulty has been experienced in getting work done, so much so that in two instances proceedings before the Magistrates had to be commenced to enforce the requirements of Statutory Notices.

CASE A.

Non-compliance with notices served under the Public Health Act, 1936. (a) Section 39 to repair sink drain. (b) Section 93 to repair fireplace which was causing smoke to enter the living-room.	The work was done before the date of hearing and the case was therefore withdrawn on payment of costs.

CASE B.

Non-compliance with notice served under Section 93 of the Public Health Act, 1936, to repair roof of bay window.	The work was done before the date of hearing and the case was therefore withdrawn on payment of costs.

Hotels, Inns and Public Houses

A survey was commenced of the sanitary accommodation at all the licensed premises within the Borough as it was considered that the accommodation at many premises was not up to the standard of modern requirements. 66 visits were made during the survey which was not completed at the end of the year.

Inspection and Supervision of Food

The important matter of improving the standard of hygiene in the handling of foodstuffs has made some progress but has been retarded by the retirement in October 1952 of one Sanitary Inspector whom it has not been possible to replace despite repeated advertisement for a successor, consequently it has been necessary for the Sanitary Inspector specialising in

food hygiene to devote some part of his time to the work of the district without an Inspector.

There have been three prosecutions for the sale of articles of food which were considered to be unfit for human consumption.

CASE A.
Sale of teacake containing string — Vendor fined £5 and costs.

CASE B.
Sale of bread containing metal — Vendor fined £20 and costs.

CASE C.
Sale of chocolate eclair containing nail .... — Vendor fined £5 and costs.

At this point it is necessary to record the concern which has been expressed by members of the food trades, and which is shared by the Council's Officers, at the number and variety of metal objects and other 'foreign' articles which are found in dried fruit imported by the Ministry of Food. Should these nails, pieces of wire, stones, buttons, etc., be missed in the washing and screening process to which it is essential the dried fruit should be subjected, and by some mischance get into an article of food then the vendor is liable to prosecution. The attention of the Ministry has been drawn to this matter and it is admitted that an improvement in the standard of dried fruit is desirable and that steps are being taken to bring this about. It is to be hoped that these efforts will soon be successful.

The registration of hawkers and the premises where their foodstuffs are stored, as required by Section 47 of the Barnsley Corporation Act, 1949, has been proceeded with and at the end of the year 45 premises had been registered involving 262 inspections. When the original survey of the premises was made, it was apparent that a standard was necessary to apply as a yardstick when judging the varying types of premises put forward for registration, the details of this standard are as follows:—

No fish or rabbits to be stored in premises used for the storage of vegetables unless stored in such a manner as to prevent risk of contamination.

No food of any kind to be stored in a building or part of a building which is used as a garage, stable, or for the housing of any animal or birds, or in any part of a dwellinghouse.

WALLS.
To be of such material as to allow of easy cleansing and to be kept at all times in a good state of repair.

FLOOR.
To be of impervious material and so sloped as to drain to a properly trapped self cleansing gully outside the building, such gully to be properly connected to the drainage system.

CEILINGS.
To be underdrawn with approved durable material.

WOODWORK.
The woodwork of windows, doors, etc., to be kept in a good state of repair.

VENTILATION.

Permanent means of ventilation to be provided.

YARD.

The yard surface to be paved with a suitable impervious material and to be effectually drained to the satisfaction of the Senior Sanitary Inspector.

The premises to be adequately proofed against rats and birds.

Where the premises are situated near to stables or buildings used for the housing of animals and birds, such stables or buildings, being in the same occupancy as the premises where food is stored, shall be provided with a properly constructed manure pit fitted with a cover, and all necessary steps shall be taken to prevent the breeding of flies in such manure pit.

REFUSE RECEPTACLES.

A sufficient number of portable refuse receptacles of non-absorbent material with tightly fitting lids, to be provided for the reception of waste arising from the storage of food on the premises.

Many visits have been made to cafés, restaurants and other places where food is prepared and generally the standard of cleanliness was satisfactory, the finer points of hygiene, such as washing hands after using the closets, or not licking finger or thumb to assist in picking up wrapping paper, are matters for the individual food handler to remember, and it is only by that person's realisation of the danger to health which may result from the non-observance of cleanly practices that they will be remedied.

Milk Supply

Licenses issued under Milk and Dairies Regulations, 1949; Milk (Special Designations) (Raw Milk) Regulations, 1949; and Milk (Special Designations) (Pasteurised and Sterilised Milk) Regulations, 1949:—

20 Distributors of Milk } making a total of 98 on register after allowing for cancellations due to cessation of business.

1 Dealers (Pasteurisers) Licence.

9 Dealers Licences to use designation "Pasteurised".

1 Supplementary Licence to use designation "Pasteurised".

6 Dealers Licences to use designation "Tuberculin Tested".

88 Dealers Licences to use designation "Sterilised".

1 Supplementary Licence to use designation "Sterilised".

BACTERIOLOGICAL EXAMINATION OF MILK.

Methylene Blue Test.

126	samples of Tuberculin Tested Milk	112 satisfactory
		14 unsatisfactory
26	samples of Pasteurised Milk	26 satisfactory
3	samples of Tuberculin Tested Pasteurised Milk	3 satisfactory

Phosphatase Test.

26 samples of Pasteurised Milk	25	satisfactory
	1	unsatisfactory
4 samples of Tuberculin Tested Pasteurised Milk	4	satisfactory

Turbidity Test.

21 samples of Sterilised Milk	21	satisfactory

Examination for the presence of T.B.

36 samples of Raw Milk	32	Negative
	4	Positive

The four samples showing the presence of tubercle bacilli were dealt with by the Medical Officer of Health serving notice on the producers prohibiting the sale of raw milk from their herds and directing the milk to be pasteurised. These notices remained in force until such time as the Medical Officer was satisfied that no further danger to health would arise by consuming the milk in its raw state, when they were withdrawn.

Ice Cream

The number of premises registered for the manufacture, storage or sale of ice cream at the end of the year was 175, of this number 25 were first registered during the year 1952.

The Methylene Blue Test was applied to 122 samples with the following result.

90	were	placed in	Grade 1
19	were	placed in	Grade 2
9	were	placed in	Grade 3
4	were	placed in	Grade 4
122			

The 13 samples in Grades 3 and 4 were regarded as unsatisfactory samples, the producers were informed and, where required, advice was given regarding the steps to be taken to prevent unsatisfactory samples in the future.

The chemical standard for ice cream which was in operation at the beginning of 1952, was altered in July, the minimum fat content being reduced from 5% to 4%, and the minimum percentage of milk solids other than fat being reduced from 7½% to 5%, the percentage of sugar remained the same, 10%.

41 samples of ice cream were taken for chemical analysis.

No. of samples with a fat percentage above						3	and	below	4		1
,,	,,	,,	,,	,,	,,	4	,,	,,	5		1
,,	,,	,,	,,	,,	,,	5	,,	,,	6		1
,,	,,	,,	,,	,,	,,	6	,,	,,	7		2
,,	,,	,,	,,	,,	,,	7	,,	,,	8		3
,,	,,	,,	,,	,,	,,	8	,,	,,	9		3
,,	,,	,,	,,	,,	,,	9	,,	,,	10		10
,,	,,	,,	,,	,,	,,	10	,,	,,	11		10
,,	,,	,,	,,	,,	,,	11	,,	,,	12		2
,,	,,	,,	,,	,,	,,	12	,,	,,	13		4
,,	,,	,,	,,	,,	,,	13	,,	,,	14		2
,,	,,	,,	,,	,,	,,	14	,,	,,	15		1
,,	,,	,,	,,	,,	,,	21	,,	,,	22		1
											41

Meat and Other Foods

As in previous years the Public Abattoir continued to be used as a Government Slaughterhouse whilst one privately owned slaughterhouse was licensed for the slaughter of horses for human consumption, the licence for one Knackers Yard was also renewed.

There has been an increase of more than 7,200 in the number of animals slaughtered and inspected at the Public Abattoir and on cottagers' premises, the details of the animals slaughtered and inspected are as follows:—

Beasts	7,232
Sheep	26,160
Calves	2,101
Pigs	5,877
Cottagers' Pigs	32
	41,402

FRESH MEAT CONDEMNED DURING THE YEAR

Beef	63,815 lbs.	Beef Offal	142,612 lbs.
Mutton	1,441 lbs.	Mutton Offal	3,539 lbs.
Veal	1,619 lbs.	Veal Offal	456 lbs.
Pork	13,585 lbs.	Pork Offal	4,305 lbs.

TABLE VI

CARCASES AND ALL ORGANS CONDEMNED AS TOTALLY UNFIT FOR HUMAN CONSUMPTION.

Animal	Tuber-culosis	Accident	Inflamm-atory Diseases	Parasitic Diseases	Other Bacterial Diseases
Bulls ...	1	—	—	—	—
Bullocks ...	6	—	2	—	—
Heifers ...	23	—	—	—	—
Cows ...	61	—	8	—	2
Calves ...	6	6	19	—	10
Sheep ...	—	2	26	—	2
Pigs ...	14	10	7	—	8

TABLE VII

CARCASES PARTIALLY CONDEMNED AS UNFIT FOR HUMAN CONSUMPTION.

Animal	Tuber-culosis	Accident	Inflamm-atory Diseases	Parasitic Diseases	Other Bacterial Diseases
Bullocks ...	15	—	—	—	1
Heifers ...	16	—	—	—	1
Cows ...	34	3	—	—	1
Sheep ...	.....	1	1	—	—
Pigs ...	5	2	—	—	1

TABLE VIII

VARIOUS ORGANS CONDEMNED AS UNFIT FOR HUMAN CONSUMPTION.

	Heads	Tongues	Lungs	Livers	Stomachs	Kidneys	Hearts	Spleens	Udders	Mesenteries	Intestines
TUBERCULOSIS											
Bulls ...	7	7	7		1					2	2
Bullocks ...	144	144	263	64	10	1	10	8		73	73
Heifers ...	150	150	313	52	9		7	11		79	79
Cows ...	237	237	617	95	21	5	15	18	14	150	150
Calves ...			1	1							
Pigs ...	238	238	73	80	49		58			153	153
INFLAMMATORY DISEASES											
Bulls ...			1					1			
Bullocks ...	6	8	99	27	7	14	24	11		3	3
Heifers ...	1	1	73	22	12	20	13	20	3	7	7
Cows ...			28	49	9	51	9	13	331	6	6
Calves ...			2	4	4		1	1		5	5
Sheep ...	2	2	3	4	13		3			17	17
Pigs ...	10	10	92	103	67	4	75	29		96	96
PARASITIC DISEASES											
Bulls ...	1	1	1	1			1	1			
Bullocks ...	32	32	98	1423			40	24			
Heifers ...	54	54	96	976			61	44			
Cows ...	9	9	25	560			14	7			
Sheep . .			125	1663							
Pigs ...			3	6							
OTHER BACTERIAL DISEASES											
Bulls ...											
Bullocks ...	34	34	33	89	6	9	4	7		9	9
Heifers ...	20	20	13	37	4	7	4	3		4	4
Cows ...	14	14	13	44	12	11	7	9		18	18
Calves ...				3						1	1
Sheep ...			15	14	4		14	1		5	5
Pigs ...			10	11	26	2	9	3		35	35

TABLE IX

ANALYSIS OF INSPECTION OF MEAT

	Cattle excluding Cows	Cows	Calves	Sheep and Lambs	Pigs
Number killed	5,698	1,534	2,101	26,160	5,877
Number Inspected	5,698	1,534	2,101	26,160	5,877
ALL DISEASES EXCEPT TUBERCULOSIS : Whole carcases condemned	2	10	35	30	25
Carcases of which some part or organ was condemned	2,845	650	16	1,684	270
Percentage of the number inspected affected with disease other than tuberculosis	49.9%	43.6%	2.4%	6.5%	5.01%
TUBERCULOSIS ONLY : Whole carcases condemned	30	61	6	—	14
Carcases of which some part or organ was condemned	860	754	2	—	341
Percentage of the number inspected affected with tuberculosis	15.6%	53.1%	.38%	—	6.04%

OTHER FOODSTUFFS CONDEMNED AND VOLUNTARILY SURRENDERED

FRESH MEAT FROM SHOPS		
English Beef	510 lbs.	Bonetaint
English Beef	128 lbs.	Decomposition
English Beef	74 lbs.	Bruising
English Mutton	17 lbs.	Decomposition
English Pork	17 lbs.	Bonetaint
English Pork	116 lbs.	Decomposition
English Pork	151 lbs.	Bruising
IMPORTED MEAT FROM SHOPS		
Beef	390 lbs.	Decomposition
Mutton	25 lbs.	Decomposition
PIGS' HEADS (EX BACON FACTORIES)		
98 Pigs' Heads	1,250 lbs.	Tuberculosis
FISH		
Fresh Fish	401 lbs.	Unsound
Prawns	85 lbs.	Unsound
RABBITS		
Rabbits	297 lbs.	Unsound

Fruit, Vegetables and Nuts		
Prunes	71½ lbs.	Unsound
Dates	33½ lbs.	Unsound
Figs	21 lbs.	Unsound
Nuts	29 lbs.	Unsound
Cabbages	2,128 lbs.	Unsound
Dried Peas	4 lbs.	Unsound
Bread and Cereals		
Flour	20½ lbs.	Unsound
Cakes	55¾ lbs.	Unsound
Cake Mixture	46¼ lbs.	Unsound
Biscuits	153¾ lbs.	Unsound
Cereals	27¾ lbs.	Unsound
Custard Powder	5 lbs.	Unsound
Other Foods		
Bacon and Ham	13,743¼ lbs.	Unsound
Poultry	41½ lbs.	Unsound
Chocolate Teacakes	2¼ lbs.	Unsound
Salt	4 lbs.	Unsound
Pudding	1 lb.	Unsound
Butter	14 lbs.	Unsound
Margarine	56 lbs.	Unsound
Cooking Fat	165 lbs.	Unsound
Cheese	254¾ lbs.	Unsound
Jam	3 lbs.	Unsound
Fruit Pulp	15,178 lbs.	Unsound
Frozen Eggs	82 lbs.	Unsound
Sweets	47½ lbs.	Unsound
Chocolate	40 lbs.	Unsound
Prepared Foods		
Cooked Meats	108¼ lbs.	Unsound
Black Pudding	49 lbs.	Unsound
Meat Pies	18 lbs.	Unsound
Beasts Runners	50 lbs.	Unsound
Sausage	74 lbs.	Unsound
Fish Cakes	12¼ lbs.	Unsound
Preserved Foods		
26,786 tins	35,528¾ lbs.	Unsound

Horseflesh

The number of horses slaughtered at the one privately owned horse slaughterhouse, dropped considerably with a consequent reduction in the number of visits to the slaughterhouse; the figures are 968 horses inspected and 175 visits, against 1,626 horses and 252 visits in 1951.

The following horseflesh and offal was condemned:—

7 lungs	Inflammatory conditions
3 livers	Inflammatory conditions
19 lungs	Parasitic conditions
88 livers	Parasitic conditions

33 lbs. Horsemeat.....	Bruising
1 carcase and offal	Moribund
1 carcase and offal	Melonosis
1 carcase and offal	Peritonitis

Estimated weight, 3,587 lbs.

Summary of Food Condemned

	Tons	Cwts	Qrs.	Lbs.
Fresh Meat (from Abattoir)	103	5	3	8
Fresh Meat (from Shops)		9	0	5
Imported Meat (from Shops)		3	2	23
Pigs' Heads (Ex Bacon Factories)		11	0	18
Fish		4	1	10
Rabbits		2	2	17
Fruit, Vegetables and Nuts	1	0	1	19
Bread and Cereals		2	3	1
Other Foods	13	4	2	8¼
Prepared Foods		2	3	3½
Preserved Foods	15	17	0	24¾
Horseflesh and Offal	1	12	0	3
	136	16	2	0½

Prosecutions

SLAUGHTER OF ANIMALS ACT, 1933.

One person was prosecuted for slaughtering without being in possession of a licence as required by Section 3 of the Act and was fined 20/-.

Examination of Various Foodstuffs and Other Material

In connection with an outbreak of food poisoning under investigation by the Medical Officer of Health, one sample of prunes, two samples of milk, one sample of cheese which had been nibbled by rats, and one sample of cat excreta were collected and submitted to the Public Health Laboratory, Wakefield, for bacteriological examination; in no case were pathogenic organisms found.

One sample of Breakfast Oats was examined by the Public Analyst following a complaint from the purchaser that the Oats contained mouse droppings, the analyst stated that "the sample consisted of ground oats which had been discoloured through the effects of moisture."

Part of a loaf of bread was received with the complaint that it contained some foreign substance; from its appearance the substance appeared to be oil or grease and this was confirmed by the Public Analyst after he had examined it. The vendor of the loaf was prosecuted during 1953.

Food and Drugs

A total of 296 samples of various foods and drugs were taken for analysis and submitted to the Public Analyst.

MILK

41 samples all of which were reported by the Public Analyst as 'genuine', although in seven instances the Freezing Point Test (Hortvet) had to be applied to establish that fact.

Whilst complying with the minimum 3% Milk Fat, the seven samples were all below the minimum standard of 8.5% Milk Solids other than Milk Fat as laid down in the Sale of Milk Regulations, 1939. The details are as follows :—

	Milk-Fat	Milk Solids other than Milk-Fat	Freezing Point (Hortvet) C°
No. 1	3.15	8.37	—0.550
No. 2	5.10	8.36	—0.538
No. 3	3.30	8.47	—0.542
No. 4	3.60	8.35	—0.538
No. 5	4.45	8.47	—0.537
No. 6	3.55	8.39	—0.541
No. 7	3.65	8.48	—0.536

The average composition of the 41 samples was :—

Milk-Fat	3.77%
Milk-Solids other than Milk-Fat	8.73%

SAMPLES OF FOOD AND DRUGS (OTHER THAN MILK) SENT TO THE PUBLIC ANALYST DURING 1952

Article	Gen-uine	Adult.	Total	Formal		Informal	
				Gen.	Adult.	Gen.	Adult.
Aspic Jelly	1		1			1	
Black Pudding	3		3			3	
Brawn	1		1			1	
Bun Flour	1		1			1	
Chicken Noodle Soup	1		1			1	
Coconut	5		5			5	
Coconut Cream	1		1			1	
Coffee	2		2			2	
Coffee and Chicory Essence	1		1			1	
Cream Tartar	1		1			1	
Dressed Crab	2		2	1		1	
Fish Cakes	4		4			4	
Glace Cherries	2		2			2	
Ground Nutmegs	1		1			1	
Honey	1		1			1	
Ice Cream	39	2	41	1	1	38	1
Icing	1		1			1	
Lemon Cheese	1		1			1	
Mayonnaise	1		1			1	
Meat Pie	4		4			4	
Mixed Spice	1		1			1	
Pickled Onions	2		2			2	
Palm Kernel Oil	1		1	1			
Pastries	1		1			1	
Plum Pudding	1		1			1	
Poloney	3		3			3	
Potted Meat		3	3		1		2
Rice	2		2			2	
Beef Sausage	30	2	32	2	1	28	1
French Ring Sausage	1		1			1	
Krakow Sausage	1		1			1	
Beef Sausage Meat	2	1	3			2	1
Pork Sausage	13	3	16		1	13	2

Article	Genuine	Adult.	Total	Formal		Informal	
				Gen.	Adult.	Gen.	Adult.
Semolina	1		1			1	
Shortbread	2		2			2	
Sponge Mixture	3		3			3	
Strawberry Jam	2		2			2	
Table Jelly	5		5			5	
Table Jelly Crystals	1		1			1	
Thirst Quenchers	1		1			1	
Tomato Soup	1		1			1	
Malt Vinegar	2		2			2	
White Pepper	6		6			6	
Fat	3		3			3	
Marshmallow Creme	1		1			1	
Orange Squash	1		1			1	
Pork Dripping	1		1			1	
Strawberries in Syrup	1		1			1	
Synthetic Cream	4		4			4	
Vita Cream	1		1			1	
Blancmange Powder	1		1			1	
Carraway Seeds	1		1			1	
Castor Oil	1		1			1	
Chicken, Ham and Tongue Paste	1		1			1	
Composition Essence	4		4			4	
Cough Mixture		1	1				1
Custard Powder	2		2			2	
Dripping	2		2			2	
Epsom Salts	1		1			1	
Glaubers Salts	1	1	2	1			1
Grape Fruit Squash	1		1			1	
Ground Rice	2		2			2	
Indian Brandee	1	1	2			1	1
Lemon Cheese	2		2			2	
Liquid Apples	1		1			1	
Medicinal Paraffin	2		2			2	
Mustard	1		1			1	
Non Brewed Condiment	1		1			1	
Nut Mixture	2		2			2	
Orange Curd	1		1			1	
Parsley	1		1			1	
Potted Crab	1		1			1	
Sago	1		1			1	
Salmon and Shrimp Fish Paste	1		1			1	
Beef and Pork Sausage		4	4				4
Suet	1	1	2			1	1
Sulphur and Yeast Tablets	1		1			1	
Sweet Spirit of Nitre		1	1				1
Syrup of Cupmoss	2		2			2	
Syrup of Figs	1	1	2			1	1
Syrup of Squills		2	2		1		1
Tomatoes	1		1			1	
Tongue Paste	1		1			1	
Baking Powder	1		1			1	
Meat Paste	5		5			5	
Escade Tonic	1		1			1	
Fruit Wine	1		1			1	
Ground Almonds	1		1			1	
Ground Ginger	1		1			1	
Lime Water	1		1			1	
Mincemeat	5	1	6	3	1	2	
Olive Oil	1		1			1	
Peppermints	1		1			1	
Piccalilli	1		1			1	

Article	Genuine	Adult.	Total	Formal		Informal	
				Gen.	Adult.	Gen.	Adult.
Pork and Veal	1		1			1	
Rabbit Pie	1		1			1	
Sal Volatile		1	1				1
Toffee Lollipops	1		1			1	
Vanilla Flavour	1		1			1	
Welsh Rarebit	1		1			1	
	230	25	255	9	6	221	19

PARTICULARS OF OTHER FOODS—ADULTERATED SAMPLES

Sample No.	Article	Adulteration or Offence	Remarks
5126 Formal	Pork Sausage	Deficient in meat 27.3%	Vendors prosecuted. Firm fined £5 and costs. Servant fined £2
5128 Informal	Beef Sausage	Slightly deficient in meat	See 5173
5159 Informal	Potted Meat	Contained 58.1% meat. Should be described as Potted Meat Paste	Vendor warned by letter
5168 Informal	Potted Meat	Contained 53% meat. Should be described as Potted Meat Paste	See 5187
5173 Formal	Beef Sausage	Deficient in meat 17.6%	Refers to 5128. Vendor prosecuted. Fined £5 and costs
5178 Informal	Pork Sausage	Deficient in meat 35%	Formal sample genuine. Vendor warned.
5187 Formal	Potted Meat	Contained 52% meat. Should be described as Potted Meat Paste	Refers to 5168. Vendor warned by letter
5223 Informal	Ice Cream	Deficient in fat 27.8%	See 5233
5233 Formal	Ice Cream	Deficient in fat 14%	Refers to 5223. Further Formal sample genuine
5240 Informal	Pork Sausage	Deficient in meat 14.6%	Formal sample genuine
5243 Informal	Beef Sausage Meat	Contained excess of fat	Vendor warned
5252 Informal	Beef and Pork Sausage	Contained 63.5% meat. Should have been described as beef sausage	Vendor warned

Sample No.	Article	Adulteration or Offence	Remarks
5253 Informal	Suet	Deficient in fat 12.1%	Unable to obtain formal sample
5264 Informal	Glaubers Salt	Contained the equivalent of 160.3% of crystallised sodium sulphate. Had lost a considerable amount of its water of crystallisation	Formal sample genuine
5282 Informal	Cough Mixture	Not labelled as per Section 2, Pharmacy and Medicine Act, 1941	Letter of warning sent
5284 Informal	Sweet Spirit of Nitre	Deficient in Ethyl Nitrite 29.6%	Vendor and manufacturer warned by letter
5317 Informal	Indian Brandee	Was a substitute and did not contain sweet nitre	Formal sample taken in 1953
5320 Informal	Sal Volatile	Deficient in Ammonia 34.8% Deficient in Ammonia Carbonate 32.6%	Vendor warned by letter
5322 Informal	Syrup of Figs	Contained 3.7% Vegetable Oil	Formal sample taken in 1953
5376 Informal	Beef Sausage	Contained preservative not declared	Vendor warned by letter
5388 Informal	Beef and Pork Sausage	Contained 57.4% meat. Should have been described as Beef Sausage	Vendor warned by letter
5390 Informal	Beef and Pork Sausage	Contained 62.7% meat. Should have been described as Beef Sausage	Vendor warned by letter
5391 Informal	Beef and Pork Sausage	Contained 57.7% meat. Should have been described as Beef Sausage	Vendor warned by letter
5400 Informal	Pork Sausage	Contained preservative but was not declared	Vendor warned by letter
5401 Formal	Mincemeat	Contained 61.3% of soluble solids and 2.41% of fat. Deficient in soluble solids and slightly deficient in fat	Vendor warned by letter

Part V

SCHOOL HEALTH

Education Act, 1944—Sections 33, 69 and 100.
Handicapped Pupils and School Health Service Regulations, 1945.
(S.R. & O. 1945, No. 1076)—Regulation No. 55.
(Annual Report of the School Medical Officer).

As for each year for some considerable time past, it is possible to report a small but definite improvement in the general health and well-being of the school children of Barnsley during 1952. The statistical evidence of this improvement will be found amongst the figures in the Tables at the end of this part of the Report.

The members of the Education Authority and its officers cannot but feel a quiet satisfaction in this annually repeated statement which represents each year further progress towards a fitter and healthier community. Reference has been made in previous reports to the manner in which the School Medical Service with its history of steady but unspectacular achievement typifies the personal preventive Health Services. It is perhaps unfortunate that the results of this painstaking persistent routine work lack the drama necessary to appeal to popular imagination. If it were able to do so a greater measure of well-deserved appreciation might be forthcoming.

Apart altogether from recognition of the effort put into a worthwhile job, the School Health Service is deserving of more attention from the community. The annually repeated reports of a barely noticeable improvement in the findings at school medical inspections only show a part of the picture. Furthermore they only present that part in a piecemeal fashion. There is a good case for critical research into the effect on the general health of the nation of the work done by the School Health Service during the last 40 years. Such research would call for widespread enquiry and would involve the sampling of a number of adult age groups in relation to the services available for them during their school life. In this way it might be possible to assess the full value of routine medical inspection of the supposedly normal individual followed by remedial treatment of any defects detected at this inspection. There is little doubt that such research would result in strong factual support for this approach to preventive medicine. Unfortunately work of this kind is rather beyond the resources of any single Education Authority. There would therefore seem to be a good case for carrying out a National rather than a local investigation. It is possible that the results of an investigation of this kind, given adequate publicity, would prove sufficiently spectacular to create a new interest in the School Health Service and preventive medicine as a whole within the community. This would be most desirable.

It is usual each year to consider at this point the relationship between the School Health Service and the National Health Service. In many ways it would be easy for the preventive work done in the schools to become absorbed into the sphere of the Local Health Authority—the more so as a very great deal of this work is done by personnel who are officers of the Health Authority as well as of the Education Authority. At the same time the School Health Service has an important educational function which is almost certainly best developed along with other educational activities. Indeed the opinion has already been expressed elsewhere in this series of reports on the health of Barnsley that the real future of Health Education lies in the schools rather than in posters stuck on hoardings or exhortations attached to the walls of public lavatories. For this reason alone, for a considerable time to come it would seem advisable that School Health should be closely identified with the Educational Service rather than with the Health Service.

During 1952 experiments were carried out at Kendray Junior School whereby a member of the medical staff took classes in elementary physiology and hygiene amongst various age groups attending the school. This work was largely in the nature of a pilot experiment and the experience gained was insufficient to allow of firm conclusions being drawn. The impression was gained, however, that children of the age groups "10 plus" are receptive to this kind of teaching and that it has a very great value in establishing an entirely new relationship between the children and the school doctor. Much more remains to be done on these lines, both by the medical staff alone and in consultation with the educationalists. In the future it is hoped to extend these experiments to a wider field, particularly to the older children at Grammar and Secondary Schools where something is already being accomplished amongst the girls in the Mothercraft Classes conducted by the School Nursing Staff.

There is little doubt that the School Health Service as an educational service offers the best solution to the problem of establishing within the community well-informed opinions relating to health. The English educational system has accomplished a very great deal in the enlightenment of the people in many fields. There is, therefore, no reason why, through its School Health Service, it should not replace with an ability to accept reasoning based on scientific fact many of those prejudices which have caused the National Health Service to develop as a "Sickness Service." This task is one of some magnitude as many of the prejudices to be eradicated are amongst the first beliefs transmitted to the pre-school child by its parents. Thus by the time the child's intellect has developed sufficiently to accept Health teaching, such beliefs are fairly firmly implanted and their influence has to be overcome. It is in dealing with this problem that the Educationalist can be of great assistance but his efforts alone are unlikely to be attended by complete success.

Here the School Health Service occupies the key position as link between Health and Education. Such a link is essential if the full potentialities of the conception of Health Education outlined above are to be realised. So far the School Health Service co-operates fairly well with those parts of the National Health Service which are not the responsibility of the Local Health Authority. This co-operation might perhaps best be described as of the "ad hoc" type. It is necessary, however, that this co-operation should

extend beyond such artificial limits. This is particularly the case in relation to the general practitioner services where the tendency is to deal with individual cases as and when they arise. Nevertheless the family doctor usually ensures that the individual receives the remedial care that is immediately necessary for him at the time. Thus, if viewed from the curative approach, this may well be regarded as reasonably satisfactory. Unfortunately it does not reach the wider and more important fields of preventive medicine and Health Education.

The busy general practitioner tends to limit himself to the immediate needs of his individual patient and rarely concerns himself with the wider community issues. The result of this has been difficulties and differences between the Educational Services and the practitioner. These could easily be avoided if the practitioner would only consult the School Medical Officer whose job consists of dealing with these wider issues before taking a particular line of action. The great majority of these problems arise over school attendance. The practitioner is often consulted because a child is thought by his parents to be unable to attend a normal school. Examination by the doctor shows that there may be some immediate grounds for this belief and a certificate excusing attendance is issued without any of the possible alternatives being considered. There is little objection to this in the case of an acute illness but all too frequently series of certificates are issued in respect of children who have some chronic complaint which makes attendance at a normal school merely somewhat difficult and certainly does not preclude attendance at a Special School. For such children by statutory provision special educational facilities are available. These facilities have been provided on the principle that no physical handicap should be allowed to deprive a child of his education. The Barnsley Education Authority is ready and willing to provide these facilities on the recommendation of the School Medical Officer who by statute is the officer charged with the duty of ascertaining whether the handicap is sufficient to justify such special education. It is, therefore, in such cases only necessary for the family doctor to notify the School Health Service; thereafter all necessary arrangements will be made by the Education Authority to ascertain whether or not the child in question is in fact "handicapped." Much friction could be avoided if practitioners would adopt this course. Indeed if they would pass all problems of medical justification for absence from school for more than a few days to the School Health Service these would be most willingly undertaken.

Apart altogether from the immediate problems of compliance with the law regarding compulsory school attendance, the issue of certificates in respect of absence from school has far-reaching implications which might be considered with advantage at this point.

In the first place, many parents tend to be over-anxious about a child who is not perfectly normal in every way or a child who has had a serious illness in infancy. With a high proportion of such parents, the approach to health matters is clouded by superstitions and prejudices that either have been disproved or lack any foundation of scientific fact. Others spoil the child they regard as delicate and knowingly or unknowingly encourage the "enjoyment of ill-health." In this way the child is provided with a ready-made escape mechanism to avoid doing anything that is disliked (including attending school). Such children tend to be constantly on the family doctor's

visiting list and the usual question asked of the doctor is " He shouldn't go to school, should he? " The doctor, being human, follows the line of least resistance and issues a certificate. In many cases this certificate becomes the first of a series. Alternatively, some other slightly incapacitating condition supervenes and a certificate in respect of it is duly obtained. The doctor is busy and often overlooks the fact that on account of his certificates the child has been absent from school for a considerable period. Not only has this affected his education but far, far worse it has set in motion all the psychological factors which lead to the addition to the community of another hypochondriac.

Then there is the child whose parents, without consulting the doctor, keep him at home from school because he has succeeded in making them think he is ill. Before he has, in his own estimation, fully recovered the School Attendance Officer becomes interested. The parents then rush to the family doctor who, by reason of the " free choice " and " capitation fee system " of payment, is only too anxious to please. The parents describe, and probably exaggerate, the child's symptoms to the doctor. The doctor at this stage cannot verify the story told to him by clinical examination; nevertheless he salves his conscience and issues a retrospective certificate to cover the child's absence. So the immediate danger of prosecution is averted and everybody, including the doctor, is quite happy. Unfortunately a seed has been sown in the child's mind. Later when for some reason or other escape from school becomes desirable, the symptoms are again developed and the whole process of Attendance Officer, doctor and certificate is repeated. It must be remembered that this process takes place in the individual's most formative years. The more often it is repeated, the more certain it is that when the child becomes an adult he will have developed an outlook in which the value of medical certificates, and indeed medical opinion generally, is completely debased and held in contempt. The existence in the community of only a few individuals holding such views is a menace both to its mental and physical health as well as being most damaging to the esteem in which the medical profession is held.

In drawing attention to these implications, it must be made perfectly clear that the very great burden under which the general practitioner labours is fully appreciated. It is, however, suggested that on account of this very burden he should co-operate with the School Health Service to the extent of transferring to it all decisions involving prolonged absence from school. This is advocated on the grounds that under present arrangements a short-term curative approach, however well-intentioned, to such cases can often be most damaging to the Health Education of the community. Also that a purely curative approach to a young individual suffering from a physical handicap can induce a tendency to self-pity and neurosis. An educational approach would, on the other hand, almost certainly foster the spirit necessary to overcome the physical handicaps involved. Finally, the School Medical Officer is in a far better position than the family doctor to consider the ultimate physical and mental benefit to the child and can well afford to oppose the mistaken kindnesses of the ill-informed and superstitious parent when these threaten the well-being of the child.

It is to be hoped that in the future the general practitioners of Barnsley will give serious consideration to this question of the issue of certificates and so make complete the already good co-operation that exists between them and the School Health Services.

Co-operation between the School Health Service and that part of the National Health Service provided by the Sheffield Regional Hospital Board during the year has been excellent. Adequate Specialist and Consultant sessions are now available at New Street Clinic. The waiting lists for ophthalmic and orthopædic investigations, which caused concern in previous years, have been effectively diminished. In addition the good working arrangement whereby school children who require operative remedial treatment receive this in the Barnsley Hospital Management Committee's hospitals has been continued and improved.

The co-ordination between the School Health Service and those services provided by the Barnsley Corporation under the National Health Service Act as Local Health Authority is well nigh complete. The same personnel comprise the medical, dental and nursing staffs of both services. Thus continuity of care as regards the individual is ensured. No hard and fast boundary is encountered as regards preventive care when the child attains school age. The school doctor who gives him his first inspection at School is the Assistant Medical Officer who has seen him at his periodic visits to the Infant Welfare Centre. The school nurse is the Health Visitor who has advised on his welfare since the midwife ceased to visit.

Up till 1952 there had, however, been to a certain extent an artificial demarcation between the School Health records and those of the Child Welfare Services. It was obvious that there was need for co-ordination here and to secure it a senior Statistical Clerk has been appointed and charged with responsibility of assimilating the health records of the individual into a single continuous system. This involves a surprising number of difficulties but the progress already made shows that it is a practical proposition and one offering wide opportunities of providing a service of great value to the community as well as to the individual. There seems little doubt that there will be in the future a demand for comprehensive individual records either on account of the development of an Industrial Health Service or by reason of the coming into being of " Health-Centre practice." Such records cannot be brought into being at once but must grow up with the individuals to whom they relate. Tardiness in providing a system of keeping them will most certainly result in the loss of much valuable and irreplaceable information.

Reference has already been made to the steps that are being taken to co-ordinate the educative functions of the Health Authority with the work of the Education Authority so little more need be said on this aspect except to emphasise once more its very great importance to the community.

SCHOOL HYGIENE

All school premises are examined each time they are visited by the Assistant School Medical Officer for the purpose of carrying out routine medical inspection. Any hygiene defects that are detected are fully discussed with the Head Teacher concerned. It is usually found that where defects are not of a structural nature this is sufficient to ensure that they are remedied. Where the defect is of a structural nature, this is dealt with through administrative channels by the Director of Education. In this way a number of marked improvements in school hygiene were effected during the year.

For a number of defects in school hygiene, such as over-crowding, there is only one solution, and that is the implementation of the Authority's building programme as quickly as possible. Apart from the relief of over-crowding this would allow the replacement of several unhygienic premises which have long outlived their usefulness by modern schools in the design of which hygienic principles have received adequate attention.

During the year the survey of the hygienic conditions prevailing in all schools in the County Borough was continued. Special arrangements have been made to record the results of this work and to correlate the findings at the survey with those of the periodic visits of the medical officers to the school. In this way a full "hygienic record" of each school has been brought into being and is proving to be of considerable value.

MEDICAL INSPECTION

The total number of children examined at routine medical inspections in 1952 was 3,535. This comprises:—

1,397	Entrants
217	Children of the second age group
848	Children of the third age group
1,073	Other periodic inspections.

This represents a decrease of 1,654 in the number of periodic inspections when compared with 1951. The total number of special inspections and re-inspections carried out was 9,499 and this on the other hand represented an increase of 1,708 when compared with the previous year.

These figures are interesting when it is recollected that by reason of the improved staffing conditions the periodic inspections showed a marked increase in 1951. During 1952 considerable time was spent in following up defects ascertained in the previous year. Thus the increase in special inspections accounts for the decrease in periodic inspections. (See Appendix Table I).

FINDINGS AT MEDICAL INSPECTION

General Physical Condition

The figures for the estimate of the general physical condition of children examined in the course of medical inspections are shown in Table IIB in the Appendix.

It will be recalled that reference has been made in several previous reports to the effect on the classification by any particular observer of the physical standards of the children encountered in his previous medical experience. Also it has been pointed out that the impressions gained by the observer are largely subjective and that any assessment must be based on this. Consequently the possibility of a fairly large margin of variation due to these factors must be borne in mind when considering such figures as those contained in Table IIB. Nevertheless even if allowance be made for this, bearing in mind that the team of observers working in 1952 was substantially the same as in 1951, there is little doubt that the figures in the table represent a considerable improvement over previous years.

Not since the present standards were adopted for 1947 has the figure for children showing "poor" general condition fallen below 2% until 1952. Also reviewing the years since 1947 there has been maintained a steady and definite increase in those classified as "good." Though the chain of scientific proof, of effect supported by cause, is not altogether complete it would seem that the effects of the National scheme for social insurance are making themselves felt amongst the school children of Barnsley. Cursory review of the situation at first suggests a torrent of comment. Reflection advises a suspension of judgment. For the purposes of this year's report it is felt that the dictates of reflection ought to be obeyed and full comment reserved to await the figures and studies which subsequent years will most certainly provide. Table IIB, however, is not only highly satisfactory in itself but undoubtedly contains a great promise of sustained improvement in the future.

Uncleanliness

Table III in the Appendix shows that during 1952 attention to cleanliness has been increased still further. Increase in vigilance (as shown by increased number of examinations) has been accompanied by a slightly disproportionate increase in the number of children showing evidence of infestation with vermin.

Mention was made in last year's Report of the institution of a new method of recording the findings in cases of uncleanliness and of the adoption of an improved routine for examination. 1952 has been the first full year for which figures for these innovations are available and it is a matter for some satisfaction that there is not a much greater apparent increase in the number of children showing infestation. The methods brought into use in Barnsley have been devised with a view to ensuring that the provisions of Section 54 of the Education Act, 1944, can be made use of with the maximum facility. Great care is now taken to ensure that cleansing notices are served on parents in such a way that the procedure set out in the Section is meticulously observed. As a consequence of this one cleansing order (Education Act, 1944, S.54(3)) was issued and the machinery for compulsory cleansing put into effect. It worked most satisfactorily. The pupil in question was, after examination by the Schools Medical Officer, conveyed to the Health Services Clinic at New Street and was there cleansed by a properly authorised person. A full record of the procedures involved was preserved for future use should a prosecution for neglect under this Section become necessary.

The fact that 1,802 individual Barnsley school children were found to be infested during the year suggests that there has in the past been room for greater activity in dealing with cases of chronic infestation. Generally speaking the vast majority of parents and children abhor the harbouring of vermin just as much as do the members of the School Health Service. In the event of the discovery of an accidental infestation such parents and children co-operate to the full in getting rid of the vermin and make every effort to prevent a recurrence of this state of affairs. Most of these accidental infestations result from the presence in the schools of children whose parents through ignorance or laziness regard infestation as a healthy condition and head lice particularly as the accompaniments of normal life. It is appreciated that the ideal way to deal with such families is by education and conversion to accepted standards of hygiene. However, this process of education and

conversion must be a long-term policy and it does not provide a solution to the immediate problem of protecting clean children from those few families who spread vermin in the schools. It is only fair to say that many of the children of these families are themselves genuinely distressed by their chronic state of infestation and are most grateful for cleansing. They attempt to keep themselves free of vermin but rapidly become re-infested in their own homes from their less enlightened elders. In attending school they repeat the process of spreading head lice to their fellow pupils.

In dealing with such reservoirs of infestation the procedure set out in S.54 of the Education Act, 1944, is extremely tedious and cumbersome whilst the penalty prescribed in the event of a successful prosecution is hardly a deterrent. Given adequate powers it would not be difficult for the Education Authority to eradicate entirely the head louse from schools. This would, however, call for changes in legislation. It is suggested that additions be made to the present statutory powers contained in Section 54. These should apply where it has been necessary to exclude a child from school for uncleanliness and to issue a cleansing notice to the parents on three occasions in any school year. In such cases the Education Authority might bring the parents before a Court of Summary Jurisdiction. On the facts being proven the Court might make an order requiring the examination of all members of that child's household by the Medical Officer of Health. Any person found to be harbouring vermin or their nits at such examination would then be compulsorily cleansed by order of the Court to the satisfaction of the Medical Officer of Health. This would get over the difficulty that recurs time and again of cleansing children at the School Clinics only for them to be re-infested immediately they return home.

The cleansing and disinfection arrangements at New Street Clinic remain available as in previous years for use at parents' request. They are also used by the School Nurses when statutory action under the Education Act, 1944, S.54(5) becomes necessary.

Eye Defects

248 cases of defective vision requiring treatment were found during the course of inspections. Once again this number is within the expected range and compares with 449 cases found in 1951 and 346 in 1950. When making a comparison with previous years the total number of periodic inspections for the year must be borne in mind. It is usually at periodic inspection, particularly of children of the second age group, that defects of vision are detected. The number of such inspections was lower in 1952 than in 1951. This may account to some extent for a smaller number of visual defects being detected as shown in Table II. Although the completion of new schools and the movement of population in the Borough by reason of re-housing to the areas served by these new schools may be another factor in this, there are however still many children attending old schools where unsatisfactory lighting arrangements exist and where these tend to be aggravated by unavoidable overcrowding. Until there is a substantial reduction in the number of children being educated under these conditions no permanent decrease in the number of visual defects can be expected.

As in 1951, the number of cases of squint requiring treatment amounted to 56. Other eye conditions requiring treatment found at school medical inspection totalled 13, one less than in the previous year.

Ear, Nose and Throat Defects

188 children were found to require treatment for ear, nose and throat defects. As is usual, the great majority of these were cases of enlarged tonsils and adenoids. 143 children were noted for observation of defects of this nature. 29 children showed defects in hearing which called for treatment and 34 were found to have otitis media in need of treatment. Much of this ear trouble arises from neglect of adenoid growth in the naso pharynx by parents who either do not recognise its presence or, if they do, fail to appreciate the seriousness of nasal obstruction in children. There is a great opportunity for the practice of preventive medicine in dealing with otitis media in children. That this is recognised and acted upon is reflected in the number of children, noted above, referred for observation of nose and throat defects.

Orthopædic Defects

A total of 37 cases of flat foot requiring treatment were recorded and nine were referred for observation. This shows an increase over the previous year despite the fact that a smaller number of inspections was carried out.

21 cases of bad posture were referred for treatment and 19 for observation whilst other orthopædic defects calling for treatment number 17 and for observation 12.

These figures cannot be said to be impressive but they represent perhaps a very important aspect of the preventive work that is done by the School Health Service. Often these defects are so slight as to be imperceptible except to the highly trained observer, but treatment at this early stage prevents great disability in later life. An example of this is "flat foot." The course of a child's whole future life may be influenced by his ability to stand for long periods. This he could not do without great discomfort if he suffers from untreated flat foot.

Table II in the Appendix contains a detailed statistical statement of the defects found at medical inspection during the year.

ARRANGEMENTS FOR TREATMENT

School Clinics

Barnsley : Medical Services Clinic, New Street, Barnsley

MINOR AILMENTS CLINIC

Monday to Saturday	9 a.m. to 11 a.m. daily

CONSULTATION CLINICS—Attended by Doctor

Thursday and Saturday	9 a.m. to 12 noon

EAR, NOSE AND THROAT CLINICS

Tuesday	2-15 p.m.
Thursday	9-30 a.m. to 12 noon

EYE CLINIC

Monday, Wednesday, Thursday, Friday	2 p.m. to 4 p.m.

SKIN CLINIC

Tuesday	2 p.m. to 4 p.m.

ORTHOPÆDIC CLINIC

Monthly, by appointment ..... Every 3rd Friday 2 p.m.

DENTAL CONSULTATION CLINIC

Saturday .... 9-30 a.m. to 12 noon

Otherwise by appointment

ULTRA VIOLET LIGHT CLINICS

Wednesday afternoon and Saturday morning

Ardsley : Hunningley Villa, Hunningley Lane, Stairfoot

Monday .... 2 p.m.

Lundwood : Littleworth Infants' School

Monday .... 9-30 a.m.

Athersley : Athersley Junior School

Monday .... 9-30 a.m.

Monk Bretton : Old Council Offices, High Street

Friday .... 9-30 a.m.

Malnutrition

As in past years, school milk has been available for all those children who were in need of it as well as, in certain cases, vitamin tablets. During the year 1,847,995 bottles of milk were supplied to children attending the Authority's schools.

The School Meals Service supplied 1,179,253 meals to school children during the year. This shows an increase over 1951 which it is most pleasing to observe. The School Meals Service has done more than any other single factor to banish malnutrition from the community. Not only does a school meal ensure that the children receiving it obtain an adequate supply of food but it also ensures that the diet is balanced in that it contains the proper proportions of protein, carbohydrates and fats. This latter factor is perhaps more important than the former as much malnutrition in the past has been caused by the lack of one essential food factor rather than by an insufficient calorific intake.

In addition, school meals have an educative effect. They accustom children to a properly regulated diet and do a very great deal to stamp out faddiness and idiosyncrasies of appetite which in the past have played a decisive part in certain cases of malnutrition.

Apart from this it has not been necessary to institute any special measures to deal with malnutrition. When individual cases are encountered arrangements are made for treatment at the Open Air School when it appears the régime there will accelerate the return to normal nutrition.

Uncleanliness

Reference has already been made to the arrangements for dealing with this. No alterations were introduced during the year.

Minor Ailments and Diseases of the Skin

Reference to the time-table of clinics shows that the existing arrangements were continued during 1952.

Visual Defects and External Eye Diseases

In the three previous Annual Reports reference was made to the long list of pupils with eye defects awaiting examination by an Ophthalmologist. This was largely due to the staffing difficulties encountered by the Sheffield Regional Hospital Board. In the Report for 1951 mention was made of the steps taken by the Board at the request of the Barnsley Education Authority to overcome these difficulties. Resulting from these steps Mr. N. L. McNeil was appointed as Ophthalmologist (S.H.M.O.) and commenced duties on April 2nd, 1952, since when he has undertaken some four sessions weekly at the Education Authority's Clinic in New Street. Until Mr. McNeil took up duties the arrangement whereby Dr. Wilkie, of Sheffield, an ophthalmic practitioner, conducted four refraction sessions per week was continued. By these measures the long waiting list has been substantially reduced. This is shown by the increase during the past year in the number of attendances (Appendix Table IV, Group 2). New cases are now seen within a short and reasonable period. On this account it is extremely unlikely that the figures for 1952 will be repeated in any future year although it may be several years before a mean level is reached.

About one-third of the new cases referred to the Ophthalmologist are of squint and muscle unbalance. This accounts for a large number of attendances as children with squint require to visit the clinic much more frequently than those with simple refraction defects. It is a matter for some satisfaction that it is now possible to give the attention it merits to squint amongst children. It is to be hoped that it will be possible to put children with this defect under the care of the Ophthalmologist at a very early age, in some cases during the pre-school years. In this connection particularly there has been an improvement in the co-ordination between the hospital and Education Authority services during the past year. Arrangements have now been made for the appointment of an Orthoptist at the Beckett Hospital. In this way it is possible for Mr. McNeil to co-ordinate orthoptic treatment and operative treatment (which the former does not, of course replace) with the prescription of glasses and regular examination in the schools. This is individual preventive work in its truest sense. Attention to the eyes of children with squint when it first becomes evident to an expert observer can prevent a great deal of partial blindness and defective vision. It is extremely satisfying to be able to report so much progress in this direction.

Ear, Nose and Throat Defects

Mr. Rowe, Consultant Ear, Nose and Throat Surgeon at the Barnsley Beckett Hospital, continues to conduct two weekly sessions at the New Street Clinic. In addition to clinical examination and treatment, audiometric examinations are carried out as well. During the year the Education Authority has decided to replace the existing obsolescent audiometer with one of the latest design. An order has been placed for this instrument but delivery cannot be expected until the middle of 1953.

Arrangements for operative treatment in those cases where the consultant surgeon considers it necessary continue to be satisfactory. Here again a fairly smooth working arrangement with the local hospitals exists largely through the good offices of Mr. Rowe.

Figures for the year's work will be found in the Appendix, Table IV, Group 3. It will be seen that there is a general all-round increase in the number of children receiving treatment and the figure of 225 school children recorded as having received operative treatment for tonsils and adenoids compares favourably with 137 in 1951. This will undoubtedly have its effect on the waiting list for this form of treatment.

Orthopædic and postural defects

The arrangements for orthopædic examination outlined in the Report for 1951 continued. Mr. Lawson, the Orthopædic Surgeon, paid 11 visits to New Street Clinic to hold sessions during the year.

The figures for children treated are contained in the Appendix Table IV, Group 5, and an analysis of these is contained in Tables Va and Vb.

All these figures are interesting when compared with those for 1951. The overall numbers of children treated both at the Authority's clinic and at the hospitals is almost constant—348 in 1951 and 343 in 1952—but in 1952 a higher proportion of these children were treated by means of remedial exercises, physiotherapy, and so forth, at the Authority's clinic. There is still a very great deal to be done in this direction and the day is not far distant when the appointment of a full time physiotherapist on the Authority's staff will become essential.

Child Guidance

The Barnsley Child Guidance Centre continued to work during 1952 under the arrangements referred to and described in previous annual reports. The figures for the year are contained in Table IV, Group 5. This shows that 55 children were dealt with by the Educational Psychologist. This compares with a figure of 285 reported for 1951.

In Part III of this report, when considering the Health Authority's obligations in the field of mental health (National Health Service Act, 1946, S.51), reference was made to the relationship between Child Guidance and Mental Hygiene. It would seem that there is a tendency for the service which was originally termed "Child Guidance" to become more and more an educational service and less and less a health service. It is no doubt necessary that the educational approach be maintained in observing the child's aptitudes and abilities. It may also be justified in ascertaining the psychological background causes of behaviour problems which give rise to difficulties in teaching and social relationships in school. Adjustment of such psychological difficulties by an Educational Psychologist can provide a not inconsiderable contribution toward the mental hygiene of a community. By this means conflicts are resolved and mental strain is reduced. As these are psychological predisposing causes of certain forms of mental ill-health in later life their removal in the case of a given individual has a potential preventive value. Unfortunately all problems of child behaviour are not so simply solved. A proportion of them, higher probably than is realised, have as an underlying cause latent mental disease or deficiency and many of them are recognisable as such only by those psychiatrists who have spent a life time in the study of mental illness. In order to deal with such cases and to adopt the appropriate remedial treatment (particularly in cases of early dementia præcox) it is essential to have available an adequate psychiatric consultant service.

In Barnsley the tendency for child guidance to become more and more educational in character is evidenced by the marked reduction in the number of cases shown as "treated" at the Child Guidance Centre through the School Health Service. The school medical staff recognise those cases which call for psychiatric investigation and this is now carried out by an Assistant Medical Officer with special experience in this work. At present this is only possible in the more outstanding cases but there are indications that the Sheffield Regional Hospital Board will be able to make available the services of a child psychiatrist in the not too far distant future. When this occurs it will be necessary to decide whether to adhere to the original concept of "Child Guidance" with its team—Consultant Psychiatrist, Psychiatric Social Worker and Educational Psychologist—working together under the direction of the Psychiatrist as part of the School Health Service or whether to break entirely new ground.

There is quite a good case for the adoption of the second course. A possible method of doing so would be to develop a consultant child psychiatric clinic with a Psychiatric Social Worker as an integral part of the School Health Service. This would have the advantage of a very close affinity with the Health Authority's Mental Health Service. This is specially important in the case of psychiatric disorders where observation and treatment may be spread over many years. With such a clinic it would be possible to deal with children whose behaviour problems come to the notice of the School Medical Officers; this would, as it developed, ensure that the fullest possible use would be made of such consultant psychiatric services as the Regional Board could make available. At the same time the Educational Psychologist could continue to develop the educational approach still further and would ultimately cease to have any connection with the School Health Service whatsoever.

Development on these lines would suffer from one great disadvantage. It would result in the establishment of two distinct departments dealing with behaviour problems in children from two different approaches. It is conceivable that the divergence between these approaches might be so great as to render their co-ordination almost impracticable. This would, however, be outweighed by the interest in mental hygiene which such development would stimulate amongst the school medical staff. With a competent psychiatric opinion available there would be real encouragement for the study of Mental Health amongst school children at medical inspection. This in turn could not but have a most beneficial effect on the Health Authority's mental health work.

Finally it is suggested that if development along these lines should be contemplated, the term "Child Guidance" should be dropped at the earliest opportunity. Fresh names would therefore become necessary to indicate the clinics held by the Psychiatrist and the consultations afforded by the Educational Psychologist.

Speech Therapy

In 1952, as for a number of years previously, Miss E. Chambers, Headmistress of Raley Modern Secondary Girls' School, assisted the School Health Service by treating children suffering from speech defects. Reference

to the Appendix, Table IV, Group 6, will show that during the year 38 children received treatment for speech defects of various types:—

Cerebral palsy	1
Delayed speech	6
Cleft palate	1
Post-operative rehabilitation, Tonsils and Adenoids	6
Stammerers	3
Lispers	6
Deaf child stammerer	1
Deaf child lisper	1
Chronic sinusitis	1
Motor aphasia	1
Mental defective, later removed from Register	1
Attended several times during year for various conditions but did not continue treatment (removed from Register)	10
	38

Of these 38, seven children completed their course of treatment and may be regarded as cured. The success of treatment depends, except in unusually obstinate cases, on regularity of attendance. Slow progress is in most cases due to irregular attendance. Experience has shown that the regularity of attendance is largely proportional to the interest taken by the parents in the child's defect. Most parents co-operate fully and the satisfactory results obtained are in a large measure due to this. The arrangement with Miss Chambers works extremely well and it is to be hoped that it will continue for many years to come.

Ultra Violet Light treatment

The arrangements for this continued during 1952. 98 children were treated at New Street Clinic, making a total of 1,039 attendances. This represents a decrease in the number of children but an increase in the attendances made when compared with 1951, the figures for that year being 119 and 960 respectively. During the year it was found possible to commence ultra violet light sessions in conjunction with the Minor Ailment Clinic at Littleworth School. Here 17 children were treated, making 167 attendances in the process. During the year it became evident that the ultra violet light lamp at New Street Clinic was approaching the end of its useful life and arrangements are being made for its renewal.

As in previous years, full use was made of the ultra violet lamp in examining children suspected of being infected with the fungi of ringworm. This application of ultra violet light has proved most valuable in controlling infections of this kind.

OPEN AIR SCHOOL

Mount Vernon Open Air School provides non-residential accommodation for 80 children. The children are selected for admission by the School Medical Officers and transport is provided to bring them to the school daily. On arrival at the school each day the children are served with breakfast.

Instruction in personal hygiene as well as the usual educational subjects follows until dinner time. After dinner there is a period of complete rest and after this there is a further session of school work until tea is served. On finishing the tea meal the children are conveyed to their homes.

These arrangements allow children who, for a variety of reasons, are unfit for the rough and tumble of ordinary school life to avoid an interruption in their education. They also provide a means of rapid build-up in the case of children whose general condition has fallen below normal physical standards. The children are under constant medical and nursing supervision and great care is exercised in selecting children for admission. In this way a maximum amount of benefit is derived from the somewhat limited accommodation available.

It is interesting to note, in view of comments made in other parts of this report that the number of children with "healed tubercular disease" recommended through the Chest Clinic has decreased in recent years. This is undoubtedly due to the increasing separation which is occurring between the School Health Service and those services operated by the Regional Hospital Board. This is, to say the least, unfortunate, as children of this kind do very well at the Open Air School. Children who suffer from non-tuberculous chest conditions do very well also. There have, however, been one or two spectacular failures. These have in some measure been due to poor attendance and lack of persistence on the part of the parents. Experience has shown that children with non-tubercular chest conditions should be admitted as early in their school lives as possible and preferably during the Spring and Summer terms. In this way regular attendance can be established before the bad weather and parents discover that going to school even on wet days does not result in a "chest attack." If no attempt is made to institute Open Air School treatment until after eleven years of age, the physical disability is usually well established and is not so amenable to environmental treatment.

The popular idea of an Open Air School is to associate it with chest illnesses. This is in fact wrong, as the majority of children who attend the school are those who for want of a better designation are termed "delicate children." Delicate children may be said to belong to three categories:—

(1) Children whose resistance has been lowered by a series of illnesses in quick succession, e.g., measles followed by whooping cough, etc. They generally improve rapidly and are discharged to their own school after a few months;

(2) Children who may have been delicate in infancy and have poor appetite or food fads, and show other signs of maternal anxiety. They generally do well with the individual expert attention provided, helped by plenty of fresh air, and their neighbours' example;

(3) Children with unsatisfactory home environment—for example, the father may be out of work for long periods through ill-health, keeping the family on the poverty line. The child may suffer from recurrent infections due to bad housing and gross overcrowding, or the child may come from a "problem family." These children usually improve, though sometimes very slowly, but they tend to relapse on discharge to an ordinary school.

As well as "delicate children" a small proportion of children with the rheumatic diathesis find their way to the Open Air School. In view of the well-known theory that an Open Air School régime is unsuitable for such children, any who are admitted are kept under special supervision by the Consultant Pædiatrician.

Finally, a few children attend the school on account of disabilities which preclude attendance at an ordinary school. These children are waiting for admission to residential schools for special education. (The difficulty in finding accommodation of this kind need not be emphasised here). In some cases there is little prospect of suitable arrangements being made; for example, one child has a slowly progressing muscular dystrophy. He is still able to attend the Open Air School where he is under continuous supervision. Until the present it has not been possible to find residential accommodation within easy reach of Barnsley. In view of the hopelessness of the prognosis it would be unkind both to him and to his family to send him away any great distance from home.

As in previous years, the school was kept open during the Summer holidays for children whose parents wished them to attend voluntarily. The nurse attached to the school continues not only to provide nursing supervision of the pupils but also to follow up cases of absence.

On the whole, the remedial work of the school during 1952 was satisfactory and it is difficult to see how the community would have obtained more benefit from it in its present form. Consideration might, however, be given in the future to the provision of a residential Open Air School on a somewhat less exposed site. There are a number of cases where a residential school would be much more appropriate and more beneficial to the pupils. An example of this is the family who undo all the good done to the pupil during the day at the Open Air School by allowing or even encouraging bedtimes as late as 11-30 p.m. or midnight. The advantage of a residential school in such cases is obvious.

A summary of the numbers of pupils and the various conditions treated is shown in tabular form. (Appendix Table VI).

SCHOOL DENTAL SERVICE

The following report has been received from the Senior Dental Officer.

The continued shortage of School Dental Officers is reflected in the Report of work done at Schools and at the Central Dental Clinic during 1952. During the greater part of the year, only one Dental Officer was available; from April until early August, two Dentists were employed at the Clinic and when one left to go into private practice, leaving again only one Officer, it was decided to discontinue routine school inspections until the long waiting list of children requiring treatment had been reduced. The assistance of the School Medical Officers during this emergency period proved of great value in that they referred to the Dental Officer at the New Street Dental Clinic any child found at the School Medical Examination to be in urgent need of dental attention. Dental Reference Cards (known in the Dental Clinic as "Pink Cards") were also in the possession of

Headteachers, normally to be issued to any child whose parents requested a Dental Inspection, but during this period the cards were issued to the "toothaches" who were seen by the Dental Officer at the New Street Clinic as and when they presented themselves. Some idea of the amount of work outstanding from schools inspected prior to June 1952 may be obtained from the fact that in November 1952 some 600 extraction cases had still to be seen. This backlog of extractions was completely cleared by the end of the year and routine dental inspections of Schools has now been re-commenced.

Much criticism has been levelled against the School Dental Service on the subject of "gas sessions," largely on the grounds that a school child requiring a tooth extraction has to wait a considerable time in the Clinic Waiting Room. The practice in the New Street Clinic is to arrange appointments in quarter-hourly groups, and it is rare for any child to spend more than 30 minutes on the Clinic premises. The average number of patients treated at a "gas session" is 30; as many as 40 children have been treated in a three hourly session but exceptional sessions such as this prove too great a strain on both dentist and anæsthetist.

Schools are inspected by the School Dental Officer in accordance with a rota kept in the Clinic, the ultimate ideal being to ensure that each school is inspected every 12 months—the attainment of this ideal will depend upon the future availability of Dental Officers. Briefly, the routine for inspection of a School follows these lines—the Headteacher is informed that a Dental Inspection is imminent and a suitable date arranged. The Dental Clerk then visits the school with the Clinic's file of Ministry of Education Dental Record Cards (Form 11.M) and ensures that a Record Card is available for each pupil. On the appointed day, the School Dental Officer and Dental Attendant visit the school and inspection of the children by classes is carried out. Inspection is of necessity brief—it might be called an Emergency Inspection since a complete record of the mouth is not made, neither is a probe used to detect carious cavities in permanent teeth. Each child is examined to ascertain its need for extractions to eliminate sepsis, and for conservation of the permanent dentition. This year, 383 children of the total of 2,855 inspected at schools were placed in the category D.N.R. (teeth defective, but not referred)—i.e., 13 per cent. The point being made here is that these children might normally be referred for treatment if there were sufficient School Dentists to give the necessary prophylactic treatment. With the situation as it is at the moment, the teeth of the children in the D.N.R. category are on probation until the urgent extraction and filling cases have been treated.

Should there be any time available after a School Dental Inspection, a short lecture on the care of the teeth is given to as many children as possible. The courteous co-operation of the Headteachers in this matter, as in all other matters relating to the Dental Inspection, is worthy of mention. Until such time as the Senior Dental Officer is in a position to visit all schools to propagate the doctrine of Care of the Teeth, the help of the teachers is invaluable in influencing the children in their attitude to the Dentist.

A child found to require treatment is subsequently given an Acceptance Card to take home to its parents. The parents are asked to sign whether they will give consent for the child to receive all dental treatment which

may be found necessary throughout the years of school life or whether they wish otherwise. If consent is given, the child is placed in the "A" Acceptance Group. Some parents will give consent only to certain forms of treatment and these form the "B" Group. Group "C" consists of those children whose parents desire that no dental treatment whatsoever shall be provided by the School Dental Officer at any time during school life. It is gratfying to note that 79.06% of the parents of the Barnsley School Children elected to have their children treated by the School Dental Officer. The "C" Acceptance Group included 206 children receiving treatment at a private dentist; the remainder refused all forms of treatment.

Appointments are then made for the children requiring treatment, priority being given to the "A" Acceptance Group.

The Dental Clinic report shows two new items this year:—dentures fitted and orthodontic appliances fitted. During the year, 14 children came to the Clinic after an accident at school; the story varied from falling down in the schoolyard to "bumping into so and so's fist." Three children lost their front teeth "at the Baths!" It was decided in these cases that a denture bearing one or more teeth was necessary, which gave great satisfaction to the young girls supplied with their missing front teeth. The orthodontic appliances were supplied to children with marked malformation of the teeth; whilst it is appreciated that orthodontics is a luxury service in a short staffed Dental Clinic, cases do arise where it is essential that some form of regulation treatment is initiated. Saturday morning, normally devoted to consultations with parents, was utilised to provide the necessary treatment. A record of children requiring orthodontic treatment is maintained—the waiting list at the moment has 107 cases outstanding.

Dental statistical returns are shown in the Appendix Table VII.

HANDICAPPED PUPILS

A total of 48 children were ascertained during the year as handicapped pupils requiring special educational treatment in accordance with the Handicapped Pupils and School Health Regulations, 1945. Once again the majority of these, 29 in number, belonged to the category of delicate children and received their special education at the Open Air School. The figures for 1952 remained almost constant when compared with those for 1951—48 as against 47. This is interesting in view of the fact that there was a decrease in the number of children subjected to routine inspection. It suggests that both parents and teachers are now conscious of the arrangements that can be made for handicapped children and see to it that they are brought forward for special inspection. In 1952 there was a marked increase in these special inspections and an ever-increasing amount of the Assistant Medical Officer's time is spent in carrying out special inspections and examinations aimed at ascertaining handicapped pupils. This in itself has had much to do with the reduction in the number of routine periodic inspections. Full statistical details are shown in Table VIII in the Appendix.

Blind children

Three blind and three partially-sighted children were in residential special schools during the year. One blind and one partially sighted child were awaiting admission to special schools. As with all handicapping

defects where blindness is accompanied by another defect such as mental retardation, it is extremely difficult to find a place in a special school for any child so affected.

Deaf children

Nine totally deaf and two partially deaf children were in special schools at the end of the year and one partially deaf child was awaiting admission to a special school. Ascertainments for the year amounted to one child totally and one child partially deaf. This position is materially more satisfactory than that reported at the end of 1951. The improvement is largely due to the great degree of co-operation and assistance that the Education Authority has received from the Yorkshire School for the Deaf at Doncaster. Additional accommodation became available in this institution and a proportion of it was made available to Barnsley children. It is therefore unnecessary, once again, to draw attention to the need for early placement in special schools of children ascertained to be deaf. There would seem now to be every reason to believe that in the future adequate accommodation will be available for such cases as may occur in Barnsley.

Delicate and physically handicapped children

Delicate children are catered for to a great extent through the facilities provided at the Education Authority's Open Air School. This provision has been already described in this report. In addition, from time to time the Education Authority provides residential convalescent treatment in special cases, as after a long illness. This is usually arranged at the seaside Home of some voluntary institution.

Reference has already been made to the need which exists for residential school accommodation for delicate children. There are a great many arguments in favour of this in a certain type of case and it is to be hoped that it will be possible for this provision to be made in the not too distant future.

Again it is necessary to draw attention to the needs of the physically handicapped child, particularly the child with multiple handicapping defects. In Barnsley the number of physically handicapped children awaiting admission to special schools has risen from nine in 1951 to 13 at the end of 1952. This has occurred despite the unremitting efforts of the Director of Education and his staff to obtain suitable accommodation for them. It is agreed that neither the total number nor the increase is large but both are of some considerable significance.

There would appear to be a National shortage of special school accommodation for physically handicapped pupils and those few institutions which cater for these children tend to select those whose handicaps offer the best chance of satisfactory, if not dramatic, results. This is, of course, natural with the demand as it is and it can be argued that such a policy ensures that the best possible use is made of the accommodation available. The effects of this policy are most obvious when applied to that group of children who suffer from spastic pareses due to birth injury. There is no doubt at all that very great benefit is done to those children who are acceptable to the special schools. At the same time there is much heart-burning amongst the parents of other "spastics" the nature of whose infirmities makes them unacceptable. It is, moreover, virtually impossible for the

officers of the Education Authority to satisfy the parents of these unfortunates that the apparent miracles performed on other (and what to them seem similar) cripples are not available for their particular children. It is even more difficult to convince these parents that this situation is not entirely the fault of the Education Authority. This existence of even a small dissatisfied group of this kind in the community can add greatly to complexity of this already very difficult problem. There is therefore no doubt at all that this position is very unsatisfactory for everybody concerned and attention has been drawn to it in previous Annual Reports.

It is felt nevertheless that once more emphasis should be laid on the need for some form of central clearing house for physically handicapped children. A " Regional " residential school with hospital facilities to which all physically handicapped children from the areas of Education Authorities forming the " Region " could be admitted in the first instance would satisfy this need. This school would have specially trained teaching staff and also a specially experienced medical staff. A detailed assessment of each child's aptitudes and abilities such as is impossible under the ordinary conditions of ascertainment for the purposes of Form 4 H.P. could then be made. Vacancies in the various existing special schools could be allotted on these assessments. In this way the best possible use could be made of the accommodation already available. The suggested institution would then be required to retain and provide the necessary educational facilities for those who could not be placed elsewhere. Finally, if by reason of handicap any particular child were totally ineducable, the grounds for this decision would be satisfactory. It would be known that the ineducability was in fact due to the handicap and not just because it was impossible to provide suitable educational facilities.

It would seem then that until some action is taken at a National level, Barnsley Education Authority and many other Education Authorities may expect to see the number of physically handicapped children awaiting placement increase each year. This offers a great opportunity for leadership both to the Ministry of Education and the Association of Education Authorities.

Educationally sub-normal and maladjusted children

Five children were ascertained as educationally sub-normal and one as maladjusted. Four children were reported to the Health Authority under the provisions of the Education Act, 1944, Section 57(3), and four under Section 57(5). At the end of the year 21 educationally sub-normal children and one maladjusted child were awaiting placement in special schools. This represents a decrease of one when compared with 1951. Places were found for four educationally sub-normal children and one maladjusted child in special schools during the year.

As in previous years, educationally sub-normal children form the largest group of handicapped pupils awaiting placement in special schools. Despite this, during 1952 there was no increase in the numbers waiting which in fact decreased by one. This was due to additional accommodation becoming available, making it possible to place four children. There are further indications that this is the beginning of an easing of the situation. With more accommodation becoming available there is a reasonable hope

that a complete solution of the problem of the placement of these pupils in special schools will be reached in the not too distant future.

Epileptic children

Two epileptic pupils were in attendance at special boarding schools at the end of the year. The one pupil who was newly ascertained was placed before the end of the year.

INFECTIOUS DISEASES

All questions relating to infectious disease in the County Borough have been dealt with in that section of the report devoted to this subject. The figures giving the incidence of infectious diseases notified as occurring in children of school age during the year are as follows :—

Disease	No. Notified
Scarlet Fever	133
Diphtheria	2
Pneumonia	13
Meningococcal Infection	3
Measles	394
Whooping Cough	97
Poliomyelitis	2
Dysentery	19
Food Poisoning	2
TOTAL	665

Immunization against Diphtheria

The total number of children of school age known to have received a complete course of immunization by the 31st December, 1952, was 11,357. During the year 73 school children received a primary course of injections. Though this number seems small it need not be regarded as unsatisfactory. It is far more important that children should receive their primary immunization before reaching school age. It is pleasing at the same time to see that at least a few parents who have neglected to have this done before their children have reached school age have rectified their neglect. The fact that only 615 children received a reinforcing dose during their school life is more disturbing. It is to be hoped that a higher proportion of parents will give consideration to reinforcement in the future.

RECIPROCITY WITH OTHER AUTHORITIES

The results of medical inspection by Medical Officers of the Barnsley Education Authority of pupils domiciled in the West Riding of Yorkshire who attend schools in the County Borough are shown in the Appendix Table IX. The results of medical inspection of pupils domiciled in Barnsley by School Medical Officers of the West Riding County Education Authority or attending schools in the County Council Area (Division 24) are shown in the Appendix, Table X.

PHYSICAL EDUCATION—SWIMMING

As in previous Reports, figures on this aspect of physical education are included :—

TOTALS FOR WINTER AND SUMMER SWIMMING
(SEPTEMBER 1951 TO AUGUST 1952)

AT THE RALEY AND CORPORATION BATHS.

Number of individual children sent to baths	6,595
Total number of attendances made	71,602
Number of children who could swim at least ten yards at the end of the session	3,703
Number of children who gained Education Committee Certificates :	
1st Class	10
2nd Class	160
3rd Class	663
Number of Life Saving Certificates :	
Elementary	181
Intermediate	150
Bronze Medallion	151
Bronze Bar	29
Bronze Cross	9
Bar to Bronze Cross	4
Award of Merit	7

PART V APPENDIX.

MEDICAL INSPECTION RETURNS

TABLE I

MEDICAL INSPECTION OF PUPILS ATTENDING MAINTAINED PRIMARY AND SECONDARY SCHOOLS
(Including Special Schools).

A.—PERIODIC MEDICAL INSPECTIONS.

Number of Inspections in the prescribed Groups:—	
Entrants	1397
Second Age Group	217
Third Age Group	848
Total	2462
Number of other Periodic Inspections	1073
Grand Total ...	3535

B.—OTHER INSPECTIONS.

Number of Special Inspections	5094
Number of Re-Inspections	4405
Total	9499

C.—PUPILS FOUND TO REQUIRE TREATMENT.

	For defective vision (excluding squint)	For any of the other Conditions recorded in Table IIA	Total individual Pupils
Entrants	8	202	208
Second Age Group ...	37	19	53
Third Age Group ...	116	47	159
Total (prescribed groups) ...	161	268	420
Other Periodic Inspections ...	74	120	187
Grand Total ...	235	388	607

TABLE II

A.—Return of Defects found by Medical Inspection, 1952.

Defect or Disease	Periodic Inspections		Special Inspections	
	Requiring Treatment	Requiring Observation	Requiring Treatment	Requiring Observation
Skin	28	7	2	...
Eyes - a. Vision ...	235	25	18	...
b. Squint ...	50	7	6	3
c. Other ...	10	3	3	...
Ears—a. Hearing ...	27	5	2	...
b. Otitis Media ...	29	10	5	1
c. Other ...	10	5	1	...
Nose or Throat	152	131	36	12
Speech	7	18	1	2
Cervical Glands ...	4	15	2	...
Heart and Circulation ...	8	27	...	2
Lungs	11	32	...	1
Developmental—				
a. Hernia	3	...	...	...
b. Other	2	6	...	...
Orthopædic—				
a. Posture	20	19	1	...
b. Flat Foot ...	32	9	5	...
c. Other	16	12	1	...
Nervous System—				
a. Epilepsy ...	...	...	...	...
b. Other	2	7	...	1
Psychological—				
a. Development ...	3	6	...	...
b. Stability	2	36	2	...
Other	27	26	4	2

B.—Classification of the General Condition of Pupils inspected in the Routine Age Groups.

	Inspected	A (Good)	%	B (Fair)	%	C (Poor)	%
Entrants ...	1397	574	41·08	797	57 05	26	1·86
Second Age Group	217	60	27·65	156	71 88	1	0·46
Third Age Group	848	291	34·32	552	65 09	5	0·58
Other Periodic Inspections ...	1078	389	36·25	668	62·25	16	1·49
Total ...	3535	1314	37·17	2173	61·48	48	1·35

TABLE III

INFESTATION WITH VERMIN

1.	Total number of examinations in the schools by the school nurses or other authorized persons	38,124
2.	Total number of individual pupils found to be infested	1,802
3.	Number of individual pupils in respect of whom cleansing notices were issued (Section 54(2), Education Act, 1944)	32
4.	Number of individual pupils in respect of whom cleansing orders were issued (Section 54(3), Education Act, 1944)	1

TABLE IV

Return of Defects during the year ended 31st December, 1952

TREATMENT OF PUPILS ATTENDING MAINTAINED PRIMARY AND SECONDARY SCHOOLS (INCLUDING SPECIAL SCHOOLS)

GROUP I—DISEASES OF THE SKIN (excluding uncleanliness for which see Table III).

	Number of cases treated or under treatment during the year	
	By the Authority	Otherwise
Ringworm—		
(i) Scalp	18	15
(ii) Body	5	1
Scabies	11	.....
Impetigo	236	6
Other skin diseases	271	142
Total	541	164

GROUP 2—EYE DISEASES, DEFECTIVE VISION AND SQUINT.

	Number of cases dealt with	
	By the Authority	Otherwise
External and other, excluding errors of refraction and squint	134	75
Errors of Refraction (including squint)	—	1,686
Total	134	1,761
Number of pupils for whom spectacles were :		
(a) Prescribed	—	926
(b) Obtained	—	678

GROUP 3—DISEASES AND DEFECTS OF EAR, NOSE AND THROAT.

	Number of cases treated	
	By the Authority	Otherwise
Received operative treatment :		
(a) for diseases of the ear	—	9
(b) for adenoids and chronic tonsillitis	—	225
(c) for other nose and throat conditions	—	25
Received other forms of treatment	367	495
Total	367	754

GROUP 4—ORTHOPÆDIC AND POSTURAL DEFECTS.

(a) Number treated as in-patients in hospitals 4

	By the Authority	Otherwise
(b) Number treated otherwise, e.g., in clincics or out-patient departments	194	149

GROUP 5—CHILD GUIDANCE TREATMENT.

	Number of cases treated	
	In the Authority's Child Guidance Clinics	Elsewhere
Number of pupils treated at Child Guidance Clinics	55	—

GROUP 6—SPEECH THERAPY.

	Number of cases treated	
	By the Authority	Otherwise
Number of pupils treated by Speech Therapists	38	—

GROUP 7—OTHER TREATMENT GIVEN.

	Number of cases treated	
	By the Authority	Otherwise
(a) Miscellaneous minor ailments	1,539	1
(b) Other (specify)	—	—
Total	1,539	1

TABLE V a

ORTHOPÆDIC TREATMENT

Inspections at the Clinic

Visits of Orthopaedic Surgeon .... 11 sessions

NUMBER OF CASES SEEN BY THE ORTHOPAEDIC SURGEON :

Tubercular—New Cases	....	—
Re-examinations	....	7
Non-Tubercular—New Cases	....	51
Re-examinations	....	158

NUMBER TREATED AT THE CLINIC :

194 children of school age have been treated during the year.

858 attendances of school children have been made for observation and exercises for postural defects.

Children requiring splints, adjustments to shoes, etc., have attended the Beckett Hospital. Orders executed by Ellis, Son and Paramore.

Children requiring Physiotherapy and massage have been treated at the Queens Road Remedial Centre.

ADMISSION TO HOSPITAL :

Four children have been admitted to the Beckett Hospital.

Several school children are on the waiting list at the Beckett Hospital for operation.

TABLE V b

INSTITUTIONAL ORTHOPÆDIC TREATMENT

BRCKETT HOSPITAL :

Initials	Age	Diagnosis	Admitted	Dis: charged	Condition on Discharge	Result
MM.	16	Excision. Ex ostosis Dorsum Right Foot	4.12.52	8.12.42	In Plaster	Good
J.B.	13	Arthrodesis for Left Hallux Rigidus	29.12.52	Still in Hospital	—	—
S.J.	14	Double Keller and Spike Arthrodesis. Left 2nd Toe	27.9.52	18.10.52	Good	Good
D.B.	14	Exision. Exostosis both Os Calces	28.1.52	2.2.52	In Plaster	Good

TABLE VI

MOUNT VERNON OPEN AIR SCHOOL

Statistical Summary of Children in Attendance during 1952

Medical category	Number in School 1st Jan., 1952	Number admitted in 1952	Number discharged in 1952	Number remaining in school 31st Dec., 1952	Average stay of discharges	
					Yrs.	Months
Healed Tuberculous Disease :						
Healed Primary T.B.	10	2	9	3	2	7
Contacts	5	1	3	3	2	10
Healed Cervical Adenitis	1	—	1	—	1	9
Resolved Plural Effusion	2	—	1	1	1	3
Post T.B. Hip	—	1	—	1	—	—
Non-Tuberculous Chest Conditions :						
Asthma	7	1	2	6	4	6
Bronchiectasis	5	—	1	4	2	10
Lobectomy Post Operative	2	1	2 *	1	2	6
Chronic Bronchitis	4	1	2	3	2	5
Delicate Pupils	27	23 †	8	42	2	2
Upper Respiratory Infections	3	1	—	4	—	—
Chronic Otorrhoea	1	—	1	—	—	4
Heart Conditions :						
Congenital Disease	2	—	2	—	4	3
Rheumatic Disease	4	—	2	2	1	5
Miscellaneous :						
Spina Bifida	1	—	—	1	—	—
Nephrectomy Post Operative	1	—	1	—	1	6
Muscular Distrophy	1	—	—	1	—	—
Post Poliomyelitis	2	1	—	3	—	—
Post Meningitis	—	1	—	1	—	—
Nervous Instability	—	1	—	1	—	—
TOTAL	78	34	35	77	—	—

* 1 deceased. † 2 Re-admissions.

TABLE VII

DENTAL INSPECTION AND TREATMENT CARRIED OUT BY THE AUTHORITY

Number of Children inspected by Dentist .	
Routine age groups	2,855
Specials	640
TOTAL	3,495
Number found to require treatment	2,112
Number referred for treatment	1,729
Number actually treated	1,371
Attendances made by children for treatment	5,034
Half-days devoted to :	
Inspection	16
Treatment	513
TOTAL	529
Fillings :	
Permanent teeth	2,228
Temporary teeth	73
TOTAL	2,301
Number of teeth filled :	
Permanent teeth	1,808
Temporary teeth	60
TOTAL	1,868
Extractions :	
Permanent teeth	571
Temporary teeth	2,654
TOTAL	3,225
Administration of general anaesthetics for extraction	1,765
Other operations :	
Permanent teeth	895
Temporary teeth	119
TOTAL	1,014
Dentures fitted	14
Orthodontic appliances fitted	2

Age Groups Examined at School

Age	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	29	147	320	278	354	356	289	318	183	185	181	170	45	—

73.97% of the total number of children inspected were found to require treatment ; of these 79.06% accepted treatment.

TABLE VIII

HANDICAPPED PUPILS REQUIRING EDUCATION AT SPECIAL SCHOOLS OR BOARDING IN BOARDING HOMES

	(1) Blind	(2) Partially sighted	(3) Deaf	(4) Partially Deaf	(5) Delicate	(6) Physically Handicapped	(7) Educationally sub-normal	(8) Maladjusted	(9) Epileptic	TOTAL (1—9)
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
In the calendar year :—										
A. Handicapped Pupils **newly placed** in Special Schools or Homes	1	1	5	—	32	1	4	1	2	47
B. Handicapped Pupils **newly ascertained** as requiring education at Special Schools or boarding in Homes ..	1	1	1	1	29	8	5	1	1	48

Number of children reported during the Calendar Year under
Section 57 (3) (excluding any return under (b)) ... 4
Section 57 (3) (relying on Section 57 (4)) ... —
Section 57 (5) 4
of the Education Act, 1944.

	(1) Blind	(2) Partially sighted	(3) Deaf	(4) Partially Deaf	(5) Delicate	(6) Physically Handicapped	(7) Educationally sub-normal	(8) Maladjusted	(9) Epileptic	TOTAL (1—9)
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
On or about December 1st :—										
C. Number of Handicapped Pupils from the area—										
(i) attending Special Schools as (a) Day Pupils	—	—	—	—	71	5	—	—	—	76
(b) Boarding Pupils ..	3	3	9	2	—	4	4	—	2	27
(ii) Boarded in Homes ..	—	—	—	—	—	2	—	1	—	3
(iii) attending independent schools under arrangements made by the Authority ..	—	—	—	—	—	—	1	—	—	1
TOTAL (C) ..	3	3	9	2	71	11	5	1	2	107
D. Number of Handicapped Pupils being educated under arrangements made under Section 56 of the Education Act, 1944 :										
(i) in hospitals ..	—	—	—	—	—	—	—	—	—	—
(ii) elsewhere ..	—	—	—	—	—	2	—	—	—	2
E Number of Handicapped Pupils from the area requiring places in special schools (including any such unplaced children who are temporarily receiving home tuition)	3	1	—	1	2	13	21	1	—	42

TABLE IX

WEST RIDING PUPILS EXAMINED BY THE BARNSLEY SCHOOL MEDICAL OFFICERS AT THE HOLGATE GRAMMAR SCHOOL AND TECHNICAL SCHOOL DURING 1952

Periodic Medical Inspections.

1 (a) Number of inspections in the prescribed groups :

Entrants	10
Second Age Group	44
Third Age Group	158
Other Periodic Inspections	—
	212

1 (b) Other Inspections : Re-inspections 2

1 (c) Number of pupils found to require treatment :

Group	For Defective Vision (excluding Squint)	For all other Conditions	Total Individual Pupils found to require treatment
Entrants	—	4	4
Second Age Group	5	1	6
Third Age Group	17	6	21
Other periodic inspections	—	—	—
Total	22	11	31

2 (a) **Return of Defects Found by Medical Inspection.**

	Requiring Treatment	Requiring Observation
Skin	—	1
Eyes :		
Vision	22	8
Ears :		
Hearing	2	—
Otitis Media	1	—
Other	1	—
Nose and Throat	5	—
Cervical Glands	—	1
Heart and Circulation	—	1
Lungs	—	1
Orthopædic :		
Posture	2	1
Flat Foot	2	—
Other	—	1
Other Defects	1	—

Parents present 44

2 (b) **Classification of the General Condition of Pupils Inspected.**

Group	No. Inspected	(Good) A No.	%	(Fair) B No.	%	(Poor) C No.	%
Entrants ...	10	6	60.0	3	30.0	1	10.0
Second Age Group	44	38	86.37	6	13.63	—	—
Third Age Group	158	42	26.58	115	72.78	1	.63
Other periodic inspections	—	—	—	—	—	—	—
Total	212	86	40.57	124	58.49	2	.94

TABLE X

BARNSLEY COUNTY BOROUGH PUPILS EXAMINED BY THE WEST RIDING COUNTY COUNCIL (Division 24) AT SCHOOLS DURING 1952

No. of Inspections

Periodic Medical Inspections :

1 (a) Number of Inspections in the prescribed groups :

Entrants	—
Second Age Group	—
Third Age Group	154
Other Periodic Inspections	52
Total	206

1 (b) Other Inspections :

Special Examinations	14
Grand Total	220

1 (c) Number of pupils found to require treatment :

Group	For Defective Vision excluding squint	For all other conditions	Total Individual Pupils
Entrants	—	—	—
2nd age group	—	—	—
3rd age group	14	2	16
Other perodic inspections	4	1	5
Totals	18	3	21

2 (a) Return of defects found by Medical Inspection :

	Requiring Treatment	Requiring Observation
Skin	1	3
Eyes :		
Vision	18	37
Squint	—	2
Other	—	—
Ears :		
Hearing	—	2
Otitis Media	—	1
Other	—	—
Nose and Throat	—	—
Speech	—	—
Cervical Glands	—	2
Heart and Circulation	—	3
Lungs	—	3
Developmental :		
Hernia	—	—
Other	—	3
Orthopædic :		
Posture	—	4
Flat Foot	1	—
Other	1	3
Nervous System :		
Epilepsy	—	1
Other	—	1
Psychological :		
Development	—	—
Stability	—	3
Other Defects	—	20

2 (b) Classification of the general condition of pupils inspected :

Group	Number Inspected	Good A		Fair B		Poor C	
		No.	%	No.	%	No.	%
Entrants	—	—	—	—	—	—	—
Second age group	—	—	—	—	—	—	—
Third age group	154	122	79.22	32	20.78	—	—
Other Periodic Inspections	52	44	84.61	8	15.39	—	—
Total	206	166	80.58	40	19.42	—	—

Health Committee

(as at 31/12/52)

Chairman: Alderman E. Sheerien, J.P.

Vice-Chairman: Mrs. Councillor M. Brannan

His Worship the Mayor: Councillor L. Briggs, J.P.

Alderman W. Gill, J.P.
Alderman R. Newman
Miss Councillor M. Ryan
Councillor H. I. Addy
Councillor B. Armitage
Councillor T. R. Brown
Councillor A. Butler
Councillor F. B. Crow
Councillor F. Elliott
Councillor A. Lowery
Councillor G. Race, J.P.
Councillor J. G. E. Rideal, D.S.O., T.D.
Councillor R. Skelly
Councillor G. Whyke

Co-opted Members:

Dr. L. V. Broadhead
Dr. N. Pick

Sanitary Committee

(as at 31/12/52)

Chairman: Alderman A. Dunk, M.M., J.P.

Vice-Chairman: Councillor G. Burkinshaw

His Worship the Mayor: Councillor L. Briggs, J.P.

Alderman H. Burgin
Alderman W. Leach
Alderman A. Wright
Miss Councillor M. Ryan
Councillor F. B. Crow
Councillor H. Dancer
Councillor J. H. Foster
Councillor W. Hunt
Councillor S. Jubb
Councillor W. Martin-Chambers
Councillor G. Race, J.P.
Councillor T. O. Roberts
Councillor G. Whyke
Councillor H. Wills

Education Committee

Chairman: Alderman E. Sheerien, J.P.

Vice-Chairman: Alderman A. E. McVie, J.P.

His Worship the Mayor: Councillor L. Briggs, J.P.

Alderman C. Bentley
Alderman H. Burgin
Alderman A. Dunk, M.M., J.P.
Alderman W. Gill, J.P.
Alderman J. Guest, J.P.
Alderman A. Wright
Mrs. Councillor M. Brannan
Miss Councillor M. Ryan
Councillor F. B. Crow
Councillor H. Dancer
Councillor F. Elliott
Councillor J. Halton, M.M.
Councillor G. Mason, J.P.
Councillor J. G. E. Rideal, D.S.O., T.D.
Councillor T. O. Roberts
Councillor S. Trueman
Councillor J. Wood

Co-opted Members:

Miss E. Hepworth
Miss M. A. Wilkins
Mr. C. E. Green
Rev. Canon W. C. Hudson
Rev. Canon A. P. Morley
Rev. J. W. Thompson

Staff of the Public Health Department

Medical Officer of Health, Schools Medical Officer and Superintendent of the Blind:

G. A. W. Neill, T.D., M.D., D.P.H., Barrister-at-Law.

Deputy Medical Officer of Health and Deputy Schools Medical Officer:

Margaret W. Blackwood, M.B., Ch.B., D.P.H.

Assistant Medical Officers of Health and Assistant Schools Medical Officers:

Clara L. M. Scally, M.B., B.Ch., B.A.O., L.M., D.P.H.

James Ross, M.B., Ch.B.

Thomas Barry, L.R.C.P. & S. (I).

Health Visiting Service

Assistant Superintendent Health Visitor and School Nurse:

Mrs. M. E. Milburn, S.R.N., S.C.M., H.V. Certificate.

Health Visitors and School Nurses:

Miss E. M. Garnett, S.R.N., S.C.M., H.V. Certificate.
Mrs. A. Hudspith, do.
Mrs. E. M. Page, do.
Miss J. Young, do.
Miss A. Kay, do.
Miss J. Witty, do.
Miss I. S. Hawcock, do.
Mrs. H. Gough, do.
Miss M. Baker, do.
Miss E. M. Seabury, do.
Mrs. C. Totty, do.
Miss E. E. Gelder, do.
Mrs. A. E. Jackson, do.
Miss E. L. Young, do. (Commenced 28/6/52).
Mrs. D. Gibson, do. (Commenced 28/6/52).
Mrs. A. Thompson, S.R.N., S.C.M., S.R.F.N., H.V. Certificate (Commenced 17/10/52).

Health Visitor Trainees:

Miss E. L. Young, S.R.N., S.C.M. (Terminated 27/6/52).
Mrs. D. Gibson, S.R.N., S.C.M. (Terminated 27/6/52).
Mrs. A. Thompson, S.R.N., S.C.M., S.R.F.N. (Terminated 16/10/52).
Miss B. Clarke, S.R.N., S.C.M. (Commenced 7/10/52).

Departmental Staff Nurses

Mrs. A. Metcalfe, S.R.N.

Miss E. A. Hazlehurst, S.R.N.

Mrs. M. E. Edge, S.R.N.

Mrs. M. D. Burrows, S.R.N., S.C.M. (Part-time).

Mrs. I. Higgins, S.R.N., S.C.M.

Miss B. Clarke, S.R.N., S.C.M. (Commenced 1/9/52). (Terminated 6/10/52).

Pre-Nursing Pupils:

Miss M. Burd (Terminated 4/1/52).

Midwifery Service

Non-Medical Supervisor of Midwives:

Miss M. M. Moore, S.R.N., S.C.M., S.R.C.N., Q.I.D.N.

Domiciliary Midwives:

Miss E Rushton, S.R.N., S.C.M.

Mrs. K. Tomlinson, S.R.N., S.C.M. (Temporary Relief). (Terminated 8/10/52).

Miss R. A. Chamberlain, S.R.N., S.C.M.

Mrs. T. Brownson, S.R.N., S.C.M.

Mrs C. M. Dempsey, S.R.N., S.C.M. (Terminated 8/1/52).

Mrs. C. Moisley, S.R.N., S.C.M.

Mrs. A. Taylor, S.R.N., S.C.M.

Mrs. R. E. Bedford, S.C.M. (Practising under Defence Regulations).

Miss S. Doherty, S.C.M. (Terminated 6/5/52).

Mrs. B. Hartley, S.C.M.

Mrs. A. Horne, S.R.N., S.C.M. (Commenced 24/3/52).

Mrs. G. Bailey, S.R.N., S.C.M. (Commenced 1/9/52).

Home Nursing Service

Superintendent of District Nurses:

Miss M. M. Moore, S.R.N., S.C.M., S.R.N.C., Q.I.D.N.

District Nurses:

Mrs E. Allen, S.R.N., S.C.M., Q.I.D.N.S.

Mr. G. R. Trueman, S.R.N., Q.I.D.N.S.

Mrs. E. Brooks, S.R.N. (Terminated 31/8/52).

Mrs. H. Padgett, S.R.N.

Mrs. I. Worrall, S.R.N. (Terminated 31/5/52).

Mrs. E. Cross, S.R.N. (Terminated 31/3/52).

Miss D. Major, S.R.N., S.C.M., Q.I.D.N.S. (Re-commenced 15/3/52 after Queen's District Training).

Mrs. M. E. Walshaw, S.R.F.N.
Mrs. M. Allen, S.R.F.N. (Part-time). (Terminated 6/12/52).
Miss J. Crawford, S.E.A.N.
Mrs. S. Burnham, S.E.A.N.
Mrs. D. Parkin, S.E.A.N.
Mrs. M. McGuinness, S.E.A.N. (Part-time).
Mrs. M. Barraclough, S.E.A.N. (Part-time). (Terminated 13/12/52).
Mrs. W. Grant, S.R.F.N. (Commenced 6/10/52).
Mrs. J. Taylor, S.R.N. (Commenced 21/4/52).
Miss K. M. Hutchinson, S.R.N., S.C.M. (Part I), Q.I.D.N.S. (Commenced 8/8/52).
Mrs. E. Davies, S.R.N. (Part-time). (Commenced 2/4/52).

Nursing Orderly:
Mrs. M. Martin.

New Street Day Nursery

Mrs. M. McConnell, S.R.N., S.C.M., Q.I.D.N.S., Matron,
Miss K. M. Tracey, Deputy Matron.
Mrs. A. Hooson, Warden.
Mrs. M. E. Carroll, Temporary Nursery Assistant.
Miss M. Jones, Nursery Staff Nurse. (Terminated 23/3/52).
Miss G. Worthington, Student. (Terminated 31/7/52).
Miss R. Hutson, Student. (Terminated 21/3/52).
Miss G. Sykes, Student.
Miss A. E. Blueman, Student.
Mrs. K. Connolly, Nursery Assistant. (Commenced 7/1/52).

Prevention of illness, Care and After-Care

Miss N. E. M. Benzimra, Social Worker.

Blind Welfare

Mr. A. Henshaw, Assistant Superintendent.
Miss E. I. Mitchell, Home Teacher.
Mr. J. Moore, Home Teacher.
Mr. H. V. Davis, Home Teacher.
Miss E. White, Workshop Supervisor.
Miss H. Shaw, Clerk. (Commenced 21/3/52).

Mental Health

Miss S. A. Wain, Duly Authorised Officer.
Mr. H. W. T. Smith, Duly Authorised Officer.
Mrs. S. Crossland, Duly Authorised Officer.
Miss C. Byrne, Supervisor, Occupation Centre.
Miss A. Smith, Assistant Supervisor, Occupation Centre.
Miss M. Outram, Assistant Supervisor, Occupation Centre (Unqualified).
Miss M. Price, Assistant Supervisor, Occupation Centre (Unqualified). (Commenced 27/10/52).
Mrs. E. M. Molyneux, Occupation Centre Assistant. (Part-time).

Domestic Help Service

Mrs. P. M. Gardiner, Domestic Help Organiser.
Miss D. Smith, Assistant Domestic Help Organiser. (Commenced 27/11/52).

Dental Service

Mr. J. Kilner, B.D.S., Senior Dental Officer. (Commenced 27/3/52).
Mr. J. Hawcroft, L.D.S., Dental Officer (Temporary). (Commenced 14/1/52—Terminated 18/8/52).
Miss M. B. Howard, Dental Attendant.
Miss R. Sharpe, Dental Clerk.

Administrative and Clerical Staff

Mr. B. Payne, Administrative Assistant and Chief Clerk.
Mr. J. Faulkner, Senior Clerk.
Mr. K. Holling, Record Officer. (Commenced 1/12/52).
Miss M. Harris, Senior Shorthand-Typist.
Mrs. S. Clarke, Shorthand-Typist.
Miss J. Turner, Clerk. (Terminated 31/8/52).
Miss M. Buckle, Clerk.
Miss J. Walker, Clerk, Care of Mothers and Young Children.
Mrs. M. Court, Clerk, Care of Mothers and Young Children.
Miss A. V. Gyles, Clerk, Care of Mothers and Young Children.
Miss B. Shorthouse, Clerk, Care of Mothers and Young Children.
Miss S. M. Bambrough, Clerk, Care of Mothers and Young Children.
Miss B. Clarke, Senior Clerk, School Health Service.
Mrs. E. Stephenson, Clerk, School Health Service.
Miss M. R. Smith, Clerk, School Health Service.
Miss R. Godridge, Clerk. (Commenced 1/9/52).
Miss L. I. Oldham, Clerk. (Commenced 29/12/52).

Sanitary Service

Mr. W. H. Spalton, Senior Sanitary Inspector.
Mr. A. Pemberton, Deputy Senior Sanitary Inspector.
Mr. C. Henderson, Assistant Sanitary Inspector. (Terminated 18/10/52).
Mr. F. Midgley, Assistant Sanitary Inspector.
Mr. E. S. Hackney, Assistant Sanitary Inspector.
Mr. A. Smith, Assistant Sanitary Inspector.
Mr. A. Milner, Assistant Sanitary Inspector.
Mr. D. R. Worrall, Senior Clerk.
Mr. P. R. Hunt, Temporary Clerk.
Mr. A. Foster, Clerk/Student Sanitary Inspector. (Terminated 30/9/52).
Miss H. Hunt, Clerk/Typist.
Miss B. Livesey, Shorthand Typist.

INDEX