[Report 1950] / School Medical Officer of Health, Salford.

Wellcome Collection
183 Euston Road
London NW1 2BE UK
T +44 (0)20 7611 8722
E library@wellcomecollection.org
https://wellcomecollection.org

CITY OF SALFORD.

EDUCATION COMMITTEE.

SCHOOL HEALTH SERVICE.

REPORT

OF THE

SCHOOL MEDICAL OFFICER,

J. L. BURN, M.D., D.Hy., D.P.H.,

For the Year ended 31st December, 1950.

CONTENTS

SCHOOL HEALTH SERVICE REPORT.

To the Chairman and Members of the Education Committee.

Mr. Chairman, Ladies and Gentlemen,

"*As the hope of the earth is the Spring,*
So the hope of the race is the child."

There is no more important task than the care of the child. The School Health Service offers great opportunity to preserve, promote and enhance the health of the child.

You will find in these pages an account of some of the care which is given to our school children and, through them, to their families and to our community.

There is evidence in this report of the ways in which the health and welfare of the children are supervised. There are various "screens" through which the nearly 30,000 children pass so that we may find those children who need special care. A combination of both old and new methods is used in the search for children who may be suffering from defect which deprives them of that full health which should be their birthright.

I give below a brief resume of a few features of our work :—

(1) *The Rapid Survey Method.* In addition to the routine medical inspections, the rapid survey by nursing staff has been shown to be a valuable instrument in our hands to check up periodically the physical state of the children. This method has brought the school health visitor into closer contact with the teacher and child. Any child in whom she finds a condition which requires medical investigation is noted and an endeavour is made for the medical officer to call at the school within a week or so. In this way, the advantage of examination both by the school health visitor and the medical officer is combined and economy in the doctor's time is effected. One other advantage is that the child is seen with the teacher. A further account of this rapid survey is contained in the report on page 10.

(2) *Closer Co-operation with the Pædiatrician.* The pædiatrician in charge of the children's beds in hospital is also consultant pædiatrician to the School Health Service. He conducts school health clinics and his advice is generally available. The obvious advantage of this is that he has the hospital beds and hospital facilities for special investigations immediately to hand when required.

(3) *Special Class for Partially Deaf Children* (page 29). This class has continued its good work.

(4) *Spastic Class.* The spastic class moved to newer, larger and better premises where 12 children attend. This is an economical feature of the educational care of children suffering from cerebral palsy. Another interesting feature is that, on average, the children admitted to this class have lower I.Q's than are generally accepted by other cerebral palsy units. Expense is not involved for residential treatment and all the advantages of home life and parental care are preserved. (Page 33).

(5) *The Pre-Tonsillectomy Clinic* has proved its value. Every child on the " tonsil " list can be reviewed by the pædiatrician and consultant ear, nose and throat specialist. After investigation, a decision is taken as to whether the recommendation for the tonsil operation shall go forward and the child's name remain on the list and, secondly, with what degree of urgency the operation is necessary (page 7).

(6) *Sweep Test* (page 34). Perhaps the most interesting investigation which took place during the year was the testing out of the so-called sweep test by which means the hearing of each child can be individually tested in a quicker and more effective way than the group test.

(7) *Notification of Rheumatic Conditions* up to the age of 16 has helped in the provision of special educational treatment for those few children suffering from rheumatic diseases. Notification here, as elsewhere, has proved to be essential to better care.

(8) *Handicapped Children.* Once again a Christmas visit to the circus at Belle Vue was organised for 100 Salford handicapped children. Another Christmas treat for the children was the Children's Party at the Art Gallery, Peel Park, to which 300 handicapped children were invited ; this party is organised by the staff of the department.

(9) *Diphtheria Immunisation.* An effort has been made to increase the number of children immunised in order to continue the high percentage (over 95 per cent.) of children immunised. New entrants to school continue to receive booster doses on admission.

(10) *Clinic Premises.* I am glad to be able to report the improvement which has taken place in your clinic premises. Individual chairs have been provided in place of the old communal benches, to take one example.

The routine work of the school medical officer and school health visitor, in their co-operation with the parents and teachers is, of course, the main way in which we work. There are branches of special provision for special cases such as the asthma clinic, foot health clinic and provision for the child afflicted with cerebral palsy.

Another point of interest has been the attack on the problem of the child with *verminous infestation.* For 10 years there has been no prosecution of parents for this condition. This does not signify that there has been neglect of the problem. I have never been able to persuade myself of the value of prosecution in these cases. Rather is there need for better education of the parents and of the public as a whole, and better technical care. Whilst the right to prosecute is still reserved as a weapon, I am proud that you have not resorted to prosecution in a single case. There are those who will say that we

should be ashamed of not having brought parents before the court ; but our attitude is entirely deliberate and positive. It seeks not to punish but to secure co-operation and to help. I have never had cause to regret this policy though I deplore the careless neglect of some parents.

Yet another interesting point—we have adopted, over a period of 10 years, an attitude to epidemic disease which has not meant the exclusion from school of contacts except in the (fortunately rare) diseases such as polio. For all the common infections of childhood, the system has been that all contacts are examined by a doctor or a nurse at the time the original patient is diagnosed and, in the vast majority of cases, the children have been allowed to attend school. In some thousands of cases of infectious disease—scarlet fever, chicken-pox, mumps, measles, whooping cough, etc.—I cannot recall one instance in which the spread of the disease has occurred as a result of this " freer " policy. The saving of school time which has resulted from this policy must be really significant. (In the case of diseases such as scabies, prompt treatment of family contacts has enabled the school child to attend school with safety the day on which, or the day after, the original case was diagnosed).

The scope and extent of methods of ascertainment and facilities for treatment of the educationally subnormal child is, in my opinion, far inferior to that of the detection of physical subnormality. I am glad to learn you are providing three additional special classes in the Broughton area—this is a heartening example. I am aware of the difficulties in providing rooms in already overcrowded schools for these children and of the host of other difficulties which beset you in your plan to provide children with the education suitable to their ability and aptitude. Nevertheless, the task must be faced ; for it is the least satisfactory aspect of your provision for special educational treatment of handicapped children.

When we read that there were over 27,000 juvenile delinquents in England and Wales in 1948, the better ascertainment and care of the educationally subnormal child becomes of special significance. There is no doubt a proportion of these children find the competition with their more fortunate fellows in the same class too much ; they become disheartened and seek satisfaction in doubtful activities. On the subject of delinquency, it is interesting to note that from 20 per cent. to 40 per cent. of the children have some emotional disorder and therefore earlier ascertainment and care might do comething to prevent delinquency. In the special class the educationally subnormal child can feel happier and more effective. He will come more closely under the care of the School Health Service.

Personal Environment.

Personal environment is a very important factor in child health. The dictionary defines " environment " as " that which surrounds or encircles " ; environment, therefore, must include personal and psychological influences which, though difficult to see and measure, are nevertheless of decisive importance.

Consequently, environment is more than the house and street in which the child lives, the air he breathes, the water he drinks. School health services are more than milk, meals and medical inspection, more than teaching the children to be clean, more than the school buildings—school environment. The influence of the teachers are all-important because people rather than premises influence health.

The staff have tried to be one with the people and their problems. The services of the whole staff are made available for Parent/Teacher Associations, etc. A number of film strips have been prepared—one on the School Health Service attractively portrays the variety of services available.

I should like to take this opportunity of recording appreciation of the work of the medical, nursing and administrative staffs, to whom credit is due for the work detailed in this report.

It is no mere formality to refer with grateful thanks to the help which has been given by you, Mr. Chairman and members of the Physical Care Sub-Committee, by Mr. F. A. J. Rivett, Director of Education, and the teaching and administrative staffs of the Education Department.

I have the honour to be,

Your obedient Servant,

J. L. Burn

School Medical Officer.

MEDICAL INSPECTION OF SCHOOL CHILDREN.

Arrangements are made for each child to be examined by the School Doctor as soon as possible after first admission to school, during the last year of primary school life and during the last year of secondary school life. The parent is invited to be present at these examinations and it is most important that the mother or father should attend because the first principle of the work of the School Health Service is to teach, stimulate and encourage the parents in the better care of their children.

The Local Education Authority, through the School Health Service, has made arrangements to provide medical treatment for pupils as follows :—

Observation at School Clinic when the School Doctor may find, at the examination in school, that further investigation is necessary or if the parent requests this.

Treatment of Minor Ailments such as cuts, septic spots, sore eyes, etc., by the School Nurse at the Minor Ailments Clinics. At some schools it has been possible to open Minor Ailments Clinics, thus reducing loss of school time and avoiding danger to the children from traffic on busy roads.

Pre-tonsillectomy Clinic.

Children referred because of enlarged tonsils and adenoids are examined at this Clinic by the Ear, Nose and Throat Specialist, Dr. Cavanagh, who decides on the need for operation. In those cases where there is a possibility of avoiding operation the decision is postponed for a period of two to six months and the child is examined again then. This extra supervision has been very effective in avoiding operation in many cases.

Ear, Nose and Throat Clinic.

Children with diseases of the ear, nose or throat are examined by the Specialist at this Clinic. Appropriate treatment is carried out until the child is seen again by the Specialist.

At this Clinic children whose hearing is defective are examined by the Specialist and arrangements made for admission of the child to the Partially Deaf Class in Regent Road School if the loss of hearing is such that the child has not been able to benefit from the instruction under ordinary classroom conditions. In this class the children are taught to lip-read and to use a hearing aid. They remain in this class for about six months to one year and they are then usually able to return to a normal school.

Eye Clinic.

Children whose eyesight is not normal are referred to this Clinic for examination by the Eye Specialist. When glasses are advised a prescription for these is given to the parents who are asked to take this and the child to to any Optician on the National Insurance List. When the glasses are fitted the child is examined again by the Eye Specialist to make sure that the eyesight is then normal.

Where the child has a squint or glide, glasses are always necessary and in addition, treatment is given at the Clinic for the weak eye. Having this treatment, the good eye may be covered for a time in order to strengthen

the weak muscles of the other eye. If the squint is still present when wearing glasses an operation may be necessary to straighten the eye. Although the squint can be cured in this way the vision of the squinting eye is not improved by the operation.

Other eye disorders such as conjunctivitis and styes are referred to the Eye Specialist if they do not improve quickly with treatment at the Minor Ailments Clinic.

SKIN CLINIC.

The Skin Specialist holds a clinic at Regent Road every Thursday afternoon, where Salford school children suffering from any type of skin disease may be referred by the school doctor. The work of the Clinic is closely connected with this Skin Specialist's Clinic at Hope Hospital so that if hospital investigation or treatment is required this can be arranged without any difficulty.

SCHOOL DENTAL SERVICE.

The importance of this Service is shown by the figure for last year when over 68 per cent. of the children inspected in school by the School Dentist were found to require treatment. School children are given gas when teeth have to be pulled out and just over 3,500 anæsthetics were given for this treatment for Salford school children in 1950.

A special branch of the School Dentists' work deals with the regulation of teeth which are badly formed or are out of true position and a new clinic has been opened at Encombe Place for this orthodontic treatment.

CHIROPODY.

Clinics attended by the Chiropodist are held at Regent Road and Murray Street and regular foot inspections are carried out in all the schools. All defects discovered receive prompt treatment and parents are advised if shoes are not suitable.

SPEECH DEFECTS.

Children with a stammer or any similar trouble have special training either in school or at a Clinic and results from this treatment are good.

ASTHMA CLINIC.

Children suffering from asthma are examined at Regent Road Clinic by the Consultant Paedictrician, Dr. R. I. Mackay, and after a very complete investigation, treatment is arranged with good results.

OPEN AIR SCHOOL.

Delicate children very often require to spend one or more terms at our Open Air School at Barr Hill where they appear to improve in health very quickly. This school accommodates only 100 pupils.

NERVOUS DISEASES.

Specialist opinion regarding school children suffering from any nervous disease is obtained from Dr. J. S. Parkinson at Salford Royal Hospital.

SPASTIC CLASS.

This is a Special Class at Cleveland House for children handicapped by a paralysis which makes them unfit to have education in an ordinary school.

ORTHOPAEDIC CLINIC.

Crippled children are examined at this Clinic by the Orthopædic Specialist, Mr. D. D. Cranna. A member from a surgical appliance maker is also in attendance at this Clinic and he arranges for all repairs and alterations to shoes, splints, etc.

PHYSIOTHERAPY.

Various forms of physiotherapy are available at Regent Road, Police Street and Murray Street. Children who have had tonsils and adenoids removed are invited to attend for breathing exercises for a period of six weeks. Special breathing exercises for asthmatic children are given at the three clinics and at the Open Air School where most of the asthmatic children attend.

SUNLIGHT CLINICS.

Three sunlight clinics are available to school children at Regent Road, Police Street and Murray Street Clinics.

Nursery Schools.

The report deals with the following nursery schools :—

Hulme Street ;
Kara Street ;
Markendale Street ;
Cook Street ;
London Street.

Each school has been visited once every month except when the school has been closed for holidays. Each child was examined at alternate inspections unless progress was unsatisfactory, when it was seen each visit. Any child absent at the time of the inspection was seen the next visit.

The date and time of the inspection is put on the notice board of the nursery school but few mothers avail themselves of the invitation to be present. An attempt is being made to persuade the mother to be present for the first inspection but without notable success. The majority of mothers will be present if a definite invitation is given because of the child's unsatisfactory condition or progress.

The response to invitations for special clinics is still poor—particularly for treatment which requires continued attendance, e.g., massage and exercises, artificial sunlight, dental treatment other than extractions.

The general health of the children in the nursery schools is good and shows definite improvement during their attendance. Only one child has shown no improvement whatsoever and a stay in a Convalescent Home has been arranged for this boy.

The following is a list of recorded infectious diseases :—

Chicken Pox	8	
Measles.....	34	
German Measles.....	11	
Whooping Cough	2	
Dysentery Sonne	3	(no records kept in some schools).
Mumps.....	16	
Impetigo	2	
Scabies	0	

There has been a greater incidence this year of minor respiratory troubles and of tonsillitis and cervical adenitis but only one case of pneumonia is reported.

The standard of cleanliness is fairly good. Verminous and nit infested heads are found to reoccur in the same children. The children are regularly inspected by the health visitor or clinic nurse visiting the school, but the actual cleansing appears to be left to the mother—who is very frequently in full-time employment. There have been no cases of scabies reported in any nursery and only two children have been excluded with impetigo.

School Nursing Service.

The duties of School Nurses may be divided, roughly, into clinic, domiciliary and clerical work, with clinic work predominating during 1950.

During the year, for the first time, all schools were taken over by health visitors. Clinic work was delegated to the six remaining school nurses, clinics nurses and some (few) health visitors. Hygiene attendants assisted in both schools and clinics where necessary.

Work in Schools.

(*a*) *Hygiene Inspections* were conducted in most schools every term and a greater effort made to improve general cleanliness and to reduce head infestations. Re-inspections have been made more frequently and home follow-up work intensified.

Compared with the infestation rate of schools for which health visitors were responsible in 1949—some 12 per cent.—the rate for 1950—17 per cent.—seems high. This may be accounted for by the fact that the schools taken over during the year were in bad areas where the general standard of hygiene was low, in one school the infestation rate was 45 per cent.

(*b*) *Medical Inspections.* Health visitors have assisted the school doctor at most inspections, and have carried out vision testing, weighing and measuring, and any other necessary preliminary measures.

(*c*) *Infectious Disease Outbreaks.* Nine schools were visited during the year with reference to outbreak of infectious disease and a total of 1,042 children examined.

(*d*) *Nursery Schools.* Daily visits have been paid where possible. All children were seen but only those in an unsatisfactory condition or referred by the Superintendent were examined at the daily visit. All children were examined once a month when possible and were also examined monthly by a medical officer. Head cleansing is the responsibility of the nursing staff. It is to be regretted that the pediculosis rate among these children remained consistently high, 22.9 per cent. in 1949 and 23 per cent. in 1950. The figure in individual nursery schools varied in 1950 from 13.3 per cent. at Kara Street Nursery to 44.7 per cent. at Markendale Street.

Rapid Surveys.

This comparatively new aspect of school nursing has shown interesting developments but is still only in the experimental stage.

The surveys have a two-fold function.

(1) *Medical.* The detection of defects, which should be followed by prompt medical investigation, and where necessary, treatment.

(2) *Education.* To serve as an occasion for individual health education of pupils.

From an *educational* point of view, three factors are important :—

(*a*) *Time.* An atmosphere of haste discourages pupils from taking this opportunity for health discussion and without participation of the pupils much of the value of teaching is lost.

(*b*) *Assistance.* Help with preparation of the room, clerical work and marshalling the children, etc., is important as it leaves the health visitor free to discuss health with the pupil. Help is also important with children too young to benefit from health discussion, as much time is otherwise spent in helping with undressing, thus leaving the health visitor little opportunity for contact with class teachers.

Hygiene attendants have been very effectively used to assist with this work, but assistance was limited as the establishment of hygiene attendants does not allow for expansion of their duties to the extent needed.

(*c*) *Privacy.* Most senior pupils are eager to make the best use of this opportunity for health education provided they are not overheard or overlooked at the time. Efforts made by head teachers to ensure privacy were much appreciated. Sometimes the Head Teacher's own room was offered ; or a classroom, or part of the hall screened off by mobile blackboards had given the necessary seclusion. It would be helpful if, in those schools where the only accommodation available is a cloakroom, screens could be provided and where the floors are of composition or stone, some form of washable rug or cork mats be provided.

The findings at rapid surveys varied according to the type of school and area, the most important being the high incidence of suitable and/or defective footwear with its resultant train of minor foot defects. More important are the potentialities for permanent foot disabilities, which may show serious results in adult life.

It was interesting to note the reaction of the children as a whole to a survey whilst actually in progress. Common faults, discussed with friends by the early examinees became strikingly less common as the survey proceeded and—to quote from a health visitor's report—" the last two sessions brought to light many washed necks, trimmed finger nails and even new vests and shoes."

With consolidation and expansion of the medical and educational aspect of this work, Rapid Surveys may rightly claim the central place in the School Health Visitor's work in the future.

CLASSROOM TEACHING.

Requests from head teachers for the health visitor to give talks on hygiene and mothercraft have been met. At each of two schools one health visitor has given an average of one lesson every week during the school year. Senior

girls were taught mothercraft and hygiene and children in a lower class hygiene only. The children showed great interest and the response to teaching was good. All lessons were given in collaboration with head and class teachers whose co-operation and help were greatly appreciated.

Teaching of Mothercraft in schools.

CLINICS.

School Clinics were staffed whenever possible by clinic nurses and by the remaining six full-time school nurses, rather than by health visitors.

All nurses undertaking treatment of Minor Ailments attended Dr. Cavanagh's Ear, Nose and Throat Clinic for a " refresher " session. Head mirrors and aural speculi were supplied to all clinics and where necessary adjustable lamps, sterilisers and other equipment, needed to improve efficiency, were provided.

Work in Schools.	Health Visitors.	Clinic and School Nurses.	Total.
Medical Inspection Sessions	486	44	530
Hygiene Inspection Sessions	873	110	983
Hygiene Re-inspections	250	11	261
Special Visits to Schools	309	67	376
Special Visits to Nursery Schools	510	—	510
Vision Testing Sessions	137	30	167
Rapid Survey Sessions	224	10	234
Audiometer Testing	—	48	48
Diphtheria Immunisation Sessions	—	76	76
Miscellaneous Sessions	53	2	55
TOTAL SESSIONS	2,842	398	3,240

School Clinic Work.	*Health Visitors.	Clinic and School Nurses.	Total.
Minor Ailments Sessions	179	1,973	2,152
Routine Medical Sessions	378	895	1,273
Specialist Medical Sessions	—	620	620
	557	3,488	4,045

Domiciliary Visiting School Children.	†Health Visitors.	School Nurses.	Total.
Medical follow-up	508	382	890
Cleanliness follow-up	525	123	648
Special visits	—	23	23
	1,033	528	1,561

Report of the Work in the Ear, Nose and Throat Clinic.

Dr. Florence Cavanagh reports :—

During 1950 the Ear, Nose and Throat Department continued its work. Certain aspects have been of particular interest :—

The pre-tonsillectomy clinic has been continued. The full effect of this work will not be assessed for another year or so. So far, however, we feel that two good points have developed :—

1. We have prevented several children from having unnecessary operations.
2. Where it has seemed that operation is essential to restore the child's health, we have been able to hurry this forward.

The class for the partially deaf is running at full strength. Several children have now spent a few terms there and have moved on to normal schools. Most of these youngsters have done well in their new spheres. One child who had become deaf following tubercular meningitis, and had lost her speech as a result of deafness, is now able to talk again. We are looking forward to the time when we can have a separate class for the young children—at the moment the ages range from 5—15 and this is obviously not in the best interests of any of the children.

The treatment of chronic ear discharge remains a great problem. Several different lines of treatment have been used. Though we have had many successes there is a hard core of resistant cases which remain as a challenge.

Unfortunately some fail to receive adequate treatment for many reasons :—

1. Parents do not regard the discharge as serious.
2. Children are often not upset by this discharge.
3. General practitioners are too overworked to give the necessary time to the rather lengthy procedure of dressing such an ear.
4. Teachers do not like the children to miss lessons in order to have treatment.
5. Nurses are not always interested in every branch of their work and as ear cases are time-consuming when given the care they ought to have, those who do not care for this branch may " scamp " the work.

A supervising ear, nose and throat nurse. Recently in Salford we have promoted one of the nurses to a special post. This particular nurse has had considerable experience in ear, nose and throat diseases, but even more important, she is interested in the work and has been able to obtain results far

superior to any other results we have experienced. This nurse now attends once or twice a week all the major clinics where ear dressings are done. In this way we hope that the whole standard of work will be improved.

Ophthalmic Clinic.

Dr. John Scully reports that during the past year this clinic has been held five times weekly at the Education Offices. Children attend this clinic who suffer from defective vision, squint and external diseases of the eye.

Cases are referred to the ophthalmic clinic from the following sources :—

Children sent by medical officers during medical inspection in the schools, children referred by school teachers, children recruited from the maternity and child welfare clinics, children brought by parents themselves and, lastly, children referred by opticians.

With the exception of those cases referred from the maternity and child welfare department, the children in schools are examined by the medical officer, health visitor, or school nurse, at the age of 7 to 8, either by means of Snellens Test Type, or if illiterate, with the aid of the Illiterate E Test.

The clinic is receiving increasing help from the teaching staffs in the schools in the matter of referring cases. As they are with the children most of the day, they are in a better position to detect symptoms such as screwing up the eyes in distant vision, holding print too close, frowning when reading, and especially when the child shows signs of educational retardation.

There has been an increase in the number of educationally backward children sent for examination, but in not more than approximately 30 per cent. is there any marked defect in visual acuity. Even, however, when the sight is found to approximate to normal, it is not felt that an interview with parent and child is wasted time. The parent, without exception, is pleased to discover that a visual defect is not present and this further emphasises the need on the part of the parent to share with the teacher the responsibility of giving special encouragement to the backward child.

There is a steady reference of cases from the Maternity and Child Welfare Department for squint or lacrimal obstruction. The latter condition is restricted to children in infancy or between the ages of one and two and responds to local treatment for a few weeks or months, in the majority of cases, and it is only a small percentage of cases which require lacrimal probing in hospital. The usefulness of the early reference of cases of squint cannot be over-emphasised in the pre-school child. In recent years there has been maintained a constant reference from the Maternity and Child Welfare clinics of children with this defect. They are refracted under mydriatic, and glasses, where necessary, are often prescribed within a week or two of the squint occurring.

Not a few children just out of infancy but able to walk are fitted with " tie-on " spectacles for constant wear. The mothers of the older pre-school children (ages 3 to 4) are particularly gratified with the early improvement in visual acuity in the squinting eye as a result of occlusion and the wearing of glasses.

Since the inception of the National Health Service Act in 1948 there has been a noticeable increase in the number of parents who bring their children for eye examination when any defect is suspected. This is in marked contrast to the prejudice against the wearing of glasses not so many years ago.

There has been noticeable co-operation by opticians in sending children to the clinic for refraction under mydriatic so that the full amount of hypermetropia or myopia may be corrected.

Lastly, and importantly, the rapid surveys of children in schools, including eye-testing, brings to light children with visual defect who have been missed at routine inspection due to illness or for other reasons.

It will be appreciated that the young patients drawn from these several sources represent a high percentage of the school population in the city which suffer from visual defect.

Refraction Clinic.

Ten to 14 cases are sent for per session and the waiting list for patients to be seen is no longer than three weeks. If a child does not attend at the first invitation, the invitation is repeated for three times at intervals of a fortnight or three weeks. If no response occurs to the invitations, the child is home visited. As a result of these efforts, less than 5 per cent. of the children come into the category of defaulters. Occasionally, the child or the parents do not collect the glasses from the optician and a home visit is made as a result. Since the inception of the National Health Service Act, there have been no cases which have not received their glasses.

The children suffering from short sight are seen every six or twelve months according to the progression of the myopia. The long sighted children are tested every 12 or 18 months.

Since 1st January, 1950, the clinic has had the services of an orthoptist for four sessions per week and during the year an average of 50 to 60 occlusions have been examined weekly and 10 to 12 orthoptic treatments per week have been given.

SQUINT.

These patients usually have a hyper-metropic refractor error. They are examined under a mydriatic and glasses are prescribed when necessary. All such cases are referred to the orthoptist and are seen by the latter within three months of the time of refraction.

Patients undergoing occlusion are seen monthly and when the vision is equal, or nearly so, at three-monthly intervals.

Orthoptic training may be given at the earliest at the age of 7 and the child attends at weekly intervals. A waiting list for those children requiring operation is compiled following orthoptic investigation and the cases are classified according to the type of squint.

PARTIALLY-SIGHTED CHILDREN.

It is now proposed to accommodate about 15 children with a poor degree of visual acuity at a sight-saving class in the new open-air school at Irlams-o' th'-Height, and consent from the parents has been obtained for this number as a commencement.

In accordance with the National Health Insurance Act, the parents are instructed, on receiving form O.S.C.2, to take this and the child to an optician on the National Health Insurance list. When the glasses are fitted and supplied by the optician, the child is asked to attend again for a test of visual acuity and the fitting and lenses are checked.

By arrangement, the opticians are notifying the clinic when the glasses are fitted, so that the further supervision is ensured. Post-cards are supplied to opticians on application.

Artificial eyes are now supplied free of charge, and it is gratifying to note that none of the few children to whom this applies has been without an " eye."

All repairs and adjustments are dealt with immediately and are not placed on the waiting list. All cases sent as " urgent " by teachers and doctors are given an early appointment, also child welfare cases and older children accompanied by parents who are concerned about their children's sight.

TABLE.

	Boys.	*Girls.*
Attendances at Orthoptic Clinic for Occlusion and Routine Inspection	1,300	1,209
Attendances at Orthoptic Clinic for Treatment	131	174
New Cases of Strabismus	147	137
Number of Refractions	2,130	
Number of Cases of Eye Diseases	226	
Number of pairs of Glasses prescribed	631	592
Number of pairs of Glasses obtained	631	592
Operations for 1950	48	

INTERNAL EYE DISEASES.

These are discerned on internal examination of the eyes under Mydriatic drops, and are comparatively rare. Treatment is advised, and the child is seen frequently. As these are often due to general causes, the child is referred to special departments such as the Municipal Clinic, Tuberculosis Department or to hospital for further treatment which cannot be given at the clinic.

EXTERNAL EYE DISEASES.

These comprise external diseases of the eyes and lids, and are often referred from other clinics. The number of cases varies with the time of the year, such diseases being more prevalent in the spring and autumn when there are cold winds and variable weather. General health is usually lower in spring following the winter. The children are examined and they are referred for treatment to the nearest school clinic and continue treatment at home.

Cases of Blepharitis are becoming rarer, due to modern methods of treatment which are applied regularly, and because of persistence in treatment after an apparent cure. It is also due in many cases to the wearing of spectacles for correcting stigmatism. The more serious types of inflammation such as phlyctenular conjunctivitis and ulcers of the cornea, both of which are likely

to lead to defects of vision, are also not so frequent. This again is due to modern medicine clearing up the condition more quickly, before permanent injury is done to the eye, and also to the children's persistence in the treatment both during and after the attack. In many cases these are due to low general health and the children are referred to the Sunlight Clinic and given Cod Liver Oil and Malt or other vitamin supplements.

The acute suppurative conditions are rarely seen now because the child is treated in the early stages before the deeper tissues are involved.

" Styes " are not seen so frequently now, and the milder infections of lids and conjunctivæ are treated and cured before they involve deeper tissues and the condition becomes chronic.

The milder conditions of Conjunctivitis are still seen, but quickly clear up under regular treatment, and leave no after-effects.

These children are rarely advised to be absent from school, as experience teaches that the condition clears up quicker when the child attends school and attends the clinic regularly, which they tend not to do if absent from school. The risk of infection to other children is very remote, except in the rare cases of acute suppurative conditions. In many cases both parents are at work during the day leaving the children to play unsupervised in dirty surroundings, and aggravate their condition by rubbing the eyes. In school, however, under more regular supervision such aggravation is often avoided.

Consultant Skin Clinic.

Dr. A. J. Gill reports :—

This clinic is held once weekly at Regent Road on Thursdays at 2-30 p.m. and provides facilities for diagnosis and treatment of skin disorders in Salford school children. Beds for those children in need of hospital care are available in the children's wards at Hope Hospital.

The need for hospitalisation of skin diseases during childhood continues to decrease for the categories of sepsis, *e.g.*, impetigo, septic scabies, but is still required for the type of case which can prove most intractable (*e.g.*, asthma—infantile eczema, psoriasis, chronic urticaria).

During the year under review, quite a large series of capillary nævi have been treated with Thorium X. In general, the smaller raised cavernous nævi occurring on the body are left untreated and the great majority of these lesions appear to clear spontaneously before school age is reached. For the larger lesions, and particularly those occurring on the face, which often give rise to considerable anxiety in the minds of the parents, treatment by repeated paintings with Thorium X in varnish or alcohol is very satisfactory. Cosmetic results are good. There is a complete absence of scarring, the nævi gradually fading and flattening over a period of 6 to 12 months.

The incidence of virus infections during the school years remains high. These include verrucæ, plantar warts and molluscum contagiosum. The main centres of dissemination of these conditions, and in particular the two latter, appear to be the swimming baths. Practically every child seen who was suffering from molluscum contagiosm gave a history of recent attendance at the swimming

baths. These lesions, once contracted, spread rapidly over the body and it would appear advisable, at " rapid survey " examinations particularly, to watch out even for the single small umbilicated pimple which is typical and refer it for treatment before multiplication takes place. Swimming should be forbidden until the skin has been clear for some weeks.

One other noticeable feature during the past year has been the increasing number of cases of sensitization to penicillin applied locally to the skin as ointment or cream. It would seem preferable to use penicillin locally for septic lesions in the form of an aqueous spray or as the powder. If the ointment or the cream is used it should be used only for short periods and omitted at the first sign of intolerance.

During the year 250 new cases and 289 old cases were seen.

The distribution by age groups was as follows :—

	Old Cases.	*New Cases.*
Adults	90	42
School Age	165	191
Under 5's	34	17

School Dental Service.

Report by L. H. Pollitt, Esq., L.D.S., Senior Dental Officer.

The year started with the school dental service facing its most difficult position since the war and owing to shortage of staff the Murray Street Clinic was closed and the Regent Road Clinic was only able to be operated on a part-time basis. Later in the year the position deteriorated still further and for a time the staff was reduced to two full-time officers. As a result of this shortage routine treatment and inspections had to take a second place in order to meet the demands for casual treatment.

It is, therefore, with considerable pleasure that I can report, in spite of the universal shortage of public dental officers, some improvement in staff position as a result of which it has been possible to re-open the Murray Street Clinic part-time and to have a full-time clinic at Regent Road again. Whilst there is still room for further improvement it will be possible to undertake more routine work if the staff position remains as at present. During the year we were sorry to lose the services of Mr. H. Walker who has retired and Mr. L. Miller who has resigned, and glad to welcome Mrs. B. Levy and Mr. A. Frankenstein.

In the past year 6,395 children were inspected, of whom 4,993 were found to require treatment and 987 were referred by the School Medical Officers and Nurses. The number of children treated was 6,223 for whom 2,500 fillings in permanent teeth were done and 730 temporary teeth filled. Other operations including crowns root treatments, prophylactic treatments, etc., numbered 1,405, and 243 operations—chiefly silver nitrate treatments—were carried out on temporary teeth. Sixteen children were fitted with partial dentures.

Orthodontic Service.

In January we lost the services of Mr. N. Wild under whose direction the service had been started, but we were fortunate to find a successor in Mr. I. McCracken who attends for two sessions a week. Of all the services provided

by a school dental service, apart from the immediate relief of pain, probably none is so much appreciated as the orthodontic service. The demands for such treatment can only be met, however, in a very partial measure.

Nearly all appliances are of the fixed stainless steel variety and during the year 54 appliances were fitted and 225 visits were made by children. The purchase of an X-ray unit will be of considerable advantage for diagnostic purposes as well as giving facilities for checking progress at various stages of treatment.

Foot Health Clinic.

Mr. Franklin Charlesworth, F.Ch.S., reports :—

There is nothing more fascinating than the supple and graceful feet of a healthy child. The symmetry and beauty of their graceful contours are the delight of every mother. If children born with sound, healthy feet could be kept without shoes and brought up in an environment of springy turf and soft sands during their pre-school years, their structural and postural stability would be assured, provided that on commencing to wear shoes they were based upon sound anatomical and physiological principles.

The environment of the modern child, however, is one of hard unyielding wooden floors and later stone or concrete pavements and roads, which have made it necessary to protect and support the feet against these harsh non-resilient surfaces. In spite of the uncompromising condition of our modern environment it is possible to keep the feet of the child sound and healthy by proper attention to foot hygiene and the fitting of appropriate footwear at an early age.

The proper care of the feet involves only a few very simple rules. The feet should be washed regularly and dried thoroughly, particular attention being paid to between the toes, a little talcum powder sprinkled in the interdigital surfaces and dusted over the feet will ensure the absorption of surplus moisture. Proper trimming of the nails is important. Faulty nail trimming is frequently responsible for the development of troublesome defects. The toe nails should be trimmed straight across and not rounded or cut away at the corners. The grooves of the nails should not be probed with sharp instruments such as pointed scissors, as this may result in piercing the tissues with a consequential inflammation or a possible infection.

Socks should receive careful consideration. Tight socks are frequently responsible for minor deformities of the toes and even structural weakness in the feet due to impairment of the proper functioning of muscles. In the process of washing woollen socks tend to shrink, particularly so if very hot water is used. Excessive shrinkage in this way quickly make a pair of socks, originally adequate in size, much too small for the child to wear without injurious effect to the feet. A liberal amount of surplus material in the toes of socks is necessary to allow for normal shrinkage and the creeping back of the socks when the shoes are pulled on to the feet. Rough darning, seams and holes may result in blisters, abrasions or even corns.

The structure of the feet of young children are simple and the joints very mobile. For this reason, in the case of children under 2½ years of age, it is advisable to fit boots rather than shoes. The footwear can be secured more firmly to the feet, holding the floor of the shoe in close contact to the sole of

the foot, ensuring proper support. As the feet of the child have not as yet been distorted good quality shoes on natural form lasts, conforming to the contours of the feet, should be fitted. To ensure a proper fit it will not suffice to ask the child if the shoes are comfortable. The joint spaces in the child's feet are so large that the foot can be severely squeezed up without causing actual pain, thus permanent damage can be done without it being realised. The weight-bearing foot is usually measured with a standard size stick, two additional sizes being added to obtain the shoe size. Shoes fitted in this way should provide the necessary toe clearance. If shoes have been correctly fitted they should fit snugly round the heel and instep and the hinge of the foot correctly related to the hinge of the shoe.

If the healthy development of the child's feet is to be maintained a proper appreciation of the aforementioned factors by all concerned is essential. Every endeavour is being made by this department to promote the interest of parents, teachers and the child. Attractive window displays with appropriate models, charts, etc., have been used. Posters illustrating faulty and correct posture and simple exercises for the healthy development of the feet have been displayed at schools. Lectures to health visitors is another method that has been used to disseminate appropriate knowledge and advantage has been taken of regular school surveys to obtain the co-operation of the principals and teachers. The fullest advantage is taken of contact with parents at the foot health clinics to utilise that all important personal contact to the fullest extent to gain their willing co-operation and to instruct them.

Fig. A. Foot inspection at a school.

The regular foot inspection carried out at schools have brought to light many interesting facts (Fig. A) not the least of which is the prevalence of mobile pronated feet (Fig. B). It has been argued by some authorities that a

high percentage of these cases is self-correcting, as the muscles gain strength so they will be able to provide the necessary support. Whilst this is undoubtedly true it must be pointed out that in the interim period neglect of pronated feet will result in faulty posture and gait. This may be maintained even though the long arch weakness has been overcome. It should also be pointed out that it is almost impossible to distinguish between congenital and acquired mobile pronated feet in children. It is, therefore, advisable to take steps to re-establish

Fig. B. Mobile Pronated Feet.

structural stability of the feet and thus safeguard against the development of defects in posture and gait. To this end all cases of long arch weakness have been referred to the clinic where medial wedges of cork have been fitted to the shoes in all but the severe cases. The latter have been placed on the list at Hope Hospital where in due time they have been fitted with corrective surgical insoles.

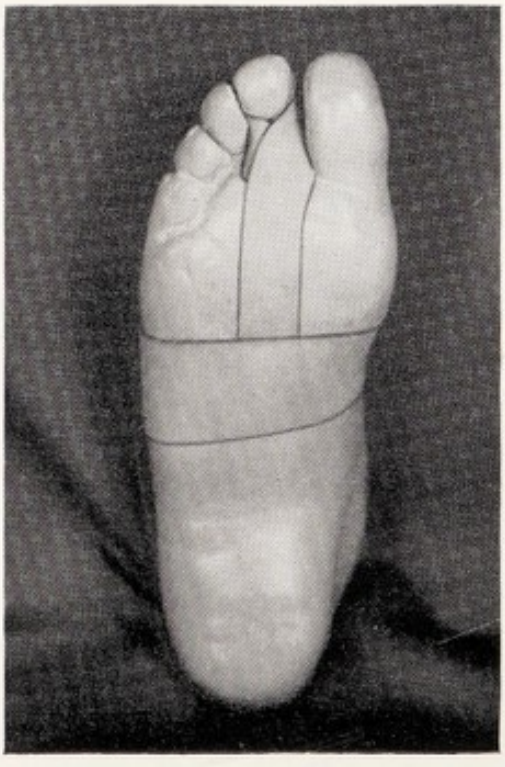

Fig. C. Traction sling for overlying Second Toe.

CORK WEDGES.

The difficulties attending the prescribing of leather wedges to the soles and heels of the shoes are many. Even these wedges to be truly effective should be so placed as to cause a tilting of the floor of the shoe. It is necessary that these wedges should be inserted, in the case of the sole, between the middle and outer sole and, in the case of the heel, the heel should be lifted and the wedge inserted at the base. It is unfortunate however that this method of attaching

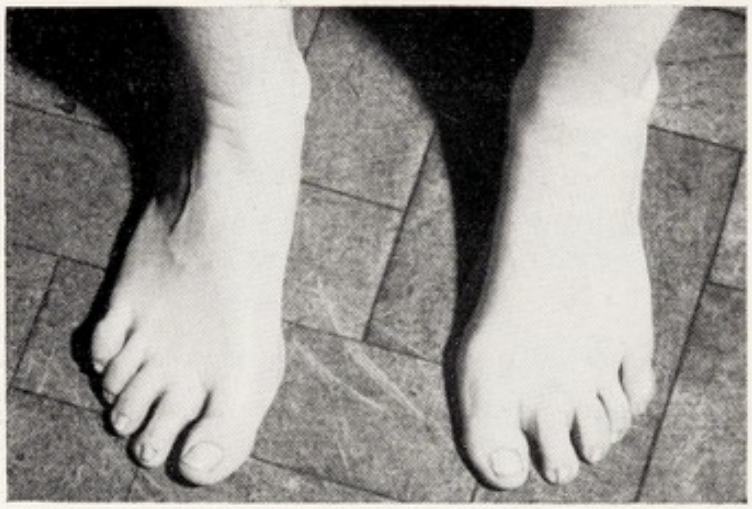

Fig. D. Hallux Valgus—Girl, age 11 years.

wedges is rarely carried out. It is also unfortunate that the leather which is usually fitted on the top of the sole and heel is rarely wedged shaped, but merely a flat piece of leather with the edge abruptly bevelled. This indifferent attempt at wedging is quite unsatisfactory, the effect aimed at is not achieved and the leather wears away very rapidly. The relative high cost of such an alteration cannot be overlooked particularly as the result is so indifferent. To solve this

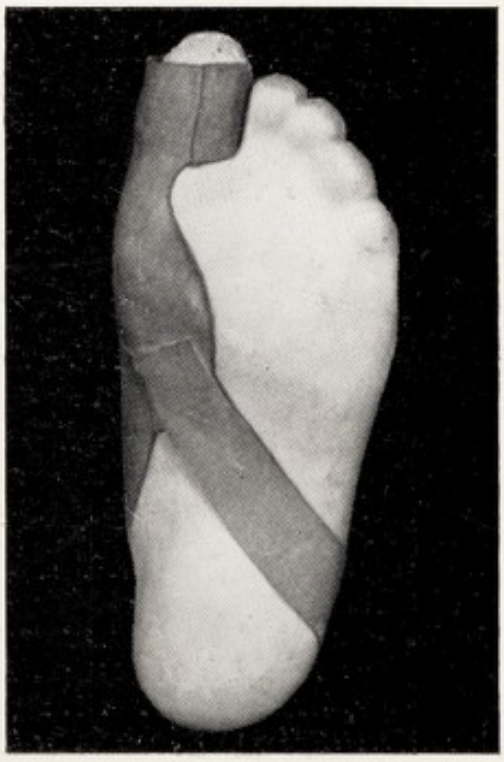

Fig. E. Hallux Valgus
Traction Sling.

problem cork heel wedges have been devised and consist of a leather heel sock and a wedge shaped piece of cork $\frac{3}{16}$ in. thick and $1\frac{1}{2}$ in. wide. The cork wedge is fitted along the medial half of the sock, the anterior end of the cork being bevelled. Where necessary the thickness of the wedge can be increased by adding a further layer of cork. The advantages of this simple device are that a proper wedge effect is achieved so far as the heel is concerned, and the

Fig. F. Contracted Second Toe.

cost is very modest—the appliance being provided as part of normal treatment and eliminating the necessity of the parent being put to considerable expense by having leather wedges fitted. The use of the wedges have been confined to the less severe cases of pronation and have proved highly satisfactory. Careful check of all cases treated has shown most gratifying results as is evidenced by the statistical report.

Fig. G. Toe Splint with Brace.

LESSER TOE DEFECTS.

In the case of defects of the lesser toes very satisfactory results have been achieved by the use of simple corrective devices, such as traction slings (Fig. C) for the correction of hallux valgus (Fig's D, E) and overlying toes. Toe splints and toe props have been devised and effectively used in the treatment of underlying toes and contracted toes (Fig's F, G). In the treatment of the above conditions experience has taught us that the most satisfactory results are obtained in treating underlying rotating toes and hammer toes, by first securely splinting with felt and Z.O. plaster and correction in this way is usually obtained in a very short time—usually about a month. This form of splinting is then discontinued and a replaceable toe splint or prop substituted.

VERRUCA.

The continued decline in the number of cases of verruca is very satisfactory. This improvement is undoubtedly the result of the interest and co-operation of heads of schools and teachers, which has resulted in early diagnosis, prompt treatment and the prevention of the spread of infection.

OTHER DEFECTS.

The number of cases of nail defects, bunion and metatarsalgia are relatively very small and such as they are, are confined in the main to the age group 13 years to 15 years.

The very encouraging results achieved during the past year are due to the excellent team work and enthusiasm of all concerned.

Speech Therapy.

At the beginning of this year the speech clinics re-opened a fortnight after the commencement of the school term owing to the absence through illness of the speech therapist.

Two clinical centres only have been in operation, those serving the Broughton and Salford, 5, areas. Meanwhile, cases are constantly being referred by medical officers and head teachers, of children attending schools in the Pendleton and Salford, 3, areas. In all, about 40, during the past year. In addition, there are also others referred before 1950, and still awaiting treatment by a speech therapist.

During the year, 35 visits to schools and 74 home visits were made.

Children attending the Spastic School, at Hope Hospital, have continued to receive speech treatment, consisting of one session each Wednesday morning, throughout the year, and for the most part fairly steady progress has been noticeable.

During September, the opening lecture for the third session of the Salford Nursery Assistants' Discussion Group, at the Education Office, was given by the speech therapist, and entitled "Speech Defects and Therapeutic Treatment." This had special regard to the child of nursery and infant school age, and stressed the emotional aspect underlying or accompanying speech disturbance, with the child's great need for security. Various reading matter used in the speech clinics was also displayed.

TREATMENT OF STAMMERING CHILDREN.

Whatever the type of stammer, whether tonus spasm (inability to utter the desired speech sound), or clonus (repetition of a speech sound), there is loss of self-confidence, to a greater or lesser degree. It is this loss of confidence which is responsible for the appearance of such obvious signs of nervousness as hurry and tension. A vicious circle is thus set up, and the ensuing conflict leads on to stammering. Treatment, therefore, aims at building up the child's confidence, by restoring to him a proper appreciation of himself as an individual.

As a first step it must be clearly pointed out that the stammer is not an integral part of the personality, but only a bad habit which has been acquired ; that differences of temperament are largely responsible for the fact that one person may perhaps be more inclined to fall prey to a stammer than another exposed to similar conditions. This sensitivity of nervous make-up, it is emphasized, in actual fact a gift if used in the right way. Used in the wrong way, it becomes a menace to the possessor, resulting in self-consciousness with all its attendant miseries. Used aright, it bestows upon the individual a greater degree of perception and appreciation of things seen and heard, with a finer discrimination between what is worthwhile and what is not, and a more steady understanding, sympathy and insight into the minds and feelings of other people. The force of this argument is intended to show to the stammerer that there is nothing wrong with himself as a person, but only with his attitude towards himself, and so towards his performance generally ; that his confidence is there—a little under the surface at present—but capable of being brought right up on top.

The foregoing remarks, clothed in language which can be readily accepted and assimilated, are offered only to the older child. The younger individual is content with a simple explanation ; e.g., " you stammered because you hurried and got tightened-up." But all of them are made to understand the need for self-control in order to gain the mastery over the bad-habit circle—anxiety, hurry and tension, which " like a magnet " tries to pull them in the wrong direction.

This sense of hurry or urgency appears to be common to all stammerers, regardless of the form the stammer may take. They feel that someone is waiting for an answer and may become impatient if they fail to reply quickly. Or again, standing up to read aloud in class, that the eyes of the class are upon them—criticising and judging them unfavourably—and that they may make a bad showing and so lose face.

Many children go through what is known as the " cluttering " stage, usually around four to five years of age. This is a normal phase of development, though not necessarily experienced by every child. At this stage the brain is working faster than the speech mechanism is able to form the words, and the resulting jumble is called cluttering. The danger is that a parent on hearing it may feel anxious about the child's speech, become impatient with him or her, and a true stammer may thus be started. The best way of dealing with this onrush and jumbling of speech on the part of the child is to speak quietly and calmly oneself, waiting without impatience to hear what it is the child wants to say, and as far as possible letting him do things for himself in his own time.

Feelings of self-mistrust and insecurity are most frequently bred in the home environment. It is not always recognised by parents that no two children are alike, that different gifts are bestowed on each, that the child approaches

a problem or situation in his own particular way ; and so, feeling this difference as a slight upon themselves, they fail to comprehend and respect their child's individuality. Thus, there is often impatience on the part of one or other of the parents, with a tendency to praise one child unduly while running-down the other (and, as it seems to them, less fortunate) child. Broken homes, divided parental control, lack of love and understanding all play their part in engendering in the child's mind a feeling of insecurity and personal inadequacy.

While one cannot always remove or control undesirable factors in the environment, some sort of adjustment is often possible, with the co-operation of the parents ; and in the child's visits to the speech clinic much can be done to restore and build-up his sense of security upon which depends his faith in himself. In some cases, however, where the emotional maladjustment is of a more serious nature and the home background more deeply disturbed, it may be necessary to refer the child for special psychological treatment at the Child Guidance Clinic.

Regarding treatment at the speech clinic, the next point is to make the child realise that if he can learn to keep calm and take his time all will be well. I get the child to copy down and repeat out loud such phrases as : " I can take my time " : " I can take an easy breath " : " I can keep relaxed " : " I can speak slowly "—and so on. A piece of elastic, stretched and then released, provides a good example of tension followed by relaxation. Similarly, a pencil gripped too tightly serves to illustrate nervous tension—the speed of writing is hindered and the pencil lead may be broken : in the same way, the stammerer with nervous haste, tries to force his words out and the speech pathway becomes blocked : or I may describe a crowd of people attempting to force their way through an exist—in church or cinema—if they rush the door few get out, but if they go out slowly and in orderly manner the building is easily emptied.

Relaxation forms the basis of the treatment, but no child is asked to lie down and learn to relax until he has first understood just why he should carry out this exercise, and how it will benefit him. Before relaxing his muscles completely, he is asked to stretch each limb in turn, and then all limbs together, while lying down (a cat is a good example of this). The object of the exercise is two-fold : in the first place, stretching tones up the muscles and makes subsequent relaxation easier, and in the second place, the child feels the difference between the pull and letting-go of the muscles. The children remain down, quietly relaxing, for some four or five minutes ; and this, at first, needs the exercise of some self-control if the child is to refrain from the tendency to fidget. Actually, as a greater degree of spontaneous relaxation is attained, he becomes less inclined to want to do this, and in the end usually sustains the relaxed state for the required four or five minutes very well indeed. The next stage is for the child to learn to put into practice, while he is up and about (particularly in the speech situation), what he has achieved while lying down : to know when he is tense and to let himself " go easy."

Besides relaxation, there is reading aloud, reciting of rhymes (sometimes of their own invention), rhythmical counting, and other activities such as drawing and colouring, playing competitive games, describing pictures, etc. There are never more than four children in a class at a time. In this way, I am able to give them individual attention, follow up their case histories, and generally keep an eye on them.

It may so happen that a child is bad at one particular thing, say reading or writing ; but if it can be demonstrated that he does well in another direction (and I am thinking here of his performance at the speech clinic)—at some game, for instance—or at drawing—the disturbing effects of his particular limitation are minimised ; and indeed, as he gains in confidence, the very item which aroused this feeling of inferiority tends to improve quite considerably because the child has ceased to feel that it is a bogey. Instead, he is fortified by the knowledge of his recent achievement. (One wonders whether the tendency to " mirror-reading," exhibited by some children, isn't after all due to anxiety ? They try to grasp the word too quickly).

Besides a good deal of free drawing, which is usually a great favourite with the children, they are asked to copy certain drawings and diagrams designed to illustrate how nervousness, hurry and tension (and so, stammering) can be overcome : the antidote is a complete swing-over in the opposite direction : for example, a clock, with pendulum swinging first in the wrong and then in the right direction—the latter leading to self-confidence and easy speech.

Miming appears to be of considerable value to some children as a builder-up of confidence. On one occasion I suggested a to class of boys that they should each do a mime in turn. A boy called W. (a very bad stammerer) immediately jumped up and volunteered to " take the floor." It was at once obvious that the child had a natural gift for miming. He was, in fact, excellent. Shortly afterwards, I visited his school and learnt from the headmaster that W. had quite suddenly shown general improvement : greater sociability, more keenness all round, and a lessening of the stammer. This improvement was also apparent at the speech clinic on subsequent occasions.

Where a young child develops a repetitive stammer which troubles him not at all, and of which he may even be unconscious, there is the danger that harm may be done by drawing attention to it, and so creating an anxiety state. For this reason, it is undesirable that children under seven years of age should receive direct treatment for a stammer. A home visit instead, resulting in an adjustment somewhere, may serve to put the matter right. Even should the young child exhibit nervous tension, the indications still are that the case would be best tackled through an approach to the parents rather than by treatment at the speech clinic. If the child is attending school, it is always most helpful to have the teacher's opinion regarding him and his parents. All parents of stammering children (whether attending for treatment or not) receive a circular letter with remarks intended as guidance to them in the handling of their child's difficulty.

Any tendency to worry about the stammer should be checked (and this applies to people in the child's immediate vicinity as well as the individual himself). If a child can so far disregard his stammer that he doesn't mind whether other people hear him stammering or not, then he is well on the way to self-adjustment.

During the past year 91 children received treatment at the Speech Clinic.

Total number of attendances amounted to 1,570.

Details of children who received treatment :—

At Broughton County Secondary School—

Dyslalia	17
Stammerers	27
Stammerers with Dyslalia	2
Sigmatism	4
Athetosis	1
Nasal Speech	1
Total	52

At Regent Road School—

Dyslalia	21
Stammerers	13
Stammerers with Dyslalia	4
Sigmatism	1
Total	39
General Total	91

Children interviewed and waiting admission number 33. A further 10 children were also called for interview, but failed to attend.

Children referred to me during the past year and not yet called for interview amount to 21. Besides this number there still remain to be interviewed 61 cases referred by head teachers in 1948, but this latter list is undergoing constant revision. Many of these children are referred again through the medical officer, and others have been found to be no longer in need of speech treatment.

In five cases interviewed no special treatment was required.

Discharges during the Year.

Final discharge—satisfactory	21
Provisional discharge—satisfactory (and awaiting final discharge)	11
For re-admittance and further treatment	1
Stood down temporarily	2
Discharged—further improvement unlikely	6
Discharged on admittance to Child Guidance Clinic	3
Discharged because of failure to attend or unsatisfactory attendance	10
Left school, having shown great improvement	4
Left school, having shown slight improvement	2
Left Salford area	2
TOTAL	62

(In 3 of these cases, where treatment had lapsed, the mother was working and there was no one to bring the child to the clinic).

Special Investigation Clinic.

Dr. R. I. Mackay reports that during most of 1950, sessions of the Asthma Clinic were held monthly by reason of pressure of work in the Department. In the first ten months of the year, several new cases were seen and some of the more urgent of the follow-up cases were reviewed.

A similar course was followed this year as previously in the study of the new cases, but the investigation of the asthma syndrome in each individual child has included an X-ray of the chest and nasal sinuses and a white cell count with a differential count. In previous years not every child had these investigations performed after the first consultation, but in the more severe and resistant cases these tests were eventually deemed necessary. The information gained from the examinations has made it possible to assess the importance of the factors of allergy, infection, and emotional disturbances more rapidly. Having made these assessments, treatment was advised either by reference to the appropriate Local Authority Services or by recommendations to the family doctor. Very few of the new cases seen this year have been seen for the second time to assess progress.

The children attending for follow-up examination were selected because of deterioration in physical condition or because of resistance to treatment. In many cases, laboratory or radiological examinations were performed and on the basis of these treatment was modified, or more frequently instructions regarding regimes and routines of physical treatment were emphasized. A few children required admission to hospital to break the asthma habit and these and others were referred for convalescence. School leavers were advised on suitable occupations, and efforts were made to put them in touch with the Juvenile Employment Bureau.

Certain reorganisation took place on November 1st which made it possible to extend the Asthma Clinic and to hold weekly sessions. This clinic now includes all children concerning whom the School Medical Officers may desire a consultant opinion and for whom hospital investigation is not likely to be required and all the children remaining on the files of the Asthma Clinic.

Cases are invited by appointment and sufficient time is allowed for full examination and discussion of each patient. Radiography of the chest, certain skin tests, hæmoglobin estimations and routine urinalysis can be performed in the clinic but some children have been referred to the X-ray Department and Laboratory at Hope Hospital for other tests as indicated.

One of the most important features of this clinic is that the Medical Officers of the School Health Service attend the clinic with the Pædiatrician on a monthly rota. In general, children referred by a Medical Officer will be invited to a session attended by that Medical Officer.

The majority of the children seen to date are asthmatics, some of them new cases, but the variety increases and a selection of problems facing the School Medical Officers present each week for discussion. Some of these problems are purely medical but emotional disturbances and social and educational problems are also included if such a consultation may contribute to their solution.

Report on the Work of the Special Class for Partially Deaf Children, Regent Road School.

The special class at Regent Road is now in its third year and well established. Reports from Head Teachers and parents of the children who have passed through the class are most encouraging. These children, whose ages range from seven to twelve are now enjoying normal school education ; there is " nothing the matter with them." They have renewed self-confidence, added abilities and every hope of being accepted as normal citizens.

An incident occurred during a conversation between a visitor and the specialist teacher of the class. It took place at an outing for handicapped children of Salford, and the question arose : " Are there any of your past pupils here today ? " On receiving a negative reply the visitor asked : " Why not, they are still deaf, are they not ? " to which the teacher replied : " Oh yes, but they are no longer handicapped."

They are no longer handicapped. That is the purpose of the class. It is for children who, because of their defective hearing, have fallen behind their fellows in school work ; whose mental outlook is daily becoming more gloomy ; who find themselves left out of games, isolated from friends and misunderstood by adults. It is for these children that the knowledge of lip-reading and a fuller understanding of the world of comparative silence, or at the best distorted sound, around them is going to be of the greatest value in later years. To this end they are taught self-confidence. Nothing is done for them that they are capable of doing themselves. They are not to be pitied. They must be encouraged to do better. So they are taught to tumble and balance like acrobats. To bandage and carry like ambulance men. They have their own boxes, containing everything they require for their school work, and their own tables and chairs, which they must keep clean and polished. There is an indoor garden of bulbs and seeds to be cared for, and a tank of fishes and water creatures to be looked after. If things get spilt, the mess must be cleared up without fuss.

Listening to the wireless is still fun, even though a hearing aid has to be used.

Normal class subjects include ten minute oral reading with the teacher by each child every day. The keeping of a personal diary, first in pictures, later in writing, is undertaken daily. Arithmetic, according to ability, and with individual attention by the teacher, takes up four and a half hours of each week. Handwriting and English usage occupy two hours. Visits to Worsley for nature study, and to the City museums and exhibitions in Salford and Manchester are always popular. At the end of the school year in June a special day out to Birkdale was arranged. The class travelled by road in the teacher's shooting brake and spent a wonderful day in warm sunshine among the sand dunes. The children collected sea holly and shells, snails and a toad and bunches of wild flowers for " their mums." They had a grand time.

First Aid in the classroom.

At Christmas they staged a Nativity Play and a small exhibition of their handicraft was shown at the City Art Gallery. Both these events were sources of real pride and encouragement. From time to time visitors to the City call in to see the class, and they can always be sure of a display of agility, lip-reading practice or a short classroom play put over with enthusiasm by these children, who normally would have remained silent and morose in the presence of strangers.

The Christmas Story.

A further addition to the amenities of the classroom this year has been the installation of running water. The children now wash each mid-day and at other times when necessary. It is possible under supervision to keep their feet clean after physical training activities which are carried out in bare feet.

During the winter they have a daily gargle, which has appeared to be beneficial As there is an open fire in the classroom wet socks and footwear can be dried out, and this again has reduced the incidence of catarrhal colds.

Since 1948 the class has had 24 children through the register. Fifteen have returned to normal schools. The class consists of a maximum of ten children, generally five boys and five girls, and they remain or move according to the time it takes for them to reach the standard of specialised knowledge required of them. Some children take six months, others much longer, according to the degree of their handicap. Then they return to normal school, and after a period a report is sent in by their Head Teacher. If they fail to progress they may return for a further course, but up to now only one boy has found this to be necessary.

Here are some excerpts from recent reports by Head Teachers :—

J. " The above boy was much below the average of his class when he was admitted but he has made steady progress and now his work is a good average. . .He does not appear to have any difficulty in following oral lessons. He pays close attention to his lessons and tries very hard."

P. " He takes an active part in school work and is not afraid to ask questions where he has not understood at first. His attitude is alert and he is making good progress. . . In all subjects he is up to the class average. In the woodwork shop he is making excellent progress and is one of the best boys. He is now an enthusiastic member of the School band and is learning to play the cornet. His music master is very pleased with his rapid progress."

R. " The above boy has certainly benefitted by attending the Partially Deaf Class. Before attending this class he was a rather dull type of child, rarely smiled, and his work was generally poor. There is a marked difference now ; he is happy in class and his work has improved greatly. His teacher considers him quite up to the average. The boy himself tells me that he can now, by a combination of hearing and lip-reading, follow everything that goes on in his class."

E. " Has taken an increasing part in the general life of the School. She now finds it as easy to converse with other children as she did to speak with adults on arrival. She moves about the school with growing confidence. She is in the third group out of four in her year. Her English is of good standard for this class and her books are neat. She enjoys the practical subjects where she can go at her own speed."

In all cases the improvement has been marked by happiness, confidence and the ability to forge ahead. Truly they are no longer handicapped children.

Home Observation Service.

This service is in fact a confidential arrangement made between the parents of the handicapped child and the Maternity and Child Welfare and School Health Services. Parents are usually anxious to co-operate in any way they can to obtain for their ill or handicapped children the best treatment possible, and it is thought that parental interest and co-operation in this way should be encouraged.

Suitable Cases.

These are chosen from children with Epilepsy, Rheumatic Fever, Asthma, etc., or children who are subject to " fits " or " attacks." Where the Medical Officer dealing with the child considers that some more definite detail is desirable than " hazy " recollections of " fits " or " attacks."

OBJECT.

The object of this service is to provide a complete case history giving actual date, time of day or night and duration of " fit " or " attack," its nature and severity, during the periods between visits to the Clinic. The complete picture thus presented should in certain cases give some indication of the child's response to treatment.

METHOD.

(1) A consent form is signed by the parent. Full co-operation of parents is essential as the record, to be of value, must be complete and reliable.

(2) A specially prepared and simplified two-monthly record card providing space for daily notes is supplied.

(3) The home is visited at least once every two months and the notes on the card are carefully revised in the presence of the parent.

(4) Notes are submitted to the specialist dealing with the case together with the usual medical records.

Special Class for Children Suffering from Cerebral Palsy.

During the past year the attendance and general health of the children in the Special Class have been very good. Regular visits have been made to them by an Assistant School Medical Officer, the Orthopædic Specialist, Physiotherapist and Speech Therapist.

In December the class moved from Hope Hospital into pleasanter and more spacious premises at Cleveland House. This enabled more pupils to be admitted to the class, so that now twelve cerebral palsied children (instead of eight) benefit from this form of special educational treatment.

The children are transported to and from Cleveland House by the ambulance service. The lunch time journeys, however, have now been completely eliminated. The preparation on the premises of a mid-day meal for the children means that they are rested, and consequently better able to assimilate the afternoon's lesson.

Lessons in the open air—Cleveland House.

Home Bound Children.

Report by Miss M. H. Hall, Home Teacher.

Home teaching is by now a well-established service, this being the second year since its commencement. Five children are benefitting from it and much useful work is being done.

INDIVIDUAL REPORTS.

L.D. (*Spina Bifida*). This girl achieves more in two half-days of individual teaching than she could in two weeks of ordinary school time. She is making rapid progress in spite of the fact that she rarely does the work set for home-work because she has to mind baby brother and do household duties when mother is out at work. She now produces letters in quite legible handwriting with pen and ink, is an excellent reader and knitter and shines at arithmetic.

J.B. (*Post-Poliomyelitis*). This girl was making good progress until she developed pneumonia from which, at the end of the year, she had not fully recovered.

J.B. (*Tuberculous Spine*). He has a particular bent for reading and for craft work, including basketry. His physical condition, unfortunately, is rapidly deteriorating.

M.L. (*Hydrocephalus*). M's vision is so poor that our work together has to be entirely oral. She has a retentive memory and knows her arithmetic tables thoroughly. She enjoys learning poetry and appreciates the music provided by gramophone records. Much of her time is spent in listening to the wireless.

R.E. (*Congenital Heart Disease*). This boy's intelligence seems to be impaired. He is learning to read but is very much behind the usual standard for his age. He enjoys art and craft lessons.

All the children take part in the cheap milk scheme and receive a daily pint of milk for 1½d.

Comparative Audiometric Survey.

During 1950 research was made into the comparative values of three forms of audiometric group tests. The services of a fully-qualified teacher of the deaf were secured for this work. It was hoped, by conducting a special survey, to ascertain if group testing by pure tone audiometer is practicable and more effective than the present method of testing by gramophone audiometer.

The three tests in question were :—

(*a*) *Gramophone Audiometer Test.* This system has been recommended by the Ministry of Education as the accepted method of group testing of school-children, and is at present widely used by local authorities. Sound is produced through single telephones, the test material consisting of spoken numbers commencing loudly and ending with sounds scarcely audible. Each ear is tested separately. For the purpose of this survey, a child was considered to have failed the test if he could not record correctly four out of six numbers at the 9 decibel level (corresponding to a 20 decibel loss by pure tone audiometer).

(*b*) *Pure Tone Audiometric Test. Massachusetts' System.* This system was evolved in the U.S.A. and is designed to test groups of twenty (or forty) children at one time. Testing is made at the 20 decibel level on the frequencies of 500, 1,000, 2,000 and 4,000 c.p.s., the tester making his own master sheets ; each child is given the prepared test paper bearing lists of " yes " and " no " and he must underline the appropriate word according to whether he hears or does not hear the sound. Each ear is tested separately. Two or more errors warrant failure.

(*c*) *Individual Pure Tone Audiometric Sweep Test.* Under this system, testing is carried out at a 20 decibel level on the 500, 1,000, 2,000, 4,000 and 6,000 frequencies. (It is felt that possibly 256 should be included, or substituted for 6,000). Each child has an individual test and each ear is tested separately. The child indicates when he can hear the pure tone by tapping on the table with a small wooden hammer. The results of the test are recorded by the operator —the child is not called upon to do any written work. Inability to hear on one frequency (either ear) constitutes a failure.

NUMBER OF CHILDREN.

This pilot survey was carried out with approximately 200 children in the ten/eleven years age range, at various schools throughout the City. The schools were not specially chosen, either for acoustics or convenience, the value of the survey being its application to general conditions throughout the country.

(*a*) *Gramophone Test.* The equipment consists of electric gramophone, twenty headphones and headbands. (Twenty children were tested at one sitting). It was found that the attachment of the headbands to the phones, the movement of desks to make best use of the lengths of flex available, the general distribution of papers, pencils, supervision of fitting of earphones and explanations of the test itself, all these occupied a period of time ranging from 25 to 35 minutes according to conditions. Where the children were unable to complete the test forms (name, address, age, etc.). an additional period of time was necessary so that help could be given to them. The recording itself lasted about ten minutes. For the purpose of this survey, no re-tests were made. However, in almost every case the children had taken this test before.

(*b*) *Massachusetts' Test.* The collection of the gramophone equipment and its substitution with the double headphones and audiometric connections of the pure tone test, occupied about 30 minutes. On the occasions when this test was taken first, the movement of furniture and setting up of the equipment took 20/25 minutes according to conditions. Explanations and demonstration varied according to the children being tested. In the case of this test (as with the gramophone test) it was found that blackboard demonstration was the best method of ensuring that the children understood just how the test was to be done, one child being chosen to take the test at the blackboard at an increase level of loudness which would certainly be heard by all present.

This test, including the sound of pure tone transmitted, was entirely new to the children.

(*c*) *Pure Tone Sweep Test.* When this test is given on its own, the children would, of course, come into the room one at a time, so that the room itself could be a small one—staff common room, store-room, or small library reading-room, according to school accommodation. In order to accommodate a group of twenty children for the first two tests, the rooms used during this survey were much larger, and it was impracticable for the children to go elsewhere until the testing was completely finished.

This test was entirely new to the children. The testing time per child averaged 2½ minutes.

Results of Testing.

Of the three tests, the gramophone brought the greatest number of failures, but many of these would have been eliminated normally, by re-testing. The proportion of failures was roughly Gramophone, 10 ; Massachusetts, 6 ; Sweep Test, 6. There were two cases where deafness in the high frequencies (4,000 level) was revealed by the Sweep Test, but the child reached the required standard in the Gramophone Test.

Generally speaking, it seemed that the Pure Tone Test Sweep brought the most accurate results of the test of hearing only (as contrasted with test involving written work) after one test with the minimum of equipment. Although the Sweep Test is taken individually, the average time spent with each child is 2½ minutes, so that twenty children can be tested in 50 minutes. The other tests (likewise with twenty children) including setting up and removal of equipment, and marking of test papers, take approximately one hour, but re-tests will be necessary.

It was found that the personal contact and word of encouragement possible in the Sweep Test were important factors in the accuracy of the response. Where there was any doubt or hesitation on the child's part as to whether he heard any of the sounds at a certain frequency, it was ranked as a failure. It was also found that many children had difficulty in recognising the 500 c.p.s. (and sometimes the 1,000) frequency at first hearing. However, by commencing testing at 1,000, followed by 2,000, 4,000, 6,000 and back to 500, a response at that level was often then obtained.

Referring to the Survey itself, of the 213 children tested, only 102 passed all three tests at the accepted level. Of the 111 who failed in one or more tests (and who were subsequently tested individually by pure tone down to threshold) 40 children had losses of 20 decibel or upwards. It may be revealing to record these individually :—

14	children	had	losses	at	the	20	decibel level.
11	,,	,,	,,	of	25/30	decibel	level.
7	,,	,,	,,	,,	35/40	,,	,,
6	,,	,,	,,	,,	45/50	,,	,,
1	child	,,	,,	,,	55/60	,,	,,
1	,,	,,	,,	,,	65/75	,,	,,

The crippling effect on the child's mind of such hearing losses, especially where the intelligence is below average, results in a history of educational failure and the " couldn't-care-less " attitude where school work is concerned. This small survey revealed all too clearly the urgent necessity to ascertain the most effective, rapid and accurate method of group testing. It is necessary for the test to produce accurate results with every type of child, and especially with those whose educational attainment and/or intelligence are not high, as it is in this category that deafness is so often found.

The children who failed the audiometric tests were all seen by the consultant otologist in attendance at the school clinic. Thorough examination of the ear, nose, and throat, was made, and appropriate recommendations, e.g., treatment of disease, special educational treatment, were carried out.

Comparison of Tests.

(*These are, of course, merely views based on experience in Salford*).

TEST I—GRAMOPHONE.

Advantages. The child is dealing with figures which it hears every day. This gives an element of confidence to some children.

This test does, in favourable circumstances and with average and bright children, record their ability to hear speech within the classroom.

Disadvantages. Once the record is started, the test must continue, no matter what extraneous noise may occur. In cases of bad interruptions, the record must be played again.

The child must not only hear the voice but must distinguish what is said. Where the child has a quick wit, he can guess accurately at the quieter levels. Where his concentration and intelligence are less, this affects the level at which he can interpret the sound he hears.

The writing down of numbers from dictation requires a degree of alertness and intelligence and educational attainment.

Any degree of nervousness or tension may result in failure without evidence of actual deafness.

Having a form to complete makes some children uneasy. In the classes of backward children, they were definitely confused by it.

The equipment takes a long time to set out, especially if the classroom furniture has to be moved. The headphones are packed in an awkward way, with separate headbands to be attached each time.

Twenty headphones bring a confusing mass of wires which can become complicated in a small room with active children.

The equipment itself is not easily portable by one person.

A room of some size must be placed at the disposal of the tester. Every school has not such a room available without upsetting an entire class. (In Secondary Schools, where series of classes visit the one room, the testing affects more than one class).

It is necessary to supervise the fitting of each headphone.

The marking of test papers takes some time.

Re-tests are necessary in many cases.

TEST II—MASSACHUSETTS.

Advantages. Headphones exclude extraneous noise.

Test can be held up for interruptions of any sort.

The child is not asked to distinguish one sound from another. The decision is merely " did I hear it or did I not ? "

Disadvantages. The ability to underline a " yes " or " no " as the result of an aural decision requires a definite standard of intelligence and mental response.

If the rhythm of testing is slowed down to allow for the slower members, the child has time to copy from an adjoining paper.

The setting up of the equipment takes a long time. (In view of the expensive nature of the headphones, individual supervision of their fitting was necessary to ensure careful treatment).

Many of the girls and younger children were frightened by the formidable appearance of the headphones and so many wires (and to the fact that the whole was connected to an electric plug !) Above all, many children expressed dislike of the compressing effect of the two tightly-fitting ear-pieces.

It is necessary to glance over all the answers, as the correct total does not always indicate a completely correct record.

A room of some size must be placed at the disposal of the tester. Every school has not such a room available without evacuating an entire class.

Re-tests are necessary in many cases.

The equipment is definitely not portable by one person (except by special transport).

TEST III—PURE TONE SWEEP TEST.

Advantages. The equipment is portable, easily taken from school to school and set up. This means a great saving in time.

The child's response is given by a blow with a gavel and the children enjoy this " play." Full co-operation is also easily obtained even from children suffering from some speech defect or nervous tension when they realise that no speech response is necessary. The response can, of course, be a verbal one—there is no need for any writing.

There is a minimum of upheaval at the school ; any ordinary room will do. The test has been done in ordinary classrooms and staff rooms and no special efforts were made to keep the room quiet, yet it is considered that reliable results were obtained.

The possible inaccuracy of writing down the results by the children is lessened. No chance of copying from neighbour.

Re-tests are unnecessary.

There is no marking of papers afterwards.

Children of low intelligence can be tested. In classes of educationally subnormal children (I.Q. 65 to 85), satisfactory results have been elicited and recorded.

Satisfactory tests have also been performed in the case of a few $4\frac{1}{2}$-year old children of average intelligence.

Considerable experience has been gained in testing 5-year olds and there is little doubt that the test can be satisfactorily performed by 5-year olds. Of some 5-year old children, all were able to perform the test.

If the child subsequently requires an individual test, the procedure being similar, it will be easy for him to perform second individual audiometer test having had some practice with the pure tone sweep test.

There is nothing for the child to break.

The test is quickly performed—certainly quicker than the group test.

The procedure can be halted if there is a sudden noise.

The equipment is less expensive.

Tests seem to accord exactly with clinical audiometer tests later.

The child is tested purely as an individual. All the time of the operator can be devoted to the one child. This avoids many errors which occur in any group test. The experienced operator can be sure, before the test proceeds, that she has established co-operation with the child ; she can give reassurance when necessary.

The children like the test as it seems part of a game. All the children like to use the hammer to indicate response. No difficulty has been experienced in any single case.

Testing hearing by the Pure Tone Sweep Test method.

Pure Tone Sweep Test.

It was decided, after comparison of the tests had been made, to continue group testing by means of the sweep test only. A further group of 500 children was tested.

Age of Child.

The test was carried out satisfactorily with children of all ages down to 4 years 9 months, but it was felt that 5 years 4 months was the lowest general age at which the test could be termed invariably accurate. At this age the child had generally been at school for some three months and had acquired an element of the discipline of concentration.

Testing was also carried out with educationally subnormal children. The average I.Q. was 65—the age ranged from 8 to 11. The test used was Pure Tone Sweep Test, this being the only " group " test of which the children were capable. Testing was carried out in the staff room, the children coming in one at a time. In every case, the child's signal coincided with pure tone transmission ; where the transmission was delayed for a moment or so, the child waited. The average time spent with each child was five minutes, although one particularly talkative child (I.Q. 46) needed a longer period before a positive response was attained. In his case there was some degree of high tone deafness, and two more children failed the test on one or more frequency. The children showed obvious enjoyment at performing the test and there was no sign of nervousness.

PROCEDURE.

Wherever possible, with the Headmaster's approval, the operator spent the first five or ten minutes with the class to be tested, talking individually to the children about their various activities. In this way it was felt that the children accepted her presence in the school and came more willingly to be tested. In some schools, news of the worker and her " wireless set " had been entered on the Infants' News Sheet for the day.

The ideal arrangement allowed for three children to be present at once, one being tested and two watching. As one child returned to the classroom, another was sent. In this way it was possible for each youngster to watch what was going on before his turn came to be tested.

The atmosphere of the test was planned to appear as much like a game as possible, to avoid any suggestion of medical examination. Those children who regarded the proceedings with some element of suspicion were in so many cases those who were, in fact, suffering from some element of deafness and it was so necessary that their nervous fears should be quelled to ensure a satisfactory test.

When the first three children were seated and the initial friendly overtures accomplished, attention was drawn to the " wireless set " and the children asked to listen for any noise it might make. Short sound intervals were made at 2,000 c.p.s. 90 decibel intensity, the earphones lying on the desk and turned towards the children. Explanation and demonstration showed that each time the sound was heard, a tap was to be made with a small wooden hammer provided for the purpose. This method of response was found to be the most natural for the children, and the little hammer (an auctioneer's) was immensely popular with them. Only a few moments were taken over these preliminaries, and the earphones were then suitably introduced to the first child so that he could hear the " little squeaks "—much softer than those heard so far. Double headphones were used, one phone transmitting, the other excluding extraneous noise. The hammer was then handed over and the test commenced.

The first sounds were put through at 40 decibels (2,000 c.p.s.) to ensure, in most cases, that it could be heard and also to give easy practice in response. Very few children needed more than three " squeaks " in practice. Intensity was then reduced to 20 decibels and the actual test continued.

The most satisfactory order of frequencies was found to be 2,000, 4,000, 6,000, 1,000, 500, 250. About three transmission intervals were allowed for each frequency, unless there was any doubt as to the response. From the child's point of view, the sounds at varying frequency followed in succession, but care was taken to avoid any semblance of regular rhythm. It was found that children of this age were more honest than their elders, and there was no effort to tap indiscriminately. To avoid confusion, the sounds were made deliberately firm and at fairly slow irregular intervals. As in all audiometric tests, most children gave the response immediately the sound was transmitted, but some waited until it ceased. Care was taken to keep an inscrutable face so that the child—who invariably kept his eyes on the operator's face—had no clue as to the moment of transmission. At the same time, his own face revealed his response as well as the responsive hammer tap.

Where the child failed in any frequency he was regarded as having failed the test, and listed for invitation to the clinic for audiometric test down to threshold. It was found that when such children came to the clinic they were quite prepared for the test, and gave accurate response by a similar method, quite pleased with the opportunity to show their mothers how clever they could be.

Two points regarding the test are worthy of mention. With these young children and the E.S.N. classes, it was realised that what the child saw was much more important than what was said to him so that every effort was made on the part of the tester to make precise, self-explanatory movements, so that by visual reception and subsequent imitation the child was able to perform the test satisfactorily. In order to ensure that this was a pure test of hearing and not of verbal or educational ability, the response was intended to eliminate speech on the part of the child, In many cases where he was too shy, or from speech or mental defect unable to speak intelligibly (and often embarrassingly aware of the fact) the manual response was accurate and without hesitation.

The average time taken with each child was three minutes. The individual examination allowed for personal contact between tester and testee and appropriate variations in methods of handling.

The present gramophone audiometric group test is made at 7/8 years of age and in so many cases the child's lack of educational attainment, and nervous temperament bring unreliable results. The value of a reliable test suitable for five year olds is obvious.

Final Analysis of Test Results.

No. of children tested.	No. of failures.	No. of children subsequently found by individual pure tone tests to have normal hearing.	Nett total of children with defective hearing.	Effectiveness of screening.	Percentage of failures.	
					Initial.	True.
506	63	12	51	81%	12%	10%

Report on Physical Education.

(*Submitted by the Organisers of Physical Education*).

The end of another year shows Physical Education still fulfilling an important function in the educational life of the City. Whilst progress is not spectacular it is steady, and will be reviewed under the various headings, which are as under :—

(*a*) Physical training, including clothing and equipment.
(*b*) Organised games and out-of-school activities.
(*c*) Dancing.
(*d*) Swimming.
(*e*) Teachers' classes.
(*f*) Work in Youth Clubs.

PHYSICAL TRAINING.

This work continues to be carried on unobtrusively in the educational establishments of the City. The daily physical training lesson continues to form part of the curriculum in all schools, and in the Infants' Department, where there is a greater need for physical activity, two periods daily are the rule in the majority of schools. The work is still hampered by lack of gymnasia and indoor accommodation, and during the past year difficulties in this direction have increased considerably in many schools, since some halls previously available for physical activity are now having to be used as classrooms for ordinary subjects. Owing to the post-war increase in the birth-rate (which is now being reflected in increased school attendances) and the strict control of new buildings, the position is not likely to show a relative improvement. It is pleasing, however, to report that it has been possible to arrange for one school to have the use of a nearby fully equipped gymnasium.

Definite progress can be shown in the provision of large apparatus for physical education during 1950, it having been possible to supply some apparatus of this type to 12 Infant Departments, 7 Junior Mixed and 9 Senior or All-standard Departments, making a total of 28 Departments equipped in 1950. Much still remains to be done in this direction, but many schools, particularly Senior and All-standard Departments, cannot be considered for large portable gymnastics since there is no available space in the school for either using or storing it. The supply of small physical training apparatus (footballs, balls, hoops, ropes, skittles, bands, etc.), has been maintained to all departments. It has also been possible to send an allocation of Plimsolls into every school in the City, and for the first time it has been possible to include the Infants' Departments in this allocation. It is hoped to continue to do this, since lack of soft shoes hampers the work, particularly that done with large apparatus.

The removal of top garments for physical activities continues. This varies considerably from school to school, but in all departments some clothing is removed, and the number of schools where children are stripping down to shorts only or shorts and vests is increasing.

There is an increase in the number of schools who are using the newer more informal approach to physical education, and this is proving much more attractive and enjoyable to both pupils and staff. The introduction of big apparatus in the Junior and Infant Schools has materially assisted in this, and has provided a much wider variety of activities.

Shortage of suitably trained women for girls' work continues.

ORGANISED GAMES AND OUT-OF-SCHOOL ACTIVITIES.

Excellent use has been made of all available playing space in the City, both in and out of school hours. A new area became available for athletics during 1950 when the Crescent Athletic Ground was opened. This ground was well marked and equipped for all branches of athletics, thus enabling several schools to hold their own athletic sports on it. In addition the Youth Clubs were also able to use it in the evenings.

A new departure has been the introduction of boxing for schoolboys in out-of-school hours. Forty boys are now enrolled in two classes and attend with great regularity each week at the South Salford Youth Club, which is equipped with a portable boxing ring and the other necessary equipment.

On the girls' side there is a shortage of suitable grassed spaces for hockey, for which there is an increasing demand now that the 15-year age group remains in school. It is hoped that the Northumberland Street site may be available in 1951 and so ease this position.

The Salford Schools Sports Federation reports progress in all the many activities for which they cater. Many thousands of the City's children aged between 10 and 15 years have participated in one or other of the activities organised by the Federation through their schools, developing the corporate spirit necessary for team games, gaining a knowledge of standards of play and a developing character which should stand them in good stead in later years. Activities covered are football (Association and Rugby), netball, cricket, rounders, athletics and swimming.

The Organisers of Physical Education would like to express their thanks and appreciation to the many teachers who so willingly give of their leisure time to umpire, coach and control these many activities. The results in the following activities of the Salford Schools Sports Federation should have some mention :—

(*a*) *Swimming.* A record entry was achieved in the Federation's Gala, and several Junior Schools entered the Junior competitions for the first time.

(*b*) *Cricket.* The City team reached the second round in the League matches, where they were knocked out by the eventual Champions.

(*c*) *Netball.* The progress made in 1949 was maintained and improved upon in 1950, the City team being placed third in the Lancashire County Rally and runners-up to Manchester in the League matches. Early in 1950 notification was received that two of the four teachers who sat for the "A" Umpire's Certificate in 1949 had been successful. At the end of 1950 a further three teachers sat for this examination, the results of which are not yet known.

(*d*) *Athletics.* Two afternoons and one evening were devoted to Inter-school Sports, some 55 schools taking part. In the Lancashire School Sports four competitors were chosen to represent the County at the Annual Sports, and two of these competitors were successful in gaining First Medals.

DANCING.

Dancing continues to form part of the curriculum in Infant Departments and in schools where there are girls. In one or two All-standard Mixed Schools mixed dancing classes have been inaugurated and it is pleasing to note that the children really seem to be gaining something from this work, not only physically but socially and æsthetically.

SWIMMING.

Nine plunge baths were available during the Summer months and five during the Winter. None of these is open for a full day in the week, and it inevitably follows that this limited the amount of use which could be made of them. During the Summer months provision was made for 148 classes of 30 children to attend under six instructors (three women, three men), and 16 classes of 20 children under one woman instructress. In the first four months of 1950 provision was made for 48 classes to attend under two instructors. In the last four months of 1950 there was an increase in the swimming facilities available, it being possible to arrange for 62 classes to attend under three

instructors (one man and two women). Unfortunately the weather during this time was particularly bad, and this, coupled with the Influenza epidemic and the shortage of fuel for heating the plunge bath water, has reduced the overall attendance during the Winter months. The weather during the Summer season was generally poor, and this affected the attendance of children, both during the term and during the holidays and out-of-school hours, when so much valuable practice is done. Inevitably this caused some slight fall in the number of one-length certificate winners, as compared with 1949. In 1950, 1,055 children gained the third class or 25 yards certificate, 947 the second class or 50 yards certificate, and 601 the first class or four lengths certificate. Seventeen girls were awarded the Advanced Certificate. This shows an appreciable increase of the two- and four-lengths certificates. In addition the Baths Committee awarded 1,055 free season tickets to children gaining a certificate for the first time.

Very good results were obtained in the Royal Life Saving Society's Examinations with a total of 477 awards, which is an increase over the 1949 figures of 177 awards.

The Humane Society for the Hundred of Salford medals for proficiency in the art of life saving were competed for by a large number of children, and eight boys and four girls were awarded medals, being the maximum awards allowed. The high standard shown by the competitors reflects credit on the instruction being given in life saving, which is an important part of the swimming scheme.

Work in Youth Clubs.

During the past year much progress has been made in the direction of open air physical activities both in winter and summer. Organised athletics are now available to boys and girls between 15—21 on three evenings per week during the summer on the Crescent Athletic Ground. Rounders and Netball Associations have been established for girls and some 15 clubs took part in a Rounders League, whilst 16 clubs have participated in a Netball League.

Efforts are being made to encourage Basketball among youth and to this end a Leaders' Course in Basketball Coaching and Refereeing has been organised in conjunction with the Central Council of Physical Recreation.

During the year progress was made in encouraging gymnastic and keep-fit classes within the various Youth Clubs and a Boxing Club was established last May.

There has been an increase in the number of clubs participating in Country, National and American Square Dancing.

Other activities such as Football (Soccer and Rugby), Cricket, Table Tennis, Tennis, Badminton, have not only maintained steady progress, but increased interest has resulted in additional clubs joining in.

Camping has become very popular and more clubs and organisations now arrange for a week under canvas each year.

PHYSIOTHERAPY DEPARTMENT.

Progress has been made and much good work completed during 1950.

Re-painting of the sunlight clinic and exercise rooms at the Regent Road Clinics greatly added to their cheerfulness, and with the addition of the new strip lighting and the cream walls, the rooms are now bright and sunny, giving a feeling of well-being and health rather than emphasising illness.

We very much appreciate the loan of the Rob walking apparatus from the Regional Hospital Board. It has been very useful and it is hoped that shortly we may have one of our own.

Orthopaedic Specialist Service.

Full use has been made of the service. Arrangements have been made for children to be accepted for treatment at any of the three available hospitals, so that the waiting time for treatment is cut to a minimum. There are, however, still a few parents who, when notified of a vacancy in hospital for their children, ignore the invitation without explanation, and this leaves an empty bed which could otherwise have been used.

Sunlight Treatment.

Fortunately, it has been possible to maintain the three sunlight clinics throughout the year. Since the commencement of a special clinic for children who have completed the course of physiotherapy, it has been possible to weigh children on completion of a sunlight course, and it is gratifying to find that definite gains in weight are made as well as improvement in appetite and general well-being.

Physiotherapy Treatment.

This year it has been possible to open additional clinics at Cleveland House, Landseer Street and Encombe Place. Thus, minor orthopaedic conditions, such as pronated feet and knock-knees, can be treated before the condition becomes serious.

It seems as if yearly outbreaks of poliomyelitis are liable to accur, and they greatly add to the work of the physiotherapy department. Frequent treatment must be given to these patients. Various forms of electrical treatment are available, and it is hoped in the near future, that we may have our own warm pool. This acquisition would complete the list of apparatus required in the treatment of these cases.

Children who experience difficulty in getting to the clinic are brought by ambulance, and Salford Ambulance Service has been most prompt and helpful in bringing children for treatment.

A representative from the orthopaedic appliance suppliers visits the clinic weekly, so that in conjunction with the orthopaedic surgeon, the case of each child requiring an appliance is discussed, and the most suitable type supplied.

Repairs to calipers are completed in two or three days, and shoes are surgically altered in a week—a satisfactory arrangement in these days of shortages and long waits.

BREATHING EXERCISES.

The majority of children suffering from asthma appear to be attending the open-air school, where we have eighteen children on exercises. Unfortunately, owing to so many activities in the school, the physiotherapist is able to attend only once a week. It is felt that much more benefit would be obtained from twice weekly treatment. It must unfortunately be admitted that in spite of repeated encouragement, very few children practice the exercises at home. Special asthma breathing exercises are given at other clinics, as required.

The ear, nose and throat specialist has been anxious for us to give breathing exercises as used at St. Bartholomew's Hospital to a selected number of children. This we are now doing, but the classes have not been long enough established for their value to be assessed.

Health Education Report.

It has been said that " health is not a subject but a way of life."

During the year, health education has been influencing the lives of schoolchildren in various ways. Information on matters relating to health has been given by the distribution of posters and pamphlets in the schools at the request of teachers. Talks have been given by members of the Department to parent-teacher associations.

The Health Department has been concerned with the high rate of accidents in the home, especially amongst children—consequently home safety has been a subject of health education. A Home Safety Council has been established with representatives of teachers, parent-teacher associations and other interested local organisations. It is hoped that it will be possible to run home safety exhibitions in schools and to hold poster and essay competitions amongst the children.

Visual aids have always played an important part in health education and this year a film strip illustrating the school health service has been made. The film strip shows the historical progress made in school health, preventive and curative treatments are illustrated and there are references to future developments. It is possible for talks to be given on different aspects of school health, according to the composition of the audience whether it is composed of nursing or social worker students, members of parent-teacher associations or laymen.

Effective health education rests upon the co-operation between parent-teachers and the public health department. Parents and teachers play the most effective part in health education, for they are able to study the individual child and by their great influence they can train him. Members of the public health authority support the teaching given by parent and teacher with technical information and help with specialised subjects.

Health education can only be completely effective if these three influences are in agreement concerning the aims in view. In Salford there is a very happy relationship. It may be said that the widest interpretation of health education is that through teaching the beauty and joy of both physical and mental good health every member of the community may be able to enjoy life to the full. This end can only be attained by arousing in the child the awareness of his

responsibility for his own health ; good habits may be formed at an early age, a healthy environment encourages the appreciation of beauty and good health, whilst a good example set by adults can awaken the wish to aim high.

Visual and aural aids must be used with an emphasis on the joy of healthy living. Young children can be taught about health the play way ; a game of dental snakes and ladders has been invented to encourage children to take care of their teeth. It is hoped to introduce more such games, incorporating health education, e.g., jig-saw and crossword puzzles. These aids could be used in the clinics' waiting rooms where the children spend a certain amount of time.

A magnetic blackboard has been made and it is expected to complete a flannelgraph for health education purposes especially to encourage group discussion and activity. Suggestions have been made for competitions to be held amongst schoolchildren in order to encourage them to take an active interest in their own health.

Convalescence.

During 1950, 71 schoolchildren were referred to the Almoner by School Medical Officers for the arrangement of convalescence. Of this number, 61 children were admitted to Convalescent Homes for a minimum period of four weeks. The remaining ten children failed to take advantage of the arrangements made.

As in the immediate past, the Invalid Childrens' Aid Association were responsible for placing the children in suitable homes, which included those at West Kirby, St. Annes, Freshfield, Abergele, Taxal Edge and Macclesfield.

There were also 38 schoolchildren referred direct from the Almoners at the local hospitals.

In all the above-mentioned cases the full cost of maintenance was borne by the Education Committee.

Though the actual number of children receiving convalescent treatment during 1950 is lower than in previous years, one feels that those who went were in actual need of convalescent treatment as such. Children in need of a holiday rather than " treatment " were accommodated at the Prestatyn Camp—a much more joyful arrangement and unconnected in the child's mind with " being poorly."

Salford Poor Children's Holiday Camp, Prestatyn.

During the year six groups of handicapped pupils, comprising over three hundred children, enjoyed a week's holiday at the camp. They were accompanied by special helpers who supervised bathing expeditions, visits to the nearby town, beach play and all the other activities which made the holiday such a pleasure.

Sanitary Conditions in Schools.

In previous reports attention has been drawn to the bad environmental conditions in many of the older schools.

I am happy to report that progress has been made during the past year. Most trough closets have been converted into modern sanitary conveniences, some washing facilities have been provided, classrooms decorated, yards paved, etc.

Problems of dust from hundreds of scholarly feet, particularly where classrooms with suspended floors are used for recreation, are receiving the attention of my Department, as is the correct use of the means for ventilation.

Dusting with a damp cloth to "settle" the dust and lessen risk of infection.

School Meals Hygiene.

With regard to the supervision of school canteens I am pleased to observe that Salford is well to the fore. The Catering Trades' Working Party appointed by the Minister of Food, whose report has just been published, reports as follows : " Wherever catering is conducted in conditions approaching that of a monopoly, that is to say where there is little or no competitive element, much depends upon full recognition by management and staff of the need to establish and to maintain hygienic conditions of a satisfactory nature. We do not suggest that special legal provisions are required for the control of these catering establishments but we consider that local authorities should have their attention drawn to the necessity of regular and special inspections to ensure that satisfactory hygienic standards are maintained in all these places."

Washing up after school dinners.

The Education Committee very wisely anticipated this recommendation by about two years in the appointment of a Food Inspector specially for this purpose. No outbreak of food poisoning occurred last year in school canteens and just one mild outbreak this year, probably brought about through the breakdown of a refrigerator.

Inspection of meat at school canteen by food inspector.

Experiments are being carried out by the Salford Health Department in temperature control of foodstuffs. This is a new approach to the problem of food poisoning in connection with communal feeding. Hitherto almost all activity has been concentrated on cleanly conditions which though admirable in itself has not been effective in reducing the incidence of food poisoning in this country. The principle of temperature control is well understood by the supervisors of Salford School Canteens. The scourge of food poisoning had been reduced to negligible proportions. Wherever there has been an occurrence in recent times there has always been a breakdown in temperature control.

The outbreak of food poisoning which happened this year in one of the school canteens is particularly interesting in that it shows quite clearly the importance of this principle. Continuing outbreaks had occurred over a long period of time in connection with this canteen which provides some 1,600 meals per day and it was thought that a stop had been put to these happenings by the rigid application of principles of temperature control. The lesson had been hammered home time and time again to the supervisor who is a clean, conscientious and intelligent woman. Persistent investigation into the cause of the last outbreak revealed no breakdown in the routine adopted to control the temperatures of the food. In a last effort, however, the refrigerator itself was examined—and found to be not functioning.

Briefly stated the principles adopted are as follows :—

(1) All foods of animal origin are efficiently heat treated. Whenever meat, milk, duck-eggs, dried egg, etc., are used separately or as ingredients of a composite meal they must be efficiently heat treated. The efficient cooking of sausage is a problem in itself.

(2) All cooked food if not for immediate consumption is cooled rapidly and kept in a cold room or refrigerator at a temperature below 50°F. On no account is prepared food left in the kitchens overnight.

Temperature control has been emphasised for many years in Salford canteen kitchens and whilst there is still an occasional mishap there is no doubt that in ordinary circumstances the effectual control of food poisoning lies in this direction.

Some Notes on the Health of the School Child.

Our aim is better health for the child. By " health " we do not mean mere freedom from disease, mere freedom from uncleanliness ; we mean something positive, vital, effective. We want cleaner, healthier, happier children, with their health preserved and enhanced. If the health of the child is subnormal, it should be restored by all means in our power. The fact that there are unhelpful influences (such as unsatisfactory parents, unsatisfactory school premises) which we cannot alter now should encourage us all the more to give attention to those points which we can do something to remedy. The simple hints given below may be of help to all who can spread the ideals of health education among children and their parents.

Education in Personal Cleanliness.

Here are simple rules :—

(1) Prevent close exposure of persons to spray from the nose and mouth, as in coughing, sneezing, laughing or talking. Children must be taught to use handkerchiefs in preventing the spread of spray infection. If no handkerchiefs are available, clean pieces of cloth or clean tissue paper may still be obtainable.

(2) Prevent the use of common or unclean eating and drinking utensils, or use in common of toilet articles of any kind such as towels, handkerchiefs, combs, hairbrushes, drinking cups.

(3) Encourage children to keep hands or unclean articles away from mouth, nose, eyes, ears, genitalia.

(4) Encourage the washing of hands in soap and water after emptying bowels or bladder, and always before eating. Frequent soap and water baths should be stressed in lessons on personal hygiene.

PREVENTION OF COMMUNICABLE DISEASES.

(*a*) *Importance of School Hygiene.* Open windows for ventilation whenever possible. Children to be as much out of doors as possible—particularly during exercises. Not only do currents of fresh air reduce droplet infection, but the lining of the nose, throat and lungs is maintained in a healthy condition. On the other hand, over-warm, moist, still air enables disease germs to grow. Even in old buildings, thorough ventilation is possible in the play interval.

(*b*) *Spacing of Children.* The risk of infection is reduced if children are well spaced in the classroom. Lessen crowding and you lessen infection. In a Nursery during the afternoon sleep children might be " staggered "—head to foot—in order to prevent one child breathing directly into the face of the next child.

(*c*) *Use of Individual Equipment.* Each child should have its own *toothbrush* which must not be mixed with those of others. Toothbrushes used in common do more harm than good. The same thing applies to *combs* ; the practice of dipping combs into disinfectant for a second to cleanse them is not sufficient. Careful supervision of *towels* will prevent some contagious diseases (" Pink Eyes," etc.), from spreading. The provision of individual towels—common in Nursery Schools but rarer amongst older children—will do much to limit the spread of these diseases, but if there are not individual towels, there should be all the stricter supervision of common towels. We can break the chain of infection by breaking any other links.

(*d*) *Hand Washing.* After visiting toilet and before eating.

(*e*) *Nose-breathing.* As the nose is an air-filter, children should be trained and encouraged in nose-breathing. Any persistent mouth-breather should be referred to the clinic. Children should be taught, when sneezing, to hold a handkerchief to the nose and mouth. They should be encouraged to have a clean handkerchief, piece of linen or tissue paper for nasal hygiene. Every effort should be made to stop an apparent deterioration in the provision, which some parents are making for their children, of handkerchiefs or pieces of clean linen.

(*f*) *Nasal Drill.* It is recommended that the first minute of both morning and afternoon sessions should be spent in nasal drill. The correct way to clear the nose is to hold the handkerchief up to the nose without pinching it, thus leaving both sides free, Forcible blowing should be avoided. This exercise need take no longer than about half-a-minute, and the remainder of the time should be spent on deep breathing exercises *in* and *out* through the nose. If any child should experience discomfort or difficulty he should be referred for medical advice. Exercises in breathing and the use of the handkerchief should be taken in connection with singing and physical training.

HEALTH HINTS.

School Meals should be adequate in quantity and high in quality. They should contain ample supplies of first class protein foods—milk, fish, liver, eggs, etc., of which some children have very little. The children should be encouraged to eat all the protective foodstuffs—raw vegetables, etc.—whenever possible in order to raise resistance to disease.

Milk. Every child should have his full allowance of milk, with the possible exception of those children who would be upset by taking it.

Vitamins. The supply of vitamin preparations for the under-fives will also help to build up child health. Certain vitamin preparations—cod liver oil and malt, etc.—can be supplied free from the school clinics.

Lessons in Health Education should be colourful, attractive and capture the imagination of the child, in order to encourage life-lasting habits.

The School Health Service recommends the following advice to parents :—

Sleep. Sleep is second only to food in importance to health. See that your child sleeps with the windows open. The bed should be comfortably warm and the room comfortably cool.

Hours of sleep :	5 to 7 years	12 hours	Minima.
	7 to 10 years	11 „	
	10 and over.....	10 „	

Breakfast. See that your child starts the day well with a good breakfast

Adequate Dental Care. The child should be trained to use his toothbrush from an early age. The dentist should be consulted regularly.

Provision of Good Footwear. It is important to see that the children have well-fitting shoes with ample space for growing feet and the that footwear keeps out the wet.

Open Play Spaces and Parks. Full use should be made of open play spaces and parks. The health of the children is considerably raised by outdoor physical exercises.

Road Safety. Teach your child kerb drill.

Keep the child's hair clean, brush daily and wash weekly.

Do not give medicines without medical advice.

Clinics. In addition to clinic services there are other facilities in the School Medical Service, such as attendance at *Open Air School*, *Sun-ray Clinics*, which will further help in the case of debilitated children. When the Medical Officer or School Nurse visits the school, there is opportunity for any special or urgent case to be referred to such Medical Officer or School Nurse. It is particularly important to seek advice about discharge from the ears or nose.

COMMUNICABLE DISEASES.

The attached table gives details of some communicable diseases of importance to children. It includes a list of early signs of disease, the incubation periods and periods of exclusion. Unfortunately these diseases are generally most infectious in their early stages, even before a rash appears—hence control of them is most difficult. A previous attack usually, but not always, protects against subsequent infection.

One of the most serious of communicable diseases—diphtheria—can and is being wiped out. For several years there have been no deaths from diphtheria in Salford.

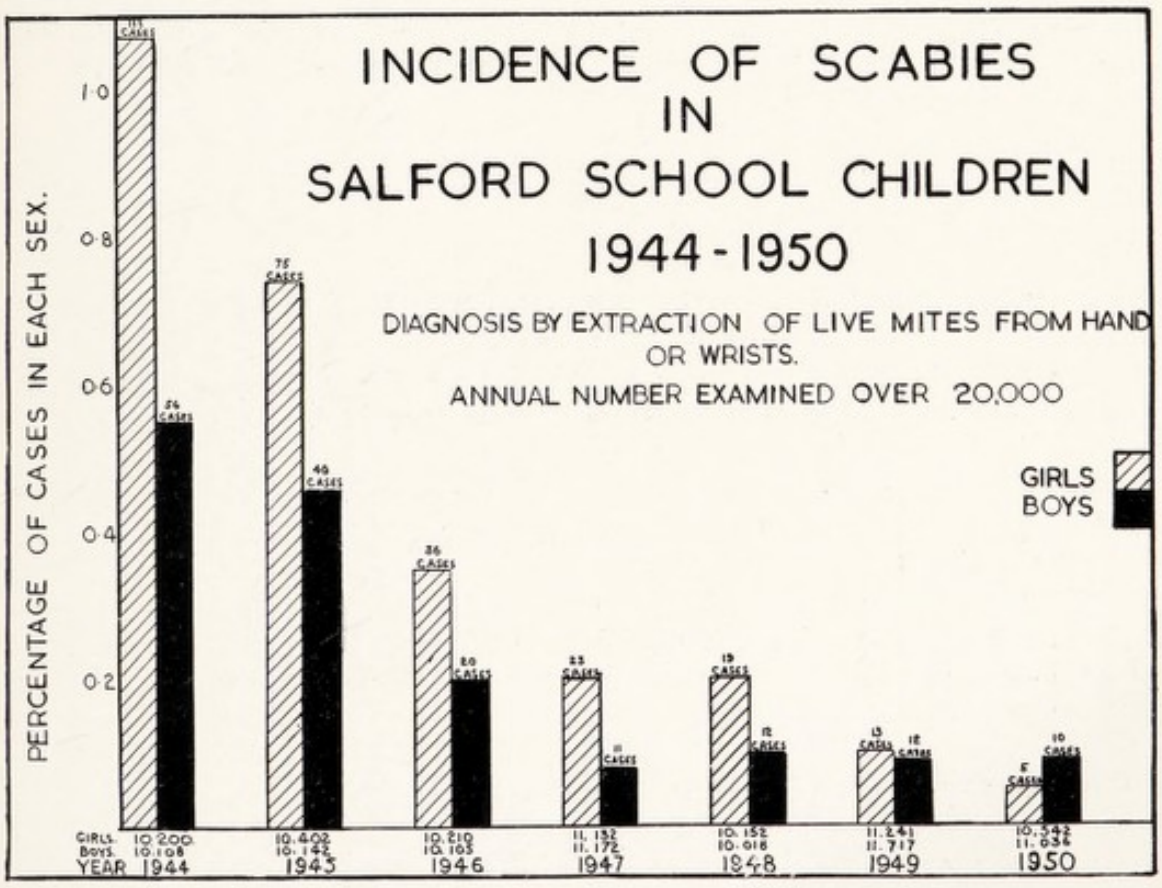

TABLE OF COMMUNICABLE DISEASES.

The School Medical Officer and his staff are glad to give advice in individual cases or in any case of difficulty in the application of these recommendations.

The period of exclusion is given in the last column, and should be taken as a guide—there may be special reasons why contacts should be excluded for a further period.

Disease.	Usual Incubation Period.	Interval between onset and appearance	Early Signs.	Period of Exclusion.	
				Patients.	Contacts, *i.e.*, other members of a family or playmates.
MEASLES.....	About 10 days from date of exposure to onset of fever.	3-5 days.	Catarrh, coughing, sneezing, watery eyes, followed later by blotchy rash.	Usually 14 days after the appearance of the rash if the child appears well, or until pronounced fit by practitioner or medical officer of clinic.	Any contact suffering from a cough, cold, chill, or red eyes should be immediately excluded contacts may attend.
WHOOPING COUGH.	7-21 days. Commonly 7 days almost uniformly within 10 days, and not exceeding 21.	—	Catarrhal head cold ; later a short harsh cough, spasms of coughing, or coughing accompanied by vomiting.	Until pronounced fit by practitioner or medical officer of clinic.	Any contact suffering from malaise, catarrh or cough should be excluded and kept under observation. Other contacts may attend.
DIPHTHERIA.....	2-5 days. Occasionally longer.	—	Onset insidious, beginning with malaise, slight feverishness and perhaps slight soreness of throat.	Until pronounced by a medical practitioner to be free from infection and fit for school.	If there are any suspicious signs, the child should be excluded. For any contact not immunised, arrangements should be made for immediate immunisation. Contacts at home should be examined by a doctor or nurse before return to school.
Every child should be protected against this disease : Immunisation Clinics for school children are held every Saturday morning at the School Clinic, Regent Road, Salford, 5. Other times on application.					
STREPTOCOCCAL SORE THROAT.	2-5 days.	—	Chill, high temperature, vomiting, sore throat.	Until pronounced by a medical practitioner to be free from infection and fit for school.	None.
SCARLET FEVER ..	2-5 days.	1-2 days.	Sore throat, often with headache and vomiting. The rash may follow 1 to 2 days after.	Seven days after discharge from hospital or from home isolation (unless "cold in the head," discharge from the nose or ear, sore throat or "septic spots" be present)	Unless there are suspicious signs such as malaise, "cold in the head" discharge from the nose or ear, sore throat or "septic spots," contacts need not be excluded. Contacts at home should be examined by a doctor or nurse before return to school.

Disease.	Usual Incubation Period.	Interval between onset and appearance	Early Signs.	Period of Exclusion.	
				Patients.	Contacts, *i.e.*, other members of a family or playmates.
ACUTE ANTERIOR POLIOMYELITIS. (Infantile Paralysis).	7-14 days. (may be from 3 to 35).	—	Headache, stiff neck and spine. (Only small proportion of infected persons are clinically recognisable). Sometimes paralysis develops in first few days of illness.	Until pronounced fit by medical practitioner or medical officer of clinic.	Exclude for 21 days.
GERMAN MEASLES.	10-21 days. (Usually about 18 days).	0-2 days.	Slight malaise, headache, pain in neck or limbs, slight nasal cold.	7 days from the appearance of the rash.	None.
MUMPS.....	12-26 days. (Usually about 18 days).	—	Swelling, usually a little in front of or below the lobe of the ear.	On subsidence of all swelling.	None.
CHICKENPOX.....	2-3 weeks. (Commonly 14-16 days).	0-2 days.	Usually first sign is appearance of rash, with "vesicles" or small blobs.	14 days from the date of the appearance of the rash.	None.
SMALLPOX ..... (Minor Smallpox	7-16 days. 10-21 days).	3	Usually first sign in minor smallpox is appearance of rash and malaise.	Until the patient is pronounced by a medical practitioner to be free from infection.	21 days unless recently successfully vaccinated, when exclusion is unnecessary.
DYSENTERY	1-7 days. (Usually less than 4 days).	—	Frequent motions, sometimes headache and vomiting.	Exclude until child is well.	None.
DIARRHOEA	—	—	Do.	Do.	Do.
EPIDEMIC JAUNDICE	15-35 days. (averaging 25 days).	—	Nausea, malaise, headache.	Two weeks.	Do.
SCABIES			Small spots, red or whitish, on wrists or forearms or between fingers. Later an itching rash with scratch marks.	None after one treatment has been given.	Immediate treatment of all family contacts and playmates to be examined.
RASHES OR OTHER INFECTIONS.			Impetigo, sores, ear discharges, nasal discharge, inflammation of eyes or eyelids, should have prompt attention.		

STATISTICAL TABLES.

TABLE I.

Medical Inspection of Pupils Attending Maintained Primary and Secondary Schools.

A.—Periodic Medical Inspections.

Number of Inspections in the prescribed Groups—	
Entrants	2,525
Second Age Group	2,990
Third Age Group	1,835
Total	7,350
Number of other Periodic Inspections	945
Grand Total	8,295

B.—Other Inspections.

Number of Special Inspections	5,634
Number of Re-Inspections	11,739
Total	17,373

C.—Pupils Found to Require Treatment.

Number of Individual Pupils Found at Periodic Medical Inspection to Require Treatment

(excluding Dental Diseases and Infestation with Vermin).

Group. (1)	For defective vision (excluding squint). (2)	For any of the other conditions recorded in Table IIA. (3)	Total individual pupils. (4)
Entrants	34	471	503
Second Age Group	538	495	994
Third Age Group	286	242	506
Total (prescribed groups)	858	1,208	2,003
Other Periodic Inspections	4	183	188
Grand Total	862	1,391	2,191

TABLE II.

A.—Return of Defects Found by Medical Inspection in the Year Ended 31st December, 1950.

Defect Code No.	Defect or Disease.	Periodic Inspections. Number of Defects. Requiring treatment.	Periodic Inspections. Number of Defects. Requiring to be kept under observation but not requiring treatment.	Special Inspections. Number of Defects. Requiring treatment.	Special Inspections. Number of Defects. Requiring to be kept under observation but not requiring treatment.
	(1)	(2)	(3)	(4)	(5)
4.	Skin	131	221	515	41
5.	Eyes—				
	(*a*) Vision	862	59	82	11
	(*b*) Squint	81	125	33	14
	(*c*) Other	80	62	195	32
6.	Ears—				
	(*a*) Hearing	65	62	111	38
	(*b*) Otitis Media	79	144	476	79
	(*c*) Other	74	78	348	106
7.	Nose or Throat	348	1,217	1,282	965
8.	Speech	27	91	58	55
9.	Cervical Glands	35	565	412	298
10.	Heart and Circulation	12	155	118	229
11.	Lungs	77	346	386	262
12.	Development—				
	(*a*) Hernia	4	24	6	8
	(*b*) Other	4	69	10	52
13.	Orthopaedic—				
	(*a*) Posture	82	104	101	75
	(*b*) Flat Foot	96	63	69	19
	(*c*) Other	209	225	189	84
14.	Nervous System—				
	(*a*) Epilepsy	..	23	15	10
	(*b*) Other	25	139	48	93
15.	Psychological—				
	(*a*) Development	9	27	27	17
	(*b*) Stability	12	35	133	150
16.	Other	86	142	1,585	746

B.—Classification of the General Condition of Pupils Inspected during the Year in Age Groups.

Age Groups.	No. of Pupils Inspected.	A. (Good).		B. (Fair).		C. (Poor).	
		No.	% of Col. 2.	No.	% of Col. 2.	No.	% of Col. 2.
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Entrants	2,525	818	32·4	1,503	59·5	204	8·1
Second Age Group	2,990	1,025	34·3	1,743	58·3	222	7·4
Third Age Group	1,835	827	45·1	933	50·8	75	4·1
Other Periodic Inspections	945	300	31·8	573	60·6	72	7·6
Total	8,295	2,970	35·8	4,752	57·3	573	6·9

TABLE III.

Infestation with Vermin.

(i) Total number of examinations in the schools by the school nurses or other authorised persons	72,893
(ii) Total number of individual pupils found to be infested	3,917

TABLE IV.

Treatment of Pupils Attending Maintained Primary and Secondary Schools.

GROUP 1.—Diseases of the Skin.

	Number of cases treated or under treatment during the year.	
	By the Authority.	Otherwise.
Ringworm—		
(*a*) Scalp	34	..
(*b*) Body	45	..
Scabies	78	..
Impetigo	87	..
Other skin diseases	1,084	..
Total	1,328	

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	226	..
Errors of refraction (including squint)	*2,260	..
Total	2,486	
Number of pupils for whom spectacles were—		
(*a*) Prescribed	*1,223	..
(*b*) Obtained	*1,223	..
Total	1,223	

GROUP 3.—Diseases and Defects of Ear, Nose and Throat.

	Number of cases treated.	
	By the Authority.	Otherwise.
Received operative treatment for—		
(*a*) Diseases of the ear	4	..
(*b*) Adenoids and chronic tonsillitis	608	21
(*c*) Other nose and throat conditions	2	..
Received other forms of treatment	107	..
Total	721	21

* *Including cases dealt with under arrangements with the Supplementary Ophthalmic Services.*

GROUP 4.—Orthopaedic and Postural Defects.

(*a*) Number treated as in-patients in hospitals	57
(*b*) Number treated otherwise, e.g., in clinics or out-patient departments	4,426

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	126	..

GROUP 6.—SPEECH THERAPY.

	Number of cases treated.	
	By the Authority.	Otherwise.
Number of pupils treated by Speech Therapists	91	..

GROUP 7.—OTHER TREATMENT GIVEN.

	Number of cases treated.	
	By the Authority.	Otherwise.
(*a*) Miscellaneous minor ailments	16,674	..
(*b*) Other—		
(i) Chiropody	422	..
(ii) Sun Light	1,143	..
(iii) Neurological Clinic	83	..
TOTAL	18,322	

BARR HILL OPEN AIR SCHOOL.

Report—Leavers During 1950.

BOYS. *Left* 36

Average increase in weight	9.4 lbs.
,, stay in weeks	69.5 weeks.
,, age on admission	9½ years.

Diagnosis :

Bronchitis	5	T.B. Hip	3
Anæmia	3	T.B. Metacarpal L. Lupus	1
Malnutrition	8	T.B. Adenitis	1
Bronchitis and Asthma ..	3	?T.B. Arthritis	1
Bronchitis and Malnutrition ..	1	Cervical Adenitis	1
Malnutrition and Anæmia ..	4	Delicate	1
Asthma	2	Chronic Nasal Catarrh	1
Epilepsy	1		

Reasons for Leaving :

Transferred to ordinary school as fit	30
,, ,, ,, ,, (parents' request)	1
,, ,, ,, ,, (behaviour problems)	1
Switzerland	1
London Hospital	1
15+	2

GIRLS. *Left* 34

Average increase in weight	9.5 lbs.
,, weeks' stay	60 weeks.
,, age on admission	11 years 1 month.

Diagnosis :

Bronchitis	9	Post Pneumonia Febrosis ..	1
Anæmia	6	Malnutrition and Kyphosis ..	1
Malnutrition	3	Very enlarged Tonsils	1
Malnutrition and Anæmia ..	3	?Migraine	1
Delicate	2	Anæmia and T.B. Contact	1
Necrosis Lacrimal (bone)		T.B. Hip Ankylosed	1
Bronchitis	1	Old T.B. Hip	1
Bronchitis and Anæmia ..	1	Mesenteric Adenitis ? T.B. ..	1
Asthma	1		

Reasons for Leaving :

Transferred to ordinary school as fit	28
,, ,, ,, ,, (parents' request)	1
15+	5

Salford Child Guidance Clinic.

Number of cases referred, 1950, by—			
Teachers			25
School Medical Officer			51
Children's Officer			3
Education Office			4
Hospitals			8
Private Doctors			6
Court			7
Probation Officer			7
Parents			18
Others			7
Outside Salford			37
			173
Referred because of :—			
Enuresis and allied difficulties			32
Stealing and truancy			34
Failing at school			12
Stammer			4
Tics			3
Fears			11
Food fads and sleep difficulties			9
Other behaviour difficulties, *e.g.*, temper, masturbation			68
			173
Diagnostic interviews			126
Diagnosis only		31	
For treatment		77	
Test		18	
		126	
I.Q.—			
130+		3	
120-130		16	
110-120		20	
100-110		18	
90-100		27	
80- 90		19	
70- 80		10	
60- 70		6	
Below 60		5	
Not tested		2	
		126	
Waiting diagnostic interview, January, 1950		69	
Referred in 1950		173	
			242
Seen in 1950		126	
Waiting, December, 1950		66	
Closed without being seen, *e.g.*, removed, improved, referred to other agencies		50	
			242
Cases Closed		223	
of whom 55 not seen because on first contact—			
Improved	25		
Other agency	12		
Unsuitable	4		
Failed, etc.	14		
Children seen for first time			126
Children seen for treatment			110
Number of interviews in the Clinic			1,416
Number of home visits			225
Number of school visits			83