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City of Salford

ANNUAL REPORT

OF THE

Medical Officer of Health

FOR THE YEAR

1952

BY

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

MEDICAL OFFICER OF HEALTH

City of Salford

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Members of the Health Committee,

1952.

Alderman W. W. CRABTREE, *Chairman.*

Councillor J. HALL, *Deputy Chairman.*

Councillor A. F. CARROLL, J.P. (*Mayor*)

Alderman V. A. DARLEY, J.P. (*Deputy Mayor*)

„ J. BRENTNALL, J.P.

„ G. H. GOULDEN, J.P.

„ J. SHLOSBERG

„ M. WHITEHEAD (Miss)

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„ M. E. BUTLER, J.P. (Mrs.)

Councillor E. M. COOPER (Mrs.)

„ M. FERGUSON

„ C. R. V. HAYNES, J.P.

„ E. E. MALLINSON (Mrs.

„ F. M. MARRON (Mrs.)

„ G. A. MARSHALL

„ T. H. MELLOR, J.P.

„ N. WRIGHT

STAFF—1952.

MEDICAL OFFICER OF HEALTH ...	J. L. BURN, M.D., D.Hy., D.P.H.

MATERNITY AND CHILD WELFARE.

Senior Medical Officer	Miss M. SPROUL, M.B., Ch.B., D.P.H.
Superintendent of Health Visitors and Nursing Staff	Miss B. M. LANGTON, D.N. (London), S.R.N., S.C.M., H.V. Cert.
Non-Medical Supervisor of Midwives	Miss F. M. SANDERSON, S.R.N., S.C.M., M.T.D.
Supervisor of Day Nurseries ...	Miss L. HOLLIDAY, S.R.N., S.C.M.

ANALYSIS OF FOOD AND DRUGS.

Public Analyst	A. ALCOCK, A.M.C.T., F.R.I.C.

SANITARY INSPECTION.

Chief Sanitary Inspector	J. C. STARKEY, M.R.S.I.

MENTAL HEALTH.

Senior Mental Health Visitor and Duly Authorised Officer ...	E. SMITH until November, 1952. D. BOSTOCK from November, 1952.

HEALTH EDUCATION.

Health Education Officer	H. L. LATHAM, C.R.S.I.

SOCIAL WELFARE INCLUDING DOMESTIC HELP.

Almoner	Miss B. CHADWICK.

ADMINISTRATION.

Chief Administrative Assistant...	E. WOOD, C.R.S.I.
Chief Clerk	J. F. PRESTWICH, C.R.S.I.
Medical Officer of Health's Secretary	F. G. DOBSON, C.R.S.I.

INTRODUCTION.

To the Chairman and Members of the Health Committee.

Mr. Chairman, Ladies and Gentlemen,

I have the honour to present my annual report on the health of the City of Salford for the year 1952, included in which on pages 99 to 133 is a copy of a Special Survey of Services provided by the Local Health Authority under the National Health Service Acts which was prepared at the request of the Minister of Health.

Once again it gives me great satisfaction to be able to report the new low record in deaths of infants under one year of age, namely, 34·5 per 1000 live births. While this rate is still in excess of the national rate (27·6) it is gratifying to know that the improvement of recent years has continued and that in spite of the disadvantages of being born in a large industrial city, the danger of dying before his first birthday is only a third of that of an infant born twenty years ago. This great improvement has not been due entirely, of course, to the efforts of the health services—better housing conditions, better standards of living, greater knowledge, have all contributed their share ; but it may fairly be claimed that during the last thirty years the guiding hands have been those of the various branches of the public health service.

Health Statistics.

The population according to the Registrar General's estimate at mid-year 1952 was 176,400 a decrease of 400 as compared with that of a year ago.

Death Rate. The death rate for the year was 12·1 a decrease of 1·9 as compared with that for 1951.

Birth Rate. The birth rate for the year was 17·6, this being slightly higher than that for the previous year.

Infantile Mortality Rate. As already mentioned, the infantile mortality rate for 1952 was 35.

Maternal Mortality Rate per 1000 *Births.* This was 0·63 per 1000 total births, a very low figure and one giving cause for great satisfaction.

Smoke Abatement.

In May, 1952, the decision of the Minister of Health with reference to the Salford (Lower Kersal, Weaste and Duchy Road) Smokeless Zones Order, 1951, was received. The Minister stated that after consultation with the Minister of Fuel and Power on the question of supplies of smokeless fuels he had decided that he would not be justified in confirming the Order at the present time. He further stated that in reaching this decision he had had particularly in mind information from the Minister of Fuel and Power that adequate supplies of smokeless fuels were not likely to be available, and the fact that extensive conversion of existing grates, which would be necessary, would consume more steel than could be spared at present. On receipt of the Minister's decision I reported to the Committee that in view of the constant assurances by the Gas Industry and other smokeless fuel manufacturers that they could readily meet the situation, and the contention that the replacement of old appliances creates very little, if any, demand for new steel, If ound it difficult to reconcile the two points of view.

I therefore asked the Committee to approve in principle of the recognition of another zone. The Committee approved of my recommendation and gave authority for a detailed survey of the premises to be made. I am hopeful that in due time it will be possible to prevail upon the Minister of Health to approve of the proposed new scheme.

Home Helps and the Care of the Aged.

The development of the Home Help Service continues to be an important feature of the Local Health Service and there is every indication that it will be a long time before the needs of the City in this respect will be fully met.

The proportions of the types of cases who receive aid from the Home Help Service vary in different areas, but in Salford, as in other towns of similar type, the great majority of individuals helped are old people. Of the total number of cases helped under the scheme during 1952, over 71 per cent. were persons over 60 years of age.

The fact that the average age of the population is constantly increasing is in itself a sign that if the enormous cost of institutional and hostel accommodation for old people is to be kept within bounds, the need for help in the home will grow year by year. The Director of Civic Welfare tells me that he estimates the number of aged persons (i.e., men over 65 and women over 60 years of age) in Salford to be 22,000, nearly 13 per cent. of the whole population. One thing is certain, however, whatever the cost of the Home Help Service may be or may become, it will never be more than a fraction of that of providing and maintaining the hospital and hostel beds which would otherwise be required.

There is a wide misunderstanding by the public of the problem of the aged, including even a misunderstanding of the word itself. Every person should not automatically cease work of any and every kind merely because he becomes 65 or 70 years of age and allow himself, if he has no home of his own, to be spoon-fed in an institution for the rest of his life. The old saw that " a man is as old as he feels " is as true today as ever it was. Boredom may well be a heavier burden than the years themselves. Both the national and the individual interests demand that suitable work should be available for men and women to the limit of their working capacity, whatever their ages may be. Untold benefits—financial, physiological, and mental, would result from a satisfactory solution of the problem of finding work for old people, so much so that the subject is worthy of the most careful consideration by the Ministry of Labour, employers' organisations and the trade unions.

Midwifery Service.

As foreshadowed in my last annual report, the adaptation of Jutland House, Trafford Road, Salford, as a training Centre for pupil midwives, a breast-feeding clinic, and as the headquarters of the premature baby service and the night midwifery service, was completed in 1952. The premises were formally opened in October last.

From the beginning there has been no doubt as to the success of the scheme. The flow of pupils has been well maintained and the situation of the premises in relation to the public need in South Salford is ideal.

In one's gloomier moments before the Centre was opened, one felt that its situation in a thickly populated district, on the verge of the Docks area, might be a deterrent to obtaining and keeping pupils and staff. With one exception, however, these fears proved to be without justification. The service

is working well and smoothly, the pupils are obtaining a thorough training, and the public are well served.

Day Nurseries.

The Council's Day Nursery Service continued to be well used during 1952, and all the evidence goes to show that there is no waning in its popularity in Salford. There are still lengthy waiting lists and the demand for places in the new nursery in Hayfield Terrace, Pendleton, which was opened in October, 1952, was heavy in spite of the falling off in employment which was taking place at that time. It is not expected that there will be any shortage of applications for places in the nursery which will be opened in Bradshaw Street, Higher Broughton, in 1953.

Family Guidance.

I am glad to be able to report a step forward in the setting up, even though on a small scale, of a family guidance service in the City.

This service which commenced in May, 1952, operates as part of the Council's Maternity and Child Welfare Scheme. Up to the present, the scheme has been very limited in its scope and, therefore, in its results, but it is hoped that as it becomes more widely known it will prove of great benefit to people who experience difficulty in their matrimonial affairs.

Home Nursing.

In 1952 the number of cases nursed by the Salford Home Nursing Service was 369 more than in 1951, and the number of visits paid increased by more than 7,000.

The need for, and the value of the Home Nursing Service is becoming more evident year by year.

Not merely is the cost of the service very low in relation to the cost of hospital treatment, but it enables many patients who do not wish to enter hospital to remain at home without detriment to their chances of recovery. If the truth were known, many patients would prefer to remain at home if they could be assured of proper care and treatment such as can be afforded by their family doctors, the Home Nursing Service and sympathetic relatives. The strain upon the relatives, of course, by the need for continuous attention to patients who may be ill for years is, naturally, a factor of great importance, even where the patients' relatives would like to keep them at home. This gives rise to the thought that if a grant from public funds were available to the relatives in such circumstances they might prefer to employ help (not necessarily through the Home Help Service) rather than allow their sick relations to enter hospital.

The widening of the circle of home nursing activities would be of advantage to the hospitals by reducing the demand for beds and so making more accommodation available for acute cases. The extension of home nursing by a reversion to the former practice of " looking after one's own " is undoubtedly one method by which the enormous cost of the hospital service may be kept within bounds.

Mental Health.

The important problem of dealing with the mentally sick is under constant consideration by the Health Committee. The provision of accommodation, particularly for the older types of patients, although actually the responsibility of the Regional Hospital Board, has received special consideration, and with

the co-operation of the Board it has been possible to deal with cases within a reasonable length of time.

As stated, however, in my fuller report upon the Mental Health Service (see pages 86 to 91) I am unhappy about the necessity for procuring the entrance to mental hospitals of old people, particularly women who are suffering from senility rather than mental illness. The difficulties in dealing with this type of case are largely mechanical and are due to the fact that no special accommodation such as that which is so often referred to as the "Half-Way House" type is available. I am hopeful that by constantly bringing attention to this problem, and by goodwill on the part of all the authorities concerned, particularly the Ministry of Health, it may be possible to avoid placing the stigma of mental illness upon many aged persons.

I am glad to be able to report that Salford is in a fortunate position in relation to the admission of mental defectives to hospitals.

It is hoped that during 1953, it will be possible to open the premises formerly known as the Friends' Meeting House in Langworthy Road, Salford, as an additional occupation centre for mental defectives and by so doing to release the Oldfield Occupation Centre in Liverpool Street for use as an occupation centre for young adult and adolescent males. When these changes have taken place, Salford will be reasonably well supplied with occupation centres.

HEALTH CENTRES.

It is regretted that it has not yet been possible to make any definite progress in the provision of health centres in Salford.

Some authorities have been able to establish experimental centres ; but general ministerial approval has not yet been given. In the view of the undersigned, the establishment of such centres should go hand in hand with group practice by medical practitioners. Unfortunately, up to the time of writing this report, it has not been possible to provide a suitable site or to find a group of practitioners willing to practice together.

Admittedly, Health Centres are expensive to maintain but there is no doubt that doctors practising from such centres and the patients attending them would benefit by their establishment.

AMBULANCE SERVICE.

The Ambulance Service again maintained a high state of efficiency during 1952.

Perhaps the most important new aspect of the year's work consisted of attempts to secure economies by co-operation with representatives of the Local Hospital Management Committee as a result of which a reduction in the number of patients conveyed was brought about.

The introduction of a system of radio-telephony in October, 1952, was approved by the City Council. This has undoubtedly increased the general effectiveness of the service and has saved many vehicle-miles and increased the speed with which patients can be dealt with.

Thanks are due to the Director of the Central Garage who is responsible for the day to day operation of the Service.

TUBERCULOSIS—MASS MINIATURE RADIOGRAPHY SURVEY.

In October, 1952, an important conference took place between representatives of the three main branches of the Health Service, when a scheme

was submitted on behalf of the Manchester Regional Hospital Board for a mass miniature radiography survey of as many persons living and working in Salford as possible. The scheme which involves the concentration of the whole of the Board's miniature radiography units in this area was heartily approved by all the authorities concerned, and working parties were set up with a view of inaugurating the scheme in April, 1953. Your Medical Officer of Health was appointed Co-ordinating Officer.

At the time of writing this report the scheme is well under way and already 55,000 persons living and/or working in Salford have been examined.

The decision to organise the survey in this area was taken because of Salford's unfortunate experience in relation to Tuberculosis. In 1951, Salford's death rate from respiratory tuberculosis was 49·2 per 100,000—this being the second highest mortality rate for the twenty large towns in England and Wales.

It is believed that this positive attempt to find hitherto undiscovered sources of infection will have a great measure of success and so help to reduce the incidence of tuberculosis in the City. I hope it may be possible to include a full report upon the survey and its results in my annual report for 1953.

Whatever the outcome of the survey it will certainly provide useful data and experience for any similar surveys which may be made elsewhere.

Co-ordination of Health Services.

Once more the Health Committee took an active part in endeavouring to bring about closer co-operation with the hospital authorities and general practitioners through its representatives on the Salford Health Services Joint Advisory Council. It is obvious, although apparently the fact is not generally recognised by all of the authorities operating under the National Health Service Act, that if the best is to be obtained from the Health Services there should be the closest possible co-operation, not only at officer level, but also at authority level. Views have been expressed that there are already enough committees and that co-operation can be successfully maintained by multi-representation of members of the various bodies. When one considers the importance of the issues involved one cannot but realise how futile is the view that authorities do not need to confer formally and regularly upon the important issues involved. It is surely contrary to the public interest that important decisions relating to the Health Service should be made by individuals instead of by the authorities they represent.

I feel strongly that co-operation under the National Health Service Act can be secured only by regular meetings of formally appointed representatives of the authorities concerned as well as by consultations between responsible officers.

Details of the deliberations of the Joint Advisory Council can be found on pages 101 to 104 of this report.

Conclusion.

At the time of writing, the Salford Health Service is overshadowed by the death of the late Chairman of the Health Committee, Alderman W. W. Crabtree, whose interest in the health service was widely known. Alderman Crabtree had been a member of the Health Committee for eighteen years and had acted as Chairman since 1945. Only quite recently he was appointed Chairman of the Manchester Port Health Authority of which he had been Deputy-Chairman for many years. Apart from other considerations, his local knowledge, his interest in people, and his wide humanity, were of immense help both in and out of Committee. Alderman Crabtree often continued

to carry out his duties and to take an active interest in public affairs when far from well, and it is possible that had he spared himself more he would have been able to enjoy longer the public life he loved so much. The loss of Alderman Crabtree's knowledge and experience cannot fail to be felt in the municipal life of Salford.

To the members of the Health Committee I offer my warmest thanks for their continued encouragement and support during the year under review. I feel sure that nowhere in the country is there a keener desire for a first-class Health Service than that which exists in the Salford Health Committee, and I appreciate that its efforts are limited only by local financial considerations.

To the quality and to the extent of the work of the staff of the Health Department this volume is in itself a tribute, but I cannot let the occasion pass without expressing my appreciation of their efforts throughout the year.

I am particularly indebted to Mr. E. Wood (Chief Administrative Assistant) for his contribution of many years of able and devoted service to Salford public health.

I would like to record deep indebtedness to Dr. Margaret Sproul, to all of the medical staff, and to many members of our public health team—Mr. J. C. Starkey (Chief Sanitary Inspector) ; Miss B. M. Langton (Superintendent Health Visitor) ; Miss F. M. Sanderson (Non-Medical Supervisor of Midwives) ; Miss B. Chadwick (Almoner) ; Miss L. Holliday (Supervisor of Day Nurseries) ; Mr. A. Alcock (City Analyst) ; Mr. H. L. Latham (Health Education Officer) ; Mr. J. F. Prestwich (Chief Clerk).

There is also another indebtedness to be gladly recorded—to the Chief Officers of the Corporation ; to Dr. Lee (Chest Physician) ; and to the officers, too numerous to mention individually, of the Regional Hospital Board ; the Hospital Management Committee ; and the Local Executive Council. To Dr. Parker of the Public Health Laboratory Service, and the family doctors (who are also members of the health team) I would like to pay a warm tribute.

A feature of our work is co-operation with colleagues in voluntary organisations—the Family Service Unit (Mr. Elwyn Thomas) ; the Manchester and Salford Council for Social Services (Mr. F. Dougals Weeks) ; the Salford Council of Social Service (Mrs. J. A. Stoddard) ; and also with the staff of several departments of Manchester University.

The work of the Salford Public Health Service is a team effort.

At the same time, I desire to express my appreciation of the assistance constantly received from chief officers of the Corporation, members and officers of the Regional Hospital Board, the Hospital Management Committee, the Executive Council and voluntary bodies concerned with the Health Service.

I have the honour to be,

Your obedient Servant,

J. L. Burn.

Medical Officer of Health.

HEALTH DEPARTMENT,
143, REGENT ROAD,
SALFORD, 5.
July, 1953.

CONTENTS.

STATISTICAL SUMMARY, 1952.

Area.—The City of Salford has a total area of 5,202 acres.

Population.—(Registrar-General's Estimate at Mid-year, 1952)		176,400
„ (Census, 1951)		178,036

Density.—The Mean Density of the City is equal to 33·9 persons per acre.

Live Births	**Legitimate**	**1,516 Males,**	**1,397 Females**	2,913
	Illegitimate	**91 „**	**96 „**	187
			TOTAL	3,100
Annual Rate of Births per 1,000 of the Population				17·6
Still Births	**Males 33** / **Females 28**		**Total**	61
Annual Rate of Still Births per 1,000 Total Births				19·3
Deaths	**Males 1,114** / **Females 1,029**			2,143
Annual Rate of Mortality per 1,000 of the Population				12·1
Percentage of Total Deaths occurring in Public Institutions				50·2%

Deaths from Puerperal Causes :—	Deaths.	Rate per 1,000 Total Births
Puerperal Sepsis	..	..
Other Puerperal Causes	2	0·6
TOTAL	2	0·6

Death-rate of Infants under one year of age per 1,000 live births :—

Legitimate, 31. Illegitimate, 96. Total	35
Deaths from Measles (all ages)	..
„ „ **Whooping Cough** (all ages)	..
„ „ **Diarrhoea** (under 2 years of age)	7

TABLE M. 4.

SHOWING THE BIRTHS IN THE CITY OF SALFORD, DEATHS OF LEGITIMATE AND ILLEGITIMATE INFANTS UNDER ONE YEAR OLD AND THE PROPORTION OF DEATHS UNDER ONE YEAR OF AGE PER 1,000 BIRTHS DURING THE YEARS 1938 TO 1952.

Years.	Births.			Percentage of Illegitimate Births to Total Births	Deaths under One Year.			Proportion of Deaths under One Year per 1,000 Births.		
	Total.	Legit.	Illegit.		Total.	Legit.	Illegit.	Total.	Legit.	Illegit.
1938	3145	3037	108	3·4	233	213	20	74	70	185
1939	2925	2808	117	4·0	202	194	8	69	69	68
1940	2884	2742	142	4·9	219	209	10	76	75	70
1941	2518	2377	141	5·5	240	215	25	96	90	177
1942	2823	2632	191	6·8	217	203	14	77	77	73
1943	3085	2863	222	7·2	214	203	11	69	71	50
1944	3251	3025	226	7·0	202	182	20	62	63	88
1945	3022	2749	273	9·0	183	168	15	61	61	55
1946	3849	3610	239	6·2	205	180	25	53	50	104
1947	4220	3973	247	5·9	258	240	18	61	60	73
1948	3761	3570	191	5·1	157	147	10	42	41	52
1949	3628	3387	241	6·6	193	181	12	53	53	50
1950	3354	3123	231	6·9	144	128	16	43	41	69
1951	3091	2881	210	6·8	107	103	4	35	36	19
1952	3100	2913	187	6·0	108	90	18	35	31	96

TABLE M. 5.

SHOWING THE BIRTH-RATES, ALSO RATES OF MORTALITY FROM ALL CAUSES, FROM THE SEVEN PRINCIPAL ZYMOTIC DISEASES, AND FROM TUBERCULOSIS OF RESPIRATORY SYSTEM, CANCER, NERVOUS DISEASES, HEART DISEASES, BRONCHITIS, PNEUMONIA AND THE INFANT MORTALITY RATE DURING THE YEARS 1938 TO 1952.

Years	Population	Rates per 1,000 Population from									Deaths under One Year to 1,000 Births.	Marriage Rate.
		Births.	Deaths, All Causes.	Seven Principal Zymotic Diseases	Tuberculosis of Respiratory System.	Cancer.	Nervous Diseases.	Heart Diseases.	Bronchitis.	Pneumonia.		
1938...	199,400	15·8	13·1	0·3	0·9	1·7	0·8	2·8	0·6	1·0	74	...
1939...	196,600	14·9	14·3	0·2	0·9	1·8	0·7	3·8	0·7	1·0	69	...
1940...	173,200*	16·6	19·1	0·3	1·1	2·0	1·1	5·3	1·7	1·2	76	...
1941...	159,720*	15·8	16·8	0·4	1·1	1·7	1·1	4·3	1·1	1·2	96	...
1942...	153,300*	18·4	14·5	0·4	0·9	2·2	1·0	3·4	0·9	0·8	77	...
Average 5 years		**16·3**	**15·6**	**0·3**	**1·0**	**1·9**	**0·9**	**3·9**	**1·0**	**1·0**	**78**	...
1943...	153,000*	20·2	15·7	0·3	1·0	2·2	0·9	2·7	1·9	0·9	69	...
1944...	155,810*	20·9	14·6	0·4	0·9	2·1	0·9	2·4	1·9	0·6	62	...
1945...	157,300*	19·2	15·5	0·2	0·9	2·0	0·8	2·2	2·9	0·8	61	...
1946...	169,470	22·7	13·3	0·2	0·8	1·9	0·9	1·8	2·0	0·6	53	...
1947...	174,070	24·2	13·3	0·4	0·8	2·0	0·5	2·1	1·9	0·6	61	...
Average 5 years		**21·4**	**14·5**	**0·3**	**0·9**	**2·0**	**0·8**	**2·3**	**2·1**	**0·7**	**61**	...
1948...	178,100	21·1	11·8	0·2	0·8	2·1	0·7	1·6	1·4	0·4	42	...
1949...	178,900	20·1	13·1	0·2	0·6	1·9	0·7	2·1	1·8	0·7	53	...
1950...	177,700	18·9	12·9	0·1	0·4	2·3	0·7	1·9	1·7	0·5	43	...
1951...	176,800	17·5	14·0	0·1	0·5	2·1	0·8	2·4	2·2	0·5	35	..
1952...	176,400	17·8	12·1	0·04	0·34	2·1	0·7	2·2	1·7	0·6	35	...
Average 5 years		**19·1**	**12·8**	**0·13**	**0·53**	**2·1**	**0·7**	**2·0**	**1·8**	**1·5**	**42**	...

* Civil population.

SANITARY CIRCUMSTANCES AND ADMINISTRATION

Housing

Implementation of the Compulsory Purchase Order, made by the Council in December, 1949, and confirmed by the Minister in June, 1951, in respect of the large slum area referred to as Trinity No. 1 Clearance Area, has proceeded throughout 1952. The area originally included 462 dwellinghouses, 3 public houses and 21 other buildings.

The rate at which the slum property is vacated and demolished naturally depends upon the speed at which new dwellings are completed and made available for rehousing purposes by the Housing Committee. The number of new dwellings made available for this purpose has fallen somewhat short of expectations. Nevertheless considerable progress has been made ; by the end of the year the number of buildings in the area vacated and demolished reached a total of 196. The transfer of the land to the Corporation is proceeding satisfactorily ; blocks of flats are already well on the way towards completion on that section of the area first cleared whilst the second large section is cleared and ready for building operations which, it is anticipated, will have commenced before mid-1953.

In November, 1952, notice to treat and notice of entry were served in respect of the third section of the area and it is expected that this will be cleared by July, 1953, enabling the Corporation then to enter upon and commence the clearance of the fourth and final section of this area of 14½ acres.

Redevelopment of the land thus cleared with new dwellings in the form of flats, together with current schemes on other small sites within the City boundaries and the overspill houses now under construction in considerable numbers to the north-west of Salford and also to the south across the County boundary, will make practicable the clearance of more slum property. Unhealthy areas have already been surveyed and will become the subjects of official representation to the Council early in the New Year.

Following this pattern of clearance and redevelopment of cleared sites it is confidently expected that the long overdue change in housing conditions will be brought to fruition ere many years have passed. The rate at which the slum problem is tackled should accelerate because the number of families without homes has diminished.

Apart from the slum clearance programme we still have to cope with the day to day problems so common in housing administration today, viz : failure of landlords on financial grounds to carry out works of ordinary maintenance ; abandonment of property by owners ; individual houses discovered to be hopelessly unfit for human habitation ; and also the very serious matter of buildings becoming dangerous on account of lack of attention and war damage. Notwithstanding every effort to preserve in use every house which would provide shelter for a family it has proved necessary during this year for the Salford Council to take formal action for the demolition of 111 houses : 23 totally unfit houses, by demolition orders under Part II Housing Act, 1936 ; 88 houses which were the subjects of dangerous structure notices.

CONTROL OF INSECT PESTS—MUNICIPAL DISINFESTATION SERVICE.

The volume and scope of operations in this field and some indication of the economic aspect of the service are outlined in the following tables :—

TABLE 1

Insects attacked.	*Number of operations.*
Bedbugs	541
Cockroaches (three species)	444
Two-winged flies (housefly and blow flies)	59
Fleas	28
Lice (three species)	11
Crickets	2
Mosquitoes and midges	9
Food-beetles and mites	6
Silverfish	2
Wood-boring beetles	2
Moths	11
Earwigs and garden beetles	4
Wasps	3
TOTAL	1,122

This total of 1,122 does not include routine operations at hospitals, canteens and dining centres under the control of the Director of Education, nor the large volume of disinfestation work carried out in connection with slum clearance, in all of which cases the treatment administered is for general insect control.

It should also be noted that this is a total of primary operations and does not include retreatment after reinspection which is so frequently found to be necessary when dealing with the cockroach family of insects.

The next table shows the wide variety of types of building requiring treatment for insect infestation. Only two cases warrant special mention : (*a*) a large warehouse in which thousands of beds and pillows were stored was discovered in the summer time to be heavily infested with clothes moths. The owners of the stock, faced with serious loss appealed for assistance and a few days work by the Department's operators subsequently proved to have relieved the situation ; (*b*) a timber yard, buildings, and kilns, were discovered to be infested with a colony of the large Australian cockroach, an insect which up to the present time is confined to Dock warehouses. The firm concerned were importers of tropical timber. The treatment given by the Corporation's service eradicated the pest.

TABLE 2

Types of premises.		*Number treated.*	*Totals.*
DOMESTIC PREMISES.			
Privately owned houses and flats		548	
Council „ „ „ „		43	
House-and-shop		20	
Houses-let-in-lodgings		12	
Common lodging houses		3	
Seamen's „ „		1	
Ex-Army hutments		28	
Allocation of Council tenancies—			
Treatment of furniture	284		
„ „ new homes	169		
	—	453	
Houses cleansed from vermin prior to demolition—			
Individually unfit	14		
Clearance area	116		
	—	130	
NON-DOMESTIC PREMISES.		—	1,238
Canteens, kitchens, dining centres, etc.		78	
Restaurants and cafes		3	
Bakehouses		10	
Retail food shops		7	
Public houses		3	
Clubs, hostels, etc.		5	
Factories		16	
Stores		8	
School buildings		3	
Baths and washhouses		5	
Offices		4	
Barracks		1	
Fire Station		1	
Cinema		1	
Stables		1	
		—	146
HOSPITALS, ETC.			
Visits to hospitals (three)		62	
Day Nurseries and Clinics		9	
		—	71
VERMINOUS PERSONS.			
Persons, clothing and bedding cleansed		11	
		—	11
TOTAL			1,466

The disinfestation service comprises two full-time operators with assistance of temporary labour during the summer peak period, equipped with spraying and dusting machines, and a light van to transport men, equipment and materials from job to job. The men are supplied with overalls, boots and mackintoshes.

Insecticide used throughout the year has been D.D.T. in the various formulations found to be effective having regard to habits and reactions of specific pests.

The service is not entirely financially self-supporting but, as will be seen from the following Table 3, the bulk of the work is invoiced to some person who, before work is commenced, has signed a form of order undertaking to pay the cost of the work entailed. Moderate accounts are rendered based upon operator's time, cost of materials and haulage plus a small establishment charge. The City Treasurer experiences little difficulty in collecting the money involved.

TABLE 3

Type of premises.	*Number treated.*	*Totals.*
DISINFESTATIONS FOR WHICH EXPENSES WERE RECOVERABLE.		
Privately-owned premises treated on order from owner ...	144	
,, ,, ,, ,, ,, occupier ...	490	
Occupied Corporation dwellings—		
Charged to Housing Manager 21		
,, ,, tenants 22		
—	43	
Entry into Corporation tenancy expenses recovered by Housing Manager from tenants—		
Treatment of furniture 183		
,, ,, new home 169		
—	352	
Charged to Corporation Departments for buildings other than dwellings	49	
Special Contracts—		
Hospitals and nursing homes 62		
School canteens, kitchens, etc.... 67		
—	129	
—		1,207
DISINFESTATIONS FOR WHICH EXPENSES WERE NOT RECOVERABLE.		
Houses cleansed prior to demolition—		
In clearance areas 116		
Individually unfit... 14		
—	130	
Clearance area furniture cleansed	101	
Verminous persons (statutory obligation)	11	
Treatment of premises occupied by impecunious persons ...	13	
Destruction of wasps, midges, etc., for public good	4	
—		259
TOTAL OPERATIONS		1,466

Smoke Abatement

During the year under review a decisive forward step has been witnessed by the establishment of a Smokeless Zone in the central area of Manchester.

At the same time it has to be recorded that the Minister of Housing and Local Government decided he would not be justified in confirming the Salford Smokeless Zone Order and intimated that in reaching that decision he had particularly in mind information from the Minister of Fuel and Power that adequate supplies of smokeless fuels were not likely to be available and the fact that the extensive conversion of existing grates would consume more steel than could then be spared.

In the autumn, however, the Minister of Fuel and Power announced an additional coke allocation of half a ton per domestic registration, and later it was found that $1\frac{3}{4}$ million new grates had been installed throughout the country during 1952. It can justifiably be claimed that replacement of old grates by new takes no more, very often less, out of the steel pool than it puts back into it.

This result is felt to be only a temporary set-back however, and a new scheme, smaller than the original, is in course of preparation. The smokeless zone method of securing less smoky conditions in large towns offers the greatest prospects and has considerable advantages over any other.

Quite a controversy emerged from the marketing of nutty slack in mid-winter. It is totally unsuitable for use on the new grates and gives rise to excessive smoke on any open grate. The worst London fog for many years, when deaths from respiratory diseases rose alarmingly, coincided with the introduction of nutty slack and may have influenced the N.C.B. in discontinuing its advertising campaign.

Industrial smoke production, although considered a lesser evil than that of domestic origin, continues to receive particular attention by the Department.

Statistics are here given which, in some measure, convey an idea of the extent of that work.

Ignorance more than deliberate carelessness is often the root cause of black smoke production from manually stoked furnace plants, and accounts for most of the 129 short period emissions recorded. Without sufficient knowledge of the elementary principles of combustion, the operator finds it difficult to adapt his method to the varying grades of coal. Unfortunately the type of operator referred to cannot be persuaded to interest himself in the classes organised for his benefit and of those who do attend many find that the lectures are too technical.

Automatic mechanical stoking with coal suited to the particular method chosen is the most reliable method. With this in mind, mechanical firing has been advocated where the steam-load has warranted it, whilst where boiler power has been more than ample coke firing has been recommended. Three boiler plants have been converted to mechanical firing and two firms have agreed to burn coke instead of coal. Three other firms have equipped their furnaces with Fuel Research Station firedoors. Some firms unfortunately do not display willingness to co-operate and the necessity to institute legal proceedings then arises. Only two such reached that stage however.

The nuisance class referred to in the category " smoke-not-black " usually involves a very low chimney and a small boiler. The only difficulty experienced is the delay in delivery of new steel tubing. Second-hand tubing is usually not worth erecting. In only four of the fourteen cases dealt with were the chimneys raised in height, alternative methods of abating the nuisances being found in the others such as changing from coal to coke (3), discontinuing the burning of trade waste in boiler furnace (2), igniting fires by gas (1), etc.

Arising out of complaints in the Lower Kersal area and the River Irwell valley between Swinton and Pendlebury and Prestwich, a rapid survey of solid deposit in the area was conducted in conjunction with those two authorities from 12th June to 4th July. Much of the grit was alleged to originate at the new Agecroft power station chimney and the siting of the twelve recording stations was arranged on that assumption. Consideration of the results did not lend support to the allegations however.

It transpired that some pollution arose from the power station ash dump at Carr's Lake, Agecroft Road, Pendlebury, in dry windy weather and further heavy pollution from the directions of Pendlebury and Clifton. The dump surface was consolidated by heavy rolling. The Swinton and Pendlebury

authority is following up the matter with further surveys. Their investigations are not yet completed but evidence points to a colliery chimney and a large colliery spoil heap being the sources of pollution by grit.

INDUSTRIAL BLACK SMOKE NUISANCES.

Complaints	4
Observations carried out	644
Black smoke emissions recorded—	
Up to 2 minutes aggregate per observation	129
From 2 to 4 minutes aggregate per observation	41
„ 4 „ 10 „ „ „ „	39
Over 10 minutes „ „ „ „	8
Observation Notices served	85
Abatement „ „	5
„ „ complied with	*6
Inspections of furnace plant	28
Advisory visits	23

* One served in 1951.

NUISANCES FROM INDUSTRIAL SMOKE-NOT-BLACK.

Complaints	12
Observations taken	22
Nuisances detected	15
Abatement Notices served	1
„ „ complied with	1
Inspection of furnace plant	9
Advisory visits	4

GRIT, ASH AND DUST EMISSIONS.

Complaints	3
Nuisances detected	4
Observations and investigations carried out	27
Abatement Notices served	—
„ „ complied with	—

PRIOR APPROVAL OF STEAM GENERATING, ETC., FURNACES.

Details of six new furnace plants were submitted for approval, one being a waste-heat boiler burning trade waste having a calorific value little short of coal.

The proposals in two cases were not approved and in each of them the owners agreed to burn coke in the furnaces.

One unsatisfactory plant installed without having been certified came to the knowledge of the Department through the heavy smoke produced. Representations to the firm were of no avail. A prosecution was contemplated but before a Summons could be issued the boiler was discarded after having proved itself incapable of producing the steam required of it.

NOXIOUS EFFLUVIA.

Three complaints of pollution by objectionable fumes have been dealt with. In one of them the source of origin was evidently in a neighbouring authority's area. As much data as possible was collected and forwarded to H.M. Inspector of Alkali, etc., Works, who later stated the information had been useful to him in tracing the source and cause. Satisfactory solutions were found in the other two cases through consultations with the firms concerned.

It is gratifying to know that following representations made to him in 1951 by representatives of local authorities in the area, the Minister of Housing and Local Government has now agreed to the appointment of an additional Inspector under the Alkali Works Regulations Act, 1906, for duties in the Manchester area. Previously control was effected from Liverpool. His duty is to ensure that emissions of certain industrial gases do not exceed the limits permitted by Statute.

Shops Act, 1950

I must thank the Chief Constable and his staff for their co-operation in enforcing the provisions regarding half-day closing and the early closing of shops and in connection with the restriction of Sunday trading.

Complaints of contraventions were investigated and the co-operation of shopkeepers sought and obtained.

In the case of environmental hygiene, notices were issued where necessary, and the standard of arrangements for the health and comfort of shop employees was maintained.

During the year two more shops were registered for Sunday trading by persons observing the Jewish Sabbath.

There were no contraventions in connection with the employment of adolescents.

Milk and Dairies

The milk supply in the City is now 100 per cent. designated milk, the one remaining dairyman retailing ungraded milk discontinued the trade towards the latter part of the year and now bottles pasteurised milk supplied by a large processing dairy.

Salford is shortly to be included in a " specified area " and this will prohibit the sale of milk by retail unless sold under a " special designation."

There are four processing dairies in the City, one of which also carries on the process of sterilisation.

Three of these dairies pasteurise milk by the holder method and one by the H.T.S.T. method.

In addition to the four processing dairies there are eight distributors, one of which bottles pasteurised milk on his premises. The other seven buy milk in bottles from the larger dairies.

The remainder of the milk consumed in the City is delivered by dairies from surrounding authorities and this constitutes over 50 per cent. of the total.

The following licences, in accordance with the Milk (Special Designations) Regulations, 1949, were issued during the year :—

Pasteurising Establishments	4
Sterilising „	1
Bottling „ (excluding above)	1
Tuberculin Tested licences in conjunction with pasteuriser's licences	3
Supplementary licences (wholesale and retail traders)	13
Dealer's licences (wholesale and retail traders)	8
„ „ (milk shops)	758

Samples of milk are taken weekly from all sources of supply and submitted to test for :—

(1) efficient pasteurisation by the phosphatase test ;
(2) efficient sterilisation by the turbidity test ; and
(3) keeping qualities by the methylene blue reduction test.

These samples are obtained from dairies, distributing vehicles, shops, schools canteens, hospitals, etc., and, as the tabulated results below show, the percentage of failures is very low.

	Number tested.	*Passed.*	*Failed.*	*Per cent. failures.*
Phosphatase	473	462	11	2·3
Turbidity	127	127	—	—
Methylene Blue	299	285	14	4·6

One hundred and eighty-two methylene blue tests were not carried out as the maximum shade temperature reached 65 degrees F.

All failures are followed up by inquiries to the dairies concerned and if necessary by stage to stage check of the process.

The majority of failures are accounted for by :—

1. some temporary breakdown in the plant ;
2. insufficient heating of the holder at the commencement of the process ;
3. staffing problems.

Regular testing of milk bottles is carried out to test the efficiency of the washing machines and on the whole prove satisfactory.

In one instance, a dairy installed a more modern type of washing machine but were unable to obtain the results given by the discarded machine. Tests from the various stages indicated that the soaking tank was the source of the trouble and despite daily sterilisation of this section and daily renewal of the detergent, little improvement was made. On the advice of the Inspector a small percentage of hypochlorite solution was added to the soaking tank and this produced the desired results to the satisfaction of both parties.

Staffing of dairies is a very serious problem and the majority of complaints received may be attributed to this cause. Very few people like the early morning start, the six-day week without week-ends off and the comparatively low wage, consequently the majority of dairies are understaffed and have a constantly changing personnel.

Market Stalls

The only open-air market in the City is quite modern and of permanent design. It was erected on part of the old Cattle Market in Cross Lane. It is owned by the Corporation and administered by the Markets Committee.

Market days are Mondays and Saturdays when the 208 permanent stalls are filled to capacity. In addition to these permanent stalls there is ample room for the 36 caravans, motor vehicles, ice-cream vehicles and moveable stalls. Of these 244 stalls some 35 to 40 sell food of the following types :—

Horse-flesh.	Ice-cream.
Wet Fish.	Sweets.
Tripe.	Biscuits.
Cooked Meats.	Confectionery.
Black Puddings.	Snacks.
Shell-fish.	Grocery.
Greengrocery.	

More than 60 per cent. of these traders come into Salford from outside districts and inquiries are sent to the various authorities as to the conditions of preparation and/or storage of the goods sold by these people.

From one of these enquiries a local authority discovered an unregistered bakehouse which did not comply with the requirements of the Food and Drugs Act, 1938.

The only hygienic control over these stalls is the Food Byelaws which were adopted in November, 1950, and are administered by the Food Inspectors. As these Byelaws are very elastic and not as specific as Section 13 of the Food and Drugs Act, 1938, standardisation is very difficult and leads to discontent amongst the stallholders and amongst local food shop proprietors.

For example, a stallholder provided a glass partition and counter to protect his biscuits and after a few weeks he removed this protection stating that the stall had been converted into a shop and he was losing trade to other stalls who had provided biscuit tins with glass lids which were opened to form a screen along the front of the stall. He stated that when the glass screen and counter were standard equipment he would reintroduce them.

Shopkeepers complain of the very high standard required in their premises as compared with stallholders who, in many cases are not local ratepayers, and rob them of trade.

One big problem appears to be the washing of soiled hands, and although lavatories are provided for the stallholders, they are loth to leave their stalls unattended. An attempt is being made to get them to provide a bucket full of clean water, soap and a towel on each stall.

Public Houses

During the year a survey of the public houses in the City has been initiated and up to the present a total of 180 premises have been inspected, the number of licensed houses in the City being 280.

Letters have been written to the breweries concerned and meetings with managements have taken place. As a result of this action many recommendations have been implemented and plans prepared for future alterations.

The principal recommendations have included drainage, improvements to cellars, glass and personal washing facilities, adequate and suitably sited sanitary conveniences and decorating. Washing machines of various types have been installed experimentally in various houses and results over a period will be observed.

It is also intended to test the efficiency of various methods of glass washing by use of litmus-lactose gelatine. The glasses after being washed are coated with this solution and can be left in the care of the publican who can observe for himself the results. It will be of great interest to note the results obtaining from single sink washing, twin sink washing, both single and double sinks with the use of sterilisers, and washing machines.

There has been little need to direct any criticism at pumps and pipe lines, the majority of pipes being either of good quality metal, plastic or glass. Frequency of cleansing is also a feature to which it has been unnecessary to draw attention.

Ice-Cream

During the year, 44 shops were registered for the sale of pre-packed ice-cream, and one new factory for the manufacture, storage and sale of hot mix ice-cream. There are now over 400 premises in the City registered for the manufacture, storage or sale of ice-cream.

Regular visits are made to all registered premises to ensure that the Regulations and Section 13 of the Food and Drugs Act are being complied with.

One hundred and sixty-eight bacteriological examinations of ice-cream were made during the year and were graded :—

Provisional Grade	1	92
,,	2	27
,,	3	23
,,	4	26

The 26 grade 4 samples were from 5 manufacturers where there was faulty sterilising technique on the plant. These faults were overcome and subsequent samples have proved satisfactory. All unsatisfactory samples were loose ice-cream ; only 2 samples of pre-packed ice-cream were placed in provisional grade 3.

Ham Cooking and Canned Foods

With the de-rationing of ham, three applications were received from grocery and bacon warehouses for the cooking of hams. The cooking to be carried out is principally boiling but one firm is roasting in addition to boiling.

The cooking of meat for sale is a registerable process under Section 14 of the Food and Drugs Act, 1938. The number of hams processed weekly is in the region of 2,000 and this figure is expected to be increased.

In each case separate preparation and cooking rooms disconnected from the warehouse have been provided. Solid walls have been required in all cases and partition walls either for disconnection from the warehouse or internal division have not been permitted. Attention has been directed to wall and floor surfaces, tables and working surfaces, steam removal, wash tanks, floor drainage, grease interception, personal washing facilities, etc., in fact, all the features essential to well constructed and equipped hygienic premises.

A further process for which registration has been applied is the canning and manufacture of sausages. The works and alterations have been executed to the specification of the department and have resulted in a hygienic, well constructed and laid out factory.

It is pleasing to record that there has been full co-operation between the Health Department and the managements of the various firms in executing the alterations and works.

Fish and Chip Shops

In 1951 a survey of all fish and chip shops in the City was completed and 140 premises were registered for fish frying under Section 14 of the Food and Drugs Act. Outstanding work was completed at a further 16 shops in 1952, thus bringing all premises to a reasonable standard. Difficulty of bringing the work to a satisfactory conclusion was found in a few instances where the business changed hands at short intervals and in others where the business closed down for a considerable period.

It is gratifying to note that occupiers are now instigating improvements to their business without pressure from this Department.

The practice of all new businesses being inspected by the Sanitary Inspector before opening is to be commended and ensures that they are at least as satisfactory as existing shops.

Routine supervision is being maintained.

Pet Animals Act, 1951

This Act, to regulate the sale of pet animals, came into operation on the 1st April, 1952, and the administration was delegated to the Sanitary Inspectors.

The Act deals with accommodation for pets, temperature, lighting, ventilation, food and drink, and precautions with regard to infectious disease and fire. Further it prohibits the sale of animals at an immature age, the sale of pets to persons under 12 years of age, and the sale of animals in the street.

A survey of the City revealed nine premises from which pets were sold, all of which confined their sales to birds and fish.

An annual fee of 10s. 0d. is payable for the licence.

Exhibition

During November, the Sanitary Inspectors co-operated with the Royal Technical College, Salford, who arranged an exhibition demonstrating the activities of the various departments of the College.

An impressive display showing the numerous and varied facets of a Sanitary Inspector's work was produced at short notice.

Members of the staff were on duty during the exhibition and were very gratified by the interest shown by the visiting public.

Water

The water supply is obtained from the Manchester Corporation's reservoir at Longdendale and Thirlmere. In general, the supply has been satisfactory in quantity and quality. For further details relating to quality see the City Analyst's report.

All dwellinghouses in the City are supplied from public water mains direct to the houses.

There are 52,000 dwellinghouses in the City and a population of 178,036 (Census, 1951).

Statistics

The following tables are included to give some idea of the nature and extent of the work carried out during the year :—

Nature of Inspection.	*Totals.*
Sanitary defects (roofs, gutters, drains, etc.) under Public Health and Housing Acts	37,682
Sublet houses	619
Seamen's lodging houses	59
Common „ „	42
Canal boats	5
Factories with power	622
„ without power	60
Workplaces	57
Outworker premises	27
Shops Acts inspection	955
Schools	8
Cinemas, theatres, etc.	69
Public conveniences	636
Stables	19
Piggeries	22
Pet shops	6
Diseases of Animals Act inspections	14
Dairies	111
Food shops	3,087
Food stalls and vehicles	882
„ manufacturing premises	806
Restaurants and snack bars	641
Canteens (factories, schools, etc.)	1,624
Unsound food	628
Food samples and others	2,128
Infectious diseases	711
Food poisoning	155
Smoke observations	723
Miscellaneous	8,378
Offensive trades	6
Disinfestations	1,373
Housing Act inspections (Section 11)	294
„ „ „ (clearance areas)	434
TOTAL	62,883

List of Samples Taken

Food and Drugs Act samples other than milk	312
Milk for Phosphatase Test	461
„ „ Methylene Blue Test	335
„ „ Fats and Solids-not-Fats, etc.	1,088
„ „ Turbidity Test	121
Ice-cream	180
Fertiliser and Feeding Stuffs Act samples	11
Pharmacy and Poisons Act samples	5
Water supply samples	27
Swimming bath water samples	76
Rag flock samples	3
TOTAL	2,619

Complaints and Notices

Complaints received	7,400
Statutory Notices issued	3,635
„ „ abated	5,398
Intimation Notices issued	4,860
„ „ abated	2,663

Cases Heard before the Magistrates

Offence	No. of Cases	Decision of Magistrate
PUBLIC HEALTH ACT, 1936.		
(1) For failing to comply with the requirements of notices under Section 93 of the Act to remedy nuisances at dwelling-houses.	166 69 3	Nuisance Orders. Cases withdrawn. Cases adjourned *sine die*.
(2) For emitting black smoke from a works chimney.	1 1	Nuisance Order. Dismissed.
FOOD AND DRUGS ACT, 1938.		
(1) For selling cream which did not comply with Cream Standards Order.	1	Fined £25 0s. 0d. with £2 12s. 6d. costs.
(2) For contravention of Labelling of Food Order, 1950.	1	Fined £10 0s. 0d. with £2 12s. 6d. costs.
(3) (*a*) For selling ice-cream deficient of 40% fat ; and (*b*) For selling ice-cream deficient of 34·4% fat.	1	Fined £10 0s. 0d. for (*a*) and £10 0s. 0d. for (*b*) with £5 0s. 0d. costs.
(4) (*a*) For applying false label to food ; and (*b*) For publishing a label not in accordance with the Labelling of Food Order, 1952.	1	Fined £1 0s. 0d. for (*a*) and £1 0s. 0d. for (*b*) with £2 2s. 0d. costs (Analysts fee).
(5) For selling milk deficient in milk solids-not-fat to the extent of 42% when compared with the presumptive standard of the Sale of Milk Regulations, 1939.	1	Fined £5 0s. 0d. with £2 2s. 0d. costs.
(6) For selling ice-cream lollies deficient of 50% sugar and 42% milk solids other than fat when compared with Food Standards (Ice-Cream Amendment) Order, 1952.	1	Dismissed under the Probation of Offenders Act.
(7) For selling food (milk and sugar mixture) not of the substance demanded.	1	Fined £15 0s. 0d. with £5 0s. 0d. costs.
TOTAL	247	

Factories Act, 1937

1. INSPECTIONS FOR PURPOSES OF PROVISIONS AS TO HEALTH.

Premises	No. on Register	Number of		
		Inspections	Written Notices	Occupiers Prosecuted
(1) Factories in which Sections 1, 2, 3, 4 and 6 are to be enforced by the Local Authorities	133	60	7	Nil.
(2) Factories not included in (1) in which Section 7 is enforced by the Local Authority	1,108	622	58	Nil.
(3) Other premises in which Section 7 is enforced by the Local Authority (excluding outworkers' premises) ...	Nil.	Nil.	Nil.	Nil.
TOTAL	1,241	682	65	Nil.

2. CASES IN WHICH DEFECTS WERE FOUND.

Particulars	Number of cases in which defects were found			
	Found	Remedied	Referred To H.M. Inspector	Referred By H.M. Inspector
Want of cleanliness (S.1)	6	...	6	...
Overcrowding (S.2)	...	...	...	...
Unreasonable temperature (S.3)	...	...	...	...
Inadequate ventilation (S.4)	1	...	1	...
Ineffective drainage of floors (S.6)	...	...	...	...
Sanitary conveniences (S.7)—				
(*a*) Insufficient	9	5	...	...
(*b*) Unsuitable or defective	71	40	...	11
(*c*) Not separate for sexes	1	1	...	...
Other offences against Act (not including offences relating to out-work)	7	...	7	...
TOTAL	95	46	14	11

Outworkers

SECTION 110—

Number of outworkers in August list required by Section 110 (1) ...	314
Nature of work—Making, etc., of wearing apparel	163
,, ,, ,, brass and brass articles	151
Number of cases of default in sending list to Council...	Nil.
,, ,, prosecutions for failure to supply list...	Nil.

SECTION 111—

Number of instances of work in unwholesome premises	Nil.
,, ,, Notices served	Nil.
,, ,, prosecutions in respect of outworkers' premises	Nil.

Summary of Food Poisoning Outbreaks, 1952

Total number of outbreaks	Number of cases	Number of deaths	Organisms or other agents responsible with number of outbreaks of each	Foods involved with number of outbreaks of each
4	101	Nil.	Staph Aureus... 1 Cl. Welchii ... 1	Cheese ... ... 1 Pork 1

Unsound Food

The following articles of unsound food were condemned during the year as unfit for human consumption :—

Article.	*Weight lbs.*
Meat (canned)	9,653
Soups („)	428
Fish („)	1,888
Jams	175
Cereals (loose)	206
Milk (canned)	1,980
Vegetables (canned)	2,973
„ (loose)	55
Bacon	74
Fruits (canned)	22,226
„ (dried)	148
Meat	868
Cheese	1,192
Sauces	21
Biscuits	70
Miscellaneous	631
TOTALS	42,588 lbs.

Total weight condemned 19 tons, 28 lbs.

CITY ANALYST'S REPORT

SUMMARY OF SAMPLES

Food and Drugs Act Samples from the City of Salford	1,405
Tests on Heat-Treated Milks	672
Fertilisers and Feeding Stuffs Act Samples	11
Pharmacy and Poisons Act Samples	5
Waters (including Swimming Bath Waters)	104
Contract Samples examined for the Purchasing Committee	117
Other Miscellaneous Samples	55
Tests connected with Investigations of Atmospheric Pollution ...	898
TOTAL	3,267
Samples from the Borough of Eccles	148
Samples from the Borough of Stretford	182
GRAND TOTAL	3,597

FOOD AND DRUGS ACT, 1938

Table 1 summarises the samples taken under the Food and Drugs Act, 1938, and the Defence (Sale of Food) Regulations, 1943. The percentage of adulteration was 4·3 compared with 3·6 for 1951.

Tables 2 and 4 list the adulterated samples and give a brief summary of the type of adulteration and the action taken.

TABLE 1

FOODS.

Samples.	Number examined.	Number adulterated or otherwise giving rise to irregularity.		Per cent. adulteration.
		Preservatives only.	Other ways.	
Milk	1,087	—	46	4·2
Apricots, Dried...	1	—	—	—
Beans in Tomato Sauce, Tinned	15	—	—	—
Broth, Tinned	4	—	—	—
Butter	4	—	—	—
Cereal, Baby	1	—	—	—
Cheese...	4	—	—	—
Cheese Spread	3	—	—	—
Chocolate, Dairy Milk	1	—	—	—
Chocolate, Powdered Sweetened	1	—	—	—
Cocoa	2	—	—	—
Coffee and Chicory Essence	7	—	—	—
Coffee, Soluble	1	—	—	—
Cornflour	3	—	—	—
Crab Paste...	2	—	2	100·0
Crab, Tinned Dressed	1	—	—	—
Cream, Pure	1	—	1	100·0
Cream, Synthetic	1	—	—	—
Dairy Cream Ices	1	—	1	100·0
Dates, Stoned	2	—	—	—
Dripping	2	—	—	—
Fat	15	—	—	—
Fat, Cooking	4	—	—	—
Fat Extender	1	—	—	—

TABLE 1—*Continued.*

Samples.	Number examined.	Number adulterated or otherwise giving rise to irregularity.		Per cent. adulteration.
		Preservatives only.	Other ways.	
Fat Whipping Compound	1	—	—	—
Fish Cakes	2	—	—	—
Fish in Tomato Sauce, Tinned	3	—	—	—
Fish Paste	2	—	—	—
Flavoured Essence	4	—	—	—
Flour, Plain	2	—	—	—
Flour, Self-Raising	9	—	—	—
Fruit Drink, Real	1	—	—	—
Grape Juice, Tinned	1	—	—	—
Gravy Browning	1	—	—	—
Ice Cream	18	—	2	11·1
Ice Cream Lollies	2	—	2	100·0
Ice Lollies	2	—	—	—
Jam	9	—	—	—
Jelly	2	—	—	—
Jelly Crystals	2	—	—	—
Lemonade Powder	1	—	—	—
Lemon Cheese	2	—	—	—
Lemon Curd	1	—	—	—
Margarine	4	—	—	—
Marmalade	6	—	—	—
Marshmallow Creme	1	—	—	—
Meat Paste	4	—	—	—
Meat, Pressed	2	—	—	—
Meat Rissoles	2	—	—	—
Meat Savouries	3	—	—	—
Meringue Powder	1	—	—	—
Milk and Sugar Mixture	1	—	1	100·0
Milk, Condensed	6	—	—	—
Mincemeat	7	—	—	—
Mustard Compound	1	—	—	—
Non-Brewed Condiment	2	—	—	—
Orange Squash	3	—	—	—
Peanut Butter	1	—	—	—
Peas, Tinned	6	—	—	—
Pepper, White	2	—	—	—
Potato Crisps	3	—	—	—
Protein Food	1	—	—	—
Raspberryade Powder, Effervescing	1	—	—	—
Rice	3	—	—	—
Sago	4	—	—	—
Sausage, Beef	6	1	—	16·6
Sausage, Pork	3	—	—	—
Semolina	2	—	—	—
Soup, Tinned Strained	2	—	—	—
Suet, Beef	3	—	—	—
Sugar	4	—	—	—
Sweetening Powder	1	—	—	—
Sweets	4	—	—	—
Syrup, Golden	4	—	—	—
Table Creams (blancmange)	1	—	—	—
Table Delight (blancmange)	1	—	—	—
Tea	13	—	—	—
Tea Tablets	5	—	4	80·0
Tomato Ketchup	2	—	—	—
Tomatoes, Tinned	6	—	—	—
Treacle	2	—	—	—
Vinegar, Malt	1	—	—	—
TOTAL FOODS	1,353	1	59	4·4

TABLE 1—*Continued.*

DRUGS.

Samples.	Number examined.	Number adulterated or otherwise giving rise to irregularity.		Per cent. adulteration.
		Preservatives only.	Other ways.	
Caffeine Citrate	1	—	—	—
Calamine Lotion	1	—	—	—
Camphorated Oil	2	—	—	—
Castor Oil	1	—	—	—
Cherry Cough Syrup	1	—	—	—
Cod Liver Oil and Malt	1	—	—	—
Cough Mixture	1	—	—	—
Epsom Salts	5	—	—	—
Epsom Salts, Exsiccated	2	—	—	—
Fullers Earth Cream	3	—	—	—
Glauber's Salts	5	—	—	—
Glauber's Salts, Exsiccated	2	—	—	—
Glucose Drink	1	—	—	—
Glucose Sip	1	—	—	—
Glycerine, Borax and Honey, Compound	1	—	—	—
Glycerine and Borax	2	—	—	—
Glycerine of Thymol, Compound ...	1	—	—	—
Laxative Chocolate	1	—	—	—
Laxative Tablets	1	—	—	—
Malt and Cod Liver Oil	2	—	—	—
Malt Extract and Cod Liver Oil	1	—	—	—
Malt with Halibut Liver Oil, Extract of	1	—	—	—
Orange Juice, Concentrated	1	—	—	—
Petroleum Jelly	2	—	—	—
Rochelle Salts	6	—	—	—
Rose Hip Syrup, National	2	—	—	—
Seidlitz Powders	1	—	—	—
Seidlitz Powders, Extra Strong	1	—	—	—
Winter Sip with Glucose	1	—	—	—
Zinc and Castor Oil Ointment	1	—	—	—
TOTAL DRUGS	52	—	—	0·0
TOTAL FOOD AND DRUGS ...	1,405	1	59	4·3

TABLE 2

MILK ADULTERATION.

No.	Nature of Adulteration.	Remarks and Action Taken.
B 1277	Deficient 10% milk fat	Formal samples taken and found to be genuine.
B 1278	Deficient 20% milk fat	Formal samples taken, see A 81 below.
A 81	Deficient 12·7% milk fat	Two "Appeal to Cow" samples taken. See special observations.
B 1396	Deficient 3·3% milk fat	Formal samples taken, see A 116 below.
A 116	Deficient 3·3% milk fat	The farmer was advised by letter to consult his local Agricultural College with a view to improving the quality of his milk.
B 1474	Deficient 6·6% milk fat	Formal samples taken, see A 140 below.
A 140	Deficient 3·3% milk fat	Further formal samples taken and found to be genuine.
B 1480	Deficient 7·5% milk fat	Formal samples taken and found to be genuine.

TABLE 2—*Continued.*

No.	Nature of Adulteration.	Remarks and Action Taken.
B 1525	Deficient 6·6% milk fat	Further samples taken, see B 1613, B 1614 and B 1616.
B 1613	Deficient 18·3% milk fat... ...	Formal samples taken, see A 190 and A 193 below.
B 1614	Deficient 16·6% milk fat... ...	
B 1616	Deficient 13·3% milk fat... ...	
A 190	Deficient 13·3% milk fat... ...	See special observations.
A 193	Deficient 3·3% milk fat	
B 1530	Deficient 3·3% milk fat	Further samples found to be genuine.
B 1533	Deficient 6·6% milk fat	Further samples taken, see B 1608 below.
B 1608	Deficient 5·0% milk fat	Further samples found to be genuine.
A 156	Deficient 5·0% milk fat	Further formal samples found to be genuine.
B 1669	Deficient 10·0% milk fat... ...	Formal samples taken, see A 201 below.
A 201	Deficient 5·0% milk fat	Further formal samples found to be genuine.
B 1712	Deficient 13·3% milk fat... ...	Formal samples taken, see A 219 below.
B 1715	Deficient 1·6% milk fat	
A 219	Deficient 6·6% milk fat	Average fat content of the whole consignment, of which this sample represented only one churn, satisfied the Sale of Milk Regulations, 1939.
B 1893	Deficient 3·3% milk fat	Further samples found to be genuine.
A 277	Deficient 4·2% non-fatty solids. Freezing Point (Hortvet) —0·503°C.	Fined £5 and ordered to pay 2 guineas costs. See special observations.
B 1946	Deficient 5·0% milk fat	Further samples found to be genuine.
B 2104	Deficient 8·3% milk fat and 7·5% non-fatty solids. Freezing Point (Horvet) —0·503°C.	Formal samples taken the following day were found to be genuine. This source of supply is being kept under observation.
B 2106	Deficient 4·5% non-fatty solids. Freezing Point (Hortvet) —0·504°C.	
B 2187	Deficient 3·3% milk fat	Further samples found to be genuine.
A 356	Deficient 8·3% milk fat	Further samples taken, see A 358 and A 360 below.
A 358	Deficient 23·3% milk fat... ...	"Appeal to Cow" samples were taken and on analysis these showed the herd to be yielding milk of a fat content below the statutory presumptive minimum limit of 3 per cent. The Area Milk Production Officer was informed by letter of these results.
A 360	Deficient 3·6% milk fat	
B 2250	Deficient 2·3% non-fatty solids. Freezing Point (Hortvet) —0·522°C.	The freezing point results showed extraneous water to be present in all three cases. Further samples were taken, see B 2265, B 2267, B 2268, B 2271 and B 2273.
B 2251	Deficient 1·2% non-fatty solids. Freezing Point (Hortvet) —0·525°C.	
B 2256	Deficient 0·6% non-fatty solids. Freezing Point (Hortvet) —0·527°C.	
B 2265	Deficient 2·9% non-fatty solids. Freezing Point (Hortvet) —0·519°C.	Small amounts of extraneous water present in all five cases. Formal samples taken, see A 372, A 373, A 375, A 379 and A 380.
B 2267	Deficient 2·1% non-fatty solids. Freezing Point (Hortvet) —0·519°C.	
B 2268	Deficient 3·6% non-fatty solids. Freezing Point (Hortvet) —0·518°C.	
B 2271	Deficient 1·7% non-fatty solids. Freezing Point (Hortvet) —0·519°C.	
B 2273	Deficient 3·8% non-fatty solids. Freezing Point (Hortvet) —0·521°C.	

TABLE 2—*Continued.*

No.	Nature of Adulteration.	Remarks and Action Taken.
A 372	Deficient 2·7% non-fatty solids. Freezing Point (Hortvet) —0·525°C.	Farmer cautioned by letter to take steps to ensure that extraneous water does not gain access to his milk.
A 373	Deficient 3·3% non-fatty solids. Freezing Point (Hortvet) —0·525°C.	
A 375	Deficient 2·0% non-fatty solids. Freezing Point (Hortvet) —0·520°C.	
A 379	Deficient 1·4% non-fatty solids. Freezing Point (Hortvet) —0·524°C.	
A 380	Deficient 0·9% non-fatty solids. Freezing Point (Hortvet) —0·526°C.	
A 366	Deficient 10·0% milk fat... ...	Since this milk was also naturally poor in non-fatty solids the Area Milk Production Officer was informed by letter of this poor quality milk.

The following samples of milk showed figures for non-fatty solids below the presumptive minimum limit of 8·5% non-fatty solids of the Sale of Milk Regulations, 1939, but were adjudged genuine (apart from any deficiency in fat) on the Hortvet freezing point test.

TABLE 3

Serial Number	Total Solids %	Fat %	Non-fatty Solids %	Freezing Point °C. (Hortvet)	Acidity °Richmond
B 1287	11·21	2·85	8·36	—0·563	18
B 1288	11·27	3·15	8·12	—0·553	19
B 1289	12·34	4·20	8·14	—0·551	21
B 1358	12·00	3·70	8·30	—0·529	15
B 1364	12·82	4·50	8·32	—0·529	16
B 1366	11·88	3·60	8·28	—0·534	17
B 1369	12·02	3·70	8·32	—0·536	15
B 1394	11·50	3·40	8·10	—0·534	18
B 1396	11·18	2·90	8·28	—0·538	19
B 1397	11·61	3·30	8·31	—0·546	17
B 1400	11·65	3·30	8·35	—0·542	16
B 1402	11·93	3·60	8·33	—0·541	17
A 115	11·46	3·20	8·26	—0·542	18
A 116	11·08	2·90	8·18	—0·542	18
B 1469	11·55	3·25	8·30	—0·534	16
B 1474	11·15	2·80	8·35	—0·547	15
A 140	11·20	2·90	8·30	—0·541	16
A 143	11·25	3·00	8·25	—0·542	15
B 1525	11·00	2·80	8·20	—0·545	15
B 1527	11·75	3·50	8·25	—0·545	15
B 1532	12·00	3·60	8·40	—0·557	17
B 1533	10·95	2·80	8·15	—0·540	15
B 1534	11·30	3·20	8·10	—0·545	14
B 1535	12·05	3·60	8·45	—0·548	15
B 1536	11·55	3·30	8·25	—0·549	14
B 1604	12·25	3·90	8·35	—0·548	17
B 1608	11·25	2·85	8·40	—0·550	16

TABLE 3—*Continued.*

Serial Number	Total Solids %	Fat %	Non-fatty Solids %	Freezing Point °C. (Hortvet)	Acidity °Richmond
B 1609	11·35	3·00	8·35	—0·540	16
B 1610	12·00	3·60	8·40	—0·552	17
B 1611	11·80	3·35	8·45	—0·547	19
B 1612	11·85	3·60	8·25	—0·555	18
B 1614	10·85	2·50	8·35	—0·546	16
B 1616	10·90	2·60	8·30	—0·550	17
A 190	10·90	2·60	8·30	—0·562	15
A 192	11·50	3·20	8·30	—0·551	16
A 193	11·30	2·90	8·40	—0·551	16
A 194	11·70	3·40	8·30	—0·547	17
B 1797	11·70	3·40	8·30	—0·536	16
B 1801	11·84	3·40	8·44	—0·538	14
B 1803	11·68	3·35	8·33	—0·536	15
B 1837	11·80	3·40	8·40	—0·535	16
B 1888	11·28	3·00	8·28	—0·539	16
B 1891	11·96	3·65	8·31	—0·530	16
B 1893	11·28	2·90	8·38	—0·539	16
B 1942	11·74	3·45	8·29	—0·548	14
B 1943	12·52	4·35	8·17	—0·547	14
B 1946	11·14	2·85	8·29	—0·548	14
B 1948	11·40	3·05	8·35	—0·547	14
A 332	11·40	3·25	8·15	—0·539	15
A 366	11·00	2·70	8·30	—0·558	18
A 367	11·20	3·00	8·20	—0·549	16
A 368	11·30	3·05	8·25	—0·553	17

Milk

The average composition of the 1,087 samples analysed was as follows, the corresponding figures for the previous five years being given for comparison :—

	1947	1948	1949	1950	1951	1952	Minimum requirements.
Fat %	3·52	3·48	3·49	3·51	3·57	3·53	3·00
Non-fatty Solids % ...	8·71	8·76	8·76	8·75	8·70	8·68	8·50
Total Solids %	12·23	12·24	12·25	12·26	12·27	12·21	11·50

Of the 1,087 samples analysed, 46 (4·2%) were unsatisfactory. Of these, 30 were fat deficient, 15 were deficient in non-fatty solids and 1 sample contained extraneous water as well as being deficient in fat. Details of these milks are given in Table 2. None of the samples contained colouring matter or preservative.

Before any milk was reported upon as adulterated, as judged by deficiency in non-fatty solids, it was submitted to the Hortvet freezing point test (unless souring had occurred) and any samples with a freezing point less than —0·529°C. were reported as being of poor quality but genuine (see Table 3).

The above rate of adulteration, although higher than last year, cannot be interpreted literally since any milk found to be adulterated in the normal routine sampling results in immediate attention being paid to that source of supply. Further samples are obtained and there is a greater likelihood of these being adulterated than milks taken by random sampling. The adulteration falls into three main classes : small fat deficiencies, milks containing small amounts of extraneous water, often due to pin-point leaks in coolers which have escaped detection, and the grosser types where resort has to be made to legal proceedings or strongly worded cautionary letters.

Many milks, which on informal sampling revealed small fat deficiencies, were subsequently sampled formally, i.e., following the procedure set out in Section 70 of the Food and Drugs Act, 1938 ; dividing the sample into three parts and sealing each portion. It is only in respect of such formal samples that legal proceedings can be taken under the above Act, and in the foregoing tables they are prefixed with the letter ' A.' One of the three samples so obtained was left with or sent to the farmer, one submitted to me, and one retained by the Sampling Officer in case of any dispute when it could be sent to the Government Analyst. It was rather significant that in the greater number of cases the milks improved in quality and the fat contents rose to normal values after the farmer had received the formal sample.

Once again, however, it is necessary to draw attention to the formidable list of poor quality milks, a total number of 51, thus outnumbering the adulterated samples. These milks have a non-fatty solids content below the statutory presumptive minimum of 8·50% of the Sale of Milk Regulations, 1939, but freezing point determinations show these deficiencies to be due to natural causes, not to the presence of extraneous water. The term " natural causes," however, is somewhat misleading as they can usually be rectified by feeding, milking at regular intervals, and breeding for quality rather than quantity of milk. It is unlikely that this state of affairs will be rectified until it is made the subject of rigorous absolute standards and the conscientious farmer is rewarded by payment on the quality of his milk as well as on its quantity.

Below are outlined, as Special Observations, some of the more interesting cases of milk adulteration illustrating the procedure adopted in following up deficiencies and the *modus operandi* of investigating these cases.

SPECIAL OBSERVATIONS

MILK, *Samples Nos. B* 1278 *and A* 81. Informal sample of milk No. B 1278 was found, on analysis, to contain only 2·40% of fat and hence on comparison with the presumptive minimum limit of 3·00% for fat of the Sale of Milk Regulations, 1939, was 20·0% deficient in fat. A formal sample (No. A 81) of this source of supply was then obtained and found, on analysis, to be 12·7% deficient in fat. The farmer was then visited and samples representative of both evening and morning milking of the herd were taken, such samples being designated as "Appeal to Cow" samples. Analysis showed these to consist of milk satisfying the above Regulations. This data was submitted to the Town Clerk with a view to instituting legal proceedings but subsequent investigation showed that it was not possible to take any action since the Milk Marketing Board were unable to produce copies of the contract and milk directive with the consequence that it could not be proved who was responsible for the milk at the time and place of obtaining the sample.

MILK, *Samples Nos. B* 1613, *B* 1614, *B* 1616, *A* 190 *and A* 193. Informal samples Nos. B 1613, B 1614 and B 1616 represented three out of seven churns of farmer's milk in course of delivery to a City dairy. On analysis they were found to be 18·3%, 16·6% and 13·3% deficient in fat respectively, when compared with the minimum presumptive limit of 3% for fat of the Sale of Milk Regulations, 1939.

The following day the whole consignment was sampled formally, two samples, A 190 and A 193, being found to be 13·3% and 3·3% deficient in fat respectively. The average fat content of the whole consignment was

however, well in excess of that demanded by the above Regulations and since the whole would be bulked at the dairy no action was taken.

MILK, *Sample No. A* 277. This formal sample, purchased from a shop in the City, was found, on analysis, to contain only 8·14% of non-fatty solids. On comparison with the minimum presumptive limit of 8·50% for non-fatty solids of the Sale of Milk Regulations, 1939, it was 4·2% deficient in non-fatty solids. The freezing point (Hortvet) of —0·503°C. showed this deficiency to be wholly accounted for by the presence of extraneous water. Investigations subsequently showed that a leak in the processing plant at the dairy was the means whereby water had gained access to the milk. It was considered that more care ought to have been exercised at the dairy and legal proceedings were instituted resulting in the dairy company being fined £5 and 2 guineas costs.

MILK, *Samples Nos. B* 2250, *B* 2251 *and B* 2256. These informal samples, representing three out of twelve churns of farmer's milk in course of delivery to a City dairy, were found, on analysis, to be 2·3%, 1·2% and 0·6% deficient in non-fatty solids respectively. Freezing point determinations carried out on these samples showed the deficiencies to be due to the presence of extraneous water. Further samples of the whole consignment were taken on the following day, please see next paragraph.

MILK, *Samples Nos. B* 2265, *B* 2267, *B* 2268, *B* 2271 *and B* 2273. These informal samples represented five out of twelve churns of the above farmer's milk in course of delivery to the dairy. On analysis, they were found to be 2·9%, 2·1%, 3·6%, 1·7% and 3·8% deficient in non-fatty solids respectively, and again freezing point determinations showed these deficiencies to be due to the presence of extraneous water. The whole consignment was sampled formally on the following day, please see below.

MILK, *Samples Nos. A* 372, *A* 373, *A* 375, *A* 379 *and A* 380. These formal samples represented five out of twelve churns of the above farmer's milk. Again analysis showed non-fatty solids deficiencies of 2·7%, 3·3%, 2·0%, 1·4% and 0·9% respectively, with the freezing points showing the presence of extraneous water in each case. Since only certain churns contained extraneous water whilst others contained genuine milk the possibility of a leak in the cooling system could be eliminated. In my opinion improper drainage of the churns after rinsing was a possible cause of the contamination and these findings were conveyed to the farmer by letter requesting him to take more thorough precautions against water gaining access to his milk. Further samples taken at a later date were all found to be genuine.

In addition to the milk samples examined under the Food and Drugs Act, 1938, 672 samples of heat-treated milk were submitted for examination by the phosphatase or turbidity test. The results obtained on these are tabulated below :—

Type of Milk	Number of Samples	Sufficiently heat-treated	Insufficiently heat-treated	Grossly under-treated
Pasteurised	473	460	10	3
Sterilised	199	199	—	—
TOTAL	672	659	10	3

TABLE 4

ADULTERATED OR IRREGULAR SAMPLES (OTHER THAN MILK).

Sample No.	Description	Nature of Adulteration or Irregularity	Action Taken
B 1447	Crab Paste... ...	Deficient 32·7% of fish content on a 70% basis.	Formal sample taken, see A 134 below.
A 134	Crab Paste... ...	Deficient 11·9% of fish content on a 70% basis.	The alleged variation in the composition of crab still under investigation, see below for full details.
A 69	Pure Cream ...	Unsatisfactory label	Legal proceedings instituted. Fined £35 and 5 guineas costs, i.e., total of £40 5s. 0d.
A 207	Dairy Cream Ices	Contained no dairy cream...	Legal proceedings instituted. Case dismissed without costs to either party.
A 165	Ice Cream	Deficient 40% fat	Same manufacturer. Fined £10 in respect of each sample and ordered to pay £5 costs, i.e., total of £25.
A 176	Ice Cream	Deficient 34·4% fat	
A 274	Ice Cream Lollies	Deficient 50% sugar and 42% milk solids other than fat.	Legal proceedings instituted. Defendant, who pleaded guilty, given an absolute discharge.
A 364	Ice Cream Lollies	Unsatisfactory label	Manufacturer interviewed.
A 327	Milk and Sugar Mixture.	Contained skimmed milk powder and 31·9% of wheat flour.	Legal proceedings instituted. Fined £15 and £5 costs, i.e., a total of £20.
B 2227	Beef Sausage ...	Contained undeclared preservative.	Butcher interviewed and the need for declaration of preservative pointed out to him.
B 1558	Tea Extenders ...	Unsatisfactory label	Legal proceedings instituted. Fined £2 and 2 guineas costs, i.e., total of £4 2s. 0d.
A 181	Sweetened Tea Tablets.	Unsatisfactory label	
B 1657	Tea Tabs	Unsatisfactory label	Manufacturer communicated with.
B 1697	Tea Saving Tablets.	Unsatisfactory label	Manufacturer communicated with.

CRAB PASTE, *Samples Nos. B* 1447 *and A* 134. The informal sample, on analysis, was found to have a fish content of 47·4%. On comparison with the Food Standards (Fish Paste) Order, 1951, which requires fish paste to have a minimum fish content of 70%, this sample was 32·7% deficient in fish. A formal sample, No. A 134, was obtained and analysed. In this case the fish content was found to be 61·7% and hence, on comparison with the above Order, was 11·9% deficient in fish.

Examination of the tins showed that the crab paste originated in Norway and had been imported by a British company. The proprietors were notified of these findings and they expressed great concern since the tins on export from Norway were warranted to conform to the Food and Drugs Laws of this country. Analyses were made of crab paste from different Norwegian packers and quite a wide variation in the crab meat content was obtained.

The view was put forward that the composition of crab varies according to age, fishing ground, and time of year, but I am not convinced that such wide variations as indicated by the above results exist. This problem is being investigated by the British Food Manufacturing Industries Research Association, the Norwegian laboratories, and the Society of Public Analysts.

PURE CREAM, *Sample No. A* 69. This formal sample was sold in cartons bearing no other designation than the words " Pure Cream." Analysis showed the product to consist of an emulsion of edible fat sweetened with cane sugar. The fat did not consist of milk fat which would be the case if the sample was pure cream, in fact no milk fat was present, edible vegetable oil being the only fatty matter present. Since it was sold as a pre-packed article of food, in order to conform with the labelling of Food Order, 1950, the ingredients composing it in the order of the proportion in which they were used, the ingredient used in the greatest proportion being specified first, and the name of the packer should all be stated on the label. Also, in my opinion, the article should have been described as " Synthetic Cream " so that an intending purchaser would not be under the impression that he was buying a dairy product. At the court hearing before the Stipendiary Magistrate the defendants were fined £25 for selling an article as cream not in accordance with the Food Standards (Cream) Order, 1951, and £10 for contravening the Labelling of Food Order, 1950. Five guineas costs were also awarded, making a total of £40 5s. 0d.

DAIRY CREAM ICES, *Sample No. A* 207. This formal sample, on analysis, was found to be similar in composition to ordinary ice cream and complied with the Food Standards (Ice Cream) Order, 1951. The special qualification " Dairy Cream," however, in my opinion suggested that real cream was an important addition to the product. If such was the case the fat would consist wholly or largely of milk or butter fat, and accordingly the sample was especially tested for this ingredient. None was in fact found, the fat appeared to consist wholly of margarine and therefore, in my opinion, the use of the designation " Dairy Cream " would lead an intending purchaser to believe that he was obtaining a much superior article to ordinary ice cream.

Legal proceedings were instituted and at the hearing before the Stipendiary Magistrate the defendants alleged that the description " Dairy Cream Ices " had been in use for a period of sixteen years, and that at its inception butter was the only fat used in its manufacture and that it was intended to revert to this practice as and when the supply position rendered it possible. It was also put forward by the defence that at the present time the public would not expect dairy cream to be present and that the label had become more of the nature of a trade mark than a definition of the composition of the product.

The Stipendiary Magistrate gave a considered judgment to the effect that the label was not calculated to mislead, but that it was false, expressing an opinion that the summons had been brought under the wrong heading. Accordingly, therefore, he dismissed the case without costs to either party.

ICE CREAM, *Samples Nos. A* 165 *and A* 176. Formal sample No. A 165 was found, on analysis, to contain only 3% of fat and hence on comparison with the minimum requirement for fat of the Food Standards (Ice Cream) Order, 1951, was 40% deficient in fat. The vendors were warned of this result and advised to increase the fat content of their ice cream. The shop was visited later and a formal sample obtained (No. A 176). This, on comparison with the above Order, was found to be 34·4% deficient in fat. Legal proceedings were instituted with respect to both samples and at the hearing before the Stipendiary Magistrate the defendants were fined £10 in respect of each sample and ordered to pay £5 in costs, i.e., a total of £25.

Ice Cream and Frozen Confectionery. During the first half of the year the Food Standards (Ice Cream) Order, 1951, was in force requiring ice cream to contain not less than 5% of fat, 10% of sugar, and 7·5% of milk solids other than fat. In July, the Food Standards (Ice Cream) (Amendment) Order, 1952, was introduced, reducing the above minimum requirements of fat and milk solids other than fat to 4% and 5% respectively, the minimum sugar content remaining unaltered. In these Orders any reference to ice cream includes a reference to ices but nothing in these Orders shall apply to water ices, including ice lollies. In my opinion these latter products should consist only of coloured, sweetened, flavoured, frozen water.

A difficulty arose when products appeared on sale to the public under the designation of " Ice Cream Lollies," often containing as little as 10% of ice cream. One such sample, No. A 274, on analysis, was found to consist of ice cream originally conforming to the above Standards diluted with an equal amount of water and sold as " Ice Cream Lollies." Legal proceedings were instituted with the hope that the ice cream content of these confections could be regularised, it being contended by the prosecution that since the product contained only ice cream diluted with water it should come within the orbit of the Food Standards (Ice Cream) Order. At the hearing before the Stipendiary Magistrate the defendant, who entered a plea of guilty, was given an absolute discharge.

Ice Cream Lollie, Sample No. A 364, was sold as a prepacked article with a label bearing a statement that the ingredients were " fruit juice and sugar." Advertising matter displayed in the shop, however, described it as an ice cream lollie, whilst analysis showed it to contain 10% of ice cream of composition conforming to the Food Standards (Ice Cream) (Amendment) Order, 1952. The manufacturers were interviewed and it was pointed out that the Labelling of Food Order requires a complete statement of ingredients to be declared on the labels of prepacked articles of food. They agreed to amend the label and have since submitted labels which are in my opinion satisfactory.

Milk and Sugar Mixture, *Sample No. A* 327. This sample was taken formally following a complaint from a local confectioner that on using this product a large batch of confectionery was spoilt. Analysis showed it to consist of 29·0% skimmed milk powder, 39·1% sugar, and 31·9% wheat flour. Thus the sample, in my opinion, was adulterated in two ways, firstly by the inclusion of skimmed milk powder instead of full cream milk powder, and secondly in a very gross manner by the addition of flour. Legal proceedings were instituted in respect of this sample and at the hearing before the Stipendiary Magistrate the defendants were fined £15 and £5 costs, i.e., a total of £20.

Tea Extenders, *Samples Nos. B* 1558 *and A* 181. The informal sample, No. B 1558, bore a label stating that the ingredients were " Caff. Cit., Soda Bic., Soda Chlor., Excipients." The label also bore a claim that in addition to saving tea they would also save sugar. In view of this claim and the fact that none of the above ingredients possessed sweetening power, saccharin was especially tested for and found to be present to the extent of 13·1%. The above declaration of ingredients omitted to mention saccharin, on which the advertising matter was largely based, and an intending purchaser was not informed that the basis of the sugar saving properties of these tablets was saccharin.

A formal sample, No. A 181, of this article was purchased and on analysis proved to be identical in composition with the informal sample. Legal proceedings were instituted and at the hearing before the Stipendiary Magistrate the defendants were fined £2 and ordered to pay 2 guineas in costs, i.e., a total of £4 2s. 0d.

TEA TABS, *Sample No. B* 1657, and TEA SAVING TABLETS, *Sample No. B* 1697. The Tea Tabs bore a label stating that the composition of the tablets was " Caff. Cit., Soda Bic., Soda Chlor., Excipients." The Labelling of Food Order, 1950, requires the ingredients to be specified in the order of the amount present, that in greatest proportion to be specified first. Analysis showed that the correct order of the ingredients should be " Soda Bic., Soda Chlor., Caff. Cit., Excipients."

A similar state of affairs appertained to informal sample No. 1697, Tea Saving Tablets, the composition as declared on the label being " Caffeine Cit., Soda Chlor., Soda Bic., Tannin, Excipients," whereas the correct statement should have read, " Soda Bic., Soda Chlor., Caffeine Cit., Tannin, Excipients."

Letters were written to the manufacturers in question requesting them to amend the labels, but subsequent enquiries showed that they had gone out of business, thus illustrating the mushroom existence of many of these attempts to cash in on present day shortages and rationing.

FAT FROM FISH AND CHIP SHOPS. A number of complaints were received about the strong odour in fish and chip shops when frying was in progress, and concern was also expressed as to whether the fried products would be injurious to health. The Sampling Officer procured samples from various premises in the City, in each case from the pans in current use. The samples were tested for the presence of mineral oil, but in all cases it was completely absent, and the unsaponifiable matter was normal for ordinary vegetable oils.

The free fatty acid content was also determined and only in one case was over 2% present, this sample containing 2·8% in terms of oleic acid. The free fatty acid content of an oil will gradually increase with each heating, so this determination affords a guide as to whether the fat had been used for over too long a period. In my opinion the fat should be changed when the free fatty acid content rises above 3%. This survey shows that the fish and chip shops are carrying on their business in a satisfactory manner and that no danger to public health exists.

All the samples of fat analysed contained large proportions or consisted entirely of palm kernel oil which was being allocated by the Ministry of Food, and whilst this oil is perfectly edible and non-injurious it tends to vaporise at a lower temperature than other fats and oils. This is the cause of the slightly acrid fumes which have been noticed, but no adverse ill effect will arise in the fried product.

OTHER ANALYSES

Salford Drinking Water and Swimming Bath Water.

Twenty-six samples of drinking water were examined in the course of the usual monthly full chemical analysis of the public supply. Water is supplied by Manchester Corporation Waterworks from service reservoirs at Prestwich (Thirlmere water), at Gorton Lower (Longdendale water), and Audenshaw (mixture of Thirlmere and Longdendale water). Water is supplied to Pendleton

and Broughton from the Prestwich reservoir, whilst the water supplying the remainder of the City is either Longdendale water or a mixture of Thirlmere and Longdendale water. Average figures of composition, compiled from monthly analyses are as below :—

TABLE 5

(All results except pH value are expressed as parts per million).

Source	Thirlmere	Longdendale
Total Solid Matter	41	88
Chlorine as Chloride	6·8	10·1
Ammoniacal Nitrogen (as N)	<0·01	0·05
Albuminoid Nitrogen (as N)	0·03	0·04
Nitrate Nitrogen (as N)	0·38	0·79
Nitrite Nitrogen (as N)	Nil.	Nil.
Oxygen absorbed from permanganate solution at 27°C. — 3 minutes	0·36	0·70
Oxygen absorbed from permanganate solution at 27°C. — 4 hours	0·76	1·37
Carbonate Hardness	14·0	13·9
Iron	0·16	0·43
Residual Chlorine	0·01	0·03
pH Value	7·0	7·6
Physical Characteristics	Clear, faint earthy odour when warmed.	Faintly turbid or opalescent, slightly yellow. Faint earthy odour when warmed. Slight deposit.
Microscopical appearance of Deposit	A few diatoms and algal cells.	Fine mineral particles, a little vegetable debris, a few diatoms and algal cells.

All the samples submitted were found to be practically free from lead. It will be noticed from the above analytical figures that the Longdendale supply contains much more iron than the Thirlmere supply. Although this iron is originally in solution, under certain conditions it can be deposited, giving rise to complaints of dirty water, the "dirt" consisting of flocculent iron hydroxides and carbonates. This is not harmful but it is a distinct drawback in laundry work where it can lead to the typical brown stains on fabrics known as " iron mould."

At all the swimming baths in Salford the water is subjected to chlorination to ensure the absence of micro-organisms of water-borne diseases and samples of the water in use are regularly submitted to this laboratory. Seventy-six samples were submitted during the year and in every case sufficient chlorination was being maintained, particularly during the summer months when contamination is likely to be at its highest due to the increased number of bathers.

CONTRACT SAMPLES SUBMITTED BY THE PURCHASING COMMITTEE. One hundred and seventeen samples were analysed during the year, ranging from foodstuffs such as meat extracts, preserves, custard powders, etc., to commodities typified by soaps, polishes, turpentine substitutes. Although the advertisements asking for tenders to be submitted to the Corporation usually set out a specification to which the products should conform it has in many cases been found, on analysis, that the samples failed to satisfy the requirements demanded. It is in such instances that an efficient analytical service is a great advantage, enabling the " wheat to be sorted from the chaff."

FERTILISERS AND FEEDING STUFFS ACT, 1926. Six fertilisers and five feeding stuffs were submitted under the above Act. One feeding stuff was found to be deficient in oil content when compared with the amount guaranteed on the Statutory Statement, whilst the other ten samples were satisfactory.

PHARMACY AND POISONS ACT, 1933. Two samples of ammonia and three of phenolic type disinfectants were examined for compliance with the Act. One sample of ammonia was deficient in ammonia content. The manufacturers, on being informed, admitted it was very old stock and replaced it at the shop in question.

HEALTH DEPARTMENT. Twenty-eight samples were examined, consisting mainly of tinned goods suspected of containing metals due to corrosion of the containers, as evidenced by their " blown " condition.

MISCELLANEOUS SAMPLES. Twenty-four samples were tested, submitted by neighbouring authorities. Fees of £43 4s. 6d. were charged and paid to the Health Department.

ATMOSPHERIC POLLUTION

Special atmospheric deposit gauges, which measure the rainwater and the dirt from the atmosphere brought down in the rain, are situated at four different points in the City. The collected dirt is separated from the water and submitted to a lengthy analysis whereby it is split into its component fractions consisting of tar, combustible matter and grit or ash, whilst the separated rainwater is examined for soluble impurities, chlorides, sulphates and its pH value, which is a measure of its acidity or alkalinity determined.

TABLE 6

SOOT GAUGE OBSERVATIONS.

Monthly Averages—Tons per Square Mile.

	Salford : Broughton M.S. School.	Salford : Ladywell Hospital.	Salford : Drinkwater Park.	Salford : Vine Street, Kersal.
Rainfall in inches	2·58	2·81	2·61	2·84
Tar ... ... (Insoluble matter.)	0·26	0·19	0·30	0·21
Carbonaceous matter other than tar ... (Insoluble matter.)	4·66	5·04	7·69	4·94
Insoluble matter.	15·74	18·04	20·37	19·73
Ash ... ... (Insoluble matter.)	10·82	12·81	12·38	14·58
Soluble Matter	8·18	15·81	9·80	8·53
Total Solids	23·92	33·85	30·17	28·26
Chlorides (Included in soluble matter.)	2·20	3·54	2·28	2·26
Sulphates (Included in soluble matter.)	2·47	3·38	2·99	2·45
pH Value	4·0	4·1	4·0	4·1

The above results show that the deposition of soot over the City is fairly uniform. The pH value of 4 indicates that the rainwater is acid which accounts for its corrosive action on paint and buildings, the acid being derived from solution of sulphurous impurities in the air arising from the burning of solid fuel.

The sulphurous gases in the atmosphere were also measured directly at Regent Road and Ladywell Hospital by the " lead peroxide " method in which a surface of known area, so treated as to be sensitive to acid sulphur gases, is exposed under standard conditions. Every month the apparatus is changed and the amount of sulphur impurities determined ; the results are expressed as milligrammes of sulphur trioxide per 100 square centimetres of exposed surface. The table below shows the variation in the daily average throughout the year and the significantly greater amount present in the air during the winter months when fuel consumption is at its greatest.

TABLE 7

Month.	Milligrammes Sulphur Trioxide per 100 sq. cm. Daily Average.	
	Regent Road.	Ladywell Hospital.
January	5·40	3·21
February	4·15	2·44
March	3·46	2·41
April	2·19	1·70
May	2·36	—
June	2·58	1·54
July	1·56	0·65
August	1·79	1·14
September	2·30	1·66
October	3·80	2·93
November	4·23	2·99
December	6·24	4·85

Volumetric Apparatus for Sulphur Dioxide and Smoke.

This apparatus is of particular value since it measures directly the above impurities in the atmosphere from day to day. Air is pumped from the external atmosphere through a special paper filter and then through a solution of dilute hydrogen peroxide, both of which are changed daily. The solid particles of soot are trapped on the filter paper which is compared with a series of standard papers from which the concentration of smoke in the atmosphere can be evaluated. The dilute hydrogen peroxide converts the sulphur impurities into sulphuric acid which can be estimated and expressed in terms of sulphur dioxide.

The results obtained are tabulated below and again the heavy pollution during the winter is evident, being one of the reasons why sufferers from bronchial trouble so dread the winter.

TABLE 8

DAILY AVERAGE CONCENTRATIONS OF SMOKE AND SULPHUROUS IMPURITIES EXPRESSED AS MILLIGRAMMES PER CUBIC METRE.

Month.	Smoke.	Sulphur Dioxide.
January	0·70	0·64
February	0·72	0·77
March	0·48	0·40
April	0·50	0·40
May	0·36	0·27
June	0·35	0·23
July	0·28	0·21
August	0·32	0·21
September	0·43	0·30
October	0·57	0·42
November	0·90	0·64
December	0·91	0·66

BOROUGH OF ECCLES

During the year, 127 samples were received from the above Borough for examination under the Food and Drugs Act, 1938. Details of these samples are given in the following table :—

TABLE 9

SAMPLES EXAMINED.

Samples.	Number examined.	Number adulterated or otherwise giving rise to irregularity.		Per cent. adulteration.
		Preservatives only.	Other ways.	
FOODS.				
Milk	85	—	4	4·7
Beer, Mild	1	—	—	—
Cheese, Processed	1	—	—	—
Cheese Spread	1	—	—	—
Coffee, French	1	—	—	—
Cream, Synthetic	2	—	—	—
Cydapple	1	—	—	—
Fish Cakes	3	—	—	—
Flour, Self-Raising	1	—	—	—
Honey	1	—	—	—
Ice Cream	9	—	—	—
Jam, Apple and Raspberry	1	—	—	—
Jelly, Table	2	—	—	—
Lemon Barley	1	—	—	—
Nut Mixture	1	—	—	—
Paste, Chicken and Beef	1	—	1	100·0
Paste, Salmon	1	—	1	100·0
Sauce, Thick	1	—	—	—
Soft Drink Powder	1	—	—	—
Sponge Mixture, Sweetened	1	—	—	—
Sweets	1	—	—	—
Tomato Ketchup	1	—	—	—
Vegetable Soup	1	—	—	—
Vinegar, Malt	1	—	—	—
DRUGS.				
Catarrh Pastilles	1	—	—	—
Herbal Tablets	1	—	—	—
Iodised Throat Tablets	1	—	—	—
Juniper Pills, Compound	1	—	—	—
Sulphur Tablets	1	—	—	—
Tincture of Iodine	2	—	2	100·0
TOTAL FOODS AND DRUGS	127	—	8	6·3

TABLE 10

ADULTERATED OR IRREGULAR SAMPLES.

Sample No.	Description.	Nature of Adulteration or Irregularity.	Remarks and Action Taken.
1856	Milk	Deficient 3·3% milk fat and 7·7% non-fatty solids. Freezing Point (Hortvet) —0·527°C.	
1860	Milk	Deficient 10% milk fat and 5% non-fatty solids. Freezing Point (Hortvet) —0·541°C.	Farmer advised to seek advice with a view to improving the quality of his milk. See special observations.
1861	Milk	Deficient 11·6% milk fat and 5% non-fatty solids. Freezing Point (Hortvet) —0·544°C.	
1931	Milk	Deficient 4·1% non-fatty solids. Freezing Point (Hortvet) —0·514°C.	Investigation made at the dairy as to how extraneous water had gained access to the milk. Caution issued. Further samples found to be genuine.
1919	Chicken and Beef Paste.	Deficient 4·2% meat content on a 55% basis.	Manufacturer cautioned.
1918	Salmon Paste...	Deficient 45·4% fish content on a 70% basis.	Fined £5 and ordered to pay £3 13s. 6d. costs, i.e., a total of £8 13s. 6d. See special observations.
1924	Tincture of Iodine B.P.	105·2% over strength ...	Formal sample taken, see No. 1927 below.
1927	Tincture of Iodine B.P.	86·8% over strength	Manufacturer cautioned. See special observations.

Milk.

The average composition of the 85 samples analysed was as follows, the corresponding figures for the previous five years being given for comparison :—

	1947	1948	1949	1950	1951	1952	Minimum requirements.
Fat %	3·48	3·45	3·38	3·41	3·54	3·52	3·00
Non-fatty Solids % ...	8·50	8·66	8·58	8·62	8·70	8·65	8·50
Total Solids %	11·98	12·11	11·96	12·03	12·24	12·17	11·50

Of the 85 samples analysed, 4 (4·7%) were unsatisfactory. Of these, 3 were deficient in fat and 1 was deficient in non-fatty solids due to the presence of extraneous water. Particulars of these milks are given in Table 10.

SPECIAL OBSERVATIONS.

MILKS, *Samples Nos.* 1856, 1860 *and* 1861. These formal samples represented three out of six churns of farmer's milk and on analysis they were found to contain 2·90%, 2·70% and 2·65% of fat respectively. On comparison with the minimum presumptive limit of 3% for fat of the Sale of Milk Regulations, 1939, they were 3·3%, 10% and 11·6% deficient in fat respectively. Their non-fatty solids contents also came below the 8·50% minimum presumptive limit of the above Regulations, but their freezing points showed this not to be due to the presence of extraneous water. The average fat content of the whole six churns was, however, satisfactory and the farmer was advised to seek advice with a view to improving the quality of his milk.

SALMON PASTE, *Sample No.* 1918. This formal sample, on analysis, was found to contain only 38·2% of fish and on comparison with the Food Standards (Fish Paste) Order, 1951, which requires fish paste to contain not less than 70% of fish, was 45·4% deficient in fish. Legal proceedings were instituted and at the hearing the defendants were fined £5 and ordered to pay £3 13s. 6d. in costs, i.e., fines totalling £8 13s. 6d.

TINCTURE OF IODINE, B.P., *Samples Nos.* 1924 *and* 1927. Informal sample No. 1924, on analysis, was found to contain 5·13% weight in volume of iodine and 5·44% weight in volume of potassium iodide. The British Pharmacopœia specifies this product to contain 2·5% weight in volume each of iodine and potassium iodide. The sample is thus approximately twice the stipulated strength. Accordingly the shop was visited and formal sample No. 1927 procured. There was, however, only one bottle left in the shop and only the iodine content could be determined. This was found to be 4·67% weight in volume and on comparison with the standard of 2·50 per cent. weight in volume of iodine demanded by the British Pharmacopœia it was 86·8% over strength. This, in my opinion, was not a very serious offence and the manufacturers, on interview, gave an undertaking to the effect that they would exercise a stricter control over the manufacture of their products.

ICE CREAM. The Food Standards (Ice Cream) (Amendment) Order, 1952, came into operation on 7th July, 1952, requiring ice cream to contain not less than 4% fat, 10% sugar, and 5% milk solids other than fat. Nine samples were submitted during the year and all were found to satisfy the above Order on analysis. Their average composition was 9·9% fat, 13·4% sugar, and 8·2% milk solids other than fat, thus showing that products considerably superior to that required by law were being sold.

SWIMMING BATH WATERS. A total of twenty-one swimming bath waters were examined and all contained a small excess of free chlorine over that present as chloramines. This indicates that chlorination is keeping pace with pollution and that no danger exists of any infection by the pathogenic micro-organisms of water-borne diseases.

BOROUGH OF STRETFORD

During the year, 182 samples were received from the Borough of Stretford for examination under the Food and Drugs Act, 1938. Details of these samples are given in the following table :—

TABLE 11

SAMPLES EXAMINED.

Samples.	Number examined.	Number adulterated or otherwise giving rise to irregularity.		Per cent. adulteration.
		Preservatives only.	Other ways.	
FOODS.				
Milk	105	—	5	4·8
Arrowroot	2	—	—	—
Cakes, Eccles	1	—	—	—
Cheese, Processed	2	—	—	—
Cherries, Glace	1	—	—	—
Coconut, Sweet Tenderised Desiccated	1	—	—	—
Cream, Synthetic	2	—	—	—
Custard Powder	2	—	—	—
Egg Albumen Substitute	1	—	1	100·0
Fruit, Dried	1	—	—	—
Fruit Essence	2	—	—	—
Gelatine	1	—	—	—
Gravy Browning	1	—	—	—
Herbs, Dried	2	—	—	—
Ice Cream	23	—	2	8·7
Jam	2	—	—	—
Jelly Powder	1	—	—	—
Meringue Powder	1	—	—	—
Mincemeat	1	—	—	—
Morfat	1	—	—	—
Orangeade	1	—	—	—
Paste, Fish	2	—	—	—
Paste, Meat	2	—	—	—
Peas, Tinned	4	—	—	—
Potato Crisps	2	—	—	—
Sage	1	—	—	—
Sodium Alginate	1	—	—	—
Suet, Chopped	1	—	—	—
Tea Tablets	1	—	—	—
Vinegar, Malt	3	—	—	—
DRUGS.				
Camphorated Oil	1	—	—	—
Cough Rings, Children's	1	—	—	—
Digestive Mints	1	—	—	—
Epsom Salts	1	—	—	—
Epsom Salt Tablets	1	—	—	—
Iodised Throat Tablets	1	—	—	—
Nerve Tonic	1	—	—	—
Seidlitz Powders	2	—	—	—
Wintergreen Ointment	1	—	—	—
Zinc Ointment	1	—	—	—
TOTAL FOODS AND DRUGS	182	—	8	4·4

TABLE 12

ADULTERATED OR IRREGULAR SAMPLES.

Sample No.	Description.	Nature of Adulteration or Irregularity.	Remarks and Action Taken.
1207	Milk	Deficient 3·3% milk fat ...	Further samples taken, see No. 1218 below.
1208	Milk	Deficient 5·0% milk fat ...	
1218	Milk	Deficient 6·6% milk fat ...	See special observations.
1285	Milk	Deficient 2·9% non-fatty solids. Freezing Point (Hortvet) —0·527°C.	Further samples taken and found to be genuine.
1339	Milk	Deficient 5·9% non-fatty solids. Freezing Point (Hortvet) —0·514°C.	"Appeal to Cow" samples taken. Farmer cautioned.
1251	Egg Albumen Substitute.	Contained very little protein.	See special observations.
1265	Ice Cream ...	Deficient 9·3% non-fatty milk solids.	Manufacturer cautioned.
1266	Ice Cream ...	Deficient 4·0% fat	Manufacturer cautioned.

Milk.

The average composition of the 105 samples analysed was as follows, the corresponding figures for the previous five years being given for comparison :—

	1947	1948	1949	1950	1951	1952	Minimum requirements.
Fat %	3·51	3·55	3·48	3·58	3·54	3·56	3·00
Non-fatty Solids % ...	8·65	8·69	8·72	8·73	8·70	8·66	8·50
Total Solids %	12·16	12·24	12·20	12·31	12·24	12·22	11·50

Of the 105 samples analysed, 5 (4·8%) were unsatisfactory, 3 being deficient in fat and the other 2 deficient in non-fatty solids.

SPECIAL OBSERVATIONS.

MILKS, *Samples Nos.* 1207, 1208 *and* 1218. Informal samples of farmer's milk, Nos. 1207 and 1208, were found, on analysis, to be 3·3% and 5% deficient in fat. This source of supply was kept under observation and a further informal sample (No. 1218) was taken at a later date. Analysis showed its fat content to be 2·80%, and hence on comparison with the minimum presumptive limit of 3% for fat for the Sale of Milk Regulations, 1939, was 6·6% deficient in fat. It was deemed sufficient to advise the farmer to improve the quality of his milk and the Food and Drugs Sampling Officer of the Cheshire County Authority, in whose area the farm was situated, was also notified.

MILK, *Sample No.* 1339. This formal sample, on analysis, was found to contain only 8% of non-fatty solids and hence on comparison with the statutory minimum presumptive limit for non-fatty solids of 8·50% of the Sale of Milk Regulations, 1939, was 5·9% deficient in non-fatty solids. The freezing point (Hortvet) of —0·514°C. showed this deficiency to be due to the presence of extraneous water. The farmer was cautioned by letter to take more care to ensure that extraneous water does not gain access to his milk.

EGG ALBUMEN SUBSTITUTE, *Sample No.* 1251. This informal sample, obtained as the result of a complaint from a school kitchen, was found, on analysis, to have a total solids content of only 2·4% and a protein content of only 0·8%. In appearance, it was a pale yellow viscous liquid and unsatisfactory in use as regards its culinary properties. With such a low protein content it cannot, in my opinion, be regarded as a genuine albumen substitute. Since only one drum of the product was in question and no records were available of its purchase it was withdrawn from use.

ICE CREAM. The Food Standards (Ice Cream) (Amendment) Order, 1952, came into operation on 7th July, 1952, requiring ice cream to contain not less than 4% fat, 10% sugar, and 5% milk solids other than fat. Twenty-three samples were submitted during the year, twenty-one samples being found satisfactory on analysis. The average composition of the satisfactory samples was fat 9·6%, sugar 12·6%, and milk solids other than fat 9·3%, thus being considerably in excess of the legal requirements.

ICE CREAM, *Samples Nos.* 1265 and 1266. Formal sample No. 1265 was found, on analysis, to be 9·3% deficient in non-fatty milk solids, whilst formal sample No. 1266 was 4% deficient in fat. The manufacturers of these ice creams were warned of the necessity of complying with the minimum legal requirements, and further samples taken at a later date were found to be satisfactory.

CARE OF MOTHERS AND YOUNG CHILDREN, DOMICILIARY MIDWIFERY SERVICE, HEALTH VISITING, HOME NURSING, Etc.

Investigations. The following special investigations have been and are being carried out by the staff of the Department, either independently, or in collaboration with other organisations :—

NEW-BORN INFANT SURVEY in conjunction with the Social Medicine Unit of the University of Oxford.

RETROLENTAL FIBROPLASIA SURVEY in accordance with a Ministry of Health request.

VIRUS INFECTIONS DURING PREGNANCY in conjunction with the General Register Office, Somerset House.

DISINFECTION IN NURSERIES. A local investigation to ascertain the value, or otherwise, of the use of disinfectants in day nurseries.

CHEMO-PROPHYLAXIS in co-operation with the Medical Research Council.

SUPPLEMENTARY PROTEIN. A local investigation into the effects of introducing liver concentrate into the diet of certain children.

PREMATURITY in collaboration with the National Birthday Trust.

SURVEY OF CHILD HEALTH in conjunction with a Joint Committee of the Institute of Child Health (University of London) ; the Society of Medical Officers of Health and the Population Investigation Committee.

These surveys have entailed a great deal of extra work, which has been undertaken most willingly by all members of the staff.

Jutland House. This building, which houses a hostel and training school for ten pupil midwives, residential accommodation for two teaching midwives, headquarters for the Premature Baby Service, and accommodation for the Night Midwifery Service, was officially opened on 27th November. At the opening ceremony many guests expressed their satisfaction at the arrangements made here for the training of pupil midwives.

Day Nurseries. On the day that Jutland House was opened, the first new Day Nursery since the War was opened. The Nursery, in Hayfield Terrace, Pendleton, situated very near " Hanky Park," is an improvement on the War-time Nurseries and has accommodation for fifty children.

New Child Welfare Centre. The use of premises as a Child Welfare Centre were secured at the Leicester Road Methodist Church, Salford, 7, in February. The centre is open for one session weekly and is proving more convenient for the mothers who live in that area and who are not able to travel the long distance to the Murray Street Centre.

Competitions. Two competitions were held for parents of children attending the Welfare Centres—a cake baking competition and a make do and mend competition.

The entries for the cake baking were very few, but the standard of baking was good. The judging was done by our cookery demonstrator.

A very much higher number of entries were received for the make do and mend competition, and great ingenuity was shown by both mothers and fathers in the making of children's garments from cast-off adult garments.

STATISTICS

Birth Rate. The total number of births occurring in the City was 3,161, giving a birth rate of 17·6.

Infant Mortality. One hundred and seven infant deaths occurred in the City, giving an infant mortality rate of 34·5, the second time on record that this has been below 40.

As in previous years the chief causes of death were Prematurity, Congenital Malformations, Debility and Respiratory Diseases, in that order. These conditions accounted for 76 (71%) of the deaths. There were four deaths caused by accident. Sixty-three of the deaths occurred in the first month of life, more than half of these being due to prematurity.

Deaths of Children One to Five Years. Sixteen deaths occurred among the children of this age group throughout the year. Five occurred between the ages of one and two, four at two years, four at three years, and three at four years. Six of the deaths were due to pneumonia or bronchitis, two to pneumococcal meningitis, and one to acute encephalitis. Included among the children who died from pneumonia were two who were mentally defective, one who had cystic disease of the pancreas, and one who had a perforated appendix. Two children, aged two and three years, died from malignant disease. There were two accidental deaths—one from a fall from a swing, and one under anæsthesia.

Stillbirths. There was a reduction in the number of stillbirths this year as compared with 1951, the figures being 61 in 1952, and 99 in 1951. The stillbirth rate for the year is 19·3.

Maternal Deaths. I regret to report that two Salford mothers died as a result of conditions associated with childbirth. Both died in hospital, the causes of death being :—

(1) I (*a*) Heart failure ;
(*b*) Pulm. Oedema ;
(*c*) Mitral stenosis.
II. Eclampsia (delivery of stillborn infant 1½ hours before death).

(2) Obstetric shock and hæmorrhage following rupture of the uterus during labour.

SUPERVISION OF MIDWIVES

Sixty-seven midwives notified their intention to practise during the year —28 from Hope Hospital, 10 from a Nursing Home, and 29 from the Domiciliary Service.

DOMICILIARY MIDWIFERY SERVICE

Resignations and Appointments. Two appointments to the Service were made to fill vacancies created by the death of one midwife who had been on sick leave for a considerable time and the resignation of another.

Sick Leave. There was a considerable reduction in the amount of sick leave among the staff, the average per midwife being 15 days approximately, as compared with 27 days in 1951.

Post-Graduate Courses. One of the teaching midwives attended a Course organised by the Royal College of Midwives, especially for midwives engaged in the practical teaching of Part II pupils.

A series of talks and practical instruction were given by Miss Outram, Principal of the Manchester School of Physiotherapy, on the subject of " Relaxation and Ante-Natal Exercises." The instruction was given to approximately half the Municipal Midwives and has already proved valuable in ante-natal work.

Ante-Natal Care.

1. *Clinics.* Forty-two clinic sessions per month are held and managed exclusively by midwives. These continue to be successful.

Number of clinic attendances	4,963
,, ,, women who attended	1,609

In addition to the above-mentioned arrangements, on an average, six midwives attend the surgeries of two family doctors each month to assist in ante-natal care of patients booked for Maternity Medical Services.

2. *Exercises.* The lack of physiotherapists has made it impossible to organise regular sessions of instruction in ante-natal exercises. To meet the need the midwives have given instruction in their own clinics whenever staffing has made this possible.

3. *Mothercraft Instruction.* One midwife continued mothercraft instruction in her own home until the Part II training was reorganised at Jutland House in August, 1952. Since then no classes have been held. A combined effort between health visitors and midwives is anticipated early in the new year. Until then the mothercraft instruction will be given individually at ante-natal clinics.

4. *Home Visits.* The visiting of expectant mothers in their own homes takes up a tremendous amount of the midwives' time.

Apart from the routine visiting of their own booked cases, the midwives have investigated the home conditions of mothers requesting Hope Hospital delivery.

Number of ante-natal visits		11,857
,, ,, home investigations		350
,, ,, bookings accepted :		
First quarter	409	1,544
Second ,, ...	446	
Third ,, ...	343	
Fourth ,, ...	344	

An analysis of the home investigations is given below :—

Home Conditions	Booked	Not Booked	Not Known	Total
Bad	97	2	46	145
Fair	14	10	18	42
Good	18	85	47	150
No access to the home	4	3	6	13
TOTALS	133	100	117	350

Deliveries. The number of domiciliary births for the year 1952 closely approximates the number for 1951. On an average 50% of these have been delivered in far from ideal surroundings, but wherever the home conditions have been unsuitable the mothers have been advised to apply for a hospital bed. Many of these are reluctant to do so, and in spite of adverse circumstances still continue to have normal confinements.

Statistics.

	Year 1952	Year 1951
1. Number of cases attended :		
(*a*) As midwives	1,212	1,191
(*b*) As maternity cases	105	129
TOTAL	*1,317	1,320
2. Number of births attended :		
(*a*) Live births	1,324	1,312
(*b*) Stillbirths	7	27
TOTAL	*1,331	1,339

* The difference between the two totals represents 14 sets of twins.

It will also be noted that there is a difference of 227 between the number of bookings and the number of cases delivered. This figure indicates the number of cases lost to domiciliary practice by (*a*) removals, (*b*) miscarriages, (*c*) transfer to hospital for abnormality.

3. Average number of cases per midwife	60
4. Number of domiciliary miscarriages	10
5. Number of cases having had gas and air analgesia (approximately 50% of total cases) :	
(*a*) Midwives' cases	576
(*b*) Maternity cases	54
TOTAL	630
6. Number of cases having had pethidine (approximately 20% of total cases) :	
(*a*) Midwives' cases	267
(*b*) Maternity cases	31
TOTAL	298

All midwives have been trained in the use of pethidine and an adequate supply is always available for every case requiring this drug.

7. Number of Night Midwifery Service calls :	
(*a*) to cases	1,050
(*b*) for cars	753
8. Number of deliveries between 8 a.m. and 8 p.m.	612
„ „ „ „ 8 p.m. „ 8 a.m.	705
TOTAL	1,317

9. There were six calls for Emergency Blood Transfusion, of this number four were admitted to Hope Hospital for further treatment, whilst two remained at home. All made an uneventful recovery.

Stillbirths. 1952 has seen a sudden drop in the number of domiciliary stillbirths, i.e., 27 in 1951, and 7 in 1952.

There is no apparent reason for this decline, but the summary of the cases is as follows :—

Cause.	*Predisposing Cause.*	*Presentation.*	*Full time or Premature.*	*Macerated or Fresh.*	*Total.*
A. Abnormal Foetus.					
1. Spina bifida with hydramnios.	—	Breech.	Full time.	Macerated	1
B. Asphyxia.	1. No ante-natal care. Persistent slight bleeding from 20th week. B.B.A.	?	Premature.	Fresh.	
	2. Placental insufficiency	?	Premature.	Macerated.	
	3. Tight cord round neck during delivery (P.M. refused)	Vertex.	Full time.	Fresh.	3
C. Cerebral Haemorrhage.	Torn tentorium.	Vertex P.O.P.	Full time.	Fresh.	1
D. Unknown Causes.	1. Nil. Fœtal death at 36 weeks. Health of mother good.....	Breech.	Premature.	Macerated.	
	2. No ante-natal care. Single girl. B.B.A.	?	Full time.	Fresh.	2
		Total			7

Comparative Statistics.

	1951	1952
Abnormal fœtus	8	1
Asphyxia	13	3
Ante-partum hæmorrhage	1	0
Toxæmia	1	0
Cerebral hæmorrhage	1	1
Unknown causes	3	2
Totals	27	7

Puerperium. The mother confined in her own home continues to receive the attention of her midwife up to a minimum of 14 days.

Number of nursing visits 23,949

In addition the Domiciliary Midwives have attended 52 cases discharged from hospital before the tenth day of the lying-in period. Those discharged after the tenth day have been visited as soon as possible by the Health Visitor. The following subjects are closely linked with the puerperal state, namely :—

A. Infection.

(*a*) *Puerperal Pyrexia.* There is a slight decline in the number of notifications of puerperal pyrexia occurring in district practice—13 in 1951, and 10 in 1952. The 1952 cases were dealt with as follows :—

Number of cases nursed at home	9
,, ,, ,, transferred to hospital	1
Total	10

Classification of Causes of Puerperal Pyrexia.

Cause.	*Number.*
Pyelitis	1
Breast infections	1
Puerperal sepsis	2
Thrombo-phlebitis	1
Conditions associated with pregnancy	1
Pyrexia of unknown origin	4
TOTAL	10

Comparison between Hospital and District.

	1951	1952
Number of hospital notifications	37	31
„ „ domiciliary notifications	13	10
TOTALS	50	41

(*b*) *Pemphigus Neonatorum.* An increase in the incidence of pemphigus neonatorum occurred. A sporadic case was diagnosed in February and a further two in November. The latter two occurred in the same area, and in the same midwife's practice, but no epidemic resulted. The area of skin involved in these two cases was quite extensive, but both made satisfactory progress, the nursing care being in the hands of the Home Nursing Service.

(*c*) *Ophthalmia Neonatorum.* Three cases of ophthalmia neonatorum occurred in district practice. All were successfully nursed at home by the Home Nursing Service.

B. BREAST FEEDING. This year's figures show an increase of almost 100% on the number of notifications of supplementary artificial feeding, but the number for complementary feeding is almost static. Some use has been made of the Breast Feeding Sister both in the ante-natal and lying-in periods. Although this assistance has been greatly appreciated where used, the number participating is exceedingly small.

Number of notifications of artificial feeding :	
(*a*) Complementary	42
(*b*) Supplementary	48
TOTAL	90

C. NEO-NATAL DEATHS (domiciliary up to 14 days). An appreciable reduction in the number of domiciliary neo-natal deaths up to the fourteenth day has occurred. The most significant feature is the number of such infants weighing 5½ lbs. and under. Post-mortem examination revealed that the majority of these "premature" infants had died of pulmonary complications.

Classification of Causes of Neo-Natal Deaths.

	Cause.	*Birthweight.*	*Age at Death.*	*Total.*
1.	Cerebral hæmorrhage	4 lbs. 2 ozs.	3 days.	1
2.	Respiratory infection	Not weighed.	4 days.	1
3.	Prematurity and Atelectasis	1 lb. 15½ ozs.	1 day.	
		1 lb. 10 ozs.	1 day	2
4.	Pulmonary congestion and patent ductus arteriosus	3 lbs. 9 ozs.	4 days.	1
5.	Prematurity (no p.m.)	3 lbs. 12 ozs.	1 day.	1
6.	Congenital heart	6 lbs. 0 ozs.	1½ hours.	1
	TOTAL			7

Maternal Deaths—Nil in domiciliary practice.

Medical Aid (Pregnancy, Labour and Puerperium).

Mother.

Pregnancy.	1.	Toxæmia	19	
	2.	Ante-partum hæmorrhage	14	
	3.	Miscarriage	27	
	4.	Death in utero	3	
	5.	Hypertension	4	
	6.	Rhesus Negative with antibodies	1	
			—	68
Labour.	1.	Delayed 1st stage	16	
	2.	„ 2nd „	15	
	3.	Retained placenta	12	
	4.	Post-partum hæmorrhage	15	
	5.	Malpresentation	14	
	6.	Prolapsed cord	1	
	7.	Uterine inertia	4	
	8.	Disproportion	5	
	9.	Ruptured perineum	177	
	10.	Premature labour	14	
	11.	Fœtal distress	12	
	12.	Maternal distress	7	
			—	292
Puerperium.	1.	Pyrexia	35	
	2.	Phlebitis	9	
	3.	Breast complications	15	
	4.	Subinvolution	1	
	5.	Mental states	4	
			—	64
		Other conditions in mother	31	
			—	31
		TOTAL		455

Infant.

1.	Ophthalmia neonatorum	1	
2.	Pemphigus neonatorum	1	
3.	Discharging eyes (non-purulent)	96	
4.	Asphyxia	7	
5.	Congenital abnormalities	10	
6.	Jaundice	3	
7.	Septic spots or blisters	9	
8.	Prematurity	40	
9.	Stillbirth	1	
10.	Other conditions in infant	50	
	TOTAL	218	

Summary of Medical Aids.

Mother	455	Number of medical aids in which doctor was booked for maternity medical services	442
Infant	218	Number of medical aids where no doctor was booked	231
TOTAL	673	TOTAL	673

Night Midwifery Service.

This service continues to function between the hours of 8.0 p.m. and 8.0 a.m., but since 19th September, 1952, has operated from Jutland House, Trafford Road, Salford, 5.

PART II MIDWIFERY TRAINING SCHOOL

Teaching Staff.

1. Approved Lecturers : Dr. M. Sproul, M.B., Ch.B. D.P.H. (Public Health) ; Dr. A. J. Gill, Venereologist.

2. Approved Teachers : Theoretical—Non-Medical Supervisor of Midwives. Practical—Five Municipal Midwives.

Accommodation. On 18th August, 1952, all pupil-midwives were transferred to the new hostel : Jutland House, Trafford Road, Salford, 5, which provides accommodation for two midwives, a Warden-housekeeper, and ten pupil-midwives.

Training School Statistics.

Number of pupils in training 1st January, 1952	8
,, ,, ,, ,, ,, 31st December, 1952...	10
,, ,, ,, who discontinued training	0

Examination Results.

Number of successful examination candidates	13
,, ,, unsuccessful ,, ,, ...	1
Total Entries	14

The failure was successful at her second attempt.

The Supervisor of midwives lectures to pupil midwives.

SUPERVISION OF HOSPITAL MIDWIVES

Statistics.

Number of midwives in practice in hospital on 31st Decmbeer, 1952 — 24

NUMBER OF NOTIFICATIONS (infectious diseases).

(*a*) Puerperal pyrexia	31
(*b*) Ophthalmia Neonatorum	2
(*c*) Pemphigus „	0

NUMBER OF NOTIFICATIONS (C.M.B.).

Artificial Feeding.	1952	1951
(*a*) Complementary	62	80
(*b*) Supplementary	30	38
TOTAL	92	118

N.B.—A considerable reduction in the incidence of artificial feeding has occurred in hospital practice.

Summary of C.M.B. Notifications and Notifications of Infectious Diseases affecting :—

A. Domiciliary Midwifery.
B. Institutional Midwifery.
   (1) Hospital.
   (2) Nursing Home.

C.M.B. Notifications	Stillbirths	Deaths	Laying out of Dead Body	Infection	Artificial feeding	Medical Aid
Domiciliary	7	6 (infants)	5	15	90	673
Institutional :						
(1) Hospital	Not required	Not required	Not required	Not required	92	Not required
(2) Nursing Home	1	1 (infant)	2	0	4	1
TOTALS	8	7	7	15	186	674

Notifications : Infectious Diseases	Ophthalmia Neonatorum	Pemphigus Neonatorum	Puerperal Pyrexia
Domiciliary	3	3	10
Institutional :			
(1) Hospital	2	0	31
(2) Nursing Home	0	0	0
TOTALS	5	3	41

INSPECTION OF NURSING HOMES

There are two Nursing Homes in the City—one with 18 beds for medical and surgical cases and one with 20 beds for maternity cases. An inspection of each home was carried out during the year.

Statistics—Maternity Home.

Number of live births	124
„ „ stillbirths	1
TOTAL	125
Number of premature live births	3
„ „ „ stillbirths	0
TOTAL	3
Number of premature infants transferred to hospital	1
„ nursed entirely in Nursing Home	2
TOTAL	3

N.B.—Of the latter group, one died within 24 hours and the other survived the 28th day.

Number of abortions notified (between 18th and 28th week)	1
Number of notifications (infectious diseases) :	
(*a*) Puerperal pyrexia	0
(*b*) Ophthalmia neonatorum	0
(*c*) Pemphigus „	0
Number of notifications (C.M.B.) :	
(*a*) Medical aid	1
(*b*) Artificial feeding—	
(1) Complementary	0
(2) Supplementary	4

CARE OF MOTHERS AND YOUNG CHILDREN

Ante-natal Clinics. The attendances at Medical Officers' Ante-natal clinics were rather higher than those for 1951—4,802, as compared with 4,355. These attendances were made by 1,610 individual mothers of whom 1,387 were " new."

Two-hundred and ninety-five mothers were sent by general practitioners for blood tests only.

As usual specimens of blood were taken for Kahn tests, Hæmoglobin estimations and for tests for Rhesus factor.

Kahn Tests	1,227
Hæmoglobin Estimations	1,257
Tests for Rhesus Factor	1,229

Five mothers were found to be Wasserman positive and were sent for treatment.

Two hundred and six mothers were found to be Rhesus Negative and of these nine were found to have antibodies and were referred to hospital for delivery.

Repeat Rhesus tests are done on all Rhesus negative mothers at or about the thirty-sixth week of pregnancy.

Post-natal Clinics. The number of mothers attending the clinics for post-natal examination are fewer than ever—only 220 attended during the year. More and more of these examinations are being carried out by general practitioner obstetricians who are " booked " for Maternity Medical Services.

Child Welfare Centres. With the addition of the Leicester Road Centre there are now 24 Child Welfare Sessions and nine Toddler Sessions held weekly throughout the City.

The attendances at Toddler Sessions were not quite so good as when these special sessions were first started—only 40·17% of the children invited attending during the year. It is interesting to note the difference in the response to these invitations in the different areas.

Centre.	*Number invited.*	*Number attended.*	*Percentage attending.*
Cleveland	620	310	50%
Langworthy	1,422	669	46·55%
Ingleside	483	214	43·97%
Regent	1,124	429	41·08%
Police Street	1,656	455	38·35%
Ordsall	813	296	38·22%
Encombe Place	676	259	37·68%
Crescent	410	152	35·44%
Murray Street	1,648	572	34·21%

One Medical Officer, who sees the children at Regent Road, Police Street and Ingleside Centres, reports that among the 1,098 children seen at these three centres she found 405 defects. At Murray Street Centre 316 defects were found among the 572 children examined, and at Langworthy only 107 of the 669 seen were referred for the treatment of various minor disabilities.

The general report from all centres was that only 50% of the children are taking up their Vitamin Supplements, with the exception of Cleveland Centre, where it was found that 73·2% of the children seen were given Cod Liver Oil Compound, 20·7% were given alternative preparations of Vitamins A and D, and that 6·1% were given no A and D preparations at all. A similar picture is shown with regard to Vitamin C, 89·5% of the toddlers seen at Cleveland Clinic were having orange juice, 6·7% a substitute preparation, and only 3·7% were given no additional Vitamin C.

Using the same classifications as in the School Medical Service the general conditions of the children seen were recorded as follows :—

Centre.	*Number of children seen.*	*General condition.* A (Good)	B (Fair)	C (Poor)
Cleveland	294	228	65	1
Langworthy	549	326	208	15
Ingleside	214	145	69	0
Regent	429	247	179	3
Police Street	455	280	174	1
Ordsall	296	116	165	15
Encombe Place and Crescent	259	98	40	121

The principal defects found at these " toddler " examinations were general debility, bronchitis, enlarged tonsils and adenoids, upper respiratory catarrh, dental caries, orthopædic conditions, the chief one being genu-valgum.

There is still a great deal of ignorance among the mothers about suitable diet for children of this age group, of common food values, variety and culinary knowledge.

Out of fifty mothers questioned consecutively at one of the centres only one possessed a cookery book.

A considerable amount of educational work is still necessary before the standard of care and well-being of each child in the community reaches its optimum.

Domiciliary Premature Baby Service. From 24th September, 1952, the Premature Baby Service has had its headquarters in Jutland House. The transfer of equipment and responsibility for its upkeep has involved extra time, money and effort.

Also during the year it has been possible to provide special flannel gowns for the smallest of the premature infants born at home. This has proved invaluable where the smallest garments purchased in shops have been far too big and have also been unsuitable regarding type of material and style.

The increase in numbers of premature and immature infants nursed at home, plus maintenance of equipment, has made the present staff situation very acute at times, especially during the holiday season. The provision of transport in emergency has helped considerably, but if the shortage of hospital accommodation continues, a third premature baby nurse will be required in the near future.

Staff.

Number of staff 1st January, 1952	2
„ „ „ 31st December, 1952	2

Statistics.

1. Number of domiciliary live premature births	81
2. „ „ „ premature stillbirths	3
TOTAL	84

LIVE PREMATURE BIRTHS.

1. Number transferred to hospital	13
2. „ nursed at home	68
TOTAL	81

Results of the latter are as follows :—

Birth Weight.	Died in first 24 hours.	Died 2nd–7th day.	Died 8th–28th day.	Survived 28 days.	Totals.
Under 2 lbs. 3 ozs.	2	0	0	0	2
2 lbs. 3 ozs. and under 3 lbs. 4 ozs.	0	0	0	1	1
3 lbs. 4 ozs. and under 4 lbs. 6 ozs.	1	2	0	8	11
4 lbs. 6 ozs. and under 4 lbs. 15 ozs.	0	0	0	20	20
4 lbs. 15 ozs. and under 5 lbs. 8 ozs.	0	0	0	34	34
TOTALS	3	2	0	63	68

NURSING VISITS.

1. Number of nursing visits to premature infants (domiciliary born and hospital discharges)	2,882
2. Number of nursing visits to immature infants (i.e., over 5½ lbs. but requiring special care)	189
TOTAL	3,071

COMPARATIVE FIGURES—NURSING VISITS.	1951.	1952.
Premature infants	2,072	2,882
Immature „	60	189
TOTALS	2,132	3,071

Special Worker concerned with difficulties of Breast Feeding. As in former years one full-time nurse with special experience in problems of breast-feeding was employed throughout the year. Her main duty is visiting in the home where there are difficulties connected with breast feeding which need prolonged and frequent visits which the general health visitor cannot fit into her already overcrowded programme of work. The special nurse also works in close collaboration with the district midwives, and she attends certain Ante-natal and Child Welfare Clinics. Special scales are supplied, in order to carry out test feeding, for which transport to the homes is provided.

The majority of cases are referred because breast feeding has not, for varying reasons, been fully established.

	1952	1951
NEW CASES REFERRED DURING THE YEAR :		
(*a*) Infant Welfare Centre Medical Officers	102	77
(*b*) Health Visitors	18	68
(c) Midwives	15	9
(*d*) Hope Hospital	4	3
(*e*) General Practitioners	3	
(*f*) Mother's request	1	
Total new cases	143	
Brought forward from previous year	10	

AGE GROUP OF NEW CASES :					Total.
0—4 weeks	First babies	52	Others	18	70
4—8 „	„ „	34	„	19	53
8—12 „	„ „	10	„	2	12
12 weeks plus	„ „	3	„	5	8
TOTAL	First babies	99 (69%)	Others	44	143

PLACE OF BIRTH OF NEW CASES :	
Home	33
Hospital	110
TOTAL	143

	1952	1951
Home Visits	1,346	1,129
No access calls	134	110
VISITS TO CLINICS :		
Ante-Natal Clinics	28	43
Infant Welfare Centres	32	66

CASES DISCHARGED TO HEALTH VISITOR :		
(*a*) Completely breast-fed	40	
(*b*) Partially	33	
(*c*) Artificially fed—		
Advised by own Doctor	11	
„ „ Infant Welfare Centre Doctor	2	
„ „ Hospital Doctor	2	
Mother's own decision	34	
	49	
(*d*) Mothers refusing to attempt to breast feed	13	

The cases of failure to establish breast feeding came mainly from mothers who were indifferent from the start towards this natural function. The supply of milk in these circumstances is often inadequate from the commencement and quickly fails ; and there is often a reluctance on the mother's part to continue with even partial breast feeding. The majority of the mothers concerned come from the overcrowded areas in the City.

A follow-up survey was undertaken in respect of cases referred July, 1951—June, 1952. During this period 153 cases were referred, of which 49 were discharged fully breast fed, and 50 partially breast fed. At the end of six months it was found that of those discharged fully breast-fed :—

(*a*) Babies fully breast-fed for 6 months or longer	25
(*b*) „ „ „ „ 3–4½ months	10
(*c*) „ „ „ „ 3 months or less	10
(*d*) Mothers left district...	4
TOTAL	49

Of those discharged partially breast fed :—

(*a*) Babies partially breast fed for 2½ to 6 months	39
(*b*) „ died	2
(*c*) Mothers left district...	1
(*d*) Cases carried forward to 1953	8
TOTAL	50

Dental Care. (Report by Senior Dental Officer).

This year it has been possible for mothers attending three of the ante-natal clinics to be seen by the Dental Officer on the first day they attend the clinics. From the other ante-natal clinics they have to be referred and an appointment made. From the table below it will be seen that a greater number of expectant and nursing mothers have been examined than has been possible in the past. Figures for 1951 are given in brackets.

(*a*) NUMBERS PROVIDED WITH DENTAL CARE.

	Examined.	Needing Treatment.	Treated.	Made Dentally Fit.
Expectant and Nursing Mothers	198 (16)	183 (16)	140 (11)	109 (10)
Children under five years	410 (353)	377 (351)	344 (297)	263 (297)

(*b*) FORMS OF DENTAL TREATMENT PROVIDED.

	Extractions.	Anæsthetics.		Filling.	Scale Given Treatment.	Silver Nitrate	Dressings.	X-Ray.	Dentures.	
		Local.	General.						Full.	Part.
Expectant and Nursing Mothers	217	32	34	61	13	2	4	2	7	5
Children under five years ...	703	19	253	68	...	63	34	...	...	...

Physiotherapy Service. The year 1952 has shown steady and continued improvement in the work of the Physiotherapy Department. Various staff changes had led to interruptions in the work of the clinics, but by the end of the year the staffing position had improved greatly and all clinics were open.

Sunlight Clinics. The four sunlight clinics held at Regent Road, Langworthy, Police Street and Murray Street have been fully employed throughout the year. All children referred for treatment have been invited at once and no waiting list has been allowed to accumulate. More outside doctors have taken advantage of the service offered and there has been a welcome increase in the number of children sent for treatment.

The weekly clinic held by a maternity and child welfare medical officer has continued to prove helpful in assessing the benefits derived from artificial sunlight and other forms of physiotherapy treatment. The late clinics on Monday and Thursday at Regent Road have been continued for the benefit of mothers who are working and unable to bring their children until after five o'clock.

Remedial Exercise, Massage and Electrical Clinics. These are held at least twice weekly at the clinics—Regent Road, Landseer Street, Langworthy Health Centre, Cleveland Clinic, Police Street and Murray Street.

Remedial classes are held for early orthopædic conditions in the toddler, as during their development many of them show a considerable degree of knock-knee or pronated feet and it is advisable that correction should be obtained before the child is five years of age, as by that age the bones often become too firm for non-operative correction to be obtained. The mother joins in the exercise classes with the child and so learns with the child and is able to practise the exercises at home.

Better and quicker results are obtained the earlier any congenital deformity is treated and the physiotherapists pay daily visits to the homes of new born babies and may correct in a few weeks deformities which, if neglected at birth, would require many months or years of treatment in later life.

Fortunately during 1952 there was no large outbreak of poliomyelitis necessitating a big increase in physiotherapy work and more time could be given to the early treatment of minor orthopædic faults as well as more serious conditions. Special attention is paid to the treatment of babies with cerebral palsy, because it is known if treatment is started early enough crippling deformities can be prevented and the child given a far greater chance of being able to lead a normal life in later years.

Greenbank Children's Home. A physiotherapist visits the home three times weekly to give treatments as owing to staff shortages it was found impossible for the children to attend the clinics. There is no artificial sunlight lamp at present, but it is hoped before next winter one will be available.

Day Nurseries. Sunlight treatment is given to the children at the nursery, but unfortunately very few children ordered physiotherapy treatment by the medical officer ever attended to receive it, with the present number of staff it is impossible for a physiotherapist to visit all the nurseries required, and very few mothers will take time off work to bring the children to the clinic, nor will they avail themselves of the early evening and Saturday morning facilities available.

Ante- and Post-Natal Exercises. These classes are available at two centres —Landseer Street and Langworthy Health Centre. They are run in conjunction with the midwives' clinics which saves the mothers' time, and enables closer co-operation between the physiotherapist and midwives which is to the mothers' benefit. The progress is slow in convincing busy mothers that special exercises,

as different from their daily activities, would help them before and after childbirth, but the best encouragement is given by the mother who returns and says how much the exercises helped during the process of childbirth and please could she now have some post-natal exercises to tone up her relaxed muscles.

Neumann-Neurode Infant Exercises. Neumann-Neurode infant exercises were given to babies under 12 months mostly, but some small toddlers under two years old also attended.

In addition to the healthy babies some minor weaknesses were treated, for instance, cases of constipation, poor muscle tone, umbilical hernia, slight torticollis, bowlegs, valgus feet and pigeon toes, and children who were overweight and generally reluctant to move, sit or stand.

Psychological Service.

Family Guidance Clinic.

This new service was started in May to deal with problems affecting the mental health of the family. A psychiatrist attends Langworthy Centre one session per week. Unfortunately, the service is limited to those families where there are children under five years, and consequently the attendances have been rather low. Cases are referred from medical officers and health visitors. I give below a statement of the attendances to the end of the year :—

First two months	(May and June)	9 attendances.
Second „	„ (August and September)	35 „
Third „	„ (November and December)	21 „

Classification of Problems.

1.	Marital disharmony :	
	(*a*) with physical difficulties	1
	(*b*) with infidelity or desertion	4
	(*c*) separated	2
	(*d*) with cruelty	1
2.	Neurotic or pre-psychotic symptoms	5
3.	Immaturity or Instability	Several (in other groups).
4.	Psychological difficulties with physical manifestations	Nil.
5.	For advice *re* children	3
6.	Miscellaneous—housing problems, etc.	1

Psychological Clinics.

Miss Schofield continued her work in the clinics during the year. One session at Regent Road Welfare Centre was discontinued so as to allow one to be held at Langworthy Centre.

The actual problems discussed have been very varied—from mothers' personal anxieties, frustrations and irritations, to every conceivable difficulty in children. Housing difficulties still account for many difficulties in family life.

A noticeable change during the year has been the increasing number of mothers who have sought help as soon as a problem occurs. The mothers have got to know Miss Schofield through her talks to individual mothers in the waiting and weighing rooms at the Centres. Many behaviour difficulties can be nipped in the bud and major problems avoided in this way.

In the Ante-natal Clinic group talks and individual talks have been given on mental health subjects, e.g., " Personal Relationship," " Childbirth not an Illness but a Time of Fruition," " Enjoying Baby," " Family Problems and their Solutions," " Breast-feeding a Blessing to Mother and Child," " Happiness brings Health of Mind and Body."

During the latter part of the year several students have attended Miss Schofield's sessions. These included four Home Nurses, two Psychiatric Social Workers, one Speech Therapist, and four Student Nursery Nurses.

Family Planning Clinic.

Fifty-two mothers were referred by Medical Officers of the Department and 33 attended.

Cookery Demonstrations.

The cookery teacher reports that during the year the attendances at the demonstrations have been very good. One new centre was opened at Murray Street Clinic, and it is hoped to open one at Langworthy Centre shortly.

Leaflets on " What to Give a Toddler for Tea " (a subject which worries mothers very much), and " Packed Lunches for Workers " have been prepared and are available at the clinics. Other leaflets are in course of preparation.

One mother had never boned a joint, so brought one to the clinic. She was then taught how to do this. She now reports that she always bones joints, the bones make the basis of soup for the baby, stuffing replaces the bone and so makes the joint go further.

Christmas is always the highlight of the year and beautifully decorated cakes were carried home in triumph by the mothers. Many of them, so delighted with their newly discovered skill, afterwards iced and decorated cakes for relations and friends.

Mothers' Clubs.

Regent Area. A very successful Mothers' Club has been formed in connection with the Regent Road Centre under the direction of the Centre Superintendent, and meets fortnightly at Jutland House. There are forty members and the average attendance at meetings is 27. The members have formed their own committee.

Activities have included English and Scottish Country Dancing, educational film strips, talks, a beetle drive and a theatre outing.

Encombe Place. This Club was closed during the summer months owing to the lack of support. It was re-opened in October, and by the end of the year there were twelve regular members.

The members of this Club were invited by the Jutland House Club to supper and a musical evening, which was a great success.

Murray Street. This is the oldest and most firmly established Club. Fortnightly meetings are held at which the average attendance is 29.

A very varied and interesting programme was carried out during the year, including both social and educational activities. At Christmas a very successful children's party was held for the children who attend the clinics, presents for them being provided from funds raised by members of the Mothers' Club.

The Clubs are very grateful to the Health Committee for allowing them the use of clinic and other premises for Club purposes. Great credit is due to all for the successful running of the Club, but particularly to the Centre Superintendents and Health Visitors who do a great deal in their spare time to ensure their smooth running.

The Unmarried Mother and Her Child.

Staff changes during the year caused interruptions which resulted in curtailment of the work. For five months in the year there was no one to do these special duties. Since October the section has been staffed by a part-time health visitor who devoted three and a half days weekly to the work. Nevertheless, 67 expectant mothers were interviewed. They included :—

54 single girls and divorcees	39	first pregnancies.
	7	second ,,
	4	third ,,
	2	fourth ,,
	2	fifth ,,
7 married women	4	first illegitimate pregnancies.
	2	second ,, ,,
	1	third ,, pregnancy.
6 widows	5	first ,, pregnancies.
	1	third ,, pregnancy.

The ages of the girls and women ranged between 15 and 42 years. There were 2 under 16, 6 between 17 and 18, 7 between 19 and 20, 20 between 21 and 25, 14 between 26 and 30, and 18 over 30 years of age.

Each expectant mother was advised, and where necessary, was helped to keep her baby. Only six finally sought adoption, one placed her baby herself and five were referred to Registered Societies.

The position regarding these babies at the end of the year was as follows :—

With mother	39
Mother married before the birth of the baby	5
Child with mother and putative father (co-habiting)	4
Stillbirths	2
Adopted—mother and child left Salford	1
,, —left Salford	5
Mother married another man, child with her	1
,, and child left Salford	3
Babies died	2
Baby placed in a Home	1
Births pending	4
TOTAL	67

The sources of notification of these sixty-seven expectant mothers were :—

Children's Officer	2
Almoners	30
Other social workers	3
,, Local Authorities	2
Health Visitors	20
Voluntary	4
Midwives	1
Family Doctor	2
City Councillor	2
Girl's parents	3

There were 45 unmarried mothers and women with illegitimate children seen by the special worker for the first time after the birth of their babies (44 in their own homes and 1 in hospital). This group was made up of :—

Single women	31	first pregnancies.
	2	second ,,
Married women	3	first illegitimate pregnancies.
	2	third ,, ,,
Widows	4	first ,, ,,
	1	second ,, pregnancy.
Divorcees	1	first ,, ,,
	1	second ,, ,,

Two hundred and four illegitimate babies were born in the City during 1952. All were visited. Those regarded as unsatisfactory, of whom there were 14, were visited thereafter as often as was possible by the special worker. Those regarded as satisfactory were visited by the district health visitors, who informed the special worker of any noteworthy changes. Ten of the 14 unsatisfactory families were registered as neglectful and were visited by, or in conjunction with, the special health visitor for the child neglected in its own home.

The movements of all illegitimate children were watched. Removals out of the City were notified to the appropriate authorities and confirmation was obtained.

The *Children's Welfare Fund* has been of very great assistance in providing practical help. Many girls at first think it quite impossible for them to keep their babies, but when given a little assistance and encouragement most respond by making provision worthy of any babe. Perambulators in excellent condition have been obtained at low prices from generous helpers ; they are then bought (at the same low prices) by the unmarried mother, often with the help of their families. Some have been provided free in cases where definite need has been established. This service seems to give satisfaction and pleasure quite beyond what it would appear to deserve.

Assistance in obtaining affiliation orders has been given. All mothers of illegitimate children were advised to seek such orders within the twelve months prescribed by the law. Some required legal assistance and were referred to the Legal Aid Society. Three cases have been prepared for hearing in 1953.

Number of office interviews	37
„ „ special visits	13
„ „ visits to illegitimate children	37
„ „ „ „ unmarried mothers	186

Co-ordination with Children's Officer.

This is carried out by the Worker for the Unmarried Mother. Children placed with prospective adopters by the Children's Officer were visited during the three months' probationary period and reports sent to him at the end of that time. After the adoptions were made legal the children were visited in the ordinary way by the area health visitors.

Number of visits to children with adopters	12
Visits yielding no access	51

DAY NURSERIES

At the end of the year there were seven nurseries in the City with 320 places. The seventh nursery at Hayfield Terrace, Pendleton, was opened for the admission of children on 13th October, a small number of children being admitted each week until the register was full. Unfortunately an epidemic of measles occurred soon after the opening (two children were apparently incubating the disease on admission) and this lowered the attendance considerably.

The average daily attendance at the nurseries throughout the year was as follows :—

Six Nurseries.	Under 2 years	69 or 76·7%	of Children on register
	Over 2 „	176 „ 79·4%	„ „ „ „
	TOTAL	245 or 78·3%	„ „ „ „
One Nursery (Hayfield Terrace).	Under 2 years ...	6 or 57·6%	„ „ „ „
	Over 2 „ ...	19 „ 53·9%	„ „ „ „
	TOTAL	25 or 54·8%	„ „ „ „

During the year the demand for places in the nurseries has been very great. The number of applicants far exceeds the number of places and waiting lists are still long. Priority is given to those in greatest need.

The number of temporary admissions has been increased this year, 141 children being so accommodated as compared with 111 in 1951. The reasons for the admission of these children were as follows :—

Mother's confinement	91
Illness of mother	28
„ „ father	14
Parents separated	5
Mother deserted	2
„ a relief cleaner in a nursery	1
TOTAL	141

In order to give help to more families all children are admitted to the nurseries for a six months' period only. At the end of this period each case is reviewed, and if it is considered advisable, the child is allowed to remain in the nursery, particularly in those cases where the mother is the sole bread-winner, or where there is prolonged illness of one parent.

Training of Students. It is with regret that I have to report that three of the thirteen students who entered for the Certificate of the National Nursery Examination Board were unsuccessful. One of these three gained her certificate at the next attempt, but the other two failed to make the grade after two attempts.

The educational standard of many of the girls who wish to train as nursery nurses on leaving school is not good. Their general knowledge is poor and they lack the ability to express themselves. One reason for this may be that we are now getting the school-leavers whose education was disrupted by war-time conditions. But this is not the sole explanation, for one finds that there is lack of desire to learn.

Infections. The following table shows the amount of infection that has occurred in the nurseries throughout the year :—

NUMBER OF CASES.

Infections	Fitzwarren Street	Eccles Old Road	Howard Street	Summerville Road	Wilmur Avenue	Hulme Street	Total
Measles...	16 March and May	22 1 May 1 Aug. 1 Oct. 19 Nov. –Dec.	3 2 June 1 Aug.	16 3 July 1 Aug. 1 Nov. 11 Dec.	5 1 Feb. 1 Apr. 1 July 1 Oct. 1 Nov.	14 1 May 12 July 1 Nov.	76
Rubella...	13 11 April and May 1 June 1 July	7 3 Apr. 4 May	2 October	17 2 March 10 April 3 May 2 Dec.	2 Feb.	7 May	48
Pertussis	...	6 5 Mar. and Apr. 1 Aug.	...	...	2 March	4 July	12
Mumps...	...	...	1	...	...	...	1
Chickenpox	17	4	1	1	5	3	31
Dysentery (Sonne)	...	...	2 May	...	8 1 May 7 Sept.	32 Dec.	42

Medical Officer's Report. (For six day nurseries only). During the year the number of children " passing through " the Day Nurseries has increased due to admission of a greater number of temporary admissions and also to the fact that children are now admitted for six months only unless there are some special reasons for allowing them to stay longer. Consequently individual children have not been medically examined as frequently as in former years. The babies up to fifteen months of age have been seen at each inspection : new entrants and children who have been ill are seen at the first inspection following their admission or return. The tweenies and toddlers have been examined as far as possible at three monthly intervals. The general health of the children has been satisfactory, but there has been some increase in the incidence of infectious diseases, particularly colds and throat infections.

Use of Disinfectants in the Prevention of Spread of Infection. On 1st June, 1950, the six nurseries then in operation were divided into two groups. The first group was to use Chloros as a general disinfectant, i.e., for disinfecting toilet seats, chambers, infected linen and children's and staff's hands after toiletting, and the other group was to use soap and water only for these purposes.

During the test, charts are kept recording the daily attendance and the date of the occurrence of Diarrhœa (i.e., loose stool containing no pathogenic organisms), Dysentery (i.e., loose stool containing organisms of the Dysentery group), Measles, Pertussis, Colds, Rhinitis, Bronchitis and Rubella. The

charts will also show in which room in the nursery the infection occurred and also the number of days a child or member of staff was absent with the infection.

Educational Activities. The Teacher Superintendent reports that all nurseries have maintained a good standard of work, and that considerable improvement has occurred at Eccles Old Road and Howard Street Nurseries following the appointment of a new warden at each of these nurseries.

All the wardens are keenly interested in their work and give up a good deal of their own time to the making of improvised equipment. All understand the necessity for providing a quantity and variety of play activities during each day. There is sufficient material to prevent quarrelling and both staff and children have grasped the necessity for more careful treatment of the toys than was once the case.

The greatest problem common to all nurseries is endeavouring to supply equipment of the larger variety without adequate space for storage. Whilst every angle of mental development is catered for, the opportunities for physical development through the use of scrap materials, such as boxes, tyres, hoops, large tins, large bricks, etc., are fewer than they could be. Such materials could be available at little cost, but without storage space must be done without.

Play in the tweenie rooms resembles in many cases much that is happening in the toddler rooms. Though the activities need much more supervision, the tweenies are given the opportunity to paint, model, draw, bath dolls and wash dolls' clothing, build and play in sand. All have Wendy houses and nature tables.

The training of students provides the staff in the two- to five-year age group with an incentive to keep abreast of the latest ideas and methods in nursery education.

Gardening has now become an accepted activity in all nurseries. At one nursery more success has perhaps been achieved than elsewhere and the children have three plots—one for their digging activity, one for vegetables, and one for flowers. Last year a good crop of lettuce and potatoes was grown, dug up and eaten by the children. The flowers provided decoration for the nature table. The children had thus much opportunity for training in the care of growing things. At another nursery a good crop of potatoes, radishes and lettuce was grown, but before the children could gather it in it was removed by intruders.

HEALTH VISITING SERVICE

The definition of the function of the health visitor, although influenced greatly by changing philosophies and the concepts of the Health Service under the National Health Service Act, is taking shape, but slowly. The tendency is still strong for health visitors in Salford, as in other parts of the country, to concentrate attention on the child under five years. One reason for this lies in the traditional and well-established systems by which the health visitor is made aware of the existence of children in the age group who are living on her area. A system has yet to be evolved which would give her similar regular information regarding adolescents, adults and others in need of her services.

Staff. The equivalent of 42·2 full-time health visitors and clinic nurses were employed during the year, plus 7 lay assistants. Combined health visiting/school nursing/tuberculosis visiting was undertaken as in former years.

Specialist services were increased towards the end of the year by the appointment from existing staff of one specialist visitor for mental health, making a total of five health visitors responsible for specialist duties.

Seven health visitors were appointed to the permanent staff following completion of compulsory service under the Salford health visitors' training scheme.

Five student health visitors qualified during the year and began their first year's service as health visitors according to their terms of agreement.

Three full-time and two part-time health visitors and seven clinic nurses were appointed from outside the Department.

The Deputy Superintendent Health Visitor obtained an appointment as Superintendent School Nurse and left the Department in August after five years' service.

Changes in staff throughout the year were more numerous than in former years. The employment of married women, though welcomed because of the general shortage of health visitors, is not without its disadvantages. Of the fourteen members of the staff who resigned during the year, four left for posts nearer home, one emigrated to Canada, and the remaining nine were all married women leaving for domestic reasons, six to have babies of their own. A further three members of the staff intimated that they would be leaving for the same (latter) reason early in 1953.

A general description of the work of the health nursing service is given in the report to the Ministry of Health following circular 29/52.

Domiciliary Work. Fewer home visits were paid than in 1951. This was due to several reasons, viz :—

(*a*) The change in policy inaugurated the previous year when it was decided that the system of regular routine visiting of children under five years should be superseded by one which provided for visiting according to need. More time is needed to deal with specific problems than is needed for routine visiting.

(*b*) Employment, from existing establishment, of five health visitors in specialist duties. Time spent in contacting other social agencies, conferring with colleagues and writing reports is of necessity time consuming. Moreover, the area covered by these visitors when paying special home visits is wider, and fewer visits are therefore possible.

(*c*) An increase in clinic work.

Home Visiting.	1952.	1951.
*Visits to children under 1 year	13,224	16,768
* ,, ,, ,, 1–5 years	25,925	29,391
,, ,, expectant mothers (excluding unmarried expectant mothers)	369	510
,, ,, adults (individuals 141)	391	279
,, ,, tuberculosis patients	2,915	3,672
Follow-up medical visits, children 5–15	1,375	761
,, Cleanliness visits, children 5–15	550	634
Visits to adolescents (B.C.G. follow-up)	199	138
Miscellaneous visits to children 5–15 years	169	...
Carried forward	45,117	52,153

Brought forward	45,117	52,153
Special visits	1,785	1,925
Visits to aged persons	3,307	1,615
„ „ unmarried mothers (including expectant unmarried mothers)	186	455
„ „ breast feeding mothers (by special nurse)	1,256	989
	51,651	57,137
Additional visits—no access	7,261	9,111
GRAND TOTAL	58,912	66,248

* Including visits of special worker to illegitimate children.

Clinic Work. There was an increase in Infant Welfare Centre staff sessions—of 420, and in Ante-natal staff sessions—of 80—the equivalent of full-time occupation for one additional worker, or, in terms of homevisits, approximately 2,500. The increase was partly due to the opening of new toddler clinics.

Clinic Sessions.	*Health Visitors.*		*Clinic Nurses.*	
Infant Welfare	2,905	(2,636)	221	(70)
Ante- and Post-Natal	696	(690)	120	(46)
Chest Clinic	138	(75)	127	(87)
Family Planning	3	(36)	59	(20)
School Minor Ailments	105	(125)	2,059	(1,717)
„ Clinic (Medical)	53	(280)	955	(684)
„ „ (Specialist)	—	(—)	791	(644)
Miscellaneous	45	(—)	31	(—)
TOTAL	3,945	(3,842)	4,343	(3,268)

N.B.—Bracketed figures—1951.

Hospital Liaison Sessions.

Hope Hospital (127) ; Ladywell (7)	134
Neo-Natal Clinic sessions	36
TOTAL	170

Time Distribution.	*Full Staff.*		*Health Visitors Only.*	
Domiciliary, Clinics, Schools } Including travelling time during 1952.	27·7%	(27·13%)	30·31%	(30·78%)
	38·5%	(36·4%)	27·3%	(27%)
	10·14%	(9·8%)	12·2%	(12%)
Clerical	18·58%	(19·3%)	24·13%	(23%)
Hospital Liaison	·65%	(·27%)	1·0%	(·36%)
Miscellaneous	4·41%	(2·9%)	5·0%	(·3%)
Ambulance	—	(·25%)	—	(·13%)
Travelling	Not calculated.	(4·2%)	Not calculated.	(3·8%)

N.B.—Bracketed figures—1951.

Clerical Work. The percentage of time spent in clerical work is high, and I would again stress that much of this work could and should be carried out by a clerk.

Staff Education. One health visitor attended a two weeks' general refresher course, and another attended a mental health course for the same period, twenty health visitors attended a one-day course arranged in Salford on mental health, and twelve attended a week-end general course in Manchester.

Staff meetings are regularly held within the department. A discussion group was formed in collaboration with workers from the Child Guidance Clinic ; meetings are held fortnightly.

The Superintendent Health Visitor attended a five-day conference arranged by the Royal College of Nursing for Public Health Nursing Administrators at Hoddesdon, Herts.

Research. Among the surveys in which health visitors are taking part is that sponsored by the World Health Organisation and the Rockefeller Foundation to define the type of health and welfare workers who are best qualified to meet the various needs of the family with the greatest economy of time, money, and woman power. A parallel survey is being carried out in France. Salford is one of the three areas in this country to be covered by the team. The enquiry will be completed in 1953. Other surveys included :—

1. Institute of Child Health, University of London (Society of Medical Officers of Health)—Population Investigation Committee.
2. Newborn Infant Survey—Social Medicine Unit, Oxford.
3. The National Birthday Trust Fund—Inquiry into Prematurity.
4. Medical Research Council (B.C.G.) Investigation.

Social Clubs. (See section for Care of Mothers and Young Children).

Specialist Health Visiting.

(*a*) *Hospital Liaison.* The work in this field has developed to include visiting since October of the children's wards at Ladywell Hospital, and attendance earlier in the year at the Neo-natal Clinic and the pædiatric out-patient department at Hope Hospital.

The pædiatric out-patient clinics offer a good field for health teaching of older children and their parents. Talks have been illustrated by posters and film strips, and have aroused interest and even evoked occasional questions !

Attendance at the neo-natal clinic gives an excellent opportunity for the specialist worker to supplement the advice and teaching of the general health visitors, and as many of the babies attending are premature babies, to establish contact with the Premature Baby Nurses.

Turnover of information between the specialist and general health visitors depends for success on the speedy transfer of reports. Difficulty is experienced where information is required regarding the home conditions of schoolchildren previously unknown to the health visitor, and where often both parents are working when visits are paid. Delay also occurs when a health visitor feels she has insufficient knowledge of the family without paying a further visit, but is handicapped by having fixed school or clinic sessions to which she must give priority.

Statistics relating to the work indicate the minimum, and do not give a full and accurate picture of the work carried out. The figures relate only to duties arising directly from routine visits to the hospital and to the children seen during these visits. Work referred by telephone, or arising from discussion regarding children no longer in hospital, and enquiries other than the original follow-up, or request for reports on home conditions, is not shown.

The number of times children were referred to the specialist health visitor in hospital was 2,960. Of these, 1,974 referrals were made to health visitors. The number of children admitted suffering from gastric disturbances, including faulty diet, was 38. This comparatively low figure for an area such as Salford perhaps gives some indication that the work of health visitors in the homes and centres is not in vain. The number of children treated at other hospitals, however, is not known, and the actual number of children so affected cannot therefore accurately be estimated.

In October, November and December, seven cases of gastro-enteritis were admitted to Ladywell from the district, and three transferred from other hospitals.

Forty-six children were admitted to Hope Hospital with chronic chest complaints, as compared with 112 acute cases ; 24 cases of rheumatism and chorea, and 10 cases of meningitis—including six cases of tuberculous meningitis, plus 10 cases of primary tuberculous complex. Many of these conditions could have been prevented and all will need supervision over varying periods to ensure at best a complete and lasting recovery ; at the least prevention of the need for readmission to hospital.

As is shown below, 57 children were sent away for convalescence and the discharge of 50 children was delayed as a result of the reports and recommendations of the health visitors. These are results which can be shown statistically. Less concrete and more valuable is the work carried out in the homes, where, in conjunction with the hospital, there is continuity of treatment and advice. Instructions and advice given to the mothers at hospital on discharge of the child is frequently modified according to the health visitor's assessment of parental care, and to her knowledge of existing conditions and difficulties and the degree of co-operation in the home which is likely to be achieved.

Office work connected with this service is heavy, and must of necessity be so if the health visitors are to be kept well informed on the one hand and the specialist visitor on the other.

Children under four weeks of age.

Seen at Neo-Natal Clinic	333
Referred to health visitor from Neo-Natal Clinic (including defaulters)	374
Seen at Out-Patient Department and during Ward Rounds	1,062
Referred to health visitor	841

Children between the ages of one month and 15 years.

Total seen at Hospital	2,816
Referred to health visitor	2,748

Particulars relating to children admitted to Hospital.

Tonsils and Adenoids	823
Ear, Nose and Throat (excluding Tonsils and Adenoids)	73
Acute Chest conditions	112
Chronic Chest	46
Pulmonary Tuberculosis	10
Meningitis (including Tuberculous Meningitis)	10
Nephritis	6
Surgical cases	204
Gastric conditions	38
Rheumatism and Chorea	24
Epilepsy	7
Cardiac disease	1
Neo-natal sepsis	6
Others, including children seen at Ladywell—November and December (66)	322
Cases where discharge delayed following Health Visitors' reports	57
Convalescence arranged following Health Visitors' reports	57
Referred to open-air school following Health Visitors' reports	2

Student Nurses. In addition to the duties described above, the specialist health visitor makes all the arrangements for student nurses from Hope Hospital and Pendlebury Children's Hospital to see something of the work carried out in the health service. Student nurses attend several times a year in groups of 12 to 20. Each student spends one session in home visiting with

a health visitor, and another in paying observation visits to the various health and school clinics. A talk is given to each group outlining the different sections of the work. Thus the hospital nurse is given some idea of the scope of the public health service ; of the home conditions of hospital patients, and of the services available for patients on discharge from hospital.

(*b*) *The child neglected in his own home.* (See report appearing on page 96 under " Designated Officer's Report.")

(*c*) *Mental Health.* There is little to report here as the specialist visitor was appointed only in December. Arrangements were in hand for her to spend at least one month in the Mental Health Department in January, 1953.

(*d*) *The Unmarried Mother and her Child.* (For report see Section on Care of Unmarried Mother).

(*e*) *Aged and Infirm.* At the end of 1951, there were 1,008 elderly persons on the visiting list. A further 465 were added to the Register during 1951. Cases were referred by the following :—

Hospital Almoner	226
Medical Officer, Hospital	14
General Practitioners	19
Civic Welfare Department	48
Voluntary Organisations	23
Health Visitors	35
Home Help Department	21
Sanitary Inspectors	7
Friends, relatives, and self-notification	17
Found by special health visitor in course of her work	55
TOTAL	465

Primary visits	465
Subsequent visits by Specialist Department	1,449
„ „ „ general health visitors	227
Special visits on behalf of elderly persons	53
No access visits	90
TOTAL VISITS	2,284
Office interviews	18

Since the appointment of a Geriatrician to Hope Hospital, elderly persons awaiting admission to hospital are no longer referred to this Department. The present scheme provides for a visit by the Geriatrician to all elderly persons referred by general practitioners for admission to hospital, and the consultant decides whether or not the patient shall be admitted. Whilst this scheme may have abolished the long waiting list, it has certainly not solved the problem of care of the chronic sick in the City. Indeed there is now great difficulty in getting patients admitted where there is an acute problem, be it medical or social. In several instances, after much valuable time had been spent in a vain attempt to get sick persons into hospital, admission was gained only after relatives and friends had sought intervention by the police.

There was good co-ordination between the department and other social agencies concerned with care of the aged, and with general practitioners. In particular, appreciation is expressed of the continued help given and co-operation shown by members of the staff of the Civic Welfare Department.

The Chiropody Clinic at Hope Hospital, with transportation provided, was well and thankfully used by the old folk, who were unable to make the journey by public transport.

The problem of care of the elderly is a difficult one and only the fringe of it has been touched in this, as in other cities. Salford has a particularly big problem in that the City contains a large, and is likely to continue to contain an ever increasing proportion of elderly persons. Many younger members of the community are being transferred to housing estates outside the City ; and of the elderly persons leaving the City, the majority are of the type not likely to create a problem. A proportion of those left are elderly persons needing services not covered by the provisions of the National Health Service Act ; the elders who are in that half-way stage between full health and complete dependence. Mental as well as physical health is involved, as age often brings infirmity of mind, but not necessarily of a certifiable degree. These cases are neither suitable for admission to hospital or to any of the Local Authority Homes for the elderly. Yet they are unable adequately to care for themselves at home.

Next year, when an extension of this service is made, it is hoped to reintroduce the system of referral to this Department of all aged and infirm persons known to the Civic Welfare Department. This practice was discontinued throughout the year, as it was found impossible, with present staff, to cope with the number of persons referred.

At the end of the year, 1,351 cases remained on the visiting list.

Nursery Nurses' Training Course. One special health visitor, with much experience in teaching, is seconded to the Education Department to act as part-time health tutor to nursery nurses in training. Arrangements are also made for students to pay observation visits to Day Nurseries and to Maternity and Child Welfare Centres.

Clinic Nurses. Dispensations allowing up to eight nurses to assist health visitors with district work were granted by the Ministry of Health.

One clinic nurse was employed mainly to assist the specialist health visitor for care of the aged and infirm.

In addition to undertaking clinic work of varying kinds, all clinic nurses carry out domiciliary work in connection with Diphtheria Immunisation. A total of 5,734 visits were paid for this purpose, plus 5,598 no access calls.

Hygiene Attendants. Hygiene Attendants are employed to assist in the work of the public health and school health services, which does not need for its performance the services of a state registered nurse or health visitor. Their duties consist of attendance at :—

(*a*) *Child Welfare Centres*, where they undertake the weighing of children, preparation and clearing up of the Centre and general duties.

(*b*) *Ante-Natal Clinics.* To act as attendant to the Medical Officer and serve tea to the mothers.

(*c*) *School Clinics.* As attendant to Medical Officers and Chiropodist, and to assist with treatment of minor ailments. One attendant is employed full-time at the Eye Clinic.

(*d*) *Schools.* To assist health visitors during Annual Surveys and hygiene inspections.

(*e*) *Scabies Clinic.* To carry out the treatment of scabies.

In addition, attendants carry out duties in connection with :—

(*a*) *Diphtheria Immunisation.* Preparation for sterilisation by autoclave of all equipment to provide for separate syringe and needle for each individual injection given.

(*b*) *Mantoux and other tests carried out outside the Chest Clinic.* As above (*a*).

(*c*) *Disinfestation.*

(1) Disinfestation of heads of children in schools or in clinic.

(2) Disinfestation of heads (and person when necessary) of adults and aged and infirm persons.

(*d*) *Domiciliary Work.*

(1) Where any child or person is unable to attend a Centre for disinfestation of head or body, or for the treatment of scabies, treatment is carried out at home.

(2) Home visits to make appointments for Specialist Clinics.

(3) Assisting a mother in special need, for example, the daily bathing of new baby for a time as (this year) in the case of a blind mother who lacked confidence to handle her baby ; and a mother incapacitated by crippling arthritis of both hands who was physically incapable of bathing and dressing a young baby ; and helping a mother with several children under 5 years to prepare and bring children in special cases to a clinic.

(4) Assisting with the bathing of elderly persons in their own home. This has been done only in isolated cases, as the establishment of attendants does not allow for this necessary extension of their work.

Sessions preparing needles and syringes		929
Clinic sessions attended		2,189
Visits to schools with, and without, Health Visitors		218
Miscellaneous sessions		96
Number of cleansing operations in clinics :		
(*a*) Relating to children 0–5 years	30	
(*b*) „ „ „ 5–15 „	183	
(*c*) „ „ adolescents and adults	12	
	—	225
Number of cleansing operations in schools :		
(*a*) Relating to children 3–5 years	14	
(*b*) „ „ „ 5–15 „	87	
	—	101
Visits to homes		230

SCABIES.	*New.*	*Old.*	*Total.*
Number of adults treated	173	11	184
„ „ children 5–15 years	75	10	85
„ „ „ 0–5 „	26	6	32
TOTALS	274	27	301

Of the figures stated above, 28 persons were treated in their own homes because of sickness or infirmity. The remainder were treated at Ladywell, where two sessions —one afternoon and one evening—are held each week.

During March an additional 50 patients were treated at " The Homestead."

BODY VERMIN. Six cases were treated at Ladywell.

HOME NURSING SERVICE

Some developments in the Home Nursing Service are to be reported for this year. The first of these was the enlargement of the District Room, which for a long time had been too small. The staff have now ample space for the storing of their bags and for the care and preparation of their equipment.

A resident housekeeper was appointed and took up duties in November. It is hoped that she will relieve nursing staff of the many domestic duties they had to perform in the Home and to give the administrative staff more opportunity for the actual supervisory duties on the district.

Work of the Staff. At the end of the year, in addition to the Superintendent and Deputy Superintendent, the staff was made up as follows :—

4 Queen's Nurses
5 Male Queen's Nurses } full-time.
1 State Registered Nurse
2 State Registered Nurses—part-time.
3 State Enrolled Assistant Nurses.
2 Auxiliaries.

We are glad to have the part-time workers on the staff, but their usefulness is limited, as they do not, as a rule, desire to work at week-ends and as each member of the whole-time staff has one week-end off duty per month, it is sometimes difficult to fit in the work at these periods.

The amount of work carried out continues to increase. A total of 2,848 patients were nursed in their own homes during the year. The number of visits paid to these patients was 45,786—7,553 more than the previous year. The number of new cases for the year was 2,589, an increase of 343 on the figures of 1951.

As before, the greatest number of cases (82%) were referred by family doctors, 14% were referred from the various hospitals in Salford, Manchester and Eccles, 2% from this Department, and the remaining 2% made application direct to the Service.

A great variety of cases were referred, the largest number (1,064) being classified as acute medical and including cases of acute bronchitis, otitis media, pernicious anæmia, phlebitis, mastitis, pleurisy, influenza, tonsillitis and urinary infections. Six hundred and thirty-two patients were treated with penicillin, and 152 with streptomycin. Also among the new cases were 84 suffering from diabetes mellitus, 102 from tuberculosis, and 79 from carcinoma.

Two hundred and five patients were prepared for X-ray treatment.

I give below some further statistics in connection with this service :—

Population of City	176,400
Nursing staff	14·25
Population per nurse	12,377
Cases nursed	2,848
Cases per nurse	203·5
Nursing visits	45,786
Visits per nurse	3,270·5
Visits per case nursed	16
Population per case nursed	61·9

Training. Seven candidates entered for training during the year and all were successful in the examination for the Queen's Nurses' Roll.

The Manchester and District Nursing Institution was given facilities at the Home for the " Lecture Block " in the new system of training introduced this year. Each " block " consists of a four weeks' course.

Post-graduate Training. One member of the staff attended a Post-graduate Course organised by the Queen's Institute at Bangor.

Co-operation with Local Hospitals. Twenty-two student nurses from Salford Royal and Manchester Children's Hospital visited the Home. After a talk by the Superintendent on Home Nursing, each nurse spent a morning on the district with a member of the staff.

Loans. Two hundred and fifty-four articles of nursing equipment were loaned out during the year. These included back rests, bed cradles, mackintoshes, steam kettles, air rings, bed pans and urinals. Some of the chronic cases have had the use of equipment for years, e.g., one patient has had an air ring for ten years, another has had a bed cradle for four years.

Salary Scales of Staff. It is to be regretted that the Whitley Council has not seen fit to bring the salaries of Home Nurses up to the same level as that of other members of the public health nursing staff or of hospital staffs. This will have a bad effect on the recruitment of staff for the Home Nursing Service, which can do so much to relieve the hospital service by giving the patients nursing attention in their own homes.

ALMONER'S DEPARTMENT

The following is an account of the work done in the Almoner's Department during 1952.

1. Home Help Service.

Home Helps employed at 31st December, 1952	142	(5 full-time, 137 part-time)
Average weekly hours worked	2,870	
Cases assisted in 1952	598	
,, on books at 31st December	329	
Number of visits paid	1,463	

Analysis of cases assisted—

Infirmity due to old age	138
Bronchitis, asthma, etc.	25
Blind or partially blind	34
Rheumatism and arthritis	57
Heart conditions	55
Cerebral hæmorrhage	29
Skin, varicose ulcers, etc.	6
Diabetes	14
Cancer	32
Fractures	18
Blood pressure	13
Spinal conditions	5
Pulmonary tuberculosis	10
Muscular paralysis	8
Parkinsons disease	1
Jaundice	1
Post-operative	14
Burns	2
Neurotic	10
Pre-Natal	7
Maternity	76
Post-Natal	20
Sick mothers with young children	23

A fuller account of this service will be found in the survey of the local health services (see pages 123 to 125).

2. **Loan of Nursing Equipment.**

During 1952 the following articles were loaned :—

Bedpans	42
Air rings	38
Urinals	16
Dunlopillo bed	1
Iron bedstead with pulley	1
Cot-bed	1
Bed-rest	1
Feather pillows	12

The above figures refer to loans made in the Almoner's Department and are additional to loans made by the Home Nursing Service.

No provision has been made for the loan of invalid chairs or spinal carriages. In several cases the Almoner has been able to arrange for these to be borrowed from Voluntary agencies and in two cases has loaned wheel chairs which had been received as gifts.

3. **Convalescence and Recuperative Treatment.**

(*a*) PRE-SCHOOLCHILDREN. Arrangements were made for 17 children (two failed to go) to have periods of convalescence varying from four to twelve weeks.

(*b*) SCHOOLCHILDREN. One hundred and seventy children of school age had periods of convalescence, in most cases four weeks, but in several cases where it was considered necessary on medical grounds, extensions were granted.

Twenty-nine children failed to take advantage of the arrangements made, though eleven of these were cancelled in order to keep within the estimated expenditure for 1952/3.

(*c*) MOTHERS WITH YOUNG CHILDREN.

A review has been made of nine families who were sent to Brentwood during the last eighteen months. In six cases the results have been excellent and in two of these there is no doubt that a catastrophe was averted.

The review has shown once again the wisdom of preventive work. Successes have been " families with problems " rather than those who have already become " problem families." In the first group the family still feel some responsibility for the solution of their own troubles. The second group have largely shed their problems on to the various social services.

In view of the long waiting list at Brentwood and the fact that places there are precious, it is important to choose carefully and try to send cases where there will be some response. It has been found that younger women who have a reasonable intelligence and the wish and intention to improve both their health and mothercraft, respond best.

The Warden at Brentwood (Miss Abrahams) endeavours, whilst accepting all kinds of cases, to keep the number of the neglectful problem type down to a minimum. Thus the " hopeful " families are always in the majority.

Even in cases where there appears to be little or no improvement, it is thought that the women have benefited from their stay at Brentwood in that they have learned something which lasts. It is very difficult to assess the value of the treatment in these cases, as the improvement has not always appeared immediately.

In discussing with Miss Abrahams the families who have been to Brentwood, it was very significant that her assessment of the mothers and their capabilities was found to confirm the health visitors' opinions in practically every case.

I give below a brief note upon the cases reviewed :—

Mrs. A was very poorly, both physically and mentally, when she was admitted. She had got to the stage where she dare not go out alone and spent most of her time weeping. She had quite a good home and a good husband. Twelve months after her discharge from Brentwood the Health Visitor's report is " now appears to be well, mentally and physically. Cares for her home and baby in a satisfactory manner."

Mrs. B. This woman was on the point of a nervous collapse following the birth of twins. The difficulty here was not that she was a careless mother, but feeling so weak and ill and with her increasing family she could not keep up her own good standard of housecraft. She had become discouraged to the point of despair. Health Visitor now reports : " Now in good health. Clean comfortable home. Children are healthy and well cared for. Former good family relationship completely restored. Mrs. B states ' if it had not been for Brentwood and my husband, I never would have got better.' "

Mrs. C. This woman was overwrought by having the continual care of three children under four years of age. Her health had deteriorated and she was becoming less careful than usual. Health Visitor now reports : " A good clean mother. General health greatly improved."

Mrs. D. This woman was separated from her husband and had the continual care of two very young children, the oldest of whom is handicapped. She was sent to Brentwood for Christmas, 1951, and returned greatly improved in general health and spirit. She has, since her return, been employed as a part-time home help, her mother having the care of her two children whilst Mrs. D is at work. Health Visitor now reports : " Greatly improved in health and spirit. Mother and two children had put on weight, the mother has maintained a better state of health and continues to care for and cope adequately with her handicapped daughter."

Mrs. E had extremely bad housing conditions. Lived near a transport depot and was in daily terror of her children being run over. Her three children were continually ailing and it was thought by the Pædiatrician that the mothers anxiety state, together with the fact that she was terrified of allowing them out of doors to play, contributed to making the children ill. Health Visitor now reports : " General improvement and seems more capable of taking care of her three children." This family has been rehoused since return from Brentwood.

Mrs. F is on the " neglected family " list. She is a widow and her youngest two children were illegitimate. Her oldest boy was in an approved school. She was sent to Brentwood for Christmas, 1951, and whilst the improvement is less spectacular in this case, both the Health Visitor and the Family Service Unit worker state that the home and Mrs. F's mothercraft have vastly improved. They are convinced that the visit to Brentwood did a lot of lasting good in this case.

Mrs. G. This woman had an intense anxiety state before her admission to Brentwood. She was herself the product of a broken home, and unfortunately little is known about her present condition as she disappeared shortly after her return from Brentwood and her husband has not seen or heard of her since.

Mrs. H. Her oldest child, John, is paralysed and almost blind. Mrs. H. was highly sensitive about this and appeared to be convinced that her husband was ashamed of the child. She was emotionally unbalanced by her divided loyalties and lavished over much love and attention on John to the exclusion of her husband. Miss Abrahams was greatly grieved that this woman quarrelled with another guest and left abruptly after only two weeks' stay. She badly needed what Brentwood had to give and could have done with staying three months. The Health Visitor reports that the conditions at home are unchanged though the children are physically well. The Almoner and the supervisor of Day Nurseries saw Mr. H shortly after Mrs. H came home ; he seemed completely unaware of his wife's emotional difficulties—apparently she is willing to discuss her difficulties with anyone but him.

Mrs. J was extremely ill on admission. She was cohabiting with a man to whom she had borne two children. She was at that time recovering from one of a series of abortions. Her legal husband and her mother had the care of her legitimate children. In contrast to Mrs. F, where the moral situation was similar, no improvement occurred in this case. Miss Abrahams felt that this was one of the very few cases known to her where there was nothing whatever to build upon. (It is interesting to note here that an almost identical statement appears in a report on this family made by the Health Visitor to the Neglected Children Co-ordination Conference). Mrs. J had no mother love, was completely indifferent about her children and indeed was quite relieved when one child developed measles and was removed to the isolation hospital. Miss Abrahams considers that with a woman so completely self-centred Brentwood could do nothing. This is the only case which we regard as a complete failure.

To Brentwood Recuperative Centre :

Mothers with 2 children	4
,, ,, 3 ,, ...	3
Mother ,, 4 ,, ...	1

To Leonard House, Colwyn Bay :

Mother with 1 child	1

Eight mothers and a total of 17 children failed to go to Brentwood after arrangements had been made.

(*d*) ADULT CONVALESCENCE. Seven adults had periods of two weeks' convalescence and seven others for whom arrangements were made failed to go.

4. **Tuberculosis.**

Five hundred and sixty-one patients (or their relatives) were interviewed chiefly in connection with their domestic problems, finances or with the issuing of certificates for food priorities.

5. **Venereal Disease.**

402 new cases were interviewed.
346 visits were paid to patients defaulting from treatment.
704 letters were sent to defaulters.

6. **Miscellaneous.**

Fifty miscellaneous interviews and ten visits are recorded—many more took place.

7. **Children Neglected in their Own Homes.**

The Almoner acts as Chairman at the Co-ordination Conferences on neglected children and an account of this work will be found in the Designated Officer's report.

HEALTH EDUCATION

The permanent Health Education Officer resumed duty in mid-February, 1952, after having been on leave of absence for the preceding eighteen months with World Health Organisation of the United Nations.

Health Education activities developed slowly in keeping with a restricted budget, but nevertheless, several important advances were made during the year.

Our Children's Health Club, run in conjunction with the local press, had an active membership of over 800 children at the end of the year. A weekly series of short biographies on the lives of famous men and women under the title of " Pioneers of Health " gave the life stories of such giants of the past as Pasteur, Lister, Florence Nightingale, Madam Curie, Banting, and ran for over thirty insertions. Other successful ventures of the Children's Health Club were a series of articles on " Food and Diet," on " First Aid," on " Healthy Living," and on " The Systems of the Body." A special film show held with the co-operation of one of the larger local cinemas was attended by over three hundred children and a Sports Day for members of the Children's Health Club attracted over 200 entries from club members.

Further experiments were undertaken in the use of visual aids particularly of rear-projection screens as an aid to group teaching in clinics and hospital out-patient waiting rooms. The demand for the use of the existing film strip projector became so pronounced that Committee approval for the purchase of a second projector was requested and obtained. The library of film strips was further increased and now houses over one hundred strips, both from home and abroad, and includes a growing section of self-produced strips. The filmstrip " Care of the Elderly " was re-made in its new and streamlined form and a number of copies of this strip have been loaned to various authorities in other parts of the country. A new strip on the " School Health Services " has been completed and widely screened.

Work is at present in progress on remaking " Problem Families " and on a new strip on the work of a Local Health Authority. When this strip is completed it will portray a brief reference to public health history over the past century and will detail the present services of a Local Health Authority and the interrelationship between the various branches of the National Health Service.

A new " Salford Handbook of Health Services " was produced at little cost to the Department and widely distributed with the object of presenting, in a concise and useful manner, a guide to the various Health Services provided under the National Health Service Act and other health legislation.

The Health Education Section is responsible for detailed arrangements for observation visits for groups of student district nurses and for lectures on Health Education to groups of student health visitors and student nurses. In addition, observation visits are arranged for post-graduate students of the Faculty of Economic and Social Studies of the University of Manchester and for overseas visitors referred through the Ministry of Health and the Manchester Regional Hospital Board. These visits although time consuming to the limited resources of the section are, nevertheless, felt to be one of the most valuable functions of Health Education.

The normal day to day activities of the section continue to increase and during the year 54 talks to organised groups throughout the City were arranged and film and filmstrip shows to meetings of staff and members of mothers' clubs and parent/teacher groups were given. The use of 16m.m. sound films for teaching purposes is seriously handicapped by the lack of suitable equipment and by the cost of its hire. Since the closure of the film service of the Central Office of Information early in the year, the use of sound film has virtually ceased, although there is large source of valuable material which could be readily used if funds permitted.

Poster displays were maintained in all centres and in display windows on Health Department premises and use was made of light display sets of the Central Council for Health Education. The active co-operation of the local press was much appreciated and short articles on a variety of subjects were published and received favourable comment.

Two very successful courses were held in co-operation with the Central Council for Health Education, one a two-day course on Mental Health, and the other an afternoon and evening course on Cancer Education. These courses which permit of the discussion group technique of evaluation are invaluable in stimulating interest and enthusiasm amongst staff.

MENTAL HEALTH SERVICE.

Annual Report, 1952.

An outline of the work undertaken by the Mental Health Service during 1952 is to be found in the Special Survey carried out in accordance with Ministry of Health Circular 29/52 elsewhere in this report. Consequently, the annual report will not be as comprehensive as is usual.

Introduction.

The fourth complete year of the Local Health Authority's Mental Health Service has now passed, and with it these features have become apparent :—

(1) The process of re-educating the general public in its attitude towards mental health has continued satisfactorily, and this attitude which was once derisive and negative, is becoming positive, thereapeutic and understanding. The process is not yet complete, but in a period of four years great strides have been made. There is a growing awareness that the mental and physical aspects of ill-health are not separate watertight compartments, but are often subtly inter-related, and are but different facets of a single complete picture.

(2) As a result of the changing attitude towards mental illness, and as more people realise the facilities offered by the Mental Health Service, more people are coming forward for advice, out-patient treatment,

or admission to mental hospital under voluntary status. Social workers are referring more cases for advice on what procedure to follow in the process of social rehabilitation where the case presents abnormal behaviour problems, and general practitioners are referring patients earlier, resulting in mental hospitalisation being avoided by earlier treatment through out-patient clinics.

(3) As a result of more people availing themselves of early treatment, long waiting lists have accrued throughout the year at hospital psychiatric out-patient clinics, it sometimes being necessary for a patient to wait up to six weeks for an apppintment to see a psychiatrist. This in some instances has proved detrimental to the patient, and cases have been known to deteriorate to such a degree as to require action under the Lunacy and Mental Treatment Acts before the appointment could be kept. This negative feature can only be met by the provision of yet more psychiatric staff and more clinics, since it is not a problem which is going to decrease without these facilities.

This overloading of existing facilities is noticeable throughout the whole Mental Health field, not only in out-patient clinics but also in the waiting lists for Mental and Mental Deficiency Hospitals. Unless the problem is investigated, proposals made and implemented, there may be a complete break-down in the Mental Health system in the country. There are three main fields in which might be favourably considered and proposals implemented on a joint financial basis by the Regional Hospitals Board and the Local Health Authorities.

(*a*) The provision of more psycho-geriatric units and the amendment of existing legislation in respect of aged persons to allow admittance to one hospital of all aged persons whatever their disability, with multi-lateral canalisation according to a person's particular needs at any given time. This would be in the interests of all old people and would leave the mental hospital beds for those urgent psychotics needing hospitalisation and allow for wider application of the principle of voluntary admission.

(*b*) The provision within the Local Authority structures of Day Hospitals or Therapeutic Centres, where early psychotics and advanced neurotics could be referred when they were in a too far advanced stage to respond to ordinary out-patient techniques alone, but could remain within the community if other therapeutic measures usually found in mental hospitals (*e.g.*, social therapy, occupational therapy, psycho-drama, etc.) were available.

(*c*) The provision of "half-way" hostels for mental defectives in urban areas so that more defectives could be placed on licence and live in these hostels until social rehabilitation has been achieved.

Staff.

During the year Mr. E. Smith, Senior Mental Health Officer, left on attaining retiring age, and was succeeded by Mr. D. Bostock. There have been no changes in establishment.

In August, 1952, a supervisor of an occupation centre was seconded for a year to attend the Course in Manchester, organised by the National Association for Mental Health for supervisors of occupation centres.

Four assistant supervisors attended a short course organised by the N.A.M.H. in London last August during centre holidays.

Mental Treatment.

On the 31st December, 1952, 1,205 patients were actively on the mental treatment registers :—

Patients in Mental Hospitals	858
Patients under active after-care supervision (visited as frequently as required)	97
Patients under suspended after-care supervision (visited approximately every 3 months)	220
Patients under active preventive supervision...	30
TOTAL	1,205

Compared with 1951 there is a decrease of 359 patients shown on the Mental Treatment register (1,205 in 1952, as against 1,564 in 1951). The number of patients shown in mental hospitals has increased by 41 (858 against 817), and the number of patients shown under after-care and preventive-care has increased by 10 (347 against 337).

The decrease in total figures is due to a revision of register ; in the annual report for 1951, 410 patients are shown as " Those for whom the Health Authority may be called upon to take action under the Lunacy Act." The section of the register consisted mainly of cases who had been into mental hospitals prior to 1948 and whose case histories were taken over by the Mental Health Service on its inception. They were kept active, but as no recurrence has shown itself in the majority of cases, 390 cases have been removed and classified as "dead" records.

The increased total number of cases in mental hospitals is mainly due to the fact that case records are now kept of voluntary patients who are admitted to mental hospitals through sources other than the Mental Health Service.

Lunacy and Mental Treatment Acts.

During 1952, 387 cases were referred to the service for action under the Lunacy and Mental Treatment Acts, of which 258 were admitted to mental hospitals.

ADMISSIONS.	*Male.*	*Female.*
Sections 16, 20, 21, Lunacy Act, 1890	88	106
Section 5, Mental Treatment Act, 1930	1	2
Section 1, Mental Treatment Act, 1930	33	28
TOTAL	258	

1. *The problem of senile psychoses* is showing signs of increasing ; this is in itself the product of a viscious circle between the chronic geriatric hospitals, the Civic Welfare authorities and the Public Health Departments. Under existing legislation, a senile patient falls into one of three clearly defined categories, *i.e.*, chronic sick, in need of care and attention, or mentally ill. There is no allowance for the person who suffers from multiple disability. Geriatric chronic hospital beds are filled to capacity. Part III accommodation will not take in a person who shows a mental aberration ; the result is that more and more old people are being referred to the Mental Health Service for certification under the Lunacy and Mental Treatment Acts. The duly authorised Officers, on being notified, have no alternative than to take action under Section 14 of Lunacy Act, 1890, in these cases, and these old people, whose only "crime" is that they have grown old, are being admitted to mental

hospitals. This is something that was not envisaged when the new social legislation was planned and needs serious examination with a view to new legislation being brought forward to protect old people, and to meet the immediate need, urgent provision of more psycho-geriatric accommodation is necessary.

2. *Other psychoses :* The increased number of old people now being admitted to mental hospital is causing a serious blockage of beds for younger psychotics. Difficulty has been experienced during the past year in getting beds for urgent, acute, maniacal or suicidal patients. As a corrollary of this, I find that the whole object of Section I of the Mental Treatment Act, 1930, is being defeated. Patients who wish to offer themselves for voluntary treatment are not able to obtain beds, and in many cases have to deteriorate to the stage where it becomes necessery for them to be admitted to hospital under an Order.

Prevention and After-Care of Mental Illness.

As previously stated, 347 patients are under the supervision of the Service, 97 are under active after-care. In these cases frequent visits, sometimes in very serious cases weekly or oftener, are required. Most of these patients are recently out of mental hospitals and are being helped in the process of social readjustment, the duly authorised Officers working as Mental Health Social Workers. A further 220 cases are under suspended after-care ; in these cases visits are paid at approximately three-monthly intervals, but in those instances where there is any sign of relapse or social breakdown, more frequent visits are paid. In the preventive field 30 cases are being actively supervised in co-operation with the patient's own doctor, where the patient is showing early signs of breakdown. This system has two advantages (*a*) it often relieves the symptoms in those cases which are thought to be socio genic in origin ; (*b*) it helps early referral to psychiatric clinic in other cases.

In the preventive field three new services are being developed (i) family guidance ; (ii) psychological illness ; (iii) Social Workers Advisory Service.

Family Guidance.

The Family Guidance Service was already in existence under the auspices of the Maternity and Child Welfare Service to deal with family problems where there is a child of under 5 in the house. The Mental Health Service now provides a Psychiatric Social Worker to deal with the socio-clinical aspect of the work when the case appears to be within the true field of psychiatric relationships.

During the three months that the Psychiatric Social Worker has been attending clinics, 15 cases have been referred for her attention.

Psychological Illness.

This is a new service provided for general practitioners to assist with those cases of ill-health which manifest physical symptoms but which are functional in origin and which general practitioners may feel be leading ultimately to a mental breakdown that may be avoided with the help of a trained Social Worker. So far, in the past three months, 6 cases have been referred, but at the time of writing this report no true idea of whether the service is proving its worth can be given, as long-term help is necessary in each case.

Social Workers Advisory Service.

This service has been inaugurated to give advice to other case workers on abnormal social behaviour and of psychiatric facilities in the process of rehabilitation. Where the case does not warrant referral to psychiatric clinic, a Psychiatric Social Worker or Mental Health Social Worker will, if requested, work in liaison with the referring Social Worker. Since 1st October, 1952, 14 cases have been referred.

Therapeutic Social Club.

This continues to develop satisfactorily. During the year, 521 attendances were recorded. The Club is run on voluntary lines by its own committee, with members of the Mental Health staff being ex-officio members. Normal social club activities are carried out, and it is proving a great help to the members. There have been instances during the year of members having attacks of hysteria or other breakdown whilst at the Club, but experience has shown that this does not cause any difficulties within the Club group. Rather it unites members more in an endeavour to help each other with their own problems. The Club is now supervised by the Psychiatric Social Worker and two Mental Health Workers. A Consultant Psychiatrist gives his services voluntarily as Psychiatric Adviser to the Club, and he often interviews patients at the Club who are not willing to visit a psychiatric clinic, with beneficial results.

Mental Deficiency.

I am pleased to report a progressive year in the field of mental deficiency. In 1948, when the duties were transferred from the Lancashire Mental Deficiency Association a large number of cases (about 200) were under minimum supervision being regarded as stabilised. These cases were transferred along with all the others, and it was decided to review them at the end of four years with a view to de-notification, four years being regarded as a reasonable period to decide whether or not social stabilisation had been achieved, and a long enough period for any signs of social breakdown to become apparent. These cases were reviewed during the year, and as a result 156 patients were regarded as satisfactorily stabilised and no longer in need of supervision.

A further 80 cases whose records had been kept but who had been lost sight of during the war and in the post-war period had also been transferred. It was decided at that time to keep the records active in case the patients were re-notified. No such notifications have taken place ; the records have also been deleted from the active register, making a total of 236 case records removed from the "active" register. A further 12 patients have either died during the year or have been lost sight of.

The relevant statistics are as follows :—

	Male.	*Female.*	*Total.*
Patients in Mental Deficiency Hospitals	194	168	362
Patients under statutory supervision	136	106	242
Patients under voluntary supervision	103	95	198
Patients on licence from hospitals	12	18	30
Patients under guardianship	1	2	3
	446	389	835

PATIENTS UNDER STATUTORY SUPERVISION.

In full economic employment	77
Attending Occupation Centres	62
Awaiting admission to Mental Deficiency Hospitals	14
Married, occupied at home or unsuitable for training	39
Unemployable or awaiting Occupation Centre facilities	50
	242

All cases under voluntary supervision are either married or in full economic employment.

CASES REPORTED DURING 1952.	*Male.*	*Female.*	*Total.*
Under Section 57 (3) Education Act, 1944 (uneducable)	4	9	13
Under Section 57 (5) Education Act, 1944 (supervision after leaving school)	2	2	4
Other sources	...	2	2
TOTAL CASES REPORTED DURING 1952	6	13	19

Occupation Centres.

Occupation Centre training is now provided for 62 patients in two Centres and a good average attendance is maintained. A further Centre is to be opened next year for adults, and with the expansion of present Centres it is hoped to provide facilities for the training of 90-100 patients. As usual Christmas Parties, to which the parents were invited, were held, and each patient received a Christmas gift from the Committee.

The grouping of patients at each Centre is based on mental age and the children are trained accordingly. This has many advantages over chronological grouping and is proving very successful, *e.g.*, at one Centre the "nursery" group contains patients whose chronological ages range from 5 years to 12 years but whose mental ages are an average 2 to 3 years. Within this group there is every grade from high-grade idiots to low-grade feeble-minded with I.Q.'s ranging from 25 to 50. Consequently, the young child with a relatively high I.Q. will proceed to the intermediate group more quickly than the older child with the lower I.Q. The immediate mental age of a child appears to have more significance than its I.Q. for the purpose of training.

Experience leads me to believe that the Occupation Centres could be successfully used for licence cases from Mental Deficiency Hospitals, who could not be found economic work but who could be cared for at home after stabilisation has been achieved in hospitals.

VACCINATION

The following particulars relate to persons vaccinated (or re-vaccinated) in Salford during the year 1952, the total number being 66 less than the corresponding figures for 1951.

Age at date of vaccination in year.	*Under 1 year.*	*1 year.*	*2–4 years.*	*5–14 years.*	*15 years and over.*	*Total.*
Primary vaccinations	1,327	57	46	44	72	1,546
Re-vaccinations	2	—	8	25	361	396
TOTAL						1,942

The primary vaccinations under one year represented 42·8 per cent. of the total live births during 1952.

In my last year's report, I drew attention to the fact that if the present arrangements for vaccinating the public are intended to secure a high percentage of vaccination of the population as a whole, they are very inferior to those which obtained prior to the introduction of the National Health Service Act, 1946.

Recent outbreaks of smallpox in Lancashire and Yorkshire are convincing evidence of the dangers, even though they may seem to be sporadic, of the spread of the disease among a largely unvaccinated population.

It is satisfactory to know that when the disease appears the public willingly respond to the Health Authority's request for vaccination on a large scale ; but this is not enough. The risks of an outbreak are much less if the public is already well vaccinated. Doctors' surgeries would not be overwhelmed, and their practices completely disorganised, if the majority of the people were already vaccinated ; nor would local health authorities, which, in times of an outbreak of smallpox, need to concentrate all their efforts on tracing and securing the vaccination of contacts, have to face the heavy addition to their burden of setting up special clinics for large-scale vaccination.

I feel that there is justification for the inclusion in local health authorities' activities of the permanent provision of means of vaccinating any member of the public who applies to them for that purpose.

IMMUNISATION.

Appended are statistics relating to immunisation in Salford during the year 1952 :—

	0-5 *years.*	5-15 *years.*	0-15 *years.*
Number immunised January to December, 1952...	2,490	134	2,624
Total immunised at 31st December, 1952	11,606	25,901	37,507
Total immunised at 31st December, 1951	12,847	24,513	37,360
Population figure 1952	15,700	26,000	41,700
Per cent. immunised at 31st December, 1952... ...	73·9%	99·6%	89·9%
Per cent. immunised at 31st December, 1951... ...	76·3%	97·7%	89·1%
Per cent. increase	...	1·9%	0·8%
Per cent. decrease	2·4%	...	...

The children were immunised as follows :—

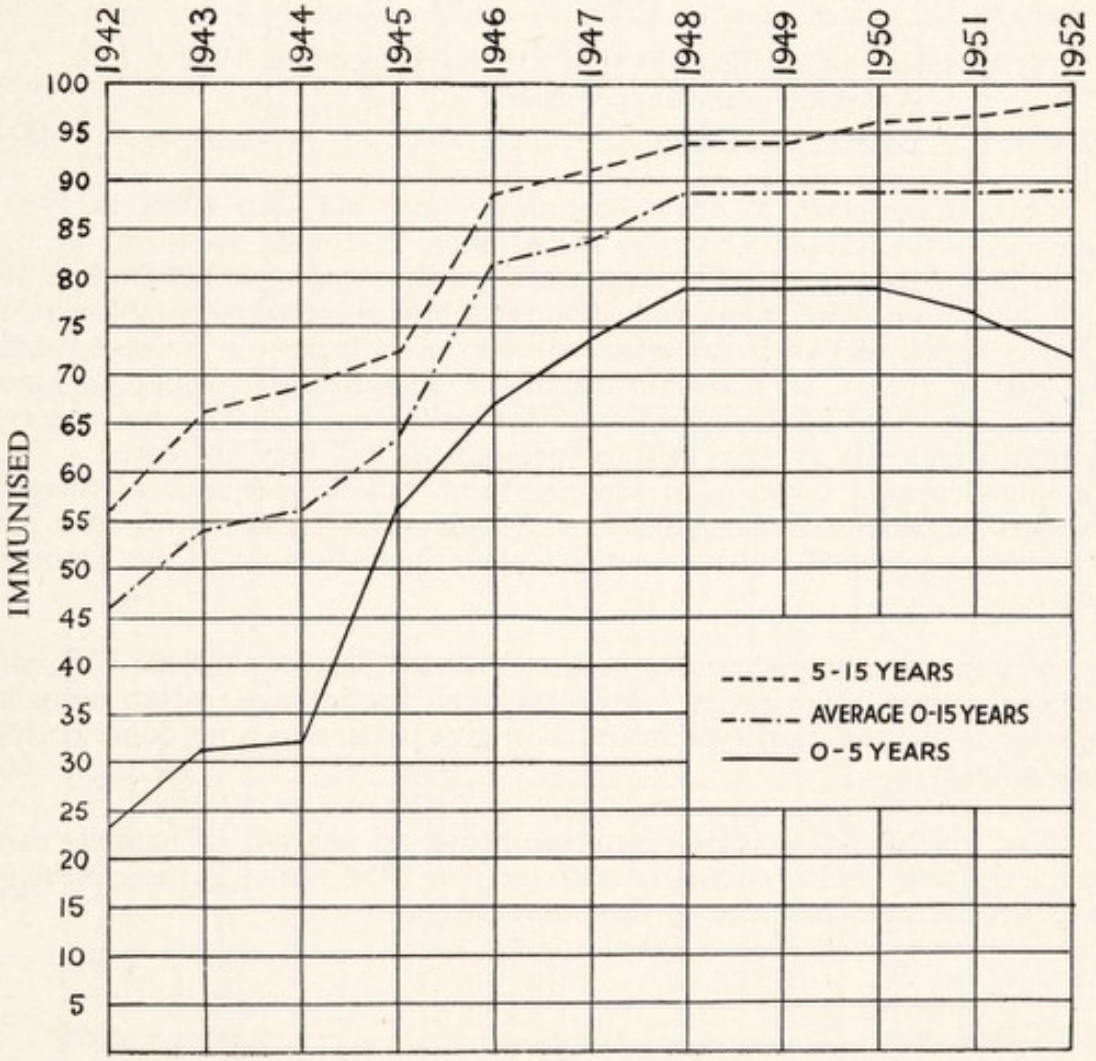
At Child Welfare Centres...	1,370
By Health Visitors and Nurses of the Local Authority at their homes	797
By Nursing Staff at schools	128
By General Practitioners	324
At Day Nurseries	2
At Hospitals...	3
TOTAL	2,624

It is satisfactory to note that no cases of reaction following immunisation were experienced during the year.

No cases of diphtheria occurred in Salford during 1952.

It is a matter for regret, however, that the percentage of children immunised in Salford at 31st December, 1952, is lower than that obtaining at 31st December, 1951. It is hoped during 1953 to make a special effort to recover the lost ground. It is feared that this reduction is due almost entirely to the fact that of recent years parents of young children have developed a sense of security from the risk of diphtheria owing to its virtual elimination by immunisation of such a large percentage of the young population. Efforts will be made to bring home to parents the truth that failure to have their children immunised will in all probability result in the loss of security.

Appended is a graph relating to diphtheria immunisation in Salford between 1942 and 1952, both years inclusive.



AMBULANCE SERVICE

The arrangements approved by the Council for the operation of the Ambulance Service whereby the Director of the Central Garage, who is responsible for its day to day control, continued during 1952. The appended particulars apply to that year.

(1)	Number of vehicles in use at 31st December, 1952 :	
	Ambulances	11
	Sitting case ambulance	1
	Sitting case cars	3
(2)	Total number of patients carried during the year	55,866
(3)	Total mileage during the year :	
	Ambulances	166,738
	Sitting case cars	49,431
	TOTAL	216,169
(4)	Number of whole-time staff at 31st December, 1952 :	
	Assistant ambulance officers	2
	Drivers/Attendants	43

Certain measures to effect economies were put into effect in 1952 as indicated in the Survey Report to the Ministry of Health appearing on pages 121 to 122 of this report. The short period of time during which these arrangements have been effective has made it impossible to prepare any reliable statistics, but it is hoped that their full effect will become apparent in mileage, staffing, etc., during 1953. To a certain extent the anticipated reduction in mileage has been negatived by the operation of the bed bureaux of the hospital services through which the average mileage per patient has been increased. This is not intended as a criticism of these services, but the despatch of increasing numbers of patients to hospitals at a considerable distance from their places of residence is bound to have an effect upon the economies of the Ambulance Service.

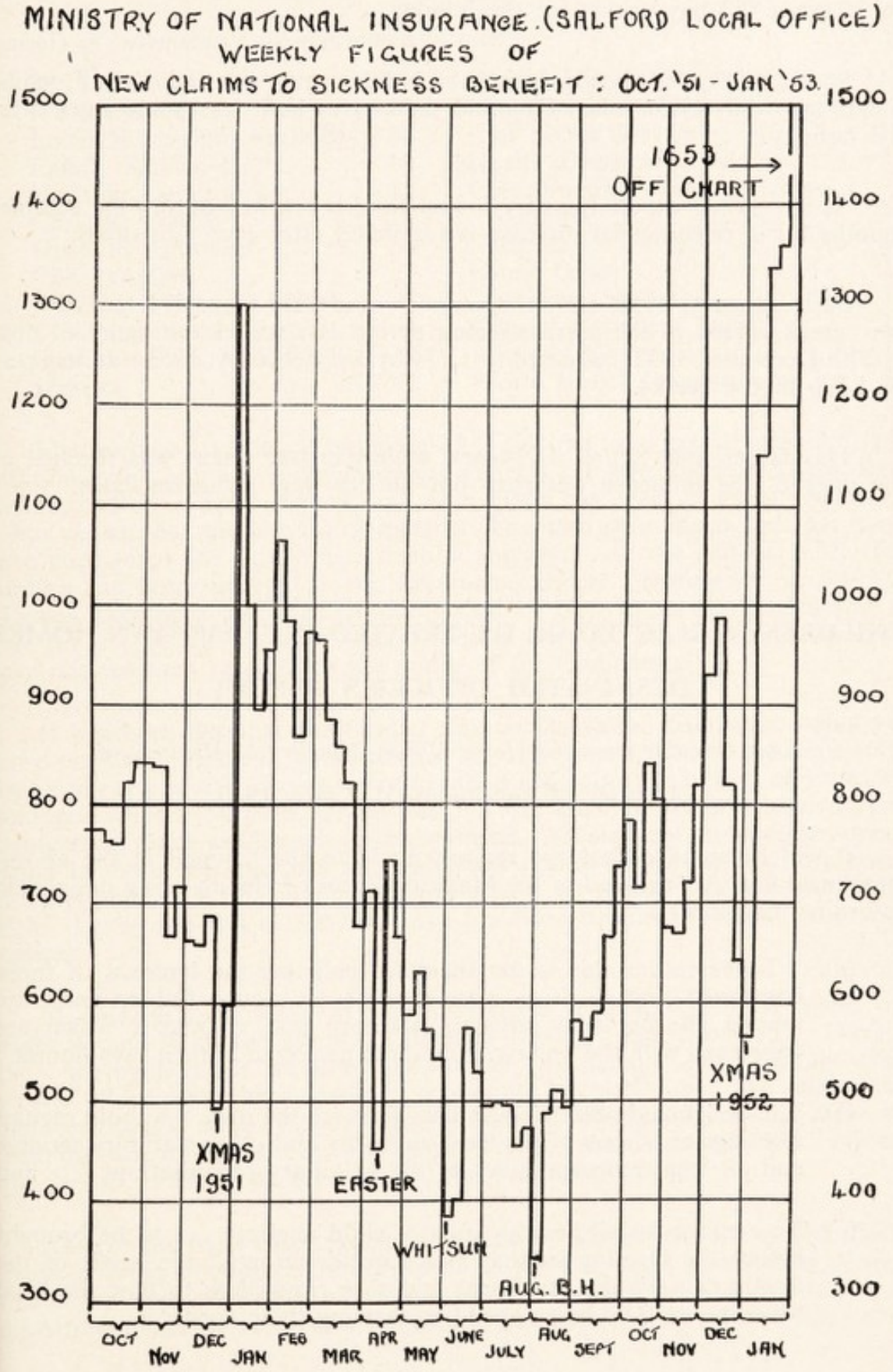
The increase in the number of long distance journeys led the Committee, during the year under review, to decide upon the purchase of an ambulance superior to the standard type in order to give patients greater comfort during long journeys.

For ease of reference, I reproduce below an analysis of patients carried during the year 1952 as compared with the year 1951, although these particulars have already been included in the Survey Report.

	1952	1951
Spastic	4,552	4,113
Midwifery	2,242	2,475
House conveyance	39,994	41,969
Inter-Hospital	3,354	3,842
Maternity	1,829	1,699
Gas and air	391	210
Mental	261	165
Infectious	719	803
Emergency	2,494	2,365
Rechargeable to other areas	30	12

New Claims to Sickness Benefit (Salford)

With the co-operation of the local officers of the Ministry of National Insurance, close observation is kept on the weekly " New Claims to Sickness Benefit " by insured persons of Salford. The accompanying chart which covers the period October, 1951, to January, 1953, presents an interesting picture.



The figures dropped to their first " low-level " at Christmas, 1951, and this fact repeated itself at each public holiday. I understand that this drop in claims before a public holiday is a common feature throughout the country.

There may be different opinions of the reason for this. It may be that some persons, who do not get full pay when off sick, hasten back to work to ensure a full pay packet for the holiday.

Some, briefly indisposed during the holiday, may not claim at all, whilst others may only claim when they find themselves unfit to resume work after the holiday.

As we should expect the very lowest level is reached during the summer months but a phenomenal increase is registered after each Christmas.

Early January, 1952, shows a jump of over 800—from 494 to 1,300—in two weeks, whilst in the corresponding period last winter the figure of 568, at 30th December, 1952, increased to 1,774 by 3rd February, 1953—an increase of 1,206 in five weeks.

This remarkable figure, 1,774 new claims in one week, was reached at the peak of the influenza outbreak but not all were influenza cases.

CHILDREN NEGLECTED OR ILL-TREATED IN THEIR OWN HOMES

DESIGNATED OFFICER'S REPORT

Joint Circular from the Home Office, Ministry of Health and Ministry of Education—31*st July*, 1950

It will be recalled that the request made to the Council in the above-mentioned Circular resulted in the Medical Officer of Health being designated co-ordinating officer.

(*a*) " To be responsible under them for enlisting the interests of those concerned and devising arrangements to secure full co-operation among all the local services, statutory and voluntary, which are concerned with the welfare of children neglected in their own homes."

(*b*) The designated officer is also charged with the duty " to hold regular meetings of officers of the local authority and other statutory services and all local representatives of the voluntary organisations " ; and

(*c*) To arrange for significant cases of child neglect . . . . to be brought before the meeting so that after consideration of the needs of the family as a whole, agreement might be reached as to how the local services could be best applied to meeting these needs.

Regular Co-ordinating Conferences have accordingly been held since June, 1951, and 115 families brought up for discussion.

During 1952, members have met on 22 occasions and the following is an analysis of attendances made by the representatives of the organisations, namely :—

Analysis of attendances by representatives of—

N.S.P.C.C.	31	Mental Health Department ...	11
Probation Officer	17	Manchester and Salford Council of Social Service	21
Local Education Authority	21	Health Department M.O's ...	3
Family Service Unit	18	Co-ordinating officer or representative	23
Housing Department... ...	12	Manchester University	6
Children Office	16	Home Office	2
Hospital Almoners	6	Greengate Hospital	1
Civic Welfare	7	District Provident Society ...	1
National Assistance Board...	5	Ministry of Pensions	1
Child Guidance Clinic ...	4	World Health Organisation ...	3
Specialist Health Visitor ...	19		
District „ „ ...	47		

The average attendance has been 12·5 and the total attendance 275. In addition to this number many University students and other interested observers have attended. The continued high attendance has been an encouragement. It has shown that the interest of members has been maintained and that they have considered the Conference method valuable. At the end of 1952, 169 families had been reported to the Designated Officer. During the year 1952, 53 cases have been discussed on one occasion, 14 twice, 6 three times and 1 four times. In the previous year, 41 cases were discussed and 54 families have not yet been brought to the notice of the Conference.

It has been felt that the limited time available for discussion would be more profitably spent in going deeper into the circumstances and reviewing the families on several occasions, rather than skimming the surface of a greater number. Of the 54 cases which had not yet received the attention of the Conference, many are known to be stabilised. All are kept under close supervision by both the statutory and voluntary bodies concerned and any crisis or deterioration in the families' affairs would be speedily known and dealt with. Up to the end of 1952 no case has been officially removed from the register.

A detailed description of the Conference procedure will be found on pages 96 and 97 of the Medical Officer of Health's report for 1952. During 1953, the method has remained substantially the same, though perhaps even greater efforts have been made to economise on staff time. An endeavour has been made to ensure that all the cases on the Conference agenda are gathered from one district so that only one district health visitor, one N.S.P.C.C. officer, one N.A.B. officer, one Housing Officer, etc., need attend.

One of the most cheering aspects of the work has been the united efforts made to avoid eviction for non-payment of rent. From a social point of view this more than any other crisis completely disrupts the family and has a disastrous effect upon children. From an economic point of view the result

of eviction is equally disastrous. No member of the Conference would condone a state of affairs where arrears of rent are continually overlooked. Nevertheless, it would appear to be bad economics to evict a family from a Corporation-owned or requisitioned house for owing say £20, when the cost of maintaining the same family in Part 3 accommodation and Children's Homes could easily cost the community that amount the very next week. Some children have remained in care for long periods following eviction at great cost to rate and taxpayers, even in cases where their parents have paid the assessed contributions.

Arrangements have now been made with the Housing Officer to acquaint the Conference with details of rent arrears before they reach such proportions as to warrant an application to the Magistrates for an eviction order. Co-ordinated efforts are then made by the appropriate workers to add their helpful pressure to that of the Housing Officers, and by advice and assistance on proper budgeting to ensure that the rent is paid regularly. Much help has been given by the officials of the National Assistance Board in this matter and in some instances arrangements have been made to pay the rent allowance direct to the Housing Officer. At least two families, one having nine children and the other six, have been preserved as a family unit by these methods.

It would be too optimistic, however, to assume that such methods will meet every case. Neglectful families do not live all in houses managed by the City Housing Committee, and it will be a long time before private landlords can be expected to consider it a social duty to keep the family intact though in arrears.

The process of building up family records from contributions made by workers dealing with individual aspects of a family will be one of the most valuable results of co-ordination. It will enable newcomers to the services to have the benefit of the knowledge acquired by their predecessors. It is thought that most members of the Conference would agree that their knowledge of this subject has been enlarged and they have been stimulated in their determination to find a remedy for this depressing social sickness Views have been changed, opinions modified and some really effective work has been done. There is, however, no place for complacency in this work. Our few successes will be the result of hard and intensive work. We will work just as hard and just as intensively on what will appear to be our failures, hoping always that the next generation of parents will be improved as the result of our labours.

Co-ordination has achieved some success, but is not in itself enough. It must be followed up by action, frequently unorthodox action, and persistence. Workers are still handicapped by having too great a case load. Part 3 accommodation is almost everywhere inadequate and unsuitable to cope with the problem of the evicted. It is in any case only resorted to when disaster has overtaken a family and broken it up. Perhaps the need is for large sub-let houses in which several families could be housed with adequate supervision. Many families seem to need almost daily visiting—the type of work done by the Family Service Unit. Present legislation, which is largely designed for dealing with mature adults, is very little help to workers dealing with the immature parents of a large family. It is quite futile to punish such parents for failing to play the game when they are incapable of learning the rules.

Families registered who are known to—

Health Visitor	169
N.S.P.C.C.	95
Local Education Authority	39
Probation Officer	30
Family Service Unit	13
Children Department	25

Families known to—

1 Agency	38
2 Agencies	39
3 ,,	50
4 ,,	33
5 ,,	7
6 ,,	2
TOTAL	169

SPECIAL SURVEY OF SERVICES PROVIDED BY THE SALFORD LOCAL HEALTH AUTHORITY UNDER THE NATIONAL HEALTH SERVICE ACTS

(*In accordance with Circular* 29/52 *dated* 19*th August*, 1952, *from the Ministry of Health*)

General

1. **Administration.**

The headquarters of the Local Health Services are in the Public Health Department, 143, Regent Road, Salford, in which are accommodated the Medical Officer of Health and all the officers mentioned below with the exception of the Superintendent of Home Nursing who operates from the Royal District Nurses' Home, which is situated less than one mile from the Health Department. Close and daily contact is maintained between all these officers.

As Salford is a compact area, no Area Sub-Committees have been appointed.

There are no joint arrangements with other local health authorities apart from a small-scale arrangement with the Lancashire County Council, whereby a few suitable cases from an adjoining division of that Council are admitted to one of this local health authority's occupation centres for mental defectives.

The Local Health Services are subject to the general direction and control of the Medical Officer of Health, who is responsible to the Local Health Authority for their organisation and administration. His duties include, of course, co-ordination of the various services.

For administrative purposes, the responsibilities are delegated as follows :—

(*a*) The Senior Maternity and Child Welfare Medical Officer is responsible for the supervision and detailed co-ordination of the undermentioned activities—

Care of expectant and nursing mothers and children under school age, including Day Nurseries.
Domiciliary Midwifery.
Health Visiting.
Home Nursing.

She is assisted in the control of these services by a number of Assistant Medical Officers of Health and School Medical Officers whose services are interchangeable as between the Health and Education Departments. The time devoted to care of mothers and children is equal to approximately four and one half whole-time medical officers in addition to the Senior Maternity and Child Welfare Medical Officer.

One Superintendent of health visiting and nursing staff (whose duties include the supervision of the school health nursing staff).

One Deputy Superintendent Health Visitor.

One non-medical Supervisor of Midwives.

One Supervisor of Day Nurseries.

One Superintendent of Home Nursing.

Close contact is maintained between the Senior Maternity and Child Welfare Medical Officer and the above-mentioned senior officers.

(*b*) Vaccination.

Records received from medical practitioners are filed for record and payment purposes by clerical staff. Particulars of these records are regularly furnished to the health visiting staff. Health Visitors devote special attention to cases of young children who have not been vaccinated, with a view of persuading their parents to allow their children to be vaccinated.

Vaccinations of infants is carried out in Maternity and Child Welfare Clinics on a small scale.

Registrars of Births are supplied with documents on vaccination for issuing to parents when registering births.

(*c*) Immunisation.

A separate section of the clerical staff devotes itself whole-time to the keeping of records and providing information relating to the progress of immunisation against diphtheria. Close contact is maintained with the medical and health visiting staff concerned.

(*d*) Prevention, Care and After-Care.

This work is closely co-ordinated by means of interchange of information, close personal contact, and conferences at which the appropriate medical staff, health visiting staff, the department's almoner and senior administrative staff attend.

(*e*) AMBULANCE SERVICE.

While the Health Committee of the local health authority is responsible for the control of the ambulance service, its day to day operation has been delegated by the local health authority to the Central Garage Committee whose chief officer (the Director of the Central Garage) is responsible for the immediate supervision of its activities. Daily contact is maintained at officer level between the Central Garage and the Health Departments, and a joint sub-committee for controlling the service has been formed, which meets monthly and on special occasions as required.

(*f*) DOMESTIC HELP.

This service is under the direct supervision of the department's almoner who combines this work with her other duties. She reports directly to the Medical Officer of Health.

(*g*) MENTAL HEALTH.

This service is under the direct supervision of the Senior Mental Health Officer who is responsible to the Medical Officer of Health.

(*h*) LAY ADMINISTRATION.

A chief Administrative Assistant is employed with responsibility to the Medical Officer of Health for the lay administration of the whole of the Department, including control of clerical staff.

2. Co-ordination and Co-operation with other parts of the National Health Service.

The following statement summarises the methods adopted in Salford for dealing with this question.

(*a*) At authority level co-ordination and co-operation has been maintained since July, 1950, by means of the Salford Health Services Joint Advisory Council which has met at approximately two monthly intervals. Appended is a summary of the principal items dealt with by the Council since its formation.

1. APPOINTMENT OF PHYSICIAN WITH SPECIAL DUTIES RELATING TO CHRONIC SICK AND THE AGED. Much consideration was given to this subject, which was raised in the first place with the intention of providing a special service for the sick and aged at home. Ultimately the matter was considered by the Hospital Management Committee, who made a recommendation to the Manchester Regional Hospital Board, as a result of which it was decided to appoint a whole-time consultant physician with responsibility for out-patient clinics at Hope and Ladywell Hospitals, with charge of 50 beds at Hope Hospital and the chronic sick at Ladywell. The consultant is also required to take a special interest in the care of the chronic sick, to visit patients in their homes and establish a close liaison with general practitioners and with the local health authority in regard to the care of the chronic sick. In this connection, the local health authority expressed to the Regional Hospital Board their intention of co-operating to the utmost possible extent.

A panel, consisting of the consultant and appropriate officials of the local health authority, meets at regular intervals to discuss problems arising in connection with the care of the aged sick.

2. Ambulance Service. Consideration has been given from time to time to the possibilities of effecting economies in this service, without reducing its efficiency. Consultations have taken place at officer level, with the result that there has been close co-operation between officers of the Ambulance Service and of the Hospital Management Committee, following which important reductions in mileage have already taken place ; it is hoped to effect still further economies in the near future.

3. Infective Pulmonary Tuberculosis. Attention has been given to this subject by the Advisory Council and, following representations by the Medical Officer of Health, the Hospital Management Committee prevailed upon the Regional Hospital Board to give authority for the provision of 20 more beds at Ladywell Hospital. A panel, consisting of the consultant tuberculosis physician and officers of the local health authority meets regularly and much useful work has been done.

Representations have been made to the Regional Hospital Board as to the desirability of sending patients to sanatoria nearer to their homes. These representations have been received sympathetically and it is hoped that, by degrees, many patients will receive consideration in this respect.

4. Group Medical Practice. Much thought has been devoted to this subject, and in point of fact, the Council is agreed as to the desirability of the introduction of Group Medical Practice in Salford. Up to the present a variety of circumstances has prevented the translation of that desire into practice. The matter, however, is kept under constant review, and it is hoped and believed that progress will be made.

5. Physiotherapists. The local health authority have been able to give assistance to the Hospital Management Committee by making available the services of physiotherapists at Ladywell Hospital when the Hospital Management Committee was handicapped by shortage of staff.

6. Chiropody Treatment for the Aged. The advisory Council was able to suggest methods by which treatment of this nature could be made available for older people who could not make their own way to clinics.

7. Recruitment Campaign for Nurses. Following discussion by the Council, general practitioners and the local health authority gave assistance to the Hospital Management Committee in connection with this campaign by the display of posters, etc., in their respective premises.

8. Amenity Beds. With the approval of the Advisory Council an informative circular, dealing with this subject, was prepared and forwarded to all general practitioners practising in Salford and district.

9. Laboratory Facilities for General Practitioners. Subsequent to the raising of this subject by a general practitioner at a meeting of the Joint Advisory Council, the Hospital Management Committee's Pathologist addressed a meeting of general practitioners on the subject of the use of laboratory services, and made available facilities whereby general practitioners could send their patients to the laboratory for investigation.

10. Collaboration of Staff. The following are instances of freedom of discussion between the staffs of the local health authority and the Hospital Management Committee.

(*a*) The Senior Medical Staffs of the hospitals and the local health authority have met frequently in order to discuss such matters as the maternity service.

(*b*) Visits by assistant medical officers of the local health authority have been paid to the pædiatric wards of Hope Hospital, accompanying the consultant pædiatrician on his rounds.

(*c*) Visits have been paid to the Health Department by student nurses of the hospitals, with a view to giving them an insight into the preventive and public health aspects of the Health Service. Talks have been given to nurses at the hospitals by staff of the Health Department, with a view to emphasising the importance of home and social environmental factors in the causation, prevention and treatment of diseases in patients admitted to hospitals.

(*d*) Health Visitors, acting as liaison officers, make twice weekly visits to children's wards to see tonsil and adenoid cases in children and child orthopædic patients ; to discuss with the Ward Sisters and Almoner's department, the home and social conditions and any special diet or medical care desirable for the young patients on discharge. These particulars are then conveyed to the District Health Visitors, who find the information of great value in " follow-up " visiting. Talks are given regularly to patients in the out-patients department in one of the local hospitals.

11. PREMATURE BABIES. The mother of every baby prematurely born in Hope Hospital is visited by a nurse before discharge, in order that home and social conditions, as well as feeding difficulties for the child, can be dealt with adequately.

12. The " ADDENBROOKE SCHEME " for the early discharge of patients from hospital has been discussed at length. Agreement on the part of the Local Medical Committee and the Medical Advisory Committee of the Salford Hospital Group has been obtained in principle, subject to certain provisos, as a limited experiment.

13. THE RELATIONSHIPS IN PRACTICE BETWEEN DOCTORS, MIDWIVES, AND HEALTH VISITORS. This subject is under continuous consideration.

14. A scheme for the direct referral of patients to X-ray Departments, by family doctors, is under active consideration.

15. The Council is being kept informed at each meeting as to progress which is being made in connection with the forthcoming intensive mass miniature radiography survey in Salford, by which means it is hoped to secure the co-operation of all local sections of the health service.

A number of other subjects have been discussed from time to time, such as the question of the establishment of the Night Sanatoria, provision of convalescent treatment, economical disposal of unused drugs and dressings, etc.

It is clear, of course, that a certain proportion of the liaison between the hospital and local health authorities, referred to above, might have taken place if the Joint Advisory Council had not been established, but it is believed that the existence of that Council has helped to develop and foster a closer relationship than would have existed but for its formation.

Perhaps the most important point arising out of the creation of the Advisory Council is that in Salford the three branches of the Health Service are now linked together, loosely, it is true, but nevertheless sufficiently strongly to permit of the mutual transmission of ideas and the making of arrangements relating to subjects of vital importance to the services. The very looseness of the link is, in some ways, of advantage, by its avoidance of the necessity for formal agreements. All that is now needed is that the work of the Advisory Council should be continued and extended.

(*a*) General practitioners are supplied by the medical officer of health with a weekly bulletin dealing with appropriate subjects.

(*b*) As indicated later, particulars of facilities available for vaccination and immunisation are supplied to registrars of births for issue to parents when registering the births of their children. A birthday card is forwarded to the parents of children attaining their first birthday, together with particulars of the child welfare services.

(*c*) A guide to the local health services is issued periodically. Copies of this guide have been forwarded to all general practitioners, and others will be made available to the public as widely as possible.

(*d*) A Health Education Officer has been appointed whose duties include the giving of lectures upon the various health services to meetings of local organisations.

3. **Joint Use of Staff.**

Doctors engaged in general practice have been employed to a limited extent on a sessional basis. At the present time three of such doctors are employed for a total of three sessions per week in connection with the care of mothers and young children.

Three twenty-seconds of the salary of the Chief Tuberculosis Physician is paid by the local health authority to the Manchester Regional Hospital Board on account of his services in connection with prevention of illness, care and after-care. Up to the present, it has been fortunate that the tuberculosis physician and his staff, and the staff of the local V.D. Treatment Centre have been housed in the same building—the headquarters of the local health authority's service. It has been possible, therefore, to maintain close personal contact at officer level with these activities and the work has been co-ordinated to a very great extent, for example, in the case of the V.D. Treatment Centre, the almoner and another member of her staff have a very close working arrangement with the staff of the V.D. Treatment Centre in connection with the supervision of cases requiring after-care, plus the tracing of contacts, and the follow-up of defaulters.

A consultant psychiatrist of the Regional Hospital Board gives much assistance on a voluntary basis with a therapeutic social club established by the local health authority in connection with their Mental Health Service.

The equivalent of the services of one half-time health visitor are given to the Chest Clinic.

4. **Voluntary Organisations.**

Following is a list of some of the voluntary agencies whose services have been sought for the benefit of Salford residents. A close and friendly liaison is maintained between the Almoners, Health Visitors and officials of these organisations, and in most instances there is a two-way referral of cases.

WOMEN'S VOLUNTARY SERVICE provide a " meals-on-wheels " service at present limited to 30 meals on one day each week ; conduct Derby and Joan clubs in various parts of the City ; run a clothing depot and supervise houses which had been converted into flats tenanted by elderly women.

BRITISH RED CROSS SOCIETY provide special invalid foods, occupational therapy, bedding and clothing.

MANCHESTER AND SALFORD COUNCIL OF SOCIAL SERVICE have a panel of visitors for the aged and provide certain amenities for them.

MORAL WELFARE ASSOCIATIONS of all religious denominations are used on behalf of unmarried mothers, children in moral danger and patients attending the Venereal Diseases Clinic.

MANCHESTER AND SALFORD DISTRICT PROVIDENT SOCIETY conduct an adult convalescent home at Southport and have on several occasions given financial help to families referred to them, e.g., paid off arrears of rent and averted eviction of a problem family.

WOOD STREET MISSION provide clothing and holidays for children.

SALFORD POOR CHILDREN'S HOLIDAY CAMP provide a week's holiday for necessitous schoolchildren during the summer months, about 60 are taken each week. The camp is made available by special arrangement to the School Health Service during several weeks each year for handicapped children.

NATIONAL SOCIETY FOR THE PREVENTION OF CRUELTY TO CHILDREN inspectors and workers are in constant contact with officers of the health services and regularly attend the Case Conferences in respect of children neglected or ill-treated in their own homes.

FAMILY SERVICE UNIT undertake the care of a number of problem families referred by the Health Department staff. There has been a very close and valuable liaison between the Manchester and Salford F.S.U. and the Local Health Services over the past ten years. The Medical Officer of Health is chairman of the Executive Committee of the Manchester and Salford F.S.U.

SOLDIERS', SAILORS' AND AIRMEN'S FAMILIES ASSOCIATION give advice and financial help to service and ex-service men's families.

LANCASHIRE AND CHESHIRE COMMUNITY COUNCIL admit Salford women and their children to the Brentwood Recuperative Centre.

CRIPPLES' HELP SOCIETY provide invalid chairs, holidays, outings, etc.

GOOD NEIGHBOURS' SOCIETY arrange for " sitters in."

CATHOLIC NEEDLEWORK GUILD provide new clothing for cases referred to them.

PRISONERS' WIVES AID ASSOCIATION give help to Salford cases.

MARRIAGE GUIDANCE COUNCIL give help and advice to cases referred by the medical officers, health visitors and almoner.

THE HOME PHYSIOTHERAPY SERVICE is carrying on invaluable work particularly with elderly people.

THE SALFORD COUNCIL OF SOCIAL SERVICE helps in many ways.

GREENGATE HOSPITAL AND OPEN-AIR SCHOOL.

Mention must be made of the wonderful work which has been accomplished in Salford over a period of many years by this voluntary hospital and open-air school. Opened originally to provide treatment and schooling for children suffering from rickets, the hospital now treats debilitated and under weight children, provides schooling during weekdays, and yet successfully maintains the home lives of the patients by permitting them to reside at home during the weekend.

Particular Services

5. Care of Expectant and Nursing Mothers and Children under School Age.

EXPECTANT AND NURSING MOTHERS.

ANTE-NATAL AND POST-NATAL CARE.

Ante-natal and post-natal sessions are held at seven of the Maternity and Child Welfare Centres in the City, an average of 68 sessions per month. These are attended by Health Visitors and Clinic Nurses, as well as by Medical Officers. The number of mothers attending for post-natal examination has been considerably reduced, as so many of the General Practitioner Obstetricians carry out these examinations.

Samples of blood for Kahn Tests, Rhesus Factor and Hæmoglobin Estimations are taken at the mother's first attendance at the clinic in early pregnancy.

Patients with suspicious vaginal discharge are referred to the Special Clinic, or to hospital for examination and treatment.

Mineral and Vitamin preparations are supplied free to mothers requiring them.

THE UNMARRIED MOTHER.

A special worker, who is a health visitor, is appointed for this work. Cases are notified by Medical Officers from ante-natal clinics, by midwives, health visitors and from the hospital ante-natal clinics. The duties of the special worker include the interviewing of expectant unmarried mothers and their relatives, either in office or home ; dealing with social problems which may arise ; contacting, if necessary, any appropriate social agency ; maintaining a register of unmarried mothers and of illegitimate children classified according to the type of home and care ; dealing with correspondence relating to the unmarried mother or her child, arranging for confinement, admission to Home or Hostel ; assisting with preparation for Court hearing of applications for Affiliation Orders. When immediate problems are solved, the mother and child are referred to the district health visitor who keeps the special worker

informed as to progress and home circumstances, and consults her should any further problems or difficulty arise—in which case the special worker may, in collaboration with the district health visitor, take further action. Close contact and full co-operation is maintained with the special health visitor for the child neglected in his own home.

MOTHERCRAFT TRAINING is given by Health Visitors. Cookery demonstrations are given during ante-natal sessions at three of the Centres, and a sewing class is held at one Centre (see Domiciliary Midwifery Section).

MATERNITY OUTFITS, which conform to the Ministry of Health's recommendations, can be obtained by all mothers booked for domiciliary confinement on production of a signed form given by a midwife.

Child Welfare

There are ten centres in the City, at which child welfare sessions are held, the number of sessions held per month being 96.

A consultant child welfare clinic attended by the Pædiatrician of the Salford Hospital Groups is held weekly at one centre. Assistant Medical Officers attend this session in turn.

Special Toddler Clinics are held at nine of the centres. To these, children between the ages of one to five years are invited for medical examination at or about their birthdays. Of the 8,852 children invited in 1952 some 3,556 attended (40 per cent.).

CARE OF PREMATURE INFANTS.

The staff employed for the care of the premature infants in the home consists of two specially trained premature baby nurses who are both State Registered General Nurses and State Certified Midwives.

The premature baby nurses are responsible for the following infants :—

(*a*) All infants weighing 5½ lbs. and under at birth who are born in their own homes, with the exception of the very small or feeble babies who are immediately transferred to hospital. (Information regarding the latter infants is obtained through a health visitor who acts as a liaison officer between the hospital and Health Department).

The midwife attends the birth, obtains the specially heated cot and informs the Supervisor of Midwives, who in turn conveys the message to the premature baby nurses. The latter immediately take over the nursing care of the infant until satisfied with its progress which is often a matter of weeks.

On discharge the infant's record is handed to the Health Visitor for inspection and finally returned to the Premature Baby Service. In this way no duplication of visits or advice is given and continuity of care is ensured.

(*b*) All infants weighing 5½ lbs at birth who lose weight to a point below that level or show evidence of immaturity or feebleness.

(*c*) All infants weighing 5½ lbs or under at birth who have been born in hospital but require special care after discharge.

The Premature Baby Nurses make special visits whenever possible to the hospital, and the patient's home to obtain full information necessary to ensure adequate care and continuity. This is a most useful and important aspect of the work but has been difficult to maintain when staff shortages either on the district or in hospital have occurred.

Equipment. The following items are for the use of the premature infant nursed in the home :—

Seven single cots with mattress (horse-hair).
One twin cot ,, ,, (,,).

Linen.
1. Cot linings made of calico.
2. ,, ,, ,, ,, blanket.
3. Nestling blankets.
4. Cot mattress covers.
5. ,, thermometers.
6. Rubber sheets.
7. Rubber hot water bottles (three per cot).
8. Gowns and masks.

Nursing equipment.

1. Aluminium nursing bags with waterproof covers containing the usual nursing equipment plus special items such as sterilised olive oil and low reading thermometers.
2. Boilable denbar plastic sheets on which to lay nursing equipment (one is left in each home).
3. Apparatus for the administration of oxygen (kept at the ambulance station).
4. Special union flannel gowns with attached hoods for the smaller infants.
5. Weighing scales for accuracy for the purpose of statistics.

Records. A special record card is kept for every infant dealt with by this service.

Headquarters. The premature baby nurses have the use of an office, bagroom and storeroom which are situated in the same building as the Part II Training School.

Supply of dried milks, etc. Dried milk (including national dried milk) is on sale at all welfare centres, as far as possible on days on which welfare sessions are held. Facilities are given at the centres to the Ministry of Food for the distribution of cod liver oil compound and organge juice.

Other infant foods, e.g., weaning cereals, are also on sale at the centres.

Dental Care.

Expectant mothers. This is carried out by the School Dental Service by arrangement with the Education Committee. It has not been found possible to organise a full scheme, owing to shortage of staff, but arrangements have now been made for each expectant mother to have an examination by a Dental Surgeon at, or soon after, her first attendance at the Local Authority Ante-Natal Clinic. Arrangements are then made for the treatment required.

Pre-schoolchildren. Children attending welfare centres, day nurseries, and nursery schools are referred by medical officers for dental treatment when required. It has not been found possible to arrange for routine dental inspection of these children.

OTHER PROVISIONS.

PSYCHOLOGICAL SERVICE. An experienced psychological worker attends the child welfare sessions and one ante-natal session. Mothers and pre-school-children showing some disturbance (anxiety, etc.) are referred to the worker by medical officers and health visitors. Talks are given to small groups of mothers in the clinics, and individual mothers are seen by appointment. This is an attempt at preventing the development of the " problem child," and thus reducing the numbers who have to attend child guidance clinics. The worker has ably dealt with the majority of these mothers, but she refers to the proper service those requiring more thorough investigation.

The total attendance at these sessions during 1951 was 1,128.

ENCOURAGEMENT OF BREAST FEEDING.

A nurse who is an S.R.N. and midwife, has been appointed to visit cases of difficult breast feeding in their own homes, and to supervise and advise on the feeding. She also attends ante-natal clinics, where she talks to the mothers on the care of the breasts, and preparations to be made for breast feeding.

A breast-feeding clinic will be established in the future in the Part II Training School.

FAMILY GUIDANCE SERVICE.

A weekly maternity and child welfare session is devoted to the diagnosis and treatment of family and psychological problems. The session is conducted by a medical psychologist and mothers are referred by medical officers and health visitors. At present, only parents with children under the age of five years can be referred.

DAY NURSERIES.

There are seven day nurseries in the City, catering for children between the ages of six months and five years. Priority is given to children of women who must go to work—widows, mothers of illegitimate children, and cases where the father is incapacitated through illness. A special endeavour is made to secure the temporary admission of children whose mothers are ill.

An eighth day nursery is almost completed and will be opened in the near future. There will then be accommodation for a total of 370 children.

6. **Domiciliary Midwifery.**

GENERAL ARRANGEMENTS. The organisation of the Service is carried out by the Non-Medical Supervisor of Midwives who is responsible to the Senior Medical Officer for Maternity and Child Welfare. The Non-Medical Supervisor is also tutor to the Part II Training School.

	Establishment.	*Present Staff.*
Non-Medical Supervisor	1	1
Domiciliary Midwives	23	22

Of the above, seventeen are non-teaching midwives and the remaining five are approved district teachers.

The City is divided into five areas, three or four non-teaching midwives booking cases in each area.

A NIGHT MIDWIFERY SERVICE is in operation whereby every domiciliary call is received over one telephone by a midwife who is on night duty for such purposes one week at a time. This midwife is suspended from ordinary duties, and each non-teaching midwife does night duty approximately once every 4 to 4½ months.

During the night one midwife out of each area (as far as is possible) is available for calls in her own area ; should she be engaged, the services of another midwife are obtained. By this arrangement each midwife only does two nights a week on duty and the rota is so arranged that they do not occur on consecutive nights.

The hours of the Night Midwifery Service are 8.0 p.m. to 8.0 a.m., and the service operates from Part II Training School.

Midwives use public transport by day but in emergency and during the night a car from the ambulance station is available.

The remaining five teaching midwives obtain their cases from two out of the five areas already occupied by non-teaching midwives and do not participate in the arrangements for the Night Midwifery Service.

EXTENT OF SUPERVISION OF OTHER DOMICILIARY MIDWIVES.

In the area of this Authority there are no private midwives practising permanently in the domiciliary field. Occasionally, a midwife from another area crosses the boundary and notifies within forty-eight hours that she has practised midwifery in the City. Such supervision extends only to the statutory notifications.

ANALGESICS.

All the domiciliary midwives are qualified to administer nitrous oxide and air and have had instruction in the use of pethidine.

The gas and air machines are kept at the ambulance station and are conveyed to and from cases as requested by the midwives.

Instruction of the mother in the use of the analgesia machine is given in the midwife's ante-natal clinic.

ANTE-NATAL SUPERVISION BY MIDWIVES.

The midwives hold their ante-natal clinics at weekly intervals in the Municipal Clinic in the area in which the patient resides. They work in groups to enable the mother to know the other midwives who may be called to her confinement. This is essential with a Night Midwifery Service.

Information about the midwife's clinic is given to the mother by letter when booking arrangements have been made.

Co-operation with General Practitioners.

The local authority's ante-natal clinics were made available to the general practitioner obstetricians for routine ante-natal care of their booked patients. All equipment was provided. Out of ninety-four practitioners on " the list " only one is at present taking advantage of the scheme.

In this particular instance the results have been worthwhile. The doctor visits the midwife's ante-natal clinic session once a fortnight, the midwife having arranged for his patients to attend on the appropriate date. The great advantage is that both the midwife and doctor know the mother equally well. The only disadvantage appears to be the withdrawal of mothers from the local authority's medical officer's clinic. The latter is a retrograde step until *all* general practitioner obstetricians have sufficient *experience* of midwifery.

Another method of co-operation is the provision of a municipal midwife to attend the general practitioner obstetrician's surgery for a special ante-natal clinic organised by the doctor. This is being done for two doctors. An advantage is that the relationship between doctor and midwife is improved but the disadvantages are many, namely :—

1. The facilities for ante-natal care are not ideal either for accommodation or equipment.
2. The midwife rarely sees the patients that she has booked.
3. The midwives would be unable to provide this service for all general practitioners on " the list " if this were requested.

Neither of the methods described is desirable for all general practitioner obstetricians until their experience and in some instances their knowledge of midwifery is greatly improved by the introduction of compulsory post-graduate training before admission to the special list.

With regard to co-operation during the labour, it is desirable for the midwife to know when the general practitioner booked for the case is off duty and which doctor intends to act as his relief. No satisfactory method has yet been devised in this area to overcome this difficulty.

All new appointments in the Municipal Midwifery Service are notified by letter to the general practitioners in the area.

There are frequent personal contacts between the doctors and supervisors of midwives dealing with the day to day problems.

Important discussions and decisions are dealt with at a higher level through the Medical Officer of Health.

Co-operation with Hospitals.

The domiciliary midwives investigate the home conditions of all expectant mothers who make application for a hospital bed after the fourth month of pregnancy.

The municipal midwives also accept the responsibility of the nursing care of mothers and babies discharged from the hospital before the tenth day of the lying-in period.

MIDWIVES' ANTE-NATAL CLINICS.

(*a*) *Ante-Natal Clinics.*

There are eleven midwives' ante-natal clinics held weekly in local authority centres. At these sessions the twenty-two municipal midwives examine their patients. From these, abnormal cases are referred to medical officer's sessions or to the general practitioner obstetrician if booked for maternity medical services.

On an average, six midwives attend two doctors' surgeries over a monthly period to assist in ante-natal care of patients booked for maternity medical services.

(*b*) *Blood Testing Arrangements.*

All domiciliary cases receive a letter inviting the mother to attend a medical officer's clinic for the above purpose. A simple explanation of the reason for the investigation is given.

(*c*) *Mothercraft.*

Mothercraft has been taught by teaching midwives to their own booked patients. Two different methods were adopted, namely :—

1. As separate sessions from the ante-natal clinic held in the midwife's own home.

   Result. Attendances were good and the instruction was appreciated, but the use of a midwife's private residence for professional purposes is not desirable, as the problem of furnishing and charges for the use of the room is likely to arise.

2. As part of a routine ante-natal clinic. Three midwives present the information to the mothers in short talks. There the problem is chiefly one of staff, time, and the keeping of an even flow of mothers into the examination room.

   Recently, premises have been acquired which offer suitable accommodation for holding mothercraft classes as separate sessions from ante-natal clinics. This will be developed in the near future and will serve a big proportion of mothers in the City.

SELECTION OF WOMEN RECOMMENDED FOR HOSPITAL CONFINEMENT ON SOCIAL GROUNDS.

1. *From a Municipal Centre.*

Wherever a mother asks for a hospital bed through a Local Authority Centre a home investigation is made by the midwife at the request of the Medical Officer. If found to be unsatisfactory, the patient is referred with a letter to the hospital where admission is always arranged.

2. *From a Hospital Ante-Natal Clinic.*

All mothers applying for a hospital bed after the fourth month of pregnancy (excluding those with a bad obstetric or medical history) have their home conditions investigated by a domiciliary midwife. The cases with adverse domestic circumstances are always booked by the hospital, whilst the remainder are given accommodation or are refused according to the availability of the remaining hospital beds.

REFRESHER COURSES FOR MIDWIVES.

The following staff are sent annually by the local authority to the post-graduate courses organised by the Royal College of Midwives :—

Two non-teaching midwives.
One teaching midwife.
One supervisor of midwives.

Within the last three years both midwives practising as premature baby nurses have been to the Sorrento Maternity Hospital, Birmingham, for a post-graduate course of one month duration on the care of the premature baby.

Other post-graduate courses attended by the staff include :—

1. A course of instruction on ante-natal exercises and relaxation.
2. One annual lecture by some well-known authority in obstetrics or allied subjects.
3. An annual course of six lectures organised by the Manchester Health Department.
4. Instruction in the use of pethidine, 1951.

THE TRAINING OF PUPIL-MIDWIVES.

Part II midwifery training is carried out entirely on the district in this City.

Accommodation for ten pupils at a time, two resident approved district teachers and a warden-housekeeper (responsible for all domestic arrangements) is provided in a hostel.

The teaching staff consists of :—

One approved lecturer in Public Health.
One approved lecturer in Venereal Diseases.
One qualified tutor.
Five approved district teachers
(two resident and three non-resident).

Three municipal ante-natal clinics and two child welfare clinics are available for teaching purposes.

7. **Health Visiting.**

Combined health visiting, school nursing and tuberculosis visiting is undertaken throughout the City which, for this purpose, is divided into 34 areas. One health visitor is responsible for all home visiting in the area allotted to her.

Particulars of staff actually employed on December 1st, 1952, are given below. Figures in brackets denote the number employed December 31st, 1947.

	1952	(1947)	
Health Visitors	30	(23)	Including specialist health visitors and centre superintendents and plus superintendent health visitor.
Clinic Nurses	18	(11)	Three of present clinic nurses hold dispensations granted by the Ministry of Health to practise health visiting.
Lay Assistants	9	(7)	
Student Health Visitors	7	(4)	

Home visiting is carried out on behalf of :—

(*a*) expectant mothers ;

(*b*) the healthy child under school age ;

(*c*) the sick child of any age, including those suffering from physical or mental handicap, infectious disease, or who are in need of home follow-up in respect of illness, accident, or convalescence ;

(*d*) children cared for in homes other than their own.

(*e*) children cared for in an unsatisfactory manner, including those belonging to problem families, neglected children and certain illegitimate children ;

(*f*) adults needing advice in case of physical and/or mental illness, including all notified cases of tuberculosis and their families, and certain patients discharged from, or in need of admission to, hospital ;

(*g*) persons needing special care, such as the unmarried mother ;

(*h*) aged and infirm persons ;

(*i*) special investigations, enquiries and surveys.

Frequency of visiting is decided by the needs of the families concerned and the number of staff available to meet them. In most categories it may be true to say that urgent needs are met, but that subsequent supervision is often inadequate for lack of follow-up due to shortage of staff.

Clinic Work.

Clinics of all types are staffed, where appropriate, by health visitors, clinic nurses, and lay assistants. Clinic nurses and lay assistants are used as much as possible for curative and other work not needing for its performance the services of a qualified health visitor. Four health visitors are employed as Centre Superintendents.

Specialist Health Visitors.

It was found that certain important aspects of work coming within the province of the health visitor under the National Health Service Act tended to remain undeveloped if left to the discretion of the general health visitor.

In order to develop the service and to arouse and maintain the interest of health visitors in aspects of health visiting outside the limitations of maternity and child welfare work, health visitors with a particular interest in, and aptitude for, certain branches of the work were employed as specialist workers. Six specialist workers are employed in connection with the following :

1. The aged and infirm.
2. Liaison with hospital services.
3. The child neglected in his own home.
4. The unmarried mother and her child.
5. The preventive aspects of mental health.
6. Part-time Health Tutor to Student Nursery Nurses.

1. The Aged and Infirm.

At the end of 1950, the number of elderly and infirm persons in special need and known to the Department was 790. During 1951, some 570 new names were added, and at the end of the year 1,008 persons remained on the visiting list.

Elderly persons were referred mainly for :—

(*a*) Investigation of home condition of patients awaiting admission to, or discharge from, hospital.
(*b*) Follow-up after discharge from hospital.
(*c*) Advice because of disabilities—deafness, rheumatism, diabetes, etc.
(*d*) Help because alone and neglected.
(*e*) Assistance in obtaining domestic help, nursing equipment, surgical appliances, chiropody, laundry service for incontinent patients, etc.

2. Liaison with other parts of the National Health Service.

(*a*) *Hospitals.* A specialist health visitor is appointed who acts as liaison officer between two hospitals (one general and one infectious diseases hospital) and the health visiting staff. The work is confined at present to the care of children, but it is hoped shortly to be able to extend the service to include adults.

Briefly the health visitor concerned effects an interchange of information obtained from the health visitors on the one hand regarding home circumstances, type of mothers, etc., and from the hospital on the other with regard to the type of illness, treatment and convalescence.

These two hospitals send to the Medical Officer of Health a copy of the letter sent to the family doctor giving particulars of illness of all children, and of treatment and suggestions for future care. This copy is seen by the district health visitor and then attached to the child's dossier at Infant Welfare Centre or School Health Service.

(*b*) *General Practitioners.* Health visitors are encouraged to call on, or telephone, general practitioners regarding any appropriate family. To further co-operation, general practitioners have been invited to have tea with health visitors at certain clinics. The response has been good, and following this, doctors are now more frequently referring to the health visitor any case which would benefit from her assistance.

Effectiveness.

Without doubt an improvement has occurred in the services rendered to the families concerned—in both instances. Hospital staffs are also now showing a greater interest in the home lives of the children.

The liaison service is limited to two ex-municipal hospitals. There is some reluctance on the part of the medical staff of other hospitals in and serving the area, including a large children's hospital, to divulge any information regarding the illness and treatment of patients. Follow-up work is carried out only in the few special cases referred by the Hospital Almoners ; in the cases met in the course of her ordinary work, the health visitor must rely on the often incorrect and/or inadequate account of the illness and treatment given by the mother. In the majority of cases no follow-up is done as the health visitor is unaware of the admission to, or discharge from, hospital.

3. The Child Neglected in His Own Home.

The main duties of the specialist health visitor are :—

(*a*) Intensive social work in collaboration with health visitor and outside social agencies for the rehabilitation of neglectful parents, and the care of neglected or ill-treated children. One of the aims is to prevent, if possible, the ultimate removal of such children from their homes.

(*b*) To co-operate with the general health visiting staff in dealing with potentially neglected children, in order to prevent, where possible, these children from becoming neglected.

(*c*) *Attendance at Case Conferences.* In addition to home visiting, school visiting, consultation with health visitors, contact with other social agencies and office interviews, the worker also participates in Case Conferences which are held regularly to discuss selected families. After an exchange of information between the social workers present, an attempt is made to establish the factors that have led to the neglect of the children concerned, and, if possible, to penetrate more deeply into the causes of parental failure. In each case the best line of action is discussed by all present. In suitable cases the special health visitor undertakes to do intensive work with the family (either in person or through the district health visitor). In such cases she reports back in due course on progress—or otherwise. It must be recognised that all general health visitors are not adequately prepared, or temperamentally suited to attempt the rehabilitation of neglectful families. The appointment of a good experienced health visitor, possessing the aptitude, patience and understanding needed for this work, is of inestimable value in any health visiting scheme. The value of her work lies not solely in dealing with the neglected or potentially neglected child, but in guiding and influencing along the right lines her less experienced colleagues ; in her ability to survey the whole field of child neglect in the city, and to step in unobtrusively at the right moment, in her knowledge of, and personal relationship with, the workers of the various social agencies interested in this problem, and in her ability to take over all aspects of a health visitor's work in any particular family where neglect exists or is suspected, should the need arise.

4. The Unmarried Mother and Her Child.

See Section 5. (Expectant and Nursing Mothers).

5. Preventive Aspects of Mental Health.

The specialist health visitor acts as liaison officer between the health visitors and the Mental Health Department, and assists the health visitors with any problems arising from mental or emotional disturbances in any particular family.

6. Part-time Health Tutor.

Assists in the training of student nursery nurses for the examination of the N.N.E.B. She is responsible for the practical work on the Health Section of the syllabus of the Board.

Student Health Visitors.

A scheme for the training of up to eight health visitors a year is in operation. The Corporation pays all lecture fees, travelling expenses connected with practical work, and first examination fees. Each student is remunerated

at three-quarters of the minimum salary of a qualified health visitor during her period of training. Full practical training is given in Salford ; and theoretical teaching carried out in collaboration with the Manchester College of Technology for students who wish to train in this area. Where a student wishes to train outside the area all financial aids are the same, but practical work is, of necessity, carried out in the area concerned. After passing the examination all are required to give twelve months' service on the health visiting staff in Salford at the full rate of pay. An option is held on future services for a further period of six months.

Facilities are offered to clinic nurses to help them to obtain the Health Visitor's Certificate, including the granting of leave of absence in order to obtain the First Certificate of the Central Midwives' Board, and the offering of financial aid as described above.

REFRESHER COURSES.

Health visitors attend a full-time Refresher Course, organised by an appropriate body, every five years following qualification. In addition, all health visitors not engaged in essential clinic work attend Refresher Courses arranged locally several times a year. During 1952 a special course with lecturers and tutors of national reputation was arranged on Mental Health by the Central Council for Health Education. Facilities for post-graduate education are provided within the Department, e.g., a discussion group was formed this year to further the study of mental health ; group leaders being the Educational Psychologist, and the Psychiatric Social Worker from the Child Guidance Clinic. Regular Staff meetings are held fortnightly in order to discuss different aspects of work, and problems arising therefrom.

TUBERCULOSIS VISITING. (See also Section 11).

The home of every newly notified case of tuberculosis is visited by a health visitor as soon as possible in order to advise as to the patient's care ; prevention of spread of infection, and to arrange for examination of contacts and to advise the family generally. Health visitors attend the Chest Clinic by rota for five sessions a week in order to keep in touch with clinic work and to maintain contact with the Chest Physician and his staff. The Chest Physician is willing to see any health visitor wishing to discuss a case with him, outside clinic hours, if he is available.

A scheme for co-ordination of health visiting with diagnostic and treatment services was formulated and successfully put into practice, but unfortunately, owing to the inability of the Hospital Management Committee to provide the necessary clerical assistance, the scheme was abandoned. Information regarding defaulters from the clinic (patients and contacts) ; particulars as to children attending (or failing to attend) for Mantoux Tests, B.C.G., the results of tests, the state of infectivity of patients and any other particulars of value to the health visitor are now seldom, sometimes never, transmitted to the health visiting section from the Chest Clinic.

Health visitors' record cards of patients are sent down to the Chest Office if, in the interest of the patient, the information recorded thereon should be made known to the Chest Physician or his staff.

8. **Home Nursing.**

On the 5th July, 1948, the District Nursing Service carried on in Salford by the Manchester and Salford District Nursing Institution, was taken over by the Local Health Authority and became part of the Health Service administered by the Medical Officer of Health.

Affiliation with the Queen's Institute of District Nursing has been continued and the Service is approved for the training of Student Home Nurses by the Institute. Since July, 1948, 25 nurses (including eight male nurses) have received their training. Student Nurses attend a course of lectures organised by the Manchester District Nursing Institution and receive their practical training in Salford. Recently a block system of lectures has been introduced and facilities for these lectures have been provided at the Salford Nurses' Home.

Co-operation with General Practitioners.

Ninety per cent. of cases nursed by the staff are referred by general practitioners.

Liaison with Hospitals.

Cases are referred from hospitals by Hospital Almoners.

An increasing number of cases are referred for treatment preliminary to X-ray examination.

First year staff from a large children's hospital and from one of the general hospitals in the Salford Group attend during the course of training and accompany the Home Nurse on her visits.

An attempt has been made to organise a refresher course for the Home Nurses in one of the general hospitals, but the co-operation of the administrative staff of the hospital has been lacking.

General Arrangements.

For the purpose of the Home Nursing Service, the City is divided up into eleven areas, to each of which is allocated one nurse. Assistant nurses and auxiliary nurses work under the supervision of the fully-trained staff, and there is a Superintendent and Deputy Superintendent, who are responsible for the general organisation of the service, the practical training of students, and the keeping of records.

Classification of Cases.

The cases attended are classified as follows :—

Surgical, mainly post-operative cases, and minor operations carried out in the patient's own home.

Medical (acute and chronic, and excluding cases of diabetes mellitus).

Gynæcological.

Tuberculosis.

Pneumonia.

Diabetes mellitus.

Cases for treatment preliminary to X-ray examination. Children under five years of age.

NIGHT SERVICE.

There is no night service, but occasionally staff are called upon to give injections of drugs late at night.

Cases of puerperal pyrexia, ophthalmia neonatorum and pemphigus neonatorum are referred to the Home Nursing Service from the Midwifery Service.

REFRESHER COURSES.

The Superintendent and Deputy Superintendent have attended administration courses organised by the Queen's Institute at Roffey Park Institute of Occupational Health and Social Medicine.

Nursing staff attend post-graduate courses at Bangor College, Wales, organised by the Queen's Institute of District Nursing.

SHORTAGE OF STAFF.

The service is at present experiencing difficulty in the recruitment of staff, both qualified and for training.

HOME PHYSIOTHERAPY SERVICE.

This is a service provided by the Manchester and Salford District Nursing Institution and brings relief of pain and suffering to many of the sick and disabled, particularly the elderly.

The full resources of modern physiotherapy are employed with the great advantage that the treatment is brought to the homes of the patients.

9. Vaccination and Immunisation.

VACCINATION.

Efforts to secure the vaccination of the child population are directed in the main through the following channels :—

1. Registrars of Births are supplied with documents advising vaccination, for issue to parents when registering the births of their children.
2. Health visitors are supplied regularly with particulars of children who have been vaccinated so that they may devote special attention to cases of young children who have not been vaccinated, by visiting the homes and advising vaccination.
3. Vaccination of infants is carried out in maternity and child welfare clinics on a small scale.
4. The importance of vaccination is stressed from time to time in talks to mothers and the public by the staff of the health department.

IMMUNISATION.

The medical, health visiting, nursing and administrative staff of the department maintain the closest possible liaison in connection with this subject and the following measures are in operation :—

(i) Registrars of births are supplied with documents for issue to parents when registering the births of their children, as in the case of vaccination.

(ii) When a child attains the age of five months, an invitation card is sent to the mother requesting her to take the child to the nearest child welfare centre so that her child may be immunised. If no response is received to the first invitation, a second invitation is sent two weeks later. If no response is made to the first two invitations, the health visitor or nurse calls at the home and advises the mother to have her

child immunised. If the mother refuses to give consent the health visitor calls at the home six months later and again endeavours to persuade the mother that immunisation is the only safeguard against diphtheria. If consent is given the child will be immunised there and then. In the case of a refusal, further visits are paid and refusal is only accepted as definite if it is maintained on three occasions over a period of eighteen months.

(iii) The importance of immunisation is kept before the public constantly in various ways, e.g., the leaflet attached to the birthday card which is forwarded to each child when it attains the age of twelve months.

(iv) *Boosting injections.* When the health visitor makes her final visit to the home (when the child is five years old) and before she passes the infant welfare record card to the School Health Service, she ascertains from the mother which school the child is going to attend. Lists are then compiled in school order of children who have received a primary immunisation. At least once every year, each school in the City is visited by a nurse for the purpose of giving a "safety injection" to every child on the school list who has received a primary immunisation, and in respect of whom the parents' consent for a safety injection has been received.

In addition, a consent form is sent to the parents of children for whom no record of immunisation is held.

It is interesting to note that during 1951, 89·6 per cent. of injections for immunisation purposes were given by the health visitors or clinic nurses, and only 10·4 per cent. by general practitioners.

The following statistics, relating to Salford children who have completed a full course of immunisation against diphtheria, give a very clear indication of the success of our scheme :—

0 to 5 years	76·3 per cent.
5 „ 15 „	97·7 „ „
0 „ 15 „	89·1 „ „

Great care is always exercised in ensuring the accuracy of these figures, special care being taken to see that the records of children who move to other areas are forwarded to the appropriate authority. Immunisation is not generally carried out by health nursing staff, but this has been done in Salford for the past ten years and the Council have seen no reason, in view of the success of present arrangements, to alter their practice.

Immunisation Against Whooping Cough.

As soon as diphtheria immunisation has been completed at child welfare clinics, mothers are requested to bring their children, a month later, for protection against whooping cough. The following figures relate to the year 1952 :—

Number of children immunised against whooping cough...	859

In age groups as follows :—

Under one month (see note below)	242
Between one month and twelve months	356
1 to 5 years	258
Over 5 „	3

Immunisation against whooping cough is carried out in clinics only.

The investigation which commenced in March, 1951, on the value of whooping cough immunisation in very young infants (the first injection is given between three weeks and one month) still continues. So far no definite conclusions have been reached. The investigation is conducted jointly by the Local Health Authority and the Department of Child Health of Manchester University.

10. **Ambulance Service.**

While the Health Committee of the local health authority is responsible for the control of the ambulance service, its day to day operation has been delegated by the local health authority to the Central Garage Committee whose chief officer (the Director of the Central Garage) is responsible for the immediate supervision of its activities. Daily contact is maintained at officer level between the Central Garage and the Health Departments, and a joint sub-committee for controlling the service has been formed, which meets monthly or on special occasions as required.

Appended is a comparison of the mileage run and patients carried during each of the three years ended 31st December, 1950, to 31st December, 1952.

	Mileage.	*Patients carried.*
31st December, 1950	220,752	48,834
31st December, 1951	231,319	57,653
31st December, 1952	216,169	55,866

Attached is a statement showing the mileage per month during the years 1952 and 1951, from which it will be seen that between 1st May and 31st December, 1952, there was a decrease of 14,561 miles as compared with the mileage for the corresponding period in 1951. This decrease is attributed to two main factors, namely :—

1. In April, 1952, an approach was made at officer level to Salford Hospital Management Committee with the result that the following arrangements were agreed upon and were put into operation immediately :—

(i) That a representative of the Ambulance Service should attend at the two general hospitals in the City from time to time, with a view of co-operating with the respective staffs, on the subject of the arrangements for the use of ambulance vehicles.

(ii) That notices should be exhibited in the respective hospitals drawing the attention of members of the public to the circumstances in which ambulance vehicles may be used.

(iii) That almoners should be impressed with the importance of ensuring that ambulance vehicles should be requisitioned only when definitely needed.

(iv) That hospitals should be supplied with pads of forms for requisitioning vehicles. Such forms to be signed by responsible persons.

(v) That as far as possible prior consultation should take place between the staffs of the hospitals and the staff of the ambulance service before ambulances are requisitioned for long distances.

(vi) That any cases or matters concerning the use of the ambulance service in which action on the part of the hospital authorities or of the local health authority appears to be desirable should be brought to the attention of the appropriate services as soon as possible.

The hospital authorities have co-operated willingly in these arrangements.

The efficient and economical use of the ambulance service has been discussed by the Salford Health Services Joint Advisory Council on a number of occasions and it has been the general opinion that apart possibly from isolated cases there has been no abuse of the service for a considerable time.

2. In November, 1952, radio-telecommunication equipment was installed at the main ambulance station and in nine vehicles. The system has proved successful in operation, having brought the vehicles so equipped under immediate control.

Below is a statement giving an analysis of patients carried in respect of the year ended 31st December, 1951, and the year ended 31st December, 1952.

	1952.	1951.
Spastic	4,552	4,113
Midwifery	2,242	2,475
House conveyance	39,994	41,969
Inter-hospital	3,354	3,842
Maternity	1,829	1,699
Gas and air	391	210
Mental	261	165
Infectious	719	803
Emergency	2,494	2,365
Rechargeable to other areas	30	12

11. **Prevention, Care and After-Care.**

TUBERCULOSIS. The home of every newly notified case of tuberculosis is visited by a health visitor as soon as possible in order to advise as to the patient's care ; prevention of spread of infection and to arrange for examination of contacts, to advise the family generally. Health visitors attend the Chest Clinic by rota for five sessions a week in order to keep in touch with clinic work and to maintain contact with the chest physician and his staff. The chest physician is willing to see any health visitor wishing to discuss a case with him, outside clinic hours, if he is available. (See Section 7—health visiting, tuberculosis visiting).

The Almoner takes every opportunity to advise and help patients suffering from tuberculosis, and their relatives. She is often in contact with the National Assistance Board and various voluntary associations, seeking help for them. Prior to 1948, the Almoner interviewed all newly notified patients but it has not been possible to continue this arrangement, nor to maintain the close liaison which formerly existed between her and the sanatoria staffs.

CONVALESCENCE AND RECUPERATIVE TREATMENT is arranged by the Almoner under the following categories :—

(*a*) Adults referred from hospitals or by general medical practitioners.

(*b*) Mothers and young children sent to Brentwood Recuperative Centre.

(*c*) Pre-schoolchildren referred from hospitals or Maternity and Child Welfare Department.

(*d*) Schoolchildren referred by School Health Service, medical officers, general medical practitioners or hospitals.

The cost is borne by the Health Committee in (*a*), (*b*) and (*c*), although mothers make some contribution in many instances, and by the local education authority in (*d*). All the homes used are conducted by voluntary agencies. The health services are specially indebted to the Invalid Children's Aid Association who do much of the administration work without charge when dealing with children.

LAUNDRY SERVICE.

A laundry service exists for the incontinent aged. Arrangements have been made for soiled bed linen and bedwear, etc., to be washed at a hospital laundry. Collections are made twice each week and a charge of 4s. 6d. per week is made for the service.

PROVISION FOR SICK ROOM EQUIPMENT.

Stocks of sickroom requisites are available for free loan from the Royal District Nurses Home, and from the Almoner at the Health Department.

CASE CONFERENCE. Children neglected or ill-treated in their own homes.

The joint circular issued by the Home Office, Ministry of Health and Ministry of Education, directed local authorities to appoint one of their officers to co-ordinate the work of all child-care agencies both official and voluntary. In Salford, the task has been given to the Medical Officer of Health.

Since 1951, Case Conferences on families where there are neglected children have been at fortnightly intervals. The members of the conference are actual field workers whose work brings them into contact with neglectful families. Representatives are invited from every department, organisation or agency interested, for example, health visiting, education, welfare, housing, probation, civic welfare, mental health, school health, together with the N.S.P.C.C., Manchester and Salford Council of Social Service, Family Service Unit, child guidance, and where necessary, the Ministry of Pensions. Representatives also attend from the Department of Social Studies at the Manchester University.

The Health Department's Almoner has special responsibilities for calling the meetings at which she acts as chairman, for the preparation and circulation of reports and for ensuring that every social worker having an interest in the cases is invited to attend and is briefed with all necessary and relevant information. She is also responsible for the selection of cases for consideration from information received from all sources and for the transfer of all information relevant to the cases.

A note on the Health Department's field work is to be found under Section 7, dealing with the work of the specialist health visitors.

12. **Domestic Help.**

This service has grown steadily since 1945 when the existing maternity home help service was extended in accordance with the suggestions in Circular 179/44. The households having priority claims upon the service are :—

1. Booked maternity cases.
2. Emergency maternity cases.
3. Mothers and young children.
4. Acute illness.
5. Elderly, infirm or chronic sick.

Approximately 15 per cent. of the work is done in the first four of these classes and 85 per cent. in the fifth.

A definite policy has been adopted in the case of elderly infirm or chronic sick cases, namely, that the service shall be spread thinly to cover as many households as possible in order to prevent recipients degenerating into problem derelict old people. This preventive angle of the work appeals greatly to the helps who also expend much private time and effort in an endeavour to keep their charges happy and comfortable in their own homes, and render their admission to hospital and institutions unnecessary.

The amount of time given to each case varies in accordance with its needs. In the case of the elderly the minimum amount of help is given in order that those who have an independent spirit may retain it, and those who are inclined to lean on others may be stimulated to use their physical resources as far as possible. In some cases one day every two or three weeks is sufficient, in others, daily visit is needed. The general average is three half-days per week.

At the end of 1952 the service amounted to 2870 hours per week, an increase of 220 hours from the end of 1951. Five hundred and ninety-eight cases were assisted during the year, the number remaining on the books at the year end being 329.

One hundred and forty-two helps were employed at 31st December, 1952, 137 on a part-time basis, and 5 in receipt of a guaranteed wage for full-time work. The practice of employing part-time staff has proved most economical in this area. The number of hours worked by each home help varies, but the great majority do twenty hours' work per week, and undertake two or three cases each.

It will be realised that house cleaning in a smoky north western industrial town is hard physical work, moreover it is the same type of work that the help is obliged to do in her own home. It has been found that loading the help with more than three households, where all the heaviest work is left for her, usually results in a breakdown in her health and the consequent payment of sickness allowances. Every effort is made to choose the right type of women for the work, and whilst in the early days there was a small degree of trial and error, the women now working have proved very adaptable and suitable for the job. There is at present no difficulty in the recruitment of women of good standard.

No pre-service training is given. One two-week course of training was arranged in 1950 and twelve home helps attended. This took place during working hours and the home helps were paid at their normal rate whilst attending the course. More recently an evening lecture course has been arranged at which attendance is voluntary. Aims of this course are :—

1. To make the helps feel that they are part of the Health Department staff.
2. To increase their knowledge of the work done by the department.
3. To try to form a group who will undertake work with families where there are neglected children, tubercular patients or derelict old people.

To this end the Medical Officer of Health, Senior Medical Officer for Maternity and Child Welfare, Supervisor of Midwives, Superintendent Health Visitor, Specialist Health Visitors for the elderly and for neglected children,

are each taking part in the course. They will be followed up by other officers of the Corporation and voluntary societies, and it is proposed to issue a certificate to those who have attended regularly at the end of the course.

The work of the helps is closely linked with every social service in the district, both statutory and voluntary. The organiser and her staff are in almost daily contact with general medical practitioners, health visitors, civic welfare, welfare and national assistance officers, and almoners. Arrangements are frequently made for the provision of " meals on wheels," the service of a chiropodist, and indeed, many other needs of the households serviced.

Requests for the service are received from all the above-mentioned officers and organisations, and from many more. Each application is investigated by a member of the organiser's staff before a home help is sent. Assessment is made of the financial situation, the need for help and the degree of priority. At the end of 1952, 80 cases were on the waiting list and only for a short period during the summer months of 1952 could the service be said to have been adequate.

Few households pay the full charge of 2s. 9d. per hour, but on the other hand, none has the service entirely free.

Difficulties. Whilst on the whole the service runs very smoothly and meets a great need, there are still some problems to be overcome.

1. The great reluctance of maternity cases and mothers with families to use the service on account of the charges made.
2. The difficulty in persuading helps to undertake tubercular households, squalid old age cases and problem families.
3. The difficulty in " prising " a help away from an old lady, who has come to regard her as a daughter, in order that the help may serve a more urgent case.

13. **Health Education.**

A Health Education Officer was appointed in January 1949, with responsibility to the Medical Officer of Health for the co-ordination of all Health Education activities.

The fullest use is made of modern teaching media, including 16mm. sound films and 35mm. film strips (of which several have been produced in the Department, including " Care of the Elderly," " Problem Families," " School Health Service," and one on the Local Health Service at present under production). Successful use has been made of rear projection daylight screens for group teaching purposes in centres, in hospital out-patients departments, in the Part II Midwifery Training School, and to organised groups throughout the City. The active co-operation of the local press has been obtained. Regular activities have been published on home accidents, and on all subjects of topical health interest, i.e., influenza, measles, polio, vaccination, immunisation, etc. A particularly successful feature has been the inauguration of a Children's Health Club, with over 600 members, run in conjunction with the " Salford City Reporter," at no expense to the authority.

The Health Education Officer is responsible for the production of the Local Health Services publications, handbooks, etc., for the provision of teaching media for use in all clinics, Mothers' Clubs, etc., for the arrangements for lectures, demonstrations, etc., to organised groups throughout the City,

and for the detailed arrangements for observation visits of student groups from local hospitals, from the Manchester and Salford District Nursing Institution, and from the Faculty of Economic and Social Studies of Manchester University, for the collection of material for the weekly bulletin to family doctors and for all general matters of publicity.

HOME SAFETY.

Salford is among the authorities that have realised the seriousness of the incidence of accidents in the home, and as part of the endeavour to find a solution to this problem, has set up a voluntary Home Safety Council. This Council is made up of representatives from all interested groups—parents, teachers, business concerns, women's guilds, corporation departments and others, and receives the official support of the City Council who make a grant towards its expenses. The Council undertakes the publicity in all forms on the subject of home safety and the provision of speakers to address meetings on the prevention of accidents in the home. Its services are given free and several of the officers of the local health authority are members of its committees.

Several rather novel publicity schemes have been used, including the publication of a series of articles in the local press, the issue of bookmarks through the public libraries, the use of film strips on home accidents, and the display in corporation transport of a large number of posters with home safety slogans designed by local schoolchildren.

14. **Mental Health.**

(i) ADMINISTRATION.

(*a*) The Mental Health Service is a part of the Public Health Department, and the Senior Mental Health Officer is responsible to the Medical Officer of Health for the supervision of the service which is controlled by the Mental Health Sub-Committee which is composed of all members of the Health Committee acting as a sub-committee.

(*b*) The established staff of the service is :—

One Senior Mental Health Officer (male)—Diploma in Social Science.
„ Duly Authorised Officer and Mental Health Worker (male)—S.R.N., R.M.N., R.M.P.A.
„ Duly Authorised Officer and Mental Health Worker (female). Post at present vacant.
„ Psychiatric Social Worker (female)—Diploma in Mental Health. (Seconded by the National Association for Mental Health).
„ Mental Health Social Worker (female)—unqualified.
„ Shorthand Typist/Filing Clerk.
Two Supervisors (unqualified) of Occupation Centres (female) (one at present seconded to the Training Course for Supervisors).
Four Assistant Supervisors (female).
Two Part-time domestic assistants (one male, one female).

A specialist health visitor for co-ordination with the Mental Health Service has recently been trained within the service. She is a member of the maternity and child welfare staff, whose functions will be to co-ordinate the mental health problems arising in that field and to act as a liaison officer between that service and the Mental Health Department. Whilst departmental officers tend to specialise in accordance with their designated duties, each officer does, in fact, deal with all aspects of mental health and mental deficiency work.

(*c*) *Co-ordination with Regional Hospital Board and Hospital Management Committees.*

There is no financial arrangement in operation between the local health authority and the hospitals board for the joint use of officers, but this authority interprets Section 28 of the National Health Act in its widest sense, and consequently does most of the mental health social work for the hospital board, which arises within the City boundaries. Most of the co-ordination takes place at officer level.

A consultant psychiatrist gives his services voluntarily to the Therapuetic Social Club. The psychiatric social worker and mental health workers work in close liaison with the psychiatric clinics, and when requested to do so, obtain social histories and do case work on the patients attending out-patient clinics. Patients on licence from mental deficiency hospitals, or on trial from mental hospital are supervised ; social reports are obtained for mental hospitals when a patient has been admitted or prior to his discharge. A fairly high proportion of the work of the Mental Health Service is done on a co-operative basis on behalf of mental hospitals. Where cases which are primarily in need of either general hospital treatment or open ward psychiatric treatment, the general hospitals' medical staff co-operate to make the beds available.

(*d*) *Duties Delegated to Voluntary Associations.*

The psychiatric social worker who works in the department has been seconded by the National Association for Mental Health on a full-time basis. This secondment is due to the fact that it has been impossible to obtain the full-time services of a psychiatric social worker on the departmental staff by advertising. No other duties or functions are delegated to voluntary organisations and no other members of the voluntary organisations are employed.

(*e*) *Training of Staff.*

With one exception, all the field staff of the Service hold either a university social science, mental health, or a mental nursing qualification. The unqualified member of staff has been doing mental deficiency social work for fifteen years and is well qualified by virtue of experience.

An Occupation Centre Supervisor (female) has been seconded on full salary to attend the Course for Occupation Centre Supervisors, run by the National Association for Mental Health ; she will finish her training in July of this year, and it is anticipated that another Supervisor will be seconded on full salary to attend the next course.

Facilities are granted for all members of the staff to attend any available Short Refresher Course or Short Course with pay. Facilities are available within the Department for the training of University Students (Social Science, Mental Health or D.P.H.), Student Health Visitors and School Nurses.

(ii) Account of Work Undertaken in the Community. Section 28, National Health Service Act.

Prevention of Mental Ill-health.

Endeavour is made to promote the general standard of mental health in the community and to educate the public's attitude towards mental illness. Wherever possible, discreet propaganda is carried out and lectures on mental health are given to interested bodies.

Family Guidance Service.

What is in effect a Family Guidance Service dealing with the psychological problems of the family is conducted by the maternity and child welfare section in one of the M.C.W. sessions. Families are referred to this service by health visitors where there are some mother and child problems. A medical officer and a psychologist are on the staff of the maternity and child welfare section, and, if in these cases, specialised social work in the field of personal relationships is required, beyond that which is capable of being given by the health visitor, they are dealt with by the psychiatric social worker.

Psychological Illness.

The Department also provides a service for cases of psychological illness, i.e., those cases which are showing physical manifestations of a deeper emotional problem. Where it is thought that mental health or psychiatric social work may help the patient with his problem, the case is accepted by the department and remedial measures are taken. This work is done by the duly authorised officers, acting as mental health workers, and by the psychiatric social worker.

Advisory Service.

The Mental Health Service provides an advisory service to other social workers, i.e., probation officers, almoners, etc., and where another social worker feels that a person with whom he is dealing requires the services of a specialist mental health social worker, since the problem is fundamentally one of mental ill-health, the case is then dealt with either directly or in co-operation with the Mental Health Service.

General Measures.

The aim of the Mental Health Service is to provide either hospitalisation at an early stage under voluntary status, or wherever possible to obtain out-patient treatment for the patients. Consequently, doctors and relatives are encouraged to notify the department of cases as early as possible so that positive steps can be taken to obtain these ends. The result is an increasing number of notifications to the service and increasing case loads for the social workers. Certain female patients who require a holiday or period of convalescence to prevent a final breakdown, are sent to convalescent homes through the services provided by the public health department's almoner.

After-care.

All patients discharged from mental hospitals, whether relieved, recovered or improved, are visited by a mental health worker within a week of their discharge, and in those cases where after-care is necessary, supervision continues. Employment is found and the patient helped to settle down again in the community. Any patient who shows signs of potential recurrences of mental illness is immediately referred back to the Psychiatric Out-Patients Clinic. Close liaison is maintained at officer level between the Ministry of Labour, D.R.Os., and all other social workers, who can help in the process of rehabilitation. An arrangement has been entered into with the Mental After-care Association for patients requiring convalescence or a period of rehabilitation before going back home, to go to their convalescent home which is being established at Southport, the local health authority accepting the financial responsibility.

THERAPEUTIC SOCIAL CLUB.

A Therapeutic Social Club is open one night a week in premises which are used in the daytime as a child welfare centre. It is run by members of the mental health staff. A consultant psychiatrist attends each week in a voluntary capacity and this has two great advantages. Firstly, those patients who cannot be persuaded to attend a psychiatric out-patients clinic can be asked to come to the club, and whilst at the club have an informal chat with the psychiatrist. On the other hand, all patients who are not potential psychotics, or under after-care supervision, can maintain an informal relationship with the psychiatrist. The club also helps patients coming out of hospital to readjust themselves to outside life by teaching them to integrate with a group. The club is run by the patients themselves and covers all the activities of a normal social club. During 1952, 550 attendances were recorded.

LUNACY AND MENTAL TREATMENT ACTS.

This work is undertaken by two duly authorised officers and the senior mental health officer, acting as a duly authorised officer. A full emergency service is maintained, each officer being on emergency call for one week in three. During 1952, 258 patients notified to the department were admitted to mental hospitals, comprising 122 males and 136 females. Of these, 61 were admitted directly to voluntary status and 3 to temporary status, and 194 under orders. Serious difficulty is encountered in obtaining beds for urgent senile cases, although urgent acute psychotics are usually found beds without difficulty. In non-acute cases the shortage of mental hospital beds is forcing the strict letter of the Lunacy and Mental Treatment Acts to be discarded because the mental hospitals do not have sufficient beds. This throws extra responsibilities on the duly authorised officer because he is prevented from carrying out his duties efficiently.

MENTAL DEFICIENCY.

At the 31st December, 1952, there were 242 mental defectives under statutory supervision and 195 under voluntary supervision, making a combined total of 437 defectives known to the Mental Health Service. Of these under statutory supervision, 77 were in employment and 62 attending occupation centres, 14 cases were on the waiting lists for mental defective hospitals, and there were 39 patients who were totally unsuitable for centres, or were married, or whose parents would not allow them to attend such clinics, or who were suitably occupied at home. The remaining 50 were either unemployed or awaiting occupation training facilities.

Defectives are usually ascertained through the School Health Service, and in these cases the normal procedure is followed, i.e., completion of form 2-HP and notification to the Mental Health Service. In cases where the notification comes from other sources, a specially appointed general practitioner completes the medical certificate and the social history obtained by the mental health social worker. It is the practice in this authority for the School Medical Officer, when he has examined the patient and decided that he is ineducable, to send for a member of the mental health staff to explain the implications of statutory supervision, etc.—it has been found that this system does much to alleviate fears on the part of the parents, and there is no gap between the child ceasing to be the responsibility of the Education Authority and coming under the Mental Health Service.

Most of the statutory and voluntary supervisions are carried out by the mental health social worker, although the duly authorised officers do some of this work, the male staff usually dealing with older male defectives who have behaviour problems.

OCCUPATIONAL CENTRES.

There are two Occupation Centres in the City at present accommodating a total of 60 patients. They are primarily for patients under the age of 16, although some older defectives also attend (it is anticipated that these will be transferred to corporation premises with the opening of an adult centre in the near future).

Each centre is staffed by a Supervisor (female), two Assistant Supervisors (female) with a part-time domestic helper.

The centres, which are housed in rented church premises, are run on the usual lines with holidays slightly shorter than school holidays. They are open from 9.30 a.m. to 4 p.m. and milk and meals are provided on the premises. (Where financial circumstances warrant it, free meals are provided). There is no special transport provided, but free travel to and from the centres for the defectives and an escort is provided on ordinary bus services. The home visiting of these patients continues to be the responsibility of the mental health social worker.

At one centre, a degree of classification of mental defect has been undertaken, and in a separate room a " nursery class " for the younger defectives is held. The higher-grade defectives in the older children and adolescents receive special attention. It is intended that when a move is made into corporation premises that the old premises will be retained for the older adolescents and adults, and that a room will be reserved for a " creche " or attendance centre for the very low-grade defectives.

No scheme is in operation for home teaching.

GUARDIANSHIP.

There has not been a case in this authority since 1948 where a defective has been placed under guardianship, although there are three cases under such an Order, the Orders being made prior to 1948.

Investigations

A number of special investigations is at present proceeding in Salford and, as these understandably involve the work of staff, particularly of medical officers and health visitors, a list of these inquiries is summarised below. Some of these are being carried out independently, others in collaboration with the Ministry of Health and other bodies.

NEW BORN INFANT SURVEY. We are participating in an inquiry carried on in conjunction with the Social Medicine Unit of the University of Oxford, in an endeavour to ascertain certain factors in relation to infant deaths, including stillbirths.

RETROLENTAL FIBROPLASIA SURVEY. This is being carried on under instructions contained in Ministry of Health letter No. 93211/1/331 of the 28th October, 1952, and relates to all children with a birth weight of under 4 lbs. 6 ozs. to ascertain the incidence of retrolental fibroplasia.

VIRUS INFECTIONS. An inquiry to ascertain the incidence of virus infections in pregnant women and the effect of such infections on the fœtus.

DISINFECTION IN NURSERIES. A local investigation has been proceeding in all day nurseries for over two years in an endeavour to ascertain the value, or otherwise, of the use of disinfectants in day nurseries in preventing the incidence or spread of infection.

CHEMO-PROPHYLAXIS. We are proceeding in co-operation with the Medical Research Council in an investigation into, interalia, the efficiency of chemo-prophylaxis in preventing the spread of sonne dysentery in day nurseries.

SUPPLEMENTARY PROTEIN. A local investigation into the effects of introducing protein (liver concentrate) into the diets of certain groups of children in comparison with "control" groups in all day nurseries has recently commenced.

PREMATURITY. Salford is participating in an inquiry into prematurity in collaboration with the National Birthday Trust.

SURVEY OF CHILD HEALTH. We are participating in a survey of child health, growth and development, which is being carried out by a Joint Committee of the Institute of Child Health (University of London) ; the society of Medical Officers of Health and the Population Investigation Committee.

SURVEY REPORT

Comments by the Medical Officer of Health

It may be helpful to look critically at our services, to ask : What are our needs ? Where are our failings ?

(1) MATERNITY AND CHILD WELFARE SERVICE. The maternity and child welfare services appear to have nothing seriously wrong with them, although shortages of staffs (particularly experienced health visitors) severely limit the amount of work which can be done.

(2) IMMUNISATION AGAINST DIPHTHERIA. The percentage rates of children immunised against diphtheria give rise to some satisfaction, although not to complacency :—

0–5 years	76·3	per cent.
5–15 ,, ...	97·7	,, ,,
0–15 ,, ...	89·1	,, ,,

(3) VACCINATION. The vaccination rate of 43 per cent. is poor, although higher than the rate for the vast majority of large towns. The passing of compulsory vaccination has resulted in a great falling off in the vaccination of infants. Comparative figures for the year 1947 and 1952 are appended :—

	1947	1952
Successful vaccinations of children under one year of age (percentage of total births)	68	43

(4) CO-OPERATION WITH FAMILY DOCTORS, HOSPITAL SERVICES, VOLUNTARY ORGANISATIONS, ETC., has been soundly established, though much better use of the machinery could be made.

(5) Health Visiting Service. The main problem is the need for experienced health visitors in an unattractive and somewhat difficult area like Salford where there is great need for the health visiting service ; it is precisely here that the supply of experienced visitors is least.

(*a*) It is suggested that consideration be given to allowing the Corporation to pay a bonus of £20 for each completed year of service, after a minimum of three years' experience following qualification.

(*b*) The service for the aged should include the appointment of lay-assistants who can help in bathing in the home.

(*c*) Recognition should be accorded to the value of the specialist health visitor whose work is described in the survey. The recognition should include a payment of say £30 per annum, i.e., equivalent to that of the payment allowed to the Centre Superintendent.

(*d*) In order to economise the time of the experienced health visitor, a somewhat greater amount of clerical assistance might be afforded.

(6) Home Nursing Service. Here again, the staff is below establishment. Efforts at recruitment of this increasingly needed service have failed. In this connection it is to be noted that student district nurses receive a training allowance of £335 per annum. This means that a state registered nurse, who is a staff nurse in hospital and whose scale of salary is £360—£460, experiences a drop in salary if she starts to take district training.

Regarding premises, it is suggested that a subsidiary home be established in the Broughton area, or that Home Nurses be allocated to, and live, on the district as midwives are allowed to do at present. Provision of housing accommodation might assist in recruitment for staff who wish to live " out." The Home on the Crescent would be retained as a training centre.

A night service has not yet been established.

(7) Home Help Service. Greater financial help will be necessary to meet the increasing need of the Home Help Service.

The big majority of cases assisted through the Home Help Service are aged persons. In spite of the great increase in the home help staff since the passing of the National Health Service Act, 1948, the demand still exceeds the number which can be employed, having regard to financial limitations in Salford.

The problem of *training* the home help in order to make her a fully effective member of the health team is a difficult problem which has not been solved in this area, although attempts have been made to do so.

(8) Health Centres. It is a matter for regret that no progress has been made in connection with the establishment of health centres in Salford. The majority of general practitioners provide surgeries which, no doubt, are the best available to them, but which in many cases are completely inadequate and unsuitable. Frequently, the surgeries are overcrowded, even to the point of overflowing, with the result that queues are formed outside the surgeries.

In spite of cordial relationship with the family doctor and their representatives, and offers to help in the provision of premises for group practice, no progress has been made. There appears to be no strong incentive among

the practitioners to join together. Undoubtedly, to achieve progress in a reasonable time, some special inducement of a financial nature will be required. To this end, one suggestion is that doctors might have the use of premises free of charge to themselves.

(9) HEALTH EDUCATION. Efforts to improve and extend sound health education for all members of the family should be made not only through recognised means of health education and the efforts of the health visitors, sanitary inspectors, and health education officer, but also through all members of the health team, including family doctors, midwives, home nurses and home helps. *Mothers' clubs*, which have been established as an informal but nonetheless valuable method of health education, should be increased in number and scope.

(10) TUBERCULOSIS. Co-operation at officer level is close, but during the last year it has been rendered most difficult and ineffective by the failure to appoint an adequate clerical staff for the chest clinic in spite of strong representations to the Hospital Management Committee. For a period of over a year, the "economy cut" (reduction of clerical staff from three to two) has damaged the service, the preventive aspects of tuberculosis have been neglected and the attack on this disease has been weakened.

(11) MENTAL HEALTH. Perhaps the most serious deficiency in the Mental Health Service is the shortage of candidates for appointment as social workers with suitable training both theroetical and practical. While it is important that some approved standard should be established, this should not be such as would make it difficult for workers to qualify in sufficient numbers to maintain a suitable reservoir of candidates. The home supervision of mental defectives is not carried out as thoroughly as it should be.

(12) CONVALESCENCE. Provision of convalescence for the adult patient has hardly been attempted in Salford.

(13) AMBULANCE SERVICE. I am informed that the efforts which have been made to secure economies in mileage in the Ambulance Service are being negatived to a great extent by decisions (which may or may not be unavoidable) of the bed bureau to send patients to hospitals situated at considerable distances from this area.

(14) ENVIRONMENTAL SERVICES. Although the National Health Service Act is not directly concerned with environmental influences which may affect the health of the people, no survey of any aspect of Salford Health Services would be complete without reference to the need for implementing :—

(*a*) A bold programme of housing both inside and outside Salford ; inside by multiple storey flats ; and outside in the overspill areas. This is a long-term policy.

(*b*) As a short-term policy, a programme of *up-grading of sub-standard housing* by provision of a hot water supply and other amenities (over 25,000 houses have no fixed hot water supply).

(*c*) Measures to bring about a *purer atmosphere*. To this end a modified proposal for smokeless zones is now being considered following the rejection of the previous smokeless zone proposals. Other methods of reduction of atmospheric pollution must be energetically pursued.

(*d*) More effective use should be made of the few open spaces in the City by the provision of children's playgrounds, parks, and green spaces.

SCHOOL HEALTH SERVICE ANNUAL REPORT

To the Chairman and Members of the Education Committee.

Mr. Chairman, Ladies and Gentlemen,

"*Children, if given half a chance, will mend their own health.*"

Our aim is to help parents by giving children more than half a chance of full health. Health is not a condition of mere absence of disease, but "*a state of being hale, sound or whole, in body, mind or soul.*"

School health is more and more concerned with the realisation of this "whole" idea of health for every child. It includes the study of all influences affecting the preservation and enhancement of health. We are concerned with the hygiene of school buildings, as well as with the prevention of the spread of diseases like ringworm or scarlet fever, which used to ravage our classrooms. We have learned to look beyond the individual child to the family in which he lives, and to his home and social background. It is vital to treat the family as a whole if we want the children to flourish individually. We can give parents guidance and advice in matters of health, but we cannot take away their responsibility towards the children—nor should we try. Indeed, our efforts must be directed towards the purpose—unpopular in these days of the welfare state, when some people expect everything to be on tap—of increasing the parents' sense of responsibility for the health of their children.

We are able to provide better and more comprehensive care for the handicapped child. It is not now sufficient to try to mitigate his handicap, to procure suitable educational facilities or even to train him for work he can do ; it is necessary to do all these and much more—to fit him for a full life with all its social, psychological and economic implications.

A feature of our school health service, of which we are more than a little proud, is the *health survey* carried out in schools by the school health visitor. In previous reports this has been referred to as the *rapid survey*, but this title may be misleading, because it is by no means always rapid, and, in fact, involves a comprehensive assessment of the whole health of the child.

Every pupil in our schools is examined annually by the school health visitor, using our health survey method. She visits the school immediately before routine medical inspection is due to take place, so that any child needing the advice of the assistant school medical officer can be seen by him almost immediately. If this arrangement is not possible the child receives an early invitation to a clinic session. The child's general condition is observed, but no detailed recording of results is done unless the child has some defect which needs attention. If possible, two rooms are used—one for undressing and an adjacent room in which the examination is conducted. In many schools lack of accommodation results in the undesirable practice of combining undressing and examining in the same room. If this arrangement is unavoidable, and personal questions can only be asked in the presence of other children,

the school health visitor visits the home to gain from the mother the information she seeks. The child is asked to remove shoes and stockings, and to strip to knickers or underpants, except in the case of the older girls who retain their vests or brassiéres. Clothing and footwear are inspected with the child.

I would refer your attention to an account of the health survey on page 15, in the form of three spontaneous conversation pieces.

Opportunities for research in the school health service are many. One such opportunity has been taken by Dr. Jeremiah, who was interested in *investigating the sleeping arrangements of children* he examined in school.

The parents of 2,000 children were interviewed, and the information obtained showed that 23% of the children had their own bedroom and the remaining 77% shared a room with one or more persons. Fifty-three per cent. slept alone, 45% shared a bed with one other person and 2% shared a bed with more than one other. In the majority of cases where children shared a bed, the bed was a double one and chosen freely by the parents as being more convenient than two single beds. This north-country popularity of the double bed may have a definite bearing on the communication of disease, and this point is being given further consideration.

It is important for parents to be present at the Routine School Medical Inspection.

In spite of talk of progress in many matters of school health, there is before us the sobering fact that the rate of *verminous infestation* in our children remains persistently high in spite of new remedies, including D.D.T. and Gammexane. It is a strange thought that before these new remedies against head louse infestation were generally known or available, Salford was one of the places where they were first tried out and their effectiveness established. It is obvious that material remedies are not enough. Co-operation of the parent, especially the mother, is needed. Infestation is usually a family problem, and if we omit to treat the family as a whole we do so at our peril. Possibly our search for infestation has become more rigorous since the availability of effective remedies, and that may be one factor in our continuing high rate. Nevertheless, the truth is that material and outside aids have their limitations. Nearly everything depends on the love and care given to children ; the interest and knowledge of the parents in their health and welfare.

Another item on the debit side of the school health balance sheet are the problems connected with the *working mother* who is away from her home all day. A child is often sent to school ill or ailing because there is no one to look after him. These border-line cases so often develop infectious diseases which have already been spread among classmates before diagnosis is made. We have noticed that the working mother never attends routine school medical inspection of the child, and therefore misses the valuable opportunity afforded for discussion of the child's physical and educational progress with medical officer and teacher.

I am happy to be able to record the good *co-operation which exists with Hope and Ladywell Hospitals* (how strange that they are both ex-municipal hospitals !) Co-operation with other hospitals in the area are not so well developed, but no doubt the links will be strengthened in time.

Another of our aims is to work in close liaison with *family doctor and specialist services*. No child is invited to the specialist clinics without the prior consent of his own doctor, to whom are sent details of the result of the examination. The specialist clinics are becoming so familiar to the doctors in general practice that many of them send children along with an introductory letter—just as they direct them to hospital out-patients' departments. In this way mothers and children are saved much travelling and waiting time. Contact has been successfully made with the family doctor by means of a *weekly bulletin* which is sent out advising them of such matters as the incidence of infectious diseases, and changes and improvements in our service.

I should like to record appreciation of the special help given to us by Dr. R. I. Mackay, consultant pædiatrician. His regular attendance at Regent Road Clinic and at the *monthly Child Health Panel meetings*, assists greatly in closing the gap between school health and hospital services.

I feel there may be a number of questions you would like to ask. May I anticipate them, and provide the answers ?

What is the general condition of our school children ?

The general condition of our children remains good. Of those medically examined in school only 4% were recorded as having "poor" nutrition. The

general condition of 41% was "good," and of the remainder "fair." These figures compare favourably with the position in recent years :—

	Good.	*Fair.*	*Poor.*
1950	36%	57%	7%
1951	38%	57%	5%
1952	41%	55%	4%

How many school children have been immunised against diphtheria ?

You may be proud of the high rate of immunisation—97% of all Salford children between five and fifteen years have been protected in this way.

What are the chief causes of death among school children ?

The following causes of death among school children were recorded during the past year :—

4 accidents by drowning.
2 road accidents.
1 subarachnoid hæmorrhage.
1 appendicitis.
1 acute leukæmia.
1 miliary tuberculosis.
1 carcinoma rectum.
1 congenital debility and mental defect.
1 nephritis.
1 bronchial pneumonia and chicken pox.
1 spinal tumour.
1 convulsion, bronchial pneumonia and mental defect.

More than one-third of the total deaths—six out of sixteen—among our school children were caused *by violence*. Two children were involved in road mishaps, and four were drowned—two in the canal, one in the River Irwell, and one in the sea whilst on holiday. All the children were boys. This is an amazing change from the days when tuberculosis and diphtheria caused the highest rates of death among young people. The majority of accidents are obviously preventable. The deaths of these healthy children on the threshold of their lives show us that no effort must be spared to reduce the deadly toll.

A long-neglected, yet very important cause of much suffering and ill-health, is the occurrence of accidents in the home. The number of these accidents does not force itself on our attention so clearly as the number of road accidents, since an injury caused at home, whether it results in death or is of a less serious nature, is not notified to the police or any other authority. And yet it has been estimated that there are at least as many home accidents as road accidents—approximately 8,000 people a year die from this cause.

We in Salford have realised the seriousness of this problem and, in an endeavour to find a solution, have set up a voluntary Home Safety Council. This council is made up of representatives from various interested groups—parents, teachers, business concerns, women's guilds, fire brigade and others.

The services which the council undertakes cover publicity in all forms on the subject of home safety, and the provision of speakers who are prepared to attend meetings, on request, to talk on the prevention of accidents in the home.

Which notifiable disease was most common among our children during 1952 ?

Measles heads the list with 740 cases, followed at some distance by whooping cough (195) and scarlet fever (161). Scabies occurred in 28 families, all the members of which (85) were treated. Conscientious treatment and diligent follow-up of cases has almost eliminated this disease, and in 1951 over 10,000 children were examined without revealing a single case. This annual survey was then abandoned as being a waste of time.

Twenty-four acute rheumatism cases were notified in accordance with the provisions of the Acute Rheumatism Regulations, 1950. All these children are carefully watched and measures taken to prevent a recurrence of the disease. The most suitable form of educational treatment is recommended for them, from a period of months in a residential school to continued instruction in ordinary school.

Twenty-six cases of pulmonary tuberculosis were reported and 18 children had pneumonia. In Salford respiratory illness often leaves bronchiectasis in its wake, and the treatment available at Claremont Open-Air School plays an important part in the pre- and post-operative care of children with bronchiectasis. Postural drainage is carried out by means of the Nelson bed, and under the supervision of the physiotherapist. The provision of such intensive treatment on school premises means that these children leave hospital at a much earlier date and benefit both educationally and socially. May the day soon come when the fresh air and other facilities of Claremont are the lot of every Salford child, well or ailing !

What provision is made in Salford for the educationally subnormal child ?

Although we have five special classes and a day special school in Salford to provide suitable education for this type of child, accommodation is still inadequate. During the year the intelligence quotients of 260 children were obtained. It was found that of these 57 could satisfactorily continue to attend ordinary school and 123 needed special educational treatment in an ordinary school or a day special school. Twenty-four children were recommended education in a residential special school ; 18 were notified to the local health authority as being ineducable.

Is any provision made for the convalescence of our sick children ?

Convalescent treatment has been enjoyed during the past year by 170 school children, who spent between four and twelve weeks in pleasant, healthy surroundings, away from the grime and gloom of the city. St. Anne's, Freshfield, Abergele, West Kirby, Taxal Edge, Macclesfield, were a few of the places chosen to restore the rosy glow to their cheeks. Cost of their maintenance —over £2,000 in 1952—was borne by the Education Committee.

The continued assistance of the staff of the Invalid Children's Aid Association in securing suitable accommodation for our children is very much appreciated.

We generally find there are a number of children who are in need of a holiday rather than recuperative treatment, and much use is made of the facilities of the Salford Poor Children's Holiday Camp at Prestatyn, on their behalf. As in previous years, groups of handicapped children—a total of 250—spent a beneficial week of their mid-summer holidays at this camp.

How many children are employed as part-time workers ? What type of jobs are popular ?

Of 469 children passed as fit to carry on part-time employment, 446 took up newspaper delivery and the others became errand boys or "entertainers." " Entertainers' " certificates are usually sought by girls who wish to take part in Christmas pantomime. The health and physical condition of these children are noted and appear, on the whole, to be above normal. They are re-examined at intervals of six months to see if their high standard of health is being maintained.

Is there any special provision for the treatment of chronic bed-wetters ?

The enuresis clinic, which was established in 1949, continues to function and is attended by Dr. Jeremiah. Enuresis is not an easy problem to overcome, and the percentage of cured cases—25%—is something of an achievement. Advice was given in respect of eighty-six children during the year.

What are the weak points in the School Health Service ?

I consider that our weaknesses include the persistent high rate of head louse infestation, the non-attendance of some mothers at routine school medical inspections, and the need for developing better co-operation with "ex-voluntary" hospitals and with family doctors.

Our staffing position needs some improvement, particularly in the case of medical officers, school health visitors and physiotherapists.

The school health visitor should help more in practical ways. Talks on parentcraft and public health services should be given to the child. Groups of children should also see, at first hand, something of the work of the sanitary inspector, home nurse and other members of the health team.

There should be more clinics on school premises. We must try to bring the services to the child instead of the child to the services.

There should be an improvement in the hygiene of school premises, from which the child consciously and unconsciously learns so much.

It does good to review our weaknesses from time to time, and to consider methods of overcoming them. I shall always welcome suggestions for the improvement of our service.

What features are on the credit side of the balance ?

Some blessings spring to mind when we settle down to count them. To name a few :—

We enjoy certain special services—the foot health clinic, ear, nose and throat clinic, pre-tonsillectomy clinic, audiometric testing, orthopædic clinic, physiotherapy, special investigation clinic, speech therapy, eye clinic, orthoptic treatment of squint, orthodontic treatment, instruction in dental hygiene by the oral hygienist.

We have modern equipment in our dental clinics, including facilities for X-ray.

We have special class provision for partially deaf, partially sighted, educationally subnormal and cerebral palsied children.

The two open-air schools offer wonderful facilities for treatment of the handicapped child.

Our home bound children are given home tuition.

We enjoy excellent co-operation with the Director of Education and his administrative and teaching staffs, family doctor, chest physician, children officer, housing manager, youth employment officer, mental health department, sanitary inspector, Hope and Ladywell hospitals, various departments of Manchester University and many voluntary organisations.

I should like to pay a tribute to the Chairman and members of the School Health Sub-Committee for the support given readily at all times.

I am most grateful to the Director of Education, F. A. J. Rivett, Esq., M.Sc., for the fine co-operation extended to this department during the year. It has been a pleasure to work with members of his staff, and in particular with the teachers of Salford, who help us so much in our aim to provide the best possible health services for our children.

My warm thanks are due too, to the medical, nursing and administrative sections of the school health service, without whose unflagging efforts the high standard of care provided for our school children could not be maintained.

I have the honour to be,

Your obedient servant,

J. L. Burn

School Medical Officer.

School Health Nursing Service.

Supervision of the health and cleanliness of children attending schools has been exercised as in former years, although staff changes adversely affected the work carried out.

There has been a shortage of staff throughout the year. One of the remaining full-time school nurses retired on superannuation, and no fewer than six married members of the staff resigned for domestic reasons.

All school nursing duties were, however, carried out. Some were even extended. Where combined work is in operation it is the general health visiting branch of the work which suffers in times of staff shortage, rather than the clinic and school work, and this has happened during 1952.

Additional clinic work was carried out, and more time and attention was given to home follow-up than in former years, mainly in relation to medical defects, but also with regard to cleanliness, verminous infestation and neglect in the home.

Reports on home conditions are now requested more frequently, and can be given in greater detail by the school health visitor who has known the family through her contacts with the pre-school child.

Changes of staff throughout the year has resulted in some lowering of standards in this and in all aspects of work, as newly qualified staff lack experience and cannot bring to their work the same degree of efficiency as that shown by health visitors who have spent some years in the service.

Personal Hygiene.

The infestation rate for the year was slightly higher than that for 1951, being 17% for primary and secondary schools against 16% in 1951.

In nursery schools, however, there was a marked increase to 29% from 19% in 1951. This increase was not shared by all six nursery schools ; in three there were fewer children infested, in two a slight increase in numbers, and in one—Great Clowes Street Nursery—an unprecedented increase from 3% in 1951 to 50%. This nursery was not well visited by the school health visitor who was ill during the early part of the year. It is easy to see that the infestation of two or three children could quickly spread to the remaining children if not checked, as possibly happened in this case.

Mothers made a greater effort to cleanse their children themselves when necessary—the number referred for compulsory cleansing was fewer than in the previous year and the number regularly referred for cleansing each term declined from 46 in 1951 to 25 in 1952.

Infectious Disease.

Twenty-one schools were specially visited with regard to outbreaks of infectious disease. It was found very difficult to control the spread of minor infections. Mothers going out to work will often send their children to school in the early stages of disease, probably suspecting them to be developing such conditions as, for example, measles, but hoping to be wrong. Meanwhile, contact with other children in the early infectious stage results in a rapid spread of infection.

MEDICAL INSPECTIONS.

School medical officers were assisted during the medical examination of pupils and the necessary preliminary weighing and measuring, vision testing and so on were carried out.

Work in schools (excluding treatment of minor ailments).

Assistance at medical examination (number of children)... ...	8,560
Number of examinations made at health surveys	11,706
„ „ „ „ „ hygiene inspections	71,567
„ „ „ „ „ hygiene re-inspections ...	9,487
„ „ individual children found to be infested	4,807
„ „ referred for compulsory cleansing	148
„ „ special examinations made *re* infectious disease ...	2,029

CLINIC WORK.

Minor ailments have been treated daily on school premises at Marlborough Road, Claremont Open-Air, Blackfriars Road, Broughton Modern, Barr Hill Open-Air and Broomedge schools, in addition to those treated on clinic premises.

All specialist clinics and routine medical consultation clinics have been attended by nursing staff.

The number of clinic sessions was increased by 492, as is shown below (sufficient to occupy one additional nurse almost full-time throughout the year).

	1952.	1951.
Minor ailment clinic sessions	2,144	1,842
Routine examination sessions	977	934
Specialist sessions	829	682
TOTAL	3,950	3,458

DOMICILIARY WORK.

Home visits were made to ensure that medical advice was understood and carried out ; to advise regarding cleanliness and verminous infestation ; to investigate absenteeism from clinics and in co-operation with the school welfare officers, absenteeism from school where this was said to be due to illness.

	1952.	1951.
Medical follow-up visits	1,375	968
Cleanliness and special follow-up visits	719	646
TOTAL	2,094	1,614
Additional visits where no access	204	

HEALTH TALKS IN SCHOOLS.

This aspect of school health work has been almost eclipsed owing to the pressure of other duties.

A mothercraft course was held at one school during the summer term, and a course on " Health—My Own Responsibility " was held in the winter term. The latter was started late in the term and was not completed. Facilities for teaching in another school were offered, but the health visitor for that area was unable to give the necessary time to take this up. At another school a start was made with a film strip series, but this was also discontinued owing to pressure of other work.

Specialist health visitor showing film strip to mothers and children.

It may be opportune at this point to remember that children learn mostly by example as well as precept.

The cleanliness of school premises is of supreme importance. A disturbing thought is that the standard of hygiene and cleanliness practised in our schools might not be high enough to be taken as an ideal throughout life, as it should be. For instance, there should be proper facilities for hand-washing after toilet, including towels which are changed daily, liquid soap in containers, and warm water. All secondary schools for girls should have an emergency stock of sanitary towels and bins for their disposal.

Cordial relationship and good co-operation was maintained between members of the school health nursing staff, the school teachers and members of other sections of the Education and other departments. On one occasion a school welfare officer reported having found an absentee from school unable to walk owing to an injury said to have been sustained a week previously, for which no medical attention was being given. The school health visitor visited the house the same evening, suspected a fracture of the foot and called in the family doctor. The boy was X-rayed at hospital the following morning and the fractured limb treated. The hospital almoner agreed, in response to the health visitor's request, that in view of the child's poor general condition and home circumstances, arrangements should be made for his admission to a convalescent home. Meanwhile, the health visitor had discovered that the child was on the waiting list for examination at the child guidance clinic. She was therefore able to inform the appropriate officer that the child would not be available for examination for a few weeks and to inform the almoner

that there was a psychological as well as a physical problem. The matron of the convalescent home was thus able to understand more easily the boy's behaviour but unfortunately his pychological condition was such that he was unable to settle down and attempted several times to abscond from the Home. He was discharged after his fourth attempt to return to his mother. The health visitor got in touch at once with the child guidance clinic so that early examination and treatment could be arranged. This account is given as an illustration of the smooth running machinery which can be put into motion for the welfare of one school child in need, where all the agencies concerned co-operate fully and freely.

HYGIENE ATTENDANTS.

Hygiene attendants have carried out the disinfestation of children and have assisted at clinics and in schools. One attendant is employed full-time at the Eye Clinic, the equivalent of another full-time attendant is occupied in assisting at minor ailments clinics. Much valuable assistance has been given to health visitors at health surveys and other examinations in schools. Receptionist duties have also been undertaken at specialist, routine medical and chiropody clinics.

Health Survey—*a verbatim report.*

" Good morning ! " " 'Morning nurse ! "

" What's your name, and where do you live ? "

" Mary Brown. Number twenty-four Smith Street, just round the corner."

" How old are you, and when do you have your birthday ? "

" I'm ten miss, and my birthday's in March, the eleventh."

" You are a tall girl, aren't you ? "

" Yes, I am tall, nurse, and so's my dad. My mum's always thin."

" Are these your clothes Mary, and your shoes ? "

" Yes, nurse. I'm wearing my wellingtons today but I'm getting some new shoes for Christmas."

" Do you wear socks inside your wellingtons ? " " Yes, nurse ! "

" That's fine." (School health visitor decides to visit the home to discuss with parent the unsuitability of wearing wellingtons in school. Girl is evidently sensitive about them. School health visitor notes that feet are clean and socks in good condition. The child's skin is well washed).

" Have you got hot water in your house ? "

" No, nurse, but mum baths me every Saturday night."

" And do you have your hair washed at the same time ? "

" Yes, nurse ! "

" Let me see it." (Examines hair). " How long it is. Does mummy comb it sometimes with a fine tooth comb ? "

" Oh yes ! And she looks in it too."

" Well it's very clean, shiny hair. I am pleased with you." (This brings a smile from the child). " I think I should wear a hair ribbon if I were you to keep it tied back in school."

" Yes, nurse ! I'll ask my mum for one."

" Do you trim your own finger nails and toe nails ? "
" No, mum does them."

" Do you have your dinner at school every day ? "
" Yes, because my mum works."

" Do you eat it all ? " " Yes."

" And do you like cabbage and carrots ? " " Yes, miss. I eat anything."

" And do you have an orange sometimes ? " " Sometimes."

" Do you brush your teeth ? Have you a tooth brush ? " " No, nurse ! "

" Well sometime, when mummy can spare 6d., she may let you buy a soft brush, and when you have it, brush your teeth this way " (indicates correct method).

" Do you go to the pictures ? " (School health visitor notes child's pallor and tired look. She is thin—probably under weight). " Sometimes, miss ! "

" Do you help with your sisters and brothers ? "
" Oh yes ! Mother goes out to work you see."

" How is mother ? " " She's all right nurse ! "

" And how is daddy ? " " Dad's poorly—he's in hospital."

" What's the matter with him ? Do you know ? "
" There's someting the matter with his chest. I think it's T.B."

" Have you had a photograph taken of your chest ? " " No, nurse ! "

" Do you sleep alone or with your sister ? " " I sleep with my sister."

" I think I'd like to see your mummy. When does she come home from work ? "
" About 6 o'clock."

" Well Mary, would you please tell her I'll be coming to see her one evening ? I should like to talk to her about daddy." (School health visitor intends to find out whether family have been X-rayed as T.B. contacts, and to investigate sleeping arrangements. She will make sure that mother is getting all available financial and material help).

" Is daddy getting better ? "
" Yes. I think so. Mum goes to see him a lot."

" I hope he's soon quite better." " Thank you nurse ! "

" You can get dressed now, Mary."

What cannot be conveyed in cold print is the pleasant, personal approach, the smile and kindly voice of the school health visitor. She notices, without mentioning the fact, any rash or sepsis on the child's skin, or perhaps the discharging ear, the general state of health, the colour and texture of the skin, the brightness of the eye, the glossiness of the hair, posture, and a score of other points, many of which can only be seen when the child is undressed, which, by their presence or absence, mean much to the discerning eye

Often the school health visitor already knows the home and social background, as she did in the case of this boy :—

" Hello John ! How are you ? " " Hello, nurse ! I'm fine thanks."

" Where do you live now ? Still in High Street ? Number six isn't it ? "
" No miss, sixteen."

" I've forgotten when your birthday is ? "
" It's June the first. I'll be seven then."

" How's your baby ? " " He's fine. Mother brought him to the clinic."

" Does he have his orange juice ? " " Oh yes. He likes it."

" Is mummy well, and is daddy well and working ? " " Yes ! "

" Do you still sleep with Billy ? "
" No ! Billy's got a bed of his own now."

" You have got a nice shirt John. It is a clean one ! "
" Yes nurse, it was clean on this morning."

" Have you had your bath this week and had your hair washed ? "
" Oh yes, nurse ! "

" Let me see your ears. Don't forget to clean them like the pussy-cat does ! Let me see your teeth. Did you brush them this morning ? "
" No nurse, not this morning."

" Well, John, I should like you to brush them twice a day, after breakfast and before you go to bed. Can you remember that ? " " I think so."

" Do you have your dinner at school ? "
" No, I go home at dinner-time."

" What did you have for breakfast this morning ? "
" Cornflakes and mashed egg and cocoa."

" Do you go to the pictures John ? " " Sometimes."

" Do you go to bed early ? " " Oh yes ! "

" What time do you go ? " " About seven o'clock—when baby goes."

" Good ! Did you go on holiday last year ? "
" Yes ! We went to a camp. It was smashing."

" You have got nice shoes on John. Who polishes them for you ? "
" My dad ! "

" And are these your socks ? " " Yes ! "

(School health visitor looks inside shoes to see that there is ample toe room). " Now listen John. Your feet are growing all the time, so when mummy buys your next pair of shoes will you see that they are long enough in front to let your toes grow straight ? Does mummy take you with her when she buys the shoes ? " " Oh yes, nurse ! "

" Do you bring a handkerchief to school ? "

" Yes—it's in my trouser's pocket."

" Don't forget to use it will you ? "

" Do you think you can remember to tell mummy I saw you in school today, and will be coming along to see her and baby at home ? "

" I'll try nurse."

The general condition of this little boy was good and as he appeared to be progressing satisfactorily, the school health visitor considered it unnecessary to refer him to the school doctor. The following account, however, illustrates that this happy conclusion is not always the case :—

" Good afternoon ! You're Patricia aren't you ? I think I have your name and address here. Have you had your dinner ? " " Yes ! "

" Do you go home for it or do you have it in school ? "

" I went to my gran's. We have our dinner when mum comes home from work at night." (Girl sniffs).

" Have you a cold Patricia ? " " Yes, nurse ! "

" Do you get many colds ? " " Yes ! So does my dad."

" Have you a handkerchief ? " " No ! "

" Well here's a piece of lint to use this afternoon—but you should have your own handkerchief you know."

" Do you have oranges and apples ? Oranges would be good for you when you have a cold. Would you ask mummy to buy some when she can spare the money ? " " Yes, nurse ! "

" Who sleeps with you Patricia ? "

(Girl replies hesitatingly). " My sisters."

" And do you have a window open at night ? " ' No, nurse ! "

(It is obvious that knowledge of elementary rules of health are lacking in the home).

" Well, try to have the window open a little bit will you ? It will help prevent you getting your colds."

" Do you have cod liver oil and malt ? " " Not now ! "

" I think you should, don't you ? I'll ask doctor to have a look at you and perhaps he'll prescribe some for you. Will you come, Patricia, if I arrange for an invitation to be sent to you ? " " Yes, nurse ! "

" Does mummy go out to work ? " " Yes ! "

" And daddy, is he working ? " " Not always."

" Tell mummy you've seen nurse in school today and that she will call and see her or daddy at home." (School health visitor intends to outline principles of health education and to tell mother that Patricia will be invited to attend the assistant school medical officer on account of the frequent colds. She looks at girl's clothes and footwear).

" Are these your shoes Patricia ? " " Yes, nurse ! "

(Shoes are second-hand and are not weatherproof. Child's socks not properly darned). " Have you got another pair of shoes Patricia ? " " No, miss ! "

(School health visitor makes a note to mention to mother method of obtaining shoes with the help of the Education Department).

" Try to stand up straight Patricia and hold your shoulders back. Walk to the end of the room for me, will you, and then come back here."

(School health visitor notices that the child is not walking well. Makes a note of her poor gait on the health survey form for doctor's information).

The school health visitor endeavours, before, during and after the survey, to confer with the teacher, and glean from her the all-important knowledge of the child "in action"—how the child is getting on in school ; is he friendly or solitary ? ; is he full of life ? ; does he eat his school dinners well ? ; is he a happy child ? ; is he effectively living up to his potentialities ?

What opportunities are opened up by the use of this health survey ! Not only for the health supervision of the ordinary child but for the early detection of deviations from the normal. This method is not new by any means ! Good medical officers and school health visitors have been doing it all their working lives, even if not exactly in the form just described.

The Ear, Nose and Throat Clinic.

Dr. Florence Cavanagh reports :—

In this account of the work of the ear, nose and throat clinic I would like to show how often contact is made with other workers—family doctor, dentist, health visitor, almoner, speech therapist, school teacher—since we have always in mind the welfare of the child as a whole.

The consultant utilizes her general medical knowledge in spotting conditions other than ear, nose and throat diseases and when signs of trouble elsewhere are found the patient is referred to the appropriate department, orthopædic, plastic, cardiac, dental, etc., for investigation.

A child's general health is frequently underminded by infections in the nose or throat, and there are times when it is important to build up his constitution before sending him to hospital for operation. I have seen many such cases in the past year and have made great use of facilities for convalescence. By close liaison with the almoner and the clerk who arranges admissions to Hope Hospital, I have been able to send certain children to convalescent homes for a few weeks and arranged their admission to hospital for operation immediately on their return, whilst their health is at a high level.

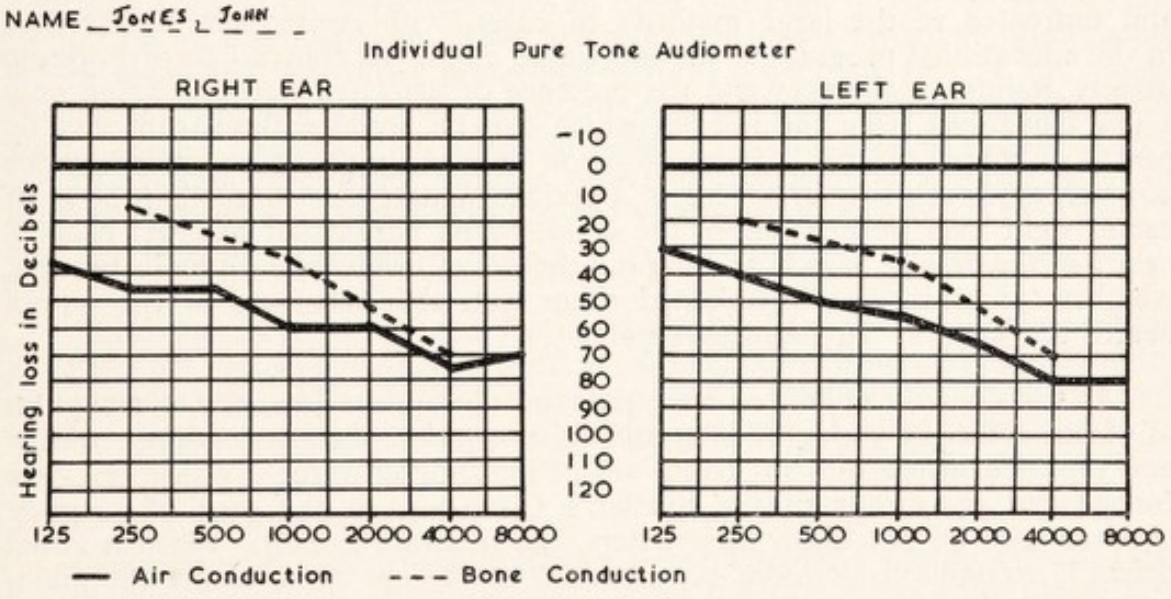
In other cases recommendations have been made for children to be admitted to open-air schools in Salford, and even to seaside open-air schools for periods of one or two years.

We have also had contact with many class and head teachers. Education is an integral part of a child's life and any doctor dealing with children must keep this constantly in mind. In my clinic, where the problem of deafness arises, this is particularly important. A hard-of-hearing child who is very clever may be able to compete with normal hearing children and do well in an ordinary school. He may need to sit on the front row in class. He may need to use a hearing aid or to attend a lip-reading class once or twice a week. With such additional help he can usually manage very satisfactorily.

On the other hand a child with a similar degree of deafness whose I.Q. is not so high or who has fallen behind in his school work because of absence due to illness, may find himself unable to do his lessons. He may become very unhappy. His school work will suffer and in some cases his general health may be affected. If we send such a child to the class for partially deaf children (which we in Salford are so lucky to possess) tremendous difference in his outlook is quickly noticed. He appears happy and his work improves. He is enthusiastic, and we have found that after a time, when his confidence has been restored, he can return to his ordinary school and hold his own with his normal-hearing classmates.

In these problems a letter from a teacher who knows the child, is invaluable. It may be realised that the child is having difficulty in keeping up with the others and the teacher knows that as he grows older and work gets harder his difficulties will increase. When a patient of this type has been examined and a chart of his hearing obtained, an estimate of his educational requirements can be formed, but it is only after talking to the parents and considering the teacher's report that a final decision is made. I have known of a number of children who, according to their audiometric charts, were only capable of education in a school for deaf children and yet, because of particular factors in the home background and in the child's intellectual ability, we have decided to leave him in an ordinary school. Two such cases are at present doing well—one aged 7 and the other 10 years.

A third patient, who has been watched for twelve years, is particularly interesting. He became grossly deafened after a serious illness at the age of six. An audiogram was obtained first when he was six and a half years old. Tests have been repeated on many occasions and have remained substantially the same.



Looking at this chart one would have no hesitation in recommending education in a school for the deaf, yet this boy has continued at an ordinary school in competition with boys who hear well and he recently passed the General Certificate of Education in six subjects.

The ear, nose and throat clinic has for some years been run on lines very similar to those of an E.N.T. Department in a children's hospital—and in fact many family doctors in the Salford area now refer cases direct to this clinic with a letter addressed to the consultant. This closer liaison with the family doctor is to be welcomed since such co-operation benefits the child.

New antibiotics have come into use and have added to our power of combatting infections. Recently we have been using chloromycetin as a dressing for discharging ears and though this is not quite as good as we had first hoped, it is, nevertheless, an excellent and useful drug. It is, unfortunately, very expensive and in order to save the Education Committee perhaps £200 a year we have written to the family doctor of each patient requiring this treatment asking if he would prescribe the necessary drops. The child has then taken the solution to the clinic nurse and we are glad to report that in only one case was there any lack of co-operation from the family doctor, and this was due to a misunderstanding which was quickly cleared up.

The problem of children with speech defects is still large. Our first concern always is to discover the cases due to partial high-tone deafness. Their treatment is straightforward, but the remainder form a difficult group. The country, as a whole, is short of speech therapists ; the length of time a child must attend for treatment is considerable and there is frequently a wait of months before a child can be admitted to the speech clinic. During this time his bad speech habits become more fixed. These children are often of the sensitive and " highly strung " type and it is impossible for such a child to retain his self-confidence. If his speech defect is not quickly remedied he tends to become a problem child with further loss of efficiency in his school work, to say nothing of his personal happiness.

Eye Clinic.

A notable contribution to the maintenance of a high standard of *vision* in our school children is made by the regular eye tests given in schools by assistant school medical officers and school health visitors. Before the days of compulsory examination of school children visual defects went undetected and untreated in the large majority of cases, with consequent interference in the educational progress of the individual child. In contrast to orthopædic defects, lesions of the skin and the presence of defective teeth, to name only a few deviations from the normal which can be noted without difficulty by parent or school teacher, defects of vision may easily go unrecognised by the non-professional observer. This is a serious matter, for more than 50% of useful sight may be lost before the child, or its parents or teacher, become aware of the defect. It is in seeking out defects of vision by routine inspection, whether symptoms are complained of or not, that members of the school health service play an important part.

It should be emphasised that pain or discomfort is rarely a symptom of visual defect in young people, and this is one of the reasons that routine and repeated inspections in school are of inestimable value. Vision tests are carried out by means of the Snellen's Chart or, in the case of younger children who do not know their letters, the Illiterate E Test. When a visual defect is recognised, periodic examinations at the eye clinic assure the maintenance of a high degree of correction of the deficiency. The parents of children who fail to attend after repeated invitations are visited at home by the school health visitor, who stresses the importance of regular attendance. By this means the number of children whose visual defect remains untreated is negligible. It has been found that co-operation is more easily obtained from the parents if the situation is fully explained to them.

Children are referred to the eye clinic from various sources—by medical officers after medical inspection in school ; by school teachers ; by school health visitors after health surveys in school ; by the staff of the maternity

and child welfare department ; by parents themselves and by opticians. Good co-operation between teachers and members of the staff of the eye clinic has existed for many years. The following quotation from a report of the Chief Medical Officer of the Ministry of Health shows how valuable is the teacher's discerning eye in this matter :—

> " One cannot over-emphasise the importance of securing the teachers' help in the discovery of young children with defective vision. As they are in constant touch with children they are in a better position than anyone else to detect symptoms, such as holding a book too close, difficulty in seeing the blackboard, adopting a bad position at the desk, or showing signs of educational retardation—which may be indicative of defective vision."

There has been an increase in the number of educationally backward children sent for examination, but in not more than approximately 30% of these children is there any marked defect in visual acuity. Yet even 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 regular flow 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 years, and responds to local treatment for a few weeks or months in the majority of cases. It is only a small percentage of cases which require lacrimal probing in hospital. The usefulness of the early reference of cases of squint in the pre-school child cannot be over-emphasised. They are refracted under mydriatic, and glasses where necessary, are often prescribed within a week or two of the squint occurring. A number of 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 three to four years) 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 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.

Treatment of Squint.

Children with squint usually have a hypermetropic 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.

In the case of myopia, when it is found that the condition is not worsening, the child is encouraged to return to ordinary school for the last three or four years of his school life. The same policy is adopted for the congenitally defective children and when the visual acuity is not below 6/36, it is arranged for such children to sit on the front row in the classroom on return to the ordinary school.

COLOUR VISION TESTING.

Colour vision testing has been carried out on 6,500 children between the ages of 11 and 18 years. The group testing method employed was the Collins-Drever group test, followed by the Ishihara test where defective colour vision was suspected.

It was necessary to pay a preliminary visit to 40 schools to arrange with the head teacher in each department for the use of a suitable room containing approximately 10 or 12 desks, which faced towards the northern light wherever possible. Each child was supplied with a stencilled chart upon which he was instructed to write his name, age and school. In the upper part of the chart provision was made for the recording of the interpretations of the five positions of the Collins-Drever group test. This test for colour-blindness is a simple one which has been constructed specially for use with children. It consists of the letter E, approximately 3in. × 2in., printed on a 9in. diameter circular card which may be rotated. The background of the letter is formed of confusion colours, printed in the form of hollow squares. The test card was hung in a suitable position and candidates asked to draw the letter in its various positions. In the lower part of the chart stencilled spaces were drawn for each of the 26 Ishihara Vision Charts used for individual testing. These tests are composed of a series of cards on which are printed backgrounds of coloured spots. Interspersed among these background spots are figures, also made of coloured spots of suitable size. These are so arranged that the colour defective cannot make use of brightness discrimination. The desks in the classroom were placed so that the possibility of copying was minimised, and the pupils were instructed that copying would invalidate the test. The stencilled charts were collected immediately on completion and the desks soon occupied by the next group for testing.

In recent years there has been an increasing conviction that pre-vocational and school testing of colour vision would be of advantage in view of the fact that many occupations of later life require a good standard of colour discrimination. It has been made clear that the undetected colour-deficient subject may be unsuitable in special branches of a great variety of occupations including the Royal Navy, the Royal Air Force, the Army, the Post Office, the Police, the Merchant Navy, the British Railways and Customs and Excise. H.M. Services and British Railways avoid this less efficient group by systematic testing. Colour defectives in branches of industry which require personnel with satisfactory colour discrimination, frequently cause a loss of time and efficiency, and as the vast majority of employees pass into industry direct from school, it would seem that school tests of colour vision would be a most satisfactory way of overcoming the choice of unsuitable employment.

Those children whose group test results showed error were re-tested individually using the Ishihara Charts. The following results of the investigations were obtained :—

Boys.		*Girls.*	
Number tested	4,816	Number tested	1,762
Number defective	190	Number defective	5
Percentage defective ...	4%	Percentage defective	0·3%

There were 150 children with complete red-green blindness, and the remainder, 45, had incomplete red-green blindness.

School Dental Service.

The year has been notable for a great improvement in the staff position, and we find ourselves at its close with a much happier prospect in this respect than has been the case for the past few years.

Large numbers of children, mainly those who have not had inspections or treatment for some time, have presented themselves or been referred by medical and nursing staff for treatment and been treated. Routine inspection in school, and treatment ensuing from this, has suffered in relationship, but the downward trend in this respect has been checked. With our Murray Street Clinic now working on a permanent full-time basis, and the reintroduction of school inspection in this area, a substantial improvement is in sight.

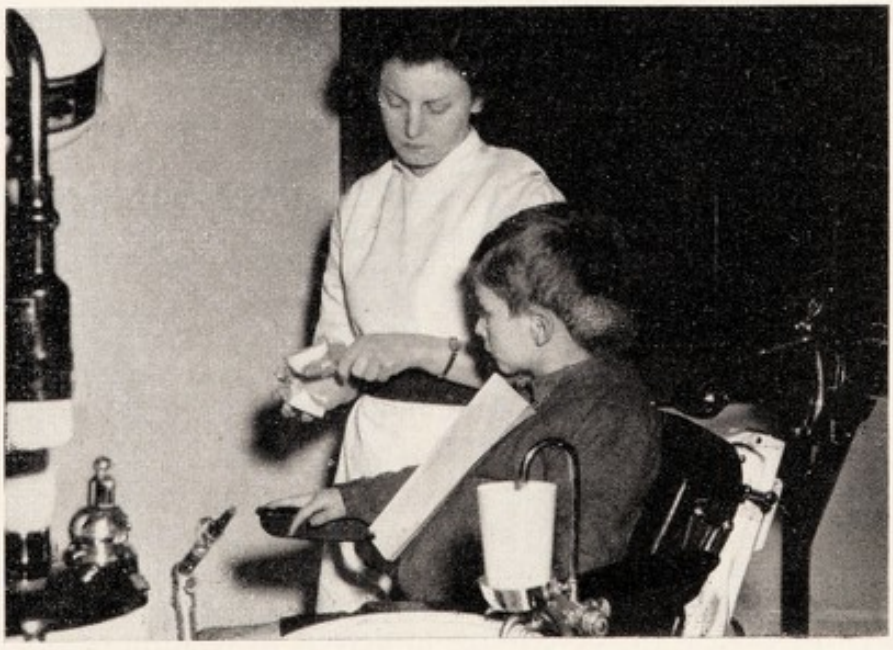
Treatment of "casuals" (mainly children suffering from toothache) inevitably entails a high proportion of extractions, and we are indebted to our anæsthetists for the provision of an excellent anæsthetic service.

Conservative Treatment. Two thousand seven hundred and eighty-two fillings in permanent teeth and 586 fillings in temporary teeth have been inserted during the year. Many more treatments of a conservative nature, listed as "other operations" (such as silver nitrate in deciduous teeth) have been performed.

Dentures. Forty-two children have been provided with partial dentures. In the main these are as a result of accidents, etc., to anterior teeth.

Oral Hygiene. This branch of the work was resumed early this year with the appointment of a trained oral hygienist.

The work of the hygienist is of great interest in that, in an age in which dental disease is widespread, it represents a new step forward in preventive dentistry. The aim is to restore the mouth to a healthy hygienic condition, in which the possibility of disease is reduced to a minimum, and to instruct



Oral hygienist demonstrating the correct method of cleaning the teeth.

the patient in the best manner in which to maintain that condition. All treatment and advice given by the oral hygienist is supervised by the dental surgeon. Whilst this is a service from which all children could benefit, for practical reasons it is concentrated upon those showing the greatest need.

During the year 1,193 children have attended for treatment, mainly scaling, cleaning and gum treatment. Instruction in oral hygiene has been given individually and collectively, both in clinics and schools.

ORTHODONTICS. The appointment, this year, of a dental technician in the school dental service has been of great value, particularly with regard to orthodontic treatment. Not only is a full orthodontic service now available, but in consequence many more children are receiving treatment than formerly. The demand continues to be heavy, but great strides have been made towards meeting it.

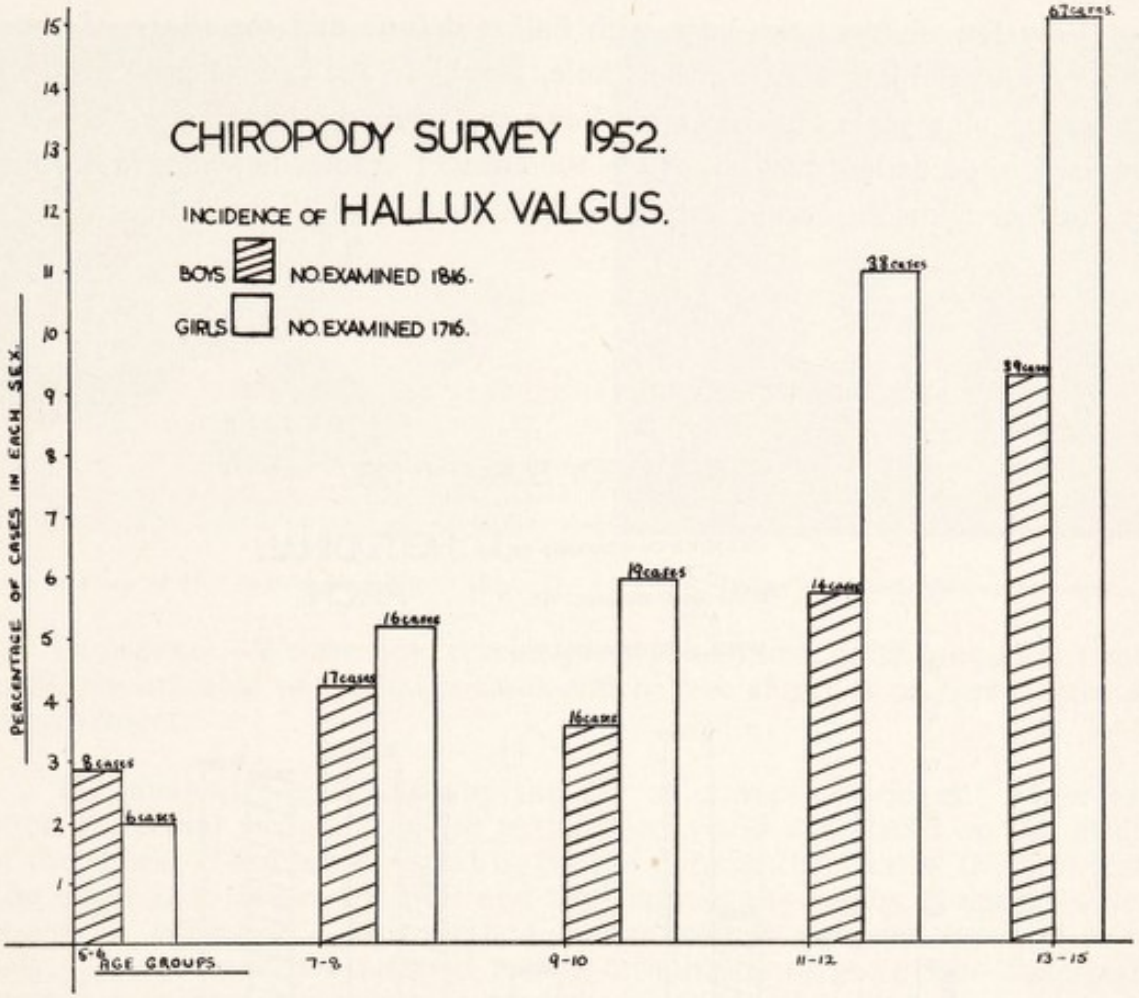
In conclusion, may I say that we are indebted to the services of the consultant orthodontists, whose advice in planning treatment has been invaluable.

Foot Health Service.

In presenting the annual report of the foot health service, we are able to show a further increase in attendance for treatment provided at Regent Road and Murray Street Clinics and the Langworthy Centre. Patients are drawn from various sources : (*a*) they are discovered as a result of inspections conducted in schools by the consultant chiropodist ; (*b*) they are referred by nursing staff from health survey examinations ; (*c*) they are sent to the clinics by medical officers, teachers and parents.

SURVEYS IN SCHOOLS. During the past year a carefully conducted survey of the feet of 3,500 children was carried out along special lines, inasmuch as great care was taken to ensure an even balance in the numbers of cases examined in the different age groups, as well as an even sex distribution. Details of this survey are given at the end of the report. In as many cases as possible social background was noted. Consideration of all these factors is essential if a reasonably accurate analysis of the statistics is to be done. For instance, a comparison of the results obtained on examining county secondary school children whose parents are in good economic circumstances, and those whose parents belong to a poor economic group, generally show marked differences. When there is little money to spend the shoes purchased are sometimes of an inferior design, and repairs to shoes are neglected for the same reason. This, naturally, influences the condition of the children's feet. Fortunately a high standard of mothercraft does not depend wholly on the financial position of the family.

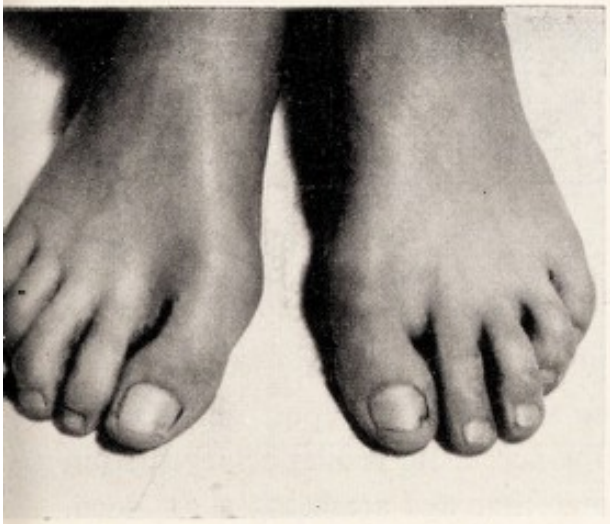
HALLUX VALGUS has received special consideration. Defects of the hallux of children and their association with gross hallux valgus and chronic bunions in the adult, has been studied. A significant factor in hallux valgus of the child is the steady increase in the percentage of defects in relation to the increasing age groups.



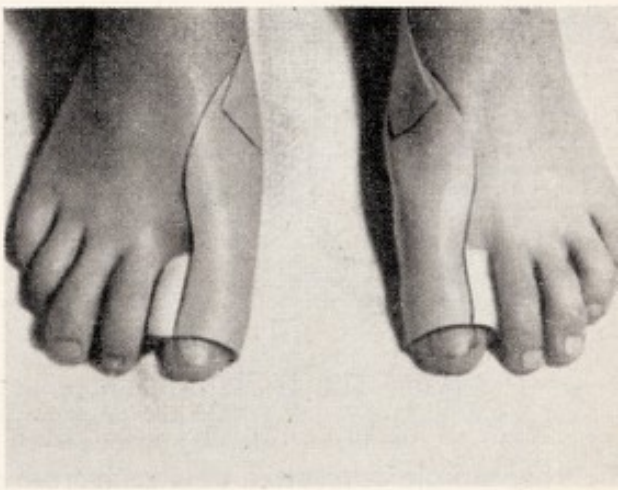
Careful examination of the cases has revealed certain aetiological factors :—

(*a*) There is an association between hallux valgus and pronation, due to the thrust of the medial side of the great toe as the child walks with the foot splayed.

(*b*) It is significant that from the age of seven years there is a marked increase in the percentage of defects in girls over boys. The degree of deviation in this factor becomes more marked as the age groups ascend due, no doubt, to the tight-fitting, conical-shaped hose, narrow pointed-toe shoes, peep toe and court shoes, worn by the older girls, not to mention the wearing of parents' " cast-offs."

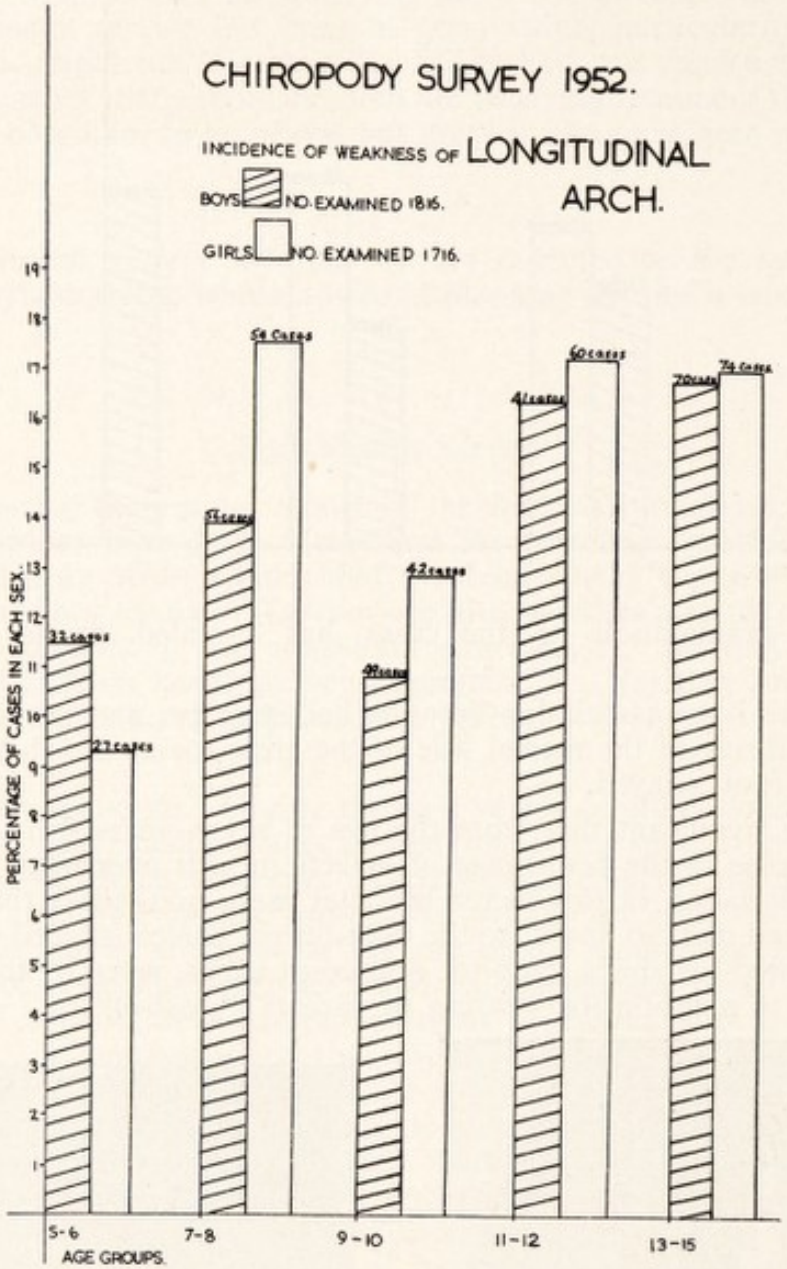


Gross hallux valgus in a boy aged 12.

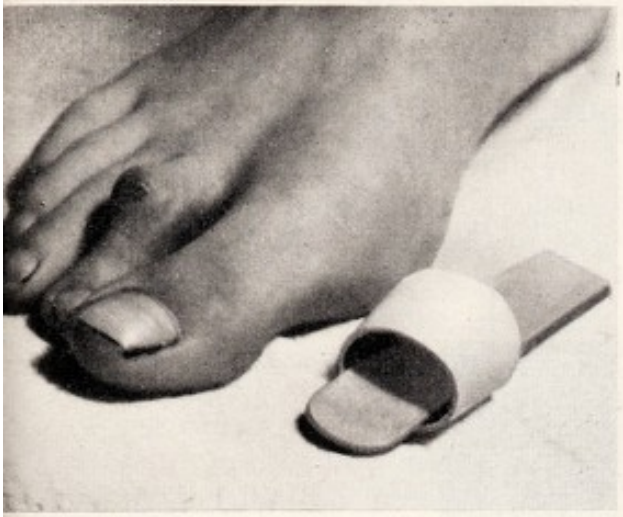


Same boy wearing corrective traction slings.

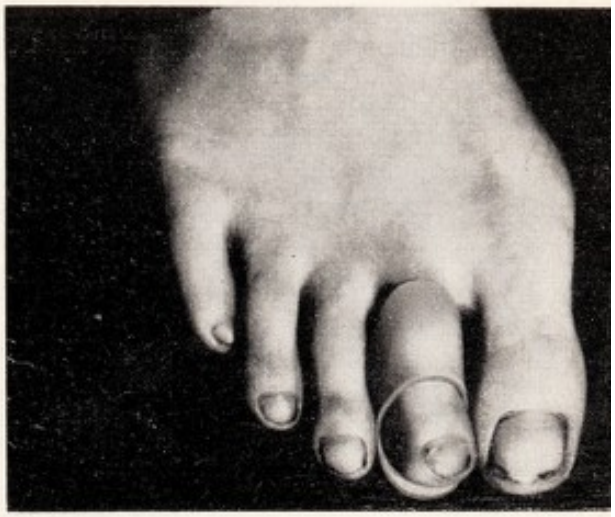
Very few children are born with hallux defects and the shape of shoes of very young children, is, on the whole, good. In the case of girls from the age group nine years and onwards, however, when the larger size shoes are required, shoe design, particularly in the cheaper grades, becomes faulty and its ill-effect upon the feet is very easily observed.



Lesser Toe Defects. There is nothing significant to report in the treatment of these conditions other than that the successful results achieved from the simple corrective devices introduced some time ago are being maintained.



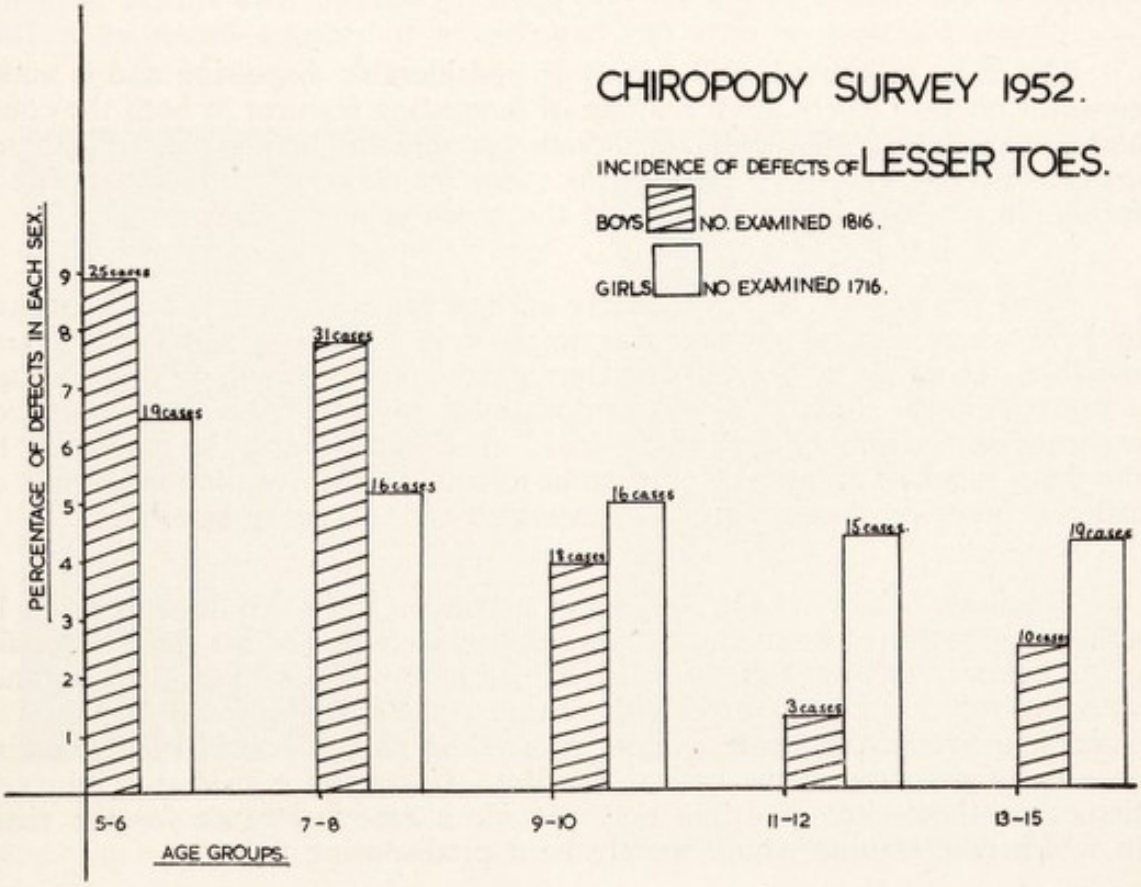
Hammer toe in a boy of 15. Replaceable splint on right.



Splint in position, showing correction.

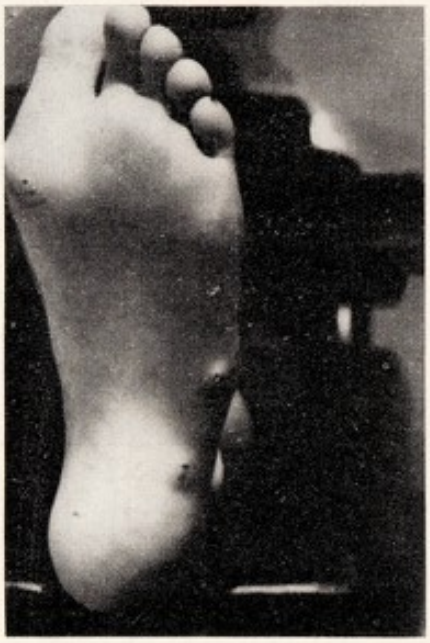
PRONATION. We are now reaching the point where, with long-term treatment, we are able to discharge cases which have shown a marked degree of improvement.

The method employed is by the use of corrective wedges. These are fitted as medial wedges attached to heel socks and are placed on the inside of the shoes. They are designed to tilt the floor of the shoe at the heel seat. The effect is to invert the heel and thus correct the valgus deviation which occurs in pronation. This method of treatment is designed for mild cases only. Severe cases are referred to the orthopædic surgeon, who frequently prescribes corrective insoles and exercises or some other form of appropriate treatment.



VERRUCAE. These are circumscribed growths of an innocent character but which are contagious and innoculable.

There are various types of warts ; the small colourless nodules occurring on the face and the body ; the fissured cauliflower-like growths which are seen occasionally on the face and so frequently on the back of the hands, and again in some cases on the dorsal aspect of the feet ; and planter warts which are found on the soles of the feet.



Plantar verrucae ball of great toe and lateral margin of foot.

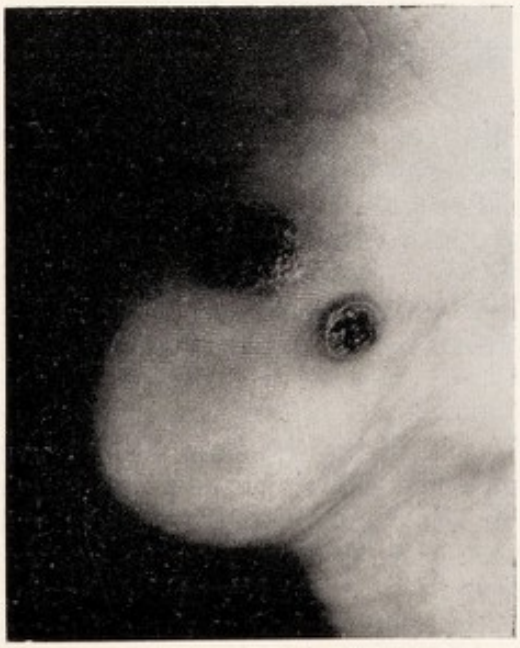
The cause of warts is still subject to considerable discussion and is under constant review. There are a number of interesting features in both the cause and the pathology of the lesions which are difficult to explain. These are (*a*) the infective nature of the growths ; (*b*) the traumatic association of the formation of these lesions ; and (*c*) the psychological factor.

Virus Theory. The infective nature of these growths was first demonstrated in 1893 when Tissaud showed that warts were auto-innoculable and transmissible. It was later proved that the infective agents could be put through a bacterial filter. Finally, it was demonstrated that warts could be produced experimentally from filter-passing virus. The virus theory is supported by the long incubation period ; in some instances the incubation period of experimentally-produced warts has extended up to twenty months.

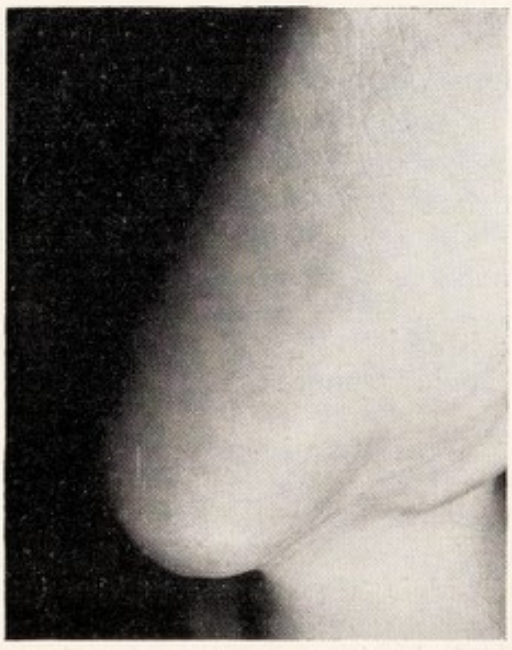
Traumatic Theory. The traumatic origin of warts would appear to be amply demonstrated by the numerous cases which come before the chiropodist in the school health clinics, in which the situation of the lesions corresponds with pressure areas associated with certain defects of the shoes or feet, i.e., sharp and prominent insole margin, protruding nail, retracted toe producing an area of pressure on the ball of the foot. It may be argued that injury to tissues on these sites of origin may provide a ready entrance for the virus, in which case trauma would merely be a predisposing factor.

Clinical features of Plantar Warts. In the foot health service we are, naturally, primarily concerned with plantar warts, which are not, as a rule, difficult to diagnose. The plantar wart has certain characteristic features, one of which is the circumscribed character of the growth, with a slight amount of callous tissue overlying the lesion which, when removed, shows a whitish line of demarcation. This is the fibrous wall separating the growths from the healthy tissue, which is a characteristic of all innocent growths. Within this whitish ring the tissue looks yellow and spongy, and often shows little dark red dots which are the enlarged and elongated papillæ of the true skin. The presence of these papillæ, containing blood vessels, makes the growth highly vascular and hypersensitive. The only reason that there is not a marked protrusion of these lesions is that the patient is standing upon them most of the time ; otherwise they would protrude like any other type of wart. This brings us to an interesting point of diagnosis—namely, that the patient complains that the warts are most painful when placing the foot on the ground first thing in the morning. Later in the day the areas become less sensitive and painful. The explanation of this is, of course, that a slight protrusion of the growths has occurred during the night while the feet have been at rest. The lesions are, therefore, very painful on first standing, until they are pressed back again into the tissues. Primary growths may be noted over pressure areas, and sometimes secondary growths in the surrounding areas. These are frequently quite numerous. They may be scattered or may form a close cluster round the primary growth.

Treatment. Treatment takes a variety of forms—potential cautery (the use of corrosive substances such as acids and alkalis) curetting, fulguration, X-ray and crimotherapy (the use of carbon dioxide snow) etc. In the Salford foot health clinics drastic measures are not often found necessary. Treatment is usually by potential cautery, and we use a combination of lactic and salycylic acid. This method is relatively painless and has proved effective with a minimum number of attendances and with no painful results.



Plantar verrucae before treatment.



Same growths after three applications of lactic and salicylic ointment. The foot as it appeared one month from date of first treatment.

In the rare instances where this treatment is not effective, cases are referred to the skin specialist for X-ray or other forms of appropriate treatment.

Psychological Factors. It should be realised that in consideration of these factors we may move away from purely physical considerations into the realms of psychology and even into fantasy. It is interesting, however, to note that today many learned authorities acknowledge the psychological factor in the treatment of verrucæ, and readily admit to the knowledge of many instances where these lesions appear to have been " charmed " away. Professional wart charmers date back to antiquity.

In conclusion, I feel it necessary to refer once again to the importance of teamwork. I am happy to record the presence in Salford of that close co-operation between chiropodist and school medical officer, consultant specialist, physiotherapist and health visitor, not to mention the administrative section of the school health service, without which no foot health service can be maintained efficiently.

Speech Therapy.

This has been an uninterrupted year for speech therapy in that, for the first time, there have been two therapists functioning without a break throughout the year, to the greater benefit of the children. Over 3,000 attendances have been made by 180 children who have received treatment during the year. There have been 43 final discharges—the speech of the children concerned becoming satisfactory after treatment.

During 1952, short talks on speech therapy have, as usual, been included in the various afternoon programmes arranged by the School Medical Officer, for groups of student nurses from Pendlebury Children's Hospital.

Once-weekly visits to Cleveland House Spastic Class have continued throughout the year, five children being under treatment. Progress in these cases is of necessity slow, but each child has been noted to have made improvement.

It is of interest to read a brief account of some of the children who are referred for speech training :—

Johnnie : aged 6 years 7 months at time of interview. Younger of two children. A small-built but sturdy child of somewhat freckled appearance, he showed such extensive dyslalia that his speech was almost unintelligible. He was a very spoilt child and had been used to having all his own way at home ; staying up late because he wanted to ; eating whenever he felt like it, and running round at meal-times. He would not amuse himself at home but liked his father or some other adult to play with him. Both parents joined in spoiling him.

Signs of an impending storm showed itself during the child's first appearance at the clinic, whither he was accompanied by his father (at that time unemployed through ill-health—the mother being out at work all day) : while the therapist was advising the parent that Johnnie should go to bed early each night, there was a sudden interruption : " I wont ! ", said Johnnie, in a low, threatening voice . . . . Some months elapsed before the child could be admitted for treatment, and, as might be expected, this was very up-hill work for a while. The boy was pert, disobedient and extremely lazy. He attended regularly, however—thanks to the vigilance of his head teacher.

A home visit was arranged, and the problem discussed between therapist and mother. Following this, the parents steeled themselves to a firmer handling of the child. As his treatment proceeded, Johnnie's speech and manner slowly but surely took a turn for the better, and this was further noticeable following a visit to his school by the therapist, when after a talk with the head teacher, it was settled that Johnnie must attend Sunday School regularly as a disciplinary measure (he used to attend but had stopped going because he liked to play out instead). Accordingly, the head teacher instructed Johnnie to report to him each Monday morning regarding his attendance at Sunday School. Thereafter, the boy began to make a determined effort at the Clinic. His manners improved considerably : instead of bursting into the treatment room on arrival at the clinic he now knocked politely at the door—and waited till it was opened !

On provisional discharge from the clinic Johnnie's speech was perfectly clear. He had then been attending for one year five months. After a further three months the therapist visited the child's school, and he was given a final satisfactory discharge.

Paul : aged 11½ years. An only child of healthy and well-cared-for appearance. The boy showed stammer and slight dyslalia on 'r' and 'l' sounds. He was extremely tense, nervous and excitable, and frequently gave way to uncontrollable outbursts of giggling during class treatment. He told the therapist that he kept on laughing in school and couldn't help it. The boy showed great anxiety about his health (at that time he was waiting for tonsils operation which was shortly performed) and, as might be expected, he lacked concentration and would frequently interrupt with some quite irrelevant remark. Relaxation therapy appeared negative at first, but after a few sessions there were signs of benefit from this.

Shortly before Christmas, when the boy happened to be on his own at the clinic, he was asked if he would like to sing a carol. This met with immediate assent, and he sang in a clear, true voice, and with great sincerity, the nervous symptoms having temporarily abated. The therapist at once contacted the singing master at his school, who stated that the boy was very tense and excitable but possessed a good voice. Accordingly, arrangements were made which enabled Paul to join numerous singing classes, and the master later reported that the boy was full of enthusiasm—always the first in the room—and appeared to live for the singing. Within a short while, he also joined his church choir. Meanwhile, Paul continued to attend the speech clinic for individual treatment of the faulty consonant sounds, but after a few weeks his attendance lapsed, and efforts to get him to continue were fruitless. During this time, however, it was noted that he had undergone a great change for the better : the excitability had abated, likewise the stammer, and he was now able to concentrate. On later enquiry, both form master and music teacher reported great all-round improvement.

Keith : aged 7 years 10 months at time of admission for treatment : younger of two brothers. Keith showed general dyslalia which was characterised by laterally-sounded consonants. He was big for his age, and rather dull-looking and heavy-eyed. He had had a good deal of illness as a baby, including abscesses in his ears. An operation for tonsils and adenoids was performed shortly after the child received his first interview at the speech clinic. On admission, he was found to be a very fluent reader, and stated that he was also quick at arithmetic. It was noticed, however, that the boy often

seemed stupid and slow to answer when spoken to. He was referred for an audiometer test, and found to be suffering from fairly severe high frequency deafness, the right ear being worse than the left. He was afterwards seen by the consultant ear, nose and throat specialist who noted that he had a polypus in the right ear. This was subsequently removed, with great improvement to the hearing in that ear. The left ear, which had been discharging, also received medical attention. Following this, the boy's speech defect began to clear up, but a psychological element presented itself regarding his handwriting which was careless and badly-formed. Keith seemed very apathetic and hopeless about this, and said he would never do as well as his brother who had won a scholarship. The school was visited, and a discussion followed with the boy's class teacher : (the speech by now was more or less normal, but Keith's attitude towards himself had to be considered). It was decided with the teacher that the boy must be encouraged to do daily copy-writing at home, and bring the work to school for the teacher's inspection. A talk with the child's mother followed, and it then transpired that both parents had been adopting a very pessimistic attitude towards Keith's writing difficulty. The mother was advised about home practice, and also the necessity for an encouraging and hopeful attitude on the part of both parents. This called forth an assurance from the mother of her willingness to co-operate.

Speech rehabilitation is not a one-man job. In this field we must enlist from time to time the co-operation of many others who may be more qualified to give us the necessary information to supplement our own assessment of the child. In almost every case it is necessary to seek further advice before and during treatment—frequently from the assistant school medical officer for investigation of general health ; from the ear, nose and throat specialist on problems of nasal obstruction, where tonsils and adenoids are thought to be enlarged, or where hearing appears to be defective ; from the orthodontist when dental irregularities are felt to contribute to the speech defect ; from the child guidance department on problems of maladjustment, which may lie at the root of the speech difficulty or may perhaps have resulted from it.

It can be seen that in the treatment of each speech defective child the work of the speech therapist is greatly eased and accelerated by the close co-operation of the parents and teacher.

Robert (8 years) was a timid speaker, his voice little more than a whisper. He is one of a large grown up family. He used to say :—

" I tint my teet are tore "	for	" I think my feet are sore."
" I wite wump chudar "	„	" I like lump sugar."
" A dwoter'd dan at the door "	„	" A grocer's van at the door."

There is little co-operation from home. His parents, both out at work during the day, are too busy in the evenings to supervise a speech lesson to remind Robert of the sound he has been learning in the clinic. But Robert's teachers are interested and are kept up to date with details of his achievements, and have arranged sentences for him to show off to his classmates just what he can do. Now he can say 'k' and 'g,' 'l' 'f' and 'u' in words and sentences, and 'th' and 's' with care. He can say—" I like lump chugar," " A gwocer's van at the door," " I think my feet are sore."

On occasion he forgets about the 'th' and 's' and sometimes the 'k' and 'g' but these sounds are becoming a more natural part of his everyday speech and it is hoped he will soon be able to use the right sound in the right place every time. There is certainly nothing timid about his speech now.

Johnny's tongue looks too large for his mouth and it moves awkwardly. Many of his consonant sounds are thick and sloppy.

" I think so " becomes " I fink tho " ; " sock " becomes " thock."
" Time " becomes " tthime "—a combination of 't' and 'th.'
He says " wabbit " or " labbit " for " rabbit."

His mother was worried because he was always bumping himself, walking into doors, falling off the pavement. This suggested that there might be some general muscular inco-ordination, and that his poor control over the speech muscles was part of a general problem. He was referred for examination by the assistant school medical officer, and is being kept under observation. At the clinic he exercises his tongue to give it :—

(1) firmness to tidy the sloppily articulated consonants ;
(2) agility to move from one consonant to another and from consonant to vowel sound as in " time " ;
(3) good movement and placing in the correction of the defective sounds.

Tom (7 years), an only child, was referred by his teacher for correction of his lisp. At the interview it was noticed he had, as well as defective 's,' 'sh,' 'th,' and 't,' a tendency towards stammering. There were frequent repetitions, of which he was quite unaware, of words, parts of words and sounds. " Will, will, will you come to my bir bir birthday ppparty ? "

The case history revealed he was a nail biter and was subject to temper tantrums. He sometimes burst into floods of tears if anyone spoke to him. It was felt at the time that there was some deep rooted psychological disturbance showing itself in general uneasiness and nervous speech. He was referred for advice to the child guidance clinic.

Special Investigation Clinic.

The work of this clinic has continued during the past year with increasing elaboration of service. There were 445 consultations during 1952, involving 245 individual children. Of the children examined 10% (23) have been referred to Hope Hospital for admission for investigation, always with the prior consent of the family doctor. As in previous years, the majority of children were suffering from disorders of the respiratory tract which often required simple measures of treatment only. Thirteen children, diagnosed as cases of bronchiectasis, have all been investigated fully and referred to the Thoracic Surgical Unit. A few of these have already had surgical treatment. Thirty-five children with rheumatism, some of whom were recent discharges from hospital, have been examined. Almost all of them were able to attend ordinary school, with no restriction of activity. One child with a long-standing heart disease has been referred to the Thoracic Surgical Unit for consideration of operative treatment of the heart condition. Children were seen with emotional disorders which often could be dealt with by simple advice to parents or adjustment of the school situation. Among these were ten cases of exogenous obesity, most of whom improved markedly when given a diet with restricted carbohydrate intake.

Although the clinical side of the work is important, by far the most progressive side of the clinic activities is the co-ordination of preventive and educational services of benefit to the child. The clinician is able to adjust

the child's way of life more directly than can be done in a hospital clinic or in general practice since the administration, in the person of the health visitor and her colleagues, is at his elbow. The consent of the family doctor, who is considered an important member of the preventive health team, is always sought before his patient is invited to the consultant's clinic. He is also furnished with a report on the findings of the subsequent examination.

Full use is made of the special educational facilities provided by the authority, particularly the open-air schools. The benefits of a period at the open-air school are very apparent when conducting follow-up examinations of the pupils attending. Very few children do not express enthusiasm when questioned about these schools. Although much valuable work is done to restore handicapped children to normal school and life, one has the impression that more children, with a wider variety of ailments, could be admitted to open-air schools in the convalescent phase for a limited period. This would prevent considerable loss of school time for these children.

There is still a small number of children, with a variety of complaints, for whom there is no satisfactory provision. Some of these have home teachers. Some might be considered suitable for the hospital school at Hope Hospital if it were not for the disruption of family life that is involved, and for the fact that this is not justified when no medical treatment can be offered. Though their numbers are small and their prospects in life often limited, these children are difficult problems to the families concerned.

Child Guidance Clinic.

The main function of the child guidance clinic is to help parents in the upbringing of those children who show signs of emotional disturbances for instance, stammering, nail-biting, nightmares, lack of self-confidence, or of concentration, poor progress at school, bed-wetting, aggressive or destructive behaviour, truanting or stealing.

Some of the children are referred to the clinic directly by the parents, but most come at the request of the education authorities, the school medical officer and the children department. Children who come before court are occasionally referred for a diagnostic interview.

The work of the clinic is based on the principle of team-work : the educational psychologist assesses the child's intellectual endowment and development, the psychiatric social worker tries to ascertain the social and emotional background in which the child has grown up, and the psychiatrist attempts to discover the emotional problems of the child himself and their causation, make a diagnosis and decide whether he can and should be treated at the clinic and/or what other steps should be taken to help him to overcome his problems.

Not all children who are referred require treatment. Sometimes all that is necessary is to reassure the parents that the difficulties which the children show are passing phases in their development. On the other hand, some children present serious problems but cannot be treated because either they are insufficiently endowed intellectually or because the parents cannot be persuaded to co-operate. It has been found that only very few children (mainly adolescent) can be treated without the co-operation of the persons responsible for their upbringing. Fortunately, the majority of parents and children who attend the Clinic co-operate well and in these cases the results of treatment are encouraging.

Special Class for Partially Deaf Children.

Since the opening of the special class at Regent Road School in September, 1948, 31 children have been admitted. The class consists of a maximum of ten children, boys and girls, of a wider age range than is normal in schools but which is not completely avoidable for a special class of this kind. It is not without its advantages.

The aim of the special class is to open another door to the world for the deaf child, to provide a vocabulary that will be acceptable to the community without fear of derision, and to give him a measure of self-confidence.

The children come to Regent Road from schools throughout Salford on the recommendation of the ear, nose and throat specialist at the school clinic. After periods ranging from six months to three years they return to normal school work, and in the majority of cases, with much improved results, as reports from head teachers testify.

Of the children who have left school and gone to work, one has become an apprentice joiner, one a shorthand typist, one a box maker, and one a plumber's mate. One girl this year was nominated for our Anne Openshaw Award for religious knowledge, and received the prize as she returned to normal school, after two years in the special class. Not all children, however, benefit to this extent and three children are to be re-admitted for further periods of tuition following adverse reports on their progress.

Activity over the past twelve months has included a Harvest Festival, when the children made up their gifts into ten hand-made baskets and delivered them each personally to child patients in Salford Royal Hospital. Hallowe'en was remembered suitably by duck-apple and other revels of the Feast of Pomona. For November 5th, the girls made treacle toffee, which all enjoyed. A Nativity Play produced in December had six performances attended by audiences of parents and children from the infants' and mixed departments. For the Christmas party the girls baked three large mince pies and the boys prepared the jellies. For Shrove Tuesday, the girls, now full of confidence, made small pancakes. Easter saw a colourful show of spring flowers planted as bulbs the previous autumn, and grown in the indoor garden of the classroom. In July, the class joined in a wonderful day's excursion to Birkdale in the teacher's shooting brake. With autumn came a " berrying " expedition resulting in three and a half pounds of crab apple and bramble jelly, gathered, cleaned and cooked by a triumphant cookery team.

With all these unusual activities the basic " three R's " are not overlooked. Reading takes first place, and the individual tuition made possible by the smallness of the class shows good results. Arithmetic, where each child works at his own speed on his own separate scheme, fills in many of the blanks left vacant by illness and school absences in early years, and enables a firm foundation to be laid for subsequent tuition in normal classes. Daily diaries help to extend the limited vocabulary of the deaf. Folk dancing and the percussion band helps to establish a rhythmic sense so lacking in the speech of the deaf. Lip-reading and speech lessons need special attention. History, geography, nature study, science and hygiene are lessons greatly assisted by the use of filmstrip and cinematograph, together with a well-stocked library of illustrated books. Daily prayers and religious instruction bring to life many of the abstract thoughts and feelings so difficult to understand in a world of visual learning.

In a friendly, cheerful atmosphere, the children rapidly regain their lost confidence. The wish to learn returns and the majority go back to normal school work, no longer so handicapped, and able to hold their own in a hearing society.

Claremont Open-Air School.

The aim of open-air school treatment is to equip the handicapped child, in as short a time as possible, to lead as normal a life as possible. This means that steps to improve his physical health and encourage his educational progress must be taken side by side. With this in view efforts are made at Claremont to provide as much medical attention as possible on the premises. The medical room is, in turn, doctor's examination room, minor ailments clinic, physiotherapist's treatment centre and sunray clinic. In this way the considerable time spent in travelling to and from outside clinics is saved, and put to better use in the classroom.

Delicate children and children with respiratory diseases form the largest groups of attenders at this school. Other handicaps include congenital heart disease, hæmophilia, epilepsy, anæmia and post-operative debility. Each of the 150 pupils is seen by the school doctor at least once during each term, and the 15 children in the partially-sighted class are visited at six-weekly intervals by the ophthalmologist. A monthly record of all heights and weights is kept by the nurse who also holds a daily session for the treatment of minor ailments. Two afternoon sessions, as well as a short daily period, are spent at the school by the physiotherapy staff who give remedial exercises and massage to the physically handicapped children, and instruction in correct breathing to the children with respiratory disorders. In addition, postural drainage of bronchiectasis cases is carried out daily on two specially made beds. During the year 145 children received some form of physiotherapy.

The average length of stay at Claremont is 30 weeks, by which time the child is generally considered fit to resume his place in ordinary school. Fifty of the 75 children who left during 1952 followed this pattern. Six of the remaining 25 left the district, 3 were admitted to hospital and places were found for 3 children in residential schools. Eleven pupils were re-admitted to ordinary school at the parents' request, the chief reasons for this being of a religious nature or an objection to the great distance between school and home.

School meals—breakfast, dinner and tea—are prepared and served in an adjoining canteen which is shared by two other schools. Medicines and vitamin supplements prescribed individually by the doctor are served immediately after meals. To facilitate the distribution of these extras each class has its own medicine tray which is wheeled to the canteen by trolley in readiness for the end of the meal.

Children for whom periods of rest and quiet are recommended spend the resting time on beds and blankets in the open shed.

The school bus continues to transport to and from school those children who live in outlying areas.

Barr Hill Open-Air School.

Barr Hill Open-air School accommodates one hundred of our handicapped children. The majority of attenders are delicate, anæmic or suffering from malnutrition, and benefit greatly from the fresh air, adequate rest, regular meals and vitamin supplements provided. Lessons and playtime are spent in the open wherever possible, and the children make good use of the playing fields at the back of the school.

Each child is seen by the assistant school medical officer at least once during each term—more frequently if necessary. These examinations are carried out on school premises, as are physiotherapy and the treatment of minor ailments by the school nurse. As with Claremont Open-air School, we endeavour to bring the health services to the child in order that his scholastic attainments should not suffer by long absences from the classroom.

The average length of stay at Barr Hill is sixteen months. Fifty-six children left during the year, the majority of them to return to ordinary schools. Others moved away from Salford and three children with bronchiectasis were transferred to Claremont Open-air School, where more intensive physiotherapy was available.

Hope Hospital School.

The work of the past year has, on the whole, been uneventful. There have been fewer long-term cases of rheumatism and chorea, and the long-term orthopædic cases have been mostly very young children. The majority of patients in the hospital school have, in fact, been among the lower age groups.

During the year there has been an increase in the number of beds reserved for tubercular meningitis patients, and the earlier rehabilitation of these has involved a good deal of specialised teaching, though the incidence of deafness among these children has been less frequent.

In the early part of the year a group of children from each ward was taken by ambulance to see " Peter Pan " at the Palace Theatre, Manchester.

We were delighted, in the early summer, to be given a piece of land in the hospital grounds, to be used as a children's garden. This was fitted out with large nursery toys, and a sand pit and pool for water play, but owing to the poor summer weather the opportunities of enjoying the facilities of what has become a charming garden have been disappointingly few.

The Christmas entertainment took the form of a film show in which children from all the wards participated.

The Spastic Class.

In the early part of the year several of the older children improved sufficiently to be able to transfer from Cleveland House to the open-air school or to ordinary schools, so that the age range is now not so wide, and the class consists mainly of infants and young juniors.

One or two of the younger children have been hindered in their school progress by absences due to operations, but as the mobility of these children has improved very considerably the delay cannot be deplored.

All but one of the children are now able to feed themselves quite normally, and the social training received at school has had most gratifying results.

The class had a most enjoyable Christmas party and also watched the film show at Hope Hospital.

Home Teaching.

The home teacher visited six children—homebound because of their physical condition—during the first few weeks of the school year. In March, one child was transferred to Claremont Open-Air School, and in May, another was notified to the Local Health Authority as ineducable. Shortly afterwards, a boy, paralysed in both legs and with only partial use of the hands, was admitted, bringing the number to the usual quota of five.

With the exception of one, these children are making good progress. Though perhaps not quite up to the educational standard of normal children of their age, each has advanced in some direction. Many times the child's condition precludes any sustained effort ; then the work proposed has to be abandoned for that session. Progress, therefore, is variable. Nevertheless the interest shown, especially in reading, and the obvious pleasure derived from their lessons, proves how valuable this scheme is.

At Christmas the teacher arranged a party at her own home where the group met together for the first time. Since then, the children have been keenly interested in one another's welfare, frequently sending messages and occasionally writing to each other.

Physiotherapy Service.

Steady and continued improvement in the work of the physiotherapy department has been shown during the past year. Various staff changes led to interruptions in treatment sessions, but towards the end of the year the staffing position improved greatly. Clinics were functioning well and children in the special schools were obtaining adequate treatment.

Four *sunlight clinics* have been fully employed throughout the year. All children referred for treatment have been invited at once and no waiting list has been allowed to accumulate. More family doctors have taken advantage of the service offered and there has been a welcome increase in the number of children sent for treatment.

The weekly physiotherapy clinic held by an assistant school medical officer has proved particularly helpful in assessing the benefits derived from artificial sunlight and other forms of physiotherapy treatment. The evening sessions on Monday and Thursday at Regent Road Clinic have been continued for the benefit of mothers who are working and unable to bring their children until after 5 p.m. This arrangement is very much appreciated.

Remedial exercises, massage and electrical treatment are given at least twice weekly at six of our clinics.

The largest increase in attendance has been in those children who have received instruction in breathing exercises after the removal of tonsils and adenoids. More co-operation is needed from mothers who fail to bring their children for a course of post-operative exercises. The only desire of some mothers appears to be for the child to have the operation. When this has

been done they feel no further effort is required on their part. Each child attending for the post tonsil and adenoid operation breathing exercises is given a leaflet of instructions to be carried out at home under mother's supervision.

During 1952 there was no large outbreak of poliomyelitis necessitating a big increase in physiotherapy work, so more time could be given to minor orthopædic faults such as round shoulders and pronated feet. It has been found advantageous, to the children, for the work of the chiropodist to be co-ordinated with that of the physiotherapist. The chiropodist provides insoles to hold the weak feet in a good position while the physiotherapist gives exercises to strengthen the weakened muscles, so that the feet can be retained in the corrected position.

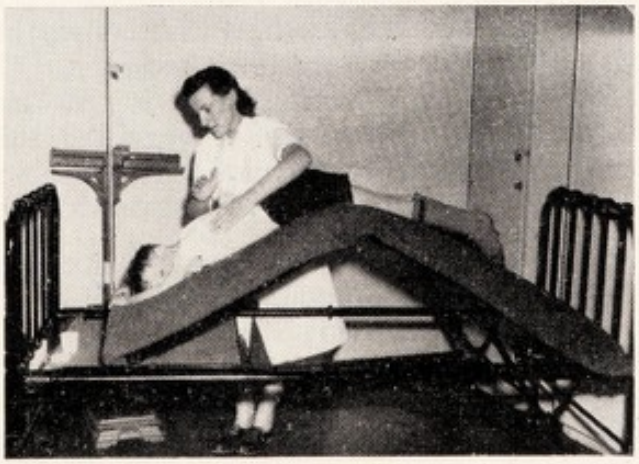
In all branches of the work it has been found helpful to give the children leaflets outlining simple exercises to practise at home.

The twelve children in the *spastic class* at Cleveland House have made slow but steady progress in physical attainments. Some have achieved more improvement than others, which is only to be expected, considering their various degrees of physical handicaps. The physiotherapists spend five half-day sessions each week in treating them. Most schools established for children suffering from cerebral palsy admit only children with reasonably high I.Qs., but no such barrier precludes cerebral palsied children from the training given in the class at Cleveland House. The aim of treatment is, wherever possible, to make the child physically capable of taking his place in an ordinary school.

In spite of every encouragement it is still felt that mothers do not play as big a part as they could in co-operating with the physiotherapist. This is shown by the fact that few mothers take advantage of the good opportunity to meet the physiotherapist at the clinic during school holidays. Attendance for treatment when the schools are closed is very poor.

Twice weekly visits for physiotherapy treatment are made to *Barr Hill Open-air School.*

Towards the end of the year it became possible to increase the amount of physiotherapy provided at *Claremont Open-air School.* A high proportion of children attending this school are handicapped by such chest conditions as pre- and post-operative bronchiectasis and asthma. Children requiring



Treatment of bronchiectasis by postural drainage.

postural drainage undergo this treatment daily with the physiotherapist's supervision. In addition, on two other weekly sessions, a total of three physiotherapists give treatment which includes artificial sunlight and remedial exercises. Other types of handicaps treated at Claremont include severe post-poliomyelitis defects, tubercular bones and congenital deformities. The recent provision of a helper to collect the children from their classrooms and assist in their undressing and dressing is much appreciated, as in this way a great deal of the physiotherapist's time is saved and put to better use in treating the children.

Report of the Organisers of Physical Education.

The event of the year was the publication of the Ministry of Education's "Physical Education in the Primary School," Part I. The title "Moving and Growing" introduced a new outlook on the whole subject. This booklet, along with Part II, which is expected to be published in the near future, will replace the 1933 Syllabus of Physical Training. The terms used in the past, *viz.*, "drill," "P.T." and "physical jerks," for the physical activities in the schools, are now part of the past and replaced by the physical education of the present day which embraces a much wider scope of activities, bringing about a different relationship between the teacher and class with a different idea of discipline and class control. This change had already begun in Salford, and it has continued to make progress during the year in many of our schools, so leading to much more enjoyable and purposeful training during the P.E. periods by both teachers and taught. The adoption of this new outlook requires a good supply of apparatus, large and small, to give all children ample opportunity to practise and acquire individually both games and gymnastic skills. The various sections of the P.E. programme throughout all types of schools are reviewed in the following order :—

(1) Physical training lesson with equipment and clothing.
(2) Organised games and out-of-school activities.
(3) Swimming.
(4) Dancing.
(5) Activities in Youth Clubs.

(1) The Physical Training Lesson, Equipment and Clothing.

The daily P.E. period is a feature of the time-table in all schools ; in infant departments it is usual to have both a morning and afternoon period. In departments where there are senior girls who spend a whole day out of school at Domestic Science, the number of periods must perforce be reduced by one period per week.

There is a general trend to adopt the more informal lesson with teacher-guided, rather than teacher-directed work, and to give the children opportunities of handling and learning to use the apparatus. This trend is more marked in the infant and junior schools. There is still further need for the provision of large apparatus in many departments, but this is costly and it is only possible to equip a certain number of departments each year. Some large P.E. equipment was sent into 27 departments during 1952.

It is the work in the all-standard departments that continues to give some concern. The lack of indoor accommodation makes it difficult to give senior children the most useful and satisfying kind of work. Some progress has been made in this direction by the use of an additional privately controlled equipped gymnasium which is visited by schools in its immediate neighbourhood. The solution will only be found when complete reorganisation has taken place.

(2) Organised Games and Out-of-School Activities.

The intense national interest in organised games and its demand for more adequately marked and level grass-covered playing space is shared by both primary and secondary schools in their request for all children to be given time during school hours to play games on a proper pitch. The Education Committee during the past year has attacked this problem with vigour and progress has been made. The development of the Stott Lane playing field has begun and will ultimately provide splendid playing facilities in the Weaste area for the future Clarendon Secondary Modern School children, and for numbers of other children also.

The Northumberland Street site in the Higher Broughton area has been completed as far as was possible on the money allowed for this purpose. Unfortunately, it was possible to level only half of the ground, and this has been given a cinder surface which makes it unsuitable for the playing of very vigorous games. Representations have been made and are being made to the Ministry of Education for further grants, and should these materialise it is hoped that it will be possible to make this site into a really good playing area.

It is pleasing to note the increased interest being taken by many more schools in cricket, rounders, and athletics. To coach and play these activities with safety and efficiency adequate markings and a good level surface are necessary. Lower Broughton Playing Field, the property of the Education Committee, can provide these facilities to the enjoyment of countless children.

The various out-of-school physical activities promoted by the Salford Schools' Sport Federation have had a very good season. Winter and summer the work of the Association has gone on with varying success but with two main aims in view, *viz.* : to engender interest, enthusiasm and skill in a particular activity, and to develop that high ideal of true sportsmanship for which our country has always been noted and which can only come from participation in fair competition and friendly rivalry.

Whilst the general standard of play or participation has not been perhaps as high as one could wish, both county and national honours and success have come to individuals and city teams. The City Association football team reached the final of the Lancashire Schools' Football Association and the seventh round of the English Schools' Trophy Competition. The athletic section had a boy who reached the final of the 220 yards in the English Schools' Championships and the swimming section for the first time in its history had a boy selected to swim for Division II in the English Schools' Swimming Championships. The city netball team reached the final in the Lancashire Tournament.

(3) Swimming.

The policy of the Education Committee that as many children as possible should be given the opportunity to learn to swim is reflected in the figures for both swimming certificates and the awards of the Royal Life Saving Society, both of which show an increase on the 1951 figures.

Of the certificates given by the Education Committee, the following awards were made :—

Third Class Certificate ... ... (One length breast stroke).	1,191
Second Class Certificate ... ... (Two lengths breast stroke).	889
First Class Certificate ... ... (Two lengths breast stroke. Two lengths back stroke).	568
Advanced Certificate... ... ... (Diving ; crawl, front and back. Breast and back stroke).	39
Total Certificates awarded	2,687

which is an increase of 312 on the number awarded in 1951.

The Baths Committee awarded 1,191 free season tickets to the children who gained the Third Class Certificate.

Twelve medals were awarded by the Humane Society of the Hundred of Salford, four being allocated to girls and eight to boys, and 130 children were examined for these awards.

A new national honour in swimming was gained by Salford during 1951. The Primary and Secondary Schools' Shield awarded by the Royal Life Saving Society to the authority showing the highest percentage increase in the number of awards during the year was won by this authority. It is gratifying to see that the figures for 1952 show an increase of 181 awards over 1951. The number of swimmers and improved standard of swimming at the fourteen school galas which were held during the year was worthy of notice. This is an increase in the number of galas for school children over the previous year.

(4) DANCING.

Dancing continues to form part of the curriculum in all schools where there are infants and girls. More of the all-standard mixed schools are introducing it successfully as a mixed class subject.

Three separate courses in dancing open to teachers of both sexes were taken during 1952 and were particularly well attended. American square, community and square dances were types of dancing covered in these courses.

(5) PHYSICAL ACTIVITIES IN YOUTH CLUBS.

(i) *Indoor activities.*

As in previous years, there has again been a steady development of indoor activities. During the year, two teachers' courses in American square and community dancing were held, and two further courses in netball. All of these courses were well attended by teachers and leaders from youth clubs.

(ii) *Outdoor activities.*

Development of out-of-door activities has made substantial progress and with the provision of more pitches by the Parks Department more clubs and organisations have been able to secure facilities.

Health Education in Schools.

During the year health education has been influencing the lives of school children in various ways. Visual and aural aids have been used to emphasise the joy of healthy living. Information on matters relating to health has been given by the distribution of posters and pamphlets in schools at the request of teachers.

A feature of our health education plan in schools is the distribution of the booklet " A New Adventure " to parents of those children about to start school. The booklet contains attractively illustrated hints on how to keep children fit, and is received with appreciation by parents.

Talks have been given by the health education officer and school health visitors to parent-teacher associations. Parents and teachers play the most effective part in health education because they are able to study the individual child and train him by their good influence.

Health education should arouse in the child the awareness of his responsibility for his own health. Good habits may be formed at an early age, and even very young children can be taught about health the play way.

The Sanitary Inspector in School.

It is not by accident that our children keep free from serious outbreaks of disease. While the doctor and nurse keep a sharp look-out for signs of ill-health and neglect the sanitary inspector keeps his eye on the environment and guards against the channels of infection.

If the doctor or nurse rings the warning bell a visit will be made by the sanitary inspector to school or home for an investigation of any environmental condition which may be affecting the child's health. For instance a dirty or verminous child means that something is going wrong at home, and a pale face may result from serious overcrowding.

Occasional outbreaks of infection call for a keener supervision of methods of transmission. Air, water, milk, prepared food, insects, rodents, hands, utensils, are all likely vehicles for infection and need constant watch.

Two outbreaks of food poisoning during the year have shown the need for a more rigid kitchen technique, particularly with regard to temperature control of food in preparation and storage. Personal responsibility cannot be too strongly emphasised in this matter and, as it is human to err, the need for constant supervision is always with us.

Those who protect us from our own shortcomings are not always welcome, but vigilance by the sanitary inspector, and even the force of law (which he seldom wields) are vitally necessary if our children are to live healthy lives and obtain full benefit from the educational system.

School Meals Service.

During 1952 the school meals service was called upon to make its response to the national call for economy in the public services. The previous target —the provision of cooking and dining services for 75% of the school population—is now no longer the policy. The Ministry of Education has requested a reduction in kitchen capacity to a level of approximately 60% provision for secondary schools and 45% for primary schools.

There has been a complete review of the organisation of the school meals service and, as a result, several dining centres have been closed and arrangements made to provide dinners for children from these centres at nearby self-contained canteens. In addition, because of a fall in demand for breakfasts and dinners during school holiday periods and on Saturdays, the number of centres open during holidays and on Saturdays has been reduced.

On the other side of the picture dining provision has been made at the new Broomedge and Stowell Memorial Schools, and towards the end of the year self-contained canteens at four new schools, All Souls' R.C., St. Thomas's R.C., Summerville, and Duke Street, were nearing completion.

Continuing efforts have been made to effect minor schemes of improvement at existing canteens and dining centres, and the Ministry of Education has approved of work proceeding in the next financial year on a major scheme of improvements at Bowker Street central kitchen.

The number of meals provided by the service in the financial year ended 31st March, 1952, was as under :—

Dinners	2,832,203
Breakfasts	71,101
Teas	74,329
Snacks (served mid-morning in the nurseries)	46,706

There can be little doubt that the service is one of the contributory factors in the improved physical health of school children.

Although the planned expansion of the service has temporarily ceased there is no lack of problems for those connected with the provision of school meals if what has already been achieved is to be first consolidated and later improved. In a small way improvement has commenced by the introduction of a new design of dining room furniture which will assist in the encouragement of a family service of meals to replace the cafeteria type of service now generally in use.

A Review of the Work of the School Health Service 1943-1952.

Let us review briefly the work of the last ten years ; many half forgotten features can be brought to light. Let us look back at the position of the school health service in 1943 when shortage of staff was a great problem. Medical and dental officers were in H.M. Forces and many of the functions of the service were restricted. School nursing was still being undertaken by sixteen full-time school nurses. In spite of the handicap of lack of staff, many special investigations were undertaken in co-operation with the Ministries of Health and Education. A large-scale *vitamin feeding test* was carried out among 3,000 of our school children to determine whether their war-time rations were having a detrimental effect on nutrition. The results of this, and of supplementary investigations, were surprising. The vitamin supplements distributed

to the children over a period of months had no consistent effect on growth, strength, endurance, fatigue potential, incidence or severity of clinical conditions, hearing and absenteeism from school. This showed that the way to better health of school children does not lie in taking pills, however popular in the public mind this may be. It proved that we must look elsewhere towards better environmental hygiene, sound health habits, the elimination of preventable disease, the diffusion of health education.

A comparison of the *hæmoglobin* content of the blood of children receiving an iron supplement with a group of "control" children, showed an increase of 10·4% in some of the girls.

It was discovered that the *Vitamin C content* of dinners cooked and eaten at home was superior to the Vitamin C content of school dinners, due to the shorter interval of time between the preparation and eating of the home dinner.

A *survey of noise in schools* showed us that some modern buildings are up to ten decibels noisier than the old-type schools. This is probably due to the free-moving chairs and tables, and the modern building materials with their tendency to reverberation.

Investigations into the *menstrual history* of 1,000 school girls showed that the onset of menstruation usually occurs between the ages of 12 and 14 years. Four hundred girls started at the age of 13. There were extremes of course ; one girl menstruated when she was 9 and two others at the age of 17. The majority of the girls, when questioned, said that their periods lasted for four days, but in four cases they continued for ten days. The opportunity was taken by the health visitor to give advice on personal hygiene.

In a survey to find out the *incidence of inguinal hernia*, 880 boys in two secondary schools were examined. Four untreated cases were found, and 22 treated cases—an incidence of 3% of the number examined. In all of the four untreated cases arrangements were made, with the consent of the parent, for operative treatment to be carried out.

At the end of 1943 steps had been taken to amalgamate the *school nursing and health visiting service*. This meant that the services of every nurse became available for utilisation in both school health and public health departments. Moreover, such co-ordination ensured continuity of care of the individual child from infancy, through school life, by someone familiar with home circumstances.

During 1945 a course of lectures on the public health services, the first course of its kind to be arranged in Salford, was given by health visitors to the children of Broughton County Modern Secondary School. Other lecture series arranged later at other schools covered such subjects as personal health and hygiene, parentcraft and the National Health Service Act.

In 1948 the superintendent school nurse retired and her duties were taken over by the superintendent health visitor. During 1949 the rapid survey, or, as it is now more appropriately called, the health survey, of school children by school health visitors was introduced. These examinations are conducted once a year, usually just before routine medical inspection, so that children not scheduled for medical examination but found to be in an unsatisfactory condition, may be referred to the assistant school medical officer whilst he is in school.

The *skin clinic* was established at Regent Road, in 1943, and was attended once weekly by the consultant dermatologist, who also conducted an out-patients' clinic at Hope Hospital. In this way there was a beneficial link between hospital and clinic services.

Mrs. Florence Cavanagh took over the supervision of the *ear, nose and throat clinic* in 1944. She introduced the system of dispensing certain simple treatments for use at home, thus saving the time of parents and children in attending the clinic. With the discovery of new drugs, aural treatment was constantly changing, and a scheme of short refresher courses was instituted so that the nurses in charge of the treatment of ear, nose and throat defects could keep up to date with new remedies. In April, 1948, the *pre-tonsillectomy clinic* was established and conducted by a pædiatrician from the Department of Child Health, Manchester University, in a room adjoining the ear, nose and throat specialist's. In 1950 the treatment of children with chronic otorrhœa became the responsibility of one specially trained nurse, and it was found that with this arrangement the discharging ears cleared up in a much shorter space of time than before.

Improvement was made in the methods and technique of the *ascertainment of defective hearing*. From 1942 to 1950 the group survey of hearing in school was done by means of a gramophone audiometer. During 1950 comparative audiometric tests were made and, as a result, the method of group testing in school was changed from the gramophone test to the "sweep" test—a superior method, which involves the use of pure tones, as does the individual audiometer. Children under five years of age who are suspected of deafness usually need the more specialised form of ascertainment provided at the Department of Education of the Deaf, Manchester University, and we are grateful to the Director of this department for his great assistance over the past ten years. Our own *class for partially deaf children* was established in Regent Road School in the autumn of 1948, and has since helped many partially deaf children to resume their places in ordinary schools.

At this time instruction in the cleansing of verminous heads and in the treatment of very minor ailments was given by health visitors to members of the staffs of nursery classes. Wherever possible the health visitor visits nursery schools daily to examine children referred to them by the superintendent.

The duties of the almoner appointed by the public health department during 1948 included the care of school children. Much advice and practical help is given by the almoner to our needy children and their parents. She also arranges convalescent treatment when recommended by the assistant school medical officers.

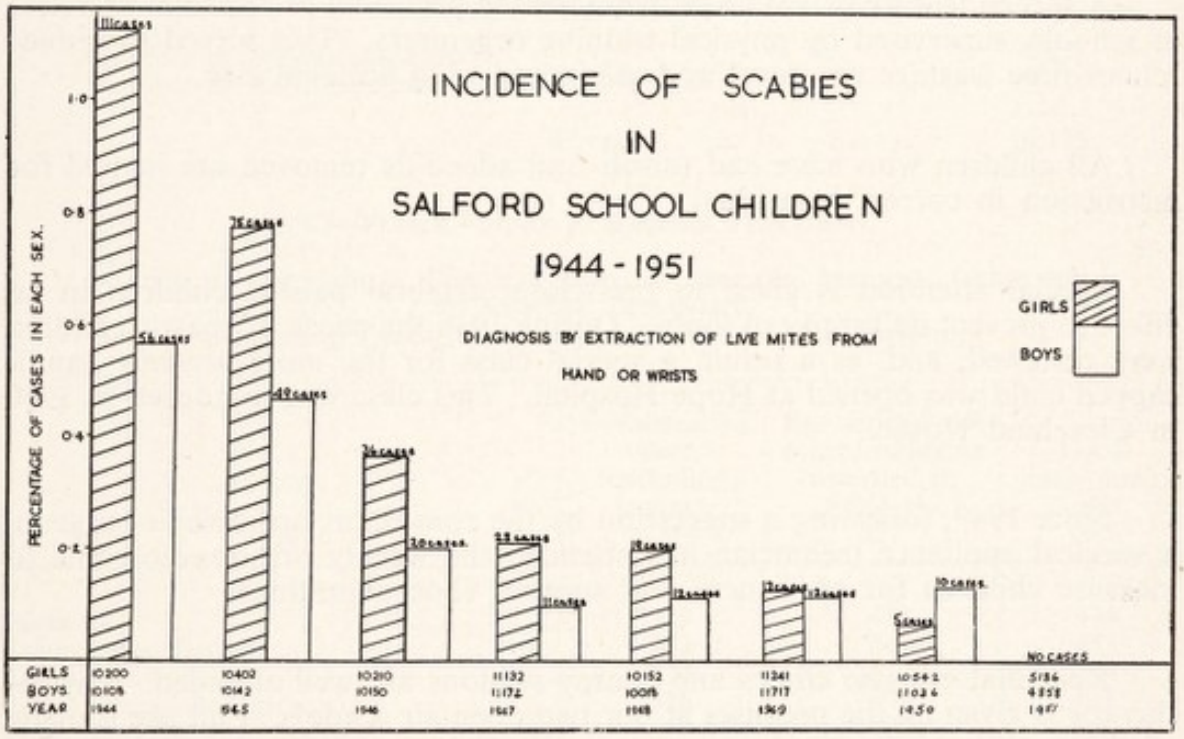
The *foot health clinic* attended by the consultant chiropodist was set up in 1945. Intensive surveys carried out in schools brought to light many foot defects hitherto untreated. A gratifying result of this service has been the remarkable fall in the incidence of verrucæ pedis and the prevention, by early diagnosis and treatment, of disabling foot defects.

During 1946 an asthma survey, involving over 100 children, was carried out by Dr. R. I. Mackay at his *special investigation clinic*. With the help of the family doctors every avenue of medical history was probed. Subsequent recommendations for these children included admission to open-air school, referral to the ear, nose and throat specialist, treatment by the physiotherapist and strong representation to the housing manager for re-housing.

The *Frederick Road Open-air School*, which began life as a park shed and was adapted to meet the needs of a school, suffered severe damage by the Irwell floods in 1946, and was closed. This meant that additional strain was put on *Barr Hill Open-air School* and, as a consequence, long lists of children awaiting admission began to accumulate. In September, 1951, the position was relieved by the opening of *Claremont Open-air School*, with its accommodation for 150 handicapped children, including a special class for partially sighted pupils. We are now in the happy position of being able to invite additional names for our greatly reduced waiting lists for admission.

Over the past few years Salford has co-operated in investigations into the effectiveness of certain remedies against *head louse infestation*. Gammexane and D.D.T. have figured largely in these trials.

An annual *scabies survey* in schools was held regularly from 1944 when over 160 children were found to be infected, until 1951, when 10,000 children were examined without a single case being revealed. The elimination of this disease is due in the main to conscientious treatment and diligent follow-up of cases over a long period of time.



The staff shortage during the war years affected the *dental service* so much that school inspections had, at one time, to be abandoned. Even in 1948, when Encombe Place Dental Clinic opened, service was at first restricted, and the position was made worse a year later by the drift of staff away from the local authority clinics to private practice, when the conditions laid down by the National Health Service Act were implemented. Since 1944 our children have had the beneficial services of a consultant orthodontist and this highly specialised type of dental work has developed so much that in 1952 there was need for the appointment of a second orthodontist.

Other dental service appointments within the last two years have been those of the dental technician and the oral hygienist. The *oral hygienist* is a specially trained operator who works under the supervision of the dental officer and treats children requiring scaling and cleaning of teeth. It is also her responsibility to educate children to a way of good dental hygiene.

The number of sessions attended by the oculist at the *Eye Clinic* have gradually increased since 1942 until he now holds five weekly sessions. The correction of squint by orthoptic treatment is an important feature of the work of the eye clinic and is carried out by two part-time orthoptists, whose service is the equivalent of one full-time assistant. The staff of the eye clinic have carried out a number of interesting investigations, including an estimation of the incidence of colour blindness in our older school children. The recent provision of a special class for partially sighted pupils at Claremont has done much to overcome the problem of deciding on the best form of education for these children.

Availability of qualified *physiotherapy* staff has fluctuated, generally on the wrong side from the department's point of view. In spite of this, increasing care has been taken of the children needing physiotherapy.

A special feature of 1943 was the increased provision of remedial exercises in schools, supervised by physical training organisers. This served to reduce school time wastage on travel and minimised road accident risk.

All children who have had tonsils and adenoids removed are invited for instruction in correct breathing.

Special attention is given to pre-school cerebral palsied children in an effort to prevent deformity of limbs. During 1946 the needs of spastic children were reviewed, and, as a result, a special class for the more severely handicapped child was opened at Hope Hospital. This class was re-housed in 1950 in Cleveland House.

Since 1949, following a suggestion by the consultant orthopædic surgeon, a surgical appliance technician has attended the weekly orthopædic clinic to measure children for appliances and surgical shoe alterations.

Remedial exercise clinics and sunray sessions are well attended. Physiotherapy is given on the premises at our two open-air schools. Full use is made of the facilities for intensive treatment at Claremont. Sunray treatment is given there, and the postural drainage of children with bronchiectasis is supervised. The apparatus used in postural drainage—the Nelson bed—is one of the latest acquisitions of the physiotherapy service.

In this brief review of work done during the past ten years, the measures taken to promote better and more comprehensive care of the child stand out clearly. The school health service will always play a vital part in the building up of child health when it grows like the children it serves, and it can grow only by research into problems of child health and by developments in the service.

STATISTICAL TABLES.

TABLE I.

Medical Inspection of Pupils Attending Maintained Primary and Secondary Schools, (Including Special Schools).

A.—Periodic Medical Inspections.

Number of Inspections in the prescribed Groups—	
Entrants	3,422
Second Age Group	2,144
Third Age Group	2,143
Total	7,709
Number of other Periodic Inspections	851
Grand Total	8,560

B.—Other Inspections.

Number of Special Inspections	3,436
Number of Re-Inspections	12,739
Total	16,175

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	15	431	434
Second Age Group	232	247	433
Third Age Group	279	312	544
Total (prescribed groups)	526	990	1,411
Other Periodic Inspections	1	130	130
Grand Total	527	1,120	1,541

TABLE II.

A.—Return of Defects Found by Medical Inspection in the Year Ended 31st December, 1952.

Defect Code No.	Defect or Disease.	Periodic Inspections.		Special Inspections.	
		Number of Defects.		Number of Defects.	
		Requiring treatment.	Requiring to be kept under observation but not requiring treatment.	Requiring treatment.	Requiring to be kept under observation but not requiring treatment.
	(1)	(2)	(3)	(4)	(5)
4.	Skin	135	452	953	533
5.	Eyes—				
	(*a*) Vision	527	135	168	125
	(*b*) Squint	96	228	85	70
	(*c*) Other	58	77	94	114
6.	Ears—				
	(*a*) Hearing..	43	175	240	119
	(*b*) Otitis Media ..	71	218	719	609
	(*c*) Other	72	196	418	314
7.	Nose or Throat	246	1,957	1,738	2,545
8.	Speech	28	155	70	109
9.	Cervical Glands	44	1240	311	882
10.	Heart and Circulation ..	19	247	176	718
11.	Lungs	40	510	343	1092
12.	Development—				
	(*a*) Hernia	7	51	10	20
	(*b*) Other	9	184	9	17
13.	Orthopaedic—				
	(*a*) Posture	36	170	58	88
	(*b*) Flat Foot	59	143	24	15
	(*c*) Other	194	519	345	247
14.	Nervous System—				
	(*a*) Epilepsy	1	25	17	30
	(*b*) Other	7	109	85	418
15.	Psychological—				
	(*a*) Development ..	3	96	5	8
	(*b*) Stability	8	157	71	112
16.	Other..	113	61	1,200	3,752

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	3,422	1,298	37·9	1,931	56·4	193	5·7
Second Age Group	2,414	835	38·9	1,254	58·5	55	2·6
Third Age Group	2,143	1,065	49·7	1,052	49·1	26	1·2
Other Periodic Inspections	851	347	40·8	475	55·8	29	3·4
Total	8,560	3,545	41·4	4,712	55·1	303	3·5

TABLE III.

Infestation with Vermin.

(i) Total number of examinations in the schools by the school nurses or other authorised persons	71,567
(ii) Total number of individual pupils found to be infested.. ..	4,810

TABLE IV.

Treatment of Pupils Attending Maintained Primary and Secondary Schools (Including Special Schools).

GROUP 1.—Diseases of the Skin.

	Number of cases treated or under treatment during the year.	
	By the Authority.	Otherwise.
Ringworm—		
(*a*) Scalp	12	..
(*b*) Body	31	..
Scabies	74	..
Impetigo	124	..
Other skin diseases	417	..
Total	658	

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	249	..
Errors of refraction (including squint)	*2,490	..
Total	2,739	
Number of pupils for whom spectacles were—		
(*a*) Prescribed	*1,262	..
(*b*) Obtained	*1,262	..

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

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	..	8
(*b*) Adenoids and chronic tonsillitis	..	948
(*c*) Other nose and throat conditions	..	106
Received other forms of treatment		
(Individual pupils seen at Pretonsillectomy clinic)	..	307
Total	..	1,369

GROUP 4.—Orthopaedic and Postural Defects.

	By the Authority.	Otherwise.
(*a*) Number treated as in-patients in hospitals	36	..
(*b*) Number treated otherwise, e.g., in clinics or out-patient departments	1076	301

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	139	..

GROUP 6.—SPEECH THERAPY.

	Number of cases treated.	
	By the Authority.	Otherwise.
Number of pupils treated by Speech Therapists	180	..

GROUP 7.—OTHER TREATMENT GIVEN.

	Number of cases treated.	
	By the Authority.	Otherwise.
(*a*) Miscellaneous minor ailments	13,251	..
(*b*) Other—		
(i) Sun Ray	711	..
(ii) Chiropody	870	..
(iii) Treatment by Neurologist	..	69
(iv) „ „ Paediatrician	..	188
TOTAL	14,832	257

TABLE V.

Dental Inspection and Treatment.

(1)	Number of pupils inspected by the Authority's Dental Officers—	
	(*a*) Periodic age groups	8,026
	(*b*) Specials	5541
	TOTAL	13,567
(2)	Number found to require treatment	10,463
(3)	Number referred for treatment	10,463
(4)	Number actually treated	11,703
(5)	Attendances made by pupils for treatment	13,689
(6)	Half-days devoted to—	
	(*a*) Inspection	53
	(*b*) Treatment	1,407
	TOTAL	1,460
(7)	Fillings—	
	(*a*) Permanent teeth	2,782
	(*b*) Temporary teeth	586
	TOTAL	3,368
(8)	Number of teeth filled—	
	(*a*) Permanent teeth	2,404
	(*b*) Temporary teeth	586
	TOTAL	2,990
(9)	Extractions—	
	(*a*) Permanent teeth	2,186
	(*b*) Temporary teeth	9,722
	TOTAL	11,908
(10)	Administration of general anaesthetics for extractions	2,880
(11)	Other operations—	
	(*a*) Permanent teeth	840
	(*b*) Temporary teeth	407
	TOTAL	1,247

Special Investigation Clinic.

During 1952, 445 consultations took place, involving 245 individual children :—

Diagnosis.	*Number of children.*
Asthma	49
Bronchitis and other chest conditions	22
Rheumatic heart disease	22
Poor general condition	21
Upper respiratory infections	14
Bronchiectasis	13
Rheumatism without heart disease	13
Nervous conditions	10
Exogenous obesity	10
Allergic rhinitis	7
Enuresis	7
Naso-pharyngeal infection	4
Pains in limbs (not rheumatism)	3
Mental retardation	3
Debility	3
Sinusitis	2
Migraine	2
Educational maladjustment	2
Epilepsy	2
Spastic diplegia	2
Abdominal pains	2
Orthopædic defects	2
Miscellaneous defects, including congenital pigeon chest, tubercular glands, erythema nodosum, epistaxis, rhinorrhœa, chronic laryngitis, thyrotoxicosis, encopresis, mesenteric adenitis, ataxia, extreme infantilism	30

Child Guidance Clinic.

Cases referred in 1952 by—

Schools	23
School Medical Officer	62
Children's Officer	4
Hospitals	5
Family Doctors	10
Court	6
Probation Officer	5
Parents	10
Others	6
Neighbouring Authorities	14
	145

Referred because of—

Enuresis and allied difficulties	26
Stealing and truancy	25
Failing at school	10
Stammer	6
Tic	1
Aggression	9
Food and sleep difficulties	14
Nervousness	21
Other behaviour difficulties	31
Advice *re* placement	2
	145

Diagnostic interviews—

Full examination	84	
Test and history only	14	
	—	98

I.Q. of those seen—

I.Q.	*Boys.*	*Girls.*	*Total.*
130+	3	5	8
120—129	8	2	10
110—119	10	4	14
100—109	14	8	22
90— 99	14	5	19
80— 89	7	4	11
70— 79	5	1	6
60— 69	0	2	2
			92
Untested			6
			98

Waiting diagnosis, January, 1952	55
Referred in 1952	145
	200
Seen in 1952	98
*Closed unseen in Clinic	64
Waiting December, 1952	38
	200

*Of these closed unseen in the Clinic—

Improved	28	
Referred to other Agencies	8	
Unsuitable	3	
Failed	10	
Refused	9	
Left area, etc.	6	
	64	
Children seen for diagnosis		98
Children seen for treatment		61
Number of individual children		139
Interviews in the Clinic		1,930
Home visits		165
School visits		55

Speech Therapy.

Langworthy Centre.

Children still on the register at the beginning of the year number 46. Those admitted during the year number 35.

Details of above :—

From previous year.	
Stammering	20
Stammering and Dyslalia	1
Dyslalia	9
Sigmatism	4
Cleft Palate	4
Idioglossia	3
Dysphonia	2
Retardation	1
Nasality	2
TOTAL	46

Admissions during the year.	
Stammering	14
Dyslalia	10
Retarded	3
Idioglossia	2
Severe Dyslalia	1
Sigmatism	3
Cleft Palate	2
TOTAL	35

GENERAL TOTAL ... 81.

Twenty-two children were called for interview and did not attend. Of those interviewed, 25 are awaiting treatment, 15 are not in need of treatment, and a further 13 are unlikely to require any treatment—awaiting re-check.

DISCHARGES.

Final—satisfactory	15	
Left school	6	2 satisfactory. 2 improved. 2 no improvement.
Left Area	1	
Died	1	
Illness	1	
Defaulted	8	
TOTAL	32	

Number of school visits, 57 ; and visits to homes, 81.

Broughton and Regent Street Centres.

Children still on the register at the beginning of the year, 44. Admissions for treatment during the year, 55. (Included in this latter figure are : three who failed to attend ; one left the area ; one no need for treatment ; two ill).

Details of above :—

BROUGHTON CENTRE.

From previous year.		*Admissions during the year.*	
Stammering	12	Stammering	7
Dyslalia	7	Dyslalia	13
Sigmatism	2	Dyslalia and Sigmatism ...	1
Stammer and Sigmatism ...	1	Sigmatism	3
Dyslalia and Sigmatism ...	1	Stammer and Dyslalia ...	2
		Dysphonia	1
		Lalling	1
		Nasal Speech	1
TOTAL	23	TOTAL	29

GENERAL TOTAL ... 52.

REGENT STREET CENTRE.

From previous year.		*Admissions during the year.*	
Stammering	8	Stammering	5
Dyslalia	10	Dyslalia	14
Sigmatism	1	Stammer and Dyslalia ...	2
Stammer and Dyslalia	1	Stammer and Sigmatism ...	1
Dyslalia and Sigmatism ...	1		
TOTAL	21	TOTAL	22

GENERAL TOTAL ... 43.

Twenty-five children interviewed and awaiting treatment. A further three interviewed and found not requiring treatment : three more probably no need for treatment—awaiting check-up.

Thirteen called for interview and did not attend (of these, three no longer needed treatment, and two had left Salford).

BROUGHTON AND REGENT STREET CENTRES.

Children referred and not yet interviewed number 24.

DISCHARGES.

Final—satisfactory	26
Provisional—for re-check	12
On admission to Child Guidance Clinic	1
Further improvement unlikely	1
Lack of co-operation	2
Stood down temporarily	2
Attendance lapsed	13
Left school	2
Left this area	1
On admission to special residential school	1
TOTAL	61

(Of the 13 whose attendance lapsed, six had shown considerable improvement).

There were 58 visits to schools and 88 home visits.

General total of admissions during the year for treatment to all Centres ...	90
General total of children treated from previous year	90
Number of attendances for all Centres	3,030

CHIROPODY SURVEY SUMMARY, 1952

Age Group	5 to 6				7 to 8				9 to 10				11 to 12				13 to 15				Total				
Sex	M		F		M		F		M		F		M		F		M		F		M		F		Total
Defect Group	B	C	B	C	B	C	B	C	B	C	B	C	B	C	B	C	B	C	B	C	B	C	B	C	
Corns	1	1	1	3	2	3	1	1	—	3	5	3	—	—	5	12	1	2	7	12	4	9	19	31	63
Verruca	—	—	—	—	1	2	—	—	—	—	—	4	—	1	—	1	—	2	1	1	1	5	1	6	13
Weak Longitudinal Arch	47	32	59	27	75	56	67	54	64	49	57	42	37	41	58	60	61	70	95	74	284	248	336	257	1125
Footwear: Degrees of Accuracy in Fitting	75	27	96	62	130	55	119	57	109	21	109	43	84	20	112	51	148	43	169	52	556	166	605	265	1592
Defects of Lesser Toes	18	25	24	19	43	31	27	16	31	18	24	16	20	3	29	15	63	10	67	19	175	87	171	85	518
Hallux Valgus	39	8	29	6	60	17	40	16	60	16	45	19	46	14	70	38	12:	39	164	67	326	94	348	146	914
Nails	—	—	—	1	1	1	—	—	—	—	—	2	—	—	1	2	3	—	3	3	4	1	4	8	17
Total	190	93	209	118	312	165	254	144	264	107	240	129	187	79	275	179	397	166	506	228	1350	610	1484	798	4242
Total Number of Children Examined, Males and Females.	281		294		405		309		457		327		251		348		422		438		1816		1716		
Total Number of Males and Females Examined.	575				714				784				599				860				3532				