

[Report 1964] / Medical Officer of Health, Salford County Borough.

Contributors

Salford (England). County Borough Council.

Publication/Creation

1964

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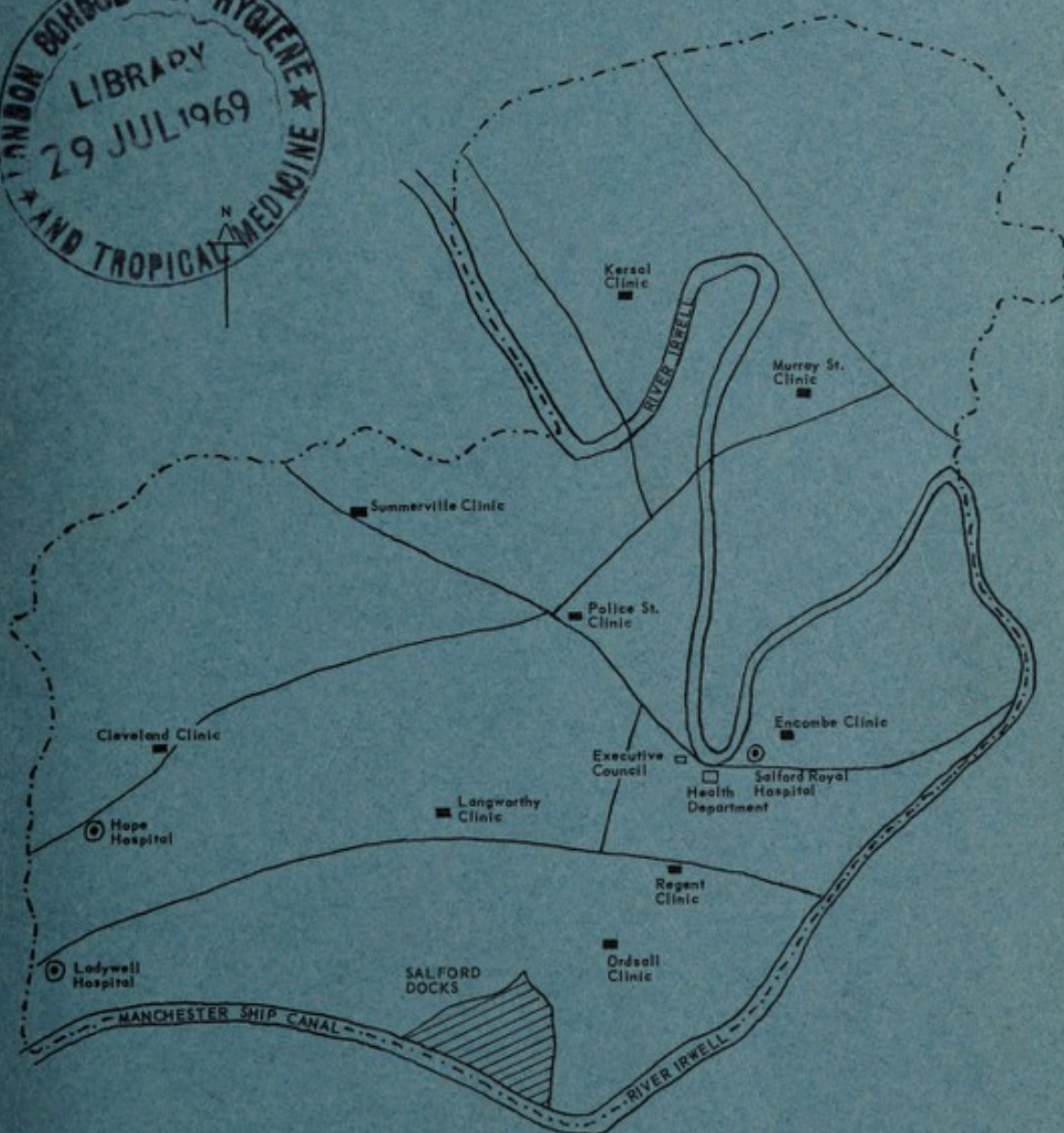
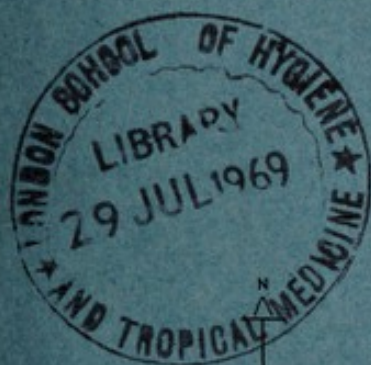
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CITY OF SALFORD
ANNUAL REPORT
OF THE
MEDICAL OFFICER OF HEALTH
1964



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City of Salford

ANNUAL REPORT

OF THE

Medical Officer of Health

FOR THE YEAR

1964

BY

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

MEDICAL OFFICER OF HEALTH

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at 31st December, 1964

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(part I)

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INTRODUCTION

"There are infirmities not only of body, but of soul, and fortunes, which do require the merciful hand of our abilities"

Sir Thomas Browne

MR. CHAIRMAN, LADIES AND GENTLEMEN,

I present the Annual Report for 1964.

Statistics —

Perhaps the saddest feature of the vital statistics, the measurers of life and death, is the relentless increase in deaths from lung cancer. Without any let up, every year more of our people suffer and die from this cause — no less than 122 Salford citizens last year — 105 men and 17 women. As a 'guestimate', over 100 of these would die because of the cancerous cigarette; and probably less than a dozen mainly on account of the cancer substances in the air breathed through the incomplete combustion of fuel. Both causes of death are preventable — one mainly by personal action, the other mainly by community action. I am old enough to remember when a case of lung cancer in the ward was a textbook rarity which students flocked to see. We cannot raise the silly excuse now that the increase is due to better diagnosis for X-ray facilities abounded and post-mortems were carried out on every death. Should we allow this killer to continue the damage it does to health and life of men and women in their prime? In the weekly Anti-Smoking Clinic (which ran without a single break during the year) we have had many men and women who had spent more than £2,000 on cigarettes during their life. All some had to show for it at the end was a chronic cough, or a bad bronchitis, or a lung cancer — or all three. Must we not save the children and the precious youth of the nation from this waste of life?

Another disquieting feature was a decided increase in deaths attributed to coronary disease which accounted for 346 deaths, an increase of 50 over the previous year. Some of the sufferers were in the prime of life. Here again cigarette smoking is accepted in this and other countries to be a factor — not the sole cause, but a factor. Here again you offered definite and positive help to the people through the Anti-addiction Clinic which tries to solve problems of alcoholism, smoking and over-weight thus making some contribution to the attack on heart disease.

A most unwelcome feature was the increase of deaths of women from malignant disease of the breast — 32, compared with 28 of the previous year. These figures give support to the need of the facilities which you provide not only in the detection of early cases of cancer in women, but of the pathological conditions which occur *before* the cancer invades the body. This is preventive medicine at its best — and preventive medicine is the best medicine.

Truly with our efforts against smoking and for the prevention of cancer in women we are fighting a glorious battle against malignant disease which causes such misery, disablement and death.

Bronchitis with 176 deaths showed a welcome reduction from the previous year. The attack must go on and intensify, as this disease causes great unhappiness, debility and disablement, as well as an earlier death.

A tremendous victory has been won in the case of tuberculosis where there were 10 deaths compared with over 200 deaths thirty years ago.

Improving the Environment

The greatest change in our public health work has been the changing concept of the term "environment". This should include not only the physical conditions of air and food, and streets and houses, but social, psychological, occupational aspects. The total environment must be modified in order to meet the needs of man.

Many factors contribute to the causes of common chronic illness, thus providing a greater opportunity for attack by the public health team – the health visitor, public health inspector, midwife, district nurse, home help; in co-operation with the family doctor, with the hospital and specialist services, with the voluntary organisations; and not least with the families who need our help and the public at large.

Measures, therefore, may be taken in the modern practice of preventive medicine by intervening and interrupting the many chains of circumstance which bind the individual to ill-health and the unfulfilment of his potential for full and effective living. More and more the total environment may be modified through health and social action. Social factors may be modified by social measures. This may come about not only by better housing, cleaner air and safer food, but we are now learning how to improve the psychological environment which affects the lives of people greatly.

The year has seen real progress in the hygiene of the air Salford people breathe, and some of the houses in which they live. Over a third of the city is now smoke controlled and progress is at an accelerating pace.

The standstill period during which the Ministry of Housing and Local Government carried out a fuel review was followed by a request for local authorities to re-appraise smoke control orders in the light of the amended adaptations.

The greater amount of work involved in carrying out adaptations, the more complicated fixing of appliances and the fact that, with very few exceptions, all houses now require adaptations to fireplaces carrying out. The consequences of this have resulted in a 50% increase in work in smoke control areas.

Our attack against smoke, dust, grit and fumes from industrial sources, boiler plants, road vehicles, etc., continues and worthwhile improvements are frequently obtained. For example, co-operation with one company resulted in the installation of an excellent new plant. Collaboration throughout the whole of the design period has resulted in the installation of a plant capable of virtually dust free operation. It is pleasing to record that the efforts made

have resulted in a fall in smoke and sulphur dioxide figures and to know that further progress in the abatement of air pollution can only result in similar reductions and a cleaner, healthier atmosphere for the benefit of all our citizens.

The clearance of unfit houses continues to absorb much of our effort – the representation of almost 1,500 houses in Clearance Areas during 1964 was a major achievement but the coming year should show even greater progress. Complementary to this programme will be our efforts to improve the living conditions of families whose homes, although structurally sound, lack those basic amenities of internal water closets, bathrooms, adequate hot water supply and proper food storage facilities. Our first improvement area of 239 houses under the Housing Act, 1964 was reported to the Health Committee in December and we will proceed to deal with further areas at the rate of at least 750 houses each year until all our worthwhile properties are improved.

Whole Health

Some decisive development has taken place in the field of health check-ups for the general public, and in the geriatric guidance service for the elderly which are described below:—

Screening Tests in Salford

During the last ten years, the two monthly visit annually of the Mass Miniature Radiography Unit has been made the occasion of carrying out of urine tests on those who wish to have them. These tests have gradually been extended.

Over the years the use of the term "Health Check-Up" has crept in, a term which has a greater appeal than that of screening tests which is little understood by the public. Nevertheless they are at the present only a series of screening tests. We are working up to the ideal of carrying out a fuller health check-up – an estimation of the "whole" health of the individual including psychological factors and attitudes to problems of work and life. At present, however, we are endeavouring to help in the identification of those people who have health problems amenable to some form of prevention or treatment. The tests now include:—

- Haemoglobin estimations
- Blood pressure estimations
- Vision tests (particularly with reference to driving of motor vehicles and road safety)
- Measurements of height and weight — with a view to the reduction of over-weight
- Urine tests

For women — cervical cytology and examination of breasts
in a nearby clinic by appointment

Opportunity is also taken for those who wish it to have access to a health visitor or social worker in order that any health and social problem which is worrying the applicants, sufficiently to interfere with their health, may be discussed.

The aim of these tests is to identify those people who need treatment and to refer them to the appropriate source of help; for example, in the case of the urine, haemoglobin and blood pressure estimations, those regarded as significant are communicated to the family doctor. Those with defects in vision, particularly those affecting road safety, are referred either to their family doctor or ophthalmic optician.

Some of the services offered (e.g. health and social advice) are little used, but at least members of the public have the opportunity of bringing forward their problems in which the health and social services might help.

Opportunity is also taken of asking volunteers to complete questionnaires which are designed to ascertain their opinion on local health matters (e.g. the control of air pollution). Criticisms and suggestions for the improvement of the health services are welcome; views are sought on several problems. A special effort is made in the anti-smoking campaign enquiring about smoking habits and offering facilities for attendance at an Anti-Smoking Clinic which is held weekly on Monday evenings.

Of course it is realised that people who attend are all volunteers, and that they form a "self-selected" section of the community.

Arrangements throughout the year

The public can have these tests throughout the year, each evening from 5.0 to 6.0 p.m. and on Thursday afternoons from 2.0 p.m. at clinic premises, 145, Regent Road. The evening clinic is staffed by the District Nursing Service (who would be present in any case at that time for it is a treatment clinic for various injections by the district nurse); the afternoon clinic is staffed by the Health Visiting Service. These facilities will be expanded according to need.

Features of this service include :-

1. Collaboration with the family doctor who is informed of abnormal findings.

2. It is an instrument of health education, providing for example a sensible slimming diet sheet for those who are over-weight, and it is a help in our anti-smoking efforts. Other health educational activities are planned. At present we are deliberately not encouraging large numbers in order that the work is of manageable size.

3. Out-of-pocket cost is low. Vision testing apparatus has been bought but all the other equipment was in the possession of the department being used in connection with our ordinary services. An electronic haemoglobinometer has been long used in our ante-natal work; this and other equipment would be expensive for the practitioner to purchase.

4. It may be that there will be a possibility of extending the services, e.g. recognition of significant varicosity of veins.

5. All these tests are done with minimal undressing.

6. The services of highly skilled staff are not necessary. Auxiliaries who are selected for their suitability for this work can be carefully trained.

7. The public are increasingly conscious of the importance of trying to detect and forestall preventable disease before flagrant signs and symptoms make their appearance. It is also acceptable to some employers who wish their staffs to have the opportunity for these tests.

Evaluation

Caution is needed in evaluation of these tests. For example blood pressure estimations may be equivocal, but at present they are retained. They may provide an individual "base-line" for future estimations, particularly if undetected cases of malignant hypertension in youngish adults come our way. In this urban industrial area it is probably wise to continue these estimations.

About some of the other tests there can be little reasonable doubt. In vision testing, failure in stereoscopic vision must surely be a hazard to drivers of motor vehicles. Over 12% of volunteers showed a serious defect, and 37% a minor defect — this is a condition where the treatment by means of appropriate spectacles is not only helpful but easy and effective. In cytology 6 confirmed cases out of 1,406 women is significant. Many low haemoglobin values have been found. A small number of hitherto unsuspected diabetics have been identified. The value of the health educational activities can hardly be questioned. An attempt at the reduction of over-weight is surely worthwhile.

At least, the individual has a fuller opportunity to participate in the practice of preventive medicine.

Health Check-Ups for the Elderly

This service has operated for over ten years (1953). It provides the opportunity for an examination by a medical officer.

The aim is to promote health (particularly through healthy nutrition) to assess the significance of ailments and disabilities, and refer patients for appropriate help, advice, and further diagnosis and specialist advice and treatment where indicated. At the present time the clinic for elderly women (with a woman medical officer in attendance) is held one week, and a clinic for elderly men (with a male medical officer in attendance) is held the next week. In the past we have been able to provide twice-weekly sessions, but owing to staff shortages this has been temporarily reduced.

Elderly people are referred to the specialist health visitor from a variety of sources. She receives information not only in the course of her own visits but through her colleagues in the health visiting services throughout the city.

The clinics do not supplant — but supplement — the work of the family doctor. In urban industrial areas it is not uncommon for large numbers of sick people attending surgeries and for there to be insufficient "time to listen".

Examples of practical help include the following :—

Deaf patients often find they can hear much better if their ears are syringed in order to remove wax which has been accumulating for many years. Those with severe conductive deafness can be helped if they are sent for a hearing aid. Old people are usually very reluctant to wear

hearing aids but as soon as they have got used to one and are able to hear much better they are delighted. A vision test often reveals the necessity to advise the patient to visit an optician for a pair of glasses. Ill-fitting dentures are frequently found, but here the problem is often that the patient realises new dentures are needed but cannot afford to pay for them.

For those living in difficult financial circumstances, whose diet is inadequate, or who are anaemic, may receive small supplements (e.g. Complian, vitamins, iron tablets); and minor skin ailments have been treated successfully.

A chiropody clinic is also held on the premises, and patients may be referred. The numbers requiring treatment, however, are a problem. Urgent cases receive priority.

Those who have had pulmonary tuberculosis often do not realise the need to continue to attend the Chest Clinic regularly or to take the prophylactic tablets which have been prescribed, but often a short talk with the clinic doctor is sufficient to convince them that these things are important. Advice given by the clinic medical officer is often successful in encouraging attendance at specialist clinics.

In special social problems (the need of home help) may present difficulties, though few seem to accept the offer of an occasional visit of a home help.

Some important medical conditions (such as abdominal masses, bleeding per rectum or marked herniae) are referred to a specialist either through the family doctor or directly (after discussion with, and consent of, the family doctor).

The front line team

Much of this report concerns the field workers — the front line of the attack — who visit the people in their homes.

The Health Committee members and their staff have done what they could in promoting co-operation with the family doctor by the attachment of some health visitors, and the support given by district nurses, midwives and home helps.

With officers of the Health Executive Council and of the Hospital Management Committee, I record grateful thanks for their co-operation.

Many voluntary organisations have directly and indirectly helped in our work.

Our health educational activities need great strengthening in view of the huge task in front of raising the whole health of the people.

A feature of our services has been greater care of the family in a score of different ways, whether by facilities for family guidance and marriage guidance; whether by doing our best in cases of family failure, or in the wide range of services for the care of mothers and young children — preparation for motherhood, problems of unmarried parenthood, the care of the handicapped child.

An enormous feature of our work is the care of the elderly through members of our staff concerned.

The care of the mentally disordered, whether due to illness or subnormality has engaged top priority. As the pages of this report show, particularly the prevention of disease, disorder and deterioration of patients has engaged attention.

The high immunisation rates against diphtheria, pertussis, tetanus, polio are highlights of our preventive measures.

A great contribution is made by public health inspectors in the fight against environmental evils. Also there is help from the provision of services of rehabilitation; co-operation with officers of national and local bodies; the extension of "social clubs" for many types of sufferers is a strong point.

The Ambulance Service has well and faithfully done its duty in the safe and efficient transport of the sick.

Altogether the year has seen the contribution by the Health Committee and its officers in satisfying the desire of the people, not merely for physical fitness, but for a happier and fuller life – the health of the whole man.

Public health work can help in the promotion of health of the individual and of the community; it can help in the avoidance of some of the unnecessary hazards to happiness as well as to life; it can help in fortifying the community against some infections; it can make some healing provision in the care and after-care of the sick and disabled; it can support the family in some of its needs, even if only by preventing the last straw falling on the backs of those least able to bear burdens. Sometimes it can modify the circumstances and the social factors which affect life and health and thus help to make the environment fit the needs of man.

I have the honour to be, Mr. Chairman, Ladies and Gentlemen,

Your obedient Servant.

J.L. Brown

Medical Officer of Health.

HEALTH DEPARTMENT,
CRESCENT,
SALFORD, 5, LANCS.

Telephone : PENdleton 5891.

STATISTICAL SUMMARY – 1964

(Based upon figures supplied by Registrar-General)

Area – The City of Salford has a total area of 5,203 acres

Population – (Registrar-General's Estimate at Mid-year 1964) 150,350

„ – (Census, 1961) 155,090

Density – The Mean Density of the City is equal to 28.9 persons per acre

Live Births – Legitimate: 1,369 Males 1,334 Females 2,703

„ – Illegitimate: 180 Males 170 Females 350

Total 3,053

Live birth rate per 1,000 population 20.31

Still-births: 43 Males 36 Females 79

Still-birth rate per 1,000 live and Still-births 25.22

Total live and still-births 3.132

Infant Deaths (deaths under 1 year) Legitimate 78, Illegitimate 15 93

Infant mortality rate per 1,000 live births – Total 30.46

„ – Legitimate 28.86

„ – Illegitimate 42.86

Neo-Natal mortality rate (deaths under 4 weeks per 1,000 total live births) 19.65

Early Neo-Natal mortality rate (deaths under 1 week per 1,000 total live births) 17.03

Illegitimate live births per cent of total live births 11.46

Perinatal mortality rate (still births plus deaths under one week per 1,000 total births)

Still births	79	}	Total, 131	41.83
Deaths under one week	52			

Maternal deaths (including abortion) NIL

Maternal mortality rate per 1,000 live and still births NIL

Deaths: 956 Males; 888 Females; 1,884

Annual rate of mortality per 1,000 of the population 12.26

TABLE 1

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 1943 TO 1964.

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.
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	107	89	18	35	31	96
1953	2964	2794	170	5.7	95	83	12	32	30	71
1954	2867	2692	175	6.1	87	79	8	30	30	46
1955	2700	2544	156	5.8	81	75	6	30	29	32
1956	2826	2682	144	5.1	83	80	3	29	30	21
1957	3026	2851	175	5.8	88	84	4	29	29	23
1958	2930	2738	192	6.5	84	78	6	29	28	31
1959	2959	2789	170	5.7	71	67	4	24	24	24
1960	2991	2752	239	8.0	80	73	7	27	27	29
1961	3018	2769	249	8.3	85	79	6	28	29	24
1962	3199	2911	288	9.0	93	85	8	29	29	28
1963	3154	2832	322	10.21	98	95	3	31	34	9
1964	3053	2703	350	11.46	93	78	15	30	29	43

TABLE 2

SHOWING THE BIRTH RATES, RATES OF MORTALITY FROM ALL CAUSES, TUBERCULOSIS OF RESPIRATORY SYSTEM, CANCER, HEART DISEASES, BRONCHITIS AND PNEUMONIA AND THE INFANT MORTALITY RATES DURING THE YEARS 1948 TO 1964

Years	Population estimated to middle of each year	Rates per 1,000 Population							Deaths under one year of age per 1,000 Births.
		Births	Deaths from						
			All Causes	Tuberculosis of Respiratory System	Cancer	Heart Diseases	Bronchitis	Pneumonia	
1948	178,100	21.12	11.81	0.78	2.16	2.44	1.14	0.48	41.74
1949	178,900	20.28	13.06	0.63	2.00	3.13	1.45	0.71	53.20
1950	177,700	18.87	12.87	0.50	2.31	3.51	1.30	0.46	42.93
1951	176,800	17.48	14.12	0.46	2.15	4.04	1.78	0.50	34.62
1952	176,400	15.57	12.19	0.35	2.12	3.35	1.33	0.59	34.52
Average 5 years		18.66	12.81	0.54	2.15	3.29	1.40	0.55	41.40
1953	173,900	17.05	12.36	0.29	2.24	3.24	1.59	0.74	32.05
1954	171,500	16.72	11.98	0.23	2.39	3.44	1.19	0.56	30.35
1955	169,300	15.95	12.30	0.22	2.08	3.46	1.33	0.78	30.00
1956	167,400	16.88	12.34	0.20	2.43	3.48	1.46	0.78	29.37
1957	165,300	18.31	12.97	0.19	2.44	3.75	1.37	0.79	28.75
Average 5 years		16.98	12.39	0.23	2.32	3.47	1.39	0.73	30.10
1958	163,600	17.91	13.20	0.12	2.20	3.70	1.56	0.84	28.67
1959	162,000	18.27	13.01	0.19	2.43	3.78	1.31	0.78	23.99
1960	161,170	18.56	12.67	0.13	2.44	3.60	1.21	0.62	26.75
1961	154,910	19.45	13.96	0.14	2.39	3.74	1.56	0.84	28.16
1962	154,000	20.77	14.90	0.08	2.42	4.23	1.67	0.91	29.07
Average 5 years		18.99	13.55	0.13	2.37	3.81	1.46	0.79	27.33
1963	152,570	20.67	13.29	0.06	2.41	3.38	1.42	1.15	31.07
1964	150,350	20.31	12.26	0.07	2.38	3.51	1.17	0.71	30.46

TABLE 3

STATEMENT SHOWING NUMBER OF DEATHS IN THE CITY OF SALFORD FROM THE DISEASES SPECIFIED REGISTERED DURING THE YEARS 1933-1964 AND THE RATES PER 100,000 OF THE POPULATION.

(a) Number of Deaths.

(b) Rate per 100,000 of the population.

Year	Bronchitis		Cancer (all sites)		Heart Diseases		Pneumonia		Tuberculosis of Resp. system		Total Deaths	
	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)
1933	200	92.2	339	156.2	591	272.4	269	124.0	248	116.0	3009	1386.6
1934	133	62.2	400	187.1	637	297.9	243	113.6	201	94.0	2932	1371.1
1935	131	62.4	348	165.7	656	312.4	236	112.4	190	90.5	2734	1301.9
1936	154	74.8	352	170.9	729	353.9	249	120.9	207	100.5	2893	1404.4
1937	141	69.9	390	193.3	779	386.0	245	121.4	178	88.2	2943	1458.4
1938	86	43.1	344	172.5	691	346.5	210	105.3	192	96.3	2611	1309.4
1939	92	46.8	366	186.2	838	426.2	201	102.2	187	95.1	2698	1372.3
1940	535	308.9	342	197.5	754	435.3	221	127.6	195	112.6	3224	1861.4
1941	333	208.5	276	172.8	559	350.0	211	132.1	173	108.3	2743	1717.4
1942	239	155.9	387	219.8	462	301.4	129	84.1	146	95.2	2223	1450.1
1943	330	215.7	345	225.5	445	290.8	147	96.1	148	96.7	2382	1556.9
1944	271	173.9	328	200.5	461	295.9	101	64.8	151	96.9	2271	1457.6
1945	416	264.5	313	199.0	472	300.1	126	80.1	146	92.8	2459	1563.3
1946	289	170.5	326	192.4	444	262.0	127	74.9	122	72.0	2266	1337.1
1947	288	165.5	351	201.6	488	280.3	122	70.1	131	75.3	2312	1328.2
1948	203	114.0	385	216.2	434	243.7	86	48.3	139	78.0	2103	1180.8
1949	260	145.3	358	200.1	560	313.0	127	71.0	113	63.2	2337	1306.3
1950	231	130.0	410	230.7	624	351.2	82	46.2	89	50.1	2288	1287.6
1951	314	177.6	392	221.7	715	404.4	89	50.3	82	46.4	2497	1412.3
1952	235	133.2	374	212.0	591	335.0	104	59.0	61	34.6	2151	1219.4
1953	277	159.3	390	224.3	563	323.7	129	74.2	50	28.8	2149	1235.8
1954	204	119.0	410	239.1	590	344.0	96	56.0	39	22.7	2055	1198.3
1955	226	133.5	352	207.9	585	345.5	132	78.0	38	22.4	2082	1229.8
1956	244	145.8	407	243.1	583	348.3	131	78.3	33	19.7	2065	1233.6
1957	226	136.7	404	244.4	620	375.1	131	79.3	31	18.8	2150	1300.7
1958	255	155.9	359	219.4	611	370.4	137	83.7	20	12.2	2159	1319.7
1959	212	130.9	394	243.2	612	377.8	127	78.4	31	19.1	2107	1300.6
1960	195	121.0	393	243.8	580	359.9	100	62.0	21	13.0	2042	1267.0
1961	242	156.2	370	238.8	579	373.8	130	83.9	21	13.5	2163	1396.0
1962	258	167.5	374	242.9	651	422.5	141	91.6	13	8.4	2294	1489.6
1963	216	141.6	367	240.5	516	338.2	176	115.3	10	6.5	2028	1329.2
1964	176	117.1	358	238.1	528	351.2	106	70.5	11	7.3	1844	1226.5

CAUSES OF DEATH — Registrar General's Return of Deaths in the City of Salford during the year 1964 (continued)

CAUSE OF DEATH	Sex	Total All Ages	Under 4 weeks	4 weeks & under 1 year	AGE IN YEARS							65—	75 and over
					1—	5—	15—	25—	35—	45—	55—		
20. Other Heart Disease	M	62	1	—	—	—	—	2	2	4	15	14	24
	F	106	—	1	—	—	1	1	5	11	15	14	58
21. Other Circulatory Disease	M	35	—	—	—	—	1	—	3	3	3	10	15
	F	25	—	—	—	—	—	1	—	—	—	7	21
22. Influenza	M	1	—	—	—	—	—	—	—	—	—	—	1
	F	2	—	—	—	—	—	1	—	—	—	—	1
23. Pneumonia	M	43	3	8	2	1	2	—	—	3	5	8	11
	F	63	1	5	—	—	—	—	—	1	3	11	42
24. Bronchitis	M	114	—	1	—	—	—	—	1	5	26	36	45
	F	62	—	—	—	—	1	—	1	4	8	19	29
25. Other Diseases of Respiratory System	M	11	—	—	—	—	—	—	1	1	2	5	2
	F	10	—	—	—	—	—	1	—	—	1	—	8
26. Ulcer of Stomach and Duodenum	M	8	—	—	—	—	—	—	—	—	3	3	2
	F	10	—	—	—	—	—	—	—	2	2	4	2
27. Gastritis, Enteritis and Diarrhoea	M	6	—	3	—	—	—	—	—	1	—	2	—
	F	6	—	2	—	—	—	—	—	—	2	1	1
28. Nephritis and Nephrosis	M	3	—	—	—	—	1	—	—	1	1	—	—
	F	6	—	—	—	—	—	—	—	1	—	3	2
29. Hyperplasia of Prostate	M	5	—	—	—	—	—	—	—	—	—	1	4
31. Congenital Malformations	M	3	2	1	—	—	—	—	—	—	—	—	—
	F	9	5	2	1	—	—	3	3	9	6	9	36
32. Other Defined and Ill-Defined Diseases	M	98	28	2	1	—	1	—	—	—	—	—	—
	F	104	18	4	—	1	—	2	3	7	13	18	38
33. Motor Vehicle Accidents	M	9	—	—	1	2	2	—	2	—	1	—	1
	F	11	—	—	1	—	1	—	1	1	2	3	2
34. All Other Accidents	M	24	1	2	3	—	—	5	1	2	7	2	1
	F	21	1	—	—	—	—	—	1	1	2	1	15
35. Suicide	M	14	—	—	—	—	1	1	—	4	7	1	—
	F	5	—	—	—	—	—	—	—	2	1	2	—
TOTAL ALL CAUSES	M	956	35	17	9	5	9	12	35	99	255	256	224
	F	888	25	16	2	2	3	7	21	63	127	235	387

ENVIRONMENTAL HYGIENE

1964 has been a year of considerable advance. In housing, more houses were represented as unfit, more houses were improved with the aid of improvement grants than ever before and with the resultant re-development of the cleared sites one can see the new Salford arising from the foundation and tradition of the old.

Continued work and effort has been made with houses-in-multiple occupation but it seems that the more that is done the more remains, and this task is proving one with no foreseeable end.

Many people in Salford are now enjoying the fruits of Smoke Control and in the areas which have now been subject to control for some time, residents are commenting that the hedgerows are cleaner and that washing remains clean whilst drying in the open air.

Whilst the vast majority of food shops comply with the requirements of the Food Hygiene Regulations, it is a pity that more attention is not paid to the display and presentation of goods by the average shop-keeper. To present a bright, clean appearance both outside and inside the premises must benefit trade and also the mental attitude towards hygiene by those employed handling food.

With these thoughts in mind we are looking forward to 1965 as a year of further progress in giving clean food, clean air and better housing to all.

HOUSING: SLUM CLEARANCE AND IMPROVEMENT

The year 1964 showed a substantial increase in the number of properties represented as unfit in clearance areas.

Clearance Areas Represented During 1964

Area	No. of dwellings
Whit Lane 1A, B, C Clearance Areas	459
High Street 1A, B, C, D, E, F Clearance Areas	505
Whit Lane 2A, B, C, D, E, F Clearance Areas	474
	1,438
Additional house and house/shop properties associated with Clearance Areas and included within the Compulsory Purchase Orders	25
	1,463

Public Local Inquiries involving 5 Clearance Areas in two separate Compulsory Purchase Orders and comprising 994 separate dwellings were attended during the year. Senior public health inspectors (2) gave detailed evidence on the condition of the properties and accompanied the Ministry Inspector to the properties concerned.

Orders Confirmed During 1964

Area	No. of Dwellings	Action following Confirmation
Ellor Street 8A, B, C, D, E	339	Entry March 1964. Rehousing in progress
Lower Broughton (River) 1 & 2	151	Entry April 1964. Rehousing in progress
Lissadel Street 1A, B, C	148	Entry July 1964. For patch maintenance and selective closure and demolition
Lissadel Street 2A, B	535	Entry effective 8th March 1965. Patch maintenance and selective closure and demolition
Total Properties	1,173	

**Unfit Houses Demolished or Closed During 1964 (involving family rehousing)
(including individually unfit properties)**

Period	Dwellings	Persons Rehoused
1st Quarter 1964	124	409
2nd Quarter 1964	261	772
3rd Quarter 1964	324	898
4th Quarter 1964	347	970
	1,056	3,049

In addition 35 families from Clearance Areas found their own accommodation.

Rehousing (Removal and Disinfestation)

The Council carries out the removal of household furnishings and effects of families from clearance areas to the new properties, free of charge to the families concerned but insists in all cases of removal to Corporation owned accommodation that disinfestation of furniture is carried out before removal. The fabric of the building is disinfested prior to demolition. In all cases disinfestation is carried out by the Health Department's disinfestation service using a residual insecticide.

Removal arrangements are carried out by private removal contractors employed on a competitive tender basis. Adequate safeguards under the contractor's Insurance scheme are insisted upon to cover the Authority against claims for damage or loss during removal.

Problems Peculiar to Immediate Demolition Areas

All families within Immediate Demolition clearance areas are rehoused within twelve months of entry becoming effective. Normal rental ceases upon

entry although a small "rate" charge is levied weekly while the house is occupied. The cessation of rent gives many families the opportunity to save for the expensive outlay of new furnishings required for the new home.

Inevitably as removals from an area progress there is an increasing problem of maintaining the occupied houses in a habitable condition, particularly where the desolation of a piecemeal picture of occupied and unoccupied houses is complicated by the effects of almost uncontrollable vandalism. The problem of maintaining the essential services, particularly water supplies and keeping roofs reasonably watertight, is difficult to solve. In Salford, we endeavour to minimise discomfort and nuisance by carrying out emergency patch repairs or re-connection of services on a minimum cost basis. The work is carried out by the Direct Labour Building Department generally within 24 hours of the receipt of a telephoned order.

The safety of empty properties awaiting demolition is of prime importance; a speedy notification of impending removals is made by telephone and confirmed by weekly circular letters to the statutory undertakings; cut off teams ensure the severance of supplies immediately a property is vacated. It is nevertheless an impossible task to ensure that empty houses are not used as "playgrounds" by the children of the neighbourhood—fortunately there has been no instance of a child being seriously injured in Salford whilst at play in the empty houses of a clearance area. The danger nevertheless exists. It should not be too much to expect parents to exercise their authority and do their utmost to put these empty houses "out of bounds" to their children.

Deferred Demolition Areas

Salford is one of the few local authorities practising the "deferred demolition" powers contained under Section 48 of the Housing Act 1957—in fact, the deferment of demolition of many properties in suitable areas is an integral and important part of our overall Clearance Area programme.

In general a well established system of patch maintenance allied to selective closure or demolition ensures that the properties remaining for their effective life (usually a minimum of seven years after entry) are at least made more tolerable for the time being.

Patch maintenance schedules are prepared following special inspections carried out immediately an area is confirmed; when "entry" becomes effective the necessary schedules of repair are formally submitted to the Housing Manager together with a detailed map showing recommendations for closure or demolition. Thereafter the properties within the deferred demolition areas become the concern of the Housing Committee and are managed in all respects by the Housing Manager.

Improvement Areas (Improvement of Properties)

The passing of the Housing Act 1964 with its powers to proceed to effect the improvement of properties within Improvement Areas (and elsewhere upon representation) was welcomed but has had the unfortunate effect at the onset of delaying somewhat our planned progress in this work.

Salford adopted in 1963 a procedure for declaring Improvement Areas as

suggested in Memorandum 42/62 and a second such area known as the "Seedley No. 2 Improvement Area" was formally declared in May 1964 (the Seedley No. 1 Area was declared in January 1963).

A brief summary of the progress achieved up to the 31st December 1964 in the first two "Persuasive" Improvement Areas is appended below.

Area	No. of Properties	Already Improved	Applications for Improvement Grant	Improvement Completed	Improvement in Progress
Seedley No. 1	254	20	95	16	79
Seedley No. 2	206	48	28	5	23

It has been found that the majority of landlords welcome our proposals for improvement whilst a certain element of resistance has been found amongst some tenants. Much experience has been gained in the technicalities of carrying out improvement during the year and much anxious thought has gone into the formulating of procedures and the detailed working of our schemes.

At the end of 1964 agreement has been reached with other Corporation Departments on the procedures to be adapted for all improvement applications; briefly the result is that from the 1st January 1965 all processing of improvement works will be dealt with by the Housing Section of the Public Health Inspectorate and all applications for Improvement Grants or authority for the issue of Improvement notices will be dealt with by a special Insanitary Properties and Improvement Grants Sub-Committee which meets weekly except when the normal monthly Health Committee is held.

In December 1964 the first "Improvement Area" under the provisions of the Housing Act 1964 was formally represented to the City Council and was approved. Survey work had been initiated on this Area earlier in the year and preliminary discussions with owners and occupiers had been held. As before, the majority of owners and tenants welcomed the Council's intentions regarding the Area and it would appear that only in a minority of cases will there be objections or lack of tenant's consent to improvements.

At the end of the year the issue of the Statutory Instrument detailing the forms of notices and orders to be used had still not been issued and this is urgently awaited—further steps to affect improvement within the Lower Broughton (Grecian Street) Improvement Area are held up until the relevant notices can be obtained although discussions are going ahead with the owners of property within the Area and seven applications for improvement have already been received.

Summarised below are the relevant details of the Lower Broughton (Grecian Street) Improvement Area.

Total No. of Properties	Already Improved	Owner/Occupiers	Tenanted Properties
239	5	85	154

All properties are capable of improvement to the full standard.

Representations from Tenants outside Improvement Areas

Up to the 31st December 1964, eight applications for improvement procedures to be instituted were received from the tenants of properties outside improvement areas. These have been acknowledged and will be proceeded with when the necessary forms are to hand.

Improvement Areas and Improvement Grants Publicity

A full scale publicity campaign is planned for 1965 and will include the following items:—

(a) A Salford Improvement Grants handbook produced by a commercial publisher, paid for by local advertisements and photographically illustrated. This handbook will contain preliminary application forms, tenant's consent forms and forms for representation from tenants outside Improvement Areas;

(b) the Ministry of Housing and Local Government mobile exhibition van — this has already been booked for early 1965;

(c) a static exhibition in modern premises showing types of equipment and suitable layouts;

(d) poster and leaflet displays in all public departments, libraries, counters of statutory undertakers, etc.;

(e) local press publicity and advertisements.

There is no doubt that every effort must be taken to inform all members of the public of the advantages to be obtained from the improvement of their houses.

Future Progress in Improvement Works

It is planned to represent approximately 750 properties per year in Improvement Areas and preliminary inspection and assessment work on the second Improvement Area under the Housing Act 1964 was already in progress at the end of 1964.

It is estimated that there are between 5,000 and 6,000 properties suitable for improvement in the City and our ultimate aim must be to effect the improvement of at least 500 houses each year over a ten year period.

This programme can only be achieved if sufficient staff resources are available. It has been found that Improvement Works, whilst proving of particular satisfaction to the staff employed thereon, are particularly time consuming and necessitate detailed supervision and constant encouragement and pressure on owners, occupiers and contractors.

HOUSES IN MULTIPLE OCCUPATION

At the commencement of the survey of houses in multiple occupation, following the passing of the Housing Act 1961, it was estimated that there were 250 multi-occupied houses in existence in the City. The end of 1964

has shown that this figure was an under-estimation; in fact, 330 multi-occupied houses have been inspected and it is now estimated that there are still upwards of 150 houses to be inspected.

The improvement of these houses to a reasonable standard of facility and management is proving to be an immense task with no foreseeable end. The problem is greatly frustrated by the rapid changes which take place both in the ownership and occupation of these houses.

Of the 330 houses inspected to date there is a nucleus of approximately 80 houses which require constant attention and supervision by the Public Health Inspector and it is these houses that have indeed been subject to intensive work during the year. Nevertheless, one regrets to report that satisfactory improvement of these houses has not been achieved and maintained. Where works have been carried out, improvement has, all too often, been rapidly undone by either bad tenants or lack of proper management.

It has been policy during the year to prosecute managers for non-compliance with management regulations but of the 14 cases taken in only 2 cases has improvement been achieved and maintained. Reference to the appended table of details of these cases will show the almost total disregard shown by managers to demands for improved management.

This is a very disturbing situation in view of the fact that at the time of visiting, of the 155 houses which are subject to Management Orders, no fewer than 51 have reached the stage at which prosecution is being considered.

In view of past experience it would not seem worthwhile to expend time in initiating lengthy court procedures if this is not going to improve the condition of the houses concerned, but instead other methods of approach must be exploited.

The execution of works in default of managers of houses in multiple occupation following notices served either requiring additional facilities or execution of works to remedy neglect of proper management, is one method which has not as yet been tried in Salford. In order that it may be understood why this course of action has not yet been taken, details are given below of estimates obtained in connection with 3 fairly typical houses in multiple occupation for the execution of works which have been required by notices—

	Estimated Cost of Default Works
Case A — Sec. 14 notice only — works to remedy neglect of proper management	£325 10 11
Case B — Sec. 14 notice only — works to remedy neglect of proper management	£521 6 0
Case C — Secs. 14 & 15 notices — works to remedy neglect of proper management and to provide additional facilities	£591 3 7

Cases B and C have, in fact, been brought before the Magistrates' and fines totalling £88 8 0 were imposed. Obviously to carry out works of this

nature and extent would raise considerable concern about the recovery of expenses involved, but on the other hand would be 100% effective in improving the existing conditions in the first instance. It is quite certain, however, that constant attention would still be required to maintain these improved conditions.

The advent of the Housing Act 1964 has given the local authority yet further power to deal with the worst cases of multi-occupation in the form of Control Orders. These orders have the effect of the Council assuming all rights of ownership to a house in multiple occupation for a period of 5 years if they are satisfied that the conditions in the house are seriously prejudicial to the health, welfare and safety of its occupants. These powers are intended for use in extreme cases but I am disturbed at the number of houses in Salford which are in such a state as to warrant action of this nature. One feels sure that the forthcoming year will see these powers brought into effect in Salford despite the cumbersome nature of the legislation and the obvious administrative difficulties which will ensue.

A further alternative method of dealing with these extreme cases is provided by individual demolition and closing order powers. However, as these multi-occupied houses are often occupied by 5, 6 or more families, extensive use of these powers would greatly frustrate existing plans for the most effective use of the allocation of houses available for families displaced from individually unfit houses and clearance areas. During the past year 4 multi-occupied houses have been subject to demolition orders and although one does not foresee a large increase in this number during the forthcoming year, one does foresee action being taken in the form of Clearance Orders or Compulsory Purchase Orders in respect of small blocks of the poorer multi-occupied houses as an alternative.

In conclusion, it is evident that the problems arising from multi-occupation are by no means nearing resolution in spite of the amount of work already carried out in this field. Perhaps a further year will bring the end nearer in sight.

TABLE 1

Summary of Prosecutions taken in accordance with S.13 of the Housing Act 1961 in connection with offences committed against Management Regulations

Case No.	Total Fines Imposed		Present Condition of House
	1st Offences	2nd Offences	
1	£10		Works completed—house advertised for sale
2	Absolute Discharge		Works completed but conditions rapidly deteriorating
3	Withdrawn		Works completed—conditions still satisfactory
4	£26		No works done—house now vacant and advertised for sale
5	£17		No works done—2nd prosecution pending
6	£17		No works done—2nd prosecution pending
7	£21	£21	No works done—demolition order under consideration
8	£24	£24	„ „ „
9	£24	£24	„ „ „
10	£44 4 0		„ „ „
11	£44 4 0		„ „ „

TABLE 2

	1962	1963	1964
No. of houses visited (1st visit)	76	91	173
Total No. of inspections and re-inspections	600	492	1490
Notices served under S.15 H.A. '61 (Requiring additional facilities)	54	33	91
" " " S.90 H.A. '57 (Requiring abatement of overcrowding)	20	4	9
Management Orders made under S.12 H.A. '61	19	74	68
" " " rescinded	—	—	6
Notices served under S.14 H.A. '61 (Requiring works to remedy neglect)	12	56	55
Directions made under S.19 H.A. '61 (Stating maximum No. of occupants in view of facilities available)	—	—	7
Houses without sufficient W.C. Accommodation	27	12	24
" " " Personal Washing Facilities	32	25	48
" " " Cooking Facilities	26	17	40
" " " Artificial Lighting to Common Parts	14	11	10
" " " Ventilation to Common Parts	17	2	3
Lettings without sufficient Artificial Lighting	6	3	3
" " " Ventilation	17	11	5
" " " Space Heating Appliances	2	—	—
Houses " " " Means of Escape in Case of Fire (Cases referred to Fire Officers)	32	54	72

DRAINS AND SEWERS

During the year the total number of inspections made in respect of drain and sewer complaints was 2,379. Included in this total are 231 complaints from the Housing Department of drainage defects in properties administered by them.

The free service with regards to simple blockages which can be easily removed by rodding or plunging is still maintained and appreciation is often expressed by owners of property who would under most Authorities have to pay for the service rendered. The Drainage Inspector has two Assistants and a van complete with equipment for carrying out his duties.

The City Engineer's Department carried out work to 58 sewers in respect of notices served by the Drainage Inspector, where the cost of maintenance is recoverable under Section 24—Public Health Act, 1936. Close co-operation exists between the Highways Surveyor and the Drainage Inspector in all matters referring to repair and maintenance of sewers.

The collapse of the main intercepting sewer in Seaford Road at a depth of 24'0" caused a subsidence in Seaford Road and caused flooding of premises with cellars in Seaford Road. This was alleviated by pumping and plugging of the cellar drains until effective sewer repairs had been carried out.

Several complaints of sewer gas were received during the winter months and in one instance at a confectioner's shop the concentration was such that the bread and confectionery in the shop became contaminated and had to be destroyed. The sewer gas was found to be coming from a broken cellar drain which was opened up and effectively repaired.

At 31 premises the Corporation carried out work in default on notices served in respect of defective drains.

Numerous complaints of percolations into cellars and basements were investigated and colour tests carried out on drains and sewers to ascertain the cause. In one case a percolation in a cellar was found to be coming from one particular drain of the house next door. This drain was opened up and eventually found to be connected to an old brick drain which when opened up in the main road was found to be disconnected from the Public Sewer. The drain was re-laid to a piped sewer at the Corporation expense.

The Drainage Inspector and Pests Officer work in close contact during investigation of rat complaints and tracing rat runs which usually lead to a defective drain or sewer.

During the typhoid epidemic at Aberdeen one person became a suspect case in Salford. Swabs were taken twice from the drains of the suspect's house and also from the Public Sewers in the vicinity and submitted to the Public Health Laboratory. No typhoid organisms were found to be present.

When any drainage work is carried out advice and assistance is always available; most contractors co-operate with the Drainage Inspector in this matter. Landlords and Agents usually give priority to drainage work and in most cases only the word of the Inspector is necessary to have the work carried out.

SMOKE CONTROL

The "Committee on air pollution" envisaged a period of 10 years in which it would be possible to eliminate the smoke problem from the worst smoke affected areas. Nearly nine years have passed since the Clean Air Act, 1956, came into force and the coverage achieved by smoke control is only about 25%. At this rate a further 30 years will pass before the original 10 year estimate of the Committee on air pollution comes into fruition.

There is no doubt that some local authorities are making very good progress in smoke control but many are most dilatory, making half hearted attempts whilst even worse are those authorities who have done nothing or have cancelled smoke control programmes. It may be that some local authorities are not convinced of the necessity for clean air, of its great value and the benefits which ensue. Several reasons could account for this attitude but whatever may be the cause the people have a right to demand and expect clean air in just the same manner as good housing, pure water, clean food and all of the other environmental factors which make for good living and the improvement of health. What is more important these are now taken for granted.

It is obviously clear and long overdue that a very hard look must be

given to the Smoke Control provisions of the Clean Air Act, 1956 and the control exercised by the Ministry of Housing and Local Government. The first consideration must obviously be to remove the permissive power regarding the making of smoke control orders and convert this into a duty for at least those areas of the country designated "Black".

Secondly, an adjustment is needed in the sharing of the expenditure involved in carrying out smoke control adaptations so that the owners or occupiers carrying out work on fireplaces and the local authority both pay a reduced proportion of the approved costs.

Thirdly, less ministerial interference is necessary regarding adaptation costs both in regard to appliances and labour. A ceiling for appliance costs is simple to determine and most desirable particularly in view of the wide range of appliances available and their widely differing costs. Even though the Ministry are aware that labour costs vary throughout the country there are unwarranted, unnecessary, and time wasting interferences by them in determining breakdowns of appliance and labour cost before confirmation is given. Even worse are the comparisons and endeavours made to force local authorities to reduce costs. There is little point in simplifying administrative procedure so that smoke control orders may be submitted more quickly if the simplification results in more delay, exasperation and frustration whilst such enquiries are made. If the Ministry of Housing and Local Government find it necessary or desirable to exercise such financial control, then the pretence of permitting the local authority to determine appliance costs, labour costs and total costs of smoke control orders should be wiped out for the sham which it undoubtedly is.

It is only right that work on fireplaces carried out with the aid of grant should be such that on completion the fireplaces should be capable of burning the cheapest fuel. The occupier can burn any fuel he chooses and it was originally envisaged that supplies of gas coke would be adequate for all smoke control areas but the changes within the gas industry have led to diminished production of gas coke. This situation has forced the Ministry to introduce a new basis for smoke control adaptations in which any type of appliance capable of burning an authorised fuel is grant aided up to the reasonable cost of that particular type. Because of strain on fuel resources exceptions are made for inset coke grates and electric fires which whilst these appliances may be installed they may not be grant aided. The adaptations now embrace and grant aid appliances for burning any of the authorised fuels. It is unfortunate that this very desirable change was not introduced at the commencement of smoke control. The basing of smoke control on one fuel—gas coke and grant aiding on the same basis inevitably led to an overwhelming use of that fuel. The present basis eliminates the previous parsimonious attitude and had this more liberal interpretation been in use since reception smoke control would have advanced more rapidly, been more acceptable and there would have been a wider use of all authorised fuels.

Inset appliances or improved open coke grates are not suitable for burning hard coke. There have been considerable number of these installed in all houses both new and existing. The cost of such grates varies from about £3 upwards, they have a life limited to a few years after which the front and bars distort or burn out. Previously a proportion of occupiers preferred not to alter their grates but burn premium fuel on existing grates

and a further proportion were ineligible by virtue of the houses having been constructed after the passing of the Clean Air Act, 1956. All of these grates are now eligible for adaptation and all owners and occupiers should, where solid fuel is preferred, install these more versatile type of appliances which are capable of burning all solid fuels and not just selected types. This will facilitate interchange between fuels and will enable the occupier to burn the cheapest fuel and thus be reflected in household expenditure and economies.

Those members of the public who reside in smoke control areas and burn coal, the merchants supplying them and the local authorities who are not pursuing a vigorous smoke control policy are doing a disservice to themselves, to their neighbours and to their citizens. This selfish action results in all being forced to breathe the air polluted smoke whether or not they object to doing so.

The new basis for smoke control will enable local authorities to go forward more rapidly complete programmes quickly and moreover there is a great demand for smoke control far outweighing the vociferous dissenting minority.

Clean air is a natural and rightful heritage—no one is entitled to or should be permitted to foul the air to be inhaled by someone else.

Railway Engines

The Industrial Revolution accelerated the development of towns and with this came all the evils associated with unsatisfactory housing. Because of the need to provide means of more rapid transport between towns the railways were introduced and these developed rapidly, so that much of the country was slashed by the lines of rival companies whilst the towns were similarly affected with the addition of sidings, marshalling and shunting yards. The coal fired engines belching smoke and blowing out grit were familiar sights on the industrial scene. At this time the smoke from railway engines attracted little attention, indeed more often it was regarded as being complimentary to the use of railway engines. The factory chimneys poured out their palls of black smoke and all the house chimneys sent up their smoke contribution. In all, this added up to a grim environment, squalid smoke blackened houses and factories, and a filthy atmosphere. The phrase "where there's muck there's money" no doubt came into use because of these conditions although the former would be more plentiful than the latter.

A long time has passed since these far off times and succeeding Acts of Parliament have resulted in very considerably improved living conditions. Many of the squalid houses have been demolished or will be demolished. The Clean Air Act, 1956, has brought about reduced smoke emission from factories so that it has now assumed negligible proportions, whilst smoke control areas are ridding the air of smoke from houses. The railway engines particularly shunting engines can still be seen puffing out smoke as they have done so often in the past. British Railways assert that their staff are trained in good firemanship and are issued with a booklet dealing with this subject. This may be but it is quite apparent from the extensive number of smoke emissions from engines that many of the staff ignore the training in good firemanship and the booklet recommendations. It is common to find engines being fired whilst they are stationary which inevitably causes excessive smoke. Firing

at stations, particularly those roofed over, causes similar emissions and in addition creates considerable discomfort and nuisance to the passengers. Not only has this practise been seen but passengers have written complaining of it.

British Railways have embarked on a programme of replacing coal fired engines with diesel engines but limitations on capital and workshop capacity inevitably combine to retard replacement.

The Clean Air Act, 1956, applies to smoke from railway engines in a similar manner to smoke from chimneys of buildings. The owner of the engine is responsible for its operation within the prescribed limits and smoke emissions in contravention thereof constitutes an offence. Because of the magnitude of the replacement problem there has been a tendency to accept smoke emissions from railway engines rather than institute proceedings against British Railways. There is restricted access to railway lines and engine numbers can be difficult to obtain and these may have been limiting factors. When the principles of good firemanship are ignored and contraventions are becoming widespread, the time has surely arrived to bring about the realisation that British Railways are responsible not merely for training staff and issuing a booklet on good firemanship but also for ensuring that classroom principles are put into practice by every member of the footplate staff every working day.

When there is so much improvement and reduced smoke emissions from houses and factories it is not good enough that railway engines persistently contravene the Clean Air Act, 1956. If proceedings are the only way, then proceedings must be taken in every case until the lesson has been learned that smoke emissions of this nature will not be tolerated.

Road Vehicles

Each year sees an ever increasing number of vehicles coming on to the roads and among these are included haulage vehicles and passenger transport vehicles. Both of these types seem to get bigger each year and the number of police escorted loads similarly increases.

Major roads pass through many towns and town centres and the traffic hold-ups result in large numbers of all types of vehicles with engines running being restricted to slow movement and sometimes no movement at all. The amount of exhaust fumes from these vehicles is considerable and it is inevitable that they will be inhaled by passers by, the effects varying according to duration of exposure.

The haulage vehicles invariably use diesel fuel and lack of maintenance or interference with the fuel devices causes them to be particularly prone to black exhaust smoke emission. This is both annoying and offensive and tends to occur when vehicles are loaded, when they are travelling uphill, when they are starting up or changing gear. It can be particularly hazardous when the following car is enveloped in clouds of black smoke and the driver is unable to see where he is going and it is a source of annoyance to smoke control area residents. These areas are increasing involving larger areas of the city and will continue to develop until the smoke control programme is completed.

The benefits occurring from smoke control are offset to the extent to which road vehicles pollute the atmosphere with exhaust fumes. In an attempt to deal with black exhaust smoke emissions a letter advising of this is sent to the owner of each offending vehicle and the results have been most gratifying. The majority of owners are unaware that their vehicles are emitting smoke and have assumed that periodic routine maintenance to be adequate for servicing purposes.

It is, however, vital to prevent our cities and towns from becoming stifled by exhaust fumes. The days of the stage coach have long passed and it should not be necessary to pass through one town in order to reach the next. More and better by-pass roads are essential and the city roads restricted to use by traffic travelling within the city. More stringent and frequent checks on all vehicles to eliminate black exhaust smoke is necessary. This should not merely consist of spot checks but should preferably be an annual test carried out in conjunction with licence renewal.

To make the air of our cities free from the effects of vehicle fumes will be costly. It is not only desirable to achieve this, but it is essential for the health and welfare of the public. To continue to add rapidly increasing quantities of pollution to the air without regard for the consequences can no longer be ignored.

FOOD HYGIENE

During the year the initial survey of food shops was completed and there now exists a comprehensive register containing a case history of every food shop in the City.

Premises are categorised as follows :—

Bakehouses and Confectioners	82
Butchers	171
Cafes and Restaurants	63
Cooked Meats and Tripe Shops	5
Fish and Chip Shops	110
Greengrocers and Fishmongers	164
Grocers	698
Sweets and Ices	122
Wine Merchants	5
	<u>1,420</u>

Revisits have continued and the majority of premises now comply with the provisions of the Food Hygiene (General) Regulations, 1960.

Legal proceedings were instituted in three cases, as follows :—

- (i) Summons were issued against a grocer whose premises were generally unsatisfactory, lacking facilities and being in a dirty condition. A fine of £60 was imposed.
- (ii) Summons were issued against a multiple store grocery firm in respect of contraventions found to be outstanding at one of their branches in

the City. The circumstances leading to this case were that a letter had appeared in the "Manchester Evening News" describing a packet of sausages which were found to be mouldy, and deprecating Salford shops generally. Strenuous efforts were being made to contact the author of the letter when another packet of mouldy sausages was brought to the office as a complaint in the normal manner. It transpired that the same shop was the culprit in both cases and the Inspector found at least one mouldy packet in the window display. Summonses were issued under Section 2 of the Food and Drugs Act, 1955, and the contraventions of the Food Hygiene (General) Regulations, 1960, were dealt with at the same time. A fine of £25 was imposed.

- (iii) Summonses were issued against a butcher in respect of contraventions at his premises. The matters were rectified prior to the case coming before the Magistrates and after hearing evidence of previous good character he was granted a conditional discharge.

MEAT INSPECTION

Cheltenham Street Slaughterhouse

In October 1963, work commenced on the conversion of disused premises at Cheltenham Street, Salford, by Manchester Meats Ltd., a new company formed by three Manchester meat wholesalers. The slaughterhouse was completed in September 1964 at a cost of approximately £67,000. A licence, previously applied for under The Slaughterhouse Act, 1958, was subsequently issued and slaughtering commenced on September 17th, 1964.

The estimated maximum throughput of animals is 500 cattle and 2,500 lambs per week. There are no facilities for the slaughtering of pigs.

The Meat Inspection Regulations, 1963, give the local authority power to make charges in respect of meat inspection. The charges which are determined by the local authority shall not exceed:—

- (a) 2/6d. for each bovine animal
- (b) 9d. for each calf or pig
- (c) 6d. for each sheep, lamb or goat.

As is common with the majority of other local authorities in Lancashire, Salford Corporation impose the maximum charges.

The total kill for the period 17th September, 1964, to 31st September, 1964, was:—

551 bovines
6,016 sheep and lambs.

The total meat condemned as unfit for human consumption:—

1 ton 6cwts. 2 qts. and 12 lbs.

SAMPLING UNDER THE FOOD AND DRUGS ACT, 1955

During the year 904 samples were taken under the Food and Drugs Act, 1955, for analysis by the City Analyst. The details of samples taken and the results of analysis will be found in the City Analyst's section to this report. The samples included 471 milk samples taken from the various milk distributors throughout the City. The points of sampling include Hospitals, Canteens, Shops, Dairies and Milk Vehicles.

A number of complaints regarding foodstuffs purchased in the City were received during the year, and several were submitted to the City Analyst for his examination. The majority of the complaints consisted of moulds and foreign bodies (including insect) in a wide variety of foods.

There were 6 prosecutions during the year under Section 2 of the Food and Drugs Act, 1955.

- (1) A complaint was received regarding a whole malt loaf, purchased in the City, containing areas of mould.

The Bakery firm in question pleaded guilty and were given an absolute discharge.

- (2) A Hot Pot Pie containing a flour beetle was purchased in the City. This was submitted to the City Analyst who gave the opinion that the insect was in the pie before cooking. The Bakers pleaded guilty and a fine of £20 was imposed.

- (3) A complaint was received that a packet of pork skinless sausages had been purchased in the City in a mouldy state. An inspection of the shop revealed that several other packets were in a similar state. This had been brought about by poor stock rotation, as the coding on the wrapper indicated that the sausages were several weeks old. The company concerned pleaded guilty to this, and three offences under the Food Hygiene (General) Regulations, 1960, and a fine of £25 was imposed.

- (4) A complaint was received from a person who had bought a Malt loaf from a shop in the City and after removing the wrapper noticed a nail and numerous hairs embedded in the loaf.

The Bakery firm were subsequently fined £10.

- (5) An apple tart was purchased from a works canteen in the City, containing a gigarette filter tip which had been baked in the tart.

The Bakers pleaded guilty and were fined £20.

- (6) A bottle of milk with black particles adhering to the inside of the bottle was the subject of a complaint from a person who had had it delivered within the City.

The Dairy concerned pleaded guilty and were fined £20.

Dairy Closure

In November of this year, the one remaining dairy in the City which processed and bottled raw milk was taken over by one of the large dairy companies, who immediately closed the premises. The dairy, Messrs. Hammersley's Ltd., had been in existence in Salford under the control of the same family for over 100 years and now, by its closure, all milk distributed in Salford is processed and bottled outside the City.

Another significant factor in the passing of this dairy is that the only raw milk now coming into the City is in the form of a limited number of bottles under the designation of "Jersey" or "Channel Island" milk untreated.

BACTERIOLOGICAL SAMPLING OF FOODSTUFFS

Ice Cream

Regular routine samples were taken from producers in the City and producers outside the City retailing in the City. The samples taken were generally satisfactory. Visits were made to all manufacturers, and advice given on hygiene and methods of sterilisation of equipment.

The depot controlling the fleet of soft ice cream vehicles which was mentioned in my report last year is now well established in the City and samples of ice cream together with inspection of vehicles and equipment has been carried out regularly throughout the year.

Milk

Regular routine samples of designated milk were taken from all supplies distributed in the City. These were examined for keeping quality and correct degree of heat treatment.

The results from these samples were generally of a high standard, and the small number of failures in respect of keeping quality was found, upon investigation, to be due to delays in distribution which were rectified.

Milk bottles and churns were tested for sterility prior to filling.

Desiccated Coconut

Samples were again taken at regular intervals during the year. The majority of these were from a Pasteurisation plant operating in the City. No samples were contaminated with *Salmonellae* organisms and coliform checks showed that efficiency of heat treatment was being maintained.

Liquid Egg

Regular sampling was carried out from Bakehouses and an egg cracking business situated within the City. These were taken under the Liquid Egg (Pasteurisation) Regulations, 1963, which came into force on January 1st, 1964. All the samples indicated that the correct heat treatment for pasteurisation was being maintained.

Miscellaneous Foods

Samples of Cooked Meats and Frozen Foods were taken periodically from food premises within the City, and the bacterial counts on these proved to be satisfactory.

FOOD POISONING

Only nine individual cases of persons affected with food poisoning organisms were notified during the year. There were no mass outbreaks which again justifies the work done in the field of food hygiene and stresses the importance and necessity of temperature control in the storage of cooked meat and other foods.

OFFICES, SHOPS AND RAILWAY PREMISES ACT, 1963

The safety, Health and Welfare of employed people at their place of work is a matter of some importance in this busy industrial City. It is not surprising therefore that this comprehensive legislation, which affects the working conditions of more than 10,000 people in this City, has aroused considerable interest among both Elected Representatives and Officers of the Council.

In order that proper enforcement arrangements could be made, the Specialist Public Health Inspector responsible for the enforcement of the Shops Act, 1950, was instructed in February 1964, to report as to the number of premises in the City likely to be affected by the Act. On the basis of this report the staff needs were assessed according to the details shown in Table F of the Appendix.

Registration of Premises

The registration of premises which should have been completed between 1st May, 1964 and 31st July, 1964, has proved to be a great problem. The exclusion from the Act of premises where only close relatives are employed for instance, affects approximately 1,600 premises and the only way to establish the facts is to visit these premises or write to the occupier.

Proper enforcement of the Act is not, of course, possible without a complete register and vigorous measures have been taken to ensure that full registration is achieved as quickly as possible.

Publicity

In addition to the national publicity carried out by the Ministry of Labour, two articles were published by the Salford City Reporter, with particular emphasis on the registration requirements of the Act. It soon became clear, however, that additional action was not necessary if full registration was to be achieved.

It was decided that the most direct and effective way was by circular

letters. Fortunately, excellent records of most shop premises were available, having been maintained in connection with the Shops Act, 1950, and Food and Drugs Act, 1955. Approximately 2,000 letters were sent out advising employers of their liability to register.

There was a great increase in the flow of registrations subsequent to these letters, but nevertheless, on the prescribed date of 31st July, 1964, only approximately 55% of employers had registered.

Registration Survey

A registration survey was carried out between August, 1964 and December, 1964, and as a result of this the register is now thought to be over 85% complete. No effort will be spared to ensure that all premises covered by the Act are registered.

Provision of Information to Employers

The number of premises affected by the Act is so large that it will of necessity be some time before all premises affected receive a general inspection. It is difficult to give a precise estimate because of the variety of types of premises involved, but it is thought that it will be not less than two years in Salford.

This being so it was felt that some contact with employers should be established in advance of the inspection of premises. It was decided to achieve this by sending circulars in reply to each registration form received. The first circular included a letter of introduction and memoranda on notifiable accidents, first aid regulations and dangerous machines.

It is anticipated that further circulars could usefully be sent when necessary. For instance, another circular is to be sent out to all registered premises when the regulations are made under Section 50, requiring employers to give information about the Act to employees.

Problems of Demarcation in Enforcement

There are many premises in Salford where both the Factories Act and the Offices, Shops and Railway Premises Act apply, usually to different parts of the premises. As a general rule the Factory Inspectorate are to enforce both Acts where the factory process is the principal activity at the premises. In other cases the division of responsibility is somewhat complex. In any cases of doubt the matter can be resolved by contacting the Local Authority or the Factory Inspectorate.

A cordial working liaison has been established with the Salford officer of the Factory Inspectorate to deal with the inevitable demarcation problems. Several joint meetings have been held, and also joint visits to premises have taken place. Satisfactory agreement has been reached in all cases of difficulty.

Co-ordination Arrangements

A great deal of helpful advice and assistance has been obtained from the regional office of the ministry of Labour established under Section 57 of the

Act for the purpose of co-ordinating the work of local authorities. The help given has been particularly useful in the sphere of safety of machinery and in cases of special difficulty an officer from this office has on several occasions visited with the local authority Inspector, to discuss the problems involved. The great value of this arrangement is that local authorities have ready access to the accumulated experience of the Factory Inspectorate in the sphere of safety of machinery.

Enforcement

Approximately 10% of registrable premises have been given a general inspection during the period August 1st to December 31st 1964. It is therefore premature to draw too many conclusions at this stage. Experience to date does, however, suggest that matters which require attention to secure compliance with the Act will fall into a wide range of categories.

In the majority of cases the list of requirements has tended to be a variety of items which can be remedied without undue difficulty, and the fears of many small employers about the possible disastrous effect of the Act upon their businesses has not been borne out. It is interesting to note that in shops where the health and welfare requirements of the Shops Act were fully observed (the spirit not the letter), then the principal matters requiring attention are the safety requirements such as first aid facilities, handrails on staircases and fencing of machinery. In only one case has it proved impossible to comply with the Act without the acquisition of additional premises, and in this case the employer was already aware of the inadequacy of his premises and had in fact already commenced negotiations for additional accommodation.

The following is a summary of various matters which have been found to require attention in the premises inspected to date.

Overcrowding

Cases of overcrowding have been found in only a small proportion of premises visited. Nevertheless, those cases found have been quite severe and in one particularly bad case twelve females were found working throughout each day in an office room with a cubic capacity of only 220 cubic feet per person. The problem was also aggravated by a ceiling height of only seven feet. In another case two people were found working in an underground room with a ceiling height of only six feet. This room was not overcrowded but clearly such rooms are undesirable. It is unfortunate that the Act does not give special powers to deal with underground rooms and with low ceilings.

Temperature

As a general rule offices have been found to have adequate heating arrangements. With shops, however, the reverse is true and in a substantial number of cases the heating appliances have been found to be quite incapable of achieving or maintaining a reasonable temperature.

Ventilation

The majority of premises tend to rely on natural ventilation and this has

usually been found adequate, subject to various repairs and improvements to windows and fanlights. In some cases difficulty has been experienced with rooms which have been subdivided with partition walls from floor to ceiling, thus creating rooms with no outside walls. These cases have been dealt with either by removal of partitions or with mechanical ventilation.

Lighting

In most retail premises a high standard of lighting is found, probably associated with selling techniques rather than with staff welfare. In offices and warehouses, cases of inadequate lighting have been found. In these cases readings have been taken with a light meter and readings as low as five lumens per square foot at desk level have been found. Regulations prescribing specific standards would be useful.

Eating Facilities (Shops only)

The standard of facilities provided varies greatly. Many shops have admirable facilities, provided under the provisions of the Shops Act 1950. In other shops the facilities are inadequate or non-existent. Where facilities are not available, it has been required that all employees have at least one hour for lunch as required by Section 19 of the Shops Act 1950 in such cases.

Floors, Passages and Stairs

A surprising number of staircases have been found without handrails, particularly staircases leading to stockrooms. A number of problems connected with openings in floors have been dealt with particularly in licensed premises and in butchers'.

Sanitary Conveniences

The majority of premises have been found to have adequate provision, and requirements have generally been such matters as lighting, cleaning and ventilation.

Washing Facilities

Most of the offices inspected have been found to have good facilities with hot running water. Many shops and warehouses (except food premises) have been found without a hot water supply. The principal difficulty encountered, however, is in premises where the number of staff employed is marginally in excess of five. The Regulations require proper separate accommodation for the sexes in such premises by 1st January, 1966. It is common in such cases to find that although the sanitary conveniences are separately allocated for the sexes, the washing facilities are communally used.

First Aid

The requirement to have a trained person on the premises applies to very few premises in Salford, because so few premises have more than 150 persons employed. Most employers have had to improve their first aid equipment and in a surprising number of cases no first aid equipment of any kind was found to be available. In the case of food premises, many employers had

provided first aid facilities in connection with the Food Hygiene Regulations 1960. These facilities fall short of the new requirements and the circular letters sent out with lists of necessary requisites have proved useful to such employers in improving their facilities with the minimum of expense.

Safety of Machinery

A number of problems have already been dealt with in connection with food slicing machines, paper guillotines, compressor motors and a baling press. The baling press was particularly important, in that the ram on this machine was not fenced, and there was a trap between the ram and the fixed bed of the machine. This machine is shortly to be replaced with a new machine, with suitable guards. The circulars from the Ministry of Labour on the subject of machinery have been particularly helpful in dealing with the problems referred to above. In addition to problems with machinery, a surprising number of cases of unsatisfactory electrical fittings have been noted and dealt with.

Accidents

Eleven accidents have been reported on form OSR. 2 and of these seven were found to be notifiable under Section 48. The injuries were all of a minor nature, and most of the accidents were relatively minor incidents. In one case, however, the accident was potentially very serious. A large sliding door approximately twenty feet high and fifteen feet wide fell on a warehouseman due to a defect in the sliding door gear. Modifications and repairs have been carried out to all similar doors on the premises to prevent a recurrence.

Something like 70% of the notifiable accidents to date have taken place in wholesale warehouses. This is not surprising as potential hazards are obviously much greater in wholesale warehouses than in offices or retail shops. A number of warehouses have been found to have teagle openings and various types of lifts and hoists. Regulations to deal with these would be welcome, although informal measures have been taken for the present.

It is difficult to say whether all notifiable accidents have in fact been notified. All employers have been circularised about this and the point is mentioned by Inspectors when visiting premises. Despite this, two of the notifiable accidents referred to in the last but one paragraph became known by press reports, and the employer had to be warned about his liability to notify.

Conclusion

The initial reaction of the vast majority of employers has been one of co-operation with the local authority. There is, of course, a tremendous amount of work yet to be done, but it is felt that the arrangements for enforcement are working well and that the improvements to premises which result, will bring about improved standards of safety, health and welfare for employees.

TABLE A – Registrations and General Inspections

Class of premises	Number of premises registered during the year	Total number of registered premises at end of year	Number of registered premises receiving a general inspection during the year
(1)	(2)	(3)	(4)
Offices	406	406	63
Retail shops	859	853	110
Wholesale shops, warehouses	89	89	10
Catering establishments open to the public canteens	226	224	8
Fuel Storage depots	14	14	1
Totals	1,594	1,586	192

TABLE B – Number of visits of all kinds by Inspectors to Registered Premises

729

TABLE C – Analysis of Persons Employed in Registered Premises by Workplace

Class of Workplace	No. of persons employed
(1)	(2)
Offices	3,432
Retail shops	2,700
Wholesale departments, warehouses	1,137
Catering establishments open to the public	1,522
Canteens	41
Fuel storage depots	110
Total	8,942
Total Males	4,510
Total Females	4,432

TABLE D – Exemptions

Nil

TABLE E – Prosecutions

Prosecutions instituted of which the hearing was completed in 1964

Section of Act or title of regulation	Number of persons or companies prosecuted	Number of informations laid	Number of informations leading to a conviction
(1)	(2)	(3)	(4)
Nil	Nil	Nil	Nil

No. of complaints (or summary applications) made under Sec. 22 – Nil

No. of interim orders granted – Nil

TABLE F – Inspectors

No. of inspectors appointed under section 52(1) or (5) of the Act	3
No. of other staff employed for most of their time on work in connection with the Act	1

HAIRDRESSERS AND BARBERS

During the course of the year applications for registration have been received in respect of 17 premises, 15 of these being for ladies' hairdressing establishments.

In the case of every new registration an inspection has been carried out, to secure compliance with the bye-laws made under the provisions of the Salford Corporation Act, 1955

The survey of shop premises being carried out under the Offices, Shops and Railway Premises Act has afforded an opportunity to review many existing hairdressing establishments, and to achieve improvements in hygiene.

SHOPS ACT, 1950

The scope of this Act is now much reduced, a substantial part of the Act having been repealed by the Offices, Shops and Railway Premises Act, 1963.

Closing hours and Sunday Trading restrictions are still in force however, and all complaints received have been dealt with informally.

PET ANIMALS ACT, 1951

A total of 16 premises are licensed by the City Council for the sale of pet animals. They have all been inspected during the year, and the requirements of the Act have been carried out.

ANIMAL BOARDING ESTABLISHMENTS ACT, 1963

Only two premises are licensed for the boarding of dogs and cats. In one of these cases a limited licence only was granted to operate between April 1st and October 31st. The licence was limited in this way because of shortcomings in the layout of the premises, and particularly because there is no heating or effective lighting.

SWIMMING BATH WATERS

During the year, three hundred and fifty-two samples were taken from the four public swimming baths and from three swimming baths situated in schools within the City. These samples were taken weekly both for bacteriological examination and chemical examination. Of the samples taken, 64 were found to have too high a chlorine content than was necessary to safeguard health and 21 were found to have too low a chlorine content to give protection against bacterial pollution. Copies of all results are sent to the Baths Superintendent as a matter of routine.

On the 6th July of this year a new swimming bath was opened; this is attached to the new Technical High School, Dronfield Road, Salford, 6. The bath has a gas chlorination plant with sand filters. It is 25 yards in length and 10 yards in breadth, the depth ranges from 3'6" to 8'6". This bath has been sampled weekly and the results, which have been satisfactory, are included in the above figures.

WATER SUPPLY

Water supply is obtained from Manchester Corporation's reservoirs and, in general, has been satisfactory. During the year eight samples of this supply were taken as a result of complaints. Analyses showed the supply to be satisfactory both as regards chemical and bacteriological standards. The complaints were due either to the presence of cyclops or to a brownish discolouration of the water caused by an excess of iron oxide. Representations to the water department resulted in these matters being rectified.

RODENT CONTROL, DISINFESTATION AND DISINFECTION

Rodent Control

The Prevention of Damage by Pests Act, 1949, requires every local authority to ensure as far as practicable that its district is kept free from rats and mice. This work is carried out by a foreman and five operators.

(a) Surface Investigations and Treatment

A free service is given to owners and occupiers of dwelling houses but occupiers of business premises are charged a rate of 15/- per hour, inclusive of materials, where complaints of rats are investigated.

Mice complaints are not as a rule investigated in dwelling houses but operator calls, advises and sells pre-packed boxes of Warfarin. Business premises are charged 15/- per hour as for rat treatments.

These pre-packed boxes of Warfarin are also sold at the Inquiry Counter at 9d. per box. Each box contains sufficient poison to make two baiting points.

No charge is made in cases where hardship is proved.

The following table shows the number of premises visited by the operators during 1964:-

Type of Premises	Complaints Investigated		Rats Treated		Mice Treated	
	1963	1964	1963	1964	1963	1964
Local Authority	17	73	4	10	28	41
Dwelling Houses	345	801	98	116	191	392
Business Premises	80	199	26	42	136	118
	442	1,073	128	168	355	551

During the year, 30 drains were found to be defective and allowing rats to escape. Preliminary notices were served on the owners and in all cases the drains were repaired or sealed off.

(b) Sewer Treatment

The miles of sewers within the City were treated three times during the year. The "bag baiting" method is still used and all manholes are baited with Warfarin containing parantitrophenal until "no takes" are recorded.

The following table gives a summary of the year's work:-

Section of System treated	Total No. of manholes in the System	No. of manholes treated	No. of manholes showing takes	Weight of bait in ozs.
38th Maintenance from 6.11.63 to 3.3.64				
Salford 1/13	944	927	78	217
Broughton 1/11	740	716	32	124
Pendleton 1/17	1,473	1,429	16	53
	3,157	3,072	126	394

Section of System treated	Total No. of manholes in the System	No. of manholes treated	No. of manholes showing takes	Weight of bait in ozs.
39th Maintenance from 4.3.64 to 26.6.64				
Salford 1/13	935	895	46	127
Broughton 1/11	740	717	17	42
Pendleton 1/17	1,471	1,430	20	50
	3,146	3,042	83	219

40th Maintenance
from 1.7.64 to 4.11.64

Salford 1/13	910	879	44	139
Broughton 1/11	740	724	42	125
Pendleton 1/17	1,471	1,431	43	102
	3,121	3,034	129	366

Disinfestation

The work of disinfestation is carried out by 2 full-time operators. Both operators are licensed drivers and are transported from job to job by a light van.

A nominal charge of 7/- per room is made to all occupiers of dwelling houses and the occupiers of business premises are charged on the basis of "time and materials". In cases of hardship a free service is given.

The following table shows the volume of work carried out:-

Insects Attacked	Number of Operations in 1963	Number of Operations in 1964
Bedbugs	182	185
Cockroaches	302	404
Wood-boring beetles	5	3
Earwigs	—	4
Flies	16	23
Golden Spider beetles	9	7
Wasps	4	4
Fleas	7	12
Ants	3	1
Moths	3	—
Steam flies	21	1
Lice	10	5
Larder beetles	13	83
Silver fish	—	2
	575	734

In addition to the 734 treatments for specific infestations, 1,108 Slum Clearance dwelling houses and lots of furniture were sprayed with insecticides prior to removal of the families to new Corporation houses, an increase of 184 jobs on last year.

Also, 15 school canteens were sprayed with residual insecticides as fly-proofing precautions and 28 visits were made to hospitals to treat for cockroaches.

1,354 tins of beetle powder were sold and 66 tins issued to Corporation tenants at the Inquiry Counter so that tenants could carry out their own treatment.

Disinfection

The Disinfection Station is situated in the grounds of Ladywell Hospital and manned by two full-time operators.

All bedding and clothing is steam disinfected in two ovens. Books, furs, leather goods, etc., which cannot be treated by steam owing to excessive damage which would arise are sprayed with Formaldehyde (in one of the ovens when not in use).

The following table shows the volume of work carried out:—

	Beds	Bundles of Clothing
Infected bedding and clothing	45	62
Verminous bedding and clothing	10	22
Clothing of patients admitted to Ladywell Hospital	—	169
Beds and bedding from Ladywell Hospital	406	519
Salford Royal Hospital	2	17
Hope Hospital	11	65
Eccles and Patricroft Hospital	—	18
Pendlebury Children's Hospital	—	2
Port Health Authority	—	1
Urmston Health Department	—	3
Swinton Health Department	4	4
Sterilising apparatus and dressing drums from Ladywell Hospital		3,029
Blankets from Ambulance Station — Salford		205
Urmston		46
Stretford		58
Eccles		22

In addition to the above steam disinfection the following disinfections were carried out by spraying with formaldehyde:—

Ladywell Hospital	109 cubicles
Salford Royal Hospital	25 cubicles
Ships' Cabins	3
Hospital Library Books	314

STATISTICS

Complaints and Notices

Complaints received	6,548
Statutory Notices issued	2,100
Statutory Notices abated	2,089
Intimation Notices issued	1,556
Intimation Notices abated	971

Nature of Inspections

Sanitary defects	11,305
Sublets (Houses in Multiple Occupation)	1,492
Common Lodging Houses	20
Caravans	22
Shops Act Inspections	174
Factories, Offices, Shops and Railway Premises	3,055
Public Conveniences	16
Places of Entertainment	57
Piggeries	2
Pet Shops	16
Pharmacy and Poisons	47
Motor Vehicle Exhaust	14
Diseases of Animals Act	104
Dairies	182
Food Shops	803
Food Stalls and Vehicles	163
Food Preparing Premises	293
Restaurants and Snack Bars	141
Canteens (Factory and School)	90
Unsound Food	475
Food Samples	68
Infectious Diseases	48
Food Poisoning	56
Smoke Observations	190
Smoke Abatement	7,756
Industrial Boiler Plants	68
Housing Act Inspections	5,666
Rodent Control and Disinfestation	1,063
Pest Act	271
Public Houses	279
Food Shop Survey	1,572
Swimming Baths and Drinking Water	271
Improvement Grant	677
Noise Nuisance	6
Hairdressers	15
Outworkers	11
Miscellaneous	1,758

Total

38,246

Calls — No Admittance

1,483

LIST OF SAMPLES TAKEN

Food and Drugs (Other than Milk)	330
Milk for Phosphatase Test	211
Milk for Methylene Blue Test	241
Milk for Turbidity Test	121
Milk for Fats and Solids-not-fats etc.	471
Ice Cream	76
Fertiliser and Feeding Stuffs Act Samples	22
Pharmacy and Poisons Act Samples	38
Water Supply Samples	8
Swimming Bath Water Samples	354
Rag Flock Samples	—
Miscellaneous Samples for Bacteriological Examination (including desiccated coconut, liquid egg, cooked meats, etc.)	159
Total	<u>2,031</u>

RESULTS OF MILK SAMPLES

Test	Milk	No. Tested	Pass	Fail	% Fail
Phosphatase	Pasteurised	48	47	1	2.0
„	T.T. Pasteurised	163	161	2	1.2
Turbidity	Sterilised	121	121	—	—
Methylene Blue	Pasteurised	78	70	8	10.2
„	T.T. Pasteurised	163	154	9	5.5

RESULTS OF ICE CREAM SAMPLES

No. of Samples	Grades
44	1
16	2
1	3
5	4

UN SOUND FOOD CONDEMNED

The following table shows a list of food surrendered for destruction during the year. It will be noticed that the Meat item is considerably higher than in previous years; this is due to a large number of imported hams found to be in an unwholesome condition.

All the foodstuffs were destroyed by burning.

Meat	19,416 lbs
Fruit	2,561 „
Vegetables	735 „
Soup	23 „
Creamed Rice	39 „
Sausage	16 „
Cream and Evaporated Milk	30 „

Fish	100 lbs
Fowl	15 "
Cheese	15 "
Bacon	56 "
Liver	2 "
Coconut	450 "
Dried Fruit	104 "
Lard	47 "
Sago	20 "
Ground Rice	361 "
Demerara Sugar	70 "
Lemon Cheese	168 "
Semolina	35 "
Cereals (Cornflakes)	4,344 "

Total 28,607

Item	Unit	No.	Value
...	...	...	...
...	...	...	...
...	...	...	...
...	...	...	...
...	...	...	...

RESULTS OF ICE CREAM SAMPLES

Item	Unit	No.	Value
...	...	...	...
...	...	...	...
...	...	...	...
...	...	...	...
...	...	...	...

UNROUND FOOD COMPOSITION

The following table shows a list of food commodities for comparison. The year is 1911. It will be noticed that the list is considerably larger than in previous years; this is due to a large number of food items being added in an unwholesome condition.

All the foodstuffs were destroyed by burning.

Item	Unit	No.	Value
...	...	...	...
...	...	...	...
...	...	...	...
...	...	...	...
...	...	...	...

CITY LABORATORY

TOTAL SAMPLES EXAMINED

During the year, 3,886 samples were examined in the City Laboratory and these may be classified as follows:—

	City of Salford	Eccles	Borough of Stretford	Sale	Urban District of Urmston	Worsley
Food & Drugs Act Samples	791	150	134	117	108	37
Pasteurised Liquid Eggs	95	—	—	—	—	—
Fertilisers & Feeding Stuff Samples	20	—	—	—	—	—
Swimming Bath Waters	346	34	—	—	9	—
Miscellaneous Samples (including Contract Samples from the Central Purchasing Committee)	236	—	2	5	12	4
Atmospheric Pollution Tests	1,786	—	—	—	—	—
	3,274	184	136	122	129	41

Total = 3,886

FOOD AND DRUGS ACT, 1955

New Regulations, Ministry Reports and Recommendations made during 1964

1. The Meat (Treatment) Regulations 1964 prohibit the addition to raw and unprocessed meat of ascorbic acid and nicotinic acid and certain substances related to these two compounds.

These chemicals were present in some dusting powders which were on sale during the latter part of 1963 for application to raw meat, and their main purpose was to maintain the fresh red colour of the meat, thus masking possible deterioration. The regulations were hurriedly introduced following reports of nicotinic acid poisoning, an unpleasant but not permanently harmful condition, resulting from the consumption of meat on which the powder had been used.

2. The Soft Drinks Regulations, 1964 revoke the 1963 Regulations (which had not yet come into operation) and re-enact them with certain amendments. The principal changes are:—

(a) standards and labelling provisions have been introduced for semi-sweet and low calorie soft drinks,

(b) the use of cyclamic acid and its calcium and sodium salts is, for the first time, permitted as artificial sweeteners in soft drinks in place of or in conjunction with saccharin,

(c) vending machines containing soft drinks must bear a declaration giving the specified description and, where appropriate, a declaration of any permitted artificial sweetener added.

3. Regulations for dried milk first came into force in 1924 and since then several amendments have been made.

The Dried Milk Regulations 1964 substantially re-enact the existing regulations in a consolidated and revised form and the changes made are based on the recommendations of the Food Standards Committee. A maximum moisture content is now prescribed for all descriptions of dried milk; the fat contents are more closely controlled and maximum and minimum percentages are prescribed for certain categories; the upper limit for fat in dried skimmed milk has been reduced from 8 to 1.5 per cent and containers must bear a declaration on the fat content.

4. Mineral oil in food was, up to 15th February, 1965, controlled by the Mineral Oil in Food Order and Regulations 1949-1955. On that date, the Mineral Hydrocarbons in Food Regulations, 1964 came into force and these revised and re-enacted the existing ones. Mineral Hydrocarbons may now be used on the rind of whole pressed cheeses, to seal eggs and as polishing or glazing agents in sugar confectionery. The regulations also lay down specifications for all mineral hydrocarbons used in food and increase to 60 per cent the amount of wax permitted to be used in chewing compounds.

5. In March, 1964, Proposals for Regulations for Canned Meat and Meat Pies were introduced. The proposed standards for pies are those suggested in the 1963 Report on Meat Pies, that is, 25 per cent meat for meat pies and 12½ per cent for meat and potato pies and similar products.

The canned meat proposals suggest compositional standards for several important classes of meat products and state that for others the meat content should be declared on the container.

6. In addition to the foregoing, two Food Standards Committee Reports were published during the year.

During the past ten years or so the increase in pre-packaging of food and the introduction of self-service stores has meant that labelling has become an important side of consumer protection. The Report on Food Labelling reviews all aspects of this subject in detail and, as stated in the introduction to the Report, the following guiding principles were followed by the members of the Committee when making their decisions:—

(a) Regulations must be designed to protect consumers and honest traders,

(b) if consumer and trade interests conflict, then the interests of consumers must take precedence,

(c) all labelling should be as clear and informative as possible.

In the Report on Colouring Matter, the Food Standards Committee has reviewed the Colouring Matter in Food Regulations, 1957 and recommended certain deletions and additions to the existing lists of permitted colours.

Food and Drug Samples

The total number of food and drug samples examined during the year was 791, a somewhat lower figure than the previous year. This was to be expected, however, and is due mainly to the policy of reducing the milk sampling and to the fact that extra duties have been taken on in testing liquid egg samples, for example.

One must not assume, however, that a reduction in total numbers necessarily means that less work is involved in analysing the samples. Routine analysis of milks is normally much less time-consuming than for most other foods and an increase in food sampling is equivalent to a much larger reduction in milks. Also, in the face of ever increasing food regulations, food additives etc. there is a constant need to do more and more on each article.

The sampling rate for 1964 was 5.11 samples per 1,000 population per year of which 3.07 were milk and 2.04 other foods and drugs. In the past 5 years the milks are down by about 40 per cent and the others have increased by 20 per cent.

No official guidance has been given on sampling rates since the Ministry of Health in 1933–1934 suggested a figure of 3 samples per 1,000 population per year, of which 1 sample should be milk.

In the past 30 years there have been many changes in the legislation controlling foods and drugs. Thus, for example, we now have regulations covering preservatives, antioxidants, emulsifiers, colouring matters, trace metals in food, etc. whereas in 1934 these were very few; many more compositional standards are now in force compared with then; stringent labelling requirements have to be met on all pre-packed foods; pesticides etc. are now more widely used on fruit and vegetables. All these appear to be good reasons why the rate of sampling of foods and drugs, other than milk, should now be more than that suggested in 1933–1934.

The position with milk, in an urban area such as Salford at any rate, is different, for whereas it is probably true to say that in 1934 the milk was supplied by many small distributors, these days it is in the hands of the few large ones. There are not, therefore, the same reasons for the milk sampling rate being higher than in 1934.

Bearing these facts in mind, it is thought that suitable present-day sampling rates for this area would be 5–6 samples per 1,000 population per year, of which 1–2 samples should be milk.

Table 1 classifies the samples examined under the Food and Drugs Act during the year and shows the number of unsatisfactory ones. 46 of the samples were 'complaints' from private purchasers and these included such things as dirty lubricating oil in bread, cigarette end in apple tart, milk bottle contaminated with cement. Legal proceedings were taken in respect of several of these 'complaint' samples.

The term 'rate of adulteration' is frequently used in food and drug reporting. This phrase in itself can be quite misleading and depends in the first place on the way in which samples are classified. Most 'complaint'

articles turn out to be adulterated or irregular and if these are classed as food and drugs, the rate of adulteration will be proportionally much higher than if they are not included. It is the practice here to class 'complaints' as food and drug samples. Thus we have a total of 62 irregular samples of which 33 were 'complaints'. This gives a total rate of adulteration of food and drug samples of 7.8 per cent and one of 3.9 per cent on samples taken by the Sampling Officer.

TABLE 1

Samples examined under the Food and Drugs Act

Samples	Number examined	Number adulterated or irregular
Alcoholic Beverages and Spirits	9	2
Baking Powder	1	Nil
Bread	10	10
Butter	4	Nil
Cereals and Cereal Products	9	1
Cheese and Cheese Products	3	1
Chocolate Confectionery	5	1
Coffee and Coffee Products	7	2
Colouring Matter, etc	1	Nil
Drugs	39	5
Eggs and egg products	1	Nil
Fat, etc. — other than Butter or Margarine	1	Nil
Fish products — canned	16	4
Fish products — other than canned	5	Nil
Flour confectionery — other than bread	11	4
Fruit — canned	9	Nil
Fruit — dried	6	1
Fruit — fresh	6	Nil
Fruit — crystallised	1	1
Ice-cream	17	1
Margarine	6	Nil
Meat Products — canned	32	9
Meat Products — pies	4	3
Meat Products — sausages	14	3
Meat Products — others	3	Nil
Milk — taken for compositional analysis		
Ordinary	437	2
Channel Islands	39	Nil
Milk — others	3	2
Milk — evaporated	4	Nil
Milk Products — others	9	2
Pickles	2	1
Preserves	12	Nil
Preservatives	2	Nil
Sauces	8	Nil
Soft Drinks	10	1
Soups	2	Nil
Spices, Condiments and Herbs	8	Nil
Sugar, Syrup, etc.	2	1

TABLE 1 (*continued*)

Samples examined under the Food and Drugs Act

Samples	Number examined	Number adulterated or irregular
Sugar Confectionery	2	Nil
Table Jellies, desserts	8	1
Vegetable Products – canned	15	4
Vegetable Products – dried	1	Nil
Vegetable Products – fresh	7	Nil
	791	62

Milk

Only two of the 437 ordinary milk samples were irregular. One was deficient in fat to the extent of 5 per cent but was part of a consignment from which several other samples were taken and the fat content of the whole was satisfactory. The other was an informal sample which contained 8.7 per cent extraneous water. A warning was given and further samples taken but these were found to be satisfactory.

The 39 Channel Islands milk samples were all satisfactory and complied with the limit of 4.0 per cent fat fixed by the Channel Islands and South Devon Milk Regulations, 1956.

Throughout the year examination of milk for the presence of traces of antibiotics was continued. Tests were made on 95 of the milk samples and all were found to be antibiotic-free.

The average composition of the milks analysed is given in Table 2, the corresponding figures for the previous five years being given for comparison.

TABLE 2

Average Composition of Milks

	1959	1960	1961	1962	1963	1964
All Milk (other than Channel Islands)						
Fat%	3.53	3.62	3.61	3.57	3.58	3.55
Non-fatty Solids %	8.63	8.68	8.65	8.68	8.72	8.82
Total Solids %	12.16	12.30	12.26	12.25	12.30	12.37
Channel Islands Milk						
Fat %	4.66	4.63	4.86	4.67	4.66	4.82
Non-fatty Solids %	9.00	8.92	9.14	9.21	9.20	9.40
Total Solids %	13.66	13.55	14.00	13.88	13.86	14.22

Pasteurised Liquid Egg

Under the Liquid Egg (Pasteurisation) Regulations, 95 samples were taken and submitted to the Alpha-Amylase test. All were satisfactory.

Unsatisfactory Food and Drug Samples (other than Milk)

Details of the unsatisfactory foods and drugs (other than milks examined for compositional quality) are given in Table 3. The serial numbers suffixed by the letter 'C' denote 'complaint' articles.

TABLE 3

Unsatisfactory Food and Drug Samples (other than Milk)

Serial Number	Description	Nature of adulteration or irregularity	Remarks
B1896	Rum	Contained the equivalent of 1.3% extraneous water.	Brewery notified. Warning letter sent to licensee.
B2011/C	Malt Loaf	A nail and some fibres of sacking material embedded in the base of the loaf.	Legal proceedings instituted. £10 fine plus 15/- costs.
B2019	Coffee	Labelling irregularity. Did not declare the name and address of the packer, or the Registered Trade Mark.	Label to be amended before further sales.
B2030/C	Sausages (cooked)	Unpalatable due to rancidity having developed to an undesirable extent.	No action could be taken as the cafe from which this complaint originated closed down several days after this incident.
B2042/C	Munchmallow	A large bristle embedded in the biscuit portion.	Manufacturers interviewed.
B1981	Sardines in Tomato Sauce (canned)	Contained 6 parts per million of tin in excess of the recommended limit of 250 parts per million.	Further samples B2076 and 7 taken.
B2076 and 7	Sardines in Tomato Sauce (canned)	670 and 500 parts per million of tin respectively.	Consignment surrendered for destruction.
B2051	Lychees in Syrup (canned)	Drained weight of fruit lower than that stated on the can.	Further sample taken.

Serial Number	Description	Nature of adulteration or irregularity	Remarks
B2075 A/C B2084/C	Corned Meat Loaf (canned)	These were all parts of the same consignment. Internally, the cans were badly corroded and the contents were in an unsatisfactory condition.	Wholesaler instructed not to offer these for sale.
B2062	Soft Drink	Misleading label. Would be more correctly described as "Black-currant Drink" and not "Blackcurrant"	The whole label of this commodity is under revue. No more of this type are being used for sale.
B2139	Ice Cream	Slightly low fat content.	Manufacturer notified. Further sample genuine.
B2152	Tinned Sardines in Tomato Sauce	Contained 10 parts per million of lead.	Stock surrendered for destruction.
B2161	Phenol Gargle B.P.C.	Label did not comply with B.P.C. requirements. Also dispensed in incorrect bottle.	Manufacturer to amend label and change type of bottle.
B2167	Seidlitz Powders	Incorrectly labelled.	Label amended by manufacturer.
B2176	Slimming Tablets	Not justified in making claims for slimming as the active ingredient was a laxative.	No further action as another Authority had taken the matter up with the makers.
B2183/C	Flour	Contaminated with black specks of mouldy flour from another source.	Containers in canteen checked. Further sample satisfactory.
B2194/C	Hot Pot Pie	Contained small beetle	Legal proceedings taken. Fine of £20 imposed.
B2207	Coffee	Slight irregularity on label.	Stock withdrawn to amend label.
B2210/C	Bread	Contaminated with foreign matter which was found to be rust.	Manufacturers given warning.
B2340/C	Milk Chocolate	Contaminated with dirt. This was in the chocolate before moulding.	Manufacturers interviewed.
B2233/C	Brown Bread	Cockroach embedded in the crust.	Manufacturers strongly cautioned.
B2262	Mixed Salad	Vitamins claimed but amounts not stated.	Importers notified.
B2265	Strawberry Jelly	Label did not bear list of ingredients.	Manufacturer agreed to amend label.

Serial Number	Description	Nature of adulteration or irregularity	Remarks
B2269/C	Pork and Ham	Contained a stone of geological origin 0.4 inches in diameter.	Canners notified.
B2279/C	Pork Pies	Affected with mould growth.	Manufacturers given warning.
B2280/C	Demerara Sugar	Had undergone micro-biological spoilage.	Stock surrendered for destruction.
B2296/C	Cheese Slices	Affected with mould.	Manufacturer and retailer interviewed.
B2329/C	Meat Pie	Contained a dried insect larva.	Manufacturers given warning.
B2330/C	Sliced Loaf	Contaminated with sacking material.	Bakers notified and bakery inspected.
B2344/C	Apple Tart	Cigarette end embedded in apple.	Legal proceedings taken. Fine of £20 imposed.
B2403/C	Milk	Bottle and milk contaminated with miscellaneous foreign matter.	Legal proceedings instituted. Fine of £20.
B2463/C	Bread	Majority of the slices contaminated with mould.	Interviewed bakery manager, premises inspected.
B2472/C	Remains of Cream Doughnut	Moth present in doughnut.	Bakery inspected.
B2487/C	Milk	Hardened sand and cement mixture firmly attached to base of bottle.	Bottler notified and cautioned.
B2543/C	Slice of Bread	Contained parts of the the body and wings of a "Daddy Longlegs", which had probably been baked in the bread.	No further action.
B2551/C	Raspberry Yoghourt	Affected with mould of the Penicillium species.	Warning letter sent to supplier.
B2534	Shandy	Contained only 0.8% proof spirit, which is regarded as insufficient for an article of this description.	Manufacturers notified.
B2351/C	Malt Loaf	Contaminated with mould.	Legal proceedings taken. Defendant given absolute discharge on payment of £6. 6s. 0d. Advocates fees.

Serial Number	Description	Nature of adulteration or irregularity	Remarks
B2580	Pickled Cabbage	List of ingredients incorrect, also address not clearly legible.	Packer notified.
B2594/C	Sliced Bread	Contaminated with dark patches of dirty mineral oil.	Baker notified. Premises inspected.
B2625/C	Part of brown loaf	Contained a piece of glass.	Legal proceedings taken. £10 fine.
B2619	Ammoniated Quinine Sulphate Solution B.P.C.	Compared with B.P.C. standard, sample was low in ammonia, possibly caused by an inadequate seal on the bottle.	Pharmacist notified.
B2646	Stoned Dates	Sample contained two dead beetles and some insect excreta.	Remainder of stock checked. Packers notified.
B2711	Ammoniated Tincture of Quinine.	Deficient in ammonia.	Pharmacist interviewed and cautioned.
B2704	Mixed Peel	Incorrect labelling	Packer notified. Label to be amended.
B2766/C	Part of sliced loaf	1¼ inch steel nail embedded in one of the slices.	Legal proceedings taken. £25 fine imposed.
B2767/C	Sliced White Loaf	Contained a 1 inch long bolt.	Legal proceedings taken. £25 fine imposed.
B2761	Beef Sausage	Deficient in meat to the extent of 25%.	Formal sample A1306 taken.
A1306	Beef Sausage	19% deficient in meat.	Severe warning given to butcher.
B2753 B2754 B2755 B2752	Vegetables & Chicken Vegetables & Bacon Vegetables & Lamb Beef & Egg Noodles	These were all Junior Dinners and the meat content was very low in each case.	Producers notified.

FERTILISERS AND FEEDING STUFFS ACT

During the year, this Act was amended by the Fertilisers and Feeding Stuffs (Amendment) Regulations, 1964. These regulations bring nitrogenous liquor within the Act and prescribe analytical methods for it; they also make changes in other methods of analysis and in certain definitions and sampling techniques.

Ten fertilisers and ten feeding stuffs were examined in 1964. Of these 9 fertilisers and 5 feeding stuffs were satisfactory and complied, within the specified limits of variation, with the statements giving particulars of composition. Details of the irregular samples are given below :—

Article	Irregularity	Action Taken
Steamed bone meal	Phosphoric acid 1.9 per cent higher than declared.	Manufacturer notified. Formula checked in order to comply with statutory statement.
Pig concentrated pellets	Fibre slightly high.	} Manufacturer notified. Formula to be amended.
Poultry food	Fibre slightly high.	
Pig rearing meal	Fibre slightly high.	
Dairy nuts	Protein and Fibre high.	
Layers mash	Oil higher than declared.	

SWIMMING BATH WATERS

At the various swimming baths in the City, treatment is continuously carried out to control the quality of the water. Samples are taken regularly from the baths and examined to ascertain, among other things, that an effective level of chlorination is being maintained. This must be sufficient to give adequate protection against bacterial pollution introduced by bathers but should not be so high as to cause complaints of smell, taste or irritation.

346 of these samples were submitted during the year.

MISCELLANEOUS SAMPLES

The majority of the miscellaneous samples examined during the year were, as usual, submitted by the Central Purchasing Committee and consisted of all types of articles used in Corporation departments. 196 of these articles, out of a total of 236 miscellaneous samples, were for this purpose.

Some of the more interesting of the remaining 40 items in this class were :

Insecticide preparations: submitted by the Pests Control Officer to determine their relative efficiencies.

Thinners: examined in connection with an incident in which several cleaners had been overcome by the vapour when using the thinners to remove polish from a corridor floor. The solvents were the usual type used in this work but the container did not bear a statement stressing the need to have the place well ventilated when using the thinners.

Frying pans: examined to determine the purity of the tinning. A British Standard Specification has now been issued which states that the tinning on all culinary utensils must have a purity of not less than 99.75 per cent tin.

ATMOSPHERIC POLLUTION

During the year, an air pollution measuring station was set up at the Landseer Street clinic and since April the daily levels of smoke and sulphur dioxide pollutants have been determined there in addition to the other five stations, situated in selected parts of the City, which have been in operation for several years. The Regent Road site was probably one of the first in the country to start making regular daily measurements and has been recording sulphur dioxide pollution since 1931.

The results for 1964 are given in the tables 4 and 5. Again there has been a reduction in both smoke and sulphur dioxide, the smoke being 7 per cent and the sulphur dioxide 5 per cent lower than in 1963. This downward trend has now been followed for several years as can be seen from the yearly overall average figures.

One means of assessing the effect of introducing smoke control areas is to study the smoke/sulphur dioxide ratio as well as the two separately. In these areas smoke will be reduced and sulphur dioxide should also be reduced but not by the same amount. Therefore, the ratio should fall as the reduction of smoke outpaces that of sulphur dioxide. Table 6 gives these ratios for the various sites and shows that the reduction at Cleveland House, the only station in a smoke control area, has continued in 1964, whereas at the other sites it has not done so.

Table 7 records the amounts of certain hydrocarbons which are present in smoke and which possess carcinogenic properties. The determinations are made using the smoke stains from either Regent Road or Police Street.

TABLE 4

Smoke Pollution – Daily Averages

Results expressed as microgrammes per cubic metre of air

Month	Site					
	Regent Road	Cleveland House	Police Street	Murray Street	Encombe Place	Landseer Street
1964						
January	722	363	558	462	521	
February	472	320	422	432	420	
March	232	204	354	384	284	
April	286	140	234	205	200	258
May	166	82	143	115	112	143
June	232	72	175	135	116	178
July	202	68	151	94	54	178
August	214	79	131	112	73	178
September	321	122	200	150	98	209
October	567	330	425	441	324	540
November	649	280	480	456	352	390
December	808	433	548	484	507	748
Daily Average for the whole year	406	208	318	289	255	313*

Overall Average – 1964 = 298
 1963 = 320
 1962 = 377
 1961 = 402

* Average for 9 months

TABLE 5
Sulphur Dioxide Pollution – Daily Averages
Results expressed as microgrammes per cubic metre of air

Month	Site					
	Regent Road	Cleveland House	Police Street	Murray Street	Encombe Place	Landseer Street
1964						
January	607	237	540	434	602	
February	403	174	349	335	453	
March	310	167	317	332	402	
April	320	188	255	212	291	292
May	280	164	200	186	222	244
June	239	136	197	155	192	245
July	229	127	169	144	111	276
August	203	125	167	142	117	207
September	279	165	177	150	164	255
October	402	199	422	307	334	409
November	499	149	493	421	341	461
December	567	206	541	477	501	654
Daily Average for the whole year	361	170	319	275	311	338*

Overall Average – 1964 = 296
 1963 = 312
 1962 = 331
 1961 = 328

* Average for 9 months

TABLE 6
Yearly Smoke/Sulphur Dioxide Ratios

Year	Site					
	Regent Road	Cleveland House	Police Street	Murray Street	Encombe Place	Landseer Street
1961	1.16	1.94	1.46	1.14	0.91	
1962	1.17	1.55	1.11	1.11	0.93	
1963	1.10	1.30	1.00	0.99	0.84	
1964	1.12	1.22	1.00	1.05	0.82	0.98

TABLE 7
Carcinogenic Hydrocarbons in the Atmosphere

Month	Microgrammes Smoke per 100 cubicmetres	Microgrammes Hydrocarbon per 100 Cubic Metres of Air			Parts per million Hydrocarbon in Smoke		
		Pyrene	Coronene	3.4 Benzpyrene plus 1.12 Benzperylene	Pyrene	Coronene	3.4 Benzpyrene plus 1.12 Benzperylene
1964							
January	55,800	0.971	0.930	2.437	17	17	44
February	40,800	0.685	1.57	8.34	17	39	204
March	35,400	4.27	2.84	12.06	121	80	340
April	28,600	0.593	0.377	2.878	21	13	100
May	16,600	2.625	0.773	2.334	158	47	140
June	23,200	0.338	0.131	2.756	15	6	119
July	15,100	0.103	0.392	1.479	7	26	98
August	13,100	0.084	0.054	1.707	6	4	130
September	32,100	0.140	0.208	4.993	4	6	156
October	56,690	1.006	0.679	13.120	18	12	232
November	64,900	3.985	3.380	15.56	61	52	240
December	74,800	2.105	0.298	25.39	28	4	339

SAMPLES FROM NEIGHBOURING AUTHORITIES

In addition to Salford, the City Analyst holds appointments as Public Analyst to the Boroughs of Eccles, Stretford, and Sale and the Urban Districts of Urmston and of Worsley, the appointments to the two latter being made in April, 1964.

A total of 612 samples were examined for these five Authorities during the year and fees amounting to £1,889 10s. 6d. have been received by the City Treasurer in respect of this work.

These Authorities represent a compact area of five units of approximately equal populations and it was thought by all concerned that it would be advantageous in many respects to try and develop a co-ordinated scheme for routine sampling of foods to cover the area as a whole. A scheme was, therefore, worked out which would attempt to give an adequate coverage of different types of articles, at the same time avoiding unnecessary repetition by different Authorities, yet allowing locally prepared articles to be sampled sufficiently.

The principle of the scheme is that all articles suitable for sampling have been allocated to one of two classes, those which are essentially 'regional' or 'national' and are likely to be common to all five Authorities, and those which are mainly 'local' ones.

The 'regional' class consists of many categories and each Authority is allocated several of these each quarter. They are arranged so that no two Authorities sample from the same category during any one quarter and also that one Authority does not sample the same category more than once a year, thus giving a reasonable variety of sampling during the year. A suitable rota ensures a change in sampling from year to year for each Authority and over a period of five years, all Authorities will cover each category at least once. Categories which consist of widely consumed commodities are included in the scheme more frequently than others, an attempt thus having been made to make the sampling roughly proportional to the degree of consumption. It will be appreciated that many of the articles in this class are made by large manufacturers and are often pre-packed.

The sampling list for 'local' samples is the same for all Authorities for all quarters and contains such articles as sausages, cakes, etc. which are prepared locally, and other articles which although not produced locally, ought for various reasons to be classed as 'local' for sampling purposes.

To work effectively, such a scheme needs the full and enthusiastic support of all Authorities concerned and although it was only started at the beginning of the last quarter of 1964, so far the scheme appears to be functioning satisfactorily and to be an improvement on random sampling by all five Authorities acting individually.

DOMICILIARY MIDWIFERY SERVICE

The trend towards hospital delivery has affected, to some degree, the pattern of work and responsibility taken by midwives. The increased numbers of mothers returning home soon after their delivery in hospital has greatly increased the number of visits a midwife must make each day and the establishment has consequently been increased by two.

Unfortunately, these homes are often badly prepared for the reception of the baby and not always suitable or warm enough for a baby leaving the centrally-heated nursery of a hospital. Teaching and "pre-arranged early discharge" do not avoid undesirable conditions, as the majority of the problems arise from the immediate complications surrounding the family at the time and day following the mother's admission to hospital. The scheme also, unfortunately, encourages too many mothers—not medically or socially suitable—to take their own discharge from hospital earlier than advised.

Co-operation with family doctors is increasing, especially with regard to ante-natal care. Two more practices (making six in all) have asked for a midwife to work with the doctor at his surgery and the advantages to the mother are legion. The chief and almost only problem to this and any future scheme, is the complete lack of day-time transport available to the midwife (unless provided by herself) and consideration must again be given to this *vital* point.

The importance of correct *selection* of mothers for hospital delivery is being more widely appreciated by all responsible, and liaison meetings are helping towards a more uniform and accurate assessment. It is, however, too frequently the mother who should have her baby in hospital who, herself, refuses to do so.

STATUTORY SUPERVISION OF MIDWIVES (Midwives' Act, 1951)

Notification of Intention to Practise

In accordance with the provision of the above Act, the number of midwives who notified their intention to practise was as follows:—

(a) Institutional	44
(b) Domiciliary	34
(c) Private Practice	0
Total	<u>78</u>

Compulsory Post-Graduate Courses

In accordance with the rules of the Central Midwives Board, midwives have contrived to attend, at least once in every five years, courses arranged for post-graduate instruction.

Attendance by Salford Midwives 1964

(a) Institutional	3
(b) Domiciliary	5
(c) Supervisors	1

Miscellaneous Notifications

(as required by the rules of the Central Midwives Board)

Notification	Domiciliary	Private Practice	Total
Stillbirth	1	0	1
Death of mother or baby	0	0	0
Laying-out of dead body	1	0	1
Infection	20	0	20
Medical Aid	1,188	0	1,188

STAFF POSITION (December 31st)

	Establishment	1964	1963	1962
Supervisor and Tutor	1	1	1	1
Assistant Supervisor	1	1	1	1
Approved District Teachers	5	5	3	3
Midwives – Full-time	22	17	17	14
Midwives – Part-time	0	4	3	4
Breast-feeding Sisters	2	2	2	2
Premature Baby Nurses	3	3	3	3

STATISTICS**(1) Clinics**

(a) Attendances :— Statistics relating to ante-natal clinic attendances will be found under "Care of Mothers and Young Children"

(b) Bookings :— Total number of domiciliary bookings 1,602 (1,590)
 Total number of cancellations (including removals, transfers to hospital, etc.) 443 (462)

(2) Home Visiting

(a) Follow-up of clinic defaulters	}	10,286	(10,200)
(b) Routine home ante-natal visits			
(c) Investigation of home conditions			
Actual homes		340	(398)
Number of visits		1,844	(2,179)

COMPARATIVE STATISTICS – HOME INVESTIGATION

Year	1964	1963	1962	1961	1960
Totals	340	398	478	264	247

Births**(1) Statistics**

Doctor booked and present at delivery	108	(191)
Doctor booked, not present at delivery	1,090	(1,018)
Doctor not booked, and present at delivery	0	(3)
Doctor not booked and not present at delivery	9	(18)
	<u>1,207</u>	<u>(1,230)</u>

N.B. (a) Two cases of twins occurred, making total number of births	1,209	(1,234)
(b) Domiciliary births formed (of total Salford births)	62.5	(58%)

COMPARATIVE STATISTICS

Year	Live Births	Stillbirths	Total
1960	1,197	10	1,207
1961	1,241	7	1,248
1962	1,341	8	1,349
1963	1,222	12	1,234
1964	1,207	2	1,209

Number of nursing visits following delivery	20,003	(20,836)
Number of nursing visits for hospital discharge	6,393	(4,473)
Total	<u>26,396</u>	<u>(25,309)</u>

(2) Analgesia

	Number of Mothers
Nitrous Oxide	1
Trilene	903
Pethidene	841
Total Inhalation Analgesia	904 i.e. 75% of all births

(3) Stillbirths

Comparative Statistics	Number of Stillbirths	Rate per 1,000 Registered Births
1960	10	8.3
1961	7	5.83
1962	8	6.0
1963	12	9.9
1964	1 + 1 notified by Police (found in canal)	1.25

SUMMARY OF CASES

Classification	Presentation	Weight	Gestation	Condition	Contributory Factors
Foetal Abnormality	Face	6 lbs.	41 weeks	Fresh	Anencephalic and spinal bifida
Notified by Police	?	?	?	Macerated	Found in canal — P.M. — stillbirth No attention at birth

(4) Neo-natal Mortality (Domiciliary Bookings)

Deaths from Birth up to 28 days	Cause of Death	Age at Death
Born and died at home 3	Uraemia Asphyxia and Virus Pneumonia Pneumonia	28 days 14 days 21 days
Born at home and transferred to hospital 6	Asphyxia Neonatorum Pneumonia Pneumonia and Skeletal Deformities Prematurity ? Cerebral Haemorrhage Diaphragmatic Hernia	1 hour 24 hours 11 days 1 day 2 days 5 days
	Reason for Transfer	Number
Mothers booked for home confinement and transferred to hospital before labour and subsequent death of baby before 28 days 17	Ante-Partum Haemorrhage Prematurity Twin Pregnancy Abnormal Foetus Pre-Eclamptic Toxaemia	5 7 3 1 1

(5) Emergency Obstetrical Unit

The emergency obstetrical unit, operating from Hope Hospital, was called out on four occasions during the year.

SUMMARY OF CAUSES

Retained placenta with post-partum haemorrhage	3
Prolapse cord (not admitted)	1

(6) Puerperium

Infection	Hospital	District	Total
Puerperal Pyrexia	33	3	36
Ophthalmia Neonatorum	2	2	4
Pemphigus Neonatorum	0	0	0

Causes of pyrexia were as follows:—

	Hospital	District	Total
Uterine Infection	4	1	5
Peritonitis (following Caesarean Section)	2	0	2
Urinary Infection	11	1	12
Chest Infection	1	1	2
Breast Infection	2	0	2
Thrombophlebitis	1	0	1
Unknown Origin	12	0	12

OPHTHALMIA NEONATORUM

Four cases were notified during the year, two of these were gonococcal in origin—in both of these cases the babies were transferred to special eye units where treatment was successful and the source of infection investigated.

BREAST FEEDING AND PREMATURE BABY SERVICES

These two units continue as invaluable, complementary services and work in close co-operation with hospital and all branches of domiciliary staff. Their *continuity* of care for the mothers and babies has, over a long period, proved its value and the Salford mothers are especially grateful. A total of 3,335 visits were made and 202 clinic sessions attended.

SALFORD PART II MIDWIFERY TRAINING SCHOOL

A further member of the staff has been successful in obtaining the Midwife Teachers Diploma.

Twenty-two pupils completed their training during the year and nineteen are known to have taken midwifery posts in some capacity immediately after qualifying.

CARE OF MOTHERS AND YOUNG CHILDREN

STATISTICS

The figures in this Section are compiled locally and do not necessarily correspond with those compiled by the Registrar General.

Births

We received 4,174 live birth notifications, 262 of which referred to births outside the City to Salford residents. There were 106 stillbirth notifications plus one not notified; eight of the stillbirths occurred outside the City to Salford residents. The adjusted births for the City were 3,149 live and 80 stillbirths. These figures, set against the Registrar General's estimated population for mid-1964, gave an estimated Live Birth Rate of 20.94 and a Stillbirth Rate of 24.77 respectively.

Of the total notified births 69.3% were institutional but of the births occurring to Salford mothers only 61.96% were institutional. Whilst this figure is higher for Salford mothers than the pre-1948 pattern, i.e. 50% home births and 50% institutional births, it is still below the recommendations of the Cranbrook Committee and the figure has hovered around 60% of our adjusted total births for the past ten years.

Infant Deaths 0 - 1 year

During 1964 there were 80 stillbirths and 92 infant deaths, i.e. deaths in the first year of life. The stillbirth rate is 24.8 per 1,000 total registered births and the infant mortality rate is 29.3 per 1,000 live births. The corresponding figures for 1963 are stillbirth rate 21.8 and the infant mortality rate 30.8.

The table below shows the distribution of infant deaths by age and the death rates:-

Stillbirths	80				
Deaths under 24 hours	32	131 Peri-natal deaths Death Rate	51 Early Neo-Natal Deaths - Death Rate	59 Neo-Natal Deaths - Death Rate	92 Infant Deaths - Death Rate 29.2
„ 1-6 days	19				
„ 1-2 weeks	4	40.6	16.2	18.7	
„ 2-3 weeks	1				
„ 3-4 weeks	3				
„ 1-6 months	28				
„ 7-11 months	5				

As can be seen in the table more than 75% of the total infant loss occurs at birth or within the first week of life and this serves to underline once again the importance of the roles of good ante-natal care and a first-class midwifery service in the prevention of infant deaths. It is unfortunately true that some infant deaths are unavoidable, e.g. those with gross congenital handicaps, but the vigilance of the midwives and the quality of medical care which the mother receives are of paramount importance in ensuring the birth of a healthy infant.

An analysis of the causes of death of live born infants is as follows:—

Respiratory disease	33
Prematurity	27
Other causes	18
Congenital defects	9
Gastro-enteritis	3
Birth injuries	2

In many cases it is difficult to classify accurately the cause of death of a particular infant and the classification depends to a large extent on the amount of information given on the death certificate, e.g. a premature infant suffering from respiratory distress and subsequently dying may be classified under "prematurity" if the death certificate reports prematurity and gives no further details: the death would be classified as respiratory disease if the certificate stated respiratory distress syndrome and gave no further details, but if the certificate states respiratory distress syndrome and prematurity one is left wondering whether to classify the death as due to respiratory disease or whether to classify it as due to prematurity. Both classifications would be correct, as in fact the child's death was due to failure to establish respiration but the question arises "would this condition have arisen if the infant had not been born prematurely?"

The table below shows the distribution of causes of death in each age group.

Causes of Death	Age at Death					Total 0-1 Year
	Under 24 hours	1-6 days	2-4 weeks	1-6 months	7-11 months	
Prematurity	17	9	1	—	—	27
Congenital Defect	4	1	2	2	—	9
Birth Injuries	1	1	—	—	—	2
Respiratory Diseases	8	6	3	14	2	33
Other Causes	2	2	2	10	2	18
Gastro-Enteritis	—	—	—	2	1	3
Accidental Death	—	—	—	—	—	—
Total	32	19	8	28	5	92

As one would expect, prematurity figures as the major cause of infant death in the first day and the first week of life and deaths due to birth injury are confined to the first week of life. Congenital defects cause deaths over the first six months of life but almost 50% of deaths due to this cause occur within 24 hours of birth. Respiratory disease causes deaths throughout the first year of life but in the early days respiratory disease generally means

difficulty in establishing respiration, i.e. neonatal respiratory distress syndrome, whereas in the later weeks and months of life respiratory disease means an infection of the respiratory system, i.e. pneumonia. Gastro-enteritis figures as a cause of death in only three cases and is of course due to an infection of the gastro-intestinal tract, this infection being introduced to the infant either in the food it is given or in the later months from the objects which infants habitually put into their own mouths.

"Other causes" of death, which is the third most important of the causes of death in the first year of life, includes a wide variety of diseases which do not lend themselves to any form of classification.

At the present time an investigation into the cause of each infant death and the contributory factors associated with each death is being carried out by this department and a report of this investigation will be included in the Annual Report for 1965.

Deaths 1 - 5 years

There were 11 deaths in this age group in 1964 compared with 19 deaths in 1963.

The table below shows the causes of death and the age groups of the children:-

Deaths of Children 1 - 5 Years 1964

Cause of Death	Aged 1 year	Aged 2 years	Aged 3 years	Aged 4 years	Total
Respiratory Disease	2	—	1	—	3
Accidental Death	1	2	2	—	5
Other Causes	1	—	1	1	3
Total	4	2	4	1	11

Accidental death is the major fatal hazard for the one to five year old child and in 1964 five children died as a result of accidents: two children were killed in road accidents, one child was drowned, one child died following scalds and one child died following burns involving more than 50% of the body area. Respiratory disease claimed only three victims in 1964 compared with seven in 1963 and there were no deaths due to gastro-enteritis. There were three deaths classified as "other causes" and in this group two deaths were due to leukaemia and one death due to epilepsy, the child being mentally handicapped.

Maternal Deaths

I am happy to report that there have been no maternal deaths in Salford during 1964.

ANTE-NATAL CLINICS

During the year ante-natal clinics were held at eight centres, namely, Ordsall Clinic, Regent Road, Encombe Place, Langworthy Centre, Summer-ville, Police Street, Kersal Centre and Murray Street. The tabulation below shows the work done at each clinic and also a comparison with the work done in the previous year.

ATTENDANCES AT ANTE-NATAL SESSIONS

Clinic	Number of sessions weekly	Total individuals at clinics	Total attendances	Consultations		New attenders
				By Local Authority Medical Officer	By General Practitioners	
		Records at Year End				
Encombe	1	130	702	166	—	96
Kersal	1	170	962	200	38	136
Langworthy	2	430	2,192	451	63	338
Murray Street	2	517	2,378	651	—	423
Ordsall	1	183	961	195	—	132
Police Street	1	120	654	157	—	102
Regent Road	1	180	1,047	216	—	147
Summerville	1	132	865	8	176	104
Totals 1964	10	1,862	9,761	2,044	277	1,478
		Plus (38 cases trans. to G.P.'s own Clinic)				
1963 figures for comparison		2,027	10,757	2,275	293	1,602

The ante-natal clinics were held at each clinic weekly with the exception of Langworthy Centre and Murray Street where ante-natal clinics are held twice weekly. A medical officer attends each clinic at regular intervals: in the case of Langworthy Centre and Murray Street, once per week: at the other clinics, once per fortnight. Each new patient (with the exception of those whose family doctors run their own ante-natal clinics) is examined by the doctor and blood samples are sent for examination following this initial consultation and again at a later stage in pregnancy. General practitioners employed on a sessional basis carried out 13% of these consultations, the remaining consultations being with members of the local authority medical staff.

As the table shows there has been a fall in the total number of attendances, a fall in the number of new attenders and a corresponding fall in the

numbers of consultations with the medical officer. This fall is due, not to a fall in the birth rate but to further progress in arranging for general practitioners in conjunction with the domiciliary midwifery service, to carry out ante-natal clinics on their own premises. During 1964, two general practitioners decided to participate in this scheme and two other general practitioners made a partial entry into the scheme.

It was apparent in the autumn of 1964 that the numbers of attendances at Police Street, Encombe Place, and Ordsall Clinics were so low that it was no longer justifiable to continue regular ante-natal clinics at eight centres and at the end of the year a firm decision to discontinue ante-natal sessions at Police Street and Regent Road was made. Ante-natal patients who were attending Police Street Clinic were offered the choice of attending Langworthy Centre or Summerville Clinic, and patients attending Regent Road Clinic were offered the choice of Ordsall Clinic, Encombe Place, or Langworthy Centre. By the end of December, 1964, all arrangements had been completed and from 1st January, 1965 ante-natal clinics are being held at six centres.

Blood Tests

The number of blood samples taken at the ante-natal clinics is as follows :—

For Wasserman, P.P.R. and R.P.C.F. tests 1,175, of which 8 were positive.

For haemoglobin estimation — 2,266.

For rhesus factor — 1,134, of which 163 were reported to be rhesus negative and 971 rhesus positive.

In addition to the routine testing, which is carried out on samples taken at the ante-natal clinics, 246 mothers attended the Rhesus Clinic at Regent Road for further blood samples to be taken. These samples are examined at the National Blood Transfusion Centre at Roby Street, Manchester. Following the first visit to the rhesus clinic the samples are tested to confirm the fact that the mother is rhesus negative and the samples are also tested for the presence of antibodies. A second test is carried out when the mother is 32 weeks pregnant, to determine whether further antibodies have developed and also to determine whether or not the antibody level is rising. The total number of patients attending the Rhesus clinic in 1964 was 246 and of these, 51 were found to be Rhesus positive and the remaining 195 were confirmed as Rhesus negative. Of the Rhesus negative mothers, 9 developed anti-D antibodies.

It is our practice to refer all mothers with anti-D antibodies to the hospital for delivery, and 8 of the mothers so affected, readily agreed to be confined in hospital. Each of the mothers had live-born infants and only one baby was severely affected by the rhesus antibodies and required exchange transfusions.

We had the utmost difficulty in persuading one mother with antibodies to go into hospital for delivery, and in fact this lady would not even go to the hospital for a consultation with the obstetrician, despite the efforts of her family doctor and the local authority Medical Officer. The lady's husband whose blood was examined, was also asked to try to persuade his wife to be confined in hospital. In spite of every effort this lady refused to go to hospital

until she was sent into hospital in labour as an emergency and she was subsequently delivered of a still-born infant. This unfortunate case underlines once again the fact that the best services in the world can do nothing to help people if the people themselves are unwilling to co-operate.

POST-NATAL CLINICS

No post-natal examinations were carried out in local authority clinics during 1964.

CHILD WELFARE CLINICS

Infant Welfare Clinics were held at nine centres during the year and figures show that although the total number of attendances at these clinics was smaller than in 1963 the number of individual children who attended was higher. The increase in the numbers both of attendances and of individual children is most noticeable at Kersal Clinic and at Encombe Place. Both these clinics serve areas containing high blocks of flats and the attendances at the clinics obviously reflect the health visitors' efforts to promote positive attitudes to health and also the confidence the mothers place in the clinic staff. The number of consultations with the doctors at the clinics has also risen and this was in part due to a better medical staffing position and also in part to the higher number of individual children attending the centres. As far as possible each child is examined by the doctor on his first visit to the clinic and it has also been noted in the past that as the age of the child rises, clinic attendances become less frequent and often the mother only brings older children to the clinic when she wishes to consult the doctor. Another factor may be the determined effort which has been made to discontinue the practice of sending doctors to clinics at fortnightly intervals. There is no doubt that the presence of a doctor at a regular session every week improves the attendance at the clinic and the mothers feel happier in the knowledge that they can consult the "baby doctor" when they feel they need to do so without the worry and confusion of wondering if the doctor will or will not be at the clinic. Sixty per cent of all child welfare sessions were medically staffed and the remainder were Health Visitors' sessions. Ten per cent of the medically staffed sessions were conducted by general practitioners employed on a sessional basis. The following tabulation shows the distribution of work throughout the clinics (the figures in brackets relate to 1963.)

CHILD WELFARE CLINIC SESSIONS
(Figures in brackets relate to the year 1963)

Clinic	Weekly Sessions	Attendances	Individuals	New Cases	Consultations	Referrals
Cleveland	2	2,200 (2,739)	353 (386)	148 (188)	313 (442)	10 (30)
Encombe	1	1,443 (1,279)	343 (277)	162 (146)	371 (262)	34 (19)
Kersal	2	3,260 (2,521)	434 (337)	187 (162)	419 (325)	29 (30)
Langworthy	4	7,513 (8,286)	1,440 (1,368)	671 (637)	1,786 (1,617)	136 (127)
Murray Street	3	5,462 (6,192)	1,252 (1,256)	701 (732)	1,194 (1,035)	162 (121)
Ordsall	2	2,266 (2,286)	430 (409)	214 (212)	588 (497)	46 (44)
Police Street	3	2,923 (3,017)	580 (565)	254 (212)	584 (586)	23 (43)
Regent	3	2,845 (3,538)	618 (659)	334 (351)	464 (556)	36 (62)
Summerville	2	2,516 (2,556)	352 (321)	165 (141)	388 (313)	54 (34)
Premature Baby	½	119	21*	32	119	1
* Plus 40 who have also attended other C.W. Clinic						
Totals	22½	30,547	5,823	2,868	6,226	531
Removed out in 1964			327 (293)			
Clinic attenders died in 1964			11 (7)			
Attended and became 5 years old in 1964			109 (89)			
Grand Totals 1964		30,547	6,270	2,868	6,226	531
Grand Totals 1963		32,575	5,985	2,812	5,778	511

The average number of attendances per child (0-5 years age group) was 4.9. This average figure can be broken down to show that children under 1 year made an average of 6.7 visits to the clinic; children from 1 year to 2 years made 5.7 visits and the 2 to 5 year olds made an average of 2.4 visits to the clinic. These figures must not be interpreted as relating to the total under 5 years population of the City; the figures have been prepared from clinic registers and relate only to children who have attended a clinic at least once during 1964. A check with the estimated population figures for the 0-5 years age group shows that 66% of children born in 1963 and 1964 attended a child welfare clinic during 1964 but the number of toddlers attending was only 20% of the estimated toddler population.

Referrals for treatment were slightly lower this year than in 1963. 20% of consultations with the clinic doctor resulted in referrals for treatment compared with a figure of 25% in 1963, and this is mainly due to a fall in referrals in the toddler age group.

When broken down into age groups we find that consultation and referral percentages are as follows:—

Age group	% of total attendances recorded as a consultation with the doctor	% of consultations necessitating a referral elsewhere
0 - 1 yr.	19.9%	3.7%
1 - 2 yrs	18.9%	6.9%
2 - 5 yrs.	24.6%	20.7%

During the year the clerical staffs of the Maternity and Child Welfare Service and the School Health Service were combined to form a new section known as the Child Health Section. This has brought the clerical staff into line with the medical and nursing services and it has resulted in the creation of three teams of clerks, a Broughton team, a Pendleton team, and a Salford team, each team being entirely responsible for the clerical work associated with the running of all the clinics in their area. This in turn has broadened the scope of the work and will enable the clerical staff to follow an infant through to school-leaving age so adding interest to their work.

One aspect of this integration has been the commencement of child health sessions in place of seven of the infant welfare sessions. At a child health session children of all ages from birth to school-leaving age attend and we hope that this new venture will encourage mothers to bring baby, toddler and school child to the same clinic session. In this way the mother will be saved the inconvenience of making two clinic visits and the doctor will be able to see the individual children in the family context, and will also be able to make greater contact with the 2 to 5 year olds.

Consultant clinics were subject to a number of minor alterations. The consultant paediatric clinic has been transferred to Langworthy Centre and there has been no decline in referrals or attendances since this alteration was made. The premature baby clinic which is held simultaneously with the paediatric clinic fortnightly has also been transferred to Langworthy Centre but in spite of appointments for this clinic being made in the latter half of the morning, there has been a decline in the number of attendances.

The orthopaedic consultant clinic has been transferred to Langworthy Centre. There has been a steady rise both in the number of referrals and in the number of attendances over the past few years, and the Langworthy premises provide better facilities to meet the needs.

Referrals and attendances at the ear, nose and throat clinic are similar to previous years. In September this clinic was transferred to Hope Hospital and arrangements were made for all outstanding cases to be referred to the hospital clinic at the appropriate time. The local authority records were made available to the hospital so that continuity of treatment could be arranged.

Co-ordination and co-operation with the hospital service appears to be satisfactory. During the year 1,552 case reports or copy letters to family doctors were received and these were followed up where necessary by medical or nursing staff.

The under 5 year old population 13,471 children is slightly lower than in 1963. In spite of heavy rebuilding within the City and a loss of infant life which has never reached 100 deaths per year since 1952, the under 5 year old population has remained at approximately 13,500 since 1961.

The work of recording removals in and out of the City remains heavy and 2,376 such records were dealt with during the year. Clerical staff were also occupied in dealing with records transferred from one clinic to another following removals within the City, and 350 such transfers occurred during the year. This figure relates only to children attending clinics and not to the total number of under-fives changing home addresses within the City.

The integrated clerical service has enabled the link-up of child welfare records and school health records to be effected more efficiently, particularly when child welfare records have had to be endorsed "removal unknown." In total 4,248 child welfare records of children from 5 to 14 years of age were attached to school health records and it is hoped that many more remaining records will be matched during the coming year. This will ensure that as full a case history as possible will be available to the medical staff when the children are examined whether at school or in the clinic.

WELFARE AND PROPRIETARY BRAND FOOD SALES

National Dried Milk sales (30,649 tins) decreased this year by approximately one tenth of the sales in the previous year; the uptake is now approximately one third of the uptake of 1954—i.e. the year when the distribution of this product was transferred from the Ministry of Food to Local Health Authorities. The decrease in National Dried Milk sales is balanced by the increased sales of proprietary dried milks, although there is as yet no increase in the sales of evaporated milks.

Cereal foods have maintained steady sales and rusks have proved to be a "best seller;" egg custard and creamed rice were introduced into our foods range this year and have been very popular. The sales of products containing vitamin supplements have been higher during 1964.

National Orange Juice sales increased slightly this year, giving an estimated uptake of 7.2% (6.9% in 1963) but Cod Liver Oil sales dropped by one sixth during 1964 compared with the previous year and give an estimated uptake of 2.6% as against 2.9% in 1963. The uptake of vitamin A. & D. Tablets has increased slightly and shows an estimated uptake of 17.3% (16.25% in 1963).

Once more we are indebted to the W.V.S. for their assistance in manning the Welfare Foods Distribution Centre at Hope Hospital, thereby introducing many new mothers to Welfare Foods and so ensuring that new families may be aware of the products sponsored by the government for the fitness and well-being of the mother and young child.

VISITS TO VOLUNTARY ORGANISATION MOTHER AND BABY HOMES

There are two voluntary Mother and Baby Homes in Salford and the relations between the Health Department and each Home are cordial. Both Homes are visited regularly and all the services of the local health authority are readily available should the necessity arise.

DENTAL CARE

Arrangements for the dental treatment of expectant and nursing mothers

and pre-school children were continued as in previous years, namely, no system of routine examination for these patients was undertaken but treatment was given on referral by doctors, health visitors, etc. This treatment was integrated with the normal work of the school clinics and was not carried out during specific sessions set aside for the purpose.

All forms of dental treatment were available, and dentures, where supplied, were fabricated under private contract with outside laboratories.

During the year a Dental Officer from the Department of Education and Science visited Salford and made an inspection of the Dental Services. The recommendations he made as a result of this visit included a specific one in relation to the prevention of dental caries and the promotion of dental health in the under five years old age group. It was suggested that medical officers and health visitors should encourage the attendance of young children for dental examination from the age of three years and to fortify this advice it was further suggested that a third birthday card, enclosing an appointment for dental examination should be sent to Salford children.

Dental Services for Expectant and Nursing Mothers and Children

Dental Treatment—Numbers of Cases

	Number of persons examined during the year	Number of persons who commenced treatment during the year	Number of courses of treatment completed during the year*
Expectant and nursing mothers	101	94	64
Children aged under 5 and not eligible for school dental service	436	364	342

*If a patient has had more than one course of treatment during the year, each course is counted.

Dental Treatment Provided

	Scalings and gum treatment	Fillings	Silver Nitrate treatment	Crowns and inlays	Extractions	General anaesthetics	Dentures Provided		Radio-graphs
							Full upper or lower	Partial upper or lower	
Expectant and nursing mothers	10	24	—	—	93	27	8	4	—
Children aged under 5 years and not eligible for school dental service	5	98	250	—	449	186	—	—	—

Figures refer to number of treatments and not to number of persons.

Number of Premises and Sessions

Number of dental treatment centres in use at end of year for services shown above	5
Number of dental officer sessions (i.e. equivalent complete half days) devoted to maternity and child welfare patients during the year	35

PHYSIOTHERAPY SERVICE

During the last year the scope of physiotherapy has been maintained in the existing field and has been expanded to help more widely in co-operation with the mental health service and also with the older people.

Physiotherapy treatments are carried out at six centres :—

Regent Road Clinic

Langworthy Clinic

Cleveland Clinic

Summerville Clinic

Police Street Clinic

Murray Street Clinic

The clinics are run on child health lines and both babies and school children are treated at the same session. At the busiest clinics an assistant works with the physiotherapist, helping with ultra-violet light or infra-red therapy. This enables a busy mother to bring children of different age groups to the same session for treatment; or a child requiring more than one form of treatment to have them consecutively.

Many children under 5 years of age have minor orthopaedic defects such as bow legs, knock knees, or are mouth breathers. Although in most cases these conditions are only a stage in the child's development and improve in time without treatment some do not and it is wiser to treat all children rather than have some left with permanent deformity requiring operative treatment later. Many young children are mouth breathers and if they can be taught to clear their noses and use them for breathing, it is hoped that the number of ear, nose, throat and chronic chest infections can be reduced and some children saved from operative treatment.

The young child with more lasting handicaps such as cerebral palsy and spina bifida benefits from treatment started as early as possible as soon as the condition is diagnosed. In this way deformities can be prevented and the child enabled to make the fullest use of all its powers. Often it is kinder and more helpful for the mother of a handicapped child to attend a clinic rather than a hospital. The atmosphere is less formal and it is not associated with illness, nor is the mother so overawed and she will often discuss problems and worries with the physiotherapist which she feels unable to discuss with a doctor or nurse in more formal surroundings. A handicapped child is not always a sick child and both child and parent must learn to live with the handicap.

At the ante-natal clinic the physiotherapist works in conjunction with the midwife. Ante-natal relaxation and breathing exercises are given to prepare the mother for childbirth and to give the mother increased confidence during labour. After baby is born the mother is often very proud to bring the baby to the clinic to show how bonny he is and to be taught post-natal exercises to correct her own posture and prevent backache and to strengthen the muscles so that they quickly regain their normal figure.

The Ante-natal clinics are held at:—

Summerville Clinic

Langworthy Clinic

Murray Street Clinic

The number of mothers attending is not large but those who do, give encouraging reports of how their increased confidence helped them during labour. Now that the midwives are working more closely with general practitioners we are hoping that more family doctors will encourage their patients to attend the classes.

During the course of evening classes held at Jutland House for prospective mothers and fathers, a physiotherapist demonstrates the exercises one evening and some fathers prove most co-operative in encouraging their wives to practice relaxation.

Realisation of how much help is needed amongst the mentally handicapped has led to increased work. The new extension opened at Wilmer Avenue for children both mentally and physically handicapped has greatly increased the amount of treatment required, and a physiotherapist attends six times per week. Many of the older men and women attending the adult centres have never had any treatment when young. Some of their deformities have become so fixed that full correction cannot be obtained but any improvement in function or mobility is a help in leading a fuller and more comfortable life. It is very fortunate that Salford has the services of an orthopaedic consultant who is always willing to visit the centres and to advise on treatment or appliances which may be beneficial.

The geriatric clinics are much appreciated by those who attend. The aims of treatment are to help the older people to remain more active and to retain their independence. It is not the aim of the clinic to carry out the work of the physiotherapy departments at the hospitals and to treat sick people; we hope to PROMOTE good health by teaching simple breathing exercises, helping stiffening joints to regain mobility and generally promoting a feeling of well-being. The psychological effect of having somewhere to go is often helpful. It is hard to make the effort to wash and dress if there is nowhere to go and the fact that they can come and talk about their minor ailments over a cup of tea, and discuss their problems is often a great relief.

During the very cold weather provision of transport would be much appreciated. It is this time of the year when aches and pains become more acute and people living alone become depressed and need to go out. Possibly some voluntary social workers might help in this way.

We are trying to visit the Day Nurseries when there are children referred for treatment. The children usually attend the nursery because their mothers are working or have social problems and in both cases find it difficult to attend a clinic and frequently default from treatment. The child is thus deprived of necessary treatment when young and may arrive at school age with some defects uncorrected.

The girls who are training as nursery nurses now include some remedial treatment in their syllabus and have attended a clinic and taken part in simple breathing exercises and corrective leg and posture exercises which they will be able to incorporate into nursery activities. The importance of adequate well-fitting shoes for growing feet was also stressed.

An increasing number of handicapped young children are now coming into residential care and as there is always a shortage of staff in the nursery it is impossible for these little ones to have clinic treatment and so must be treated in the nursery if they are not to be further deprived of a good start in life.

ADOPTION MEDICAL EXAMINATIONS

During 1964, eleven infants were examined by members of the medical staff under the regulations of the Adoption Act 1958. In all cases the children were found to be healthy and fit for adoption. One little boy is on the Register of Handicapped Children but his adopting parents were both willing and happy to make him one of their family.

In 1963, 17 children were examined prior to adoption, and in 1962, the number of such children examined was 13.

OTHER SPECIAL EXAMINATIONS

During the year, we have continued to co-operate with the Children Department in examining children who have to be taken into care. These examinations are arranged between the Child Care Officer concerned and the doctor who is immediately available to carry out these examinations and there have been no difficulties in making these arrangements. A Senior Medical Officer is also always available to answer queries about children in care, or children about to be taken into care.

CYTOLOGY

During 1964, a total of 1,453 women were invited to attend a clinic for a test for cervical cancer and an examination of the breasts: of this number only 867 i.e. 60% attended the clinic. At the Annual Check-up held in July and August, 1964, appointments at the cytology clinic were offered to women between 25 and 65 years of age and 623 women requested such an appointment, but only 280, i.e. 45% of these women actually presented themselves for the examination.

In the majority of cases no reason for failing to attend the clinic was given, but where a reason was given it was usually either that the woman had changed her mind and did not want to have the test or that the woman had changed her address during the waiting period and the invitation was returned

by the General Post Office. In the first case it must be remembered that examination for cancer of the cervix is a new venture and many women feel apprehensive about it just as in the 1930's people were apprehensive about immunisation.

It must also be remembered that during August, it being a holiday month, we were asked by the laboratory not to send too many smears for examination; consequently no extra sessions to cope with the demand were held. This meant that over the period of the Health Check-up a considerable waiting list accumulated and it took five months for this waiting list to be dealt with.

The waiting list was divided into three categories:—

- (a) Those women between 25 years and 65 years of age who were Salford residents were given top priority and were invited to the clinic strictly in rotation according to the date of their application for the test.
- (b) Non-Salford residents between 25 years and 65 years of age were given lower priority and were invited for a test only after the consent of the family doctor had been obtained in each case.
- (c) Women under 25 years and over 65 years were invited for the test after all women in the specified age groups had had appointments for the test.

A total of 867 cervical smears were sent to the laboratory for examination and 850 were reported to be normal, 14 smears suggested the presence of some inflammatory condition and a further test in six or twelve months was requested, and three smears were suggestive of a malignant change and a repeat test was requested urgently. In only one case was a firm diagnosis of cervical cancer made.

Since the cytology clinic started in July, 1963, a total number of 2,053 women has been invited for the tests, 1,355 have attended the clinic and four cases of cervical cancer have been identified and referred for gynaecological treatment.

At the same time as examining the cervix for signs of malignancy the breasts are also examined in an attempt to identify early unsuspected cancers. It has been encouraging to find that so many women know about breast cancer, and quite a number of women report that they have had treatment from their family doctor for "small lumps" or a "pain." Several women have had major surgical treatment for cancers of the breast and they are particularly appreciative of the examination as it reassures them that there is no cancer of the other breast or of the cervix.

An important feature of the clinic is the opportunity it gives to the women to discuss many and varied problems with the doctor, and it is interesting to note the relaxation of "tension" as the discussion and the examination proceed.

The sessions are held weekly at Regent Road Clinic and Langworthy Centre and at other clinics when the occasions arise. We are receiving a steady influx of requests for appointments and an evening session for those who cannot attend during the day will be held from time to time.

It is surely a wise thing to have this test done early, and repeated at intervals, and by so doing prevent the necessity of having a major operation later in life.

"HANDICAPPED" REGISTER

During the year, 138 children suffering from a handicapping condition were notified to the Child Health Section. During the year, 7 of these children died, 5 children moved out of Salford, 4 children reached the age of 5 years, and 2 children were considered to have such minor defects that they were not really handicapped – leaving a total of 120 children to be followed up.

At the year ended December 31st 1963, there were 274 children on the register, and during 1964, 81 of these children were removed from the register (7 children died, 24 children removed out of Salford, 6 were considered to be no longer in need of special supervision, and 44 children reached the age of 5 years), leaving a total of 193 children for continued supervision.

The total number of children on the register at 31st December, 1964 was 314, i.e. 120 new notifications, 193 cases remaining from previous years, and 1 case who was notified for observation in 1963, and was found to have a definite physical defect in 1964.

In past years our main sources of information about handicapped children have been hospital discharge letters and health visitors referrals, but since the inauguration of a formal register of congenital malformations, this register now constitutes the major primary source of information about handicapped children. In 1964, out of a total of 138 notifications of handicapped children 50 were direct referrals from the register of congenital malformations. It had been suggested that the number of children notified as handicapped in 1964 would be considerably higher than the number notified in 1963 before the register of congenital malformations was started, but in fact this has not proved the case. In 1964 there were 126 new notifications. It would appear that our previous system of collecting information about handicapped children was adequate and that very few handicapped children were overlooked.

The table overleaf shows the total number on the register divided into categories. The table also shows the number of new notifications in 1964, divided into categories, and the number of new notifications remaining on the register at the end of 1964. (Where a child has the misfortune to suffer from more than one handicap, the child is counted in the category of the major defect.)

	Total No. on register 31st December 1964	Cases notified in 1964	Cases notified in 1964 and remaining on the register at 31st December 1964
Blind	1	—	—
Partially sighted	7	1	1
Other eye defects	3	2	2
Deaf	5	1	1
Partially hearing	5	2	2
Delicate respiratory conditions	8	4	4
„ circulatory conditions	40	15	13
„ gastro intestinal conditions	17	9	8
„ genito urinary conditions	11	6	4
„ miscellaneous conditions	31	12	12
Epilepsy	5	3	2
Recurring convulsions	22	13	12
Mental Subnormality	52	16	14
Cerebral palsy	9	3	3
Organic diseases of the central nervous system	33	16	10
Orthopaedic defects	51	28	25
Cleft palate	10	6	6
Speech defect	3	—	—
Socially handicapped (New category in 1964)	1	1	1
Totals	314	138	120

There are forty-six children on the register who suffer from two or more major defects. In the main, the children who suffer multiple defects are those who are mentally handicapped. Ten children who are mentally handicapped suffer from congenital heart disease, and ten children suffering from mental retardation also suffer from a physical handicap of major importance, e.g. spina bifida or osteomyelitis, or are mentally retarded as a result of a major physical defect, e.g. hydrocephalus or microcephaly. There are eight children suffering from mental retardation and epilepsy, of whom three also suffer from a physical defect, and there are five mentally retarded children who have other physical handicaps. The remaining nineteen children suffer from a variety of multiple defects which do not lend themselves to classification.

In the course of the year 50 children aged 2 years and over, were referred to the School Health Service for medical examination at 4 years of age, to determine whether or not special educational treatment would be necessary when school age was reached; 6 children were referred to the Mental Health section, as they were in need of help and advice, and 11 children were notified to both mental health and school health services as it was felt that the children were profoundly handicapped and some consideration should be given to whether or not they were suitable for education in school, or would benefit from early admission to a training centre.

The names of 48 children who reached the age of five years were removed

from the register and arrangements for their education have been made as below:—

Ordinary Day School	32
Oaklands School for physically handicapped pupils	5
Claremont Open Air School	2
Parkfield Unit	1
Wilmur Avenue Centre	3
Awaiting placement by the Mental Health section	4
Wainwright House Nursery School for the Deaf	1

The task of following up the health and developmental progress of the children on this register is an arduous one. Each child on the register is visited by the health visitor at least once per year but the younger children i.e. under 2 years of age, are visited more frequently according to the nature of the handicap, e.g. an infant with coeliac disease may need to be visited every one or two months in the early stages of the disease, but once the mother understands the child's dietetic restrictions, and is able to incorporate the child's special needs into the general family catering scheme, then an annual visit to ascertain that the child is progressing satisfactorily is all that is required.

"AT RISK" REGISTER

At the end of December, 1964, there were 565 names on this register.

During the year 426 names were added to the number on the register at December 31st 1963, and 67 names were removed from the register.

New notifications 1964	426
On the register December 31st 1963	206
	632

Removed from the register due to

(a) Change of address	20
(b) Died	5
(c) Transfer to Handicapped register	2
(d) Untraced	8
(e) No longer requiring close observation	32
Total	67

Number remaining on the register

565

The main sources of information about children on this register are the hospital discharge letters which we receive from the midwifery hospitals and other hospitals in the area. Very few notifications of infants considered to be "At Risk" come from domiciliary midwives or family doctors as the vast majority of abnormal deliveries occur in hospital: even when a mother is booked for home confinement any abnormality occurring during delivery is usually referred to hospital.

The new notifications in 1964 are divided into categories as shown in the table below:—

Haemolytic disease of newborn	17
Mother Rh Neg. with antibodies	7
Abnormal births	197
Postmaturity	5
Anoxia at birth	30
Prematurity	115
Head injuries	12
Birth injury	1
Encephalitis or non-tuberculous meningitis	9
Convulsions	6
Minor congenital abnormalities under observation	10
Others	11
Maternal disease Toxaemia	2
Diabetes	1
Syphilis	3
Total	<u>426</u>

Where a child has been subjected to several abnormal influences, each of which would be an adequate reason for placing the child on the "At Risk" register, the child is counted in the category which is thought to give rise to the major effect, e.g. a premature infant born by breech delivery and suffering a degree of anoxia severe enough to be mentioned in the hospital discharge letters is counted in the category "Anoxia at birth." It will be noted in the list of cases removed from the register that only two names were transferred from the "At Risk" register to the handicapped register. This is because cases to be included on the register are carefully selected and if a child exhibits any abnormal features on discharge from hospital the child's name is included on the Handicapped register, e.g. a child discharged from hospital with a diagnosis "Mongol — not yet confirmed" is put on the Handicapped register for regular personal supervision, whereas a child who has recovered from meningitis and exhibits no abnormal symptoms on discharge from the hospital is included on the "At Risk" register.

The method of following-up children on this register is to make regular examination of the child's records at the Infant Welfare Clinic, and if the child does not attend a clinic the health visitor is requested to give a report on the child's health and progress.

Approximately 60% of the infants at risk are more or less regular attenders at the Infant Welfare Clinics, but by the time they have reached one year of age, only about 15% are regular attenders. This throws a great deal of work onto all those concerned with follow-up, and it is hoped to devise a method of improving the attendance at the clinics of babies and children at risk, during the toddler and early childhood years.

REGISTER OF CONGENITAL MALFORMATIONS

In November 1963 the Ministry of Health wrote to all Medical Officers of Health inviting them to collect information about congenital malformations observable at birth and to forward certain details for statistical purposes to

the General Register Office. Here in Salford we are happy to participate in this scheme, and from 1st January 1964 information about malformed infants has been collected and forwarded to the Registrar General in accordance with the scheme outlined to us. In fact, the collection of information about children with congenital malformations is not a new venture for us; we have over the years collected information about handicapped children and children with malformations have been included on the Handicapped Register, whenever the malformation constituted a handicap. The only alteration that had to be made within the existing framework of collecting information about these children was to request earlier notification to the Health Department about malformed children.

In order to make this information readily available early in life, the birth notification cards which are completed by a doctor or midwife present at the delivery of the child, have been amended and the information requested by the Registrar General is now included on these cards. In the past the information about malformed infants came to us either from the Health Visitor or from hospital discharge letters, and of course this information related only to live births. Since the institution of the Register of Congenital Malformations and the use of the birth notification cards as the main source of information, we are now receiving information about malformed still-born infants as well as live born infants. This is in accordance with the Registrar General's wish to collect information about all malformed both live and still-born.

Hospital discharge letters, however, are still important sources of information as numerous congenital malformations e.g. congenital dislocation of the hip, hernia, congenital heart disease, etc. are not immediately apparent at birth, but are discovered when the child is medically examined.

At the present time the Registrar General is collecting information only about those malformations which are apparent at birth or within the first four to eight weeks of life, and this means that figures produced as a result of studying the Register of Congenital Malformations do not give a true picture of the overall incidence of Congenital Malformations e.g. every case of anencephaly is reported on the birth notification cards but many malformations e.g. certain forms of congenital heart disease, diaphragmatic hernia, abnormalities of the auditory and visual organs, fibrocystic disease of pancreas etc. are under-reported as these conditions frequently do not manifest themselves until later in infancy and childhood. Although under the present system these conditions are not notified to the Registrar General as malformations, information about children so affected is received in the Health Department in the usual way, i.e. by notification of the handicap through the staff of the Health Department and these children are listed in the Handicapped Register.

The Register of Congenital Malformations is divided into ten sections, each section being concerned with one of the major systems of the body:—

0 Central Nervous System

1 Eye and Ear

2 Alimentary System

3 Heart and Great Vessels

- 4 Respiratory System
- 5 Urogenital System
- 6 Limbs
- 7 Other skeletal defects
- 8 Defects in other systems
- 9 Other malformations not included in any of the first 9 categories.

During 1964, 81 children were notified as suffering from congenital malformations; of these, 67 suffered from only one defect and 14 were afflicted with double or even treble defects. A total of 14 malformed infants were still born and 7 malformed infants died within hours or days of birth. 50 of the malformed infants were put on the Handicapped Register but unfortunately four of these children have since died, leaving 46 to be followed up regularly, as are all children on the Handicapped Register. Of the 10 remaining children, 7 were put on the At Risk Register for regular observation, one child was referred to a surgeon for treatment and one child has not been followed up at the request of a Medical Officer of Health in one of the Lancashire County Divisions as the child is illegitimate and was placed for adoption outside Salford, and the remaining child who has had treatment for the removal of an extra finger on each hand was not considered to be in need of following up other than routine visiting by the Health Visiting staff.

The following table shows the number of malformed infants (by the Registrar General's classification) live births, still-births, infant deaths, and method of follow-up. (Note where a child has a double or treble defect, the child is counted in the category of the major defect.)

R.G's Category	No. of children notified	Single Defect	Multiple defects	Still-births	Neo-natal deaths	Handicapped Register		Other follow-up
						Alive & well	Died	
0	19	14	5	9	3	5	2	—
1	1	1	—	1	—	—	—	—
2	12	7	5	1	1	8	1	1
3	2	2	—	—	—	1	—	1
4	1	1	—	—	—	1	—	—
5	9	9	—	2	1	2	—	4
6	21	20	1	—	—	19	—	2
7	4	2	2	—	1	1	1	1
8	5	5	—	—	—	4	—	1
9	7	6	1	1	1	5	—	—
Totals	81	67	14	14	7	46	4	10

In category 0 (Central Nervous System) 19 children were notified and these include 8 Anencephalics, 2 Hydrocephalics, 3 Spina Bifida, Encephalocele, 1 Hydrocephalus with Meningomyelocele and Talipes, 1 Meningocele in a Mongol, 1 Hydrocephalus with spina bifida and minor urogenital abnormality, 1 Anencephaly and spina bifida, 1 Anencephaly with spina bifida, cleft palate and hare lip.

In category 1 (Eye and Ear) there was only one notification "absent ear." This infant was still-born, premature and a twin.

In category 2 (Alimentary System) 12 children were notified as follows :—

- 2 Cleft palate
- 1 Hare lip
- 1 Imperforate anus
- 1 Enlarged liver
- 1 Hiatus hernia
- 1 Hirschsprung's disease
- 3 Cleft palate and hare lip
- 1 Hiatus hernia and pyloric stenosis
- 1 Imperforate anus and other abnormalities

In category 3 (Heart and great vessels) 2 children with congenital heart disease were notified.

In category 4 (Respiratory system) there was only one notification, 1 Choanal atresia.

In category 5 (Urogenital system) there were 9 notifications,

- 4 Genital abnormalities
- 1 Hypospadias
- 1 Bilateral hydrocele
- 1 Inguinal hernia
- 1 Cystic kidneys
- 1 Undescended testis

In category 6 (Limb defects) there were 21 notifications in all.

- 8 Talipes
- 7 Congenital dislocation of the hip
- 2 Syndactyly
- 1 Extra digits on each hand
- 2 Reduction deformities (absence of fingers)
- 1 Talipes plus ulnar deviation of left hand

In category 7 (other skeletal defects) there were 4 notifications:—

- 2 micrognathos
- 1 Chordiodystrophy and oxycephaly
- 1 Abnormalities of the vertebrae and deformity of the ribs

In category 8 (other systems) there were 5 notifications:—

- 3 Haemangioma
- 1 Exomphalos
- 1 Cretin

In category 9 there were 7 notifications:—

- 6 Mongols
- 1 Multiple congenital anomalies.

DAY NURSERIES

ATTENDANCES AND ADMISSIONS

There are five day nurseries in the City, providing 235 places for infants and children from six months to five years of age as follows :—

44 places for infants from 6 months to 18th months

84 places for toddlers from 18 months to 2½ years

107 places for children from 2½ years to five years

235 places in all

The year can be divided into two distinct periods, each of six months duration, i.e. the first six months up to the end of June when the maximum daily fee was 8/-, and the second half of the year from the beginning of July when the daily admission fee was raised to 16/- per day and later to 21/- per day. The effect on the daily attendance at the nurseries can be seen in the table below :—

1st January to 30th June

Whit week daily attendances averaged 140 to 150 children

1 week (Jan.)	„	„	150 to 160	„
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2 weeks	„	„	160 to 170	„
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7	„	„	170 to 180	„
---	---	---	------------	---

6	„	„	180 to 190	„
---	---	---	------------	---

8	„	„	190 to 200	„
---	---	---	------------	---

1 week (last week in February) daily attendances averaged over 200.

The average daily attendance was 182.3 children.

1st July to 31st December

3 weeks (August Bank Holiday, Xmas week and New Year week) daily attendances averaged fewer than 100 children.

4 weeks daily attendances averaged 100 to 110 children

14	„	„	110 to 120	„
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5	„	„	120 to 130	„
---	---	---	------------	---

1 week	„	„	140 to 150	„
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The average daily attendance was 113.5 children.

The average daily attendance over the whole year was 147.8.

The marked decline in the number of children attending the day nurseries led to a careful examination of the reasons given by the parents for withdrawing their children from the nurseries. The investigation shows that between 1st June and 30th November withdrawals from the nursery were stated to be due to :-

Increased fees	101
Removed from the register because of failure to attend	55
No further need for nursery care	21
Pregnancy of mother	12
Removals out of Salford	14
Temporary admission only	17
Reached 5 years of age	14
Temporary Discharge	1
Mother leaving employment	5

The increase in the daily fees did not affect those families where the daily charge was 7/- per child or less: the increase applied only to those families who had elected to pay 8/- per day either because they could afford to do so or because they were not prepared to divulge the family income which, of course, is investigated in every case where a reduction in the daily fee is requested.

As a result of the increase in the fees every application for admission to the nursery is now accompanied by a request for a reduction in the daily fee and this has in turn enormously increased the amount of clerical work. Since the introduction of the assessment scale in September, 1960, approximately 300 assessments have been dealt with annually but since the introduction of the economic charge, this work has trebled and the clerk is handling assessments at the rate of 1,000 per year. This work is made more onerous as we find that the family income is frequently stated to be smaller than it actually is and when verification is sought from the employers of the parents the true income is revealed. This in turn means that the original assessment of the daily fee is low, and a re-assessment has to be made. When the parents are informed of the new daily fee, it can prove to be more than they wish to pay and frequently the child is withdrawn from the nursery. Re-assessments are also carried out when the family income alters, e.g. when mother starts to work, or father is taken ill, etc. The clerical work associated with the administration of the day nurseries is equivalent to the work of 1½ full-time clerks, i.e. 15 sessions per week.

A study of the pattern of admissions to the day nurseries shows that although the number of children on the register at 31st December, 1964 is considerably lower than at 31st December, 1963 certain groups of children were affected less by the change in daily fee than other classes.

Where admission is due to (a) there being only one parent in the home or (b) mother employed in essential employment, e.g. nurse, midwife, teacher, etc., there is no appreciable fall in the number of children admitted during the year, but admissions to the nurseries due to (a) illness of a parent or confinement of the mother, (b) acute social problems, (c) financial difficulties, have all shown a marked decline.

The admissions of handicapped children have also shown a decline in spite of the fact that where admission to the nursery is an integral part of the treatment a further reduction in the daily fee may be made, particularly if the child is on the waiting list for Wilmur Avenue Special Care Unit. This may, of course, be due to the fact that this centre has recently been enlarged.

Table to show the pattern of admissions to the day nurseries during 1963 and 1964:—

Category	On Registers 31.12.63	On Registers 31.12.64	*Individual Admissions 1964 (1963 brackets)	Individual Withdrawals 1964 (1963 brackets)
Illness of one parent or confinement	16	3	63 (57)	75 (50)
Acute social problems	38	13	61 (49)	83 (42)
Children of divorced, separated, widowed or unmarried parents	76	74	90 (101)	88 (95)
Mother in essential employment	11	8	9 (11)	10 (9)
Handicapped (parent or child)	13	4	8 (14)	11 (12)
Financial	80	20	73 (82)	125 (87)
Totals	234	122	304 (314)	392 (295)

* Some children were admitted more than once during the year.

The day nursery service has changed its function since the war years when it provided a service of daytime care for the children of mothers who were on war work. Day nursery care is now looked on as a form of social service providing care for children whose parents are unable, usually for reasons beyond their control, to provide daytime care for their own children and in this respect the day nursery service has a great deal to offer in the field of preventive work, particularly in the prevention of family break-up. It is in fact quite impossible for a local authority to provide a full time day nursery service for all the children whose mothers wish to go out to work and in Salford children in this category are classed as "financial." The children are admitted to the day nurseries on a temporary basis on the understanding that should a child in one of the priority groups need admission, the children in the "financial" class would have to be withdrawn.

In 1960 when the assessment scale first came into being, two-thirds of the children on the register were classed as financial cases: during 1963 and 1964, one quarter of the admissions were financial cases and at 31st December, 1964, only one fifth of the children on the register were admitted for financial reasons.

Short stay admissions show an increase compared with 1963:—

Under 2 weeks — 44 spread evenly over all five nurseries (39 in 1963)

2—4 weeks — 38 chiefly at Bradshaw Street (31 in 1963)

4—8 weeks — 60 chiefly at Eccles Old Road (37 in 1963)

MEDICAL REPORT

During the year each day nursery was visited regularly by a medical officer and a total number of 398 medical examinations was carried out. The number of individual children examined was 292 and a number of these children, the long stay cases, were examined twice or three times during the year. Only seven children were classed as unsatisfactory at the time of the medical examination, and in each case the child improved in health during his/her stay in the nurseries.

The number of defects discovered was less than in previous years and the teeth in general show a marked improvement. Six children were considered to be very pale, and seventeen children were recommended for a course of ultra violet light. There were five handicapped children examined by the medical officer, one child with a history of congenital dislocation of the hip, two children with cardiac defects, one child with cerebral palsy and one mentally retarded child.

In considering the number of medical examinations it must be remembered that a comparatively large number of children, 142 in all, were in the nurseries for less than eight weeks and a great many of these children were not examined by the medical officer.

Owing to the decrease in the numbers of children attending the nurseries it is not possible to compare the numbers of cases of illness during the year with previous years, and no conclusions about the health of the children can be drawn from the figures. However, it is quite obvious that whilst 1963 was marked by outbreaks of chicken-pox and mumps, 1964 saw an epidemic of measles. This is not to be wondered at, as measles epidemics occur every two years, and the last outbreak of measles occurred in 1962 when there were 92 cases amongst children in the day nurseries. The following table shows the incidence of illness during the year.

Nursery	Bronchitis	Chicken-pox	Conjunctivitis	Sonnei-Dysentery	Non-Specific Dysentery	Diarrhoea	E. Coli	Jaundice	Measles	German Measles	Mumps	Otorrhoea	Tonsillitis	Whooping Cough	Pertussis	Total
Bradshaw Street	—	1	—	—	—	—	—	1	20	1	1	—	1	2	—	27
Eccles Old Road	4	—	—	—	—	12	—	—	31	3	4	2	3	—	1	60
Hayfield Terrace	—	—	—	—	—	—	—	—	1	1	—	—	—	—	—	2
Howard Street	—	1	—	28	3	—	—	—	10	1	—	—	—	—	—	43
Hulme Street	—	4	—	—	2	—	—	—	9	—	—	—	—	—	—	15
TOTALS	4	6	—	28	5	12	—	1	71	6	5	2	4	2	1	147
1963 TOTALS	11	58	4	13	—	26	2	—	33	4	28	6	8	—	—	193

The year was marred by an outbreak of Sonne dysentery at Howard Street Day Nursery and a total of 28 children were infected. In spite of the most rigorous measures the outbreak smouldered on for three months. It was generally felt that the epidemic lingered so long because parents did not recognise the importance of getting treatment at an early enough stage in the disease. Indeed in several cases the Matron reported that a child had had no treatment at all and letters had to be sent to the mothers informing them that treatment was necessary and that affected children would not be re-admitted to the nursery until adequate treatment had been given.

STAFF, REFRESHER COURSES AND STUDENTS

During the year one deputy matron, three nursery nurses and six nursery assistants resigned their appointments. Staff vacancies occurring after June, 1964, (one deputy matron, two nursery nurses and three nursery assistants) were not filled owing to the reduction in the number of children at the day nurseries.

Staff sickness leave totalled 359 days during the year. This compares very favourably with the staff sickness absence in 1963 when there were 586 days sick leave.

Two refresher courses were attended by staff members as follows:—

19th to 28th February—C.C.R. Course, 2 Nursery Assistants attended.

30th September to 6th October—C.C.R. Course, 2 Nursery Assistants attended.

There was also a Matrons Conference (22nd April to 1st May) at which one Matron attended as the Salford delegate.

At the midsummer examinations of the National Nurseries Examination Board, five Health Department students were successful and were awarded

the diploma. In September of this year the 2nd year Health Department students were transferred to the nursery schools under the previous regulations for the diploma of the N.N.E.B.

New regulations governing the N.N.E.B. course came into force in September, 1964. Under these regulations new students are given the status of full-time students. The students attend the day nurseries as observers and for practical instruction and they are no longer employed on a part-time basis by either the Health Department or the Education Department. In certain cases the students are now eligible for maintenance grants from their local education authority and in keeping with their status as students, they now enjoy primary school holidays.

NURSERIES AND CHILD MINDERS REGULATION ACT, 1948

There were no private day nurseries registered with the local health authority during 1964.

FAMILY GUIDANCE CLINIC

The provision of Family Guidance Clinics has continued to be an established part of the services available to the Salford community from the Health Department, for the promotion of good family relationships. It should be stressed here that it is largely from a stable, harmonious family background that a child can develop a sturdy, well-integrated personality, able to cope with life on the best possible terms, and later, in turn, become a mature, confident adult, able to make a positive contribution to the community.

The total number of families who attended in 1964 was 77 and the number of individuals seen was 92. The problems revealed, as before, marital disharmony, behaviour difficulties in the child—again usually because of wrongful parental and sibling attitudes—and a small number who had been mentally ill and were still needing close support.

The need for early referral continues to be essential if a dynamic and lasting change is to be made both in the person presenting initially an emotional disturbance, and in the family, and to this end the close liaison built up with head teachers, health visitors, general practitioners and probation officers, continues to be maintained. Also in the past year more contact has been made with youth club leaders in an endeavour to make every possible effort to encourage bored and frustrated youngsters who are becoming unmanageable at home and near delinquent, to develop outside activities. At the same time parents are urged to realise that they too must help to stimulate interest where possible in useful jobs about the home, e.g. girls helping their mothers with cooking, baby-care, dress-making. Equally, fathers can be of help showing their sons such things as home joinery, decorating, car maintenance and so on. The important point here is that children should not merely be expected to do these things on their own as a duty and chore, which so often leads to resentment—but as part of a general training that will be useful to them always.

Again, with active parental participation as well as encouragement, there is a common family interest shared, and enthusiasm is maintained. It is a sad indictment of many families that as a result of parental indifference—frequently simply due to lack of thought as each parent is over-busy with their own affairs—that children grow up without that sense of warm affection and caring, which is the essence of good family life.

Anything that can be done to guide parents and children into more feeling attitudes to one another, to create a happy and rich family life, must always be our aim.

CONVALESCENCE

Convalescence through local authority channels was definitely sought this year for two children (of 1 family) and 11 adults. Due to lack of funds we are not able to assist all who request financial help in this venture and it is regretted that so many rely solely upon the strained resources of the Welfare State for such help when almost negligible contributions to a medical charity would enable them to avail themselves of convalescent treatment more easily. Where income is known to be very low, applicants are referred for financial assistance to the Cotton Districts Fund.

Financial assistance was granted in respect of the 2 children on their own and to 2 adults (one a mother of 9 children who had an invalid husband and was herself a sick woman, and the other in similar circumstances who had 5 children). Arrangements were made for 2 women to stay at a convalescent home — one was able to pay the full fee but due to business commitments was unable to take up the vacancy; the other woman (a mother of 6 children who was suffering from post-operative debility) cancelled her booking due to financial difficulties although generous financial help was being afforded to her.

Two men and two women — all living at N.A.B. level — were referred for financial assistance for their convalescence to the Cotton Districts Fund. One man and two women were referred to the Civic Welfare Department for convalescence at Southport because they suffered from bronchitis.

One man and one woman commenced negotiations for convalescence but decided not to follow it up; the man hoped to arrange for a convalescence more suited to his particular illness through hospital sources and the woman decided, for unexplained reasons, not to continue arrangements although it was known that there were domestic difficulties at home.

GERIATRIC GUIDANCE SERVICE

Health check-ups for the elderly have been operating in Salford since 1953. Elderly people are visited in their own homes by a health visitor who is specially trained for this kind of work, or a clinic nurse working under the supervision of the health visitor. The old people are invited to attend special clinics which are held at Langworthy Centre. The clinics for women have a woman medical officer in attendance and those for men have a male medical officer in attendance.

Elderly people are referred to the specialist health visitor from a variety of sources. She receives information in the course of her own visits and from her colleagues in the health visiting services throughout the City.

The clinics are not intended to take the place of the family doctor but to supplement his work. Time is available for a full discussion of the patient's problems and for a complete medical examination.

Practical advice is given to help the old people deal with their problems. For example, a home help may be suggested, though some refuse or are reluctant to accept this offer.

Medical problems are dealt with by referral either to the family doctor or to a specialist. Deaf people may need to have their ears syringed in order to remove wax which has been accumulating for many years, and this service is provided at the clinic. Those with severe conductive deafness can be helped if they are sent for a hearing aid. Old people are often very reluctant to wear hearing aids but as soon as they have got used to one and are able to hear much better they are delighted.

A vision test often reveals the necessity to advise the patient to visit an optician for a pair of glasses.

A chiropody clinic for old people is held on the premises and patients may be referred. The numbers requiring treatment are a problem.

Physiotherapy treatment is provided at the clinic and this is often of great benefit. Those with fibrositis or arthritis find relief from radiant heat and massage. Some of them say that but for the physiotherapy treatment they are receiving they would no longer be able to walk. Those with chronic bronchitis or other chest complaints often find that breathing exercises and postural drainage relieve the severity and frequency of symptoms.

Those in difficult financial circumstances whose diet is inadequate or who are anaemic are helped by vitamin dietary supplements or iron tablets; and minor skin ailments have been treated successfully.

At the end of 1964, forty-nine women and thirty-two men were on the register to attend the elderly people's clinics.

The ages of the women range from sixty-one to eighty-seven years, and they are referred to the clinic for many different complaints, among them backache, asthma, migraine, excessive thirst, tinnitus, insomnia, obesity,

soreness of the mouth, tiredness, wax in ears, deafness, sore toes, catarrh, haemorrhoids, cataracts, chronic otitis, anaemia, sore nose, eczema, hypertension, oedema, chronic dyspepsia, chronic bronchitis, headaches, ulceration of the breast, abdominal pain, chest pain, depression, dizziness and varicose veins.

The ages of the thirty-two men range from sixty-three to ninety-four years. They were also referred to the clinic for a wide variety of complaints including chest trouble, digestive disturbances, varicose veins, muscular and joint pains and stiffness, trouble with vision, headaches and social problems.

It is hoped that these clinics provide some means of attaining a better degree of physical, psychological and social well-being for the elderly people.

INCIDENCE OF BLINDNESS

A1. Registered Blind Persons

A2. Registered Partially Sighted Persons

B. Ophthalmia Neonatorum.

Blind Person

A1. FOLLOW-UP OF REGISTERED BLIND PERSONS

Total number of cases registered during 1964.....56

(i) Number of cases registered during the year in respect of which Section F. (1) of Forms B.D.8 recommends:-	Cause of Disability			
	Cataract	Glaucoma	Retrolental Fibroplasia	Others
(a) No treatment	8	5	—	27
(b) Treatment:-				
Medical	—	—	—	—
Surgical	5	—	—	—
Optical	—	—	—	3
Ophthalmic Medical Supervision	3	2	—	3
(ii) Number of cases at (i) (b) above which, on follow-up action, have received treatment	4	2	—	6

A2. FOLLOW-UP OF REGISTERED PARTIALLY SIGHTED PERSONS

Total number of cases registered during 1964.....38

(i) Number of cases registered during the year in respect of which Section F. (1) of Forms B.D.8 recommends:-	Cause of Disability			
	Cataract	Glaucoma	Retrolental Fibroplasia	Others
(a) No Treatment	1	—	—	4
(b) Treatment:-				
Medical	—	—	—	—
Surgical	8	1	—	—
Optical	2	—	—	2
Ophthalmic Medical Supervision	9	2	—	9
(ii) Number of cases at (i) (b) above which, on follow-up action, have received treatment	13	3	—	11

B. OPHTHALMIA NEONATORUM

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

(ii) Number of cases in which:-

(a) Vision lost Nil

(b) Vision impaired Nil

(c) Treatment continuing at end of year Nil

HEALTH VISITING SERVICE

Aspects of work covered by the section – fully outlined in previous reports – were still in operation throughout the year.

General staff continued to undertake health visiting/school nursing/tuberculosis visiting. Specialist senior health visitors were responsible for intensive work in selected fields in collaboration with general health visitors to whom they were also available in a consultative capacity.

Efforts (begun in the 1940's) to ensure the proper use of time and skill of professional personnel continued. State Registered Nurses relieved the Health Visitor wherever possible of work requiring the services of a registered nurse without a health visitor's qualifications. Nursing auxiliaries assisted by undertaking, under supervision, appropriate duties as required to assist workers in both these categories.

Staffing

Health visiting staff losses during the year were replaced by former student health visitors, sponsored by this authority, who obtained the Health Visitors' Certificate in July. No difficulty was experienced in replacing Clinic Nurses and Nursing Auxiliaries. It was decided to appoint a number of part-time nursing auxiliaries who would not be employed at all during school holidays, thus making help available to health visitors and clinic nurses when most needed, without incurring unnecessary expenditure on staff during slack periods. Nearly 70 applications for such part-time posts were received in response to one advertisement.

A part-time domestic science teacher was appointed to undertake the teaching of domestic subjects formerly carried out at the Day Training Centre by a nursing auxiliary (a qualified domestic science teacher) who retired on superannuation during the year.

SPECIALIST HEALTH VISITOR SERVICES

(a) CARE OF THE ELDERLY

There was little change in the services provided for elderly infirm persons. The specialist health visitor who has been in charge of this service for over eight of her sixteen years with the department continued in charge of this work.

Persons referred to the section for the first time numbered 1,000 – two-thirds of whom were women. In all, 5,021 cases were dealt with during the year.

It may be of interest to note the ward distribution of elderly persons in our care :—

Ward	New Cases 1964	Old Cases	Total
Albert Park	110	379	489
Charlestown	63	272	335
Claremont	116	312	428
Crescent	40	114	154
Docks	46	229	275
Kersal	68	303	371
Langworthy	65	354	419
Mandley Park	100	306	406
Ordsall Park	60	204	264
Regent	89	456	545
St. Mathias	31	109	140
St. Pauls	31	183	214
St. Thomas	19	137	156
Seedley	53	258	311
Trinity	53	162	215
Weaste	56	243	299
Total new cases 1,000 Total old cases 4,021 Grand Total 5,021			

The age-groups and state of activity of persons referred during the year are given below, together with sources of referral:—

Age Groups

60—64 years	183
65—69 years	203
70—74 years	258
75—79 years	154
80—84 years	113
85—89 years	38
90 +	11
Under 60 years: handicapped	40
	1,000

State of Activity

Bed-ridden	107
Home-bound	168
Semi-ambulant	246
Ambulant	479
	1,000

Sources of Referral

Civic Welfare	106
Found whilst visiting	90
General Practitioners	70
Health Visitors	35
Home Help Section	25
Hospitals	149

Sources of Referral (continued)

Mental Health Section	16
Relatives and friends	310
Public Health Inspectors	11
Housing Department	71
Other statutory agencies, e.g. District Nurses	117
	1,000

Health reasons associated with referral

General health problems predominated, followed by foot conditions (needing chiropody), rheumatic, chest and cardio-vascular diseases—respectively. All cases referred had associated social problems.

Elderly persons on the register who were suffering from tuberculosis totalled 37 men and 13 women with pulmonary infections, and a further six women with non-pulmonary tuberculosis. Of these 56 patients, 6 were admitted to hospital. Three of the men lived in a local authority home for the elderly and nine in a municipal lodging house. The remainder lived under ordinary housing and living conditions. All received supervision and follow-up according to need.

Chiropody

All persons referred for chiropody were visited by health visiting section staff, and those needing treatment were placed on the waiting list. Following closure of the list in May all patients were informed of the inevitable delay in starting treatment, and many complaints were received as a result. Where only simple foot hygiene and nail cutting were necessary, nursing auxiliaries provided this domiciliary service. Nursing auxiliaries also provided foot hygiene services between appointments in collaboration with the chiropodist. A full account of the Chiropody Service is given elsewhere in this Report.

Bathing and Foot Hygiene

Owing to pressure of other work, especially that involving fixed clinic and school commitments, and general clerical duties, this service was not able to meet the demands placed upon it. Many elderly persons could not be bathed oftener than once a month—some had an even longer wait. As many elderly persons need baths more frequently than once a fortnight—the obese for example, and the handicapped, the inability to meet these needs is the more regrettable. Moreover, when it is impossible to give appointments to elderly persons for subsequent baths owing to uncertainty in the Section's time-table, further delay is inevitable. Few of the homes concerned have a hot water supply; therefore, when the auxiliary arrives unexpectedly there is a flurry of activity in putting water on to heat and to find a change of clothing, and this of course results in delay and waste of time. In some of the W.V.S. flatlets residents are permitted to use the immersion heater only at certain times on certain days, and if the auxiliary visits at the wrong time she is unable to give the service.

All males requiring baths are referred to the district nursing service as no male auxiliary nurses are employed in the health visiting section. It is hoped the appointment of a male auxiliary will be possible next year.

The cleansing of infested elderly persons is carried out by arrangement with Monsall Hospital Cleansing Centre at Manchester, or, if appropriate, by a nursing auxiliary at home.

Clinics

At present, clinics where elderly persons receive a medical check-up are limited to fortnightly short (1½ hour) sessions, men only at one session and women at the other. Physiotherapy and treatment of minor conditions may be carried out on the same premises following the examination.

Liaison with Geriatrician

Few patients need to wait more than a week for admission to a geriatric ward, but where necessary the health visitor collaborates with the geriatrician in assessing priority of admission. We are notified of pending discharge of any patient whose home circumstances may be unsatisfactory, and in addition, lists of all patients admitted to, and discharged from, Ladywell Hospital are received and appropriate follow-up carried out.

Liaison with other Agencies

There was good co-operation with other local authorities staffs and statutory bodies including home helps, public health inspectors, Housing Departments, Civic Welfare Departments, and National Assistance Board, and with voluntary organisations such as Booth's Charity, Cripples Aid, and W.V.S. (who organise Meals on Wheels, and make other provisions for the elderly.)

Elderly Persons Fund

Money coming from the Section's annual "Bring and Buy" sale organised by health visitors was used in special circumstances to meet such needs as fireguards, walking sticks, pocket money for holidays, outstanding electricity or gas bills, extra food, coal, kitchen equipment, etc. Gifts of Harvest Festival fruit and food sent by the children of Claremont Open Air School was distributed to appropriate persons.

Re-housing of Elderly People

The number of requests for elderly people to be re-housed on medical grounds was high. In a proportion of cases these requests were initiated by relatives and the elderly persons involved were not at all happy about the idea of moving into a modern flat and unfamiliar surroundings. It would seem that medical certificates in relation to housing are sometimes given too freely and without real need.

Re-housing of elderly persons into the new flats where cooking stoves are not provided causes many problems to arise, as unless the tenant can himself provide a cooker there are no cooking facilities at all.

Another problem of re-housing is that elderly people find difficulty in understanding the central heating and electricity heaters in the new flats and quite often waste a lot of electricity when first re-housed.

Services for the elderly are not expanding with the need. We must take into consideration that the average span of life of three score years and ten now finds many people active and in reasonably good health and with good prospect of further years of life – active or otherwise. We can look forward to many more old people being with us into their 90's.

This greatly increased population of old people calls for an expansion of provisions to meet their requirements. Relatives are often either non-existent or inaccessible, and friends – many of whom are in the same age group – are unable or unwilling to help.

Services for the elderly are available but in many cases are inadequate – even to their being a waiting list for admission into Part III Accommodation.

It is hoped that early consideration can be given to this problem.

The following changes took place during the year:—

	Admitted 1964	Previously on Register	Total
Number of patients died: Male	38 } 84	186 } 535	224 } 619
Female	46 }	349 }	395 }
Admitted to Hospital	40	413	453
Admitted to L.A. Home	6	57	63
Admitted to Home for Blind	—	1	1
Admitted to Jewish Home	—	3	3
Admitted to Nursing Home	4	—	4
Admitted to Nazareth House	—	2	2
Transferred to area H.V.	23	25	48
Transferred to Mental Health Section	1	15	16
Removed from Salford	15	236	251
Total transferred from Register	173	1,287	1,460

Total number carried forward to 1965 = 3,734

Number living alone = 2,178

(b) HOSPITAL LIAISON

Two specialist health visitors continued this work – one serving Hope, Ladywell and Salford Royal Hospitals, another the Chest Clinic.

Chest Clinic

There was a considerable reduction in the number of notifications of pulmonary tuberculosis, with proportionately fewer interviews with patients. Contact examination, however, continued to be readily accepted, and in the field of prevention there was a greater response towards protection of children

against this disease. Mantoux tests were greater in number as were B.C.G. vaccinations. Interviews between the health visitor and the Chest Consultant and with hospital medico-social workers were increased.

No. of notifications	52
No. of Mantoux tests	430
(a) Negative	184
(b) Positive	236
(c) Not read	10
No. of B.C.G. vaccinations	275
Patient interviews with Health Visitor	150
Almoner interviews with Health Visitor	20
Consultant interviews with Health Visitor	154
General Practitioner interviews with Health Visitor	7

Lung Cancer and Bronchitis

Contact was maintained with the Thoracic Surgeon's Clinic held monthly at Hope Hospital. Special attention was paid to patients with lung cancer and to problems, financial and otherwise, of patients and their relatives. Bronchitics were encouraged to give up cigarette smoking, seven of whom were referred to the Anti-smoking Clinic at the Health Department. General health advice and teaching was continued.

Liaison with Hope, Ladywell and Salford Royal Hospitals

Paediatric Departments

Liaison continued without any major change of policy.

(i) Hope Hospital

Information of value to district health visitors was obtained during ward rounds and at O.P.D. sessions, and was transmitted without delay to health visitors concerned. The number of consultations with, and informative notes issued to, health visitors during the year totalled 2,525; in response to which health visitors carried out appropriate follow-up work. In addition, the special health visitor responsible for hospital liaison herself carried out 55 follow-up visits.

Particulars relating to home and other appropriate circumstances were conveyed from area health visitors via the liaison health visitor to the paediatrician and other hospital staff concerned.

(ii) Ladywell

Wards were visited weekly and an appropriate interchange of information made as for Hope Hospital.

Diabetic Clinics

Criteria governing selection of patients for referral to the liaison health visitor varied between the two hospitals. Home visiting in all cases was carried out by the specialist health visitor responsible for liaison.

(i) Hope Hospital

Patients were referred by the Consultant Physician or his Registrar during O.P. sessions only if the patient had a specific problem in relation to treatment, e.g. difficulty in calculating changed dosage of insulin, or if the diabetic condition was unstable and the patient unable to give an account of treatment. Such cases were referred for home visiting to establish the source of the difficulty and to advise appropriately.

New patients referred during 1964	33
No. of patients visited	42
No. of visits paid	92
No. of visits to non-diabetics	6

(ii) Salford Royal Hospital

At this hospital, patients were referred to the liaison health visitor by the Consultant whenever a problem of any kind existed which came within the health visitor's purview. Moreover, the health visitor "sits in" at this Clinic, and was therefore able to spend some time discussing problems with patients herself. She made all the necessary arrangements for home follow-up visits where appropriate.

Ward Sisters passed on information regarding newly diagnosed diabetics about to be discharged home and needing some help and support in the early days until a routine was established. The Dietician also referred patients if she felt that dietary instructions had not been clearly understood.

No. of patients referred during the year	32
No. of patients visited	50
No. of visits paid	137

One child was referred by Dr. Komrower from R.M.C.H. for home follow-up.

As a general rule, once the diabetic problem is resolved no further visits are paid by the liaison health visitor. Sometimes one visit will suffice e.g. to check that the correct amount of insulin is being given.

Where elderly diabetics are concerned visits are continued until the problem has been dealt with; then all particulars relating to the patient are handed to the special health visitor for Care of the Elderly. If a specific diabetic problem re-appears the patient will at once be referred back to the liaison health visitor.

In all other cases a small nucleus of patients is retained on the liaison health visitor's visiting list; those, for example, who are unable to persevere with their treatment without being reminded and encouraged to do so.

This follow-up service is of great value to diabetic patients—especially to those newly diagnosed, who are often worried and confused by the diagnosis and treatment offered, and need much re-assurance and guidance to assist them to adapt to a new way of life.

(c) THE UNMARRIED MOTHER AND HER CHILD

The vacancy for this post remained unfilled.

Unmarried mothers referred to the Department were seen by members of the staff available for consultation, and were subsequently dealt with by area health visitors.

All applications, 23 in number for financial aid towards cost of hostel accommodation provided by the Moral Welfare Organisations were met, as were applications from these organisations for per capita grants in respect of outdoor case work.

(d) TRAINING OF STUDENTS

The full practical training of Student Health Visitors sponsored by this Authority was organised in former years by a specialist health visitor (Practical Tutor) until she left the service towards the end of the year. In addition, help was given with the practical Health Visitor Training of the University of Manchester Community Nursing Students. Student nurses from four hospitals also attended the Department to study social aspects of health and disease but this work was discontinued in December, pending replacement of the Specialist Health Visitor (Practical Tutor) responsible for Student Training, who left the service in October and at the end of the year was not yet replaced.

Students attended the Department as follows:—

Student Health Visitors

Five Salford sponsored students successfully completed the Course and passed the examination in July. A further five sponsored students commenced the Course in September.

University of Manchester Community Nursing Students

20 students attended the Department for periods ranging from 4 to 16 days each.

Student Nurses

Crumpsall Hospital	— 10 students attended
Hope Hospital	— 111 students attended
Salford Royal Hospital	— 76 students attended
Royal Manchester Children's Hospital	— 92 students attended
Nursery Nurses	— 36 students attended
Home Nurses	— 11 students attended

Total	<u>336</u>
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Other Students and Visitors to the Department

Medical students	17
Student matrons	2
Student teachers	6
W.H.O. (Brazil)	<u>1</u>
	<u>26</u>

(e) PREVENTION OF FAMILY BREAK-UP (Problem Families- Families with Problems)

This section of the service remained in charge of a Specialist Health Visitor as formerly. The year started with 229 old cases on the register, to which 16 more cases were added throughout the year. These were all established problem families—not to be confused with potential problem families, or families at risk of family break-up.

1964 brought several changes affecting this work.

The removal of the Health Department from Regent Road to the present position on the Crescent made it less easy of access to the many families from Regent and surrounding areas who frequented the Regent Road offices when in need of advice and help. Such people now need to make a special journey to the Crescent Offices for consultation regarding their problems.

The year also saw a change in the officers designated to co-ordinate services for these families when responsibility for co-ordination was transferred to the Children's Officer. The practice of holding Case Conferences at the Health Department, therefore, came to an end in October, after 14 years. This led to some agencies acting in isolation, resulting at times in duplication of effort.

As the new policy in relation to co-ordination was not made known before the end of the year the specialist health visitor continued to act as family case-worker, and to carry out all the aspects of her work, except that concerned with the Case Conference. It is intended to resume case conferences involving Health Department personnel in the coming year.

Implementation of certain aspects of the Children and Young Persons Act, 1963, caused a little difficulty. For example, the Gas and Electricity Boards became aware of the provision of the Act in relation to grants in cash or kind, and were subsequently less inclined in some cases to make suitable financial arrangements with case workers for the payment of outstanding arrears. Voluntary supervision by the Probation Officer—a most useful and effective service for appropriate families on our register—was also withdrawn.

In addition to the work for established problem families, a further 258 families with problems were dealt with by the special health visitor; the majority seeking help and advice of their own accord.

Referred by :—

General practitioners	10
Hospital medico-social worker	13
Probation Officer	7
National Assistance Board	5
Children's Officer	5
School Welfare Officer	5
Civic Welfare Department	4
Home Help Department	4
Psychiatric Social Worker	2
Midwives	3
Other social agencies	11
Own accord	189
	<u>258</u>

Circumstances associated with the need for help

Married women with difficulties associated with pending confinement	25
Illegitimate pregnancies	8
Mental illness	17
Widows and widowers	5
Desertions	27
Illness of parents	18
Marital problems	19
Threatened eviction	28
Miscellaneous	47
Financial problems	35
Alleged ill-treatment—usually of wife	13
Handicapped children	8
Old Aged Pensioners (transferred to Elderly section)	8

Handicapped Children

Certain handicapped children who for varying reasons have not been accepted by their non-coping parents present a difficult problem, especially where a physical disability is complicated by a mental handicap.

In order to prevent neglect and possible ill-treatment, care under Section I of the Children and Young Person's Act, 1963 has been advisable in some cases. There is, however, an unfortunate lack of provision for this type of child.

Wilmur Avenue Centre caters specially for such children in the 0-5 group who need day-time care but this is a Day and Special Care Unit where the demand greatly exceeds the number of places available. Moreover, in some instances the home and parents are unfit to provide adequate care for a handicapped child even at night and week-ends.

There is an urgent need for special services for these children, especially the very young—either a special residential nursery complemented by Day Special Care; or dedicated fostering also complemented by Day Special Care (administered by the Mental Health Section) where required. It is unfortunate that in some instances hospital beds have been occupied by this type of case and have in fact been used as a substitute for residential care.

A statistical summary of the work undertaken by the section for prevention of family break-up, is appended below:—

Established Problem Families

Cases on the Register brought forward from 1963	229
New cases added in 1964	16
Cases removed from the Register as stabilised	12
Families on the Register who moved out of Salford	18
Cases carried forward to 1965	215

Case Conferences held up to October 20th

No of families discussed: 95

Once	66	
Twice	20	
Three times	7	138 discussions
Five times	1	
Six times	1	

Average number of families discussed per session: 8

Average number of workers attending per session: 17

PREVENTION OF ILLNESS, AND HEALTH EDUCATION

Preventive work continued on lines previously established.

Whilst immunisation and vaccination fulfil a positive role in the prevention of illness, health education is the more abstract though none the less valuable aspect of the health visitor's work in the preventive field.

The result of preventative educational work is difficult to assess. If it is successful it is, ipso facto, unrecognised. The home accident that never happens is no more news than the family that never goes wrong. The child who fails to show delinquency or is kept above the borderline of neglect or malnutrition, the tuberculosis contact who is not infected, the aged person who does not die in squalor and loneliness are no more news than the well-cared for healthy baby, or the well-adjusted healthy school child. The fact that a good deal of work has often been carried out by health visitors in order to maintain this uneventful state of affairs is of equally poor news value, and is frequently unrecognised as it is unappreciated. It certainly cannot be measured statistically or presented factually in a report of this kind, although such work does ultimately influence attitudes and behaviour which in turn affect health.

Individual counselling in the home still remains the most important aspect of the health visitor's role in health education. Various forms of more formal methods of teaching in clinics have been tried over the years; lectures, talks, group discussions, demonstrations, films, and teaching illustrated by models, film strips, and other visual teaching aids.

Not all health visitors have the aptitude and interest necessary for success in the important field of collective teaching outside the home. The extent to which such work is carried out depends, therefore, on what proportion of staff possess and develop the necessary qualities; the flair and the desire to teach in this way. 1964 was a good year in this respect.

Several health visitors showed exceptional talent in the designing and preparation of posters (two of which were later reproduced by a commercial firm) and making unusual visual aids including puppets designed to attract and hold the attention of small children.

The recently appointed Deputy Superintendent Health Visitor also had a particular aptitude for teaching and had had special training and experience in methods of health education which were put to good use. She formed a small health education group from the Health Visiting staff early in the year, for the purpose of drawing up suitable syllabuses – and to suggest appropriate visual aids – which were used to good effect in the discussions in child welfare clinics which followed. Visual aids were shared on a rota basis.

It is hoped that this emphasis on health education will influence mothers to regard the "Clinic" as a centre for widening their knowledge of health matters and child care in the broadest sense rather than as a baby weighing centre used also for buying dried milk and other medicaments and receiving individual advice – although of course the latter will always have its place in any future centre development.

Teaching the mother in hospital

Following discussions between the Matron and Midwifery Superintendent of Hope Hospital with the Superintendent Health Visitor in 1963 it was arranged that a teaching programme for mothers in the post-natal wards should be drawn up and put into operation in January 1964. This was an entirely new venture.

Initially, three discussions per week took place in one of the wards, and because the experiment proved successful, it was decided that another health visitor should conduct three further discussions a week in a second ward. These arrangements have continued.

The discussions were not intended to replace or overlap the series of talks given in the ante-natal period by the midwifery staff. The subject matter was chosen in the first instance to emphasise the emotional development of the child, and to increase awareness of the need for a safe environment for the baby. Other appropriate subjects were introduced later, e.g. early development of some of the senses – sight, hearing, touch, etc., the use of clinics, the work of the Health Visitor, and so on. An "Any Questions" session, which was tried experimentally, proved so popular it was included regularly in the series.

The health visitor concerned with the project found this an invaluable opportunity to reach the mother, at a time when relieved of her domestic responsibilities she was most receptive to advice.

Other health visitors found that mothers who had participated in the hospital discussions had more knowledge of the scope of work of health visitors generally, and were eager to continue the discussions on child care at home, following discharge.

Talks to outside agencies

All requests for talks to outside organisations were met.

REFRESHER COURSES

Health visitors are sent for refresher courses every five years in accordance with the appropriate recommendations. An average of two health visitors a year attend residential courses of two weeks, held in various parts of the country. Two health visitors attended such a course at Bedford College, London, this year.

A local three-day Refresher Course was organised by the Manchester Health Department to which four health visitors, six clinic nurses, and six nursing auxiliaries were sent. The main subject of this Course was concerned with geriatrics.

IN-SERVICE TRAINING

If health education of the general public is to be effective it is necessary to ensure that staff responsible for this work are well-informed and up-to-date. In-service training helps to ensure this, and was provided as follows:—

(a) Psycho-Social Concepts in Health Education

A two-day course organised by the Central Council for Health Education and held at the Health Office — attended by 23 health visitors.

(b) Child Psychiatry — discussion group

With the appointment of a new Consultant Child Psychiatrist in-service training of health visitors in this field (first started by Dr. Cashmore in 1955, and continued sporadically according to the availability and interest of succeeding child psychiatrists over the years) was re-introduced in April. Two groups of eight health visitors attended a series of twelve discussions. A third course was in progress at the end of the year.

In addition to attending group discussions the Consultant Child Psychiatrist has been available to staff at regular intervals for consultation regarding individual cases presenting a problem to the health visitor.

(c) Paediatrics

In November, the Consultant Paediatrician from Hope Hospital began a weekly series of talks which continued to the end of the year and will be carried over to 1965 until all health visiting staff have had an opportunity to attend the course.

COLLABORATION WITH FAMILY DOCTORS

Five health visitors were attached for liaison purposes to the practices of seven general practitioners. They did not work from the surgeries, but in addition to the usual contact by telephone, when considered necessary (which all health visitors do) they paid a visit once a week to see the doctors concerned at their surgeries. Cases referred to them or discussed on those visits which were outside their own health visiting areas were passed on to the appropriate health visitor. The latter contacted the doctor by telephone later, where necessary, to inform him of her findings or action taken.

In view of the general national trend towards a closer health visitor/family doctor partnership, with the health visitor working direct from the surgery and being responsible for visiting patients in any part of the practice, a survey was carried out to discover how far the average G.P. practice differed in extent of area from that of the geographical area covered by the health visitor.

It was found that an average of 36 doctors served each health visitor's district; in addition some doctors had patients outside the city boundary. Several practices extended over half the entire city area, and although the scatter of patients over the districts of health visitors concerned was not uniform, and in some cases few in number, this meant that in several instances one practice covered the districts of some 16 health visitors.

In view of the multiplicity of health visitors on any given district which would ensue if this form of collaboration were adapted and of the administrative difficulties in correlating local authority work of the health visitors concerned with that coming from the practice it was decided to defer full secondment of health visitors to general medical practices for the time being.

NURSING AUXILIARIES

The establishment of nursing auxiliaries was reduced by one when the auxiliary nurse at the Eye Clinic was re-designated as clerk, 14 full time auxiliaries were employed throughout the year, and several part-time workers appointed towards the end of the year. One nursing auxiliary, Miss Anderson, retired on superannuation after 15 years service. She had helped considerably with the pioneer work started by the section, and was regarded with affection by the elderly persons she helped with bathing and foot hygiene, and by the socially handicapped mothers attending the Day Training Centre, where she taught domestic subjects. Miss Anderson was a highly qualified domestic science teacher who could have commanded more than double her salary as a high school teacher. She preferred to work among the underprivileged. Much of the success of the Day Training Centre, where she taught three times a week, from its inception, was due not only to the skill as a teacher, but to her friendly, motherly personality and to her understanding and influence. We would like to record appreciation of her work.

In addition to assisting health visitors in Clinics and schools, and carrying out home bathing and foot hygiene services for the elderly, nursing auxiliaries staff the syringe service, with a senior nursing auxiliary of over twelve year's service in charge. Here, all equipment for both clinic and domiciliary immunisation and vaccination is prepared and distributed, and stocks maintained throughout the year. Needles and syringes for the home nursing and midwifery services are also issued through this centre. All, except B.C.G. and Mantoux syringes and needles are disposable.

STATISTICS

A statistical summary of visits paid and clinics attended by all members of the health visiting section staff, viz. — health visiting, clinic nurses, and nursing auxiliaries is given as follows:—

Health Visitors and Clinic Nurses

Type of Visit	Access	No Access
Total visits to children 0—5	33,866	
Ante-Natal visits	647	
Visits re tuberculosis and other infectious diseases	977	
Visits to aged persons	8,114	
Special hospital discharge visits	92	
Mental Health visits	256	
Immunisation visits	5,489	
Miscellaneous	6,819	
	56,260	9,610

Grand total of visits

65,870

Clinic Sessions	Health Visitors	Clinic Nurses
Full sessions	1,977	509
Part sessions	21	1
	1,998	510

Nursing Auxiliaries

Type of Visit	Access
Aged Infirm	1,791
Foot hygiene — aged infirm	3,509
Miscellaneous — aged infirm	1,232
Miscellaneous — general	29
Scabies treatment	13
No access	1,040
	7,614

Nursing Auxiliaries – Clinic Sessions

Type of Clinic	Sessions
Infant Welfare	436
Day Training Centre	169
School Minor Ailments – including Mobile Clinic	776
Chiropody – Schools	395
Chiropody – Elderly	184
Scabies (specially arranged sessions)	4
Medical examination clinic – Schools	61
Cleansing (including bathing of children where appropriate)	114
Camp and miscellaneous	27
Health Check-up (with M.M.R.)	128
Syringe Service	413
Total	2,707

Nursing Auxiliaries – School Sessions (with and without H.V.)

Type of Work	Sessions
Health Survey	243
Vision Testing	108
Hygiene Inspection	364
Hygiene Re-inspection	126
School Medical Inspections	50
Short Visits to Schools	30
Immunisation in School	163
Total	1,084

An approximate time analysis of work undertaken by Nursing Auxiliaries is given below :—

Syringe Service	10.5%
Schools and School Clinics	30.0%
M. & C. W. Clinics	15.4%
District (Home Bathing, Foot Hygiene, etc.)	19.2%
Travelling } combined services	24.5%
Office Work }	
Miscellaneous	0.4%
	<u>100.0%</u>

HOME NURSING SERVICE

The Home Nursing Service has continued to serve those who need skilled and auxiliary nursing care in their own homes.

The emphasis has been on rehabilitation during the past year, to all members of the family.

The case load has remained fairly steady from the previous year.

STATISTICS

No. of patients on books at beginning of 1963	547	
New patients	1,907	
Total No. of patients nursed		<u>2,454</u>
No. of patients discharged from our care	1,892	
No. on books at the end of the year	562	
No. of visits		<u>62,111</u>
No. of patients on books at beginning of 1964	562	
No. of new patients	1,832	
Total No. of patients nursed		<u>2,394</u>
No. of patients discharged from our care	1,787	
No. on books at the end of the year	607	
No. of visits		<u>62,220</u>
No. of patients removed from our care during 1964		<u>1,787</u>
No. of patients recovered	898	
No. of patients transferred to hospital	339	
No. of patients removed from the district	28	
No. of patients removed for other reasons	323	
No. of patients died	199	

The referral of patients to our care has closely followed the pattern of previous years, our most consistent source being the general practitioner, with whom we work in very close contact in the care of all our patients.

Referrals

	1964	1963
General Practitioners	1,401	1,400
Hospitals	321	383
Health Visitors	59	56
Personal Applications	14	41
Midwives	4	10
Others	33	17
	<u>1,832</u>	<u>1,907</u>
Total		

There has been an increase in the number of surgical cases from hospital – in 1963 there was 136, and in 1964, 183 patients requiring treatment, and in 1963 they received 2,842 visits and in 1964, 3,907 visits.

The incidence of heart disease, stroke and circulatory disease has remained fairly constant.

Heart disease—In 1963 185 patients had 6,320 visits and in 1964 194 patients had 6,320 visits. We therefore see that education of the patients and relatives to live within the limitations of the disease has resulted in fewer visits to a number of patients.

In stroke and circulatory disease in 1963, 136 patients had 4,564 visits and in 1964 146 patients had 4,091 visits.

In 1963 72 patients with diabetes had 9,376 visits, in 1964 56 patients with diabetes had 8,444 visits. The teaching of relatives to administer the insulin and new drugs has decreased the number of visits to each patient with diabetes.

Classification of cases nursed and visits paid show interesting side lights on the trends in public health in relation to the nursing care required.

Classification of Disease

	Cases	Visits
1. Infectious Diseases		
(a) Pulmonary Tuberculosis	13	789
(b) Other forms	3	72
(c) Pneumonia (not broncho)	8	61
(d) Other infections	45	251
2. Cancer		
(a) Medical	104	3,106
(b) Surgical	28	1,136
3. (a) Heart Disease	194	6,320
(b) Stroke and Circulatory Disease	146	4,091
4. (a) Bronchitis	117	1,345
(b) Respiratory Diseases	42	661
5. Anaemia	259	6,467
6. Disease of Central Nervous System	27	919
7. Mental Illness	7	248
8. Diabetes Mellitus	56	8,444
9. Anaemia of Pregnancy	154	1,517
10. Complications of Pregnancy	27	229
11. (a) Other Medical	523	7,860
(b) Arthritis	52	2,461
(c) Kidney and Urinary Infection	—	—
(d) X-ray Investigations	86	107
12. Other Aged	151	5,574
13. Surgical Cases		
(a) Post-operative	183	3,907
(b) Ulcer-legs	62	2,773
(c) Other	107	3,882
Totals	<u>2,394</u>	<u>62,220</u>

Anaemia of Pregnancy

There has been an increase this year in cases to 154 from 97 in 1963; the average number of visits to each patient has been nine.

STAFF AND CENTRES

Miss J. Marsden took up appointment as Superintendent on 1st April, 1964.

We have had the usual turn over of staff during the year but have had no difficulty in filling the vacancies.

Senior Queen's Nurses

Two left the service, one to take health visitor training; one left to follow her husband to a midland circuit.

Queen's Nurses

One left to take a senior hospital appointment.

State Registered Nurses

One left to return to Scotland.

State Enrolled Nurses

One left to take a hospital appointment; one left to take other employment for financial reasons.

Nursing Auxiliaries

One new appointment.

Student Queen's Nurses

Three have been successful in obtaining the Certificate of the Queen's Institute of District Nursing and the Ministry of Health Certificate; two are in course of training.

New Appointments

Two S.R.N., three State Enrolled Nurses.

Staff	1st January, 1964	31st December, 1964
Senior Queen's Nurses	3	1
Queen's Nurses	6	6
Student Queen's Nurses	1	1
State Registered Nurses	3½ (Full-time 1) (Part-time 5)	3 (Full-time 2) (Part-time 2)
State Enrolled Nurses	5½ (Full-time 5) (Part-time 1)	6½ (Full-time 5) (Part-time 3)
Nursing Auxiliaries	4½ (Full-time 3) (Part-time 3)	5½ (Full-time 4) (Part-time 3)

There has been an increased awareness among the staff of group working and discussions have been of great help in solving patients' problems during the past year. To widen the knowledge and therefore give an improved service, the groups have discussed such subjects as:-

Central Sterile Syringe Service,
 Disposing of disposable equipment,
 Early detection of diabetes by urine testing,
 Problems of nutrition of the elderly in the community,
 The help we can give to the middle-aged relative with elderly relative to care for, especially when incontinence occurs,
 Intensive care for terminal patients especially those suffering from cancer,
 Cytology tests and the relief of negative result of these tests,
 Aids for rehabilitation.

The Home Nursing Service is now working from four centres (Murray Street was the Pioneer centre) and useful ideas have been passed to the newer centres.

Kersal Centre has increased in usefulness during the past year and we have three nurses in this area. We now have a loans centre at the Kersal Centre and this is of great benefit to those looking after the patients in this area, as long tiresome journeys to Regent Road are not now necessary.

Langworthy Centre is now fully occupied and the east side of the City is cared for by the nurses in this centre. Loan equipment is held here and has been in constant demand from the first.

Regent Road Centre is the oldest centre and is in almost constant use and the evening clinic is a great advantage to those who work during the day or part of the day but require treatment of some kind.

The centres are open daily for loan equipment and advice and information from 8.30 a.m. - 9.30 a.m., 1.30 p.m. - 2.30 p.m., 4 p.m. - 4.30 p.m. Monday to Friday and Saturday morning from 8.30 a.m. - 12 noon at Regent Road Centre.

CARE AND AFTER-CARE EQUIPMENT

We have a brisk turn-over of all the loan equipment that we have in stock, the centres dealing with the small items such as bed pans, air rings, mackintoshes, back rests, walking aids; the larger items - bedsteads, mattresses, lifting poles, wheel chairs, commodes - are more easily available at Regent Road, where they are stored. The larger items most constantly in demand are wheel chairs, commodes and lifting poles.

With the early discharge from hospital, patients need intensive help immediately on arrival home and in many cases we have been able to have beds, lifting poles, commodes and wheel chairs ready in the house when the patient has been discharged to our care. With this help and a great deal of time from the staff, rehabilitation has been an easier task and relatives have seen the patient restored to a greater degree of usefulness than they had thought possible, this is a very satisfying aspect of our work.

Case History—Mrs. P. Age 60 years plus. Hemiplegia

Mrs. P. had lost all interest in life but has now been persuaded to get up and walk round her room. Her husband had been in the habit of getting her up before he went to work. Returning from work during his dinner-hour washing his wife, feeding her, getting his own meal and hurrying back to work. The district nurse now calls in the morning, washes, dresses and walks Mrs. P. It has been found that she can now manage to get to the kitchen by herself and get a drink. This is a great improvement, as she is now losing some weight and her incontinence which was an almost insurmountable problem to her husband, has been lessened with increased alertness and general activity.

Loan Equipment

We have purchased during the year one special bed, which gives great benefit to a cardiac patient; wheel chairs and commodes, which have been in constant use especially during the holiday months when elderly relatives have needed these aids to retain some independence during their stay with more robust relatives.

MARIE CURIE MEMORIAL FOUNDATION

We have benefited by financial help from this fund during the past year; as we have made available to the patients suffering from cancer extra comforts during their illness—usually terminal.

We have had two patients transferred to the Marie Curie Nursing Home in Liverpool, where they receive extra care and attention not obtainable in their own homes.

Seven patients have had the services of a night nurse.

Thirty-four patients have received extra comforts, which have included Complan, egg custard, dunlopillo cushions, night wear, air purifiers.

CHIROPODY SERVICE

Local authority chiropody services have without doubt proved their value to the community, and it would appear that with the continuous demand for this service, the time has come for a re-appraisal of how best a Foot Health Service might function.

In Salford the chiropody service exists as part of the local health authority's arrangements for the prevention of illness under Section 28 (1) of the National Health Services Act 1946. No charge is made to the patient for this service.

It has long been recognised that the human body is particularly prone to foot troubles which produce anything from mild discomfort to crippling pain. To have a health service which caters for all afflictions of the patient, but does not adequately cater for defects of the feet, seems rather an incomplete service. There can be no doubt that a comprehensive foot health service, apart from alleviating pain, can often prevent a person from becoming housebound and can often turn a housebound person into an ambulant one, and in many instances can prevent minor lesions becoming more serious and a threat to the patient's general health. The local health authority, without its chiropody department is incomplete.

The groups of people not catered for by the Foot Health Service in Salford are those who are of the age between school leaving and retirement, except for those who are known to be handicapped.

During 1964, a health check-up was held in Salford and a questionnaire was handed to persons availing themselves of the facilities provided. The questionnaire contained questions relating to the feet. One thousand people completed the questionnaire and the information extracted from the section on feet was as follows:—

Of the 1,000 people of employable age, 217 had trouble with their feet; 150 of these were not having treatment for various reasons and a further 21 were treating themselves for foot lesions, and 65 people were at the time undergoing treatment.

Of the 150 foot sufferers not in receipt of treatment, the main reasons given for not seeking professional advice were cost of private treatment and lack of facilities, such as the lack of chiropodial practitioners holding evening surgeries when workers could avail themselves of private treatment. In a few cases, fear of undergoing chiropody treatment was the reason given for not seeking treatment, while a few housewives could not attend the chiropodist because of domestic responsibilities. In some cases, the foot sufferer gave as his reason for not having attention the fact that he had learned to put up with discomfort in his feet.

The thought that over 20% of a random section of the working age group of the population have painful feet is quite staggering and this figure makes it appear that the demand for foot treatment in the local authority chiropody clinics in the future will show no abatement, unless some attempt is made to cater for the chiropodial needs of the working population.

As the time progresses, the modern local health authority chiropody service is becoming a larger and more complex unit, not content with palliative work but undertaking long term curative treatment embodying appliance making, both remedial and corrective and utilising the many modern chiropodial techniques developed over the past few years.

Many elderly people find it most difficult or impossible to perform the simple task of trimming their own toenails and one must recognise that it is a waste of a chiropodist's time to perform this service for the person. This would lead one to believe that there is a place in a comprehensive foot health service for auxiliary staff to perform simple nail-trimming and other tasks associated with hygiene of the feet for those incapable of doing these things for themselves. But should a person complain of foot trouble in the region of the toenails then the chiropodist should be first of all consulted and it should be left to the chiropodist to differentiate between a normal nail-trimming requirement and what will require chiropodial attention. The chiropodist, being trained in the art of chiropodial diagnosis and having the right of diagnosis, must be allowed to exercise this right. One cannot expect an untrained person to recognise any of the conditions which may effect the peri-ungual tissues of the patient requiring treatment. It is now quite within reason that in due course some form of auxiliary chiropody service, or two-tier chiropody service, will evolve but in the interest of the patient much thought and consultation will have to be given to this development.

Local authority chiropody schemes being permissive are subject to the vagaries of any local authority wishing to run these schemes; but, once commenced, chiropody schemes must be fully supported by the administering authority. A limited or token scheme is of no real value to the community and opens wide the door of criticism for the scheme and the local authority.

A chiropody service, once established, is increasingly used by many family doctors and the diabetic and orthopaedic departments of local hospitals, and it is a very sad occurrence when a patient referred to the chiropody clinic by a family doctor or hospital cannot receive immediate chiropodial treatment because of shortage of chiropodists employed by the authority. Fortunately this does not often occur, but on the rare occasion when it does, the authority concerned is made to look somewhat incompetent. When it is known that a local health authority has a chiropody service that service is very fully used by the many other branches of the medical profession.

The chiropody section of a local health authority must be fully staffed and adequately equipped to meet the many demands that are made upon it, and there must be sufficient chiropodists available to ensure that the patients may be treated with the frequency that the chiropodists deem advisable, without producing such heavy case loads that a lowering of the standard of treatment occurs with the consequent increase in the risk of accidents.

As, when the inception of the National Health Service made articulate the amount of silent suffering in existence amongst the people who could not afford to seek medical advice and treatment, so now, the local health authority chiropody services are exposing the degree of foot suffering especially amongst the older population.

The provision of a comprehensive foot health service must be considered essential to complement the existing efforts being made to provide for the health and welfare of the nation from childhood to old age.

	1960	1961	1962	1963	1964
Total number of domiciliary treatments	563	1,177	1,659	1,857	1,303
Total number of clinic treatments	3,586	5,173	5,563	5,812	5,842
Total number of treatments given	4,149	6,350	7,222	7,669	7,145
Total number of domiciliary patients on register	184	257	367	432	404
Total number of sitting car patients on register	212	249	260	292	291
Total number of walking patients on register	993	1,224	1,600	1,851	1,656
Total number of patients on register at December 31st	1,389	1,730	2,227	2,575	2,351
Total number of new patients referred during year (1964 until May 1st)	—	663	1,059	884	*308
Percentage of appointments kept	85.74	85.76	87.2	87.0	84.0

*It can be seen that the number of new patients accepted during 1964 is below the yearly average but this number just represents those referred mainly during the first four months of the year. After 1st May it was decided to accept only emergency patients so that the present staff could treat with more frequency many patients whose appointments had become too infrequent. This temporary halt in referrals also helped to clear the waiting lists. The strategic positioning of the clinics has been of enormous help to the aged foot sufferers and the continued co-operation of the ambulance service has greatly assisted the efficient running of the service.

It is hoped to employ an additional full-time chiropodist during the coming year which should improve the Foot Health Service for the aged people of Salford still further.

CHIROPODY FIGURES FOR THE YEAR 1964 (CARE OF THE ELDERLY)

Total Number of Treatments Given			7,145
Treated at clinics	Male	910	
	Female	4,932	5,842
Treated at Home	Male	186	
	Female	1,117	1,303
			<u>7,145</u>

Langworth Road Clinic

Sitting Car Cases	Male	74	505	
	Female	<u>431</u>		
Walking Cases	Male	327	2,253	2,758
	Female	<u>1,926</u>		

Regent Road Clinic

Walking Cases	Male	190		1,205
	Female	<u>1,015</u>		

Murray Street Clinic

Walking Cases	Male	152		904
	Female	<u>752</u>		

Kersal Centre

Sitting Car Cases	Male	25	261	
	Female	<u>236</u>		
Walking Cases	Male	142	714	<u>975</u>
	Female	<u>572</u>		

Clinic Total 5,842

Domiciliary Total 1,303

7,145Total Number of Patients on Register at 31st December, 1964 2,351

Number of Walking Cases	(70.43%)	1,656
Sitting Car Cases	(12.37%)	291
Domiciliary Cases	(17.18%)	404
		<u>2,351</u>

Number of Patients Referred during 1964 308

(The register was closed, and only emergency cases accepted after 1st May)

Total Number of Clinic Sessions held in 1964 922

Sessions at Langworthy Clinic	Day	428	}	428
	Evening	46		
Sessions at Regent Road Clinic	Day	150	}	196
	Evening	49		
Sessions at Murray Street Clinic	Day	141	}	141
	Evening	49		
Sessions at Kersal Centre	Day	108	}	157
	Evening	49		
				<u>922</u>

Total Number of Patients invited to Clinics during 1964

6,502

	Invited	Attended	Defaulted
Langworthy Clinic	3,062	2,558	504
Regent Road Clinic	1,373	1,118	255
Murray Street Clinic	1,091	862	229
Kersal Centre	976	907	69
	<u>6,502</u>	<u>5,445</u>	<u>1,057</u>
		(83.74%)	(16.25%)

Attended 5,445

Number of Additional Cases

397

Dressings	143
Observation	4
Emergency	250
	<u>397</u>

Attended 397

Total Attended 5,842

ELDERLY PEOPLE'S CLINICS

A survey has been made of the elderly people at present on the register to attend the elderly people's clinics. Thirty-two of these are men and forty-nine are women. The ages of the women range from 61–87 years.

The women were seen from 1 to 32 times each and an average of nine times each. Many different complaints were the main reasons for coming to clinic. These are enumerated below:—

Backache, asthma, migraine, excessive thirst, tinnitus, insomnia, obesity, soreness of the mouth, tiredness, wax in ears, cough, sore toes, catarrh, haemorrhoids, cataracts, chronic otitis, anaemia, sore nose, eczema, hypertension, oedema, housing, chronic dyspepsia.

Chronic bronchitis and headaches were each complained of by one person.

Ulceration of the breast, deafness, abdominal pain, chest pain, and deafness causing depression were each complained of by two women.

Dizziness was complained of by four women, varicose veins by eight, depression by nine and arthritis by eleven.

Of the forty-nine women, six had their ears syringed at the clinic and one was referred to Hardman Street for a hearing aid.

Two of the women were referred to an optician for glasses; four were referred to the chiropody department.

Four of the women were told how to make arrangements for a holiday.

One of the women was provided with "meals on wheels".

Twelve of them had physiotherapy in some form, breathing exercises, radiant heat and massage, etc.

The ages of the men range from 63–94 years of age, and they were seen from 1–41 times each. They were referred to the clinic for a variety of reasons, including chest trouble (10), muscular and joint pains and stiffness (3), digestive disturbances (4), headaches (2), varicose veins (4), complaints regarding eyes and vision (3), and social reasons (2).

Of the thirty-two elderly men, seventeen had some form of physiotherapy at the clinic and twenty had their ears de-waxed with oil and syringing on at least one and sometimes on two or three occasions.

Eight of the men were referred to an optician or back to the eye hospital.

HOME HELP SERVICE

If the personal services given under the National Health Service Act by local authorities are to function efficiently an adequate and reliable Home Help Service is essential because of their dependence to a certain degree upon efficient help in the home. All hospitals are faced with the problems of the lack of nursing staff and the lack of beds, and an adequate home help scheme can relieve this pressure considerably. The aged and infirm can receive considerable benefits if they are assisted regularly and it enables them to carry on living an independent life in their own homes.

The Home Help Service is not reserved for first confinements and old people. Wherever there is sickness or social distress the home help service may be required and used by all. Home confinements, sick nursing mothers, acute illness of expectant mothers, emergencies in homes where there are young children, patients suffering from infectious illnesses (tuberculosis, dysentery, etc.), mental health patients, and chronic sick, are some of the many cases where help may be required. The preventive aspect of the work must not be under-rated and often people can live happily and comfortably in their own home almost without incident, thereby obviating the need for admission to an old people's home or home nursing or hospital admission, and little more than supervisory medical attention is required. Special efforts have also been made to assist families referred by mental health officers and specialist health visitors. Spectacular results are not expected—none are claimed—nevertheless the total amount of help given must have been of considerable assistance both to the families concerned and the officers engaged in this work.

During the year, 856 applications for help were received and 606 were accepted as being in need of assistance from the Home Help Service. These figures include 97 applications for help during confinement; 65 of these cases were supplied with help; 32 cases did not ask for help.

Sources of application (expressed in percentages):—

Health Visitors	306	36%
Hospital Almoners	130	15%
Self	105	12%
General Practitioners	86	10%
Relatives	59	7%
Friends	48	5%
National Assistance Board	36	4%
Welfare Officers	32	4%
District Nurses	23	3%
Midwives	15	2%
Mental Health Officers	8	1%
Cripples Help Society	8	1%

Home Helps

Most of the women drawn from varying income groups willing to undertake this work have some knowledge of household management and experience in dealing with children, the sick and the aged. Although a large section of the

public still regard her function as purely domestic, the Home Help becomes an intimate worker within the home. There are times when she temporarily takes over the role of mother, attending to all the household tasks, including budgeting and the general care of the family, and becomes a community worker in the true sense of the word. Home Helps are established as part of the health team, and work in harmony with the health visitor, home nurse, midwife and others.

One would pay tribute to the helps for the kindly concern which many of them show for their cases and to the voluntary work so often undertaken for them in their own time.

The service has always had a considerable staff turn-over and not all women applying for this work measure up to the accepted standard. Recruitment to the service of younger women has proved advantageous and it may be that a "pre-entry" training scheme would be beneficial in the future.

The number of Home Helps employed at the end of 1964 was 264. The average weekly number employed throughout the year was 260. The total number of hours worked was 262,035 making a weekly average of 5,039 hours.

Training

Assuming that the right type of women have been recruited, it is desirable to correlate their knowledge, experience and natural attributes in order that they are used to their greatest advantage. To this end In-Service Training has been established and a selected number of Home Helps attend. It is considered better in training of this nature to concentrate on women with some experience of the service rather than brand new entrants, as the latter require time to settle down and to become acquainted with different types of households. All aspects of the Home Help Service are put before them to ensure that they have a thorough knowledge and understanding of what is involved in the work and its many implications.

Night Sitting

During the year this service was used to provide relief for relatives who have been sitting with patients during the night and to care for very ill patients awaiting hospital admission. While great demands are not made on the service it is available to help tired and anxious relatives caring for very sick people to have a night's rest, with the firm assurance that there is someone responsible available to look after the invalid.

Staff

The administrative staff has remained constant and mention must be made of the difficulties encountered. At no time has the supply of help caught up with the demand and the chief worry is the time necessary to visit each household requesting help and the subsequent desk work, not to mention follow-up visits and supervision of Home Helps. Much time is consumed in interviews, selecting, engaging and training staff, not to mention letters and telephone calls pleading for and sometimes demanding a Home Help. Tribute must be paid to the loyalty of the staff in this section, and their excellent record of service.

Mrs Winifred Wheable left the service at the beginning of the year and was succeeded by Mrs. Catherine E. Rimmer who was appointed as Home Help Organiser and took up the post in March.

The following table shows the cases for whom help was provided during the last five years and the inevitably increasing case load.

	1960	1961	1962	1963	1964
Maternity	59	54	56	65	65
Tuberculosis	11	8	5	5	5
Chronic Sick Aged & Infirm	1,428	1,530	1,687	1,806	1,857
Other cases	33	49	47	53	75
	1,531	1,641	1,795	1,929	2,002

MENTAL HEALTH SERVICE

REVIEW OF SERVICES FOR MENTAL ILLNESS

(M. W. SUSSER, *Medical Officer for Mental Health*)

SUMMARY

Trends in the total amount of mental illness entering the care of psychiatric agencies in Salford for the 6 years 1959–1964 are reported. These are based on the community care register maintained since 1959. The relationship of such recognised mental illness, and of mental illness which does not come into the care of special psychiatric agencies, is discussed. In Salford three pressing areas are considered to need attention, namely, mental disorder in old age, chronic disablement with mental disorder and mental disorder in children.

* * * * *

Since 1957, comprehensive community care for mental disorder has been the constant preoccupation of the annual reports of the mental health service. A continuous analysis of the working of most of the services directly concerned with the care of mental disorder has been maintained, and a statistical system built up which provides a reasonable index of the extent and effects of their operation. A register of all psychiatric disorder presenting at psychiatric agencies in the North West and neighbouring regions has been maintained for six years, since January, 1959.

Much of this material has general as well as local value. A prime objective of public health is to search for the means to prevent sickness. The discovery of the social circumstances conducive to sickness helps us to do this, or at least to alleviate its course and outcome. With such chronic conditions as schizophrenia and mental subnormality and the senile mental disorders, any modification of the course of illness can be expected to make a contribution to reducing pain and burden among patients and their families.

More immediate interests are also served by these analyses. They define the scale of the particular issues in the field of mental disability in relation to other fields, and the scale of the effort which must be mounted to deal with it. Moreover, we cannot know how effective our services are without continuous enumeration. Enumeration enables us to discover what functions each agency is performing, for whom, and in what manner.

We have learned how many patients from Salford come into any form of psychiatric treatment wherever it may be, and how frequently each is referred to a psychiatric agency; we know the diagnostic categories and the age and sex groups to which they belong and from which areas in the city they arise. Much data concerning these matters can be found in our previous reports, and much more remains to be published.

In the contemporary industrial state, medical care has become a complex matter involving a multiplicity of services provided by many persons of a variety of professions. Considerable problems of co-ordination arise as patients pass between the various agencies and into different forms of treatment, and we have directed much effort to solving these problems. Patients may not choose the best paths in seeking treatment, or they may deviate from them. Without conscious effort on the part of services, the movement of patients through the system may be blocked, particularly when they are handicapped by a lack of orientation or motivation as in many mental disorders. This is the story, for instance, of many long-stay patients in mental hospitals; Rawnsley, Loudon and Miles¹ showed that many such patients in hospitals (perhaps 17%) might have been discharged if a home had been available to them.

It thus requires systematic observation to discover if services are working effectively, or if new ones are needed, and our reports have described our attempts to do this. But, intense concern with services and with patients in treatment may itself blind us to the full extent of the problems of this field.

Our statistics are concerned only with such patients with mental disorder as have been referred to psychiatric services for help. They tell us nothing of persons with mental disorder who have not sought help and who have mental disorder which has not been recognised. Moreover, our counts do not deal with mental illness in children.

For the public health worker the equivalent of the clinician's case is the community itself. He learns what is needed from observation of the community, and if certain areas go unobserved they may also go unheeded. We can be sure that there is indeed a large unobserved segment of mental disorder in our community.

First let us consider the data we have to hand. In the period 1959-64 the rate at which persons from Salford aged more than 15 years with any type of mental disorder reached all psychiatric agencies for the first time ever, (inceptions) averaged 3.2 per 1,000 per year.

The average number of episodes of mental sickness (inceptions and recurrences) for which aid was sought averaged 7.5 per 1,000 per year.

In the six years under review, the trend has been towards an increase in the work of Salford psychiatric services as a whole. The number of inceptions of illness which reached psychiatric agencies remained fairly stable and increased by 6%; the number of episodes increased by 19%. Appendix IV compares two three year periods; 1959-61 and 1961-64. Data not tabulated in the report also provides the basis for counts of annual changes.

The increase in inceptions and episodes occurred outside the mental hospitals. The number of patients admitted to mental hospitals fluctuated and showed no uniform trend during the six years. There was a fall in inceptions admitted during the second 3 year period, and virtually no change in episodes. Total hospital usage was less, since patients remained in hospitals for a shorter time (See Annual Report, 1962). Phases of well-being punctuated by phases of sickness, which are recorded as repeated episodes, to some extent replaced admissions of long duration, recorded only as single episodes, thus

¹ Rawnsley, K., Loudon, J.B. & Miles, H.L., 1962. Brit J. prev. soc. med., 16, 1.

reflects in part recorded recurrences arising from the transfer of care from mental hospitals to general hospitals, to the local authority mental health service, to general practice and to households.

In the general hospital there has been an irregular increase in both in-patient and out-patient services, although the out-patient data show some decline from a peak in 1962. In the second 3 year period there was no change in inceptions among out-patients but a definite rise in inceptions admitted to the general hospital. This compensated for the fall in admissions to mental hospitals, so that there was only a 1% fall in the total of inceptions admitted. Total episodes admitted rose by 13%, episodes at out-patients by 20% and total episodes dealt with at general hospitals by 30%.

A considerable increase occurred in mental disorder cared for by the local authority mental health service alone, (although often with the participation of the general practitioners). In the second 3 year period there was a 28% increase in inceptions, and a slightly smaller, (26%), increase in episodes. This suggests that a new class of work is being undertaken by its mental welfare officers and other facilities, in addition to the re-distribution of work referred to above. There was a steady rise year by year in the number of inceptions and episodes dealt with in this way. The increase in the number of all episodes dealt with by the local authority mental health service, including those in which other services participated, was rather less. (Appendix IV).

Increases in inceptions of illness, although small, indicate a genuine increase in the numbers of patients served. Much of the increase occurred among patients with such less degrees of disturbance as the neuroses. These lesser illnesses were not trivial. In many of the cases dealt with by the local authority mental health service social disturbance was considerable. At referral about 10% showed a marked level of social disturbance, and 30% marked or moderated disturbance. The annual inception rate of schizophrenia and senile mental disorder changed little, and few patients with these conditions remained in the care of the general hospital alone.

To some extent the increased volume of recorded service usage, as recorded by episodes, can be attributed to the expanded facilities provided by the addition of consultant psychiatrists, of mental welfare officers, of general hospital beds and of hostels and day centres, as well as to the efficiency achieved through the co-ordination of services.

Presumably the increase in volume also required a greater readiness on the part of patients and other social agencies to use psychiatric agencies. We must consider to what extent the increase in service usage might have satisfied previously unmet needs. Such needs were not previously translated into demands,¹ since in Salford there was little indication that demand had been dammed back by waiting lists. One indicator of unmet needs is the duration of symptoms before referral. In half the patients coming into psychiatric care for the first time, the presenting symptoms had been present for longer than six months at the time of referral.

There are a number of other possible approaches to the question of unmet needs. In the first place we must note that formally designated psychiatric services are not the only agencies trying to satisfy psychiatric needs. General

¹ R.F.L. Logan, 1964. *Progress & Problems in Medical Care* ed. G. McLachlan Oxford University Press, for Nuffield Provincial Hospitals Trust.

practitioners treat an unknown amount of mental disorder in Salford, but we can make a fair estimate of the amount of mental ill health that presents to them. Thus, a recent national survey of general practice yielded an estimated incidence of "mental disablement" of 10 cases per 1,000; three quarters of new cases, and about half of all cases, were referred to psychiatrists.¹

Using a criterion of "mental illness" broader than that of disablement, Taylor & Chave² found an incidence in general practice in one new town of about 8%. Practitioners referred only about one case in twenty of mental illness of this order to psychiatrists.

When a special search is made among patients attending general practitioners, then clearly identifiable mental symptoms may be revealed in many more than 10%. Most such patients suffer from neuroses and only about one in thirty are likely to be referred for psychiatric treatment. If organic illnesses with accompanying psychiatric symptoms are included, the rate of symptoms rises to 14% - 15%.³

The quoted surveys rely on the recognition of mental disorder by practitioners, and this varies with their training and concepts.⁴ In our annual reports for 1958 and 1959 we showed the considerable variation in the referral habits of Salford practitioners and discussed the sources of this variation. Moreover patients who call on their doctors cannot be taken to be a fair sample of the community; for instance, more children, more old people and more women will be seen. Community surveys have been carried out to get closer to the truth of the matter. In England one survey suggests that no less than one-fifth of adults at any one time suffer from psychiatric symptoms,⁵ and another that one-third may suffer such symptoms.⁶

A survey in Manhattan found a rather similar prevalence. About one quarter of the sample (23.4%) suffered "mental impairment" from marked or incapacitating symptoms; only about one in five could be classed as essentially well and free of symptoms.⁷

A second American survey in Nova Scotia estimated that on one measure 20% of persons (and on a more sensitive measure 39%) could be classed as having had "significant mental impairment" at some time of their lives.⁸ 57% of persons were likely at some time to have had "psychiatric symptoms" on the less sensitive measure (and 69% on the more sensitive). Only between 1% and 3%, however, would be likely to qualify as cases of the type treated by psychiatric agencies in that area.

The more inclusive the definition of mental disorder and the more sensitive are the means of detection, the larger the yield of cases. Even so, these surveys suggest that the risk of developing recognisable psychiatric symptoms in an individual's lifetime is no less than that of physical illness.

¹ Watts, Cawte & Kuensberg, 1964. *Brit. Med. J.*

² Taylor, Lord & Chave, S. 1964. *Mental Health & Environment* Longmans.

³ Shepherd, M., Cooper, B., Brown, A.C. & Kalton, G.W., 1964. *British Medical Journal*, 2, 1359.

⁴ Rawnsley, K. & Loudon, J.B., 1962. *Brit. J. Prev. Soc. Med.*, 16, 174.

⁵ Hare, E.H. & Shaw, G.K., 1965. *Mental Health on a New Housing Estate*, Oxford University Press.

⁶ Taylor & Chave. *op. cit.*

⁷ Srole, L., Langner, T.S., Michael, S.T., Opler, M.K. & Rennie, T.A.C., 1962. *Mental Health in the Metropolis*. McGraw-Hill.

⁸ Leighton, D.C., Harding, J.S., Macklin, D.B., Macmillan, A.M. & Leighton, A.H., 1963. *The Character of Danger*. Basic Books.

What is a community mental health service to do when confronted by morbidity of such dimensions? A first step must be to cut back the luxuriant foliage encompassed by the statistics. We must consider whether the spectrum of symptoms they have revealed is within the capacity of services to help, and if it is, whether such activity would be profitable.

We do not know for sure how to draw the line between those who can benefit from special services and those who cannot. At present this line is drawn by the somewhat haphazard and undirected process of successive pressures and referrals through family, neighbourhood, work and the supportive services of the state. It includes only a fraction of the, say 20%, of persons who are likely to be troubled by definite psychiatric symptoms at any one point in time.

But patients suffering from the common cold do not need doctors; this condition, which we have no means of treating, resolves of its own accord. Much minor psychiatric disorder, perhaps the bulk of it, may well be of this order. Our ignorance in these matters points to the need for fresh research to supplement the findings so laboriously accumulated. Past surveys have described the extent, the nature and the severity of symptoms. This information does not permit confidence about the significance of many such symptoms in terms of future function for the individual who displays them. We have yet to discover how to identify individuals who are more vulnerable than others, just as we can identify childbearing women who are more liable to reproductive loss than others.

Attempts to do this would lend themselves to tests of various methods of psychiatric or other intervention. We may thus hope to learn, in the course of discovering how damaging symptoms may be, whether intervention has any value. This is not to say that we should not continue to do what we believe is right and helpful. Many general practitioners and social workers are aware that by judicious support they have helped patients through psychiatric storms and social crises. Nor is it to deny that we already have good grounds for attacking a number of questions, some of which are outside the present-day limits of activity of most psychiatric services. Among the most pressing questions are mental disorder in old age, chronic disablement with mental disorder and mental disorder in children.

1. Mental Disorder in Old Age

In the light of the preceding discussion, it will not surprise the reader that a recent survey of people above retiring age living at home in Newcastle-upon-Tyne, using fairly strict diagnostic criteria, found that no less than 40% had symptoms of mental disorder.¹ About 15% of the whole were judged to have mental impairment of moderate to severe degree; about 10% of the whole were diagnosed as having senile dementia, and half of these were rated as severely deteriorated. A survey in Swansea found rather lower rates; psychosis in 7% and neurosis in 5%; both together resulted in marked mental handicap in about 10%.²

From the Newcastle figures we would predict that in Salford, among 10,619 women and 5,526 men over the age of 65 years at the 1961 census, about 2,500 people are likely to be suffering from moderate to severe mental disorder.

¹ Kay, D.W.K., Beamish, P. and Roth, M., 1964. *Brit. J. Psychiat.* 110, 146-158.

² Parsons, K., 1965

800 will be suffering from severe senile dementia alone. Each year Salford psychiatric services actually deal with about 40 new cases of mental disorder among people aged over 60 years, or one new case to 250 people. This is an incidence rate and not directly comparable with the Newcastle prevalence rate. Making due allowance for this, it is clear that many cases will never receive psychiatric care, and among them will certainly be some of that excess of old people who commit suicide.

An examination of the population changes in Salford between the last two censuses makes the situation appear even more disturbing. Although the Salford population declined from 178,194 in 1951 to 155,090 in 1960, the decline affected age and sex groups unevenly. The numbers of men and women declined in number in the 20-49 age group, but old women actually increased in number. There was a 50% increase among women over 80, from 1,063 in 1951 to 1,603 in 1961. The aged now form a greater proportion of the adult population; those over 70 years of age formed 7.2% in 1951, 8.7% in 1961. Some of these changes are caused by the selective migration of young people, leaving a residuum of the old. They present a special problem for the affected local authorities which deserves the consideration of the central government in the matter of financing health and welfare services.

Despite these census changes, referrals to psychiatric agencies show no increase among the aged during the more recent period (1959-64) covered by our psychiatric register. On the assumption that the population trend of the 1951-61 decade has continued, this finding suggests that mental disorder in old age is a problem area less visible than many. In old age the failures in social function consequent on mental illness do not have the immediate repercussions that follow on the failures of breadwinners and mothers of families.

Even general practitioners are likely to be ignorant of the prevalence of mental disability among old people in their practices. In a recent study in Edinburgh which discovered symptoms in more than half of 200 old people, about two-thirds of patients with symptoms were not known to have them by their general practitioners.¹ the Swansea survey produced a similar result. On the local authority side, in the Stockport survey only 787 of the 2,500 people aged over eighty were known to health and welfare and other local services, and many of these who were not known had severe social problems.²

Although many forms of mental disorder in old age are progressive, some are reversible, and the deteriorative course of others is accelerated by social conditions. We need not doubt that well-directed effort will be repaid by the alleviation of suffering among old people and their relatives, and by the better health and the greater self-sufficiency of old people. There may indeed be an encouraging explanation for the lack of increased referrals among old people. More effective treatments, such as tranquillising drugs, may be damping down the disturbances of mental disorder in old people.

A priority is to expand the whole range of services for the increasing number of old people, in the certainty that they will be used as soon as available. We are unlikely to be able to provide too many homes, or hospital beds, or home helps, or places in day centres for recreation and occupation, or transports and escorts to take them there. Trained workers are not available

¹ Williamson, Stokoe et al, 1964.

² Lempert, 1958.

in sufficient numbers; prolific use of welfare assistants, under the direction of a few trained workers, might make an important contribution. The Salford Welfare department already mobilises considerable voluntary effort.

To ensure that we have an adequate measure of the situation, and that the problems are not allowed to remain invisible, a register of old people in need of care will be helpful. The efforts of the Welfare Department in this direction are not adequate to cope with the psychiatric problem; for this purpose welfare registration and services depend too much on the initiative of the old people themselves. A new socio-psychiatric register will need to be compiled. This will require the active co-operation of all caretaking agencies in the community (and of general practitioners in particular), with the object of identifying all in need or at risk by virtue of their circumstances.

Screening methods could be put into operation to detect those who can be helped. For instance, a number of general practitioners make routine visits to old people. Health visitors in Salford have experimented with visiting bereaved old people (selected from the spouses of those on the weekly death notifications), since we know that those recently bereft are especially at risk of mental illness. Retirement is another crisis through which men in particular may benefit from support (although universally the problems of dependency in old age are chiefly with women who are most often the survivors).

Screening methods lend themselves to collaboration between agencies. There will also have to be continuous development within them to provide for what is uncovered by each fresh investigation; screening should be a continuous investigation. This process exemplifies the development of the public health movement in nineteenth century Britain under the guiding hand of John Simon. None of the activities advocated here can be effective without the co-ordination of the many agencies involved. This calls for some such appointment as that of a geriatrician with a public health orientation, jointly between the hospital and health and welfare authorities.

2. Chronic Handicap

Persons disabled by mental disorder are to be found both in and out of hospital. The numbers living at home or on their own in the community may have been somewhat increased by recent efforts to empty the mental hospitals; this point cannot be decided since we have no good evidence as to numbers in the past. A register of mental patients living at home in Salford and disabled for more than a year has been compiled by mental welfare officers. The list of 105 patients (64 men and 41 women) cannot be regarded as complete especially among old people, as is obvious if the rate for persons over 60 is compared with predictions from the rates described above (Appendix XII). Nevertheless the register indicates a rate (for the adult population, 15 years and over) of at least 1.2 per 1,000 for men, 0.66 per 1,000 for women and 0.9 per 1,000 for both sexes. (The figures exclude mental subnormality, for which data can be found in our previous reports, especially for the years 1958, 1959 and 1960). The main complement, about one third, suffers from schizophrenia, a fair number are young men, and about one-quarter of the total are less than 40 years old.

To the sum of these patients disabled by mental disorder and living at home must be added a number at least three times as large of long-stay hospital patients. They remain in mental hospitals despite the national trend towards shorter admissions. 344 patients from Salford, 2.9 per 1,000 total adult population, have been in mental hospitals for more than three years. Of these 15% are less than 40 years old and 56% are less than 60 years old.

It appears on inspection of Appendix XII as if there had been a gradual shift from community into hospital with ageing, since the hospital patients are older than those in the community. But although such a process may operate it is complicated by other factors.

Our data indicate that the long-stay patients admitted before 1956 were younger at the time, and more often detained in hospital after a first admission, than patients admitted in more recent years. Thus the greater age of hospital patients may in part be a consequence of their retention in hospital from admissions at an earlier time. More recent long-term admissions from Salford have been postponed to later ages and probably to later stages of chronic mental illness, and they will almost certainly be fewer in the long run. All the same we cannot be sure, as yet, that the total recruitment of new chronic patients has much declined, although the numbers in hospital have somewhat diminished.

In recent years in Salford recruitment to hospitals has been somewhat less than losses; on 1. 1. 1959, 275 patients had been in hospital more than three years, and four years later this number had fallen to 250. Most of the losses were due to deaths, and one-third to discharges. From patients admitted during the three years 1956-1958, about 3% had become long-stay hospital patients after five years. One significant attribute of these hospital patients is their marital state. Of 19 patients under 60 years of age and in hospital for more than three years since 1956, one was married, two were widowed and sixteen were single. This may not only be a consequence of their illness, but also a measure of lack of available kin support which prevents them from leaving the mental hospital.

The total population of mentally disordered persons, by the definitions given above, is 449 persons (3.8 per 1,000 adults) of whom 276 (61%) are under the age of 60. An important point shown up by Appendix XII is the reversal of the sex ratio usual for hospital admissions in Salford and elsewhere in Britain. More women are admitted to mental hospitals, and considerably more are referred to the Salford mental health service, yet both in and out of hospital fewer are found to be suffering from chronic disablement. The rates for chronic disablement are considerably lower for women than for men among those under 60 years, although approximately the same for those above 60 years.

Further study is needed to determine why this should be. It could be a result of the type of mental disorder for which the two sexes suffer; men more often have schizophrenia which is of long duration, women depression which, on average, is much shorter. It could equally well be a result of differences in male and female social roles, which make the consequences of mental disorders visible in different degrees.

A first need for this large number of chronic patients is that public health should recognise their existence and act on the recognition. We have good evidence to suggest that many, especially those who have been in hospital for a long time, are not functioning for social reasons independent of their clinical state, and demonstrations have proved that by intensive effort a number can be rehabilitated.

It is time to set up intensive programmes in our ordinary service setting. For some years such work has been carried out with reasonable success, as our data show (Appendix XI; see also Appendix XI 1963, and previous years); indeed there has been a marked increment in this work with women and old people in day centres during the past year, but the bulk of the problem remains untouched. A much bigger and more intensive effort is needed. There must be a close collaboration of hospital and local authority, both at the level of administration and of service staff. Transport will be needed and premises, and much time from social workers and other staff.

This work of rehabilitation will not be successfully completed until staff at all levels have experience with chronic mental disability both in and out of hospital. Much has been done towards this end in the case of psychiatrists and social workers. We expect soon to formalise joint appointments for social workers and to have in Springfield Hospital a firm (under Dr. H. L. Freeman who has an appointment on the mental health service) which deals with all Salford patients. Integration will not be complete, however, until junior hospital psychiatrists, psychologists and nurses gain a wider view of the range of psychiatry by working in the community services. In this way we may hope also to serve the general need for workers trained in community psychiatry. An obstacle at present is the shortage of junior psychiatrists in the mental hospitals.

3. Psychiatric Problems of Childhood

The epidemiology of childhood mental problems is not well-developed. The few who have attempted to measure mental disturbance in children have found it difficult, and we are far from being able to assess the significance of many of the symptoms children display. The more seriously disturbed children who attend special clinics are known to produce an undue proportion of disturbed adults. But some widely used indices of emotional disorder have turned out to be extremely common, and transient as well. Thus "behaviour disorders" and a variety of symptoms have been reported in as many as 40% of children, and we remain uncertain of their importance in relation to the future development of the child.^{1, 2}

This ignorance, as long as it is allowed to persist, is a matter of concern to public health. Screening methods are to hand, and the school health service affords an excellent opportunity for discovering the extent of symptoms and their significance. In a very few areas the opportunity is being used.

Enough is known to allow certain rational measures to be taken. For instance, backwardness in children without detectable handicaps to learning is one indicator that a preventive mental health service can no longer ignore.

¹ Lapouse, R., and Monk M.A., *American Journal of Orthopsychiatry* 34, 436, 1964.

² Hare & Shaw, *op. cit.*

A high proportion of such children function under definable handicaps often related to the family, some of which are reparable.¹ Among junior and secondary school children, enuresis is another such indicator of an excess of family disorders.² Frequent school absences can be considered in the same way, and there can be little doubt that school welfare officers are called upon to deal—in summary fashion—with the manifestations in children of many complex family disorders.³ The repercussions on children of parental mental disorder is another area in which the preoccupation of mental health services with adults tends to limit follow-through. In consequence much childhood distress remains hidden and neglected.

From this short list it will be plain that one or two psychiatrists in the child guidance clinic could not cope with problems made visible on this scale. Public health services may not always be able to help in such problems, but so far even the attempt is hardly made. The object must be to diffuse a knowledge of social medicine, and the skill and training of child psychiatrists and of specialist social workers, through the many agents of the public health service, that is, through school doctors, health visitors, school welfare officers and perhaps teachers as well. This knowledge and skill could be the basis for devising both mass and individual methods of approaching these problems of child health. Diffusion alone will be insufficient. Child psychiatric services need to be fully integrated with the activities of doctors and health visitors in the school health service, and they need a degree of support from the social workers of the mental health service no less than that enjoyed by psychiatric services for adults. A major task of co-ordination lies before us if we are to achieve an effective service.

Moves have been made in this direction, and a mental welfare officer works together with a child psychiatrist for his sessions on the maternal and child welfare service. We can also feel proud of the degree of integration achieved with the paediatric services in the field of subnormality.

A fully co-ordinated service could lay the foundation for the work of prevention, and make 'mental health', as a description of our services, no longer a euphemism for mental illness. It could stimulate awareness and aid recognition of the psychiatric problems of childhood in the community without creating the impasse that no acceptable action could follow.

OPERATION OF SERVICES

SOCIAL WORK, REFERRAL AND DISPOSAL

Various measures of social work in the mental health service, going back to 1958, have pointed to improvements in quality of service. More visits are made to deal with each episode; less time is spent on getting about and presumably more time is spent with patients; more information is collected systematically; and more patients are followed up. The lesser rise in inceptions than in total episodes also indicates that more work is being done for each patient. There is rather less legal compulsion in hospital admissions, although less than the hoped-for decline.

Co-operation with both general practitioners and hospitals is smoother and more effective. The percentage of referrals from general practitioners has

¹ Stein Zena A., & Susser M.W., 1963, *American Journal of Mental Deficiency*, 811.

² Stein Zena A., Susser M.W. & Wilson A., 1965, *J. Child. Dev. Neur.* In the Press.

³ Jeffries, Margot, 1965, *An Anatomy of Social Services*, Michael Joseph.

declined, but this decline is only relative to referrals from other sources (particularly health visitors, and others in the health department) and the numbers are no less than before. (Appendix I).

The increased use of the mental health service by the health department is a welcome sign of improved co-operation. Relatives, too, made more direct referrals, particularly for female patients, and many of these were given support at home. All these trends suggest that patients may be being referred for a different kind of service; we have still to analyse the characteristics of these patient. (Appendix II).

Information is lacking on some important aspects of the work, and steps have been taken to remedy this. As from next year data for a job analysis will be available, and it will also be possible to determine how many cases social workers are dealing with at a selected point in time. Unfortunately we do not have any measures of the time spent in interviews, and this may have to be covered by a sample check.

A more effective use of the skills of social workers and better co-ordination is hoped for from the allocation of special areas of interest to each social worker. Each has been given responsibility for a day centre or hostel.

For a combination of reasons, the stable core of mental welfare officers of the previous 5 years has been broken up during 1964 by the departure of 4 out of 9. There has therefore been fresh emphasis on training for new workers under the guidance of Mr. G. Mountney, who has recently assumed the post of Senior Mental Welfare Officer. In addition the department has provided training posts for social workers from the 'Younghusband' Social Workers Course of the Manchester College of Commerce. It has also taken students for field work from the Social Administration course at Manchester University, and from the N.A.M.H. course for supervisors of training centres. In addition, teachers of the subnormal from the course in the Department of Education, Manchester University, use our day centres for the subnormal to do their practical work.

This department has been protected by the loyalty of its workers from disquieting competition that has been developed between local authorities who are seeking trained social workers. Moreover, Salford has been able to restore its depleted staff in part with graduates because of its repute among social workers (see for instance the television programme 'This Week' of September, 1964, which featured the Salford service). This is not the case for many other services of the industrial north, and may not continue for Salford. Some standardisation in salaries is essential if authorities who have been prepared to spend time and money on training are not to suffer at the hands of others who make no such expenditures, but who can afford to set high salary scales that tempt trained workers.

FACILITIES

Day Centres

There has been a modest improvement in facilities during the past year. Care for mentally subnormal children benefited from the extension of the wartime prefabricated nursery centre for subnormal children at Broughton;

this provided accommodation for children on a growing waiting list for special care. The acquisition at last of a special ambulance for the handicapped eased the transport problem and enabled the centre day to begin earlier.

An increase in day centre teaching staff has allowed a wider and more stimulating range of activities to be introduced. The appointment of a full time remedial teacher, to work in child and adult centres, will broaden the range still further.

There has been no progress, however, on the junior training centre, for which planning began in 1958. We hope for more rapid progress in the building of a new adult centre, for which planning began only in 1963.

In the field of mental illness, more space has been made available for day care at Cleveland House, and staff appointed to use it. The increase in intake and in default among mentally ill women shown in Appendix IX reflects the appointment of a part time occupational therapist, who has attempted to deal with younger women for whom there were previously no facilities. During the coming year a further extension will permit similar increased usage by men.

Social Clubs

The two social clubs continue satisfactorily, and the club for subnormal patients has been enlivened by the attendance of our younger staff in the day centres.

Hostels

Patients using our hostels have somewhat altered in their attributes since the previous year. This applies mainly to men; the picture for women has changed little. More men aged over 35 years and more patients suffering from psychosis and from medium grade subnormality are resident. Outcome, in terms of the nature of the event at discharge from the hostel, looks much better among men than previously; in 1964, 16 out of 21 were classed as satisfactory, in 1962/3, 33 out of 61. (Appendix XI A).

This apparent improvement, however, may reflect other changes which are not necessarily to the good. One factor is a deliberate shift towards taking patients with a prospect of only slow or even no rehabilitation so that hostel places should not remain unused. A second factor is that failures with the more difficult types of patients – particularly 'anti-social' and aggressive psychopaths – who often need help most, has inhibited experiments with such patients.

This is a pity. We have not succeeded in our aim (See Annual Report, 1960) of building small stable groups amongst patients and staff, and so creating the conditions for learning fresh codes of social behaviour. It is evident that our resources in skill and training, as at present deployed, are insufficient to break through the considerable difficulties of providing a satisfactory milieu for many of these difficult patients. If success with them in a group setting is possible, it is perhaps only to be attained by staff with high levels of skill and training.

These problems are not new; they have been discussed in previous reports (see Annual Reports for 1960 and 1963). We have therefore tried to develop alternative policies. One of these is boarding out. A small success can be recorded in making such arrangements in one household. So far our attempts to find other suitable places, (which can be subsidised) have not succeeded and more intensive effort is required.

A second policy which should also prove economical is to set up bed-sitter residential units with the minimum of caretaking and supervision. A serious difficulty in the attempt to retain 'anti-social' patients in hostel groups is that the available sanctions are shallow and soon exhausted, until only the ultimate sanction of expulsion or compulsory admission to hospital remains. This may be due to a lack of inventiveness on our part.

In setting up new projects to provide residence we shall have to guard against leaving in our existing hostels a residuum of docile patients who readily conform with the demands of the institution. We may then be in danger of merely replacing the traditional large institutions with small ones which differ only in the smaller numbers they cater for and in the smaller number of internal facilities they are able to provide. To prevent such regression will require vigilant criticism of our own assumptions; we must try and comprehend the institution, both staff and patients, as a social system. We have made one approach to such an evaluation by arranging for social workers to take up residence in the hostels for short periods at regular intervals.

REVIEW OF SERVICES FOR THE SUBNORMAL

by

Dr. T. Fryers

Both notification and discharge figures are high for 1964. This is the result of a revision in the filing and index system of the department, which incidentally brought to light a number of anomalies in classification, and omissions from the register notifications and discharges of previous years. Moreover the opportunity was taken of discharging some persons who had been registered over the past four years as subnormal soon after leaving school, but now appear to be working satisfactorily, no longer needing our care. The results of this filing review account for the large number of discharges in the 15-19 and 20-24 age group. (Appendix VII). It also accounts for the larger number referred from source given in Appendix VI A as 'other'. These cases were culled from the files, having been previously omitted or registered as mentally ill.

The 6 children under 9 years of age 'discharged' from care are those who, having been cared for in early years by the mental health department in the Special Care Unit, have later entered the ordinary school system in ESN. classes. This is one aspect of the problem of the under 5's discussed later. In this age group too, classification by grade, though based on I.Q. scores, must be considered always provisional.

8 subnormal persons migrated into Salford from other areas, and 24 migrated out. This last figure is boosted by some omissions from previous years, but indicates the considerable mobility in the city at the present time.

Pre-School Children

Dr. R. I. Mackay, in the Annual Report for 1963, described the diagnostic and assessment services for mentally subnormal children under school age. The team consisting of Consultant Paediatrician, Local Authority doctor specialising in the care of handicapped children, educational psychologist and social worker provides continuous supervision and support for child and family from the earliest age. But many handicapped children are still not receiving this much needed attention in the first years of life, when parents most need help and the children can receive the greatest benefit.

Although there was little increase in 1964 in the number of children under school age referred to the mental health section as mentally subnormal, there was a further encouraging shift within this age group towards earlier notification. (Appendix VI C). Despite this improvement, these figures for the mental health section still underestimate the number known to the services at these ages. There is no formal notification such as occurs with exclusion from school, and referral is therefore a more ambiguous process. These children represent only a small proportion of children of this age with all types of handicap known to the health department, and their selection is to some extent arbitrary. Moreover, some have been known to the health department for some time before being 'referred' to the mental health section, and the time at which this occurs is also somewhat arbitrary.

The problem centres upon the fact that in this age group and especially during the first year of life, classification and assessment of handicaps of all types is very difficult. Difficulties arise with the large number of children who suffer from multiple handicaps; about a quarter of children referred to the mental health section as severely subnormal also have physical disabilities. Any aspect of a child's personality, and therefore the effects of any handicap, is as much a matter of potential as of achievement. In the first five years of life, these children change a great deal. Assessment of I.Q. at this age is chiefly of short-term value as a measure of current ability and of limited validity as a measure of potential. Thus the group of children referred to the mental health service and that continuing under M. & C.W. care, overlap considerably. Passage in both directions between the two groups makes meaningful classification extremely difficult. Moreover the traditional classifications of mental subnormality at I.Q. levels or by grade, valuable for adults, is of much less value for the under 5's since they frequently cross the arbitrary boundaries.

It is true also that all young handicapped children and their families need much the same sort of services, whether the handicap is intellectual or physical or both. Children with different types of handicap may have identical needs; and their families have equal need of early and continuous support.

It would therefore appear essential, both in order to meet the needs of the children and the needs of record keeping and research, to keep the entire group of pre-school children under constant review, co-ordinating the services and directing them according to particular needs, and maintaining a continuous record of each child's handicap and development. Handicaps can be categorised by five major areas of function, namely motor, sensory,

intellectual, emotional and social. It should be possible to plot the changing degree of handicap in each of these areas for each child over a period of years. It is hoped to develop along these lines during the coming year.

The data thereby accumulated should be of the utmost value in the future.

Hospital Admissions

The pattern of hospital admissions continues to change in the direction of freedom and informality. Few subnormal persons are admitted formally; most of these are the adolescents discussed below, and the distinction between 'long term' and 'short term' admissions has become less clear. Generally 'short term' admission is specifically temporary, for a holiday period or time of crisis: the hospital merely provides accommodation and care. 'Long term' admissions generally have a definite therapeutic intention, although they are still sometimes custodial or possibly even punitive. Admissions may be permanent for those for whom there is no alternative home. Apart from those few, 'long term' admission is now akin to any ordinary hospital admission, and the period spent in hospital depends upon progress and the possibilities for satisfactory placement in the community. For this reason some so called 'long term' admissions are for shorter periods than some 'short term' admissions and our terminology has been left behind. This increased freedom of movement between community and hospital is probably the reason why hospital admissions in the last two years have greatly increased. In 1964, 11 persons were admitted and 14 discharged, which continues the increase of the past few years in the two-way flow.

There is therefore developing with the services for the subnormal the relationship between hospital and community which is found in other fields of medicine. The community is the normative environment for subnormal persons as for us all, and the hospital is becoming free to concentrate upon developing specific therapeutic facilities for those who need them.

As this relationship becomes clearer and separate functions better defined, classifications and terminology once useful become out-dated. Many old usages assume long term hospitalisation as the normative experience of subnormal persons, as indeed has it often been. In Salford this is not now generally true; the normative experience may include hospital admissions, but is primarily one of working through the problems of the subnormal intelligence within the local community, with the object of achieving an effective adjustment to community life and fuller participation in it. It is to serve this end that our services for the subnormal are planned.

An example of the break-down of the old terminology is the use of 'on trial' status, which like 'short term' and 'long term' is becoming superfluous. Two groups of people are received into the community from hospital 'on trial'. First are those usually middle aged or elderly persons who have spent many years in the institution and who wish to live in the community. 'On trial' status for those who seem to us likely to benefit from a move to one of our hostels is to some extent a security, for it guarantees their return to the all embracing care of the hospital if hostel life should prove too much for them. As long as hospital and local authority staff co-operate, this arrangement can be quite informal.

The second group represents one of our biggest problems. It comprises adolescents, of intelligence on the 'border line' of normal, who have emotional and inter-personal difficulties, and who are usually labelled psychopaths because of the trouble they cause. For some of these patients, repeated and prolonged hospital admission is still used as a custodial or punitive measure, and their 'on trial' status is maintained as a threat to control their behaviour in the community. Where hospital re-admission is simple and relationships between local authority and hospital are good, as in Salford, this formal status is unnecessary. It may be that the continued threat prevents the development of co-operative attitudes and of responsible adjustment to community life.

The need remains for concentrated effort to help this group of young people. They use a considerable proportion of services, not geared to their particular needs. There is no doubt that they should be given special attention both in the community and in hospitals. In some parts of the country adolescent units have already been established, and much experimentation and research is required to discover what will best suit their needs. As the hospital and community services develop together, we may hope that they will be extensive and flexible enough to serve the vast variety of individual need, variety which exists even within the restricted field of mental subnormality.

***DAY AND RESIDENTIAL CARE FOR SEVERELY SUBNORMAL CHILDREN**

PROPOSITIONS AND HYPOTHESES

by

M. W. Susser with the assistance of T. Fryers and A. G. M. Wiseman

The falling death rate during the past two centuries has improved the life chances of successively less hardy categories of the general population. The improvement affected first young adults and adolescents, then young children, then infants; after some lag the process has reached the subnormal population, including the most handicapped among them. In our annual report for 1963 we demonstrated the marked increases in age-specific prevalence rates of registered severe subnormality in the age-groups under 10. (Some of the increase, however, and certainly that in the youngest age-group, was the result of improved registration).

Table 1 reflects the recognised need for care for the severely subnormal in Salford, a city of 150,000 people, during the period 1959-63. The table shows the distribution of grouped clinical conditions and relates these to the degree of physical handicap as judged from case records. One quarter, 25%, of the children notified as severely subnormal had severe physical handicaps; this includes the 15% who were almost totally incapacitated in that they required as much care as any infant.

The phenomenon of population increase among the severely subnormal confronts us with the question of future arrangements for their care. In the past half century, the mental deficiency hospital has been the chief institution to which we have turned once the family could no longer cope with the care of the severely subnormal child. Up to the time of admission the family might

* From a paper given to a Conference of the Spastics Society in Manchester in February, 1965.

have had varying degrees of support from the family doctor, the paediatrician, the health visitor, and the social worker from the local authority mental health service. We need to consider how well this system of care has met the problems of care for the severely subnormal including those with physical handicap.

At the community level we have some useful data in Dr. Joyce Leeson's study in the Department of Social and Preventive Medicine, Manchester University, for the Manchester Regional Hospital Board.¹ She examined the waiting lists for the mental deficiency hospitals in the region. Her results showed that these hospitals could not cope with the demand for places, especially in certain categories. The longest waiting time was experienced by patients in the lowest grade of subnormality; in this category, those in hospital and on the waiting list had waited an average of 2 years and 9 months. Children aged 5-9 years formed the largest single age-group on the waiting list. 37% of all those waiting were in need of so-called "cot and chair" accommodation; that is, they were bedfast or too young to be admitted to a ward containing mobile children. The search for factors which could explain the large variations in demand for hospital places between local areas in the region turned up only one significant result; this was that the demand for places was inversely related to the provision of day centres by the local authority. This result is significant for the planner of services in more than a statistical sense, and some of its implications should emerge in what follows; it shows that the size of the hospital task can be reduced.

Failure of the hospitals to meet the demand for care does not arise from lack of ward space but from lack of nursing staff; wards are closed for lack of nurses. This lack of staff is acute, and we would like to suggest that in most cases it is not merely a reflection of the chronic shortage of nurses common to all our hospitals. The shortage is exacerbated by the decreasing number of medium and high-grade subnormal patients in the hospitals, who are therefore no longer available to assist with nursing. Day centres for the care of subnormal patients within local communities have not had difficulties in finding sufficient numbers of staff, and probably the shortage of staff must be attributed in part to the alienation of the traditional hospitals for the mentally subnormal.

Alienation means a separation from society and a lack of the goals shared with society; in a time of full employment, alienated institutions hold few attractions as places of employment. The isolated sites of many hospitals for the subnormal, although often in the countryside in pleasant surroundings, contribute to their alienation. But perhaps a more important factor is their caretaking and custodial, and sometimes punitive, duty in relation to one of the rejected elements of our society. During the past several centuries the state has been obliged to participate increasingly in the care of permanently dependent individuals. Yet our culture has constantly emphasised the contradictory value of individual responsibility. On this ground, dependent people who could not fulfil their social obligations have invited rejection by cultures which value 'rugged individualism' and material success.

In principle, the caretaking and custodial functions of hospitals for the subnormal are no different from those of mental hospitals of the recent past. Recently mental hospitals have come to emphasise treatment more than custody, and some have overcome the forces of alienation and have achieved

¹ Leeson, J., 1964. *British Medical Journal*.

integration with the community they serve. In the case of hospitals for the mentally subnormal, efforts to achieve integration with surrounding communities may less easily overcome alienating forces. There are barriers to change which to some extent negate the reduced emphasis on custody as an explicit function of hospitals for the subnormal.

Mental hospitals are connected with the surrounding community by the movement of patients into the hospital and out of it. Such movement is in itself important to work inside the hospital. It provides the basis for the ideology of therapeutic optimism that is traditional (and probably essential) to medicine; to fulfil his ideal role a doctor must believe he can cure. This ideology derives from the curative goals, and more recently from the rehabilitative goals, of medicine. To preserve a particular goal we need to be sustained by rewards, and in the case of the practice of medicine among the most important rewards are good results from treatment. At the least we need to see movement or change from which good results can be inferred. The care of the severely handicapped patient in a hospital ward which encompasses his whole life in all its roles and for its full duration can hardly be other than caretaking and custodial. Among patients cared for in these circumstances good results can rarely be seen or demonstrated.

In the U.S.A. Dr. Rose Laub Coser¹ has made an illuminating sociological study which bears on this question. She contrasted the ideology of nurses and their performance of nursing roles in 2 hospital units sharing the same grounds. One was a large hospital unit with 650 patients classed as incapable of improvement. The second was a smaller hospital unit with 100 beds; this unit was devoted to rehabilitation, although many of the patients had disorders no less irreversible than those in the large hospital unit.

The nurses on the 'caretaking' unit described a good ward as one which was clean, neat and quiet; those in the rehabilitation unit described a good ward as one in which the patients were active and lively.

The complaints of the nurses on the 'caretaking' unit were about conditions and the nature of particular tasks, and they showed little concern with their functions in relation to patients; the complaints of the nurses on the rehabilitation unit were about relationships which frustrated effective patient care, and they were very much concerned with their work with patients.

Nurses on the caretaking unit had infrequent interactions with patients and these cast the patient in a passive role (indeed the smaller the staff/patient ratio, the less they interacted with patients and the more among themselves, in a quiet social way). The interaction of nurses on the rehabilitation unit was frequent with patients and intensive with staff. Similar patterns could be discerned among doctors as well as among nurses, particularly in their interaction with patients.

In summary, the staff of the caretaking unit regarded work as the routine accomplishment of a series of tasks. These tasks had the quality of ritual, in that they were quite divorced from the personal goals of the staff, and were performed chiefly because they were prescribed. The staff of the rehabilitation unit identified themselves with the work of their unit, incorporated its goals as personal ones, and strove to effect them.

¹ Coser, Rose Laub, 1963, in "The Hospital in Modern Society" ed. Freidson, E. The Free Press

This picture of the caretaking unit may be familiar to those who have visited large institutions which care for severely subnormal patients with severe physical handicaps. Four or five nurses among eighty or more child patients are likely to be engaged in a ceaseless 24 hour round of routines:—feeding and changing patients, getting them into chairs in the morning and getting them back into bed in the evening. By contrast, several of the features of the rehabilitation unit can be recognised in some day centres which care for children who are equally handicapped. We have an example in Salford. The unit is small and the staff/patient ratio high, say 1–5. The staff is orientated towards keeping the children active, seeking means of stimulating them and trying all the time to find some means of communication.

Those familiar with the film of the Brooklands experiment may recall contrasting elements between the two settings shown in the film that are very similar to those described in this paper. The settings are the large Fountains hospital for the severely subnormal (well known for its progressive policies) and the small Brooklands Home for children drawn from the Fountains hospital.

These contrasts are not the result merely of differences in skill, knowledge and ability available to hospital and day centre. Their source is to be found rather in the situation of the two types of institution in relation to the local community, in their functions, in the ideology that permeates their various levels, and in the structure of social relationships within them. Within the few day-care units of which we have knowledge, the central goals of the policy makers seem to be shared by the staff in the centres. This commitment, it can be suggested, is maintained by three main forces.

First is the nature and definition of the goals themselves. In day-centres these include care-taking, but they are educational and therapeutic at the same time. Possible conflict between these goals is resolved by giving priority to education and therapy over simple 'care'. In a previous report (Annual Report, 1962) Dr. Albert Kushlick has described the difficulties which can arise in day centres for the subnormal in trying to bring about commitment to shared goals at all staff levels. In the main these were difficulties attached to change, for a re-orientation was being attempted. Our experience shows that such problems can be overcome. Units which set up educational goals from the first are less likely to meet such problems.

Hospitals for the mentally subnormal face more formidable difficulties in achieving an educational orientation. The functions of these hospitals are multiple, as with day centres, and their avowed goals may include education and therapy as well as 'care'. In most, however, caretaking is likely to be given priority over education and therapy. The addition of a custodial and even a punitive element to the caretaking function diminishes still further the place of education and therapy.

Present arrangements for placing high-grade mentally subnormal persons in hospital ensure that caretaking functions are overlaid by custodial functions. A majority of such placements are made in the hope that the hospital will contain 'antisocial' and delinquent behaviour. In these circumstances it is a difficult task to pursue therapeutic goals equally with custodial goals.

The relationships of authority between staff and patients in hospitals for mental subnormality tend to reflect the clear-cut legal and custodial goals

conferred on hospitals by the laws of the past. Therapeutic goals are better favoured by voluntary relationships.¹ Asseverations by policy-makers do not modify the formal structure of authority, still less its informal structure. In day centres the structure of authority and social relations between patients and staff can be expected to be more flexible and less persistent, and they are more subject to external pressure.

A second force in day centres which probably helps to maintain commitment to educational and therapeutic goals is continuous exchange with parents. Parents learn from staff, and staff from parents about the progress and problems of the child. Staff become aware of the contributions they can sometimes make to the child's maintenance and even to its integration within its family.

There is another facet to this staff/family interaction. The staff cannot be isolated from the influence of the surrounding community, as in hospital they can be. Pressure can be brought to bear directly through councillors and through "consumer" associations of parents, and can have an important influence on relations between patients and staff in the centre.

The explicit role of the child in relation to the staff is that of a dependent recipient of care. At the same time, he has roles in relation to his family and to the surrounding community which in the day centre remain latent. But although latent, they are given implicit recognition because the centre staff must include family and community in its frame of reference. In institutions like hospitals for the subnormal which encompass the whole life and all the effective roles of the child, the family and community frame of reference hardly exist; passive dependence is the natural and complete role of the patient.

The third element which appears to promote the commitment of day centre staff to educational and therapeutic goals is that they have a sense of continuing development in the children. This source is enhanced by the movement of children through the centre, which however slow is clearly perceptible.

Appendix VIII contrasts the transits through our special care unit for severe subnormal and physically dependent children in Salford with that through the hospitals serving the community. The variety of cases, in type and grade, is much greater in the special care unit than in the hospital, and so too is the variety of possible outcomes. The special care unit in Salford is a section of a day training centre for subnormal children; it caters for those children who are so grossly retarded in mental and physical development that they require the level of care and assistance accorded to infants. Their incapacity is in some cases a result of the severity of their physical and intellectual handicaps, in some a result of emotional disorders, and in others it is in part a result of the early ages at which they are assessed and placed.

Of 66 children admitted between 1959 and 1963, 27 had moved into other groups as they qualified for higher educational levels through development. 18 were removed for a miscellany of reasons — 5 into hospital and 6 by death. Only about one-third (21 of the 66) remained. Of the 17 children admitted to hospital during the same period, 3 had died and 14 remained to be cared for in hospital.

¹c.f. Zald, M.A., 1962 *Administrative Science Quarterly* p. 22.

The virtues which we have discovered in local facilities for day care were not achieved by design. Day centres were set up to meet the problems caused by the failure of hospitals to satisfy the demand for care. In summary, their advantages flow from the maintenance of educational and therapeutic goals at all levels. These goals are favoured by mobility of patients through the centre, and by close connections with the community, and in turn these circumstances determine the type of social relations and activities within the centre.

To make local day care possible, the subnormal child must remain in his family or in some other local home. Two conditions for the support of families seem necessary if the arrangements are to be effective. First, day care must be provided for all severely subnormal children in the local community, whatever the severity of handicap, together with the assurance that should another form of care be needed in the future, all efforts will be made to provide it. Second, co-ordinated medical and social casework should follow immediately on the recognition of the possibility of severe subnormality. In Salford this has been achieved by giving the paediatrician (Dr. Robert Mackay) access to patients and their families in the Maternity and Child Welfare Service and in the Mental Health Service as well as in the hospital.

The degree of co-ordination can be measured by the continuing decrease in the age of children notified to the Mental Health Service (see Appendix VIC). Notification brings into play the resources of the mental health service; these include social work, day care and medical, psychological and educational consultation.

One can only briefly pursue here the argument that local care benefits both family and child. Hospitals for the subnormal, day centres and families are all engaged in the common task of socialising the children in their care. In this task no institution can compete with the staff/patient ratio of the normal family, nor with its commitment to the goal of preparing the child for roles in the community. Of course not all families are competent socialising agents, and some may be more damaging than even unsatisfactory institutions. For such exceptions among families and for subnormal children without families, we should try and devise alternatives which retain those features important to successful day centres and to the best types of residential care.

To do this, research will be needed to discover what these features are, and to confirm or deny hypotheses and propositions of the kind set out here.

TABLE 1
Severely Subnormal Children notified before the age of 10 years to
Salford Mental Health Department 1959-63
by Sex, Diagnosis and Degree of Physical Handicap

DIAGNOSIS	BOYS					GIRLS					BOTH SEXES				
	DEGREE OF PHYSICAL HANDICAP					DEGREE OF PHYSICAL HANDICAP					DEGREE OF PHYSICAL HANDICAP				
	None	Mild	Marked	Complete	TOTAL	None	Mild	Marked	Complete	TOTAL	None	Mild	Marked	Complete	TOTAL
Mongol	13	—	—	—	13	13	—	—	—	13	26	—	—	—	26
Brain Disorder	1	1	3	5	10	2	3	3	7	15	3	4	6	12	25
Metabolic Disorder	2	—	—	—	2	1	—	—	—	1	3	—	—	—	3
Primary Emotional Disorder	6	—	—	—	6	4	2	—	—	6	10	2	—	—	12
Diagnosis not known	10	—	—	1	11	5	1	—	—	6	15	1	—	1	17
TOTAL	32	1	3	6	42	25	6	3	7	41	57	7	6	13	83

This table reflects the recognised need for care. It does not accurately represent incidence because children have not been included if they died before notification, or if they were within the relevant age group but were notified before 1959.

SPEECH THERAPY REPORT

by

J. Marshall

During the past year 3 sessions per week have been held, one at the Crescent Training Centre, one at Wilmur Avenue Special Care Centre, and from September, one at Seedley Junior Training Centre. These three centres present different problems, and for convenience it is proposed to deal with each one separately.

1. Wilmur Avenue Special Care Centre

During the year most of the children in this centre have been seen, either individually, or observed in the group situation, in order to decide which children were most in need of Speech Therapy. Here it may be pointed out that the Speech Therapist has an important role to play diagnostically at Wilmur Avenue, as well as therapeutically, for many of the children who attend are still being extensively investigated. Six children were selected for treatment, and were seen regularly at some period during the year.

Table 1 is a breakdown of the handicaps of these six children. It will be seen that five of these children are brain damaged and are therefore those least likely to make progress with their speech through the process of normal maturation as they have all been "blocked" to a greater or lesser degree. It was necessary first to teach the children to concentrate by the use of carefully selected sense training toys, picture matching apparatus and simple picture books, eventually leading to the introduction of simple Speech Therapy exercises, e.g. babbling, making speech sounds in front of a mirror and blowing games (rainbow bubbles). All six children appear to have made some response to treatment. A further nine children have been seen intermittently to determine whether they could be helped by Speech Therapy. It is most essential that a child should have reached a stage of "speech readiness" before treatment is attempted.

In order to give some help to the other children in the centre who, due to lack of time, could not be seen even intermittently, a good deal of general speech guidance work has been carried out as follows:—

- (a) Discussions with staff members, and giving of advice on the handling of speech problems.
- (b) The introduction of blowing toys to encourage the conscious enjoyment of sound production.
- (c) Encouragement to use a greater variety of simple pictures and picture books for the stimulation of language and the building up of vocabulary.

The use of free play is an excellent stimulus to the development of speech and language for subnormal children, but it does not appear to be sufficient for the severely withdrawn and autistic children who need extra personal attention, if possible apart from the other children for a short period each day,

so that they may be helped to form the real mother-child relationship which this type of child so desperately needs.

The main problem facing the Speech Therapist is one of obtaining effective help from the parents in handling the speech difficulties of their children; some of these parents have not co-operated actively because they have not comprehended the objects of therapy, or because of emotional problems, while others have little time to devote to a particular child in a large family. Only two of the six children seen regularly have received constructive help with their speech in the home.

2. The Crescent Training Centre

During the year all the trainees in this centre have been seen individually in order to assess their speech, and some audiometer testing was also carried out. Six trainees were selected for treatment and were seen regularly. Table 2 is a breakdown of the handicaps of these trainees.

Three of the six trainees appear to have made a response to treatment, one exceptionally so.

The major obstacle to carrying out more successful Speech Therapy in this centre is that many of the trainees have no one suitable who can help them with speech practice. This is particularly so in the case of the older trainees. In two cases it was possible to enlist the co-operation of the evening class teachers, thus effecting an improvement in speech. The working purpose of the centre prohibits the trainees from receiving any regular constructive help with speech from the centre staff. However, the future possibility of a remedial teacher being employed at the centre could improve this situation.

From the experience gained during this year's work at the Crescent Training Centre, the role of the Speech Therapist appears less effective here than at the other centres.

3. Seedley Junior Training Centre

Commencing in September this centre has received weekly visits, and each child has been seen individually prior to making a selection for treatment. Regular treatment here will commence in the near future.

Conclusion

Questions have been raised about the value of speech therapy among subnormal children. Our experience has been sufficiently encouraging to warrant embarking on a controlled trial of this treatment, despite the many difficulties in selection that can be expected to arise.

TABLE I
Progress of Subnormal Children given Speech Therapy

Sex	Age at beginning of treatment	I.Q.	Number of Sessions treated	Speech Handicap	Special Handicaps	Progress
Female	9 years	23	30	Motor Aphasia	Brain Damage (Phenyl-ketouria)	(1) Marked decrease in frustration. (2) Increased babbling. (3) Increased use of speech sounds and occasional words for communication.
Female	5 years	Reserved	10	Undeveloped Speech	Athetosis Hearing Defect Emotional Withdrawal	(1) Decreased withdrawal. (2) Increased babbling. (3) Increased use of speech sounds for communication.
Male	7 years	20.3	22	Poorly Developed Speech - Dysarthria	Spastic Quadriplegia	(1) Marked increase in powers of concentration. (2) Marked improvement in development of speech and language.
Female	6 years	45	10	Poorly Developed Speech	Emotional Withdrawal	(1) Marked improvement in establishing relationships. (2) Marked improvement in development of speech and language.
Female	6 years	18	7	No speech	Autism	(1) Real attempts made to establish a relationship. (2) A good beginning made in babbling and imitation of speech sounds..
Female	9 years	Reserved	8	Undeveloped Speech	Athetosis Hearing Defect Emotional Withdrawal	(1) Decreased Withdrawal. (2) Increased use of speech sounds and occasional words for communication.

TABLE 2
Progress of Subnormal Adults given Speech Therapy

Sex	Age at beginning of treatment	I.Q.	Number of Sessions treated	Speech Handicap	Special Handicaps	Progress
Female	50 years	59	9	Stammer	Emotional Disturbance	Slight initial response to direct treatment.
Female	26 years	67	21	Multiple Dyslalia	Hearing Defect	(1) Improvement shown in her powers of sound discrimination. (2) Increased intelligibility, but not sustained.
Male	29 years	50	36	Motor Aphasia	Spastic Diplegia Emotional Withdrawal	(1) Very marked improvement in his powers of expression and in his intelligibility. (2) Very slow decrease in withdrawal.
Female	26 years	52	15	Hyper-Nasality	Hearing Defect Emotional Withdrawal	(1) Decreased withdrawal. (2) Improvement shown in lip reading ability.
Female	52 years	39	24	Dysphasia	—	Slight initial response to direct treatment. Not sustained.
Male	16 years	41	9	Dysphasia and Stammer	—	Poor response to direct treatment.

**A COMPARISON OF YOUNG SEVERELY SUBNORMAL CHILDREN AND CHILDREN
OF SIMILAR MENTAL AGE***

Ilse Hulme, *One-time remedial teacher, Salford Child Guidance and Mental Health Department.*

The impetus to undertake this research was derived partly from the forward looking trends in the Salford Mental Health Department, and partly from my own curiosity which was largely derived from the film "The Brooklands Experiment". This film showed that severely subnormal children can benefit from being treated like normal children with corresponding mental ages. At the same time I had seen training centres and hospitals which had adhered to regimentation rooted in a strong belief that these children were incapable of spontaneous acceptable interaction and activities.

My comparison of 18 normal and 18 severely subnormal children was based on mental age. The subnormal group comprised all the mobile and reasonably well adjusted children attending the Special Care Unit and a Junior Training Centre in Salford. 10 of these were mongols. The matched controls attended a local Day Nursery. Children included were expected to have a mental age of about 2 years and in the case of the subnormals only those with a chronological age of less than 12 were selected. The two groups compared as follows:

	Severely Subnormal	Normal
Boys	11	10
Girls	7	8
	18	18
C.A.: Range	3;5 - 11;5	1;11 - 4;7
Mean	7;5	3;4
M.A.: Range	1;9 - 6;0	1;9 - 5;5
Mean	3;3	3;5
I.Q.: Range	25 - 60	81 - 117
Mean	45	99

There was no significant difference in the mental ages of the two groups and a comparison on this basis seemed justified. Spontaneous play, language and instances of reasoning were observed and compared.

Play

Children were observed in free play situations under similar conditions. Observations were recorded by a diary method and were then divided into phases of play. Each of these (there were more than 1,200) was evaluated on a 9 point scale, with regard to two intellectual aspects of play behaviour: adaptiveness in the use of materials and integration of behaviour. (Ref. Lunzer, E.A. Educational Review, 11, 1959).

*The research was carried out in Salford with the help of the Salford Health Department and with the financial support of a Susan Isaac Memorial Fellowship. This is a brief report taken from the author's M.Ed. thesis accepted by the University of Manchester.

Results

1. There were no significant differences in the level of play of the two groups.
2. There was no difference in the levels of play with specifically creative materials.
3. Within the subnormal group mongols were not inferior to others.

From a qualitative standpoint, I noted that the dramatic group play was less well developed within our severely subnormal group than in the nursery group. This may have been due to the limitations which were imposed on the children prior to this investigation, the limited choice of playmates of required ages and altogether to the under-representation of the mental age group 4-5 in our severely subnormal sample. More observations of these aspects of play are indicated.

Language

The comparison of language skills was carried out with the help of a picture interview, using 10 attractive colourful pictures of common objects and scenes. The children were asked "Tell me all about this" and later on, when they were talking freely, merely "Now tell me about this." Where children said very little they could be encouraged by saying "Tell me more" or even more hopeful questions like "What do we do with it?". The unaided verbalisation, i.e. the first spontaneous response was evaluated separately from the ones given only after further verbal help. Two aspects of the response were considered:

- (a) length of utterance, and
- (b) quality of the language used.

Length of utterance was determined by a word count, which at first accepted all words whether intelligible or not. Later the number of unintelligible words was noted separately.

Results

The normal group was significantly superior in the number of words they used.

Quality of language was evaluated on a 4-point scale as follows:

1. Naming, not more than two words.
2. Compound naming; more than 2 words and stating relationships.
3. Description at some length and any comment containing a verb.
4. Any association.

Any conversation the child indulged in during the interview was recorded but not evaluated.

Again the normal children gained significantly higher scores. In the responses of the subnormals the following deficiencies were noted: lack of exploration of language by making fanciful and illogical statements, lack of enjoyment of language (as compared with the response of a nursery child who said, "This is a big fat funny bus, a big fat funny bus that's."), and a dearth of associations together with the absence of attempts at story telling. All these were present in the responses of the nursery children. Mongols were not inferior to the other subnormal children.

It was noted that the subnormal groups responded well to further questions based on the pictures and improved their scores in both the number of words they used and in the level of responses. Although this still left a highly significant difference between the two groups, the subnormal group had benefitted from the additional questions more than the nursery children who appeared to give their best spontaneously. However they had also had more previous contact with the writer so that these suggested differences are only tentatively stated and need verification by examining larger numbers under more rigidly controlled conditions.

Another important contrast was found when the quality of language in the severely subnormal children noted during free play was compared with their interview results. They had used language much more imaginatively during play. The records contained attempts at story telling, play on sounds and words, and spontaneous remarks full of vitality. As the language used during play sessions could only be recorded intermittently because of the noise and mobility of play, it was not possible to make a statistical comparison of the language during play and in the interview. But the available records give a very strong indication of this difference.

Instances of Reasoning

The available space will not allow me to describe the instances of reasoning in detail. There were two separate investigations, one exploring Piaget's stages of imitating linear and circular arrangements which can be presented by beads and the other requiring the exact imitation of small block structures built up from bricks in different sizes in 4 colours. Some of these had to be done from memory. Although these two investigations were planned to gauge the same area of ability in the children, the results contradict this. In the Piaget type experiment the severely subnormal children did as well as the normal children with the same mental age. In the reproduction of the block models they did not and were especially weak in reproducing models from memory. They were also less able to correct wrong structures when the model was brought back into view.

It seems reasonable to suggest that language would help in the solution of tasks committed to memory and there were indications in the nursery group that they used imagination in the solution of these problems. I would conclude that if play helps children to extend their range of experiences and stimulates them to use spontaneous and imaginative language, this might help them in situations requiring reasoning.

APPENDIX I
MENTAL ILLNESS

Sources of Referral to Salford Mental Health Service (Percentage of Total Notifications)

Agency	Males		Females		TOTAL				
	1964		1964		1960	1961	1962	1963	1964
General Practice	39		47		52	51	53	54	44
Health/Welfare/Voluntary Organisations	9		10		6	8	3	5	9
Police/N.S.P.C.C.	7		2		6	5	3	4	4
Hospital Psychiatrist.	13		15		10	12	16	12	14
General Hospital.	5		4		5	6	3	4	4
Relatives.	22		18		11	11	16	13	19
Other	5		4		11	8	5	8	5
Total Number	240		417		587	555	589	593	657

APPENDIX IIB

All Notifications of Male Patients Referred for Mental Illness to Salford Mental Health Service in 1964
by Source of Referral and Disposal (Percentages)

Disposal	SOURCE OF REFERRAL							
	G.P.	Health/ Welfare/ Voluntary Organisation	Police/ N.S.P.C.C.	Hospital Psychiatrist	General Hospital	Relatives	Other	Total Number
Compulsory Admission	27	10	56	16	58	15	8	57
Voluntary Admission	24	27	19	16	17	21	15	52
Psychiatric O.P. or Domiciliary Visit	16	10	6	3	—	6	—	22
Home Support (and G.P.)	27	45	19	55	25	46	54	89
Other	6	10	—	10	—	12	23	20
Total Number	94	22	16	31	12	52	13	240
Percentage of Total Referrals of Male Patients	39	9	7	13	5	22	5	—

APPENDIX III

Disposal of All Patients Referred to Mental Health Service 1960 - 1964*

Agency	1960	1961	1962	1963	1964
Compulsory Admission	114	94	53	105	98
Voluntary Admission	123	119	111	101	116
Out-Patient, Domiciliary Home and G.P. Other	29 146 86	53 144 60	86 157 60	61 157 84	61 218 39
	48%	45%	35%	41%	40%
52%		55%	65%	59%	60%
TOTAL	498	470	467	508	532

* Disposal at first notification in calendar year.

APPENDIX IV

Distribution between Psychiatric Agencies of Inceptions and Episodes of Mental Sickness in Salford (1959 - 1961) and (1962 - 1964)

	1959 - 1961	1962 - 1964	% Difference
<u>INCEPTIONS</u>			
<u>Mental Hospital</u>	300	259	- 14
<u>General Hospital</u>			
Admissions	25	64	+ 156
Out-patients	551	549	- 1
TOTAL	576	613	+ 6
<u>Total Admissions</u>	325	323	- 1
Mental Health Service only	259	331	+ 28
TOTAL	1,135	1,203	+ 6
<u>EPISODES</u>			
<u>Mental Hospital</u>	883	905	+ 2
<u>General Hospital</u>			
Admissions	35	124	+ 254
Out-Patients	774	927	+ 20
TOTAL	809	1,051	+ 30
<u>Total Admissions</u>	908	1,029	+ 13
Mental Health Service only	705	890	+ 26
TOTAL	2,397	2,846	+ 19

APPENDIX V
The Case Load* of the Mental Welfare Officer

	1959	1960	1961	1962	1963	1964
A. Mental Illness						
Number of new patients referred	233	239	255	260	298	301
Number of known patients referred	197	259	215	207	210	231
Total patients referred	430	498	470	467	508	532
Second and subsequent referrals during calendar year	73	89	85	122	85	125
Total referrals	503	587	555	589	593	657
Mental Subnormality						
Number of new patients referred	41	38	26	29	32	60
Total New Patients Referred:						
Mental Illness and Mental Subnormality	274	277	281	289	330	361
B. Total number of visits†	8,560	7,427	6,752	7,849	9,992	9,579
Number of officers (units time per annum)	6	5.6	5.06‡	6.63‡	9.03‡	9.13‡
Average number of visits per officer	1,427	1,326	1,334	1,184	1,106	1,049
C. Average number of new patients referred per officer	46	49	56	44	36	40
Average number of known patients referred per officer	33	46	42	31	23	25
Average number of referrals per officer	91	112	114	93	69	79
D. Average number of visits per new patient referred	31	27	24	27	30	26
^x Average number of visits per total referrals	16	12	11	13	16	13

*Excludes cases resident outside Salford (24 in 1964)

†Includes office interviews, visits to hospitals, etc.

‡Excludes trainees and Senior Officer who since 1961 has not undertaken casework

^xThis average is inflated because it includes visits to known subnormal patients who are not included in referrals

APPENDIX VI
New Notifications of Mentally Subnormal Persons, 1964. By Sex, Grade and Age

GRADE*	MALES										FEMALES										Total Males and Females		
	AGE										Total	AGE										Total	
	AGE											AGE											
	0-4	5-9	10-14	15-19	20-29	30-39	40-49	50+	0-4	5-9		10-14	15-19	20-29	30-39	40-49	50+						
Low	3	-	-	1	-	-	-	-	4	3	-	-	-	-	-	-	3	7					
Medium	4	1	1	5	-	-	-	-	11	3	3	2	2	1	-	1	12	23					
High	2	-	-	5	-	-	-	6	14	2	-	3	3	-	1	1	10	24					
Undetermined	4	-	-	-	-	-	-	-	4	2	-	-	-	-	-	-	2	6					
TOTALS	13	1	1	11	-	-	-	6	33	10	3	5	5	1	1	2	27	60					

*Low = I.Q. < 20. Medium = I.Q. 20-49. High = I.Q. 50 +

APPENDIX VIA
New Notifications of Mentally Subnormal Persons, 1964. By Age and Source of Referral

Source of Referral	AGE							Total
	0-4	5-9	10-14	15-19	20-29	30-39	40-49	50+
Maternity and Child Welfare	22	-	-	-	-	-	-	-
Director of Education	-	4	5	6	-	-	-	-
General Hospital	-	-	-	-	1	-	1	-
Immigration	1	-	1	3	-	-	3	-
Others*	-	-	-	7	-	1	4	1
TOTAL	23	4	6	16	1	1	8	1
								60

* Including 7 cases wrongly classified in previous years and allocated to mental subnormality in 1965.

APPENDIX VIB

New Notifications of All Mentally Subnormal Persons 1959 – 1964

Age Groups :– 0 – 4 years and 15 – 19 years

Age	0 – 4 years		15 – 19 years		Total Notifications at all ages
Year	Number	Percentage of total Notifications	Number	Percentage of total Notifications	
1959	13	32%	12	29%	41
1960	7	18%	19	50%	38
1961	11	42%	3	12%	26
1962	17	59%	4	14%	29
1963	21	68%	3	10%	31
1964	23	39%	16	27%	60

APPENDIX VIC

New Notifications during 1963 and 1964 of Mentally Subnormal Persons
under Five years of age

AGE	0 –	1 –	2 –	3 –	4 –	0 – 4
1963	1	1	9	8	2	21
1964	3	6	8	4	2	23

APPENDIX VII

Alterations in Status of Mentally Subnormal Persons on the Salford Register during 1964 by Age and Sex

	MALES									FEMALES									Total Males and Females		
	AGE									Total	AGE									Total	
	0-4	5-9	10-14	15-19	20-29	30-39	40-49	50+	0-4		5-9	10-14	15-19	20-29	30-39	40-49	50+				
Discharged from care	1	2	1	7	1	-	-	-	12	2	1	1	4	-	-	-	9	21			
Migration	2	2	-	1	3	2	1	-	11	2	2	-	4	-	4	1	13	24			
Death	2	-	1	2	1	-	-	-	6	1	-	-	-	-	-	1	2	8			
Not located	1	-	-	1	1	-	-	-	3	-	-	-	1	-	-	-	1	4			
Discharge from Institutions	-	-	-	-	4	1	2	4	11	-	-	1	2	-	-	-	3	14			
Admitted to Institutions (Long-Term)	-	-	-	3	2	-	-	-	5	-	2	1	2	-	1	-	6	11			
Temporarily admitted to Institutions	1	-	-	-	2	1	-	-	4	-	1	-	-	-	1	-	2	6			

3 severely subnormal girls under 16 and 1 boy under 16 of undetermined grade, were on the urgent waiting list for hospital admission, 31. 12. 64.
 3 severely subnormal women, age-group 50-59 remain on formal guardianship.

APPENDIX VIII

SEVERELY SUBNORMAL CHILDREN IN SALFORD

(a) Transit through a Special Care Unit

Admitted 1959-1964

Diagnosis	DESTINATION							TOTAL
	Special School*	Hospital	Family left area	With-drawn from Centre	Deaths	Day Centre for Subnormal	Still in Special Care Unit	
Mongolism	—	—	1	—	—	7	2	10
Brain Disorder	1	5	2	2	5	4	13	32
Metabolic Disorder	2	—	—	—	—	—	1	3
Emotional Disorder	4	—	—	—	1	2	3	10
Diagnosis Obscure	1	—	1	—	1	6	3	12
TOTAL	8	5	4	2	7	19	22	67

* E.S.N., Physically Handicapped, Deaf, etc.

(b) Transit through Mental Deficiency Hospital

Severely Subnormal Children under 20 years admitted to
Institutions for the Subnormal 1949-63

	Admissions	Deaths by end of 5 year period	Discharges by end of 5 year period	Still in hospital at end of 5 year period
1949-53	10	1	—	9
1954-58	11	1	—	10
1959-63	17	3	—	14

APPENDIX IX

Adult Day Centres - Register, Admissions and Discharges for 1962-64.

	MEN			WOMEN			ALL		
	Mentally Subnormal	Mentally Ill	Total	Mentally Subnormal	Mentally Ill	Total	Mentally Subnormal	Mentally Ill	Total
Number on registers 31. 12. 1962	50	13	63	48	24	72	98	37	135
Number on registers 31. 12. 1963	44	21	65	45	25	70	89	46	135
Number on registers 31. 12. 1964	57	15	72	34	43	77	91	58	149
Average daily attendance 1962									98
Average daily attendance 1963									109
Average daily attendance 1964									113
Number of admissions 1962	24	20	44	19	22	41	43	42	85
Number of admissions 1963	30	27	57	12	22	34	42	49	91
Number of admissions 1964	35	22	57	32	69	101	67	91	158
Discharges 1962	20	23	43	11	24	35	31	47	78
Discharges 1963	36	19	55	15	21	36	51	40	91
Discharges 1964	22	28	50	40	54	94	62	82	144
Discharges 1964	6	11	17	9	2	11	15	13	28
Work	-	-	-	-	6	6	-	6	6
Household Duties	-	2	2	1	3	4	1	5	6
Migrated	10	2	12	12	-	12	22	2	24
Transferred to other centres	3	7	10	14	39	53	17	46	63
Defaulted	1	2	3	-	-	-	1	2	3
Rehabilitation Unit	-	-	-	1	-	1	1	-	1
Died	-	1	1	1	-	1	1	1	2
Sick	-	3	5	2	4	6	4	7	11
Hospital	2								

APPENDIX X

Trainees entering employment from Adult Training Centres in 1964

	Age	I.Q.	Period Unemployed	Centre Attendance	Centre Attended	Type of Employment	Result
Mentally Ill Males	45		Several years	1 year	Broad Street	Labourer	Employed 5 months, returned to centre
	64		Several years	Several years	Broad Street	Night Watchman	2 weeks engagement only
	50		7 months	7 months	Acton Square	Labourer	Held for 3 months
	34		Several years	1 year	Acton Square	Cleaner	Stable
	23		Sporadic jobs	3 weeks	Acton Square	Labourer	Employment retained short period only
	45		5 months	5 months	Acton Square	Packer-Mail Order Store	Held for 2 months then new job
	36		15 months	3 months	Acton Square	Semi-skilled - Wire Works	Employed for 3 months
	56		Many years				
			hospitalised	3 weeks	Acton Square	Porter	1 week only then returned to centre
	28		8 months	1 day	Acton Square	Machine Bender	Stable
Females	50		3 months	2 weeks	Acton Square	Car Cleaning	Stable
	62		4 months	3 weeks	Out Workers	Not known	Unknown
			9 months	9 months	Cleveland House	Not known	Unknown
	17		18 months	14 months	Cleveland House	Not known	Unknown
Subnormal Males	20	69	Sporadic jobs	1 year	Broad Street	Labourer - Rubber Works	Stable
	18	68	Not worked before	6½ months	Crescent Centre	Labourer	Short period only
	56	62	Many years	1 week	Acton Square	Gardener - Parks Dept..	Stable
			hospitalised	17 months	Acton Square	Clothing Factory	Stable
	23	50	Not worked before	2 weeks	Acton Square	Cleaner	Worked 2 weeks, returned to centre
	45	82	Many years	1 year	Out Workers	Kitchen Porter	Stable
	44	70	Never worked before	9 months	Crescent Centre	Unknown	Unknown
	19	56	Never worked before	2 months	Crescent Centre	Boxmaking	Stable
	18	75	Never worked before	3 months	Crescent Centre	Food Factory	3 days only
	43	28	Never worked before	Several years	Crescent Centre	Food Factory	3 days only
Females	49	86	Never worked before	Several years	Crescent Centre	Food Factory	3 days only
	42	43	Never worked before	Several years	Crescent Centre	Food Factory	3 days only
	34	41	Never worked before	Several years	Crescent Centre	Food Factory	3 days only
	48	72	Several years	Several years	Crescent Centre	Hospital Maid	Stable
	17	52	6 months	4 months	Crescent Centre	Kitchen maid	Stable
	49	86	4 months	4 months	Crescent Centre	Domestic Work	Stable

APPENDIX XIA

HOSTELS: Residence, Admissions, Discharges 1962-64

	MEN			WOMEN			ALL		
	1962	1963	1964	1962	1963	1964	1962	1963	1964
ADMISSIONS									
One admission only	27	19	27	20	20	27	47	39	54
More than one admission	6	1	1	7	5	6	13	6	7
Reasons for Admission									
No Home	2	8	3	13	18	7	15	26	10
Lack of economic resources	3	2	3	-	2	-	3	4	3
Half-Way House from Hospital	15	10	15	4	4	10	19	14	25
Need for Protected Environment	11	6	2	3	7	4	14	13	6
Short-Term Care	4	6	6	3	4	8	7	10	14
Domestic Tension	5	3	-	9	6	12	14	9	12
Leave from Hospital	1	-	1	1	1	6	2	1	7
En route to Hospital	-	-	-	-	-	-	-	-	-
Diagnosis									
Psychosis	14	12	12	10	7	15	24	19	27
High Grade Subnormality	7	7	3	6	9	15	13	16	18
Medium Grade Subnormality	8	8	14	11	14	10	19	22	24
Neurosis	3	2	-	7	7	-	10	9	-
Psychopath	5	5	1	2	2	1	7	7	2
Not Determined	-	1	-	1	3	6	1	4	6
Age Groups									
15 -	13	13	8	10	14	13	23	27	21
25 -	9	5	2	8	3	9	17	8	11
35 -	9	10	11	10	12	14	19	22	25
45 -	6	4	8	8	8	8	14	12	16
55 -	-	3	7	1	5	6	1	8	13
65 +	-	-	-	-	-	-	-	-	-
Number Obtained Employment after Admission	8	5	10	4	8	13	12	13	23

APPENDIX XIA (continued)
HOSTELS: Residence, Admissions, Discharges 1962-64

	MEN			WOMEN			ALL		
	1962	1963	1964	1962	1963	1964	1962	1963	1964
DISCHARGES									
One discharge only	18	25	18	19	21	24	37	46	42
More than one discharge	7	1	1	3	6	11	10	7	12
Duration of Stay									
<1 month	18	9	10	16	19	28	34	28	38
1 month -	8	8	6	4	6	8	12	14	14
3 months -	5	2	2	3	3	5	8	5	7
6 months -	2	3	1	1	2	-	3	5	1
9 months -	-	1	1	-	-	1	-	1	2
12 months -	-	5	1	1	4	7	1	9	8
Outcome									
Satisfactory	18	16	16	19	27	37	37	43	53
Left by agreement	7	1	-	5	2	4	12	3	4
Placement (Home, Lodging, Foster-Care)	6	9	9	10	16	22	16	25	31
Return home after short-term care	4	6	6	3	5	7	7	11	13
Following leave from hospital	1	-	1	1	2	4	2	2	5
En route to hospital	-	-	-	-	2	-	-	2	-
Unsatisfactory	15	12	5	6	7	12	21	19	17
Deterioration & admission to hospital	4	6	2	3	4	3	7	10	5
Delinquency and Court Action	3	-	-	-	-	-	3	-	-
Left without consultation	8	5	3	3	3	8	11	8	11
Expelled	-	1	-	-	-	1	-	1	1

APPENDIX XIB

Patients in Residence in Hostels, by Age and Sex

	MEN	15 -	25 -	35 -	45 +	ALL
At 31.12.63		2	-	3	4	9
At 31.12.64		2	-	6	10	18
WOMEN						
At 31.12.63		5	3	4	6	18
At 31.12.64		2	3	4	7	16
TOTAL						
At 31.12.63		7	3	7	10	27
At 31.12.64		4	3	10	17	34

Patients in Residence in Hostels, by Diagnosis and Sex

	MEN	Psychosis	High Grade Sub-Normal	Medium Grade Sub-Normal	Neurosis	Psychopath	Not Determined	Total
At 31.12.63		4	1	3	-	1	-	9
At 31.12.64		7	2	8	-	1	-	18
WOMEN								
At 31.12.63		4	5	5	2	2	-	18
At 31.12.64		6	3	6	1	-	-	16
ALL								
At 31.12.63		8	6	8	2	3	-	27
At 31.12.64		13	5	14	1	1	-	34

APPENDIX XIC

Patients in Residence in Hostels, by Duration of Stay

	Less than 1 month	1 month	3 months	6 months	9 months	12 months	Median
At 31.12.63	4	2	1	4	1	15	12 months
At 31.12.64	4	11	5	4	1	9	3 months

Patients in Residence in Hostels, by Employment

	MEN		WOMEN		ALL	
	Working	Unemployed	Working	Unemployed	Working	Unemployed
At 31.12.63	1	8	6	12	7	20
At 31.12.64	5	13	4	12	9	25

APPENDIX XII

Known Patients Chronically Disabled by Mental Illness in Salford

Numbers and Rates/1,000 * by Age and Sex

AGE	Living at Home			In Hospital			All		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
20 -	18 (.9)	7 (.4)	25 (.6)	36 (1.8)	16 (.8)	52 (1.3)	54 (2.7)	23 (1.2)	77 (2.0)
40 -	32 (1.6)	21 (1)	53 (1.8)	76 (3.7)	70 (3.2)	146 (3.5)	108 (5.3)	91 (4.2)	199 (4.7)
60 -	7 (.8)	5 (.3)	12 (1.9)	48 (5.2)	90 (5.8)	138 (5.6)	55 (6)	95 (6.1)	150 (6.1)
Uncertain Age	7	8	15	3	5	8	10	13	23
TOTAL	64 (1.3)	41 (.7)	105 (.1)	153 (3.1)	181 (3.2)	344 (3.2)	227 (4.6)	222 (3.9)	449 (4.2)

* Rates/1,000 in brackets

Patients Living at Home by Diagnosis

Diagnosis	Male	Female	All
Schizophrenia	19	14	33
Affective Psychosis	4	5	9
Psychoneurosis	9	7	16
Psychopathy and Personality Disorder	10	1	11
Other and Not Determined	22	14	36
ALL	64	41	105

APPENDIX XIII
Mental Health Department – Staff

	31.12.1964	Resigned 1964	Appointed 1964	31.12.1964
MEDICAL				
Senior Assistant Medical Officer (Part-time)	1	—	—	1
Assistant Medical Officers (Part-time)	2	—	—	2
CONSULTANTS				
Psychiatrist (one session per week)	1	—	—	1
Paediatrician (one session per week)	1	—	—	1
EDUCATIONAL				
Psychologists (sessional work)	4	—	—	4
Remedial Teachers	2	1	1	2
SOCIAL WORKERS				
Senior Mental Welfare Officer	1	1	1	1
Social Work Supervisor	1	1	—	—
Psychiatric Social Worker	1	—	—	1
Mental Welfare Officers	8	4	3	7
	(inc. 1 part-time)			(inc. 1 part-time)
ADMINISTRATION				
Chief Clerk	—	—	1	1
Administrative Assistant	1	—	—	1
Shorthand Typists	2	—	—	2
Clerk	1	1	1	1
TRAINING CENTRES				
Supervisors	4	—	—	4
Assistant Supervisors	14	2	8	20
			(inc. 2 temp.)	(inc. 2 temp.)
Centre Assistant	—	—	—	1
Psychotherapist (part-time)	—	—	1	1
RESIDENTIAL HOSTELS				
Wardens	2	—	—	2
Assistant Wardens	3	1	2	4

IMMUNISATION SECTION

2,750 children in the age group 0-15 years completed a course of immunisation during the year, and when compared with the number of 2,650 children immunised during 1963, an increase of 100 is observed.

Below are the statistics relating to the year's work:—

	0-5 years	5-15 years	0-15 years
Number immunised during the year ended 31st December, 1964	2,604	146	2,750
Total completed immunisation at 31st December, 1964	9,966	20,465	30,431
Population figures, 1964	14,100	22,400	36,500
Percentage immunised at 31st December, 1964	70.60%	91.36%	83.37%

The children were immunised as follows:—

At Child Welfare Centres	1,786
By Public Health Nursing Staff in the homes of the children	604
By Nursing Staff at schools	146
By General Practitioners	207
At Day Nurseries	3
At Greenbank Nursery	4
	2,750

Of the 2,750 children completing immunisation, 2,604 received diphtheria pertussis and tetanus (triple antigen) injections, 145 received diphtheria and tetanus injections, and one received diphtheria immunisation only.

2,044 booster doses of diphtheria and tetanus were given to school children during 1964, and 1,091 children aged 0-5 were given a booster dose of triple antigen twelve months after the completion of primary immunisation—this shows an increase when compared with last year's totals of 1,718 booster doses given to school children and 999 booster doses given to children 0-5 years of age.

Whooping Cough Immunisation

2,604 children received whooping cough immunisation during the year; all these children were given triple antigen injections.

Poliomyelitis Vaccination

The following figures show the number of children who have completed a course of oral poliomyelitis vaccination during the year.

	3rd dose	4th dose
Children 0 – 5 years (1960 – 64)	3,301	263
Children 5 – 15 years (1950 – 59)	679	1,730
Young People (age group 1933 – 1949)	64	2
Older people up to 40 years of age	18	—

The figures below show the total number of polio vaccinations given at 31st December, 1964:—

	Completed Salk & Oral Vaccination		Fourth Salk & Oral Vaccination	
Children 0 – 5 years (1960 – 64)	8,759	63%	298	
Children 5 – 15 years (1950 – 59)	20,401	88%	10,565	46%
Children 0 – 15 years (1950 – 64)	29,160	79%	10,863	29%
Young Persons (1933 – 49)	21,751	51%	1,466	
Older people to 40 years of age	7,631	18%		

B.C.G. Vaccination

Below are statistics relating to Mantoux tests and B.C.G. vaccinations, given to 13 year old children and students attending further education establishments:—

	Consents	Positive	Negative	D.N.A.	B.C.G. Vaccination
Boys	632	40	470	122	470
Girls	723	56	528	139	528
Total	1,355	96	998	261	998
Students	11	4	4	3	4

Smallpox Vaccination

The statistics relating to smallpox vaccination during 1964 are as follows:—

Age at date of vaccination in the year	Under 1 year	1 year	2 – 4 years	5 – 14 years	15 years	Total
Primary Vaccinations	124	457	95	13	16	705
Re-Vaccinations	1	4	5	3	71	84

It will be seen from the above statistics that there have been increases in the number of children completing triple antigen immunisation, oral polio vaccination, and booster doses of diphtheria and tetanus immunisation during the year. It is hoped to maintain these increases in the following year and efforts will be made to this effect by the nursing and clerical staff.

It was noted that 200 more children completed immunisation at the child welfare centres than the previous year, and the number of district immunisations fell by 20.

INFECTIOUS DISEASES

The following table shows the numbers of infectious diseases notified during the year:—

Disease	All ages	Under 1 year	1—5 years	5—15 years	15—25 years	25—45 years	45—65 years	65 years and over
Scarlet Fever	15	—	9	6	—	—	—	—
Whooping Cough	93	13	62	18	—	—	—	—
Measles	1,094	67	764	250	13	—	—	—
Dysentery	37	5	22	7	2	1	—	—
Pneumonia	8	—	1	3	—	—	1	3
Erysipelas	7	—	—	—	—	1	5	1
Food Poisoning	9	1	1	—	—	3	4	—
Ophthalmia								
Neonatorum	4	4	—	—	—	—	—	—
Puerperal Pyrexia	36	—	—	—	18	18	—	—
Rheumatism	4	—	—	4	—	—	—	—
Tuberculosis (Respiratory)	51	—	—	2	5	19	21	4
Tuberculosis (Others)	1	—	—	1	—	—	—	—
	1,359	90	859	291	38	42	31	8

There is very little difference from the returns of recent years. As usual, the great majority of the notifications were in respect of measles. At the beginning of the year the disease seemed to be absent from the City, but cases began to occur in February and the outbreak reached a peak in the months of June and July which is an uncommon time for an epidemic of measles to occur. Cases continued to be reported until the end of the year.

Notifications of scarlet fever have been greatly reduced in recent years. Five years ago 62 cases were notified, and it was common to have two or three hundred cases each year until about ten years ago.

A further reduction in the notifications of tuberculosis is to be welcomed. The figure is about half what it was five years ago and a quarter of the total ten years ago.

In view of recent publicity it is worth pointing out that no cases of typhoid or paratyphoid occurred and the notifications of food poisoning remained low. This does not mean of course that measures to improve the hygiene of our food can in any way be relaxed.

Diphtheria and poliomyelitis were also absent from the City during the year—for the fifth year in succession in the case of diphtheria and for the second year in the case of poliomyelitis.

AMBULANCE SERVICE

The following table gives particulars of patients carried and mileage run during 1964, as compared with the previous year:—

Class of Patient	1964		1963	
	Patients	Miles	Patients	Miles
Spastic	4,119	5,282	4,802	6,419
Midwifery	2,231	10,050	2,526	11,215
House Conveyance	67,623	166,602	63,191	162,554
Inter-hospital	2,975	12,777	2,752	13,103
Maternity	1,574	10,060	1,649	10,445
Gas/Air	451	1,557	414	1,545
Mental Health	16,212	23,226	6,790	16,276
Rechargeable	298	3,102	289	3,006
Emergency	4,772	19,946	4,510	19,188
Miscellaneous	—	3,287	—	3,708
Infectious	23	198	151	1,012
Handicapped Persons	2,482	1,863	2,603	1,981
TOTALS	102,760	257,950	89,677	250,452

During the year, the ambulances carried 91,579 patients and travelled 210,088 miles, and sitting-case cars carried 11,181 patients and travelled 47,862 miles.

At the end of the year there were in operation 11 ambulances, 4 sitting-case ambulances, and 2 sitting-case cars.

The staff consisted of an Ambulance Officer, a Deputy Ambulance Officer, a Station Officer, three Shift Leaders, one female Radio-telephone Operator, one General Duties man, and 42 Driver/Attendants.

Replacement vehicles during the year were one 14-seater sitting ambulance, one additional four-stretcher ambulance, and a sitting-case ambulance, fitted with special equipment and rear loading platform of the hydraulic type. This vehicle can carry 14 patients or 8 patients and 5 wheel-chairs.

An important event during the year was the fact that the new purpose built ambulance station at Charles Street came into operation on 3rd March, and it was officially opened by His Worship the Mayor, (Alderman W. Petrie) on 20th April.

HEALTH EDUCATION

In its twin objects of preventing illness and promoting full health, Health Education took practical form in the organisation of the annual "Health Check-Up", formerly called the "Health Survey"; the name was changed to encourage the public to feel a more personal interest in it and to avoid its being considered merely an impersonal statistical survey.

A further change from previous years was in the X-ray tests by the Regional Hospital Board's Mass Radiography Unit being conducted concurrently, but in a separate building some distance from the hall where the general tests were carried out. In order to reach a wider area of the population the X-ray unit remained on one site for three weeks, then after a month in another area returned to a completely different site. Altogether 6,217 people attended the Radiography Unit.

The tests for the detection of diabetes, blood pressure, anaemia, etc., carried out by nursing staff, was attended by 3,451 people. The results of the tests were sent to each patient's own doctor.

A focal point of popular interest was the "Orthorator" vision testing machine, under the supervision of a Salford optician, which was installed primarily for the benefit of drivers.

There were three principal tests:—

- (1) Distant Vision — right eye,
- (2) Distant Vision — left eye,
- (3) Stereoscopic Vision Test.

Out of the 1,457 people who were tested, very few failed on the vertical and horizontal heterophoria tests, and the colour vision results were disregarded. Taking the test as a whole, however, only 64 (44%) passed, while 813 (56%) failed.

Out of the 813 people who failed, a further 340 would have passed had they not taken the Stereoscopic vision test, and 984 (67.5%) would then have passed.

Those who attended the Health Check-Up were given the opportunity to give information and express opinions in a questionnaire. Exactly 1,000 people (618 male and 382 female) completed these forms.

Some of the information obtained is detailed below:—

Question	Male (Affirmative replies)	Female
Whether treated by doctor in last 12 months?	54.8%	65%
Do you smoke?	58.9%	47.4%
Do you believe smoking causes lung cancer?	47.4%	41.1%
	(21.7 did'nt know	(19.1 did'nt know

Question	Male (Affirmative replies)		Female (Affirmative replies)
Should the public be told more about cancer?	85%		86%
*Method of Sex Education: Parent	55%		60.7%
Doctor	32%		20.7%
Teacher	28%		20.4%
Books	20%		26.7%

- * N.B. A considerable number felt that a combination of two or more of the methods was advisable.

Though there was a considerable variety of opinions about the age at which sex education should start, easily the most popular age was 12, with 10 as second most favoured age.

There was also a section of the questionnaire devoted to chiropody. The results of this are detailed in the Chiropody Section.

Smoking

Attendance at the Anti-Smoking Clinic, which was held throughout the year, fluctuated considerably. In January, immediately following the publishing of the Report of the Surgeon General of the United States, over 120 came to the clinic. The enthusiasm was short-lived, and attendance dropped by degrees to about 12, rising again to about 35 towards the end of the year. Excluding the 120 who came as a result of the American Report, 144 different people attended, during the year, of whom 60 came only once. Of the remaining 84 who came on several occasions, 44 stopped smoking completely; 30 cut down to less than 50% of their original amount; and 10 did not succeed at all. Of these 10, five had serious worries which had an adverse effect on their efforts to stop smoking.

Home Safety

Home accidents treated at Salford Royal Hospital during 1964

	Male		Female		Total	
	Fatal	Non-fatal	Fatal	Non-fatal	Fatal	Non-fatal
Burns and Scalds	3	238	—	203	3	441
Falls	—	690	8	925	8	1,615
Lacerations	—	449	3	377	3	826
Poisoning	—	84	—	54	—	138
Overdose	4	63	7	179	11	242
Dog and Cat Bites	—	69	—	66	—	135
Assault	—	10	—	40	—	50
Gas Poisoning	1	9	2	9	3	18
Swallowed foreign bodies	—	133	—	99	—	232
Miscellaneous	2	2,172	2	1,703	4	3,875
TOTAL	10	3,917	22	3,655	32	7,572

This represents an increase of 6¼% over 1963—an indication of the prevalent lack of awareness of the seriousness of accidents at home.

SALFORD HOUSE

During 1964 the number of residents decreased slightly in comparison with the previous year. The average number of residents was 280 per night and it is interesting to note that of the new admissions to Salford House over 75% are old aged pensioners.

The old aged pensioners who make up 70% of the hostel population, and others of younger age groups who are in some way social problems, in the main settle down in a large sympathetic group. Many of the new admissions are men from local hospitals, prison and probation hostels, the mental health department, etc. and their early behaviour in residence in most cases suggests that they will fit in and settle down happily to a reasonable rehabilitation.

The Health Visitor and Mental Welfare Officer are regular callers at Salford House and co-operated with local hospital officers and the management in recommending a number of residents for admission to various convalescent centres.

The hostel was visited by several parties of students from hospitals, welfare organisations and the local college, who wished to see the inside workings of a municipal hostel.

A very successful Christmas Party was held for 150 old aged and disabled residents. An excellent Dinner was provided with free beer, free cigarettes, and each man received a gift. Most of the gifts were provided by the Companionship Circle for the Elderly, and the Manchester Dental Hospital Social Workers.

The social club which is now well established, provides many advantages lacking in other hostels. The snack bar supplies a wide variety of meals at cheap prices, T.V. (which is a boon to the older residents), billiards, darts, and many other indoor games. The club which is run by a residents committee, is of immense benefit to the residents. It helps 'regulars' and those who stay only a few nights to develop friendly relations, and also helps to remove the problems facing a stranger in strange surroundings.