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SURREY COUNTY COUNCIL

1971
County Health Services

Annual Report of the County Medical Officer

SURREY COUNTY COUNCIL

With the Compliments

of the

County Medical Officer

County Health Department,
County Hall,
Kingston upon Thames
KT1 2DP

Telephone
01-546 1050

SURREY COUNTY COUNCIL

Annual Reports

of the

COUNTY MEDICAL OFFICER OF HEALTH

AND

PRINCIPAL SCHOOL MEDICAL OFFICER

For the Year 1971

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PREFACE

Mr. Chairman, My Lord, Ladies and Gentlemen,

I have the honour to present my annual report for 1971, prepared in accordance with the Department of Health and Social Security Circular No.1/71.

It is customary in the preface to the annual report of a medical officer of health to review the work of the department and to draw particular attention to major events which have taken place or developments in services which have been introduced in the year.

The establishment of the Social Services department of the County Council, which necessitated the transfer away from the old Health and Welfare department of a substantial proportion of its duties and responsibilities was the event which would have been expected to dominate all others, but it is astonishing to record that the staff remaining with the health department weathered the change with hardly a break in stride in continuing their duties of giving service to the people living in the county. This fact in no way diminishes the importance of the change but is rather a tribute to their resilience and the work which had been done in preparation for this change.

For many the personal relationships between field staff which have developed over the years survived any administrative changes and ensured the continuing co-operation which is so necessary if the patients – or 'clients' to use the social service term – are to receive the care and help which is their right. Nevertheless as staff change and each department develops its own and separate policies it is absolutely vital that adequate arrangements are made to ensure ready co-operation not only between the health and social services staff at the operational level but also at committee level.

The impending reorganisation of the health services away from local government makes the need for this co-operation even more important, a fact which has been recognised by the Department of Health and Social Security which has set up – amongst other groups – a special working party to study collaboration between the health and social services. The report of this group is awaited with much interest.

Within the body of the report there is much of interest and I do not wish to draw particular attention to any one item but rather to commend it to the reader in its entirety. There have been no revolutionary changes during the year, but a steady development of established policies coupled with the introduction of such services and changes as are necessary to meet changing needs.

At a time when radical change is being considered on all sides within the public service, it needs to be remembered that in the caring services, particularly for those who are most vulnerable and have little public voice, continuity of service is possibly one of the fundamental requirements and we must not lose sight of this in our eagerness for change.

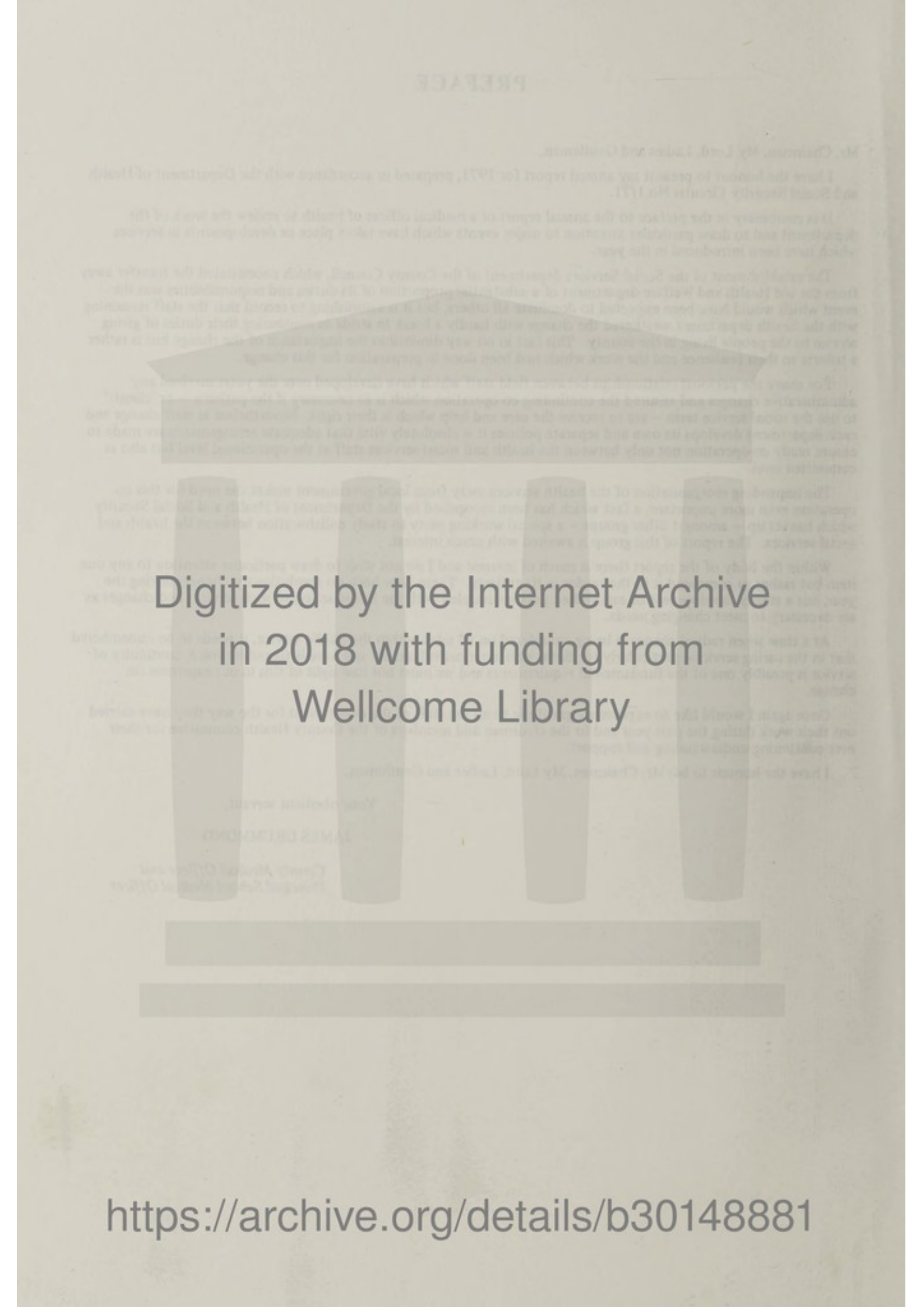
Once again I would like to express my gratitude to all the staff of the department for the way they have carried out their work during the past year and to the chairman and members of the County Health committee for their ever continuing understanding and support.

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

Your obedient servant,

JAMES DRUMMOND

County Medical Officer and
Principal School Medical Officer



CHAPTER ONE - STATISTICS

GENERAL STATISTICS AND SOCIAL CONDITIONS – ADMINISTRATIVE COUNTY OF SURREY

Area

There were no boundary adjustments during the year and the total area of the Administrative County remained as before, 418,299 acres.

Rateable Value

On 1st April 1971	£58,839,120
Product of a penny rate	£ 584,907

Population

1971 mid-year Registrar General's estimate:

Urban Areas	Rural Areas	Administrative County
808,260	202,970	1,011,230

Table 1 shows the population of each sanitary district at the censuses of 1951 and 1961 and the Registrar General's mid-year estimates for 1970 and 1971.

VITAL STATISTICS

	Administrative County of Surrey			England and Wales
	Males	Females	Total	
Live births	7,019	6,718	13,737	
Live birth rate per 1,000 estimated population			13.6	16.0
Adjusted birth rate per 1,000 estimated population			13.7	16.0
Live and still births	7,094	6,796	13,890	
Still births	75	78	153	
Still birth rate per 1,000 live and still births			11.0	12.0
Illegitimate births	440	402	842	
Illegitimate births per cent of total live births			6.0	8.0
Deaths (all ages)	5,122	5,679	10,801	
Deaths per 1,000 home population (crude)			10.7	11.6
Adjusted death rate per 1,000 home population			9.8	11.6
Infant deaths	111	96	207	
Infant mortality rate				
per 1000 live births			15.0	18.0
per 1000 legitimate live births			15.0	17.0
per 1000 illegitimate live births			17.0	24.0
Neonatal mortality rate (first 4 weeks) per 1000 live births			10.0	12.0
Early neonatal mortality rate (first week) per 1000 live births			8.0	10.0
Peri-natal mortality rate (stillbirths and deaths under 1 week) per 1000 live and still births			19.0	22.0
*Maternal deaths (including abortion)		6	6	
*Maternal mortality rate per 1000 total births			0.43	

*figures for 1970 (1971 not yet available).

BIRTHS AND BIRTH RATE

Live births occurring in the County during the year numbered 13,737 and the birth rate was 13.6 per 1,000 of the population, as compared with the figure of 16.0 per 1,000 for England and Wales. Thus the rate remains steady and consistently below that for the country as a whole.

153 still births occurred during 1971, giving a still birth rate of 11.0 per 1,000 live and still births, compared with the lowest figure previously recorded of 10.0 per 1,000 in 1969 and that of 12.0 per 1,000 in 1970.

There were 826 illegitimate births, representing 6% of live births, an increase of 55 over the previous year.

Table 2 shows the live and still birth rate and the percentage of illegitimate births over the past ten years.

CAUSES OF DEATH

The major causes of death in the County during 1971 were as follows, in order of frequency:–

1.	Diseases of the heart	3,407
2.	Malignant disease (including 66 deaths from leukaemia)	2,348
3.	Bronchitis, pneumonia and other diseases of the respiratory system (including 10 deaths from influenza and 23 from tuberculosis)	1,555
4.	Cerebrovascular disease	1,262
5.	Other circulatory diseases	602
6.	Violent deaths (including 99 suicides and 152 deaths from motor accidents)	398
7.	Digestive diseases	211
8.	Hypertensive diseases	145
9.	Diseases of the nervous system, (including 25 deaths from multiple sclerosis and 5 from meningitis)	126

Deaths from all causes amounted to 10,801, giving a crude death rate of 10.9 per 1,000 of the population compared with 11.6 in England and Wales. 5,307 deaths (49.1% of the total), took place over the age of 75 and, of these, 63.5% were female.

207 deaths occurred during the first year of life and 135 of these were under four weeks of age. Major causes of deaths were congenital abnormalities, (52 – a reduction of 43 over 1970), birth injury and difficult labour, etc., (49), respiratory diseases (42), and other causes of perinatal mortality (45).

47 children died between the ages of 5 and 15 years. The largest single cause of death was accidents (23). Of these 12 were associated with motor vehicles, 7 more than in 1970, but the same as in 1969. 6 deaths were ascribed to malignant neoplasms and 5 to leukaemia.

Between the years of 15 and 24 motor vehicles remained the largest single cause of death with a total of 42, 7 more than in 1970. This age group was the highest risk group for death from this cause, the next largest being 25 to 34 years with 22 deaths.

The major causes of death in later life show no appreciable change in comparison with the preceding year:–

(a) 2,699 deaths were attributed to coronary heart disease. Of 1,518 male deaths from this cause, 41 took place before 45 years and 535 (35.2%) before 65 years.

(b) Malignant neoplasms accounted for 2,251 deaths, the largest single group being carcinoma of the lung and bronchus with 608 deaths, a decrease of 36 over 1970. Of these 461 were males (507 in 1970) and 147 were females (137 in 1970). 7 occurred between 35 and 44 and a total of 234 (36.1%) had taken place by 64. Among females 198 died of carcinoma of the breast and 71 of carcinoma of the uterus.

(c) Under the heading of respiratory diseases, pneumonia accounted for 1,033 deaths, of whom 454 were females over 75 years. In the case of the 380 deaths from bronchitis and emphysema males, however, predominated in a ratio of over 3 to 1.

(d) Out of 1,422 deaths from cerebrovascular disease, 804 were females, 674 of whom were over 75 years.

Table 4 gives full details of all causes of death during 1971, classified in age groups for the aggregate of urban and rural districts.

Table 3 shows the infant mortality rate over the past 10 years.

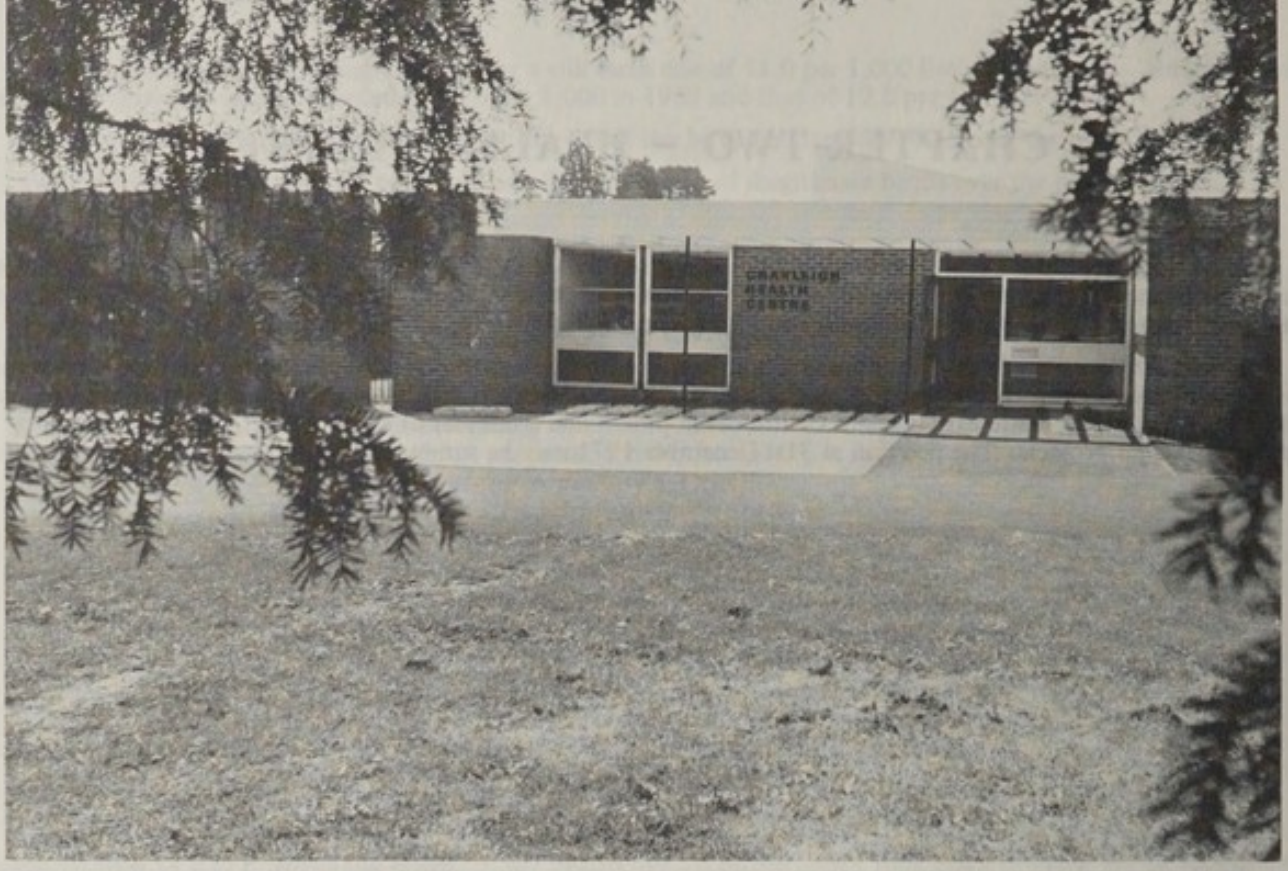
CHAPTER TWO – HEALTH CENTRES

Three further Health Centres were completed and taken into use during 1971 – two new purpose-built Centres at Cranleigh and Ewell, and one formed by the extension of existing clinic premises at Stanwell. Plans, photographs and information regarding each of these centres are given on the following pages.

The six Centres already in operation have continued to function most effectively and they have received numerous visits from others concerned in the planning of new Health Centres. General Practitioners throughout the County have shown continued interest in Health Centre development and a number of enquiries were received regarding possible further projects. The position at 31st December 1971 may be summarised as follows:–

	No. of Centres	No. of G.Ps. associated with projects
Completed and in use	9	52
Under construction	3	15
Working drawings being prepared	3	21
Sketch plans being prepared	3	15
Under active discussion	6	42
At preliminary discussion stage	6	34 (approx.)
	30	179

At Merrow and Thames Ditton, two areas where local doctors are not requiring health centre facilities, new local authority clinic premises were completed during 1971. Photographs of these clinics are also included in the following pages.



CRANLEIGH HEALTH CENTRE

Typical example of one of Surrey's latest health centres.

CHILD HEALTH

Children awaiting consultation with the medical officer at a Surrey health centre.

RECEPTION

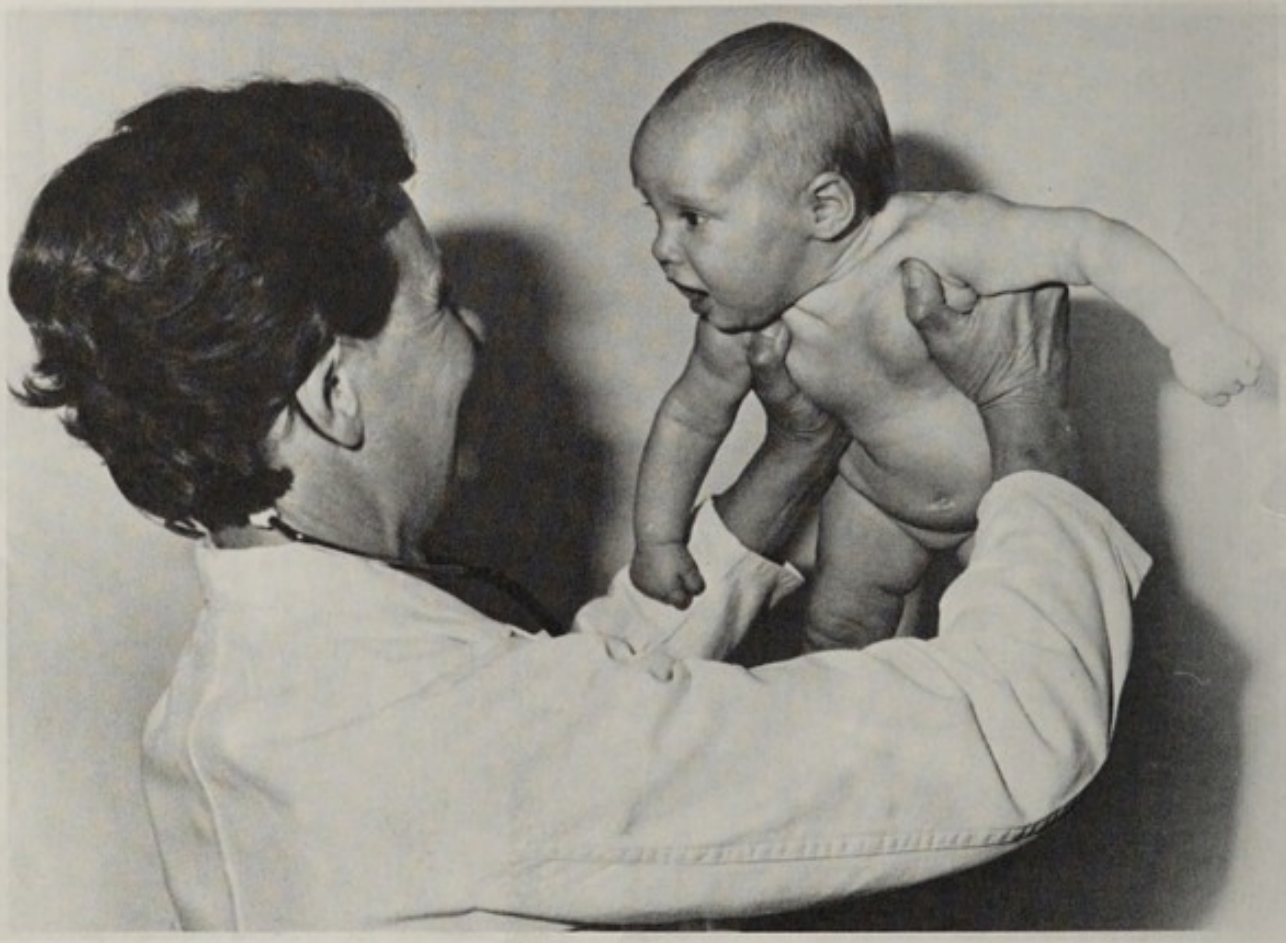
Two patients call at a busy health centre reception office.

WAITING AREA

Health centre patients waiting for their appointments in comfortable surroundings.

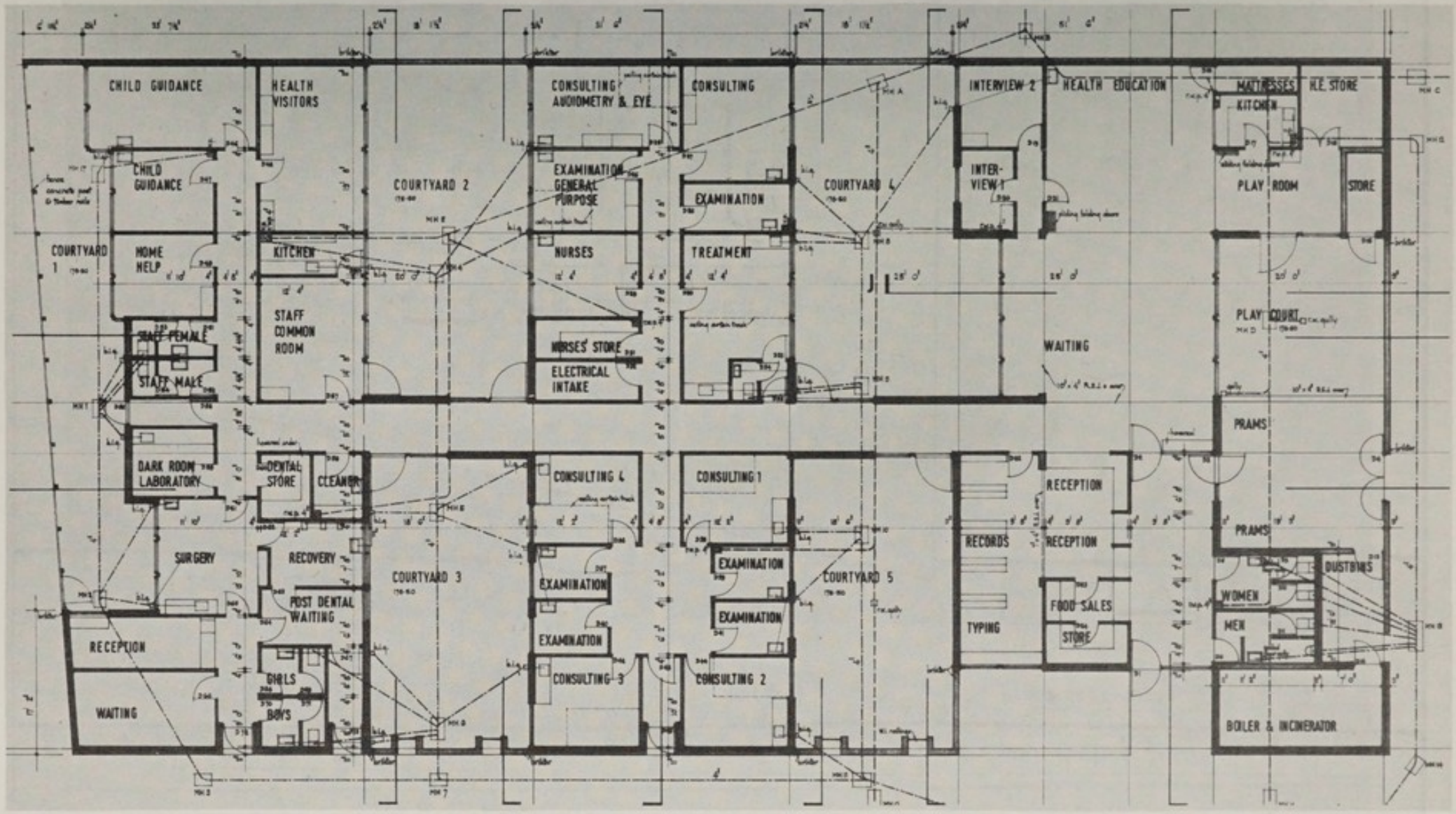
HEALTH VISITOR

A Surrey mother consults the health visitor about the health of her young child.



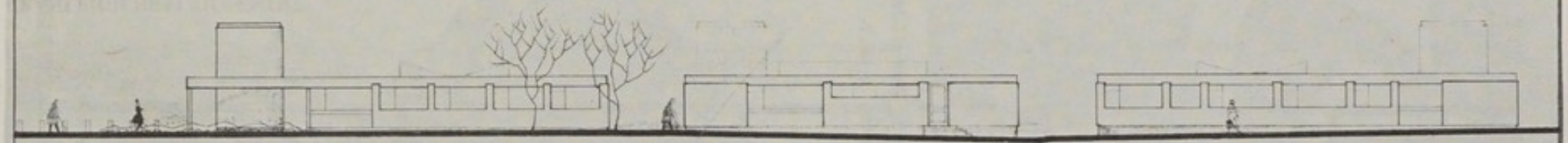
DEVELOPMENT

A Surrey medical officer examines a baby for progress in growth and development.



CRANLEIGH HEALTH CENTRE

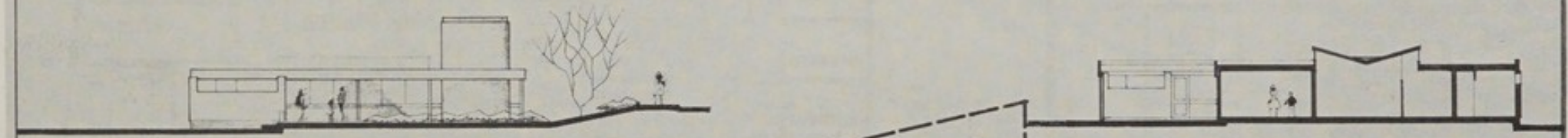
MERROW CLINIC



SOUTH ELEVATION

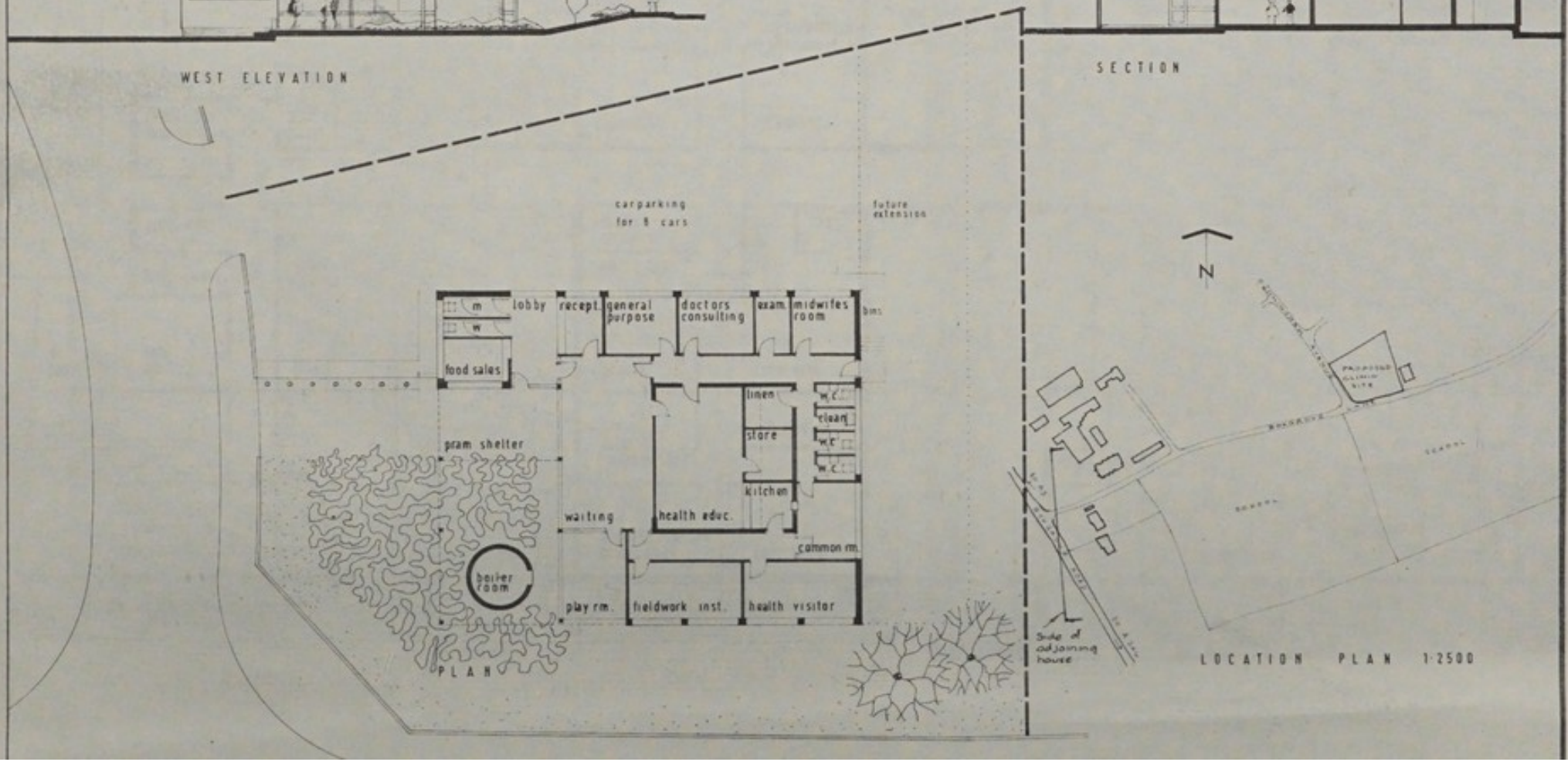
EAST ELEVATION

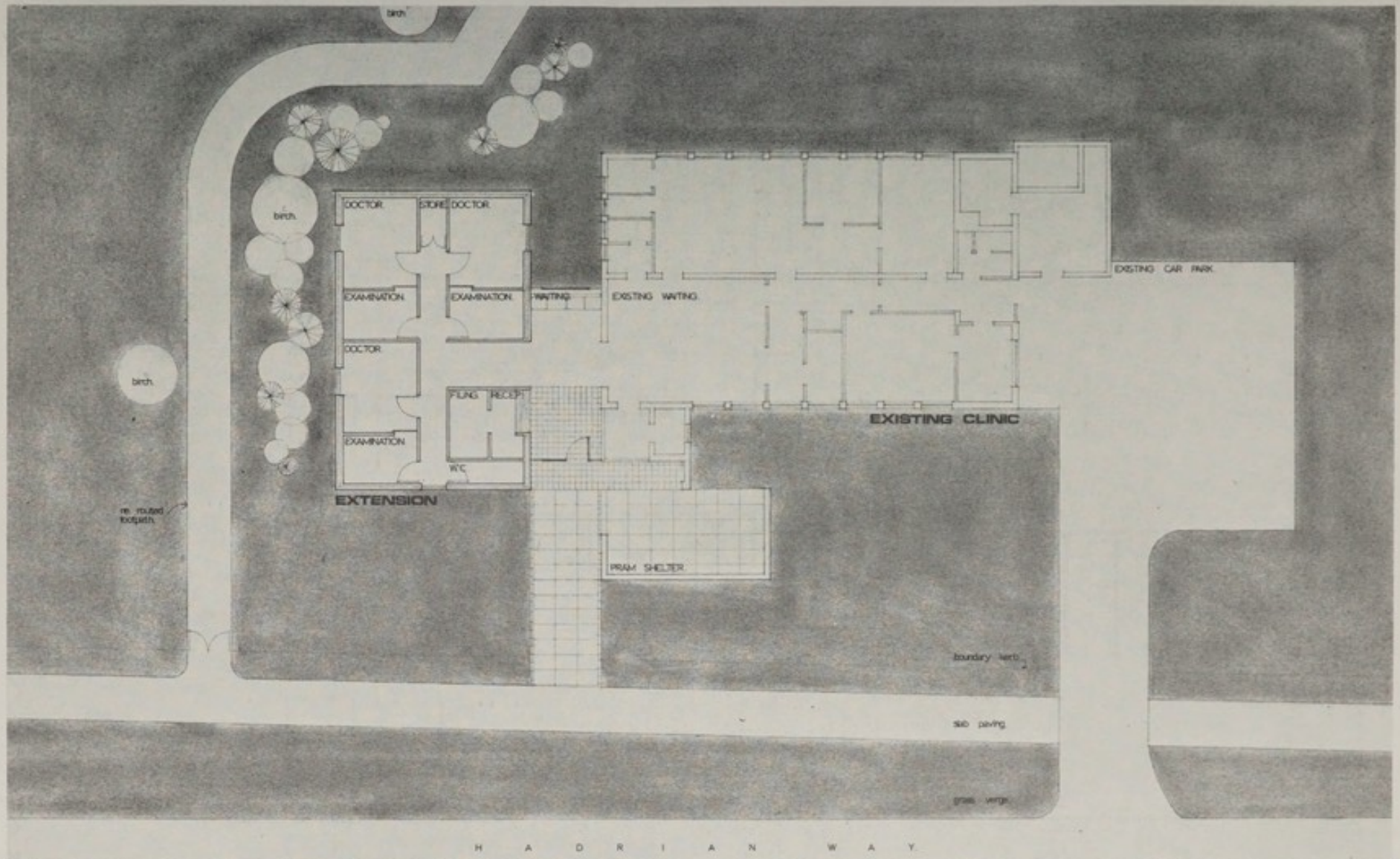
NORTH ELEVATION



WEST ELEVATION

SECTION

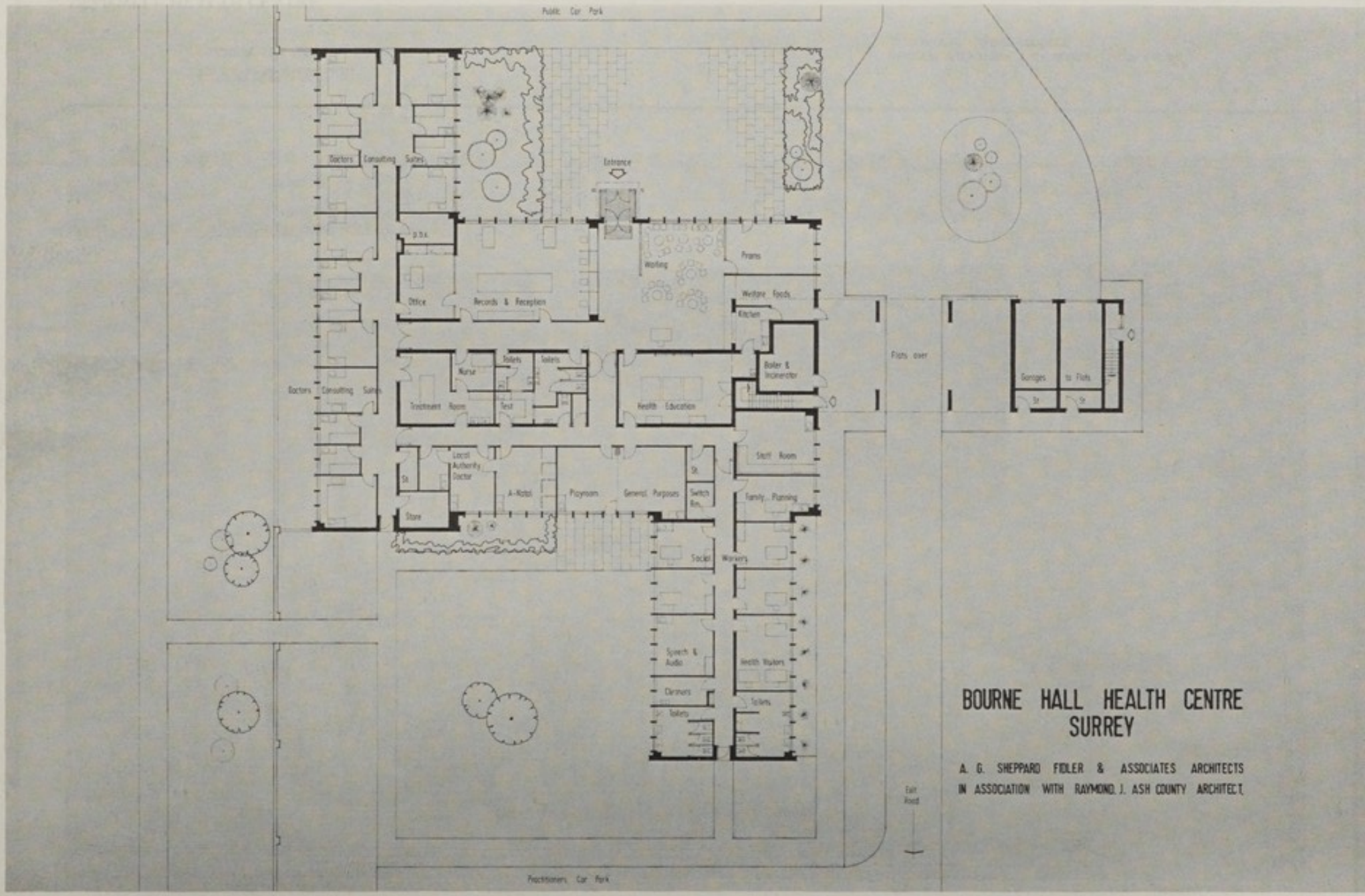




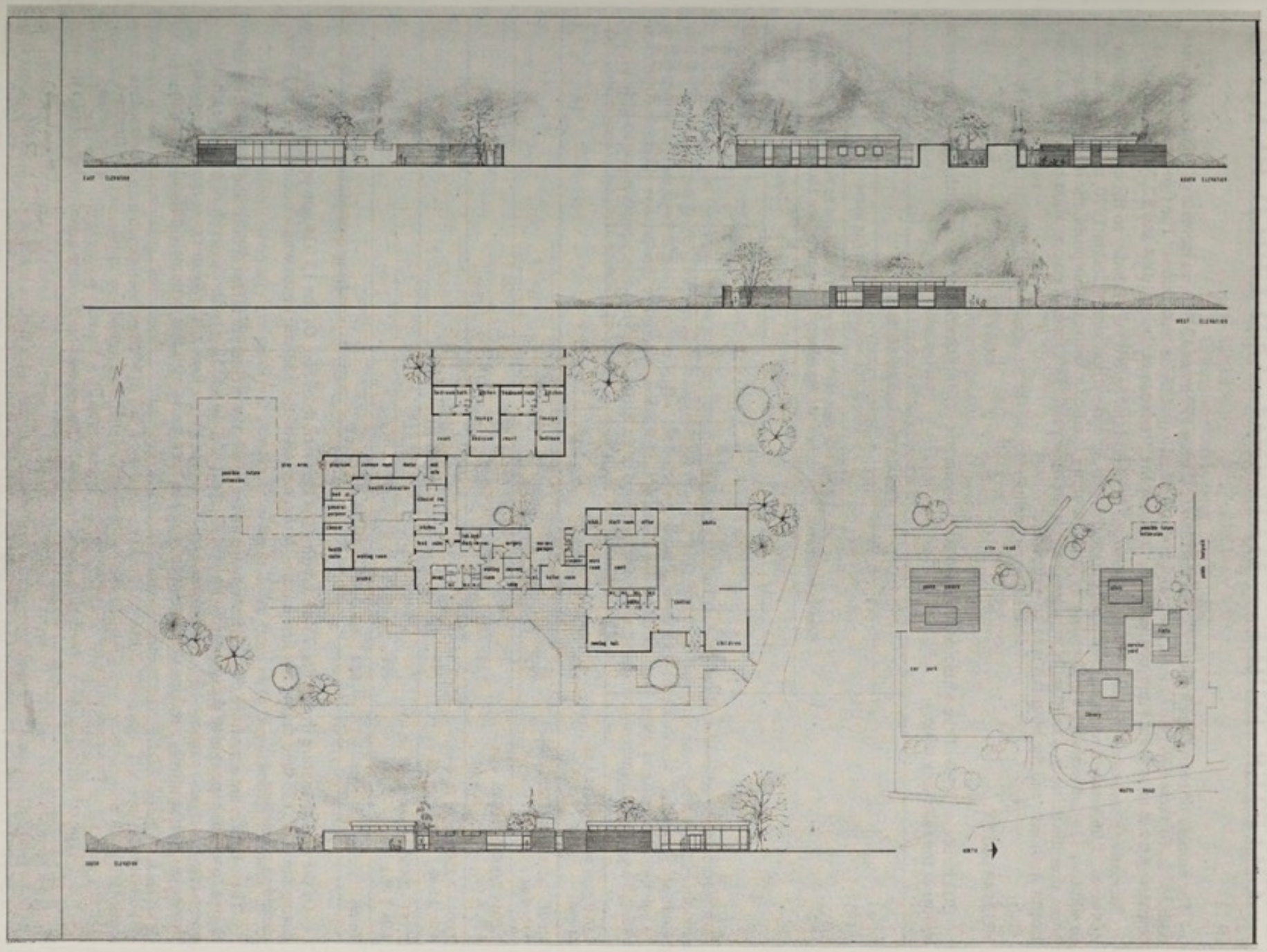
STANWELL
FLOOR PLAN

RAYMOND ASH DIP ARCH A R I B A
COUNTY ARCHITECT

STANWELL HEALTH CENTRE



BOURNE HALL HEALTH CENTRE EWELL



CLINIC LIBRARY AND NURSES FLATS AT GIGGS HILL GREEN

CHAPTER THREE – MATERNAL AND CHILD HEALTH

The number of births which took place in the County during 1971 was 13,890, an increase of 36 in comparison with 1970. Of these 678 (4.8%) took place at home and 13,212 (95.2%) in institutions. The figures show a continuing trend away from home confinement, those for the previous year being 1,064 and 12,790 respectively.

Increasing numbers of women are being discharged from hospital before the 10th day to the care of domiciliary midwives. 5,062 early discharges took place during the year, in comparison with 4,280 in 1970, an increase of 782. In addition 314 deliveries were undertaken by Surrey County Council midwives in hospitals, the mothers returning home after the delivery, a substantial increase over the previous year. This form of co-operation between the Local Health Authority and the hospitals is to be welcomed.

PREMATURITY

703 births, or 4.3% of the whole, were classified as premature (2,500 grammes or less at birth) during the year as shown in the following table:–

	PREMATURE LIVE BIRTHS												Premature stillbirths	
	Born in hospital				Born at home or in a nursing home									
					Nursed, entirely at home or in a nursing home				Transferred to hospital on or before 28th day					
		Died				Died				Died			Born	
Weight at birth	Total births	Within 24 hours of birth	In 1 and under 7 days	In 7 and under 28 days	Total births	Within 24 hours of birth	In 1 and under 7 days	In 7 and under 28 days	Total births	Within 24 hours of birth	In 1 and under 7 days	In 7 and under 28 days	In hospital	At home or in a nursing home
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)
1,000 gms. or less (2 lb. 3 oz. or less)	29	19	3	–	–	1	–	–	–	–	–	–	14	–
1,001–1,500 gms (2lb. 3 oz.–3 lb. 4 oz.)	51	13	8	–	–	–	–	–	–	–	–	–	28	–
1,501–2,000 gms (3 lb. 4 oz.–4 lb. 6 oz.)	110	10	5	–	1	–	–	–	–	–	–	–	24	–
2,001–2,250 gms (4 lb. 6 oz.–4 lb. 15 oz.)	147	2	1	–	1	–	–	–	–	–	–	–	8	–
2,251–2,500 gms (4 lb. 15 oz.–5 lb. 8 oz.)	266	2	2	2	20	1	–	–	–	–	–	–	9	–
Totals	613	46	21	2	22	2	–	–	–	–	–	–	68	–

Of the 635 premature live births, 71 died during the first month of life. Of the 13,034 non-premature live births during the year, 135 died during the first month. Moreover, 68 of the 153 still births which occurred in 1971 were classed as premature.

These figures are a measure of the disadvantage under which the premature infant is born and demonstrate the degree to which prematurity is associated with loss of infant life. In addition to the high risk of infant death, the premature infant also carries a high risk of handicap. Unfortunately a look at the figures over recent years shows that as yet comparatively speaking very little headway has been made with this extremely difficult problem.

Year	Premature births as percentage of total births	Percentage of deaths in first month (premature births)	Total Stillbirths	Premature Stillbirths	Premature Stillbirths as percentage of total Stillbirths
1965	5.8	14.0	187	107	57.2
1966	6.4	13.4	197	122	61.4
1967	6.2	12.0	167	99	59.2
1968	5.9	12.0	169	82	48.5
1969	5.6	9.5	140	74	52.8
1970	6.0	11.1	169	86	51.0
1971	4.3	11.5	153	68	44.4

CONGENITAL MALFORMATIONS

262 cases were notified during the year, involving a total of 316 malformations. 52 deaths of children under the age of 1 year were ascribed to congenital malformation. In the form of groups the notifications were as follows:–

1. Limbs	99
2. Central nervous system	62
3. Alimentary system	43
4. Uro-genital system	32
5. Eye and ear	16
6. Other parts of musculo-skeletal system	13
7. Heart and circulatory system	7
8. Respiratory system	5
9. Others	27

With regard to individual malformations, the major numbers were as follows:–

Talipes	64
Anencephalus	25
Cleft lip	23
Mongolism	19
Hypospadias, epispadias	18
Spina bifida	17
Hydrocephalus	13
Cleft palate	8
Congenital dislocated hip	7
Polydactyly	6

ILLEGITIMACY

Statistics given in Chapter 1 show that the figure for illegitimate births (826) has increased by 55 in comparison with 1970. Reference to the following table shows that over the past five years there has only been a small reduction in the overall annual figure for illegitimate births, the percentage remaining more or less steady. Although illegitimacy does not necessarily equate with unstable parental relationships, it will do so in many cases, and the well-known relationship between illegitimacy and disadvantage must continuously be borne in mind in considering these figures. The importance of health education in this field is manifest.

Year	No. of illegitimate births	%age of live births
1967	909	6.08
1968	909	6.25
1969	870	6.00
1970	771	5.50
1971	826	6.00

CHILD HEALTH CLINICS

The policy of offering regular developmental examinations for children from birth throughout pre-school life was continued and developed during the year.

In the Annual Report for 1970 the need for increased training facilities for doctors in the skill of developmental paediatrics was emphasised. At national level existing courses continued and it was possible to obtain a small number of places for doctors on these. Within the county itself a system of in-service training was instituted with a view to introducing all the remaining clinic doctors to the subject. For this purpose the county was divided in to 4 training areas, each with its own committee devoted to the organisation of training within the area. The general pattern of training throughout the county was based on a policy of providing both theoretical instruction with the use of films, tapes and filmstrips, and practical sessions with experienced medical officers. The provision of the four committees allowed for flexibility in the actual training schemes so that the needs of individual doctors could be met.

A survey of the county showed that there were some 55 doctors who required training. At the time of writing this report this is in progress and indeed a number of doctors have already completed the course. It is proposed to repeat these courses as required in order to initiate new staff who have not had training in the subject and also to assist general practitioners who wish to receive instruction.

The following extracts from reports received from the Divisions give some indication of how the provision of child health clinics has progressed during the year.

Dr. H. B. Thompson, Divisional Medical Officer, Northern Division, reports:–

"I am pleased to relate that there has been a steady expansion of the developmental clinics in the Northern Division during the year. Babies are seen routinely at the child health clinics for a developmental examination at about one month and then further examinations are offered at six months and one year with a special hearing test at seven months. Toddlers are sent appointments to attend the clinics about their second, third and fourth birthdays for progress examinations with special reference to vision, hearing and speech development. Special care is taken to ensure that any child with a suspected handicap or with an increased risk of a handicap is followed up and if the appointment at the clinic is not kept the Health Visitor will try to make sure that the "at risk" child is regularly examined.

"Immunisations against diphtheria, whooping cough, tetanus, polio and measles are encouraged.

"The response of parents to the offer of developmental examinations for their children is good. During their first year almost all babies are seen for these examinations. Over 75% of appointments sent out for the toddlers clinics are kept.

"One of our doctors also works in close liaison with a group practice where a developmental clinic is held on the premises of one of the general practitioners who has a special interest in developmental paediatrics.

"In-training sessions have been planned for 1972 and it is gratifying to know that all doctors in the Northern Division are willing to attend the course."

Dr. C. A. McPherson, Divisional Medical Officer, North Western Division, writes:–

"Further use was made of the developmental testing techniques at child health clinics and these are now in use at all child health clinics throughout the North Western Division. Three of the full-time medical officers in the Division attended university courses arranged for developmental paediatrics, and at the end of the year we were planning our own in-service training course for all medical officers in the development of the use of these techniques. All clinic centres have the special test material available, the majority of medical officers favouring the Stycar Hearing and Vision Test Material."

Dr. E. Pereira, Medical Officer of Health for Esher U.D., writes:–

"One of the two medical officers concerned regularly with infant welfare sessions attended a week's developmental paediatrics course at Bristol which was felt to be most helpful and stimulating. Both medical officers are being encouraged to employ developmental techniques in the child health clinics and are currently attending the Surrey County Council course at St. Peter's Hospital, Chertsey, in accordance with county policy.

"The senior medical officer is fully trained in developmental paediatrics including the neurological screening of neonates. This latter procedure is often carried out in toddlers clinic sessions as it is found convenient to see new babies on these occasions as well as during the ordinary infant welfare sessions.

"Anxiety is felt about the difficulty of teaching medical officers the central nervous system screening technique; this is really only readily learnt if large numbers of neonates are available for examination as are found in the maternity wards of the hospitals. This technique takes time to learn and depends on seeing a very great number of normal babies.

"It has been found preferable to keep sessions for immunisation separate from developmental examinations."

IMMUNISATION AND VACCINATION

The number of children immunised against diphtheria, whooping cough, tetanus, poliomyelitis and measles is shown in Table 6. The children commonly receive the first three in the form of a triple injection, given at 6, 8 and 12 months, with poliomyelitis vaccine given orally at the same visit. Very few children born in 1971 will therefore have completed their courses of these antigens during the year.

Measles vaccination is offered at 13 months, booster doses of diphtheria/tetanus/polio at school entry and tetanus and polio at 15 years. B.C.G. vaccination is offered at 13 years.

In July 1971 the Joint Committee on Immunisation and Vaccination of the Department of Health and Social Security recommended that vaccination against smallpox need not be carried out as a routine procedure in early childhood. This decision was reached in the light of the diminishing prevalence of smallpox in countries overseas with the reduced likelihood of outbreaks in this country. In view of this situation it had become necessary to review the balance of the risks involved in the practice of smallpox vaccination against the benefits that may be expected from it. The Committee emphasised, however, that all travellers to and from areas of the world where smallpox is still endemic should be protected by recent vaccination. They furthermore emphasised the importance of the vaccination of all health service staff who came in contact with patients. In view of this advice the offering of routine smallpox vaccination to infants and older children ceased in County Council clinics in August, 1971.

Vaccination against rubella was offered to all school girls between their twelfth and fourteenth birthdays. This was in accordance with the policy of progressively reducing the age at which this protection will be offered until in 1972 it will reach the desired level, i.e. during the twelfth year of life. In all 14,353 consent forms were issued and 10, 847 girls immunised (75.6%). This represents a reasonable response from parents showing that the majority appreciate the importance of obtaining this protection for their daughters. It is to be hoped however that the figure can be improved upon particularly as this is a simple procedure easily carried out in school (9,684 of the girls were vaccinated by School Medical Officers during school hours) and reactions to the vaccine are few.

EXAMINATION OF INFANTS SUBMITTED FOR ADOPTION

The Surrey County Council is a registered adoption agency and all infants adopted through this branch of the Social Services Department are examined by Medical Officers at the County Council's clinics prior to placement. 115 babies were examined and reported on during the year. In addition the Principal Medical Officer acts as medical referee in respect of couples requesting to adopt whose medical examinations are carried out by their own General Practitioners.

DENTAL CARE OF MOTHERS AND YOUNG CHILDREN

Arrangements have continued for the provision of dental inspection and treatment for expectant and nursing mothers and children under five years of age. This work is undertaken by the dental staff who are principally engaged in the school dental service and who devote part of their time to the dental care of mothers and young children.

The opportunity is taken through individual and group talks to advise the young mother about the importance of an adequate and well balanced diet, the avoidance of between meal snacks, especially of refined carbohydrates, the avoidance of the use of infant comforters with reservoirs containing high sugar content fluid, the supervised cleaning of her child's teeth and the need for regular visits to the dentist.

The number of sessions undertaken was 611. There were 4,393 attendances by pre-school children, 3,521 fillings were completed for the conservation of deciduous teeth and 528 teeth were extracted under general anaesthesia. Treatment for mothers included 548 fillings, 168 teeth extracted and the provision of 42 dentures.

FLUORIDATION OF WATER SUPPLIES

The County Council approved in principle the fluoridation of water supplies in October, 1965 and this decision was again confirmed in December 1969. No progress has been made regarding its implementation due to lack of unanimity of Authorities in the supply areas of the water undertakings and there are practical difficulties in fluoridating the water supplies to the County only.

CHAPTER FOUR – NURSING SERVICES

NURSING ESTABLISHMENT

In 1971 the nursing establishment was as follows:-

District Nursing and Midwifery	266
Health Visiting	227
Administrative Staff	29
TOTAL	522

In addition to the establishment, 52 part-time Nurses were employed in the School Health Service and Nursing Auxiliaries assisted the District Nursing Sisters.

STAFFING POSITION

We had some difficulty in recruiting our full establishment of Health Visitors, but otherwise we were up to establishment for most of the year.

WORK UNDERTAKEN BY HEALTH VISITORS IN 1971

The health visiting establishment was increased by 22 during the year. Table 7 shows the Health Visitors' caseload in 1971 and the comparable figure for the previous year. There is a marked growth throughout the caseload. As part of the development of the Group Attachment Schemes, more referrals are being passed to the Health Visitors by the General Practitioners and a great deal of supportive work is being done within the family situation, in particular in cases of marital stress, anxiety situations, together with many other social problems. It is an interesting development that the Health Visitors followed up over 1,000 patients who had been discharged from hospital.

In most Districts there is a well developed health education programme.

FOLLOW UP OF THE WORK STUDY UNDERTAKEN IN 1965

A further work study was carried out on the time spent by Health Visitors on office duties. The result showed a need for additional clerical assistance and this has been provided.

THE WORK OF THE DISTRICT NURSING SISTERS

The establishment of District Nurses was increased by 19 during the year. The growth of the work in this section has been maintained. There was an 11.1% rise in the number of cases cared for in their homes by District Nursing personnel and a 12.3% rise in the number of visits paid to these patients. In many Group Attachment Schemes, the District Nursing Sisters are carrying out treatments either in Doctors' surgeries or in the treatment rooms in Health Centres and it is interesting to note that 21,357 patients were treated. The majority of these patients were within the age group 5 to 65, see Table 9.

DOMICILIARY MIDWIFERY

The number of deliveries conducted by the Domiciliary Midwives continued to fall throughout the year. There was a 24.4% decrease. The total number of births was 919 and one-third of these were delivered in hospital by the Domiciliary Midwives. There was an increase of 20.9% of early discharges during the year. The Nurse Midwives continued to give good ante-natal and post-natal care to expectant and nursing mothers throughout the County.

DEVELOPMENTS WITHIN THE DOMICILIARY NURSING SERVICE DURING THE YEAR 1971

1. Group Attachment Schemes

The Primary Care Teams made up of General Practitioners, Nursing and other supporting personnel, i.e. principally Health Visitors, District Nurse Midwives, District Nursing Sisters and Enrolled Nurses, are developing into good working units. It is interesting that closer links with the Hospitals have been established in some areas, thus providing a more clearly defined pattern of progressive patient care from home to Hospital and back again to the home. Efforts are being made to develop schemes which will enable discharge of hospital patients to be carried out on a more adequately planned basis in order to provide for a more effective mustering of community resources to meet any needs of patients on return from hospital.

2. Developments with Hospitals

(a) Planned early discharge of patients after surgery in the Frimley/Farnham Area.

In preparation for the opening of the new district general hospital in Frimley the county nursing service has been participating in a research study to evaluate planned early discharge from hospital. The patients selected for this pilot study fall into two groups:–

(i) Those operated on for varicose veins, and

(ii) Inguinal Hernias.

A procedure programme has been developed and certain patients (with their agreement) are discharged within 48 hours of their operation. The after-care thereafter being given to the patient in their own home by their General Practitioner; District Nursing Sisters and Health Visitors have also given support when required.

(b) Domiciliary Nursing Care extended to the Periphery Hospitals.

A working arrangement has been agreed between the County Council and the Regional Hospital Board for District Nursing Sisters in the Walton-on-Thames area to give care to selected patients in the local Hospital. These would be patients who had been under the district nurses' care before admission or would become so on discharge and it was felt that they would benefit from the continuity of nursing care which would result.

The first patient to be cared for in this way was a woman suffering from carcinoma whom the Doctor and Sister concerned felt required care throughout the 24 hours and therefore was admitted to hospital. It was agreed by the Hospital and District Staff that the District Nurse would treat the patient three times a day, at 10.00 a.m., 4.00 p.m. and 9.30 p.m., and during these visits she would carry out the nursing care required. The Hospital Staff agreed to keep her comfortable in between these visits. Her family lived nearby and were able to visit her frequently and she was cared for in this way until she died very peacefully.

(c) There is a greater awareness of the necessity to forge closer links with the hospital staff throughout the County. Visits have been arranged for student nurses and trained staff to give them an insight into the domiciliary services.

3. Participation in Student Training Programmes

Arrangements are made for all student nurses to spend some time in the District. In the case of three hospitals, i.e. Hammersmith, St. George's and Frimley Park, special schemes of training have been approved. The Hammersmith students are trained in an integrated training scheme with the University and they spend time with the Health Visitors and complete their District Nurse and Health Visitor Training as part of their programme. In the case of St. George's, each student spends 8 weeks in the County and during this time works with the District Nurses and Health Visitors. The Frimley Park training scheme has just started and in this scheme nurses will complete their general training, plus their District Nurse training.

4. Working Parties

A working party was set up to review "The Role of the Health Visitor in the School Health Service". Miss G. G. Cox, Divisional Nursing Officer, was the Chairman of this working party, which was made up of Medical Officers of Health and Nurse members. The report of this working party is published as an Appendix on page 66. This working party was set up as it was felt that it was necessary to review the contribution of the Health Visitor to the School Health Service particularly with the coming reorganisation of the Health Services. The recommendations have been well received and are proving themselves to be helpful.

Another working party set up during the year was concerned with reviewing the very serious problem of the "battered baby syndrome" and much of the data that will be considered by this working party is being provided by the Health Visitors, who are following up cases of accidents in the home in their areas.

In the Social Services department a working party was set up "to review the present Social Services provided for the elderly in relation to the needs of the elderly". A nurse who represented the Health Department is a prominent and active member on this working party. The vital importance of close links between the Health and Social Services Departments, in order to avoid providing a fragmented service to those in need, is very much in the mind of both departments.

GROUP ATTACHMENT – A PERSONAL VIEW

I have received a report from Mrs. Joan Polglaze, one of our Nursing Sisters, which gives a very good picture of what takes place in one well integrated Group Attachment Scheme:–

"I started in the Group Attachment Scheme in January, 1969.

"For the first eight months there was little difference in my pattern of work other than the fact that I cared for the Group Practice patients only. The change occurred when I attended the surgery during evening surgery hours to do dressings and injections. I did this for two evenings each week and gradually the clinical content of my work developed and from then on, due to being in close contact with the Doctors, the relationships within the Group improved and a team spirit developed.

"In November, 1969, I was joined by another Nurse and our work both in the patients' homes and in the surgery increased and widened. We had a change of staff in mid-May 1970, when a recently district trained S.R.N. replaced the other nurse and the team was further implemented by a Nursing Auxiliary at the beginning of June and we were able to re-organise our duties and develop co-operation with other workers, principally Social Workers.

"In addition to our domiciliary work, we now covered the evening surgery work on four nights per week, and by working a rota system, managed to arrange definite off duty times while maintaining a 24 hourly coverage for the practice.

"I was pleased to initiate the Nursing Auxiliary into her duties; she worked with me for three weeks when I taught her how to blanket bath and how to establish relationships within the patients' homes. She has proved herself to be competent, trustworthy and we have great confidence in her; she never attempts anything beyond her scope and is genuinely interested in elderly people; she reports anything unusual to one of the Nursing Sisters and we, in turn, visit her patients once every 4-6 weeks.

Home Visits

"It is interesting to note that we now visit many more patients within the middle-aged and younger age groups, doing a wider range of nursing procedures.

"At present I am attending a baby now three months old who has a colostomy, which has required wash-outs regularly since he was three weeks old. The mother was very apprehensive at first, but now is much more calm.

"We have recently had a terminal cancer case with a colostomy and urine drainage, who had been sent into hospital, as there was no-one at home all day to look after her, and who returned home for several long weekends when the husband was there – as she was on injections of morphia every six hours, this necessitated early, late and mid-day visits every day. Eventually she died in hospital but this case is an example of co-operation between the Ward Sister and myself.

"With regard to evening home visits, one might imagine that these would clash with the evening surgery work. However, we assess each case separately taking the following facts into consideration:–

(1) if the patient is very incontinent,

(2) how much help is available in the home,

(3) if an evening sedative has to be given,

(4) where the patient lives,

(5) the length of time the visit will take,

and then decide whether the nurse who is on afternoon duty will visit at 4.00–4.30 p.m., or the one who is on evening surgery duty will visit at 7.30–8.00 p.m.

Work in the Surgery

"We are in constant touch with the Doctors as we work during surgery hours. There is an appointment system with patients booked every ten minutes starting at 5.30 p.m. until 7.00 p.m.; this works well because although some treatments take less time, others take longer particularly if a Doctor wishes to do an examination in the treatment room; in addition, we manage to fit in unbooked patients who come directly from the Doctor's consulting room.

"Development of work during the past three years:–

	Patients visited at home	*Treatments given in surgery*
1969	136	246 (last 3 months)
1970	226	1677
1971	251	2041

Surgery Duties

These can fall into 5 main headings.

I *Patients attending for Injections and Vaccinations.*

II *Patients attending for observation,* e.g. Overweight Patients, advising re diet and regular weight charts kept. Blood Pressure checks.

III *Patients attending for Treatment.*
(1) Ear syringing.
(2) Changing pessaries, dressings etc.

IV *Patients attending for Investigation.*
(1) Cervical Smears.
(2) Blood Tests.
(3) Urine Tests.

V *Patients attending for Examination.*
Present with General Practitioner at some examinations of Patients.

Advantages of Group Attachment

1 Everyone in the team knows whom to contact.

2 When the Doctor and Nurse know each other personally, they know how one another works.

3 It is of benefit for Doctor and Nurse to see patients together.

4 Patients like having the same Nurse to attend them in their home and at the surgery.

5 Patients are given a sense of confidence in knowing that the Nurse is working in complete liaison with their Doctor.

6 The patient often asks the Nurse to act as a "go-between" if they feel diffident about telling the Doctor about any symptoms.

7 The "working" patient appreciates being able to have his treatment in the evening, thus not missing a day's work.

8 The Nurse has a greater feeling of job satisfaction in working in a team and not in isolation.

9 The Nurse has a greater variety in her work both in age groups of patients and in nursing procedures.

10 It is possible for the Nurse to know more about a patient's background and medical history.

11 The Doctors are more likely to listen to the Nurse's advice regarding transferring patients to hospital or calling in the Geriatric Consultant to advise.

"One disadvantage is that the Nurse *might* have a feeling of conflicting loyalties between her employer and the General practitioner. However, the feeling of greater job satisfaction in working in a team of people whom you know and respect, far outweighs any disadvantage. This happy state of affairs takes a long time to come about and needs working at, but it is worth it because it benefits the total community in the end."

At the end of 1971 there were 110 schemes in operation in the County involving 352 Doctors. Table I shows the Local Authority staff working within these schemes. Table II shows the number of staff working in General Practitioners' premises and Table III shows the number of staff working in Health Centres.

TABLE I Local Health Authority Staff working within Group Attachment Schemes

	Health Visitors		District Nurses		D.N./ Midwives		S.E.N.		Nursing Auxiliaries
	P.T.	F.T.	P.T.	F.T.	P.T.	F.T.	P.T.	F.T.	P.T.
Area – S.W.	9	38	10	30	5	20	–	5	15
S.E.	4	37	12	22	2	22	4	5	12
N.W.	1	28	2	14	–	21	–	1	9
N.	5	20	6	18	–	–	–	–	3
Delegated Authority Epsom & Ewell	–	10	3	3	–	–	1	–	1
Esher	–	5	1	4	–	–	–	–	1
Woking	3	17	2	12	–	1	–	–	5
TOTAL	22	155	36	103	7	64	5	11	46

No. of practices involved in schemes – 110
No. of doctors involved in schemes – 352

Table II Staff working in General Practitioner premises

	Health Visitors		District Nurses		D.N./ Midwives		S.E.N.		Nursing Auxiliary
	P.T.	F.T.	P.T.	F.T.	P.T.	F.T.	P.T.	F.T.	P.T.
Area – S.W.	3	21	2	9	–	11	–	3	
S.E.	–	13	1	5	–	7	–	–	
N.W.	–	11	1	2	–	3	–	–	
Delegated Authority Epsom & Ewell	–	2	–	–	–	–	–	–	Work with Nursing Sisters, but not in Surgeries
Esher	–	1	1	5	–	1	–	–	
Woking	–	6	–	2	–	–	–	–	
TOTAL	4	59	10	36	–	22	–	3	

DISTRICT NURSING

The student district nurse in a Surrey training course studies in the lecture room and on the district to obtain her post-registration qualifications.

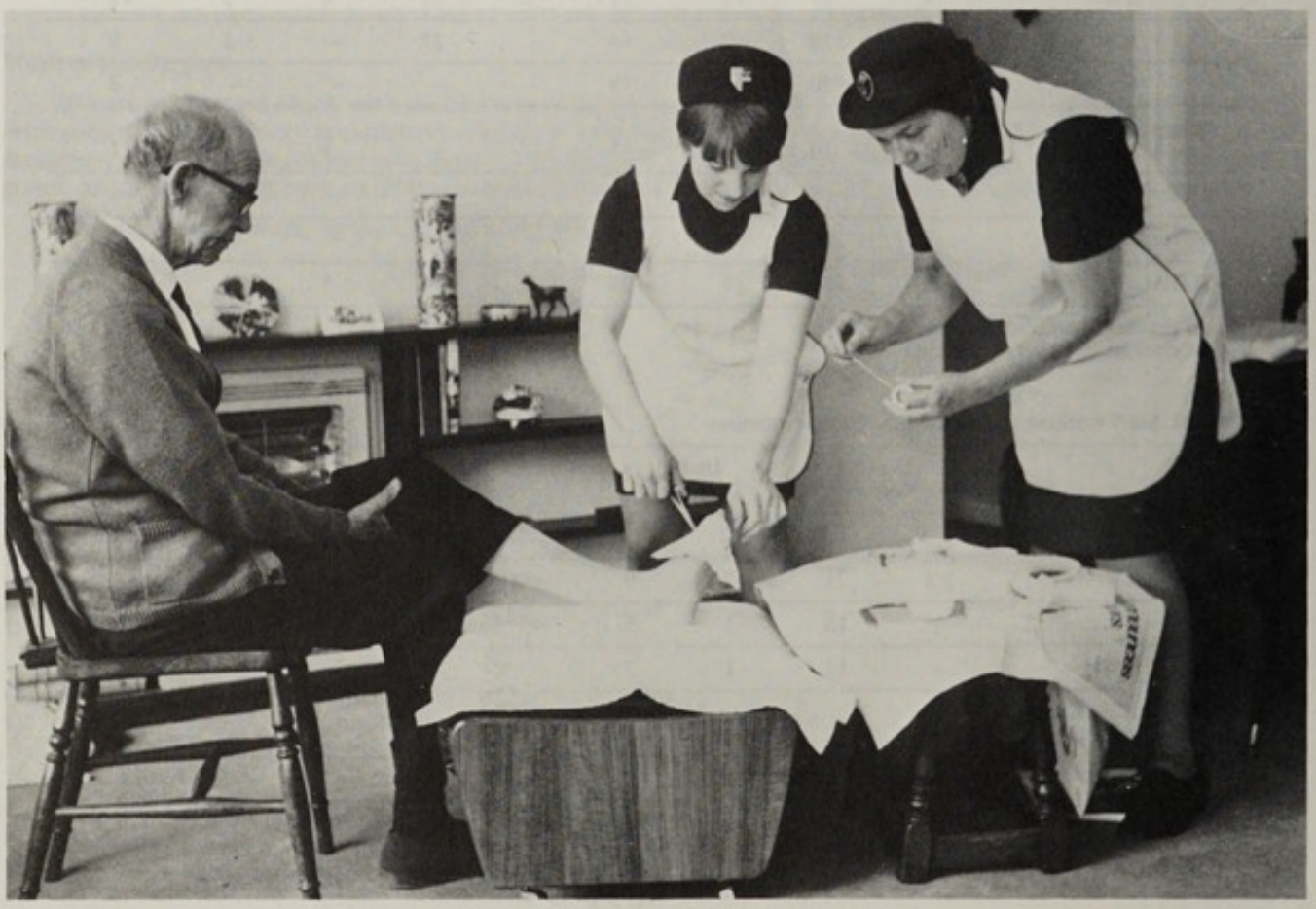


Table III Staff working in Health Centres

	Health Visitors		District Nurses		D.N./ Midwives		S.E.N.		No. of Doctors
	P.T.	F.T.	P.T.	F.T.	P.T.	F.T.	P.T.	F.T.	
Shepperton	–	1	–	2	–	–	–	–	2
Stanwell	1	2	–	2	–	–	–	–	3
Walton-on-Thames	–	6	–	4	–	3	–	–	10
Chertsey	–	3	–	3	–	3	–	–	9
Merstham	–	2	–	1	1	1	1	–	5
Tattenham Clinic	–	2	1	1	–	2	–	1	2
Farnham	–	4	1	3	–	–	–	–	9
Cranleigh	1	3	2	–	–	3	–	–	4
Ewell	–	5	3	3	–	–	1	–	8
St. Johns, Woking	–	3	–	2	–	–	–	–	4
TOTAL	2	31	7	21	1	12	2	1	56

STAFF TRAINING – HEALTH VISITORS

Twenty six candidates were sponsored during the year to take their Health Visitor training. Fourteen candidates attended Ewell Technical College and of the remaining twelve, nine went to the University of Surrey, two to Croydon Technical College and one to Chiswick Polytechnic.

DISTRICT NURSING TRAINING

The courses were based on Ewell Technical College and of the total of thirty one State Registered Nurses who qualified, twenty two were from Surrey and nine from other Authorities. In addition, seven State Enrolled Nurses from Surrey attended the training course.

IN-SERVICE TRAINING PROGRAMME

During the year the courses included:

Statutory Refresher Courses for Practising Midwives
In-Service Training for Nursing Auxiliaries.

In May the annual refresher course was held at Glyn House, Ewell for Health Visitors and Nursing Personnel.

HEALTH EDUCATION COURSES

These were attended by Health Visitors and District Nursing Sisters.

OTHER COURSES

Some members of staff were sent to approved courses on Management Training. Experienced Health Visitors attended Field Work Instructor courses and we were pleased to be able to send experienced District Nursing Sisters to Practical Work Instructor courses. An interesting course was arranged in the autumn to prepare staff to advise and work in obesity clinics.

CHAPTER FIVE – PREVENTION OF ILLNESS, CARE AND AFTER CARE

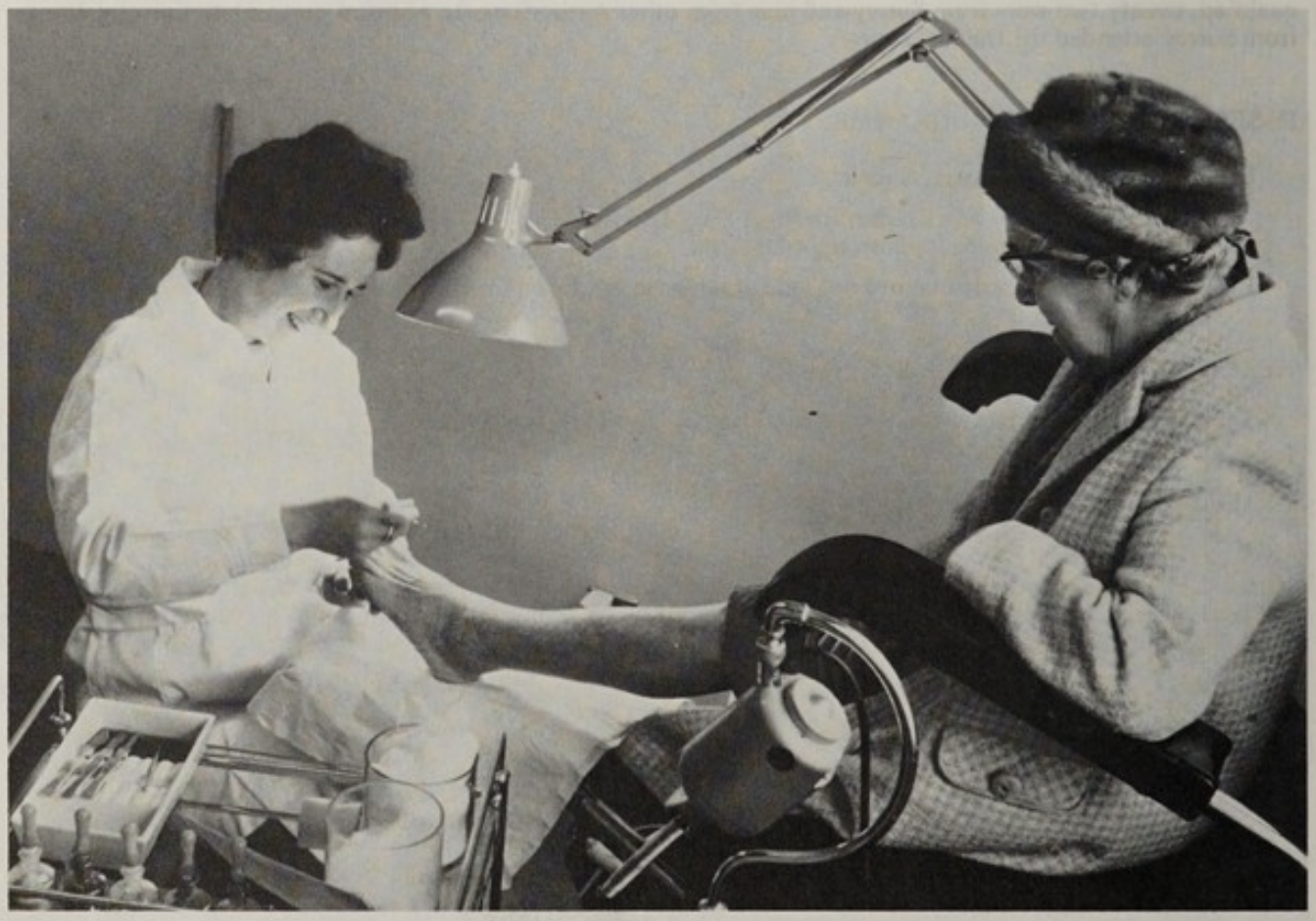
VENEREAL DISEASES

Hospital clinics continued at Guildford, Woking and Redhill during the year and the number of Surrey residents attending these clinics is shown in the table below which also includes in the column "Other Clinics" Surrey patients attending clinics at surrounding hospital clinics. The figures in brackets relate to 1970.

1971	Guildford	Redhill	Woking	Other Clinics	Total
New Cases (Surrey)					
Syphilis	4 (9)	3 (1)	1 (5)	17 (32)	25 (47)
Gonorrhoea	76 (65)	24 (24)	37 (18)	401 (218)	538 (235)
Other conditions	502 (389)	164 (99)	259 (175)	2360 (1981)	3285 (2644)
Totals	582 (463)	191 (124)	297 (198)	2778 (2231)	3848 (3016)

CHIROPODY

The chiropody service continues to expand and the establishment has been maintained at the whole time equivalent of 16.6 chiropodists. There are now thirteen full-time staff the balance being made up by sessional chiropodists. It is pleasing to report that over the past year the applications for full-time work have outweighed the applications for sessional work. This may be only a temporary or even local phenomenon but as more young people are seeking



Treatment by County Council chiropodists at health centres and clinics, homes for the elderly and voluntary clubs, gives new vigour to thousands of Surrey residents.

employment on a full-time basis with Local Authorities it leads to speculation about the possibility of developing in the future a more extensive and attractive career structure for this very important ancillary service.

Owing to the fact that a fairly full establishment was reached early in the year it has been possible to open several new clinics. At Cranleigh this started as one session per month and was very quickly increased to two sessions per week. Clinics have also been started at Heathside, Woking (one session per week), Egham (three sessions per week) and Egham Hythe (one session per week). At Sunbury, Ashford, and Thames Ditton Clinics it was also found necessary to increase the clinic coverage from one session to two sessions per week to accommodate the increasing case load.

The indirect service in Surrey continues to be carried out under the auspices of Surrey Association for the Elderly and the British Red Cross Society and here again it has been necessary to increase the number of sessions held in order to accommodate the increasing case load.

AIDS TO DAILY LIVING AND MEDICAL EQUIPMENT

Medical Loan Depots

The British Red Cross Society and the St. John Ambulance Brigade continued to maintain medical loan depots throughout the County. Nursing equipment may be borrowed from the depots for a maximum period of six months. All loans are free of charge but a deposit, which is returnable, is required.

Medical Comforts

Articles of nursing equipment required permanently by patients are supplied by the Council.

Adaptations to Homes of Patients Using Kidney Machines

Kidney machines to enable patients to undergo intermittent dialysis at home are provided and maintained by the hospital authorities, who also pay for the extra cost of electricity, running the machine, the installation and rental of a telephone where this is necessary, and provide the relevant medical services.

The cost of incidental adaptations to the homes of patients, however, is the responsibility of the Local Authority, and although such adaptations consist in the main of plumbing and electrical wiring, in some cases where no suitable room exists an extension to the property may have to be built, or a prefabricated building put in the grounds of the house.

The financial resources of the patients are assessed, to decide what they shall be required to contribute towards the cost of adapting their homes. There is no doubt that this is a matter which sometimes causes resentment among the patients or their families who are asked to pay and cannot understand why they should be asked to do so when the machine is loaned free of charge by the hospital authorites.

During 1971 four patients had their homes adapted with the assistance of the County Council as follows:–

Homes owned by Patients or Spouses	Homes Owned by Housing Authorities	Homes Owned by Private Landlords	Total Number of Applicants	Financial Assistance Given by County Council			
				Grant of Whole Cost	Grant and Loan	Loan of Whole Cost	Other Arrangements
3	1	–	4	–	2	2	–

FAMILY PLANNING

In previous years the Surrey County Council made an annual grant to the Family Planning Association to assist with the remission of fees in medical cases. For the year 1970/71 this was £1,500. As from 1st April, 1971, the County Council, along with many other health authorities, entered into a new form of agreement with the Family Planning Association known as the National Family Planning Agency Scheme. This scheme, which has the support of the Department of Health and Social Security, enables local health authorities to choose between a number of alternative forms of service for which the Family Planning Association is remunerated on a per capita basis. In this case, the County Health Committee chose application number 6, which provides free consultation and free supplies to medical cases only, as it was felt that this was the scheme most applicable to this County. The definition of a medical case under the scheme is.

"Any woman whose health, in the opinion of the examining doctor, would be expected to suffer by the increased mental, physical or social burdens placed on her by pregnancy."

The estimated cost of the service during the year 1971/72 was approximately £9,000. Efforts were made to ensure that all the staff, and particularly midwives and health visitors, were fully conversant with this new development. This scheme began, like most new schemes, to take effect rather slowly. However, towards the end of 1971 patients eligible for free consultation and supply under the agency scheme were increasingly using the clinics. During the nine months from April to December 939 women used the scheme.

A total of 21,333 individual patients were seen at Family Planning Association clinics in the county during 1971, an increase of 2,633 (4%) over the previous year. Of these 6,028 were new patients. The total number of repeat visits was 29,955.

At Surrey County Council clinics, 585 individual patients were seen (557 in 1970) and there were 2,286 repeat visits.

From the above figures it will be noted that the number of people receiving family planning through the Family Planning Association and the Surrey County Council continues to expand as in previous years and the birth rate in Surrey remains well below the national average. It must not be forgotten that family planning is also being increasingly provided by general practitioners for their own patients and that a number of hospital patients receive it from hospital sources, although unfortunately there is no method of obtaining statistics from these two sources.

The County Council continues to provide a domiciliary family planning service throughout the county as in previous years. Each individual area has a doctor available to pay home visits as required and every effort has been made to encourage the staff to make full use of the service. However, very few patients were referred to the service during the year in spite of a reminder to all members of the nursing staff exhorting them to see that all cases requiring a domiciliary visit were included. As mentioned in last year's report, the need for a domiciliary family planning service is frequently discussed and often pressed but it can only be concluded that in an area such as Surrey where clinic coverage is particularly good and easily accessible such a service may not be so widely necessary to the community as in some other areas.

WELL WOMEN CLINICS

It should be once again emphasised that the object of these clinics should be to give the patient an overall health check and not merely to take a cervical smear and it is unfortunate that this part of the examination is generally thought to be the most important part of the clinic's activity, whereas it is only part of the whole.

The number of women coming forward to County Council clinics was 6,067, an increase of 581 over the previous year. There were 4,372 return visits, an increase of 992 over 1970. 10,302 cervical smears were taken of which 64 showed abnormal cells requiring further follow up, 9 a pre-invasive cancer, and 3 an established cancer.

Apart from abnormalities uncovered by cervical smears very many abnormalities of the genital tract and of other systems in the body were found. In connection with this the importance of breast examination cannot be overstressed because, as is usual, the commonest of cancers causing death in women during 1971 was that of the breasts (198 deaths as opposed to 179 from carcinoma of the uterus).

HEALTH EDUCATION

"I have felt like a navigator on a strange sea, who is out of sight of land, is surprised by night, and has to trust mainly to the rules and instruments of his science for reaching port."
Newman. The Idea of a University.

Were we to confine attention to statistics of death and gross illness we might feel quite pleased with our present condition, at any rate in comparison with the position a century ago. It is becoming increasingly clear, however, that not being really ill is not the same as being really well, and there is yet a vast mountain of mild sub-health to be removed. People may die off less easily and drag-out longer existence; but merely failing to die is far short of living a rich life of abundant vigour, serenity and joy.

The "rules and instruments" of health education are the facts, assumptions, habits, attitudes and ideals which the professional staff of the department attempt to foster in their everyday work with people in the community. It is encouraging to report an increasing participation each year by the medical, dental, nursing and other staff in the field of primary prevention of illness. But, like the navigator, we are "out of sight of land" and there are few reliable pointers, at least in the short term, which vindicate our educational policy.

The health visitors and district nurses have again borne the main burden in community work. The continual whirl of activity in the health centres, clinics, group attachments, schools, colleges, clubs, day centres, homes and the myriad centres of voluntary activity bear testimony to the influence of the Council's staff in this very personal work. My previous reports have emphasised the wide range of topics and the types of organisation encountered.
Here and there efforts have been made to extend into new fields of opportunity. In some areas health visitors have been invited to hold discussions with teenage girls who are subject to the control of the courts. Screening work in 'Well Woman' clinics has been extended to include health education. The simple question: Do you consider yourself a well woman? reveals a wide range of problems not only relating to the patient but also to the family. Health visitors are available to listen and to help with some of these problems, such as sleep, diet, exercise, obesity, smoking, hygiene, problems with young people and so on. Meetings, discussions, displays and other publicity are reaching a wider section of the community in health centres and group attachments and it is particularly pleasing to secure the co-operation of general medical practitioners in this field.

Exhibition

The work of the County Health Department was the main topic of the County Council's exhibit at the Surrey County Show at Guildford in May. The theme of the exhibition was "Safety through the Seventies", featuring safety on the roads, on the land and in the home. The main feature showed the work of the County Ambulance Service including special transport, the emergency accident service, the radio control centre at ambulance headquarters and the regional training programme. The health education exhibits included a continuous "Safety" cinema show, a "Hazard House" prize competition, a full-size replica of a health centre health education room and an information kiosk – all fully manned by the appropriate professional and technical staff. The official attendance at the Show was put at 50,000 and it is estimated that a high proportion of this total visited the stand which was again awarded First Prize in the non-commercial trade stand section.

In June the Department mounted an exhibition in Egham dealing with dental health. This was essentially a participatory exhibit which attracted hundreds of children and their parents. The display took the form of three targets representing dentally desirable and undesirable foods. Three plastic guns firing darts with rubber suction ends scored points with a plus or minus score respectively. Children were required to 'score their age' in order to win a prize of a dental health kit comprising plastic beaker, toothbrush and toothpaste. Children then passed through to see a display of dental health charts, models and posters and to receive helpful advice on care of the teeth from dental surgeons and assistants. Finally all children received a packet of literature and an apple to take away. This was an excellent example of a combined effort by the County dental staff and the local general dental practitioners.

The department assisted with displays on home safety at shows in Guildford and Egham and technical staff also provided a wide variety of resource material for teaching and display purposes on request throughout the year.

Smoking and health

While the day-to-day work in general health education proceeded several special efforts were mounted in the fields of smoking and cervical cytology. The five anti-smoking clinics of 1970 were increased to eight during the present year. Five-day group therapy courses were promoted in conjunction with the British Temperance Society at Ashford, Merstham, Guildford, Walton, Epsom, Woking, Esher and Camberley; thus covering every administrative area of the County and involving over 500 participants with a high success rate in the short term.

The following results from one clinic are typical:–

Clinic: Ashford	No. of participants	No. of completed questionnaires received	No. who ceased smoking	No. who considerably reduced smoking	No. who reverted to previous degree of smoking
1970	75	22	14(19%)	2(1%)	6(8%)
1971	68	28	21(31%)	7(10%)	Nil

Encouraged by these results arrangements are being made for a further six clinics to be held next year.

Following the publication of the report in January by the Royal College of Physicians: "Smoking and Health Now" full publicity was given to the dangers of smoking through the good offices of all Medical Officers of Health. In addition, with the enthusiastic support of the Joint Staff Committee, I addressed a personal letter to all members of the headquarters staff who smoke inviting them to give up the habit during working hours. This was, of course, an entirely voluntary matter. Staff were asked to discuss this with other smokers in the offices in which they worked and if all resolved not to smoke, an appropriate notice entitled: "The staff in this office do not smoke", was issued to fix on the doors. In addition, each of them was issued with a small card to stand on their desks in their ashtrays, stating "I am not smoking to-day". Anti-smoking posters were distributed to notice-boards throughout the building and leaflets issued to all offices.

The scheme received a good response and it was later extended to divisional offices and other units.

Cervical cytology

A massive campaign was launched during the year to encourage all women between the ages of 25 and 65 to take advantage of the service of health screening checks offered in Surrey. Clinics for this purpose have been provided by the department in many parts of the County during the past five years and several thousands of women have already taken the opportunity to have a check on their health at these Well Woman clinics. Details of this free service were displayed in clinics, libraries, information bureaux, chemists' shops, large stores and community organisations throughout the County. A special reply-paid folder was printed and distributed so that people could make appointments at the nearest centre or refer to their medical practitioner. A special issue of 50,000 bookmarks (reaching a readership of nearly 10 million a year) was printed with the words:

"Calling all women: Cancer of the breast and cervix (womb) can be controlled. Ask your family doctor or local health clinic about cancer prevention tests."

Opportunities were given to a wide range of medical, dental, nursing, teaching and other visitors from home and overseas to discuss the health education work of the department centrally and in the divisions.

A series of press releases was provided on exhibitions, ambulance service, cervical cytology, drugs and smoking.

Training

The Health Education staff attended study conferences and courses on Health Education in Schools, Audio-Visual Aids, Sex Education, Health Education and the Nurse, Seminar for Health Education Officers and the Second World Conference on Smoking and Health. In addition attendance was made at lectures on professional subjects in London and the Home Counties throughout the year. The technical assistant commenced a two-year part time course in audio-visual aids for the City & Guilds Certificate at a Technical College.

In turn, a large part of the work of the health education officers included the training of staff in the Education, County Health, Social Services, and other departments. Whereas much of this work is on an individual consultative basis, extended courses on Health Education and Audio-Visual Aids were held for health visitors. Contributions were made to courses for district nurse students, student midwives, ambulance personnel, social workers, teachers and others. Arrangements were again made to hold two annual seminars for trainee general medical practitioners who were also provided with facilities for attachments to divisional medical officers.

CHAPTER SIX - AMBULANCE SERVICES

ORGANISATION AND ADMINISTRATION

There were no major changes in the organisation and administration of the service during the year.

CONTROL

The Feasibility Study conducted on behalf of the County Council by the Local Government Operational Research Unit into the use of computers was reported to a Special Sub-Committee which resolved that the Department of Health and Social Security be asked to consider grant aid to cover the development costs. The Department declined to authorise this in view of the fact that the proposed system would not be applicable to other services and no further action is contemplated at present.

OPERATIONAL STRENGTH

Vehicles

	Operational	Reserve
Ambulance	63	13
Sitting Case Vehicle	36	9
Control and Equipment Vehicle	4	–
Handicapped Person Vehicle (Welfare and Mental Health)	10	1
Totals:	113	23

Staff

A slight improvement in recruiting resulted in the service operating approximately 5% below establishment.

Premises

Knaphill Sub-Station

The new Station which replaces unsatisfactory premises in the Town Centre was operational from the 1st March, 1971.

Development

Work was commenced on a 6-bay extension to Chertsey Station and the provision of a new 4-bay Sub-Station at Cobham.

Voluntary Organisations

Hospital Car Service

The work undertaken by the Hospital Car Service continues to expand. During the year they conveyed 194,189 patients, 1,924,186 miles. The expansion in the use of this excellent service is a major factor in containing the number of sitting case vehicles operated. It is worthwhile to note that since the policy of expanding the service was introduced in 1965/66 no additional operational sitting vehicles have been required. The Hospital Car Service is organised, administered and operated by the Ambulance Service from its headquarters control. There are approximately 250 volunteers who give their services free, the County Council reimbursing them at a nationally agreed mileage rate to cover their costs.

Agency Services (British Red Cross Society, Godalming)

The British Red Cross Society at Godalming continue to operate a 2-ambulance station (1:24 hours, 1:8 hours) on an agency basis. They employ 6 full-time paid staff plus volunteers who provide night and week-end cover. Operationally they are controlled as part of the direct service and conveyed 7,919 patients, 53,220 miles.

Supplementary Ambulances

The British Red Cross Society and St. John Ambulance Brigade continue to provide supplementary ambulances manned by volunteers usually during the off-peak periods. During the year they conveyed 2,813 patients, 46,209 miles.

Handicapped Persons and Mental Health Transport

The Ambulance Service operate a number of special vehicles for the Social Services Committee. During the year these vehicles conveyed:–

	Patients	Miles
Handicapped Persons	33,524	128,529
Mental Health	6,880	13,208

Work of the Service

The number of emergency calls increased by 6.6%. I am pleased, however, to be able to report that the average time taken from time of call to arrival at the incident remained at 5.7 minutes despite the ever increasing traffic problem.

The service's major accident plan was operated for 43 full emergencies and 8 ground incidents at Gatwick Airport plus 23 other incidents throughout the County. On all occasions the initial action was sufficient to deal with the incident.

It should be noted that a similar number of patients must be given the same priority as 999 calls. These are in the main requests from Hospitals and Doctors for the emergency admission or transfer of patients to specialist hospitals.

The service continues to use rail or air transport whenever possible for patients travelling long distances. During the year 307 patients were transported 33,763 miles by rail and 11 patients, 3,002 miles by air.

TRAINING

As one of the nine Area Training Schools in the country training courses were held at Banstead throughout the year for Surrey Ambulance personnel and for those of a number of other Local Health Authorities.

Six recruits courses, each lasting 6 weeks, were held during the year and a total of 64 Surrey Ambulance staff and 61 from other Authorities attended. A Course for Officers and Sub-Officers lasting one week was also held.

Two officers qualified as Ambulance Aid Instructors following attendance at the Department of Health and Social Security Instructors' Course at Wrenbury Hall, Cheshire.

ANNUAL AMBULANCE COMPETITION

The annual competition was held again at the new Headquarters, Banstead. The winning team who received the Stuart Horner shield will represent Surrey in the 1972 regional finals.

SAFE DRIVING AWARDS

306 drivers were entered for the award. 60 were disqualified by accidents and 39 became ineligible through sickness, change of duties or resignation.

Among the 217 successful drivers, 95 have now completed more than 5 years continuous driving without accident. The details of the awards are as follows:–

Bar to 20-year brooch	1
20-year brooch	1
Bar to 15-year brooch	7
15-year brooch	3
Bar to 10-year medal	14
10-year medal	2
Bar to 5-year medal	45
5-year medal	22
1 to 4-year diploma	122

CHAPTER SEVEN – ENVIRONMENTAL HEALTH

MILK AND DAIRIES

The Milk (Special Designation) Regulations, 1963/65

These Regulations stipulate the conditions under which milk is classified into different categories and labelled according to the type of treatment, if any, which the milk undergoes before sale.

Standards of cleanliness and keeping quality are prescribed together with certain tests which indicate whether effective treatment has been applied and for how long.

Dealers' Licences are issued by the County Council for those parts of the County for which it is the Food and Drugs Authority, i.e. in ten of the County Districts. The work of inspection sampling and detailed supervision is delegated to the Public Health Departments of those County Districts, to whom we are indebted for their continued assistance and co-operation.

With the five yearly re-licensing period expiring at the end of 1970 this meant that the revision of the Register resulted in considerable variations in the number of registered Dealers etc., but, during the early months of 1971, the work of inspection and checking resulted in final figures which indicated that, in spite of many transfers and relinquishments, the total number of milk dealers remains steady at precisely the same figure as in December 1969, namely 467.

Details of the Licences in force are shown in the following Table.

Type of Dealers' Licence	In Force Dec. 1969	New Licences	Transferred Licences	Relinquished or Not Renewed	On Register Jan. 1971
Farm Bottle or Packed					
Untreated	1	–	–	–	1
Prepacked					
Pasteurised	171	52	8	6	217
Sterilized	65	15	1	3	77
Ultra Heat Treated	87	40	2	3	124
Untreated	37	13	–	2	48

Sampling of milk for cleanliness, keeping quality and adequacy of treatment

The total number of samples examined, to ascertain whether or not the Regulations were being observed, was 624, compared with 603 the year before.

As will be seen from the Table below, 27 samples (4.3%) were below the prescribed standard. Four samples were declared void because of abnormal atmospheric conditions, making results unreliable. Eight samples of Pasteurised milk and 19 samples of Untreated milk failed the Methylene Blue test, which is a test of keeping quality. In no case was there a failure in processing milk.

Of the Pasteurised milk failures, 2 were ascribed to distribution delays, 3 to failure to rotate stocks in proper order, including one case due to increased stocks over the Christmas period. One case involved unsatisfactory storage conditions on a motorway construction site. No reason for failure could be found in 3 other cases. The failures in Untreated milk samples were of a similar pattern. It is to be expected that there will be more failures in this category because, apart from an initial cooling after milking, there is no treatment, or processing. As this milk is kept separate and is handled in relatively small quantities delays of up to three days can take place before the milk is sold to customers, even regular customers in village stores etc. Usually the milk from the farm will be taken to a large Dairy in a nearby town where it will be kept overnight. The next day it will be collected or delivered to a local Dealer's premises from which it is delivered next day to the retail shop. Thus, although the milk is well produced and fresh as it leaves the farm, it may be 3/4 days old when purchased and consumed. Too much reliance seems to be placed on refrigeration, and not enough attention paid to speedy distribution.

Four of the unsatisfactory samples of Untreated milk were the direct result of a special sampling session to pin point the reasons for previous failures at a small bottling depot. Both churn and bottle washing samples showed the need for improvement in methods of handling. After suitable advice had been given subsequent samples proved satisfactory. Five samples failed principally because of delays in the chain of distribution, mentioned above.

Two failures were due to bad stock rotation in retailers' premises. Two others failed because conditions at the farm had been allowed to deteriorate due to the absence through illness of the farmer. One failure was ascribed to defective bottle washing equipment at another plant. This was being remedied at the close of the year. In four cases no precise reason for failure could be found. There were two samples each from two farms taken from different retail outlets. As the failures were apparently due to conditions at the production end these were referred to the Area Milk Officer of the Ministry of Agriculture Fisheries and Food, for investigation. Close co-operation is maintained with this Department.

It should be emphasised that failure to satisfy the tests prescribed by the Regulations does not necessarily render the milk unfit. Generally speaking, if milk is acceptable to the average person by taste and smell, then it is usually fit for consumption. Sampling is carried on merely for the purpose of ensuring that high standards of cleanliness and purity are maintained.

Summary of Results of Sampling

Class of Milk	No. of Samples	Appropriate Test	No. of Samples Passed	Failed	Void
Pasteurised	410	Phosphatase	410	–	–
		Methylene Blue	398	8	4
Sterilized	58	Turbidity	58	–	–
Ultra Heat Treated	75	Colony Count	75	–	–
Untreated	81	Methylene Blue	62	19	–

BRUCELLOSIS

The Government scheme for the eradication of infection amongst dairy herds caused by the presence of the organism "Brucella Abortus" is beginning to have effect, and about 20% of the herds which supply "Untreated" milk to the general public have been accepted into the scheme. Regular sampling of the milk from the other herds supplying "raw" milk must continue for the present. During 1971 milk being sold as "Untreated" was sampled and submitted to the milk ring test for elementary screening as to the presence of the organism which can, and does, produce illness in the human being. 347 samples were examined in the laboratories at Guildford, Epsom and Brighton of the Public Health Laboratory Service, to the Directors of which we are indebted for information, advice and assistance so readily forthcoming when required. In 39 cases positive results indicated the need for further action. Follow-up sampling with more detailed examination of the milk and the animals resulted in the infected animals from two herds being removed. In one instance, in the Godstone Rural District, virtually the whole herd of 40 to 50 cows was involved and required replacement. Great care was taken with the new herd and this has now been accepted into the eradication scheme as being brucellosis-free. In this District also the excellent work of checking on the "raw" milk being consumed as concessionary milk by farmworkers and their families has been continued. A further 59 samples were examined, 5 proving positive on milk ring test involving three farms. Appropriate advice was tendered to the farmers concerned on the need to call in veterinary assistance and the advantages of joining the Government eradication scheme. These figures show an improvement on the previous year and it is hoped to extend the special sampling scheme into a routine six-monthly check-up.

RURAL WATER SUPPLIES AND SEWERAGE ACTS 1944

Six schemes for the extension of main drainage facilities in rural areas or for the extension of public water supplies to groups of properties not already adequately served were submitted to the County Council for financial assistance and support. These were investigated and reported to the Highways and Bridges Committee by the County Engineer, supported by the observations of the County Medical Officer. All the schemes were approved in principle and grants amounting to 35% of the net approved costs will be made when works are completed. With rising costs all round it is inevitable that all these schemes are proving much more expensive than the "yardsticks" laid down for grant purposes. The extra costs must be borne by the District Councils. There is virtually no recovery of costs from individual properties which benefit however well endowed and all expenses not met from Government funds are recovered through the general rate. There is a need for a frequent review of the overall position, both from the point of view of requirements for extra services and the incidence of the cost of providing them. It is satisfactory to note that the Highways and Bridges Committee have recently requested information on all outstanding schemes in preparation, or envisaged, together with an estimate of the number of properties which will then be left without an adequate piped water supply and/or main drainage facilities.

Authority	Scheme	Estimated Cost £
Guildford R.D.C.	Little Cranmore Lane, West Horsley – Sewer extension	3,080
Godstone R.D.C.	Parkwood Road, Tatsfield – water supply scheme	3,200
Guildford R.D.C.	Unstead Wood, Peasmarsh – water supply	700
Godstone R.D.C.	Approach Road, Tatsfield – water supply	3,500
Hambledon R.D.C.	Willinghurst, Shamley Green – water supply	4,000
Godstone R.D.C.	Farleigh Court, Chelsham – sewer extension	14,830

FOOD AND DRUGS ACT 1955

I am indebted to the Chief Officer, Public Control Department, Mr. R. E. Kilsby for the following report on the work of his Department dealing with the above Act and its associate regulations, orders, etc. in the ten County Districts where the County Council is the Food and Drugs Authority.

General

The Food and Drugs Act endeavours to ensure that foods and drugs on sale to the public are not harmful to life, or health, that they are accurately described and are not adulterated. Foods must be fairly and accurately labelled and in many cases they must comply with statutory standards of composition. Claims for nutritional or dietary attributes must be justified, and colouring, flavouring or preservative substances must be approved and in quantities not in excess of those permitted.

The County Council is the Food and Drugs Authority for ten of the twenty-three county districts in Surrey. The estimated population of 1971 in the area for which the County Council is responsible is 329,520. The following table gives details of the 810 samples taken. This compares most favourably with the figure of 652 samples in 1970.

Articles	Number of Samples taken	RESULTS OF ANALYSES	
		Satisfactory	Adulterated or Irregular
Milk, condensed and evaporated milk, yoghourt	292	281	11
Beers, wines and spirits	17	16	1
Bread, rolls, flour and cereals	17	16	1
Butter, cream, cheese and cheese spread	84	77	7
Coffee, drinking chocolate, lemon juice and soft drinks	40	38	2
Confectionery – flour & sugar	38	35	3
Drugs and medicines	10	10	–
Eggs, chocolate covering, custard powder, slimming biscuits, spaghetti rings, yeast, camden tablets, fruit pectin and crystallized ginger	13	11	2
Fish, fish cakes & fish paste	37	37	–
Fruit and vegetables (fresh and tinned), coconut and potato crisps	70	63	7
Honey, jam, jelly, lemon curd, marmalade, marzipan, mincemeat, treacle and chocolate spread	46	43	3
Lard, margarine, dripping, cooking fat, cooking oil and peanut butter	28	27	1
Meat (cooked and prepared), chicken, cornish pasties, meat pies and puddings, meat paste and pate.	48	44	4
Pie filling, fruit pies, peel, mousse, milk pudding, dessert topping, ice cream and sugar	13	13	–
Sauces, seasoning, colouring, flavouring, soup and vinegar	21	21	–
Sausages, sausage meat and sausage rolls	36	35	1
TOTAL	810	767	43

Of the 810 samples taken 43 were found to be unsatisfactory (5.31%). This percentage compares with 7.66% in 1970 and 4.33% in 1969.

Milk

Of the total of 274 samples of milk taken only 10 were found to be unsatisfactory. Three of these samples did not conform to the presumptive minimum standard of 3% milk fat or 8.5% solids other than milk fat and the sellers were cautioned. Six samples contained added water; cautions were administered in five cases of very small quantities, such as 1%. In the remaining case the added water was 9.9% and the seller was convicted and fined £10, the Magistrate expressing the view that the presence of the water was not due to deliberate adulteration. One sample contained four pieces of vegetable tissue. The milk was fit for consumption but the local Health Authority was informed.

During the year 35 samples of milk were tested for the presence of antibiotics, of which one sample was found to contain 0.05% international units per millilitre of penicillin. It is important that people should not unknowingly be given penicillin and other antibiotics in their milk supply.

Butter

Of the 30 samples taken, six were the subject of adverse reports. In four cases there was an excess of water found in informal samples. When formal samples were procured they were all found to be 'genuine'. In a further case a formal sample was found to contain 6.8% of excess water and the sellers, who were a firm of multiple grocers, were convicted and fined £10, with £15.65 costs. Butter is now expensive and more samples are called for.

In the remaining case the butter was labelled as "not blended", but there were streaks of paler butter present. The manufacturers were notified.

Bread

There were nine samples taken, one of which contained foreign matter consisting of a metal staple. The bakers were convicted and fined £50, with £10.50 costs.

Labelling of Food

The Food and Drugs Act and various Regulations require that informative and accurate descriptions are applied to food; that advertisements shall not be misleading and that in certain cases the ingredients shall be specified in descending order. Your Inspectors examine a great number of pre-packed articles of food during the course of the year and from time to time descriptions are taken up with manufacturers. Most of these are minor errors, or other infringements which can be dealt with by negotiation rather than by prosecution. During the year under review eleven instances of this kind were dealt with.

Other Irregular Samples

A number of other minor infringements were dealt with and details are given in the table below:—

Sample	Remarks
Apricot Jam	Deficient in soluble solids. Formal sample taken and reported below.
Gooseberry Jam	Deficient in solids by 8.4%. Manufacturers notified.
Chopped Pork and Ham	Vacuum packed in polythene sheeting. Contained 72.7% of meat instead of 90% required in canned meat. Result of prosecution on similar sample by Hastings B.C. was awaited and following conviction the manufacturers, a national company, agreed to conform to the 90% meat requirement.
Pure Jersey & Guernsey cream	Sample 2.5% deficient in milk fat. A further formal sample found to be genuine.
Strawberries in heavy syrup	No individual fruit. Formal sample genuine.
Strawberries	Dimexan content caused by spray very high and could have been the reason for the taste of bitterness; impossible to trace grower.
Double Mint Centre Chocolate Cream Bar	Filling of the bar was very hard and the chocolate had numerous light coloured patches on it. Old stock. Seller cautioned.
Dripping	Free fatty acid exceeded 1.5% Discontinued product. Manufacturers cautioned.
Crystallized ginger	Customer complaint where buyer had pressed seller to supply last few pieces at bottom of container. Contained foreign matter. Letter of caution to the seller.
Spaghetti rings in tomato sauce	Consisted of tomato sauce only due to mishap at factory. Manufacturers cautioned.
Cornish Pasty	Contained piece of dirty cardboard. Seller cautioned. Evidence not complete for proceedings. Further sample genuine.
Glucose blackcurrant tablets	Not of the nature of glucose tablets. The labels have been amended and the manufacturers cautioned.
Fruit Salad in Syrup	Slight deficiency of pineapple, as compared with Code of Practice for packing of fruit salad. Inspector for area in which tins were packed notified.
Fruit Salad in Syrup	Sample was deficient in peaches and had an excess of pineapple, as compared with Code of Practice for packing of fruit salad. Inspector for area in which tins were packed notified.

REFUSE DISPOSAL

The publication of two Government reports, one on the subject of refuse disposal generally and of local authority refuse in particular, and the other on the disposal of solid toxic waste focussed public attention on the growing need to scrutinise more closely the existing arrangements for these vital services. It is obvious that there is a scarcity of disposal sites in the more populous areas where most refuse is produced, and it is inevitable that a great deal more thought, effort and money will need to be directed to this problem than has been the case hitherto. Several local district councils are finding themselves in difficulties and have sought the aid of the County Council and that of their neighbouring councils in order to try and meet their obligations to provide an efficient and economic refuse disposal service. With the likely transfer of refuse disposal functions to the County Council, all new schemes are being considered on a wider and more long term basis than before. The cost of longer hauls to tipping sites and the expense of better control for amenity reasons will need to be balanced against the more convenient, and perhaps more desirable but more expensive, means of disposal by incineration.

The County Planning Department, in co-operation with the Hampshire County Council and local authorities in north-east Hampshire and north-west Surrey took part in a combined exercise to explore the possibilities of a joint disposal scheme for the areas around Camberley and Aldershot. The Local Government Operational Research Unit produced a comprehensive study and tentative proposals have been made to cover the needs of the area for the next 25 years or so. These are being studied with a view to early implementation, as one or two of the authorities concerned will soon be in urgent need of new disposal facilities.

SURREY COUNTY COUNCIL ACT 1931 – Section 94

The special powers of control over the establishment and operation of refuse tips, where commercial concerns and local authorities transport the refuse from one county district into another area for disposal have again been extensively used. There were ten new consents issued during the year, subject to the usual safeguards to protect public health and amenity. Two tips were finished. One application was refused on the grounds that further tipping in the area would aggravate traffic conditions already congested by motorway construction work. Incidentally, the motorways under construction have in these instances sliced through existing refuse tips with resultant amenity problems.

At the close of 1971 there were 59 refuse tips covered by consents granted under the Surrey Act. Close liaison with the County Planning Department and local District Councils and the River and Water Supply Authorities was well maintained and there have been very few complaints requiring attention. There were no cases of pollution of water courses or underground sources of public supply.

CHAPTER EIGHT - MISCELLANEOUS

PRIVATE NURSING HOMES

37 nursing homes were registered with the County at the end of 1971, one more than 1970, one home having withdrawn its registration and two new ones having been registered. A total of 1,082 beds is provided, the largest home having 108 and the smallest three. The majority of beds are registered for geriatric and chronic sick cases. Only two beds in one home are registered under the Abortion Act, 1967. The inspection of homes continues to be a time-consuming but important part of the work of the department. By far the most serious problem facing private nursing homes today is that of obtaining adequate qualified nursing staff and although the majority of proprietors are most conscientious in this respect a small number need continual close supervision on this matter.

MEDICAL EXAMINATIONS

Staff

The medical supervision of all the Council's staff provided by the County Health Department covers:–

(i) The scrutiny of the medical history sheets completed by all successful applicants to officer posts and servants who are outside superannuable age, together with any follow-up or medical examination deemed necessary (including X-ray reports and special tests such as vision and mantoux where required).

(ii) Medical examination of all servants of superannuable age to determine their fitness for duty and eligibility for inclusion in the superannuation scheme.

(iii) Medical examination of teachers appointed to Surrey schools and candidates for Colleges of Education.

(iv) Annual medical examination for ambulance driver/attendants upon their reaching 60 years of age.

(v) Follow-up for cause and anticipated date of return to duty of personnel who have been absent from duty due to sickness for a long period.

(vi) Medical examination of staff who are due to retire on pension and who wish to provide an annuity for their wives in the event of their pre-decease; those requiring medical examination under the firemen's pension scheme and those who may not be fit for further duty by reason of permanent ill-health.

(vii) Medical examination of staff for other local authorities by mutual agreement on a reciprocal basis.

(viii) Triennial re-X-ray examination of staff who work in contact with children.

The total medical reports and medical history sheets relating to staff received in the Department during the year numbered 4,120.

Medical Arrangements for Long-Stay Immigrants

At the beginning of 1965 the Ministry of Health notified the Council of the following steps to be taken to deal with the rather special problems which arise in connection with the health and treatment of long-stay immigrants to this country:–

At ports of arrival long-stay immigrants, both Commonwealth and Alien, who are referred to medical inspectors are given a hand-out printed card in languages which they are likely to understand, the aim of which is to encourage them to get on to the list of a medical practitioner in their place of residence so that (if he thinks it desirable) he can arrange for them to go to a mass radiography unit, a chest clinic or a hospital for X-ray.

Long-stay immigrants who are referred to medical inspectors at the ports are also asked to provide their destination addresses and these are sent to the Medical Officer of Health of the county or county borough concerned, with a request that he attempts to persuade the immigrants to act on the advice they have been given in the hand-out. Copies of the hand-out are also required to be held by Medical Officers of Health and local officers of the Ministry of Social Security, in case they come into contact with immigrants who have not received one or apparently lost it.

These procedures are to help ensure that long-stay immigrants register with general practitioners at an early stage of their life in this country and do not wait until they fall ill. It also helps to make sure that those for whom it is appropriate, have an X-ray at an early stage.

The following table shows the number of advice notes received during the year from ports and airports relating to the arrival of immigrants into the County together with the number of first successful visits paid.

COUNTRY where passport was issued (as stated by Port Health Authority)	Number of advice notes* received during the year from ports and airports relating to arrival of immigrants	Number of first† successful visits paid to immigrants during the year
Commonwealth Countries: –		
Caribbean	39 (59)	18 (40)
India	37 (40)	11 (14)
Pakistan	79 (95)	45 (45)
Other Asian	13 (31)	3 (20)
African	66 (47)	26 (29)
Other	142 (146)	66 (88)
Non-Commonwealth Countries: –		
European	226 (396)	120 (273)
Other	81 (62)	32 (37)
TOTAL	683 (876)	321 (546)

* Advice of arrival of immigrant.
† First successful visit means the first time the Council's Health Visitor established contact with the immigrant.

The figures in brackets relate to the year 1970.

PORT HEALTH UNIT GATWICK AIRPORT

The unit is situated at the south end of the Immigration Lounge and consists of a general office, doctor's office, vaccination room, two inspection rooms, consulting room and staff room.

Gatwick is regularly served by planes from airports in Europe, North Africa, North America, Canada, the middle East, Central Africa and South America.

Health Control is carried out under the Aliens Order, 1953, the Commonwealth Immigration Act, 1962, and the Ships and Aircraft Regulations, 1966.

During the period 1st January to 31st December, 1971, there were 51,303 aircraft arrivals – an increase of 5,180 over 1970. These flights involved 4,701,030 passengers in 1971 – an increase of approximately 12-7 per cent. During this period the unit examined 6,918 Commonwealth immigrants. Of these 13 were classified as likely to require major medical treatment.

CHAPTER NINE – THE SCHOOL HEALTH SERVICE and Statistical Tables

INTRODUCTION

The work of the School Health Service is described in this chapter. Like many other Authorities, we have been taking a close look at the structure of this service during the past few years. The year has seen the commencement of a streamlined form of medical inspections, dispensing with routine inspection at eight years in favour of the selective approach, and the substitution of a leavers' interview in place of a routine examination. Unlike some other Authorities, we have continued to include a routine inspection of the children on entry to secondary school. The Working Party which recommended the new arrangements felt that, with children remaining in school for eleven years, it was only reasonable to leave a routine check on their health at about the half-way stage. This view was reinforced by the fact that during preliminary trials, the organisation of an efficient selective approach within the large new secondary schools which are evolving proved difficult and time-consuming. The alternative to a routine inspection of all children therefore appeared to be no examination at all at a time when the children were going through a major change in their educational life. Hence the continuation of this routine inspection in our new programme, which is devoted to more efficient use of existing resources of medical manpower, and which lays the emphasis of the service on the identification of those children whose health problems may interfere with their schooling.

The development of other aspects of the School Health Service has continued during the year with increased provision in the fields of child guidance, speech therapy and audiometry. The inclusion of several hundred mentally handicapped children many with secondary handicaps in the educational system has brought these children within the scope of the School Health Service and their needs are being re-studied in the light of this new development.

A memorandum covering the whole aspect of services provided for the assessment and management of handicapped children in the county of Surrey was prepared during the year and is printed as Appendix A to this chapter.

For the past few years the future of the School Health Service has been a source of considerable discussion, ranging from the need to continue to provide it at all to the way in which it should be administered within a reorganised Health Service. With regard to the former the increasing complexity and knowledge of handicaps in childhood makes it of paramount importance that those dealing with the health of the child shall work in ever closer cooperation with those providing his education. Ideally, therefore, medical and nursing staff with the ability to work within the schools and to have a reasonable knowledge of educational provisions and procedures is required. This is the aim of those employed in the School Health Service and the failure to continue this as an entity would be seriously detrimental to the children concerned. The continued expansion of services within the School Health Service over the years is a practical demonstration of this fact.

By the time this report is presented the recommendations for the future of the School Health Service will have been received and it need only be emphasised that if the development and planning of child health services is to continue to the satisfaction of the local education authority then arrangements must be made for close liaison between Health and Education not only at grass roots level but throughout the whole administrative structure.

SCHOOLS AND SCHOOL POPULATION

The following County Schools are served by the School Health Service in Surrey:–

		No. of Establishments
Primary Education		
	Nursery Schools	6
	Primary Schools	371
Secondary Education		
	Grammar Schools	18
	Boarding Schools	1
	Other Secondary Schools	69
Special Schools		
	Day Schools and Units	13
	Residential Schools	9
	Hospital Schools	9
	Hostel	1

At the end of 1971 the number of children on School Rolls was 152,308. (This is the actual number as at January, 1972 and compares with 148,386 children as at January, 1971.)

Medical Inspections

Following trials of selective medical inspections carried out during 1969 and 1970 a new system of inspection of schoolchildren was adopted as from the beginning of the autumn term. Children are now inspected as follows:–

1 On entry – full inspection.

2 On entry to junior or middle school – selective inspection.

3 On entry to senior or secondary school – full inspection.

4 Before leaving – interview with medical officer leading to a medical inspection if indicated.

The new system appears to be working satisfactorily and is designed to create a more effective approach to health problems affecting the education of the children. It also aims at creating closer links between the teachers and the health team.

Tables A, B, C, and D, give details of the work carried out during the year. The figures, while not strictly comparable with last year due to the introduction of selective inspections, do not call for any specific comment as the number of children requiring treatment or observation has not substantially altered from the previous year. However 3,475 children were found not to warrant inspection compared with 856 in the previous year.

Visual Defects

Under the new system of medical inspection, vision testing will continue to be carried out at frequent intervals as a routine measure. Figures for 1971 are given in Table E on page 00.

Audiometric Screening

Shortage of qualified audiology technicians during the year affected adversely the number of children who received their routine pure tone screening at the age of 6 years. However recruitment has recently improved and it is hoped to provide a full service during the coming year. The work of this service is shown in Table G, page 00.

Personal Hygiene

The increase in head infestation which became apparent last year has continued, but not at the same rate. 753 individual pupils were found to be infested in 1971, compared with 694 in 1970 and 332 in 1969. The continuing high incidence caused Health Visitors and School Nurses to increase their activities in carrying out examinations for this purpose and a total of 59,055 individual examinations were undertaken in 1971 compared with 43,123 in 1970.

The longer hair styles commonly in vogue make cleansing a more difficult process, and faulty techniques in the use of lotions or shampoos can be a contributory factor to their apparent ineffectiveness in use under these circumstances.

The increasing resistance of head lice to insecticides which have previously been used for cleansing is also part of the picture, and several areas of the County have been using new products to combat this. Health visitors and nurses instruct parents in the use of the various preparations with a view to overcoming the difficulties. Furthermore, in certain schools where selective examinations were previously carried out, routine inspection has been re-started.

USE OF NURSING STAFF IN SCHOOL HEALTH SERVICE

The following tables show the work carried out by Health Visitors and part-time school nurses during 1971 compared with the previous year:–

Health Visitors Fixed Appointments in 1971
(Comparative figures for 1970 in brackets)

Preparation for Medical Inspection	Medical Inspection	General Medical Clinic	Hygiene	Teaching Sessions	TOTAL	Other Visits
846 (663)	1,551 (1,175)	74 (130)	322 (278)	609 (532)	3,402 (2,778)	742 (611)

Part-time School Nurses. Sessions worked in 1971
(Comparative figures for 1970 in brackets)

Preparation for Medical Inspection	Medical Inspection	General Medical Clinics	Immunisation	Other	Total
160 (334)	1,544 (1,599)	1,437 (1,415)	1,122 (581)	1,022 (536)	5,285 (4,465)

THE ROLE OF THE HEALTH VISITOR IN THE SCHOOL HEALTH SERVICE

A working party set up to look at the role of the Health Visitor in the school health service was convened and reported at the end of the year. The report is to be circulated to staff and all schools in the 1972 spring term and is printed as Appendix B to this chapter.

The position of health visitors in schools has become somewhat equivocal during the past few years as a result of re-organisation of the health visiting service with attachment to general practice as opposed to geographical areas. In turn this has led to a diversification of the work of the health visitor and has tended to reduce the links which previously existed between schools and health visitors. The aim of the Report is to re-state clearly the policy that individual health visitors should be attached to schools as an integral part of the Educational Health Service and to lay down in some detail how this should be achieved.

SPECIAL FORMS OF TREATMENT

Audiology

Dr. E. Beet, Senior Medical Officer Audiological Service, reports:–

This has been a good year for the partially hearing units and peripatetic services as they have been fully staffed by qualified teachers of the deaf, six teachers at the units and six (seven from September) peripatetic teachers.

Attendance at audiology clinics throughout the County has been good. One of our aims at these clinics is to detect impaired hearing in children at as early an age as possible so that they can be helped to overcome their handicap and be allowed to benefit from education as fully as the nature of their defective hearing permits. Are we succeeding in doing this? Figures for children born in the five years 1967-1971 who have been found to have a hearing defect of sufficient severity to warrant the use of a hearing aid and training from a teacher of the deaf answer, in part, this question. This group of children is an important one as all of them have difficulty in learning to talk and in the use of language without help and training from specialist teachers.

There are fifty-two children in this age group wearing hearing aids. They were born in the following years:– 1967 – 13 children; 1968 – 21 children; 1969 – 11 children; 1970 – 5 children; 1971 – 2 children.

Thirty eight of the children were born to Surrey resident mothers and fourteen were born in families outside the County who later moved into Surrey; four families have left Surrey. What is interesting is to know how many children were first discovered to be deaf at a S.C.C. Audiology Clinic and to relate this figure to the number of children who should have been found by us if our detection system was fully efficient. From the total of fifty two children, eleven must be excluded as some of these children were already known to be deaf by the time their families arrived in Surrey from abroad or other parts of the United Kingdom, and others were found to be deaf at hospitals which they attended for conditions which either caused the deafness (e.g. meningitis), or are associated with deafness (e.g. congenital defects), and so would not have been found by us. This leaves forty one children. It is satisfactory to know that of these children, thirty nine were in fact discovered to be deaf at Surrey audiology clinics after referral there by health visitors, departmental medical officers, speech therapists, general practitioners and paediatricians. The two children not picked up by us were referred by general practitioners to a hospital and an audiology unit outside the County. In each case the consultant concerned referred the children back to the Surrey County Council service for supervision and training.

When considering the cause of deafness in children, national figures show that approximately one third are due to maternal rubella in the early months of pregnancy, one third result from a variety of known conditions and the remaining third are deaf for no apparent reason. The aetiology of the deafness in the Surrey children is as follows:–

Maternal rubella		17
Familial (genetic)	5	
Prematurity and perinatal anoxia	6	
Meningitis	2	17
Associated with cerebral palsy	2	
Rhesus incompatibility	1	
Congenital defect	1	
Cause not known		18
		52

Now that immunisation against rubella is possible, and is being carried out among girls in the thirteen year age group, it is a real possibility that the number of children born deaf will fall considerably in the years ahead. As children deafened as a result of maternal rubella are often severely deaf and may have other handicaps – physical, emotional and intellectual – immunisation against rubella offers us a great opportunity to prevent a serious handicapping disability among the children of future generations.

Other points of interest are that two of these fifty two children are adopted and two are with foster parents, two are severely subnormal and one is both deaf and blind.

Speech Therapy

There are three Senior Speech Therapists with area responsibilities and an establishment of 19 Speech Therapists covering school clinics and special schools, including those schools transferred to the Education Department under the Education (Handicapped Children) Act, 1970, on 1st April, 1971, from the Mental Health Service. Increasing

demands have been made for Speech Therapists to work in nursery schools, remedial centres, and ordinary schools. More group work which provides its own dynamics is being carried out by individual therapists and enables more children to receive the benefit of speech therapy.

The work of the Speech Therapy Service is shown in Table J on page 60.

Surrey Speech Screening Test

This standard test to help Medical Officers in assessing the speech of young children was reported in full in the 1970 Annual Report. During the current year requests for the test card have been received from all parts of the country and from abroad, evoking interest in many different spheres. Requests were received for copies from the Department of Education and Science, 25 Local Education Authorities in this country, Authorities in Canada, New Zealand and the British Forces in Germany, Hospitals and Institutes of Child Health, Polytechnics and Educational Psychologists as well as individual doctors throughout the country. It has also been reported in the press and provoked some interesting comment and discussion in the professions.

Intensive Speech Therapy

This form of speech therapy which gives children the opportunity of daily attendance for a limited period instead of the normal once weekly or once fortnightly clinic visit was tried out as an experiment in one area of the County this year. A Senior with other Speech Therapists undertook a pilot study and the following detailed report has been compiled by Miss G. M. Marston, the Senior Speech Therapist concerned:—

"First of all, why intensive therapy? Many speech therapists had children attending the clinic once or twice a week who were making poor progress. The weekly appointments were too far apart for reinforcement to occur and what was accomplished one week was forgotten by the next even with good parental co-operation. These children had delayed language development together with perceptual difficulties and articulation problems ranging from minor to severe.

"A particular group of patients for whom it was felt intensive therapy would be beneficial was those who for various reasons either attended irregularly or not at all.

"The possibility of setting up units for these children had been considered but the difficulties associated with such additional projects and the time required to initiate them had caused us to look for alternative methods. It had been brought to our notice that the Borough of Warley near Birmingham had already experimented with an intensive course and I visited to obtain details of their scheme. Following this it was decided to adopt a modified approach within the County of Surrey.

The children who are selected by their own speech therapists are withdrawn from school with the agreement of the Education Authority for a period of three consecutive weeks in the mornings only. 8-10 children are catered for with 4 therapists in attendance.

"Before commencing the course, the children are given a series of tests by a medical officer, an educational psychologist, and a speech therapist.

"The course involves many and varied activities, and requires a considerable amount of material, some purchased but much produced by the therapists themselves. A great deal of planning of individual as well as of group activities is required.

"The response from parents has been remarkable particularly with those who had difficulty in bringing their children to the clinic but who were only too pleased to let them participate when transport was provided.

"At the end of the course a coffee evening for parents is held and a full discussion of their children's problems and progress takes place. The response to this invitation has been most heartening and interest shown by the parents is gratifying.

"Three months later during which time the children receive no further therapy the tests mentioned above are repeated in order to establish whether lasting improvements have been made. At the time of writing, three courses have been held and evidence is encouraging. Also feedback from schools suggest that the experiment has been worthwhile.

We are grateful to our medical and educational psychologist colleagues for their co-operation. The courses will be continued and the whole procedure treated in the form of a research project with a view to establishing its validity as a method of treatment of the more difficult type of case."

Child Guidance Service

The number of children referred to Child Guidance Clinics during the year was 1,273 (1,227 in 1970) and the detailed work undertaken by the Clinics is shown in Table K.

The information contained in the tables below which indicate the staffing and establishment of the Clinics shows reasonable numbers in post with the exception of psychotherapists. This is due to a national shortage of psychotherapists and very few completing the four year training courses in this country. Discussions have been held with the Training Schools concerned and it is hoped that these contacts will yield some suitable recruits in the future.

Clinic, School or Hostel	Professional and clerical staff employed expressed as a proportion of full-time									
(1) Establishment (2) Staff in post at 31.12.71	Psychiatrists (1)	(2)	Educational Psychologists (1)	(2)	Social Workers (1)	(2)	Psychotherapists (1)	(2)	Clerical (1)	(2)
Farnham	0.6	0.5	1.0	–	1.0	1.4	0.4	0.6	1.5	1.5
Godalming	0.4	0.3	1.0	1.0	1.0	0.8	0.4	0.4	1.0	1.0
Guildford	0.8	0.8	*2.0	*2.0	2.0	2.3	1.0	–	2.0	2.0
Chipstead	0.6	0.6	1.0	1.0	1.5	2.2	0.4	–	1.5	1.5
Redhill	0.9	1.0	1.5	1.5	2.0	1.7	0.6	0.3	2.0	2.0
Epsom	0.5	0.4	1.0	1.0	1.0	1.5	0.6	0.3	2.0	2.0
Leatherhead	0.1	0.2	0.5	0.5	0.5	–	0.4	0.1	–	–
Hersham	0.6	0.6	1.0	1.0	1.0	1.2	0.4	0.4	2.0	2.0
Woking	0.6	0.6	2.0	1.5	2.0	0.6	0.5	0.2	2.0	1.7
Staines	0.6	0.6	1.6	1.6	2.0	2.0	0.4	0.4	2.0	2.0
Chertsey	0.6	0.5	1.0	–	1.0	1.0	–	0.2	1.0	1.0
The Lindens	0.4	0.4	–	–	–	–	–	–	–	–
Thornchace	0.1	0.1	–	–	0.2	0.2	–	–	–	–
Starhurst	0.1	0.1	–	0.1	0.4	0.4	–	–	–	–
Wishmore Cross	0.1	0.1	–	–	0.4	0.4	–	–	–	–
Wey House	0.05	0.05	–	–	0.4	0.4	–	–	–	–
Total equivalent full-time	7.05	6.85	13.6	11.2	16.4	16.1	5.3	2.9	17.0	16.7

* This includes the Senior Educational Psychologist.

In the reports received at the end of the year from the Medical Directors of Child Guidance Clinics, mention is made of continuing regular contact with medical officers, health visitors, school heads and counsellors, the Social Services Department, youth officers and the Probation Service. The Sidlow Bridge Day Maladjusted Unit has been of considerable assistance to the medical directors of clinics in the South-East area of the County and similar units elsewhere would be of further help in preventing a proportion of children having to be sent away to boarding schools. Group therapy is undertaken at several clinics where children can be seen by a psychotherapist while mothers can be seen at the same time by the clinic social worker.

Each year selected items from reports submitted by the medical directors of child guidance clinics are printed, and two reports of particular interest this year are given below in full. Dr. Mirza describes the work of the new clinic at Chertsey which completed its first full year in operation at the end of 1971. Dr. Morton's report, very different in style, gives an interesting insight into the dynamics of the working of the Guildford clinic. A section of Dr. Hertzog's report dealing with the possible effects of the raising of the school leaving age is also included.

Dr. Mirza, Chertsey:–

From January, 1971-January, 1972, the Child Guidance Clinic has received 159 referrals, of which 149 were taken on for treatment or under supervision. The referral rate has steadily increased throughout the year as the existence of the clinic has become known; this is in spite of the fact that the schools have been requested to send only the most urgent cases to the Educational Psychologist because of the limited time the Educational Psychologist is able to spend in this area. We found that the informal meeting we held at the clinic in November of last year for G.P.s and medical staff from the local general and psychiatric hospitals was invaluable in establishing personal contacts and has much facilitated liaison in these directions.

From the social work point of view Chertsey offers a very wide range in family social and economic backgrounds. Although we have received referrals of children from each part of the scale it has been noticeable that a large proportion have come from the caravan sites and from lower income families. Most cases have indicated the need for a full social history to be taken at the beginning of treatment and a large proportion of cases have sufficient social problems to be taken on for family casework. Lack of personnel has prevented this being done in every case where it would have been helpful. The need, therefore, for another Social Worker is imperative. It is hoped to start groups for parents in the near future now that the clinic is more established. Special effort has been made to establish good links with the local Social Services Department, Health Visitors and Probation Officers.

My work load is such that therapeutic sessions with children have to be spaced at longer intervals. I am therefore glad to have a qualified psychotherapist who devotes two sessions per week to the clinic although this arrangement is not adequate to meet the needs.

Dr. Morton, Guildford:–

It is now generally accepted at our clinic that the quickest and most effective treatment method is via the family, rather than via the individual child, although there are always exceptions to the rule. Usually we like to see as many of the family as possible because even the most unpretentious member has something to offer. The quiet little sister of the referred child could be painting a picture which sums up the whole family problem, although the family may not yet be able to tolerate the truth of that message at that particular time.

A few families do not benefit from family group therapy – perhaps because they cannot tolerate seeing themselves as separate individuals. Often in these cases, prolonged (traditional) individual therapy with, for example, the mother seeing one therapist and the child another, can lead to everybody getting together eventually. There seems to be some unknown latent "catalyst" in the family group that can be awakened to good purpose.

I have noticed in myself very marked differences in approach when seeing one family compared with another; also I have noticed this same marked difference when seeing a family for the first time, compared with seeing them later on. Most of our families are intact and middle class, but their impact on me is profoundly different, the one compared with the other. It is difficult, therefore, to recommend any particular treatment technique and, indeed, the approach of one family therapist could suit his personality but may not suit another's. For myself, I find it best to know as little about the family as possible, but not, I hope, to the point of appearing stupid. This is because I find exposure of myself to the family problem is hindered by routine history-taking. They begin to present their problems sooner when I seem not to be armed with foreknowledge that one or other of them might fear I would use to expose them, or that one or other family member might imagine would prejudice me.

Interviews at our clinic seem best conducted by two co-therapists and are intentionally non-directive, though the reason for referral is usually brought into the discussion sooner or later.

It often transpires that the various family members are not agreed on the reason for referral; alternatively, each may be wanting something different; and, additionally, the problem may seem to exist in different parts of the family, according to who is looking. Indeed, to the therapists the interview may seem at times to be noisy, confusing and verging on the chaotic. Oddly, though, the most violent interviews seem to be tolerated more easily by the family than by the therapists, as we have confirmed by retrospective discussion at subsequent meetings.

We find it best not to confine our family group meetings to the clinic. Where the school is involved and our role is primarily that of mediator between the family and the school, we find it best to include the teacher and meet at the school. When the child is in care we often find it helpful to meet at the Children's Home when the house-parents are asking for help on behalf of the child and the child has no family of his own.

Genuine "entry" into a family may be very difficult when their rules and forms of communication are idiosyncratic or unfamiliar. Fortunately their verbal and non-verbal forms of communication can be learned by a newcomer, even though sometimes it is very hard work. No doubt they are used to their own forms of communication which they have long taken for granted. It is this "learning" by us which seems to benefit the family rather than the acquisition of facts or their interpretation.

Most long-enduring systems such as families tend either to resist entry or to absorb and dissolve those who enter. For the therapist to enter at all and remain relatively intact, automatically alters the family system. Once alteration has taken place it is then possible for the family to choose alternative ways of relating and communicating, which could prove through trial and error to suit them better. Once we are accepted we can interact with the everchanging group scene until the family feels ready to carry on without us.

Perhaps it is not yet time to describe comparatively the different treatment approaches to different kinds of family problem. At this stage it seems to me as mistaken to try categorising a particular kind of family structure as it would be to adopt a preconceived pattern of behaviour towards someone I am meeting for the first time. Meanwhile, I can be sure that the family will make it clear in the first few minutes whether they can tolerate the group approach or whether splitting up with separate interviews in different rooms must first be arranged."

Dr. J. L. Hertzog, Redhill:–

"I feel bound to stress at this point the strong feeling of all staff concerning developments that will arise from the raising of the school leaving age. Our clinic is only just managing to cope with the very large numbers of referrals for school phobia and truancy and we anticipate a considerable increase in these cases as soon as the school leaving age is raised. We have never found it easy to place these children who need boarding facilities when they encounter such problems but many of us feel desperate as to what measures we can take that will be of any value when the situation is upon us. Presumably more boarding schools will be prepared to admit boys and girls when they are over 14 years of age, which is, of course, not the case at the present time."

The School Psychological Service

Mr. J. Walker, Senior Educational Psychologist reports:–

The year 1971 has been a period of development, consolidation and restriction in the work of the School Psychological Service.

In 1970, there was a certain amount of internal reorganisation of the service in order to achieve a more effective deployment of personnel, and a major proposal was the scheme for systematic educational screening in primary schools, in conjunction with the Inspectorate.

Screening was eventually completed in the Excepted Districts of all children in the 7 to 8 year age level involving group tests of intelligence and reading attainment, and on the basis of these results, together with consultation with the schools, detection of children with learning problems was further improved. Arrangements were subsequently made for remedial education from within the local Schools' own resources so far as was practical, and in certain special cases, attendance at the local remedial centre was recommended.

The Working Party, convened to evaluate the results of the study, was presented with detailed reports and it was recommended to the Education Committee to progressively expand educational screening throughout the County.

It is clear that screening of this kind enables proper provision to be made for these children at an educational risk, but it also indicates the need for a systematic follow up of certain children. Such investigations include liaison and consultation with all the supporting services provided by the County and suggests that an important need is for the further development of in-service training schemes for teachers in the improvement of techniques of detection, remedial and educational procedures, perhaps of an intensive kind, a matter being considered at present by the Inspectorate.

A pilot survey was also conducted in collaboration with the Medical Research Council on the validation of a new educational assessment procedure for use with secondary pupils in the Staines area, as well as a trial validation survey in Guildford of a group mathematics test for use in Surrey schools. Some preliminary investigations are also being conducted upon the construction of a Teachers' Check Test for use in the detection of physical and emotional symptoms of educational failure in the classroom situation.

The School Psychological Service has been closely associated with dyslexic children and a procedure has now been established by which the condition can be properly investigated and diagnosed by a team of specialists so that appropriate recommendations can be made for suitable educational provision. This development in the work of the School Psychological Service is related to Section 27 of the Chronically Sick and Disabled Persons' Act 1970.

Recent policy by the Education Committee with regard to the exceptionally gifted child has also engaged the School Psychological Service in a close examination of the procedure for the selection of such children, in collaboration with the Inspectorate, and it is proposed to prepare a report for the Chief Education Officer on the identification and educational provision for gifted children in the County.

The Education Committee's responsibility for the hospital schools for educationally sub-normal children has also involved the school psychological service in a new and varied role, which will clearly require an increasing commitment of responsibility in the use of educational methods and perhaps technology. Several publications have been prepared by the County's psychologists, quite apart from lecture programmes and case work.

The number of children referred to the School Psychological Service continues to rise, but due to the difficulties of adequate recruitment, and the shortage of psychologists in Surrey, (2.5 of establishment), the annual figure for the overall service represents only a modest improvement upon the previous year. However, the introduction of educational screening has meant that more children have actually been considered by the school staff and local psychologists through personal consultation, such selective procedures being particularly helpful where vacancies for psychologists have occurred.

It is increasingly recognised that although individual assessment is an essential part of diagnosis, the most important objective is the prescription of appropriate individual treatment, remediation, or educational placement. This trend has been continued this year by the psychologists, and to the evaluation of a child's needs in this context, which has particularly involved closer collaboration with the school medical officers in evaluating the individual child's response to his home and school environment.

Useful work continues to be done by the psychologists in their various specialist roles, and there has been an increasing commitment to lecture programmes, parent discussion, and student training schemes.

The restriction to the work of the School Psychological Service has been the relatively high turnover of staff, usually for promotion to adjacent Local Education Authorities and vacancies in the Chertsey and Farnham areas have created considerable problems in providing a service to schools, ameliorated to some extent by the provision of locum services by psychologists from other areas.

The approval of the appointment of three Area Educational psychologists from within the existing establishment has partly resolved the problem of retaining staff of suitable calibre and certainly contributed to the promotion of more officers to local services. Undoubtedly, in an authority the size of Surrey, variety and flexibility in the kind of service in the form of specialist responsibilities is a development which would enhance the service to schools, and proposals will shortly be put to the Education Committee about this plan. Similarly, there is also a need for a specific recruitment policy if the full establishment is to be maintained.

In conclusion it should be noted that the work of the School Psychological Service has proceeded satisfactorily in the last year but the changing function in the role of the service requires consideration to be given to the provision of specialist posts and systematic recruitment in order to achieve a more effective service to schools.

HANDICAPPED PUPILS

The following table shows the number of children newly ascertained as handicapped during 1971:

Category	Boys	Girls	Total
Blind	–	–	–
Partially sighted	–	–	–
Deaf	1	5	6
Partially hearing	7	3	10
Educationally sub-normal	138	108	246
Epileptic	1	3	4
Maladjusted	53	23	76
Physically handicapped	15	7	22
Delicate	9	6	15
Speech defect	4	–	4
Totals	228	155	383

The increase in the number of children newly ascertained as educationally subnormal is due to children being included in this category under the Education (Handicapped Pupils) Act 1970, such children being previously ascertained as severely subnormal and attending establishments within the Mental Health Services. The six establish-

SPECIAL EDUCATION

Mentally handicapped children now enjoy the same health and educational facilities as other children.

ments transferred to the Education Committee from the Health Committee are now included in the list of Special Schools, Table M, page 63.

A total of 386 children were on the school rolls at the time of transfer. Manor Mead, Shepperton, opened in September, 1971. This school was part of the former Mental Health Service Development Programme and was handed over to the Education Committee under the provisions of the 1970 Education Act.

Wey House School, Bramley, a residential school for 45 maladjusted girls in the age range 10-16 years, opened in June 1971. A Day Centre for 16 maladjusted boys and girls age between 5 and 11 years was opened in September, 1971, in premises formerly used by the Sidlow Bridge, Church of England School, at Sidlow, Reigate.

Two other projects have been transferred to the Education Committee. Woodlands School, Ewell, due to be replaced by purpose-built premises at Fortyfoot Road, Leatherhead, will provide 92 places for children in the age range 2-16 years. A similar school is in the course of construction at Portesbury Road, Camberley, and it is hoped that this and the new Woodlands School will be ready for occupation in January, 1973.

Remedial Education

An additional centre in the premises of Ashley First School, Walton-on-Thames is planned to open in January, 1972.

EMPLOYMENT OF CHILDREN

The bye-laws regulating the employment of children provide for an annual medical examination of children in part-time employment.

1,208 children were medically examined during the year as to their fitness to take part-time employment and all but 1 were found to be fit. The examinations are undertaken by School Medical Officers at clinics nearest to the homes of the applicants.

There were 47 licences applied for during the year for pupils to take part in entertainments. All these children were examined by School Medical Officers and found to be fit.

TUBERCULOSIS IN SCHOOLS

During the year 1 school child and 1 teacher were notified as suffering from tuberculosis.

Category	Maintained Schools	Independent Schools	Totals
School children	2	–	2
Teachers	1	–	1
Other staff	1	–	1
Totals	4	–	4

Epidemiological investigations were carried out at all four schools and a total of 799 pupils were Heaf tested. Of these 86 pupils were found to be mantoux positive. It was decided to X-ray 11 mantoux positive cases–those who had not previously received BCG vaccination. A total of 935 pupils, teachers and other staff were X-rayed only. No unsatisfactory results were reported and no further incidents arose out of the investigations.

PROMOTION OF HEALTH

Health Education

Although the prime responsibility for the child's education in health, as for his general education, is the parents', the teacher has also a most important part to play. The home is certainly the more potent in earlier years but, as the child grows older, the school becomes increasingly influential. Many schools are now setting about planning schemes of health education appropriate to the various stages of the child's development.

Early in the year a working party was set up comprising Her Majesty's Inspectors, the County Inspectorate, together with dental, medical and educational staff of the County Health department. It was decided to undertake a survey of health education in schools in order to provide a base from which further developments could proceed. Some 40 schools were included in the survey which continued throughout the year. A conference of heads and other teaching staff concerned was planned for the ensuing year.

The staff of the department, particularly the health visitors, have continued to assist the teaching staff in planning and carrying out work in health studies. There has been a further increase in the number of teaching sessions undertaken covering topics in which the staff have special expertise, including care of children, human growth and

development, Duke of Edinburgh's Award scheme, mothercraft, community care, health and beauty, smoking and health, dental health, child care, inter-personal relationships, family care, personal hygiene, first aid, venereal diseases, drugs, learning for living, home safety, growing up, knowing ourselves, home nursing, health visiting, anatomy and physiology, nutrition and general health. Schools have kindly afforded opportunities also for student health visitors to take occasional lessons in collaboration with the fieldwork instructors. The health education officers have provided extended assistance on teaching methods and resources to all schools and colleges and to medical, dental and nursing staff of the department.

An innovation in the field of informal health education was carried out in a local authority play centre during the summer holidays. A member of the health education staff spent a number of sessions with groups of young children using monster-size jig-saw puzzles constructed from double crown posters mounted on hardboard. As the children completed the puzzles which dealt with dental health, smoking and safety, the opportunity was taken to initiate a discussion with the youngsters who eagerly participated. It is hoped that this pilot scheme could be expanded in subsequent years.

The full-time lecturer in dental health education continued her work in the various areas of the county, visiting a total of 125 first, middle and special schools numbering 27,844 individuals. She also provided lectures to student dental surgery assistants, gave talks to young mothers and assisted with exhibitions. One of her responsibilities is to ensure that the dental surgeons and assistants are provided with sufficient appropriate teaching and publicity material to further their own efforts in dental health education.

The pilot scheme in the Epsom area to offer apples for sale in schools throughout the year at a fixed price was regarded a success. During the first term over 20,000 apples were consumed in that area alone thus displacing, it is hoped, an equal quantity of between meal cariogenic foods. The scheme, which has the support of the teachers, was later extended to schools in the South-Eastern Division, Esher and Woking and during the autumn term over 190,000 apples were distributed. It is hoped to extend the scheme eventually to the rest of the County.

School Children and Drugs

The system whereby Heads of Schools are asked to inform Divisional Educational Officers of confirmed cases of drug taking, and to bring suspected cases to the notice of Divisional Medical Officers so that investigations would be made, was continued during the year. In the autumn of 1971 officers of the Education and Health Departments met with police officers of the Drug Squad to discuss these arrangements which had originally been agreed in 1967. The police felt that the system was working well and appreciated the co-operation they received from the schools.

The following reports have been received from divisions:–

AREA A – 2 cases in one school (1969 – No cases, 1970 – 2 cases)
AREA B – 3 cases in one school (1969 – No cases, 1970 – No cases)
AREA C – 1 case with two other children possibly involved in one school (1969 – No cases, 1970 – No cases proven)
AREA D – 3 cases in three schools (1969 – 2 cases, 1970 – 1 case)
AREA E – 3 definite cases in one school and 1 in another school, their activities being linked. Apart from this 5 suspected cases in one school not proven (1969 – No cases, 1970 – 1 case)
AREA F – 10 cases in one school (1969 – 1 case, and 2 cases not proven, 1970 – no cases)
AREA G – 5 cases in four schools (1969 – 1 case confirmed, 1970 – 3 cases)

It still remains a difficult problem to obtain clear figures of drug abuse among young people as obviously all cases do not come to light. The above confirmed cases during 1971 total 27 under school leaving age. While this is a very small number of children there will have been other cases not identified and experimentation with drugs will have gone on to an unknown extent. It is therefore important that a firm policy of education of children in this subject be evolved. There is no doubt that it should be discussed at a level appropriate to the age of the child within the wider context of preparation for healthy living. As time goes by a body of evidence as to how this matter should be approached is being accumulated. Although some schools are making headway in this field more stimulation is required. In an effort to provide this a new memorandum on the subject of Drugs and the Adolescent was prepared and circulated to secondary schools early in 1972. Furthermore the Working Party referred to on page 50 set up to survey the whole subject of health education in schools should provide the necessary stimulus for further action.

REPORT ON PHYSICAL EDUCATION AND SWIMMING FOR 1971

Mrs. E. N. Bromfield, General Inspector writes:–

Throughout the year a full programme of in-service training courses has been carried through, well supported by the teachers in infant, junior and secondary schools. Each Physical Education Advisor has organised area courses based on suitable material for the physical education programme for the First and Middle School age range.

Middle School Programme

In addition a successful 5 days' course was held for 40 teachers who are responsible for co-ordinating the physical education programme for the Middle School range the course was basically a practicable one so the teachers followed an exacting programme of gymnastics, swimming, athletics, games skills leading to the major games, camping and orienteering.

Successful courses included in the previous year's programme were repeated.

The Residential Course for Secondary School Physical Education Specialists National Recreation Centre

The course included a wide range of activities suitable for senior pupils. Several meetings of secondary School P.E. teachers have taken place where ideas were discussed for the N.O.S.L.A. pupils.

Alpine Village Projects

In the Spring Term of 1972 four groups each one hundred plus, organised by an Education Inspector and accompanied by selected teachers from the schools concerned and a nurse, visited the Austrian Tyrol and Aprica in Italy.

Once more the combination of learning a new skill, ski-ing and environmental and language studies proved to be most successful. The standard of ski-ing was very high, 75% of the pupils achieved the One and Two Star Awards in the G.B. Ski-Tests. Since the opening of the Sandown Ski-School last September many pupils have been able to master the fundamentals of ski-ing on the dry ski-slope.

Creative Dance

As a result of the courses held at the Art of Movement Studio in Addlestone for First, Middle and Secondary School Teachers there is a much greater interest in this particular aspect of movement study. A creative dance Circle has been formed so that interested teachers may meet together twice each term to exchange ideas and to see some of the work in schools.

Tennis Clinic – Guildford

Again this year the promising tennis players from 20 schools in the Guildford area were fortunate enough to have an afternoon's coaching by Miss Evonne Goolagong the current Wimbledon Champion and her coach Mr. Vic Edwards.

Trampolining

As a safety measure it was decided that all teachers involved in teaching trampolining should have a recognised qualification. Courses have been arranged this year for those teachers wishing to gain the Surrey Certificate of Competence to teach the basic agilities.

Guildford Sports Centre

The senior pupils from schools in the Guildford Area have been using the Centre on 3 afternoons each week and have received excellent coaching in squash, badminton, trampolining, golf, archery, table-tennis and diving.

It is hoped that by introducing a variety of activities to senior pupils it will lead to the use of such facilities in out-of-school leisure time.

Swimming

Every effort continues to be made to offer children of Primary School age the opportunity to learn to swim. All public swimming pools in the County are fully time-tabled for use by schools and in some areas further provision would be appreciated.

The provision of learner pools by voluntary efforts continues to expand and this year the Education Committee has approved grants towards 17 further projects plus supplementary grants for additional improvements to four existing pools.

More schools are seeking to enclose their swimming pools and the most common methods used at present are the "Clear Span" cover or, very successfully, the "Russian Pool Shelter" as marketed by "Purley Pools Ltd.," and "Mermaid Pools Ltd.".

Maintenance of these school pools is still carried out in the main by the school caretakers with regular checks by the local Health Inspector.

The Local Government Training Board has recently issued suggested Modules for training school caretakers in the operation of small swimming pools and have produced a training manual which can act as a basis for a training course. The manual contains:–

(1) training lecture notes for retention by the caretaker.

(2) swimming pool operating instructions and diagrams.

It is hoped that eventually a copy of this manual will be made available to all schools with swimming pools.

Swimming courses for teachers have again taken place during the year. An A.S.A. Teachers Certificate Course was held at Staines Baths in February attended by 40 teachers and two half-day courses were held at school pools in Esher and Guildford during May attended by a total of 80 teachers.

School Swimming Pools

Mr. W. L. Leach, County Health Inspector comments:–

The number of "learner" swimming pools continues to grow. There are now 140 school pools in regular use. They are accepted as a very desirable addition to a school's facilities, and it is pleasing to note that many schemes now being submitted are on a more substantial basis than was the case in previous years. Most pools are now heated and have changing accommodation. Many are being covered completely and are having the "Russian" shelter type of protection to ensure a longer teaching season.

As the equipment originally provided for some of the earlier pools becomes worn out or inadequate, the opportunity is being taken to secure rather higher standards of performance especially as regards filtration procedures.

All pools are or should be operated on the "break point" system of chlorination, so that there were very few reports of unsatisfactory conditions developing during 1971. At the beginning of the season in April a one-day course of training in the operation and maintenance of school pools was arranged for those school staffs who would be doing this work for the first time in 1971. This was held at Glyn House, Ewell, and about 40 teachers and caretakers attended. This will be repeated as and when required. All plans for new pools and for alterations and extensions to existing pools are scrutinised by the various Departments involved before being approved. The principal difficulty remains, as reported last year, that the smaller and simpler filtration systems cannot cope with overloading and the numbers of "swimmers" must be limited to the number for which the equipment was designed or, alternatively, improved systems of filtration should be installed. It is not sufficient to increase the rate of chlorination, as was noted in some pools, as this is unnecessary and wasteful. Regular sampling for the checking of levels of chlorination, and ph and cyanuric acid (4ph stabilisation) are carried out by the Supplies Department Laboratory, and expert advice on all questions of water quality is readily available from there. In addition public health inspectors visit and take samples for bacteriological examination where the condition of the swimming pool appears to warrant this.

PROVISION OF MEALS AND MILK

The following table gives statistics (based on the annual October returns) as to the number of pupils taking milk and meals at maintained schools.

Number in Attendance	Number taking milk			Number taking meals	Percentage taking meals	Cost of meal	Number taking meals at	
	on grounds of age	at special schools	on health grounds				Full cost	Free
143,850 (85,952 Primary)	32,417	1,461	36	96,233	67.2	12p	89,737	6,496

SCHOOL DENTAL SERVICE

Report of the Principal School Dental Officer

There were several changes in the dental staff during the year 1971. All vacancies were filled but in some instances there were intervals before new appointments were made. At the 31st December, 1971, the Dental Officer staff consisted of 16 full-time Officers including 2 Orthodontists and 32 sessionally employed Officers equivalent to 10.4 full-time Officers. This compares with the position at the end of 1970 when there were 16 full-time Officers and 31 sessionally employed Officers equivalent to 9.5 full-time Officers.

The new clinic at Giggs Hill Green, Thames Ditton, which includes a Dental Clinic, was opened in June and the dental services in Cranleigh were transferred to the new Health Centre in August. Later in the year the dental sessions were transferred to Caterham Hill Clinic from Stafford Road Clinic, Caterham Valley, where adaptations and an extension to the building were being carried out to provide accommodation as a Health Centre.

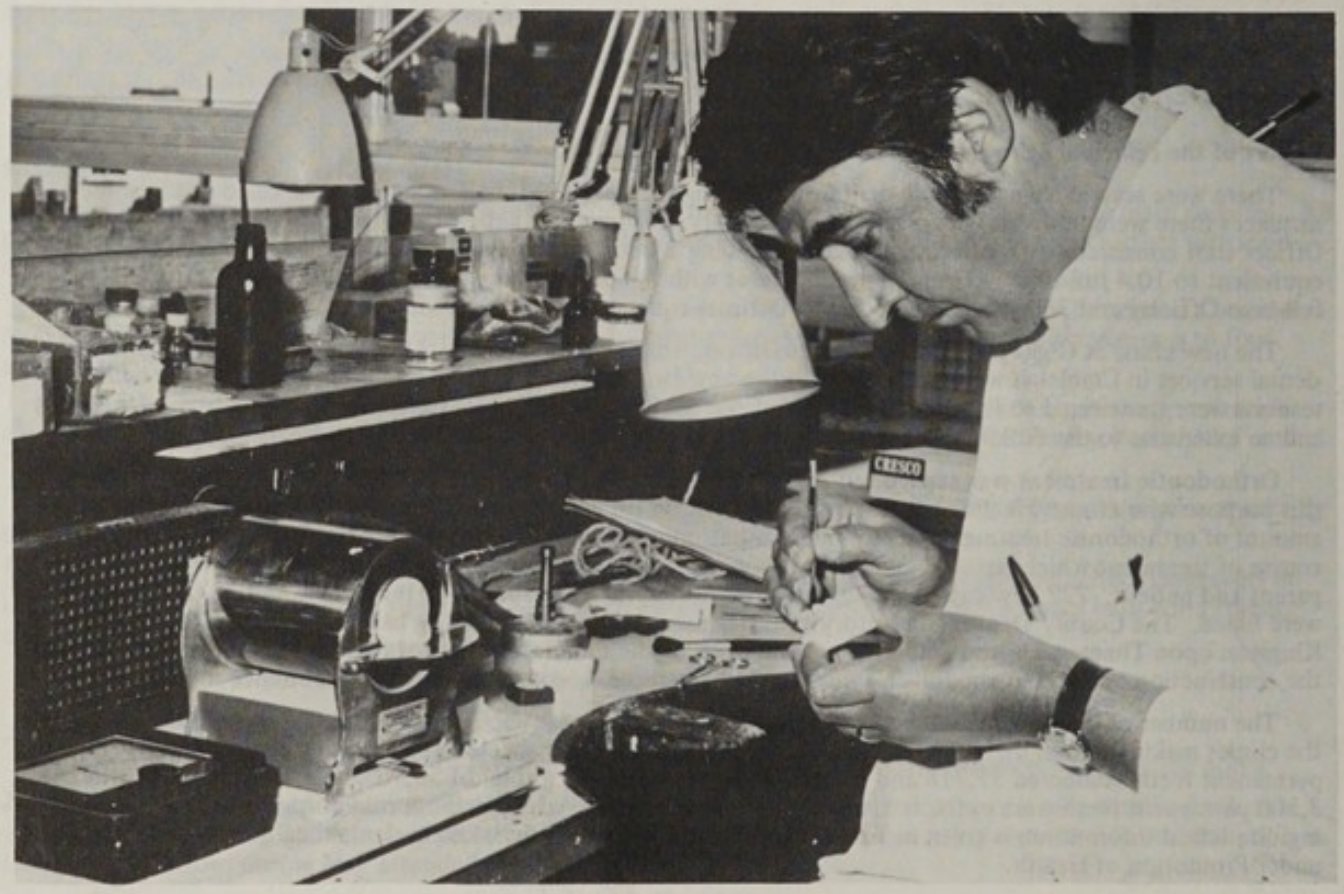
Orthodontic treatment was carried out by two full-time and four part-time Orthodontists specially engaged for this purpose who attend 18 clinics throughout the County. In addition most Dental Officers undertake a limited amount of orthodontic treatment usually in consultation with an Orthodontist. A complex case may require a course of treatment which lasts for 2 years or more and it is necessary to have the enthusiastic co-operation of both parent and patient. 722 new cases were commenced during the year and 1,540 removable and 78 fixed appliances were fitted. The County Dental Laboratory provides facilities on a cost sharing basis for the London Boroughs of Kingston upon Thames, Merton and Sutton. The work of the Laboratory for the School Dental Services included the construction of 2,270 orthodontic appliances, 61 dentures, 164 crowns and 3,323 reference models.

The number of children examined at routine school inspections was 92,256 and 14,041 were first inspected at the clinics making a total of 106,297. In addition, 11,360 were re-inspected at schools or clinics. Fillings in permanent teeth numbered 35,718 and in deciduous teeth 20,847, a total of 56,565. 8,596 deciduous teeth and 3,500 permanent teeth were extracted, some of which were removed for orthodontic purposes to relieve overcrowding. Statistical information is given in Table F and details of work undertaken in dental health education are given under Promotion of Health.

DENTAL SERVICES

1 *A senior technician is seen melting gold into a crucible in a centrifugal casting machine in order to construct a gold crown.*

2 *Waxing up an orthodontic appliance in the County dental laboratory.*



STATISTICAL TABLES – AS SUBMITTED TO THE DEPARTMENT OF EDUCATION AND SCIENCE

Medical inspection of pupils attending maintained Primary and Secondary Schools (including Nursery and Special Schools).

Table A – PERIODIC MEDICAL INSPECTIONS

Age Groups inspected (by year of Birth)	No. of Pupils who have received a full medical examination	PHYSICAL CONDITION OF PUPILS INSPECTED		No. of Pupils found not to warrant a medical examination	Pupils found to require treatment (excluding dental diseases and infestation with vermin)		
		Satisfactory	Unsatisfactory		for defective vision (excluding squint)	for any other condition recorded at Part II	Total individual pupils
		No.	No.				
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1967 and later	398	397	1	–	9	30	31
1966	6,706	6,698	8	–	238	775	880
1965	8,060	8,049	11	–	258	760	922
1964	1,082	1,081	1	733	60	117	156
1963	7,659	7,649	10	253	385	611	910
1962	2,390	2,388	2	15	122	193	297
1961	795	795	–	–	49	57	101
1960	2,124	2,113	11	218	167	215	345
1959	6,006	5,995	11	222	403	564	883
1958	2,816	2,812	4	–	193	234	387
1957	2,488	2,485	3	133	197	177	337
1956 and earlier	6,317	6,300	17	1,901	581	578	1,079
TOTAL	46,841	46,762	79	3,475	2,662	4,311	6,328

Column (3) total as a percentage of Column (2) total 99.85%
Column (4) total as a percentage of Column (2) total 0.15%.

Table B – OTHER INSPECTIONS

Number of Special Inspections	3,926
Number of re-inspections	5,990
Total	9,916

Table C – INFESTATION WITH VERMIN

(a)	Total number of individual examinations of pupils in schools by school nurses or other authorised persons	59,055
(b)	Total number of individual pupils found to be infested	753
(c)	Number of individual pupils in respect of whom cleansing notices were issued (Section 54(2), Education Act, 1944)	28
(d)	Number of individual pupils in respect of whom cleansing orders were issued (Section 54(3), Education Act, 1944)	–

Table D – RETURN OF DEFECTS FOUND BY MEDICAL INSPECTION IN THE YEAR ENDED 31st DECEMBER 1971. PERIODIC AND SPECIAL INSPECTIONS

		ENTRANTS		LEAVERS		OTHERS		TOTAL		SPECIAL INSPECTIONS	
		REQUIRING		REQUIRING		REQUIRING		REQUIRING		REQUIRING	
DEFECT CODE No. (1)	DEFECT OR DISEASE (2)	Treatment (3)	Observation (4)	Treatment (5)	Observation (6)	Treatment (7)	Observation (8)	Treatment (9)	Observation (10)	Treatment (11)	Observation (12)
4	Skin	203	634	259	280	464	888	926	1,802	118	109
5	Eyes – *(a)* Vision	507	1,550	733	628	1,419	1,764	2,659	3,942	300	770
	(b) Squint	158	276	18	39	110	278	286	593	10	9
	(c) Other	28	61	11	69	32	140	71	270	20	18
6	Ears – *(a)* Hearing	129	539	25	89	138	515	291	1,143	103	397
	(b) Otitis Media	57	471	10	33	37	231	104	735	4	37
	(c) Other	34	149	22	31	36	164	92	344	20	17
7	Nose and Throat	163	1,360	52	177	134	1,267	349	2,804	27	103
8	Speech	264	700	5	24	111	245	380	969	115	101
9	Lymphatic Glands	7	370	2	36	7	270	16	676	2	41
10	Heart	26	270	9	109	25	320	60	699	–	17
11	Lungs	68	532	14	100	74	509	156	1,141	11	62
12	Developmental – *(a)* Hernia	17	67	4	1	16	48	37	116	–	8
	(b) Other	31	510	9	60	83	404	123	974	11	101
13	Orthopaedic – *(a)* Posture	12	125	45	126	58	258	115	509	10	13
	(b) Feet	127	548	39	162	129	682	295	1,392	21	86
	(c) Other	31	308	28	95	49	392	108	795	24	43
14	Nervous System – *(a)* Epilepsy	14	74	3	17	34	68	51	159	4	7
	(b) Other	16	162	7	82	19	165	42	409	7	38
15	Psychological – *(a)* Development	28	271	73	29	154	330	255	630	36	85
	(b) Stability	37	577	1	90	52	645	90	1,312	64	124
16	Abdomen	18	217	17	33	17	233	52	483	4	17
17	Other	169	491	69	206	294	813	532	1,510	144	257
	TOTAL	2,143	10,262	1,455	2,516	3,492	10,629	7,090	23,407	1,055	2,460

Table E

(a) EYE DISEASES, DEFECTIVE VISION AND SQUINT

	Number of cases known to have been dealt with.
External and other, excluding errors of refraction and squint	113
Errors of refraction (including squint)	7,413
Total	7,526
Number of pupils for whom spectacles were prescribed	2,341

(b) DISEASES AND DEFECTS OF EAR, NOSE AND THROAT

	Number of cases known to have been dealt with.
Received operative treatment: –	
(a) for diseases of the ear	208
(b) for adenoids and chronic tonsillitis	549
(c) for other nose and throat conditions	31
Received other forms of treatment	255
Total	1,043
Total number of pupils in schools who are known to have been provided with hearing aids: –	
(a) in 1971	22
(b) in previous years	205

(c) ORTHOPAEDIC AND POSTURAL DEFECTS

	Number of cases known to have been dealt with.
(a) Pupils treated at clinics or out-patients departments	997
(b) Pupils treated at school for postural defects	190
Total	1,187

(d) DISEASES OF THE SKIN

	Number of cases known to have been treated.
Ringworm –	
(a) Scalp	–
(b) Body	–
Scabies	9
Impetigo	4
Other skin diseases	1,435
Total	1,448

(e) CHILD GUIDANCE TREATMENT

	Number of cases known to have been treated
Pupils treated at Child Guidance Clinics	1,957

(f) SPEECH THERAPY

	Number of cases known to have been treated
Pupils treated by speech therapists	3,375

(g) OTHER TREATMENT GIVEN

	Number of cases known to have been dealt with.
(a) Pupils with minor ailments	956
(b) Pupils who received convalescent treatment under School Health Service arrangements	84
(c) Pupils who received B.C.G. vaccination	11,586
(d) Other than *(a)*, *(b)* and *(c)* above:–	
Lymphatic Glands	2
Abdomen	18
Heart	30
Lungs	70
Development	114
Nervous System	42
Psychological	4
Other	106
Total *(a)* to *(d)*	13,012

Table F – DENTAL INSPECTION AND TREATMENT

Attendances and Treatment	Ages –	5 to 9	10 to 14	15 and over	Total
First visit		10,876	8,945	2,480	22,301
Subsequent visits		17,865	22,339	5,653	45,857
Total visits		28,741	31,284	8,133	68,158
Additional courses of treatment commenced		2,401	1,636	449	4,486
Fillings in permanent teeth		8,546	19,983	7,189	35,718
Fillings in deciduous teeth		18,419	2,428	–	20,847
Permanent teeth filled		7,034	17,524	6,127	30,685
Deciduous teeth filled		17,065	2,252	–	19,317
Permanent teeth extracted		567	2,469	464	3,500
Deciduous teeth extracted		6,176	2,420	–	8,596
General anaesthetics		2,103	1,115	57	3,275
Emergencies		1,214	628	149	1,991
Number of pupils X-rayed					3,301
Prophylaxis					4,005
Teeth otherwise conserved					3,466
Number of teeth root filled					241
Inlays					24
Crowns					149
Courses of treatment completed					20,426
Orthodontics.					
New cases commenced during year					722
Cases completed during year					394
Cases discontinued during year					131
Number of removable appliances fitted					1,540
Number of fixed appliances fitted					78
Pupils referred to hospital consultant					58
Dentures.					
No. of pupils fitted with dentures for the first time:					
(a) With full denture		0	0	1	1
(b) With other denture		2	12	14	28
Total		2	12	15	29
Number of dentures supplied (first or subsequent time)		3	13	17	33
Anaesthetics.					
General anaesthetics administered by dental officers					22
Inspections.					
(a) First inspection at school. Number of pupils					92,256
(b) First inspection at clinic. Number of pupils					14,041
Number of *(a)* and *(b)* found to require treatment					42,897
Number of *(a)* and *(b)* offered treatment					37,907
(c) Pupils reinspected at school or clinic					11,360
Number of *(c)* found to require treatment					6,181
Sessions.					
Sessions devoted to treatment					10,584
Sessions devoted to inspection					754
Sessions devoted to dental health education					363

OTHER SCHOOL HEALTH STATISTICAL TABLES

Table G – AUDIOMETRY IN SCHOOLS 1971

Total for Administrative County 1971	No. of Children Tested	No. of Children who failed	% Failure
Routine Sweep Tests in Schools	11,528	734	6
Other Tests	2,331	658	28

Table H – AUDIOLOGY

No. of new cases referred to Audiology Clinic from all sources						No. found to have remedial hearing loss						No. found to have impaired hearing but not necessitating hearing aid						No. found to have impaired hearing necessitating hearing aid and Auditory training					
0-2	2-5	5-7	7-11	11+	TOTAL	0-2	2-5	5-7	7-11	11+	TOTAL	0-2	2-5	5-7	7-11	11+	TOTAL	0-2	2-5	5-7	7-11	11+	TOTAL
214	515	303	194	85	1,311	6	56	94	70	20	246	3	27	27	42	27	126	5	8	7	10	4	34

Table I (1) – CHILDREN RECEIVING AUDITORY TRAINING FROM PERIPATETIC TEACHERS OF THE DEAF DURING 1971

Age	New Cases	Discharged to		Left District	Remaining Dec. 1971
		Special School	Supervision		
0-2 years	11	1	–	–	11
2-5 years	16	10	–	4	33
5-7 years	8	2	–	–	9
7-11 years	15	8	7	1	48
11+ years	25	1	2	1	34
Total	75	22	9	6	135

Table I (2) – CHILDREN UNDER SUPERVISION BY PERIPATETIC TEACHERS OF THE DEAF DURING 1971

Age	New Cases	Discharged to		Left District	Remaining Dec. 1971
		Special School	Supervision		
0-2 years	–	–	–	–	–
2-5 years	2	–	–	2	2
5-7 years	8	1	–	–	14
7-11 years	17	1	–	3	81
11+ years	85	3	28	15	208
Total	116	5	28	20	305

Table J – SPEECH THERAPY 1971

	COUNTY TOTAL
No. of sessions held	
Treatment by therapists	
In clinic	4,519
In ordinary schools	685
In special schools	1,465
Treatment by students	329
1st year	15
2nd year	23
3rd year	1
No. of cases on register at beginning of year	1,992
Added during year	1,383
Discharged	1,191
At end of year	
Under treatment	1,267
Under supervision	1,132
Awaiting admission	446
Analysis of cases	
Delayed language	684
Dysphasia	41
Dyslalia	2,134
Dysarthria	31
Dyspraxia	8
Dyseneia	73
Cleft palate	67
Hypernasality	17
Hyponasality	9
Dysphonia	10
Stammer	282
Clutter	9
Analysis of cases discharged	
Achieved normal speech	625
Were greatly improved	262
Showed some improvement	208
Little or no improvement	96
By clinic	840
Non co-operation of parents	112
Left district	111
Transfer to special school	87
Left school	22
For other reasons	19

Table K – THE WORK OF THE CHILD GUIDANCE CLINICS 1971

	Chertsey	Chipstead	Epsom	Farnham	Godalming	Guildford	Hersham	Leatherhead	Redhill	Staines	Woking	TOTAL
No. of cases on waiting list at 31.12.70	–	5	5	9	5	6	67	2	21	13	2	135
No. of cases referred during year	151	69	69	86	73	146	154	42	174	157	152	1,273
No. of cases on waiting list at 31.12.71	7	5	12	7	18	11	8	5	16	43	–	132
No. of new cases seen	151	43	51	73	47	138	85	31	125	109	128	981
No. of cases discharged	61	27	57	62	40	90	150	23	90	47	68	715
Analyses: –												
(a) Treatment completed	24	22	23	31	11	50	85	13	87	12	29	387
(b) No treatment required	1	1	21	19	9	15	7	4	–	5	27	113
(c) Non co-operation of parents	22	3	13	4	4	13	30	4	–	13	6	112
(d) Other arrangements made	10	1	–	8	16	12	28	2	3	17	6	103
No. of cases under treatment at end of year	70	27	15	35	21	125	64	6	139	88	125	714
No. of cases under supervision at end of year	20	149	20	60	42	114	5	19	153	54	115	751
No. of cases withdrawn from waiting list during year	19	14	11	8	14	4	77	8	17	18	27	217
Diagnosis at Initial Interview: –												
(a) Emotional disturbance	90	33	51	37	40	125	54	29	106	43	73	681
(b) Emotional disturbance with organic disorder	4	1	–	3	–	–	–	–	13	6	14	41
(c) Psychosomatic disorders	8	–	–	6	3	4	–	2	–	1	16	44
(d) Psychotic illness	–	–	–	3	–	1	–	–	–	–	8	12
(e) Educational problems	23	5	–	11	4	8	31	–	6	2	17	107
(f) Diagnosis not stated	10	–	–	1	–	–	–	–	–	57	–	68
No. of sessions held												
(a) Psychiatrists	224	306	238	230	143	458	361	4	453	332	271	3,020
(b) Educational psychologists	265	524	214	305	427	996	468	176	456	580	560	4,671
(c) Psychotherapists	14	40	469	262	182	–	192	100	72	44	42	1,417
(d) Social workers	481	960	589	601	455	1,012	528	96	845	546	273	6,386

Table L – HANDICAPPED PUPILS
The following table shows the number of Surrey children as at 31st December, 1971, who were ascertained as handicapped pupils and the provision made for their education:–

Category	Recommended for Special School or Hostel										To continue under observation at Ordinary School		Home Tuition		Tuition in Hospital or Special Units		Total handicapped Pupils		
	In Special School or Hostel						Parents refused consent		On waiting list										
	Provided by Surrey		Other		Total														
	B	G	B	G	B	G	B	G	B	G	B	G	B	G	B	G	B	G	Total
Blind	–	–	8	7	8	7	–	–	–	–	–	–	–	–	–	–	8	7	15
Partially sighted	–	–	13	9	13	9	1	–	2	1	2	9	–	–	–	–	18	19	37
Deaf	30	25	11	7	41	32	–	–	1	1	–	–	–	–	–	–	42	33	75
Partially hearing	22	14	59	31	81	45	–	–	2	1	41	50	–	–	–	–	124	96	220
Educationally sub-normal	891	590	12	8	903	598	21	12	52	51	7	5	1	–	–	–	984	666	1,650
Epileptic	–	–	10	7	10	7	–	–	–	–	5	1	–	–	–	–	15	8	23
Maladjusted	116	31	168	71	284	102	4	–	21	8	2	2	6	2	–	–	317	114	431
Physically handicapped	4	2	105	66	109	68	1	1	6	2	19	18	7	8	16	6	158	103	261
Delicate	29	20	23	10	52	30	1	3	3	5	2	1	–	–	–	–	58	38	96
Speech defect	–	–	1	1	1	1	–	–	3	–	1	–	–	–	–	–	5	1	6
Totals	1,092	682	410	217	1,502	899	28	15	90	68	79	86	14	10	16	6	1,729	1,085	2,814

There were also 78 boys and 55 girls attending ordinary school who were under consideration for ascertainment as handicapped pupils, and a further 24 boys and 22 girls who were at home, in hospital, or in private schools.

Table M – SPECIAL SCHOOLS AND HOSTELS
The following are provided by the Education Committee:–

Handicap	Name and Address of School/Hostel		Accommodation	Age Range		No. attending at December, 1971			
						Surrey Pupils		Out-County Pupils	
						Boys	Girls	Boys	Girls
Educationally Sub-normal	Bramley, Gosden House	80 G.	Boarding	G.	7–16	15	64	4	15
		20 B.		B.	7–10				
		20 M.	Day			9	–	1	–
	Redhill, St. Nicholas	100 B.	Boarding		10–16	67	–	23	–
		20 B.	Day			9	–	1	–
	Addlestone, Claybourne	130 M.	Day		7–16	68	64	–	4
	Camberley, Carwarden House	130 M.	Day		5–16	62	40	3	1
	Guildford, Temple Court	150 M.	Day		7–16	88	58	2	–
	Leatherhead	160 M.	Day		5–16	110	56	1	2
	Merstham, Greystone	160 M.	Day		5–16	96	62	–	4
	Woking, The Park	130 M.	Day		7–16	88	38	–	–
	Staines, Leacroft	130 M.	Day		7–16	35	30	–	1
	Caterham, Clifton Hill	75 M.	Day		2–16	35	29	6	5
	Ewell, Woodlands (with Leatherhead annexe)	70 M.	Day		2–16	37	23	1	1
	Farnham, The Ridgeway	60 M.	Day		2–16	38	29	–	1
	Guildford, Pond Meadow	80 M.	Day		2–16	54	38	1	1
	Shepperton, Manor Mead	92 M.	Day		2–16	43	27	–	–
	Walton, Walton Leigh	105 M.	Day		2–16	49	40	–	1
Delicate and physically handicapped	Guildford, Sunnydown	40 B.	Boarding		10–16	23	–	16	–
	Oxted, Limpsfield Grange	30 G.	Boarding	G.	5–16	6	20	4	1
		8 B.		B.	5–10				
		6 M.	Day			4	2	–	–
Deaf	Caterham, Portley House	60 M.	Boarding		3–11½	23	13	9	6
	Redhill, Nutfield Priory	80 M.	Boarding		11½–16	7	12	19	38
Partially hearing	Ewell, Riverview	30 M.	Day		4½–11	6	6	10	5
	Woking, Woodlands Broadmere	30 M.	Day		4½–11	16	8	–	–
Maladjusted	Bramley, Wey House	45 G.	Boarding		10–16	–	11	–	4
	Camberley, Wishmore Cross	40 B.	Boarding		11–16	25	–	5	–
	Dorking, Starhurst	50 B.	Boarding		11–16	39	–	5	–
	Guildford, Thornchace, Merrow (Hostel)	18 M.	Boarding	G.	5–12 5–11	9	6	1	1
	Guildford, Grove Class, Merrow (day class)	15 M.	Day		7–12	8	2	–	–
	Reigate, Sidlow Bridge, Day Centre	16 M.	Day		5–11	4	–	–	–
Special Unit for severely disturbed children	Epsom, The Lindens, c/o St. Ebba's Hospital	30 M.	Day		4–11	21	12	1	1
Remedial Centres	Bisley	30 M.	Day		5–11	21	5	–	–
	Caterham Hill	40 M.	Day		5–11	36	7	5	–
	(Epsom), Clayhill Centre	40 M.	Day		5–11	43	5	2	–
	Normandy	30 M.	Day		5–11	24	5	–	–
	Ottershaw	30 M.	Day		5–11	21	3	–	–
	(Redhill), Ardmore Centre	30 M.	Day		5–11	30	7	–	–
	Dorking De Clare	30 M.	Day		5–11	21	1	–	–
	Merrow	30 M.	Day		5–11	33	3	–	–

APPENDIX A

The Assessment and Management of Handicapped Children

Sheridan defines the handicapped child as being "one suffering from any continuing disability of body, intellect or personality likely to interfere with his normal growth, development and capacity to learn". The children's services provided in the community by the County Health Department and the Special Services Branch of the Education Department are essentially geared to the detection and management of such children. While functioning in their own right they are closely related both to family doctor and hospital services, and they play an important part in co-ordinating the work of the three parts of the National Health Service in respect of the individual child. The services are concerned with children from birth until they leave school.

At birth all infants are normally examined by a doctor or midwife and if suffering from any apparent abnormality are referred to the appropriate hospital consultant. If handicap is suspected or found, this is made known to the Medical Officer of Health and to the health visitor concerned. The child is then placed on the observation register for the necessary follow-up by the community services. A key person in this situation is the health visitor who will visit the home regularly and is therefore in a position to assess the child's needs and the extent to which they are being met. She will transmit this information to the Medical Officer of Health by means of regular reports.

If no disability is apparent at birth the infant is followed up by community services only. The health visitor visits regularly and the mother is encouraged to take the infant to the local Child Health Clinic (approximately 90% of children attend these clinics regularly during their first year, and somewhat less frequently thereafter). Here development is assessed, and if deviation from normal is observed by the medical officer the child is either kept under regular observation or referred for a further opinion. This may be obtained from a hospital consultant by agreement with the general practitioner, or the child may be referred to a specialist medical officer within the Health Department, as appears most appropriate.

The following services are provided within the Health and Education (School Health) Departments:–

1. Subnormality

Three Senior Medical Officers experienced in the assessment of young children with delayed development are employed within the department. Many handicapping conditions present themselves in this way, and examination of the physical condition of such children is therefore an important part of the examination.

The aim of the Senior Medical Officer carrying out the assessment is:–

(a) to instigate investigations or treatment required from other sources and to act as co-ordinator in all such matters.

(b) to counsel parents concerning management and to advise them of other agencies which will provide help and support.

(c) to make recommendations concerning the education of the child.

Assessment is a continuing process throughout the child's pre-school and school life, and in the case of pre-school children is carried out in the home. The medical officer therefore becomes conversant not only with the child and his parents but also his total environment.

Children are normally referred to the specialist Senior Medical Officer by Medical Officers of Health at the request of the following:–

Paediatricians
General Practitioners
Medical Officers working in child health clinics, schools and day nurseries
Health Visitors
Social Workers

The three Senior Medical Officers also act as school medical officers to the schools for severely abnormal children, where children may be admitted from the age of three. They also supervise the work of the school medical officers attached to other special schools for slow learners.

2. Audiological Service

The hearing of all infants is tested as part of the developmental screening process. A Senior Medical Officer is employed full-time on the work of assessing the hearing of children, and all infants who fail the screening test are referred to him. He holds clinics at regular intervals throughout the County and deals with all problems concerning these children as follows:–

(a) diagnosing hearing loss and referring cases to consultant otologists for treatment and provision of Medresco hearing aids. Commercial hearing aids are purchased as required.

(b) counselling the parents concerning management and advising them of other agencies providing help and support.

(c) making recommendations concerning the education of the child.

(d) acting as co-ordinator of a team of audiometricians, peripatetic teachers of the deaf, and speech therapists. He also acts as an important link between hospital consultants and education services.

The Senior Medical Officer is also appointed school medical officer to the schools for the deaf and the partially hearing units in the County. He sees all hearing-handicapped children regularly, whether placed in county maintained schools or in schools outside the county. While much of the work with pre-school and school children is done in clinics and schools he is also prepared to pay home visits as required, working closely with the peripatetic teachers of the deaf who visit pre-school children in the home to give auditory training.

Audiometry

In addition all children are given a routine audiometric pure tone screening test in school at about 6 years by qualified audiometricians. Those who fail are examined by medical officers and if necessary are referred for a further opinion either to the Audiology Clinic (see above) of to the ENT Consultant at the local hospital.

3. Speech Therapy

The whole question of development of speech and language in the young child is considered to be of the utmost importance and health visitors and medical officers watch this carefully. When development of speech or language is retarded the significance is assessed by appropriate investigations and any necessary treatment instigated.

Apart from this the Surrey Speech Screening Test, developed within the department, is used by school medical officers to screen the speech of all children at the time of the school-entry medical inspection (normally 5 years).

33 individual speech therapists (equivalent to 15 full time posts) are employed at clinics throughout the County for the treatment of pre-school and school children. Where appropriate speech therapists also work with groups in schools, and regular sessions are held in special schools (E.S.N. etc.).

At the time of writing the possibility of arranging pilot schemes providing short courses of intensive therapy for more serious cases of speech defect is being considered in some areas. The results of these will be assessed at a later date.

4. Child Guidance

The Education Committee provides a well-developed Child Guidance Service. Eleven clinics are situated in the main population centres in the County. Each is staffed by a team consisting of psychiatrist(s), educational psychologist(s) and social worker(s), together with a psychotherapist in some cases. The approach is that of family psychiatry and initial referral is accepted from any source, e.g. doctors, teachers, social workers or parents. The clinics maintain close links with the schools in their area through:–

5. The School Psychological Service

This educational service functions as an entity under the supervision of the Senior Educational Psychologist. As stated educational psychologists are based at all child guidance clinics, and each is responsible for a group of schools within the area served by the clinic. The psychologists thus form a valuable link between the clinic and schools in the area.

6. Physiotherapy

Physiotherapists are employed in some clinics, and in special schools on a regular basis. This is particularly valuable in special care units within the schools for the mentally handicapped.

7. Ophthalmic Services

The development of vision is closely watched at child health clinics and apparent defects referred for specialist examination and treatment. The vision of all school children is tested at regular intervals in schools. Eye clinics staffed by qualified ophthalmic practitioners are held regularly in all the main clinics throughout the County, to which children failing vision tests may be referred.

Comment: The above paragraphs cover the more specialised services provided for children. The health visiting service has not been included as a separate entity as the health visitor is concerned with all aspects of the health and well-being of all children. In the case of handicapped children health visitors visit regularly throughout pre-school and school life and submit regular reports to the Medical Officer of Health.

Apart from the specialised services, which are provided within the framework of the National Health Service Act of 1946 and the Education Act of 1944, the department is also responsible for provision of the School Health Service, a statutory requirement of the latter and available in all maintained schools.

The School Health Service

This performs three different functions which are often complementary:–

(a) identifying physical and psychological defects and arranging for treatment to be given as necessary.

(b) monitoring the effects of handicap in the classroom situation and interpreting the needs of the child to teaching staff.

(c) ascertaining which children require special education other than in ordinary school. The Education Act allows for this at any time after the age of two years. The decision to recommend special schooling may be a difficult one to take. It therefore requires a medical officer well-versed in the educational needs of

children, and with an intimate knowledge of the opportunities provided both in ordinary and special schools in the area. In arriving at a decision the medical officer will of course also take into account the views of other agencies concerned with the child.

In Surrey children receive two routine medical inspections in the course of their school lives, at 5 years and 11 years. Apart from this they are examined on a selective basis as required. As leavers they are interviewed by the school medical officer in particular relation to their fitness for future employment.

Health visitors are attached to all schools and are intimately concerned with the school and its children. The health visitor acts as leader of the nursing team in the school, as health educator and general adviser on health problems and co-ordinator of all matters relating to the health of the individual school child. In respect of the latter she forms the main link between the school and the home, and between the school, the general practitioner, and other social agencies locally.

THE REGISTER OF HANDICAPPED CHILDREN

A comprehensive register of handicapped children is kept in the Health Department at County Hall. The names of children are placed on this at the time a handicap is diagnosed. Additional information is added as it becomes available, so that records are kept up-to-date. Apart from details of the actual handicap, a social and educational record of the child is also included.

The register is available for consultation in respect of details concerning any particular child, and is also used for such purposes as obtaining statistics and to enable forward planning of services.

APPENDIX B

REPORT OF WORKING PARTY ON THE ROLE OF THE HEALTH VISITOR IN THE SCHOOL HEALTH SERVICE

INTRODUCTION

At the present time, when radical reorganisation of the health service is just over the horizon, it has become apparent to many of us working in the School Health Service, either in administration or in the field, that it would be particularly pertinent to re-examine the role of the Health Visitor in the School Health Service and redefine this in a way which would be relevant not only to the present day situation but also in the future.

The Health Visitors in this county, as in many other areas of the country, are working in direct attachment to general medical practice and greatly extending their interest from being largely concerned with the health of the mother and young child to embrace all ages within the community. This has naturally led to a reduction in the time she has had available to work in the School Health Service (unfortunately, like all of us, the Health Visitor has only a 24-hour day) and it becomes very important if she is to work effectively that we examine her function clearly. In addition, the increased use of State Registered Nurses to supplement the Health Visitors has meant that there are additional channels of communication to be maintained and relationships to be defined if the children at school are to get the support and supervision of their health which is their right.

Following the introduction of the School Counsellor and the Welfare Assistant, the development of the role of the School Welfare Officer and the setting up of the new Departments of Social Service, the report of this working party is particularly timely. If we are to avoid duplication in some areas and missed problems in others, it is extremely important that everyone is clearly familiar with the function of their colleagues who have a related responsibility.

The future arrangements for the School Health Service are at the present time unknown, but it would appear from many sources that it is likely that the work of the School Health Service will be included within the organisation of the unified National Health Service. If this is so, then it is obviously of prime necessity that those working within the Education Authorities are quite clear about the nature of the services they can expect from the new health organisations.

It is felt by the writers that their report should help to define these more clearly.

I would like to congratulate the members of the working party on the way they have carried out their study and commend the report to all who are interested in the future of the School Health Service.

JAMES DRUMMOND
County Medical Officer
Principal School Medical Officer.

January, 1972

TERMS OF REFERENCE OF THE WORKING PARTY

To review the role of the health visitor in the school health service.

COMPOSITION OF THE WORKING PARTY

The Working Party consisted of nine members of Staff of the Health Department. These were as follows:–

The Divisional Nursing Officer,
Health Visiting Services (Chairman)
An Area Nursing Officer
A Nursing Officer
A Health Visitor/Field Work Instructor
A Health Visitor
The Principal Medical Officer, Child Health
A Divisional Medical Officer
A School Medical Officer
A Senior Administrative Officer

All members had wide experience and a special interest in the School Health Service, and were representative of Central Administration and of all areas of the County.

METHOD OF WORKING

The Working Party held a number of meetings amongst themselves, and in addition took evidence from Senior Officers of the Education Department on the role of the Education Welfare Officer and from the County Inspector on the role of the School Counsellor.

The Working Party also visited representative schools in the shape of a Primary School and a Comprehensive School where they discussed the role of the health visitor with the Heads.

Members of the Working Party also held informal talks with their colleagues throughout the County and some members of staff submitted written evidence.

INTRODUCTION

In the Handicapped Pupils and School Health Service Regulations, 1945 (No.1076) issued under the Education Act, 1944 (Sections, 33, 69 and 100) it was stated that school nurses should be qualified health visitors. This was the policy in Surrey and has continued to be so. The role and duties of the health visitor in the School Health Service in the County were reviewed by the Chief Nursing Officer in March 1959 following the publication of the Jameson Report in 1956. At that time each health visitor had knowledge of the home background of a considerable number of pupils at schools in her then geographical area. In 1960 the County Health Committee set up a Special Sub-Committee on the Health Visiting Service which reported to the County Health Committee in February 1961. Their report included recommendations in respect of the School Health Service whereby part-time state registered Nurses and state enrolled nurses would take over duties being performed by health visitors at Minor Ailment Clinics and would also relieve health visitors of routine medical inspection duties at secondary schools. The amount of ancillary help already introduced at immunisation sessions in schools would be increased. In addition the provision of clerical help for health visitors was recommended. The intention of these recommendations was not to reduce the time spent by health visitors in the School Health Service but to ensure that their expertise was put to better use, i.e. health education, social advice, discussions with head teachers on health problems, handicapped children and so forth. It was considered important to have the health visitor present at medical inspections in primary schools, but while state registered nurses attended at secondary/grammar schools it was envisaged that the health visitor would retain responsibility for all the schools to which she was allocated, including secondary schools. She would visit at the end of routine medical inspections attended by the state registered nurse or state enrolled nurse to discuss with the school medical officer any problems which might have arisen.

In June 1965 the then Ministry of Health issued a circular (12/65) which set out clearly how ancillary staff could be used in the local authority nursing services generally (Appendix I). In the School Health Service the health visitor was seen as the leader of the nursing team being supported by state registered nurses, state enrolled nurses and lay assistants.

More recently the Mayston Report has set out the role, duties and responsibilities of the health visitor including her duties in the school health service (Appendix II). The report refers to "the health of a child at school" and it should be noted that in discussing the responsibilities of the health visitor Mayston states that she should have regard to the medical, psychological, and social needs of the child and his family. It should be emphasised that throughout this report we have in referring to "health" taken this same broad view.

FINDINGS

The following general observations were made:–

1 As far as the School Health Service is concerned it was felt that due regard had not been given in the Mayston Report to the effect which attachment to general practitioners, school mergers and the coming of large comprehensive schools was having on the health visitor's work in schools.

2 There are instances where the health visitors have ceased to make frequent visits to schools. This is due to several factors including the use of state registered nurses for routine duties, whereby some health visitors felt that they had no positive reason for visiting schools. Improved standards of living and hygiene and modern methods of treatment appeared to have obviated the need for frequent and regular visits to schools for the purpose of dealing with such conditions as infestations, impetigo, and so forth. Without regular visits to schools, health visitors are not sufficiently well known to the staff for social and other problems to be referred to them early enough.

3 While it was the original intention that the health visitor should visit the school at the final session of a block of routine medical inspection sessions attended by the state registered nurse, this rarely happens.

4 Some health visitors' main interests and experience are in the Maternity and Child Health field and they have allowed this to take priority over the school health service.

5 In some areas medical staff and ancillary nursing staff are not allocated regularly to the same schools. Increasingly frequent change of staff and the use of part-time staff has not only affected stability of relationships but has also caused administrative difficulties within the school health service. The factors have led to poor communication between schools and health visitors and to heads of some schools failing to appreciate the value of the cooperation and assistance that health visitors can give.

6 There is insufficient personal introduction and initiation into the service. School staff do not always know their health visitor, doctor or school nurse with the result that all feel they work in isolation.

7 Conditions under which health visitors, state registered nurses and medical officers have to work are unsatisfactory in some schools. There is often no suitable place to carry out eye testing under proper conditions and the medical rooms provided in schools are not always readily available.

8 At the outset some members of the Working Party felt that there may be overlapping of the health visitors' role with that of the Education Welfare Officer. After discussion with representatives from the Education Department it was found that there were areas for cooperation but both have their own clear role (Appendix III).

9 The introduction of school counsellors had led the Working Party to feel that here again there could be overlapping of role. The discussions with the inspector, heads of schools and a school counsellor however made it clear that the roles were separate but complementary (Appendix IV).

10 The possibility or attaching a health visitor full time to a large comprehensive school was investigated. In doing so it became clear that it was the health visitors' general work and knowledge of family life and the community that proved to be so valuable within the school environment. Full time attachment to a school would give the health visitor too narrow an outlook.

11 It was sometimes found that the exchange of information necessary for health visitors to undertake their duties effectively was poor.

CONCLUSIONS

In coming to their conclusions, the Working Party considered the Mayston Report in relation to the work of the health visitor in the school health service as applied to the County of Surrey and were in general agreement as far as her role was concerned. There were however a number of points on which they commented.

Firstly Mayston states that she "discusses all home problems with the head teacher". This raises the question of confidentiality. They considered that the extent to which home problems would be discussed would depend on this, particularly now that there is a noticeable proliferation in the number of people who may be involved in any one situation.

Secondly he states that she "deals with any outbreak of infection and relates necessary health education to the families concerned". It should be noted that the responsibility for "dealing with" an outbreak of infection lies with the Medical Officer of Health with whom the health visitor co-operates. Furthermore she undertakes health education not only in the home but also in the schools.

Thirdly Mayston states that within the school she "makes arrangements for and attends school medical inspections (and so forth)". In this connection it should be noted that clerical and administrative duties are not the responsibility of the health visitor and such arrangements should be made by administrative staff.

Fourthly they would prefer that the phrase "special responsibility for mentally handicapped children" should read "special responsibility for *all* handicapped children".

The final conclusion of the Working Party was that the role of the health visitor in schools at the present time may be defined as follows:–

1 Health educator and general adviser on health matters.

2 Leader of the nursing team ensuring effective liaison between the school, the home, and other agencies concerned with the health of the schoolchild.

The duties and responsibilities involved in carrying this out are reflected in the following recommendations.

RECOMMENDATIONS

1 Approach to schools

i A definitive health team shall be created for each school, which should include the clear allocation of a health visitor and where applicable, a state registered nurse.

ii New staff shall be introduced by a senior member of staff who herself should be responsible for maintaining the continuity of the service in the event of illness, resignation, etc.

iii The health visitor shall pay frequent routine visits to her schools. In many instances this should be in the order of once a week.

2 Health education and general advice on health matters

i The health visitor shall make herself available for the purpose of advising on health education in schools and shall take such part as is required.

ii The health visitor shall concern herself with all matters affecting the health of the school including not only infestation and outbreaks of infection but also safety precautions and the special environmental needs of handicapped children.

3 The nursing team

i The health visitor shall act as school nurse at medical inspection sessions as required, carrying out associated screening procedures, and ensuring that follow-up of cases is carried out as recommended.

ii Where a state registered nurse is employed as school nurse, the health visitor shall be responsible for supervision of her activities.

iii Where a state registered nurse is employed in medical inspection sessions the health visitor shall maintain regular contact with the school medical officer for the interchange of information.

iv The health visitor shall ensure that any necessary hygiene inspections are carried out and treatment initiated as required. She shall supervise other nursing staff involved in this activity.

4 Liaison

The health visitor shall be the principal link between the school, the home, the family doctor and other agencies on matters relating to the health and well being of the school child. It is recognised that the school health visitor may not be the health visitor to the home and therefore, in order to bring this about close personal contact with the child's own health visitor will be essential.

General Comments

i It should be emphasised that the health visitor cannot fulfil her role in school efficiently without the goodwill and cooperation of the school staff. Her primary contact will be with the head teacher but in the course of her duties she may be called upon in many instances to work with others such as school counsellors or members of the teaching staff. Not only should school staff be led to appreciate the contribution of the health visitor but on their part health visitors should make every effort to fit in with the existing organisation of the school.

ii The health visitor cannot carry out her duties effectively unless she received good administrative backing, and to this end such matters as the speedy transmission of information and transfer of records, together with other administrative and clerical procedures should be kept under constant review.

iii In order to implement fully the above recommendations reconsideration should be given to the then Ministry of Health Circular 12/65 with reference to the duties and establishment of registered and enrolled nurses and lay assistants within the School Health Service.

Acknowledgements

The members of the Working Party acknowledge with grateful thanks the help they have received from officers in the Education Department including teaching staff, those who submitted written evidence and all who discussed this project with them with interest and enthusiasm.

APPENDIX I

Extract from Ministry of Health Circular 12/65

1 General

The health visitor should lead the nursing team in the School Health Service as in the Local Health Authority Service and should similarly be supported by S.R.N.s, S.E.N.s and lay assistants. She should work closely with parents, class teachers as well as head teachers, other officers of the education authority and with school doctors

and general practitioners. Much of the home visiting in connection with school children will need to be done by her. We think she should be present at the medical examination of children on first entry to school but it will be more economical of her time to consult with the school doctor and head teacher before or after other routine medical examinations. We do not think that she need normally attend any of the clinics provided under the School Health Service. She should play an active part in health education, particularly of the young. Undoubtedly the saving of the health visitor's time, if the appropriate duties within the School Health Service are delegated, would be considerable. But, as we have suggested in paragraph 16 in respect of the Local Health Authority Services studies of the time spent on various activities by school nurses will be needed in each local authority's area to ascertain how much help can be given by ancillary staff.

2 Suggestions for duties which can be delegated to less highly qualified staff

Nature of Duties	Least qualified staff able to undertake the duties
1 *General duties in clinics and school inspections*	
Prepare and clear clinics or rooms	Lay Assistants
Reception	
Records, clerical work and filing	
Arrange further action on referals	
Marshalling children	
2 *Other duties in clinics*	
Attendance with doctor	Lay Assistants
Ophthalmic clinic, vision testing, nursing duties (e.g. eye drops)	S.E.N.
Orthopaedic clinics, nursing duties, etc. (e.g. dressings)	
Paediatric clinics	
Minor ailments – treatment	
Audiology and/or E.N.T. clinics, nursing duties (e.g. ear syringing)	S.R.N.
3 *Other duties at school inspections*	
Weighing and measuring	Lay Assistants
Simple screening tests for vision and hearing, including pure tone audiometer	
Assisting child	
Hygiene inspections – head inspections and de-infestation	S.E.N.
Attendance with doctor other than primary inspection	S.R.N.
4 *Home Visiting*	
Simple visits to school children (e.g. failing appointments)	Lay Assistants

APPENDIX II

Extract from the Mayston Report (Appendix 8, Function of Field Workers – The Health Visitor – Paragraph 3 (d))

In the school health service, the health visitor

i is the principal link between the home, the school, the family doctor and other agencies, particularly on matters relating to the health of a child at school;

ii discusses all home problems with the head teacher and in turn relates school problems to the home background;

iii works within the school as school nurse and health educator;

iv is available to discuss medical and social problems with the medical officers attending school;

v carries out health surveys as and when required;

vi deals with any outbreak of infection and relates the necessary health education to the families concerned;

vii gives the fullest support to the homes of children with emotional behaviour problems and children with handicaps;

viii within the school makes arrangements for and attends as necessary school medical inspections, screening tests for sight and hearing, hygiene inspections, special clinic sessions and immunisation programmes, and ensures that proper records are kept;

ix has special responsibilities for the mentally handicapped child under 16 years of age.

APPENDIX III

The Role of the Education Welfare Officer

The Local Education Authority has a statutory duty to ensure that children receive an efficient education and the Education Welfare Officer is the agent upon whom the legal responsibility for seeing children attend school largely devolves. Because of the variety of problems he encounters in following up school absentees and dealing with other eqnuiries he is asked to make by Divisional Education Officers he has become involved in social work.

He may spend approximately one third of his time on school visits discussing with head teachers problems including those of persistent absence and recommends various solutions in conjunction with other senior education officials, including advising on the necessity of medical examinations in cases of frequent absence on health grounds.

One of his aims is to foster good relations between home and school. He also advises and assesses the suitability of certain cases qualifying for free school meals, uniform grants, etc., and is in frequent contact with the Divisional Executive Office and the Ministry of Social Security to further this aim. He advises parents on the various forms of help open to them in dealing with problem children including child care, special education facilities, home tuition, will arrange transport by bus or car to school in certain circumstances, and will resolve difficulties arising from same and advise children of compulsory school age on types of employment open to them. Checks the validity of claims from "other Counties", i.e. "Out County" education for Surrey school children. The Education Welfare Officer may spend almost half his time on home visiting.

A small percentage of time is consumed in attending meetings and case conferences with various agencies including school governors, health visitors, social workers, discussing problems with Divisional Education Office staff, education medical officers and educational psychologists, escorting children to and from special schools, conveying them for medical examinations, Child Guidance and dental treatment when he considers parents are unable to do so. He assists in school planning by carrying out surveys to establish the numbers of children under 5 years of age and obtains information on present and proposed building programmes. Occasionally he has to give evidence on court cases arising from bad school attendance and illegal employment of children.

The Education Welfare Officer undertakes his own clerical work and maintains a complete daily work record and full notes on all cases. He prepares cases for court and prepares court reports for presentation to the Divisional Education Officer.

APPENDIX IV

The Role of the School Counsellor

The growing size of secondary school communities and the impending raising of the school leaving age has brought into focus the need to consider most seriously whether enough is being done to ensure that the personal development of pupils who are not developing and maturing like the majority, and who could leave school as inadequate persons and remain inadequate members of society, should find a source of help in a recognised and organised service operating within the school system.

Even if some pupils are fortunate enough to have the opportunity to use a teacher as a confidant, there are a number who need more than the immediate word of reassurance and understanding that can be given during a teaching session. The teacher receiving the confidence may feel that he has dealt with the situation inadequately and yet know no clearly defined line of communication to someone who has the necessary time and skill to assess a pupil's fundamental problem and the kind of help required. There is need for pupils to have someone who has time to listen, who is not too remote in the school hierarchy, and who is not too involved in making final decisions or recommendations about pupils. Some young people cannot manage on their own and may have no trusted adult to ask for help, so that ordinary everyday difficulties may accumulate and assume gigantic proportions.

The work of this service is envisaged as preventive rather than curative and with the aim of providing an early warning system, identifying problems in the early stages, taking preventive measures where possible, and so avoiding the development of many of the more serious and disturbing problems. At the same time, the sensitivity and experience of the counsellor would result in early enough consultation withoutside agencies including Child Guidance Clinics, Health Visitors, Social Workers etc. The Counsellor may find it necessary to visit homes but the emphasis is to encourage even reluctant parents to come to the school to get to know people there and to appreciate the environment in which their children live and opportunities available.

An advisory-counselling service acts as a co-ordinating agency for the work done in connection with careers, educational problems and decisions, and personal counselling, and this team is available to pupils, teachers and parents. Counselling is an enabling and supporting service for all school work and activities. Its aim is preventive rather than curative and it is a continuous process, help is available throughout a pupil's secondary school life.

As the size of secondary schools increases there is a significant increase in the development of pastoral care and counselling provision. In 1970–71 there were five senior posts of Counsellors allocated to five secondary schools that had made specific preparation for the development of an advisory-counselling service. At the same time a number of other secondary schools recruited counsellors or designated existing members of staff as counsellors. In September 1971 there were 17 secondary schools having teachers with a major responsibility for counselling.

The Education Department's policy is to encourage a school to develop the right climate amongst its members before an advisory-counselling service is instituted.

Some schools Care Committees, or similarly named bodies, on which are represented both internal and external caring agencies. For example, in one school the Care Committee has amongst its members, the Head, the Deputy Head, the Educational Psychologist, the Health Visitor, Social Workers, the Probation Officer, the Year Tutors etc. The counsellor is a permanent member of the Committee.

The Counsellor, or leader of the guidance team, is a senior member of staff and enjoys the respect, and trust of the Head and his colleagues. This is particularly important when confidential matters are involved.

The advisory-counselling service is complementary to the whole educational endeavour and its aim is to enable pupils to manage and, if necessary, to live with their problems, so that they can make the most of their time in school, and then help them put their education to the best possible use in their choice of employment or further education.

CHAPTER TEN – TABLES

HEALTH SERVICES

Table 1

Population of each Sanitary District at the censuses of 1951 and 1961, and the Registrar-General's mid-year estimates for 1970 and 1971:–

	DISTRICTS	Area in Acres 31.3.1971	Census Population 1951	Census Population 1961	Registrar-General's Estimates of Mid-year populations 1970	Registrar-General's Estimates of Mid-year populations 1971
	M. B. and Urban					
1.	Banstead	14,231	33,529	41,559	44,290	45,030
2.	Caterham and Warlingham	8,233	31,293	34,869	37,730	36,770
3.	Chertsey	9,983	30,852	40,390	45,340	45,830
4.	Dorking	9,511	20,252	22.604	22.680	22,680
5.	Egham	9,350	24,690	30,571	30,730	31,470
6.	Epsom and Ewell	8,427	68,055	71,159	71,700	72,120
7.	Esher	14,846	51,432	60,610	63,403	64,760
8.	Farnham	9,039	23,928	26,934	30,090	31,300
9.	Frimley and Camberley	7,768	20,386	28,522	43,350	45,960
10.	Godalming	2,393	14,244	15,780	18,360	18,970
11.	Guildford	7,322	48,048	53,976	58,850	58,090
12.	Haslemere	5,751	12,003	12,523	13,490	13,440
13.	Leatherhead	11,187	27,206	35,582	39,110	41,050
14.	Reigate	10,255	42,248	53,751	57,820	56,320
15.	Staines	8,271	39,995	49,259	56,850	56,370
16.	Sunbury	5,609	23,394	33,403	40,250	39,990
17.	Walton and Weybridge	9,049	38,112	45,510	52,930	51,850
18.	Woking	15,712	47,596	67,519	80,240	76,360
	Total	166,937	597,263	724,551	805,150	808,260
	Rural					
1.	Bagshot	16,083	14,109	16,180	20,620	21,180
2.	Dorking and Horley	53,943	25,832	31,710	33,790	33,990
3.	Godstone	53,517	32,823	40,225	44,960	43,390
4.	Guildford	59,644	44,936	54,888	62,330	63,060
5.	Hambledon	68,175	31,851	34,524	38,940	41,350
	Total	251,362	149,551	177,527	200,640	202,970
	Administrative County	418,299	746,814	902,078	1,005,790	1,011,230

The figures given by the Registrar-General express the populations for the 1951 Census as they would have appeared if the area boundaries at that time were the same as they are at present.

Note: The Guildford Rural District forms part of three divisional areas and the following local estimates have been made to apportion the area's total figures.

Divisions	Population – Mid-1971
North-Western	10,783
South-Eastern	1,075
South-Western	51,202
	63,060

A summary of the current population statistics of each divisional area is given below (Epsom and Ewell, Esher and Woking Excepted Districts are shown in the table above).

Divisions	Population – Mid-1971
Northern	96,360
North-Western	207,073
South-Eastern	239,255
South-Western	255,402

Table 2

Live birth rate, still birth rate and percentage of illegitimate births in past years.

Year	Live birth rate	Rate of still births per 1,000 live and still births	Illegitimate births Percentage of total live births
1961	15.18	13.55	4.71
1962	15.46	13.90	4.95
1963	15.63	11.49	5.19
1964	16.08	12.71	5.87
1965	16.49	11.58	5.75
1966	15.86	12.55	5.76
1967	15.16	11.05	6.08
1968	14.68	11.49	6.25
1969	13.90	10.00	6.00
1970	13.60	12.00	6.00
1971	13.60	11.00	6.00

Table 3

Infant mortality rate in past years in Surrey and in England and Wales.

	SURREY			ENGLAND AND WALES		
Year	Infant mortality rate	Neo-natal mortality rate	Mortality rate 4 weeks to 12 months	Infant mortality rate	Neo-natal mortality rate	Mortality rate 4 weeks to 12 months
1961	17.79	13.29	4.50	21.4	15.5	5.9
1962	16.57	12.15	4.42	20.7	15.1	5.6
1963	17.08	12.01	5.07	20.9	14.2	6.7
1964	16.64	12.71	3.93	20.0	13.8	6.2
1965	15.29	10.84	4.45	19.0	13.0	6.0
1966	16.46	11.94	4.52	19.0	12.0	6.1
1967	14.78	10.43	4.35	18.3	12.5	5.8
1968	15.74	11.07	4.67	18.0	12.3	5.7
1969	15.00	10.00	5.00	18.0	12.0	6.0
1970	14.00	10.00	4.00	18.0	12.0	6.0
1971	15.00	10.00	5.2	18.0	12.0	

Table 3a – Chiropody Service

Number of patients and number of treatments provided during 1971

		County Council Chiropodists	Voluntary Organisations	Grand Total
Patients				
Elderly		15,865	4,361	20,226
Handicapped Persons		211	–	211
Expectant Mothers		8	–	8
Others		120	–	120
	Total	16,204	4,361	20,565
Treatments				
In Clinics		10,306	19,021	29,327
In Patients Homes		19,866	–	19,866
In Old People's Homes		6,483	–	6,483
In Chiropodists Surgeries		40,352	–	40,352
	TOTAL	77,007	19,021	96,028

Table 4 – Administrative County of Surrey

CAUSES OF DEATH AT DIFFERENT PERIODS OF LIFE, 1971

The causes of all deaths during 1971 are classified in age groups for the aggregate of urban districts and for the aggregate of rural districts in the following table:–

Causes of Death	Sex	Aggregate of Urban Districts								
		All Ages	0-	1-	5-	15-	25-	45-	65-	75+
All Causes	M	4,162	94	14	28	60	146	1,089	1,217	1,514
	F	4,628	78	9	13	20	104	687	910	2,807
Enteritis and other diarrhaeal diseases	M	3	2	–	–	–	–	–	–	1
	F	3	1	1	–	–	–	1	–	–
Tuberculosis of respiratory system	M	12	–	–	–	–	–	5	2	5
	F	5	–	–	–	–	–	–	2	3
Late effects of respiratory tuberculosis	M	3	–	–	–	–	–	2	–	1
	F	1	–	–	–	–	–	1	–	–
Other tuberculosis	M	3	–	–	–	–	1	2	–	–
	F	1	–	–	–	–	–	1	–	–
Syphilis and its sequelae	M	2	–	–	–	–	–	1	1	–
	F	1	–	–	–	–	–	–	–	1
Other infective and parasitic diseases	M	10	3	–	–	2	–	3	1	1
	F	5	–	–	–	–	–	1	3	1
Malignant neoplasm buccal cavity etc.	M	8	–	–	–	–	–	2	4	2
	F	11	–	–	–	–	–	6	1	4
Malignant neoplasm, aesophagus	M	8	–	–	–	–	–	5	2	1
	F	4	–	–	–	–	–	2	1	1
Malignant neoplasm, stomach	M	89	–	–	–	–	5	33	23	28
	F	65	–	–	–	–	8	25	32	62
Malignant neoplasm, intestine	M	89	–	–	–	–	5	33	23	28
	F	137	–	–	–	–	8	25	32	62
Malignant neoplasm, larynx	M	6	–	–	–	–	–	2	4	–
	F	8	–	–	–	–	1	2	2	3
Malignant neoplasm, lung, bronchus	M	367	–	–	–	–	4	127	157	79
	F	108	–	–	–	–	2	44	37	25
Malignant neoplasm, breast	M	2	–	–	–	–	1	–	1	–
	F	179	–	–	–	–	11	77	47	44
Malignant neoplasm, uterus	M	–	–	–	–	–	–	–	–	–
	F	66	–	–	–	–	3	29	17	17
Malignant neoplasm, prostate	M	78	–	–	–	–	–	15	24	39
	F	–	–	–	–	–	–	–	–	–
Leukaemia	M	37	–	1	3	2	8	7	5	11
	F	18	–	–	2	–	1	2	3	10
Other malignant neoplasms	M	237	–	–	3	9	24	97	56	48
	F	277	–	–	1	1	17	94	66	98
Benign and unspecified neoplasms	M	6	–	–	–	1	–	2	3	–
	F	11	–	–	–	–	2	4	2	3
Diabetes mellitus	M	22	–	–	–	1	1	5	9	6
	F	28	–	–	–	–	1	4	4	19
Avitaminoses	M	2	–	–	–	–	–	–	1	1
	F	–	–	–	–	–	–	–	–	–
Other endocrine diseases	M	9	1	–	2	–	–	2	3	1
	F	14	–	2	1	–	–	3	3	5
Anaemias	M	10	–	–	–	–	–	2	2	6
	F	15	–	–	–	–	1	–	1	13
Other diseases of blood	M	3	1	–	–	–	1	–	1	–
	F	2	–	–	–	1	–	1	–	–
Mental disorders	M	9	–	–	–	–	2	2	4	1
	F	23	–	–	–	–	–	2	6	15

Aggregate of Rural Districts								
All Ages	0-	1-	5-	15-	25-	45-	65-	75+
960	17	3	3	16	40	256	260	365
1,051	18	3	3	5	22	150	229	621
–	–	–	–	–	–	–	–	–
–	–	–	–	–	–	–	–	–
–	–	–	–	–	–	–	–	–
–	–	–	–	–	–	–	–	–
1	–	–	–	–	–	1	–	–
1	–	–	–	–	–	1	–	–
–	–	–	–	–	–	–	–	–
–	–	–	–	–	–	–	–	–
–	–	–	–	–	–	–	–	–
–	–	–	–	–	–	–	–	–
3	–	–	–	–	–	1	1	1
–	–	–	–	–	–	–	–	–
5	–	–	–	–	1	3	1	–
3	–	–	–	–	–	1	–	2
17	–	–	–	–	1	3	5	8
20	–	–	–	–	1	4	9	6
–	–	–	–	–	–	–	–	–
–	–	–	–	–	–	–	–	–
21	–	–	–	–	2	6	6	7
37	–	–	–	–	1	6	7	23
–	–	–	–	–	–	–	–	–
–	–	–	–	–	–	–	–	–
94	–	–	–	–	1	39	35	19
39	–	–	–	–	–	17	17	5
1	–	–	–	–	–	–	–	1
39	–	–	–	–	4	10	6	19
–	–	–	–	–	–	–	–	–
13	–	–	–	–	–	5	3	5
20	–	–	–	1	–	1	7	11
–	–	–	–	–	–	–	–	–
3	–	–	–	–	–	2	1	–
8	–	–	–	–	–	4	2	2
54	–	1	1	1	4	24	14	9
37	–	–	1	–	3	12	19	22
2	–	–	–	–	–	1	1	–
3	–	–	–	–	2	–	1	–
8	–	–	–	–	–	3	4	1
12	–	–	–	–	–	2	7	3
–	–	–	–	–	–	–	–	–
1	–	–	–	–	–	–	–	1
–	–	–	–	–	–	–	–	–
3	–	–	–	–	–	1	1	1
5	–	–	–	–	–	–	2	3
2	–	–	–	–	–	–	1	1
–	–	–	–	–	–	–	–	–
–	–	–	–	–	–	–	–	–
3	–	–	–	–	–	–	1	2
13	–	–	–	–	–	–	1	12

Table 4 – CAUSES OF DEATH AT DIFFERENT PERIODS OF LIFE, 1971 continued

Causes of Death	Sex	Aggregate of Urban Districts								
		All Ages	0-	1-	5-	15-	25-	45-	65-	75+
Meningitis	M	3	–	1	–	–	–	1	1	–
	F	1	–	–	–	–	–	–	1	–
Multiple sclerosis	M	5	–	–	–	–	–	3	2	–
	F	4	–	–	–	–	–	4	–	–
Other diseases of the nervous system	M	50	1	1	1	3	8	14	12	10
	F	29	–	1	1	–	2	5	8	12
Chronic rheumatic heart disease	M	18	–	–	–	–	1	8	6	3
	F	81	–	–	–	–	2	26	28	25
Hypertencine disease	M	51	–	–	–	–	1	13	18	19
	F	68	–	–	–	–	1	7	12	48
Ischaemic heart disease	M	1,234	–	–	–	–	23	413	398	400
	F	967	–	–	–	–	5	84	226	652
Other forms of heart disease	M	136	–	2	–	–	2	18	28	86
	F	340	–	–	–	1	4	17	41	277
Cerebrovasinlar Disease	M	423	–	–	–	–	5	71	126	221
	F	724	–	–	–	–	5	58	121	550
Other diseases of circulatory system	M	173	–	–	–	–	4	32	51	86
	F	287	–	–	–	–	1	23	37	226
Influenza	M	2	–	–	–	–	–	2	–	–
	F	7	–	–	–	–	–	–	1	6
Pneumonia	M	348	12	1	2	–	5	34	64	230
	F	510	9	2	–	1	4	31	74	389
Bronchitis and Emphysema	M	214	–	–	–	–	–	40	94	80
	F	89	–	–	–	1	–	21	23	44
Asthma	M	11	–	–	1	1	1	5	2	1
	F	11	–	–	–	–	–	5	4	1
Other diseases of respiratory system	M	45	7	1	–	2	1	7	9	18
	F	44	7	–	–	–	3	3	6	25
Peptic Ulcer	M	24	–	–	–	–	–	3	7	14
	F	24	–	–	–	–	–	4	5	15
Appendicitis	M	5	–	–	1	–	1	1	2	–
	F	2	–	–	–	–	–	–	2	–
Intestinal obstruction and hernia	M	11	1	–	–	–	–	3	5	2
	F	19	–	–	–	–	1	3	4	11
Cirrhosis of liver	M	6	–	–	–	–	–	2	2	2
	F	7	–	–	–	–	–	4	2	1
Other diseases of digestive system	M	27	1	–	–	–	1	11	7	7
	F	39	1	–	–	–	2	9	7	20
Nephritis and nephrosis	M	18	–	–	–	–	–	4	8	6
	F	15	–	–	–	–	1	6	5	3
Hyperplasia of prostate	M	18	–	–	–	–	–	1	2	15
Other diseases of uro-genital system	M	19	–	–	–	–	–	2	4	13
	F	35	–	–	–	1	2	3	9	20
Other complications of pregnancy	F	1	–	–	–	–	1	–	–	–
Diseases of skin	M	3	–	–	–	–	–	1	1	1
	F	4	–	–	–	–	–	–	1	3
Diseases of musculo-skeletal system	M	11	–	–	–	–	–	1	3	7
	F	38	–	–	–	–	2	9	11	16

Aggregate of Rural Districts								
All Ages	0-	1-	5-	15-	25-	45-	65-	75+
–	–	–	–	–	–	–	–	–
1	1	–	–	–	–	–	–	–
6	–	–	–	–	1	2	3	–
10	–	–	–	–	2	5	2	1
5	–	–	–	1	1	1	1	1
12	1	–	–	–	–	3	3	5
6	–	–	–	–	–	4	1	1
21	–	–	–	–	–	8	5	8
6	–	–	–	–	1	2	–	3
20	–	–	–	–	–	5	1	14
284	–	–	–	–	12	87	81	104
214	–	–	–	–	–	18	60	136
40	–	–	–	–	–	7	7	26
66	–	–	–	1	1	3	9	52
84	–	–	–	–	1	15	21	47
181	–	–	–	–	4	13	40	124
36	–	–	–	1	–	5	6	24
69	–	–	–	–	–	7	15	47
1	–	–	–	–	–	–	1	–
–	–	–	–	–	–	–	–	–
65	1	–	–	–	–	8	10	46
80	–	–	–	1	–	5	9	65
62	–	–	–	–	–	14	25	23
15	–	–	–	–	–	2	5	8
1	–	–	–	–	1	–	–	–
–	–	–	–	–	–	–	–	–
16	5	–	–	–	–	2	2	7
11	1	1	–	–	–	–	1	8
9	–	–	–	–	1	1	3	4
3	–	–	–	–	–	–	–	3
1	–	–	–	–	–	–	1	–
–	–	–	–	–	–	–	–	–
2	1	–	–	–	–	–	–	1
6	–	–	–	–	–	1	–	5
3	–	–	–	–	–	2	1	–
–	–	–	–	–	–	–	–	–
8	–	–	–	–	–	1	4	3
15	–	–	–	–	1	2	3	9
1	–	–	–	–	–	–	–	1
3	–	–	–	–	–	2	–	1
7	–	–	–	–	–	–	2	5
1	–	–	–	–	–	–	1	–
11	–	–	–	–	–	3	1	7
–	–	–	–	–	–	–	–	–
–	–	–	–	–	–	–	–	–
3	–	–	–	–	–	–	1	2
4	–	–	–	–	–	1	–	3
8	–	–	–	–	–	1	2	5

Table 4 – CAUSES OF DEATH AT DIFFERENT PERIODS OF LIFE, 1971 continued

Causes of Death	Sex	Aggregate of Urban Districts								
		All Ages	0-	1-	5-	15-	25-	45-	65-	75+
Congenital anomalies	M	32	22	3	2	2	1	1	1	–
	F	34	21	1	2	1	1	5	2	1
Birth injury, difficult labour etc	M	24	24	–	–	–	–	–	–	–
	F	18	18	–	–	–	–	–	–	–
Other causes of perinatal mortality	M	16	16	–	–	–	–	–	–	–
	F	21	21	–	–	–	–	–	–	–
Symptoms and ill-defined conditions	M	24	–	–	–	–	–	1	2	21
	F	63	–	–	–	–	–	–	1	62
Motor vehicle accidents	M	82	–	2	7	24	19	17	9	4
	F	38	–	1	3	8	3	10	6	7
All other accidents	M	57	3	2	6	8	10	13	7	8
	F	34	–	1	3	5	4	5	11	25
Suicide and self-inflicted injuries	M	41	–	–	–	4	8	22	7	–
	F	38	–	–	–	–	8	17	8	5
All other external causes	M	7	–	–	–	1	3	2	1	–
	F	8	–	–	–	–	4	4	–	–
TOTAL – All Causes	M	4,162	94	14	28	60	146	1,089	1,217	1,514
	F	4,618	78	9	13	20	104	687	910	2,807

Aggregate of Rural Districts								
All Ages	0-	1-	5-	15-	25-	45-	65-	75+
5	2	–	1	–	2	–	–	–
11	7	1	1	–	–	1	1	–
5	5	–	–	–	–	–	–	–
2	2	–	–	–	–	–	–	–
3	3	–	–	–	–	–	–	–
5	5	–	–	–	–	–	–	–
5	–	–	–	–	–	–	–	5
9	–	–	–	–	–	–	–	9
20	–	–	1	8	6	1	4	–
12	–	1	1	2	2	1	1	4
11	–	2	–	3	–	6	–	–
7	1	–	–	–	1	1	2	2
13	–	–	–	–	5	5	2	1
7	–	–	–	–	1	6	1	–
2	–	–	–	1	1	–	–	–
1	–	–	–	1	–	–	–	–
960	17	3	3	16	40	256	260	365
1,051	18	3	3	5	22	150	229	621

Table 5 – INFECTIOUS DISEASES

		Total
Measles		2,948
Dysentery		102
Scarlet Fever		164
Diphtheria		–
Meningococcus	Acute Meningitis	11
Other specified organism	Acute Meningitis	3
Unspecified organism	Acute Meningitis	3
Paralytic	Acute Polio	–
Non-paralytic	Acute Polio	–
Whooping Cough		162
Infective	Acute Encephilitis	–
Post Infectious	Acute Encephilitis	–
Leptospiriosis		1
Paratyphoid Fever		–
Typhoid Fever		–
Food Poisoning		233
Malaria		4
Smallpox		–
Anthrax		–
Ophthalmia neonatorum		–
Yellow Fever		–
Tetanus		–
Infective Jaundice		151
Meningis and Central Nervous System	Tuberculosis	3
Other	Tuberculosis	27
Respiratory		88
Salmonella		11

Table 6 – IMMUNISATION AND VACCINATION

Table A – Completed Primary Courses – Number of Persons under age 16

Type of Vaccine or dose	Year of Birth					Others under age 16	Total
	1971	1970	1969	1968	1964-67		
Diphtheria	548	8,006	2,443	553	1,067	242	12,859
Pertussis	534	7,901	2,377	522	674	45	12,053
Tetanus	551	8,017	2,453	569	1,088	1,082	13,760
Polio	460	7,988	2,728	570	1,145	303	13,194
Measles	81	3,788	3,113	1,230	1,777	305	10,294
Rubella	–	–	1	–	2	10,205	10,208

Table B – Reinforcing Doses – Number of Persons under age 16

Type of Vaccine or Dose	Year of Birth					Others under age 16	Total
	1971	1970	1969	1968	1964-67		
Diphtheria	4	203	410	297	13,138	2,736	16,788
Pertussis	2	172	319	177	1,436	281	2,387
Tetanus	5	203	424	322	13,340	9,394	23,688
Polio	149	2,175	1,341	506	9,748	8,258	22,227

Table 7 – NURSING SERVICES

Showing the Health Visitor's case load during 1971

Division	Children			Problem Families		Persons over 65	Sub-Normal -16	Suffering mental illness	E.S.N.	Handicapped persons	T.B. Patients	No. of Families in Caseload
	0-1	1-5	0-5	Ref: to Comm.	Observ:							
Northern	1,414	5,897	7,311	24	108	1,190	64	79	77	127	120	7,075
North West	2,681	10,713	13,394	54	221	1,340	130	140	295	215	325	13,203
South West	3,258	12,918	16,176	17	231	1,827	77	264	266	368	475	15,371
South East	3,132	11,733	14,865	142	163	3,038	123	102	229	124	143	14,791
Epsom	797	3,370	4,167	23	62	889	26	18	40	124	–	4,126
Esher	825	3,237	4,062	70	56	2,083	32	67	116	170	8	4,953
Woking	1,213	4,546	5,759	9	23	438	–	45	111	53	12	4,914
TOTAL 1971	13,320	52,414	65,734	339	864	10,805	452	715	1,134	1.181	1,083	64,433
TOTAL 1970	13,672	54,046	67,718	245	632	8,822	475	656	905	1,151	1,400	63,619

Table 8 – THE WORK OF THE DISTRICT NURSES AND DISTRICT NURSE MIDWIVES

District	Nursing Cases 1	Nursing Visits 2	MIDWIFERY WORK: Deliveries Dom. Births 3	Deliveries Hospital 4	Early Dis. 5	A.N. Visits 6	P.N. Visits 7	CASES in Age Groups 0-5	CASES in Age Groups 65+	VISITS 0-5	VISITS 65+	No. of Patients Suffering from Cancer	No. of Incontinent Patients	No. of Patients Discharged from Hosp. to D.N.
Northern	3,421	58,301	145	–	416	3,510	5,285	75	1,943	227	33,489	137	95	262
North West	3,769	75,032	75	92	1,563	3,263	9,875	104	2,229	349	53,556	149	149	251
South West	6,130	162,814	77	90	1,072	3,370	10,480	83	4,037	332	110,772	409	405	499
South East	4,568	120,738	187	113	879	4,011	11,661	75	2,990	452	93,755	371	342	189
Esher	1,343	35,375	24	–	199	653	1,701	20	900	72	23,730	87	90	74
Epsom and Ewell	1,888	40,353	26	13	274	838	1,808	30	1,044	349	26,121	88	79	35
Woking	1,422	44,705	72	5	737	1,028	4,019	23	861	93	26,175	107	121	141
Total 1971	22,541	537,318	606	313	5,140	16,673	44,829	410	14,004	1,874	367,598	1,433	1,281	1,451
Total 1970	20,280	478,346	1,199		4,280	16,507	48,242	492	13,003	2,586	347,828	1,308	1,298	1,271

Table 9 – PATIENTS TREATED BY DISTRICT NURSING SISTERS

New Patients	Northern	North West	South West	South East	Epsom	Esher	Woking	Total
0-4	239	768	473	423	5	137	69	2,114
5-65	4,856	4,187	4,671	850	362	1,134	107	16,167
65+	515	793	1,213	186	145	198	26	3,076
Total New Patients	5,610	5,748	6,357	1,459	512	1,469	202	21,357

Table 10 – MASS RADIOGRAPHY SERVICE – STATISTICS – 1971

Type of Survey	Total x-rayed	Numbers showing evidence of significant pulmonary tuberculosis			Combined Incidence Rate per 1,000 examinations
		Male	Female	Total	
General Public attending regular weekly sites	34,645	4	3	7	0.1
Industrial groups Mental Hospitals and Institutions Contacts at work Referred by Medical Officers of Health	24,090	3	5	8	0.3
Totals	58,735	7	8	15	0.2
General Practitioner referrals	22,629	18	8	26	1.1

Abnormal Findings	General Practitioner Chest x-ray Service			Normal Mass Radiography Service		
	Male	Female	Total	Male	Female	Total
Pulmonary Tuberculosis	51	20	71	23	20	43
Non-Tuberculous Conditions	824	636	1,460	224	185	409

	General Practitioner Chest x-ray Service			Normal Mass Radiography Service		
	1969	1970	1971	1969	1970	1971
Total Number x-rayed	19,524	24,316	22,629	115,659	67,324	58,735
Significant Pulmonary Tuberculosis	36	26	26	62	37	15
Primary Lung Cancer in men aged 45 and over	83	132	132	58	32	31
Incidence Rate per 1,000 examinations	15.8	26.1	24.2	2.8	2.2	3.2
Primary Lung Cancer in women aged 45 and over	24	27	25	10	6	12
Incidence Rate per 1,000 examinations	5.6	5.3	5.2	0.5	0.4	1.8

Table 11 – NEW BUILDINGS INTO USE, 1971

Project	Total Cost	Date Taken into use
Hadrian's Way, Stamwell	15,824	10/5/71
Bourne Hall, Ewell	101,640	1/7/71
High Street, Cranleigh	67,794	2/8/71
Boxgrove Lane, Merrow	32,153	8/7/71
Ditton's Clinic, Thames Ditton	41,951	29/10/71

Table 12 – AMBULANCE SERVICE – DIVISION OF WORK BETWEEN THE COUNTY'S DIRECT SERVICE AND THE VOLUNTARY SERVICES:–

			Voluntary Organisations					
	County Service		S.J.A.B.		B.R.C.S.		Hospital Car Service	
	Patients	Miles	Patients	Miles	Patients	Miles	Patients	Miles
Year 1971	313,205	2,223,776	1,624	28,459	9,108	70,970	194,189	1,924,186

GRAND TOTALS	
Patients	Miles
518,126	4,247,391

Table 13 – AMBULANCE SERVICE – WORK CARRIED OUT BY THE UNIFIED AMBULANCE SERVICE DURING 1971

Year	EMERGENCY							MATERNITY	
	Accident		Illness		False Alarms	Totals		Totals	
	Patients	Miles	Patients	Miles	Miles	Patients	Miles	Patients	Miles
	11,198	104,150	5,236	53,150	21,254	16,434	178,554	2,421	31,182
1971									

	GENERAL											
	Hospital		Out-Patient		Infectious Diseases		Private		Non-Patient		Totals	
	Patients	Miles	Patients	Miles	Patients	Miles	Patients	Miles	Patients	Miles	Patients	Miles
	50,029	607,156	448,171	3,292,126	220	4,394	851	1,630	107,378	24,472	449,271	4,037,655

GRAND TOTALS	
Patients	Miles
518,126	4,247,391

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