[Report 1963] / Medical Officer of Health and School Medical Officer of Health, West Riding of Yorkshire County Council.

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COUNTY COUNCIL OF THE WEST RIDING OF YORKSHIRE

ANNUAL REPORTS

of the

COUNTY MEDICAL OFFICER

and the

PRINCIPAL SCHOOL MEDICAL OFFICER

YEAR 1963

RONALD W. ELLIOTT, M.D., M.SC., D.P.H.

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(as at 31.12.63)

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(as at 31.12.63)

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STANDING SUB-COMMITTEES OF THE WEST RIDING HEALTH COMMITTEE

Ambulance Sub-Committee.—All matters relating to the County Ambulance Service. (Section 27, National Health Service Act, 1946.)

Public Health Sub-Committee.—Matters relating to the Pharmacy and Poisons Act, 1933; Housing (Rural Workers) Acts, 1926 and 1942; Housing Acts; Rural Water Supplies and Sewerage Acts, 1944-61; Nurses' Act, 1957; Vaccination and Immunisation (Section 26), Venereal Diseases, Public Health Propaganda (Section 28), under the National Health Service Act, 1946; Food and Drugs Act, 1955; Milk (Special Designation) Regulations, 1960; Shops Act, 1950; and all other powers and duties of the Health Authority not delegated to another Standing Sub-Committee.

Mental Health Sub-Committee.—All matters relating to the duties of the Local Health Authority under the Mental Health Act, 1959, and the care and after-care of persons suffering from mental disorder. (Section 28, National Health Service Act, 1946.)

Welfare Sub-Committee.—Arrangements for the prevention of illness, the care of persons suffering from illness other than mental illness, or the after-care of such persons. (Section 28, National Health Service Act, 1946, and the Public Health (Tuberculosis) Regulations, 1952.)

Arrangements for promoting the welfare of persons who are blind, deaf or dumb and other persons who are substantially and permanently handicapped by illness, injury, or congenital deformity, or such other disabilities as may be prescribed by the Minister of Health, and arrangements with Voluntary Organisations therefor. (Sections 29 and 30, National Assistance Act, 1948.)

Assistance grants to Voluntary Organisations providing meals or recreational facilities for old people. (Section 31, National Assistance Act, 1948.)

Arrangements for the protection of property of persons admitted to hospitals, etc. (Section 48, National Assistance Act, 1948.)

The recovery of charges and expenses where permissible in respect of all services provided by the Health Committee.

The West Riding Distress Fund.

Welfare Accommodation Sub-Committee.—The provision and management of residential accommodation for persons who, by reason of age, infirmity or any other circumstances, are in need of care and attention which is not otherwise available to them. (Sections 21-24, National Assistance Act, 1948.)

Arrangements with Voluntary Organisations and other Local Authorities for the provision of accommodation in property maintained by them. (Section 26, National Assistance Act, 1948.)

The registration of disabled persons' or aged persons' homes. (Sections 37-39, National Assistance Act, 1948.)

Registration of charities for disabled persons. (Section 41, National Assistance Act, 1948.)

Care of Mothers and Young Children and Nursing Services Sub-Committee.—The duties of the County Council in respect of Nursing Homes (Sections 187-195, Public Health Act, 1936 and the Nursing Homes Act, 1963); Notification of Births (Section 203, Public Health Act, 1936); the care of mothers and young children (Section 22), domiciliary midwifery (Section 23), health visiting (Section 24), home nursing (Section 25) and domestic help (Section 29) services under the National Health Service Act, 1946; the Nursery and Child Minders Regulation Act, 1948; and the Midwives Act, 1951.

JOINT STANDING SUB-COMMITTEE OF THE WEST RIDING HEALTH AND EDUCATION COMMITTEES

Divisional, School Health and Dental Services Sub-Committee.—All matters appertaining to the Divisional Health Administration (Section 111, Local Government Act, 1933); and the School Health and County Dental Services. (Education Act, 1944.)

STANDING SUB-COMMITTEE OF THE WEST RIDING EDUCATION COMMITTEE

Special Services Sub-Committee.—All matters appertaining to the ascertainment of handicapped pupils and the provision of special educational treatment. (Education Act, 1944.)

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INTRODUCTION

This report is a natural follow-up of that for 1962 in that last year the details of the Ten Year Plan, as requested by the Minister, were given in full. Now we show how this plan has so far been implemented. It will be remembered that the Ten Year Plan was based on an assumption that there should be a bias towards community care rather than hospital care, and it is with this in mind that our plans have evolved in the manner reported in the following pages.

Co-operation with General Practitioners and Re-organisation within the Department

It seems fairly obvious that if the spirit of the Ten Year Plan for community care is to be furthered with any degree of success our relationship with general practitioners should be strengthened. This has necessitated a critical look at what we are already doing for general practitioners by way of co-operation, and what we can possibly do in the future. It would appear as a result of this exercise that adjustment will be necessary all round, and not least within the health department. To this end the County Council have considered and approved the Scheme which appears in full in Part VI of this report. The contents have been well received by general practitioners and the County Council alike and form a blueprint for our future mutual development. It sets out how far the County Council is prepared to go by way of assistance to general practitioners, and I am pleased with the acceptance of this document because it will, with mutual good-will, be a means of giving maximum service to the public.

There is nothing startlingly new in this approach, but it is a concentration of all the ways in which we can be of assistance to general practitioners, and indeed some of the ideas are already in operation in one form or another in various parts of the County. The aim has been to have the principles approved so that policy can be firmly based for the future. The theme which runs through the whole plan is to get general practitioners and health department staff working together, not only in spirit but also in common premises, on behalf of the patients of a particular practice or group of practices. As far as premises are concerned efforts will be made to further the principle of health centres which has suffered so badly since 1948, and in such a way that the financial burden will not be prohibitive to either side.

The Cleckheaton Health Centre, which will be opened in 1964, was a necessary step to indicate the good-will of the County Council in furthering co-operation. Now that this stage has passed I am hoping that less formal but more flexible arrangements will be possible. Certainly some general practitioners are showing a keen interest in this matter already.

Another method of co-operation is by health visitor attachment to general practitioners in their own surgeries, and seems likely to develop also with home nurses and possibly midwives. This raises the question of the new role of the health visitor which was described in my last report and which will inevitably lead to the introduction into the department of auxiliary workers and social workers in order to make it possible for co-operation by the health visitor with the general practitioner to be fostered. Ultimately as the scheme unfolds and develops it will be necessary to look at the problem of how the general prac-

titioner himself can take part further in health department activities. Already he is being used in sessional work in our clinics to a considerable extent, and new developments by way of conducting his own antenatal and child welfare clinics in our centres have prospered. I look forward to the time when our own medical staff, as a result of re-organisation of this kind, will take a more prominent part in the more specialised activities of preventive medicine. This will be our next problem, and I hope it will lead to a progressively and increasingly interesting career in public health. It is not anticipated that plans of such magnitude will develop rapidly. It will depend to a large extent on circumstances and personnel as they exist in various parts of the County, but it could be a goal to aim at. Certainly the time is ripe for such changes. Never in the history of public health has there been such an interest by general practitioners in our activities. There is a warm feeling which has come about in the last ten years and is rapidly developing. I am cheered by the way the general practitioner has accepted our advances. I am certain that his future and ours lie together, for is he not the physician to each member of the community, and are we not ourselves community physicians? Surely this common bond means that ultimately we must be one. This may well be a long term policy, but in the meantime there is infinitely much that can be done to our mutual benefit. Para: 141 of the Report of the Standing Medical Advisory Sub-Committee on " The Field of Work of the Family Doctor " under the Chairmanship of Dr. Annis Gillie summarises this developing situation adequately:—

> " We have considered the proposal that all work concerned with personal health and well-being is so closely allied that the two divisions of the Health Service concerned (*i.e.*, general medical services and preventive health services) should be under unified control. We know from the evidence we have received that effective co-operation already exists in some areas, and believe that it can be extended without this major alteration in administration. It may be that the fullest understanding is more easily achieved at the present time if problems common to the work of family doctors and local authority doctors are approached from different standpoints, but with a common purpose."

Mental Health

The community spirit of the Mental Health Act, 1959, has likewise been furthered in the years since our original plan was formulated, and each year sees further developments. The full spectrum of care for the subnormal has not yet been completely developed, but the special care units and the junior and adult wings of our centres have largely been developed. It remains now to go to completion by the development of sheltered workshops or special industrial units, in addition to the present industrial activities of the centre, in order that we may help to prepare those members of our centres who are capable of being trained for outside industrial life.

It is often forgotten that in addition to the many hundreds of subnormals in our centres there are others in the community of which we have an oversight and who do not need to be in centres. There are 700 such persons in employment to our knowledge, in addition to 600 satisfactorily employed at home.

The special care units have proved to be far more useful than was originally envisaged and are accommodating up to as many as 70 non-ambulant cot and chair cases, for which more space will be needed very soon. Extensions have been going on in all centres to provide kitchen facilities to make them independent of the school meals service and the work is nearly complete.

A scheme for graded payment of all people attending the centres has been introduced and has led to a better sense of belonging to the community and has improved morale.

The policy of training ten of the centre staff each year at suitable courses run by the National Association of Mental Health has considerably improved our position. Out of 119 staff, 41 now hold a qualification. Our aim will be to complete this process. The present position is infinitely better than it was a few years ago.

Our remaining two group training classes will disappear when the Skipton centre is opened in 1964.

I have been pleased with the way the industrial side of the centres has developed, and I am particularly grateful to the County Supplies Department for giving centres so much work to do. The amount and variety of work is expanding constantly and we have been amazed at the speed with which this work can be satifactorily carried out by adult subnormals, and by the quality of the work, which is only accepted by the County Supplies Department if it comes up to commercial standards. This has really been a gratifying experience.

In the field of care and after-care of the mentally ill considerable progress has been made. Members of the staff are frequently in attendance at mental hospitals and hence achieve a considerable degree of co-operation with the psychiatric staff. Eleven social clubs are now functioning with nearly 300 people in attendance and constantly this work is expanding. Psychiatrists and divisional medical officers alike have noticed a great improvement in the patients. Two-day centres for recently discharged hospital patients have been set up in conjunction with the hospitals concerned, and again with daily attendance there has been a noted improvement in the social adaptation of the patients, who are, of course, still under the supervision of the psychiatrist.

In-service training has continued apace. In addition to the extensive training programme conducted by the tutor many staff have attended at outside courses. Also there have been three residential courses run in our own adult training college at Grantley Hall for mental welfare officers, and four for staffs of training centres. All this has obviously been worth while as is evidenced by the gratifying comments of psychiatrists included in this report.

An attempt has also been made to provide a register of people who are willing to take patients as boarders under suitable circumstances, and has met with some little success.

A new development in conjunction with the School Health Service has been the authorised increase of the staff of psychologists from 2 to 9. The use of the services of psychologists when more are appointed will be between the two services and will be an interesting experiment. Certainly the psychologists will have much to offer in the training centres and in the hostels with regard to training policy and industrial adaptation of any particular individual. Another development is the extension of the School Dental Service to our trainees.

Maternity and Child Health and Nursing Services

Considerable attention has been drawn recently to the perinatal mortality rate in this country which, although decreasing, is still by comparison very much higher than that of some other countries. The subject was highlighted by the

reports of the National Birthday Trust on statistical research done over the last few years, and by the pressure on the maternity services due to the rapidly expanding birth rate. In spite of these factors the West Riding mortality rate has been reduced from 41·1 in 1954 to 31·1 in 1963. Good though this progress is we feel that it should be better. To this end each division was analysed statistically for its progress and the results are given in the body of this report, together with a descriptive item. Broadly the picture is one of great inequalities in various parts of the County. I am pleased to say that this matter has been tackled in conjunction with the Leeds Regional Hospital Board in a constructive way, and following a conference of maternity liaison committees it was decided to attempt to take certain steps. From all the evidence available it was obvious that both the expanding birth rate and the perinatal mortality rate could best be dealt with by making sure that the best use was made of hospital beds. This is being attempted at the time of writing by the consideration of a possible standardisation of the categories of patients to be admitted to hospital beds, and the possible adjustment of the areas for which maternity liaison committees are responsible in order to improve facilities and mutual aid between areas. It is also intended to make certain that there is adequate representation of the domiciliary services at hospital liaison committees. It is to be hoped that progress will soon be obvious in this direction.

The maternity co-operation card which is intended to be filled in by all those concerned in a patient's care, whether hospital, general practitioner or local authority, and which was introduced by the Minister, has been adopted completely as far as the County service is concerned. Increasingly general practitioners are bringing it into use, but it is regretted that the hospitals have not found it possible to play their full part here. This is certainly one of the methods of maintaining adequate care for the patient. The reason in many cases is that hospitals have devised their own cards which they are not willing to change, but unfortunately lack of uniformity in documentation in an area such as the West Riding where many hospitals, local authorities and general practitioners are involved, makes the passage of information between all concerned much more difficult.

The nursing and medical staff have concentrated on two special tests during the past year. One is for phenylketonuria in an effort to prevent some cases of mental subnormality and which has led to a detection rate over the past three years of one case in 17,622 tests, which is a rather higher incidence than was originally expected. It is felt that this work is worth while even for the few cases involved. No case was detected in 1963 although 10 false positives were reported and later found not to be affected.

The second test is the ortolani test for congenital dislocation of the hip. This scheme has been going on for one year and has certainly proved its worth. Twenty-two definite positive cases, which were treated at an early stage, were found, and which is about the right number we expected according to the known incidence of the condition. At least 60 other cases were sent to consultants for an opinion with the general practitioner's consent, and 21 of them remained under observation.

It is felt that both tests serve a very useful purpose, particularly as neither of them are time consuming in the slightest and can rapidly be carried out by all members of the staff. The real importance of these two endeavours as far as I am concerned is their indication that the health visitor in particular has a part to play in certain specific aspects of preventive medicine. I am sure that much

more could be done on these lines when suitable simple tests are available, and we should bear this in mind when reorientating the duties of the staff.

On a much more uncertain note is the attention we have been giving to the maintenance of records of congenital defects and the " at risk " register. The former is an attempt to detect any possible repetition of the thalidomide episode which resulted in defects caused by drugs administered during pregnancy, and the latter is an attempt to concentrate observation on cases which might develop defects and which are under suspicion as a result of their history. We made considerable efforts for a year to make a success of the congenital defects register, with the co-operation of general practitioners and by examinations carried out by members of the staff at intervals during the first year of life. Later a much simpler scheme, based solely on observation at birth, was introduced by the Minister, and our original scheme was abandoned in favour of the Ministry scheme. It is not our intention, however, to neglect our own experience, and at the end of 1964 it is hoped to be able to make a comparison between our original scheme and that of the Ministry to see where the right answer can be obtained. As far as the " at risk " register is concerned, however, we have run into graver difficulties, particularly with regard to what constitutes a risk. Many different definitions have been given, so much so that it has been said that normally half the children born could be put on to such a register, which makes the work of such a scheme rather ridiculous. We are left wondering at the moment whether we can get any further by relying on previous methods of detection rather than involving intricate lists, and whether we did in the past miss anything. The matter is still sub judice.

The passing of the Children and Young Persons Act, 1963, and its emphasis on preventive action under Section I, has highlighted the importance of our co-ordinating committees which continue to function, and I hope will do even more substantial work under the new legislation. Divisional medical officers are deeply involved as Chairmen of these co-ordinating committees.

I have been pleased to note the improvement in health visitor staffing both actually and potentially. This has largely come about by an increased number of recruits as trainees, based on the acceptance now of the three months midwifery course at a designated hospital, instead of Part I of the S.C.M., as a preliminary qualification.

Last year I included in the report an analysis of the work done by health visitors in certain parts of the County which was very useful for planning purposes. This year a similar analysis is included for the home nurses. It shows, as a preliminary conclusion, that the load of work is not too heavy at the present time. A small but highly significant service is the help given in the terminal illness of certain conditions by a continuous nursing service day and night. Fifty-three such cases were assisted during the year, in conjunction with the Marie Curie Foundation. More helpers could be used in some areas.

School Health

The employment full time throughout the year of a senior medical officer in the Child Guidance clinics improved the situation immensely. This supplemented the work done by Regional Hospital Board psychiatrists.

Further developments in the field of deafness need to be encouraged. We have our special clinics and audiometers in each division for routine testing and many of our health visitors are trained for early detection. It is felt, however, that to

complete this service we need peripatetic teachers of the deaf. We hope that progress can be made in this direction. In our own Bridge House School for the deaf and educationally subnormal, special facilities for this handicap are provided. It is interesting to note that although the scholars have been deaf from infancy in 25 per cent. of cases the hearing loss was not detected until after the age of five. This is far too late.

Another need is the development of day schools for the educationally subnormal, which is again receiving attention.

It is our endeavour in medical staffing in the future to have if possible one officer in each division trained in the field of maladjustment and another in the field of hearing defects. Already some improvement is being noticed as far as educationally subnormal children are concerned in that they are now being referred at an earlier age than previously—a change for the better.

Speech therapists continue to be in short supply and again the report contains comments by individual speech therapists which lead us to think that a review of procedure may be needed. Such problems as the length of treatment, which is felt by some to be too long, might well be looked at.

We welcome the introduction of a teacher on the Swinton Child Guidance Centre staff. Both the Harrogate and Swinton centres are now equipped in this way and are able to deal with disturbed children needing special and individual help.

I would draw attention to the report by the psychologists which covers the possibility of adjustment of duties to take in a wider field of work such as at audiology clinics, special schools, hostels and special surveys on, for example, educationally subnormal children, such as was carried out at Harrogate recently and which gave us the base line on which to develop a school for the educationally subnormal.

The placement of the psychotic child continues to be difficult, and although only a few cases are involved, 30 in number, they were obviously disposed of unsatisfactorily as shown in the report, and better facilities are required.

We have had cause to reassess the usefulness of the pædiatric clinics held by consultants from the hospitals in local authority premises, and it has been unanimously decided that these are mutually beneficial to pædiatrician, patient, parent and local authority supportive services, and are to continue with slight modification rather than be withdrawn into the hospital.

Two minor comments. At 3·3 per cent. we have reached the lowest figure recorded as far as the uncleanliness of school children is concerned. The report on the nutritional state which has to be made for the Ministry seems to me to be a little out of date and unnecessary.

Vital Statistics

In spite of the high birth rate of 18·2 per 1,000 population the infant mortality rate at 23 per 1,000 live births is about the lowest ever achieved.

It is impossible to ignore the deaths from lung cancer. Again the figures have increased and 704 deaths have occurred, males being six and a half times as many as females. In thirty years the male death rate has increased eightfold, but it must not be forgotten that in this same period the female death rate has increased fourfold and is still increasing. In this connection it is very pleasing to note the vastly increased penalties under the Children and Young Persons Act, 1963, for the sale of tobacco to persons under the age of 16.

Road deaths continue to mount, being commonest between the ages of 15 and 34, with males predominating in the ratio of three to one. It is of great significance that of all males dying between the ages of 15 and 24, 48 per cent. of them are due to deaths on the road, and this amongst people in the prime of life.

Staff

We have recently experienced a shortage of recruits as assistant county medical officers, and speech therapists, too, are in short supply. On the credit side we have a better situation with regard to health visitors and we are making efforts to increase our staff of psychiatric social workers by a new training scheme in conjunction with the University of Leeds, and of general social workers in conjunction with the Leeds School of Commerce, where a two year Young-husband Course is in operation. Close training links are to be established in both cases.

The County public health inspector's section is now in full operation after its re-organisation, and has an inspectorate of three and two sampling officers.

Epidemiology

There is a rapidly increasing reservoir of people immunised against tetanus as a result of the introduction of triple antigen some few years ago. There is also a school of thought developing in the treatment of tetanus by antibiotics and tetanus toxoid rather than by anti serum. It will be seen that the two changes are complementary, and will help towards the removal of dangerous reactions to anti serum.

Only one case of poliomyelitis was notified during the year and it made a complete recovery in spite of the fact that it had only been partly immunised.

There has been an outbreak of diphtheria in the Keighley area. Six cases have been confirmed including one death in an unimmunised child of two. One other case had three injections against diphtheria twelve years previously, two others were not immunised, and the remaining two had a doubtful state of immunisation. At the time of writing 8 cases and 50 carriers have been discovered. The organism concerned is atypical both clinically and bacteriologically and the impression is given that immunisation has considerable effect upon the clinical condition of any case developing, but not so much on the carrier side.

In view of the current interest in typhoid fever it is as well to remember that the disease has a relatively low infectivity as instanced by the five individual cases which occurred in the County during 1963, and from each of which no further spread was noted.

Ambulance Service

This is a rapidly expanding service, both in the number of cases dealt with and the quality and quantity of vehicles and staff. All fields of work, whether accident, out-patient, admissions or discharges have increased. 41,302 more cases were carried and 266,909 more miles run. This emphasises the great need for a trained corp of skilled people to face up to these increasing demands in order that a sense of responsibility and competence may be retained. Efforts are being made by way of training and I am sure that before very long more facilities will have to be made available for ensuring the full training of all staff to deal with modern requirements. A Ministry report on this aspect of the work is likely to be forthcoming within the next twelve months.

Health Education

Purposely, " frustration " has been made the theme of the section in this report dealing with health education. For instance, when one considers the difficulties in the past of advocating flame proof material for nightdresses and its cost and rarity, or the gigantic task of competing with a pleasant, inexpensive and well advertised habit of smoking, this is not surprising; indeed, health education is a dedicated vocation. This must always be so when we have to face the elements of freedom of action of individuals and their own personal responsibility. It goes against the grain for anyone to be tackled on these sensitive points.

This was clearly indicated recently in connection with the typhoid epidemic which showed the tremendous responsibility which everyone literally carries in his own hands and whose clean personal habits are paramount.

It does seem from departmental enquiries and from what a national survey is likely to produce that the early habit of smoking in quite a proportion of eleven year olds will justify the letter we have been sending for some years to parents of seven year olds warning them of the danger.

Health education continues to grow within the department and the contemplated re-organisation by way of providing a special staff for this purpose is now overdue. With increased superficial knowledge of medical matters which has been stimulated by newspapers and magazines, I have been struck by the depth of questioning which comes from members of the public. It is with this thought in mind, amongst others, that the County Council is being asked to ensure that the person in charge of health education shall be someone with a medical or nursing background, as well as for the more easy administration of this service, which will be carried out entirely through medical and nursing channels.

Environmental Hygiene

The Public Health Inspector's section has been completely re-organised and restaffed, and as a result is now able to undertake a much wider sphere of activity. In addition to the urgent work on atmospheric pollution, milk and rural water and sewage, more work will be possible in connection with pharmacy and poisons, and in regular contact with the districts and liaison with other departments of the County Council, particularly planning, and in the hygiene of nursing homes and schools. I look forward to a very vigorous approach to all these problems.

The subject of brucellosis was again considered during the year and has shown the weakness of present legislation in trying to eradicate the condition. We are now firmly convinced that ultimately the only sure method is an eradication scheme similar to what was done with tuberculosis with such good results. However, we must continue to use our present powers to the best of our ability. Our increased duties with regard to the sampling of milk from dealers has enabled us to support a scheme of co-operation with district inspectors so as to avoid duplication of effort as between districts and the County Council, in the detection of infected milk.

Nursing Homes

For some few years an agreed departmental standard has been used in our negotiations with nursing homes in an effort to improve the facilities and service. However, the legislation was so weak as at times to be embarrassing. The new Nursing Homes Act, 1963, however, strengthened the position quite considerably and our departmental standards, now approved by the County Council, will assist in our search for optimum conditions. The standards are reproduced in this report.

Home Helps

Already 5 per cent. of the population over the age of 65 is catered for by this service. Once again with the increased emphasis on community care we must accept further pressure and increases. Even so the help given is massive. Nearly two and a half million hours were given in the year to over 16,000 cases. It is obvious that some individuals are down to the bare minimum of useful help, hence the approved regular increase of establishment each year was not sufficient to cope with the pressure during 1963, and a further interim increase of establishment had to be added during the year.

Tuberculosis

We have tried to tackle tuberculosis from two opposing points. First to expand our present facilities of testing young children in an effort to discover early cases, either amongst the children or their contacts, and second with the co-operation of general practitioners we have offered to stimulate the taking of sputum samples from old people through the health visiting service where the general practitioner feels that there is a suspicious cough which needs investigating. It is difficult to know how far this work has progressed, but I appeal to general practitioners to further these aims as much as possible since it is from the old person, particularly the old man, that the present danger of the spread of tuberculosis comes.

Care and After-Care

The County Council is urgently requiring a convalescent home, but progress in the acquisition of such premises has been slow and full of difficulty. Ideal premises were found, but financial limitations placed on local authorities in such matters made negotiations difficult and fruitless. We are now back where we started with very little hope of success at the time of writing.

There has been a considerable expansion in our loan scheme for nursing equipment, and with the availability of new items, and particularly disposable items, we have had to attempt to reappraise the whole situation, and this has led to a departmental Working Party which has not yet finished its deliberations.

So much has been said about general practitioner liaison as far as care and after-care is concerned that we may be tempted to forget the vast amount of close work being done with the hospitals. There is perhaps no geriatric unit in the whole of the County which has not got direct or indirect contact with health visitors, and this applies to many other specialist fields such as pædiatrics, chest diseases, maternity, diabetes, as well as the mentally ill. This is invaluable both to our field staffs and the general practitioner.

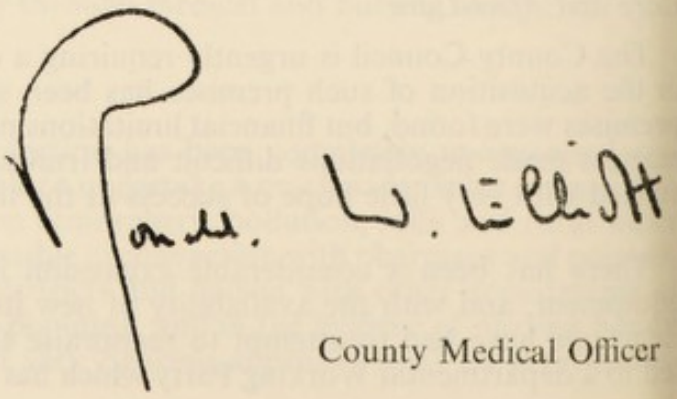
Chiropody

This year has again seen an expansion in the service and has made it necessary to overhaul our scheme, not only to meet the expansion, but also the situation caused by the new scale of fees for chiropodists, and the new system of registration which is gradually being brought into operation. A plan is being studied by the County Council which will help us with these new developments. It is expected as a result of it that the direct service will increase in volume because of the large number of chiropodists being registered and therefore eligible for employment by the Authority, and that there will be a diminution of the indirect service through voluntary bodies, some of whom will wish to be relieved of their responsibilities. No action will be taken which will reduce the service, nor will any voluntary body be required to give up its responsibilities against its wishes. I would like to record at this stage how valuable the efforts of the voluntary bodies have been and without them the service could not have grown to its present status. The practical results of these deliberations will be a definite establishment of chiropodists on the staff which will amount to the equivalent of 60 whole-time workers.

Conclusion

When I reflect on the fantastic developments in medicine in general and in public health (I avoid the term " social medicine " because I see no difference) I find it very difficult to understand the woeful utterances one so constantly hears from all sides as to the future. I think that we live in a very exciting medical age, full of promise, and I think this report justifies that conclusion. I am deeply comforted by the address recently given by the current President of the Yorkshire Branch of the British Medical Association which I understand is likely to be published. Its title, however, is indicative of the mood itself, " The best is yet to be ". The President is a general practitioner.

I wish to record my deep appreciation of the work of all the staff and the assistance given by members and officers of the County Council. Particularly do I express my thanks to Dr. J. Lyons, my former Deputy, who has left to take up the post of County Medical Officer in Devon, and I wish him luck. I welcome all new members of the staff, and hope that Dr. Francis will be happy in his new post in succession to Dr. Lyons.



Health Department,
Wood Street,
Wakefield.

June, 1964.

County Medical Officer

STAFF OF THE HEALTH DEPARTMENT

as at 31st December, 1963

MEDICAL STAFF

County Medical Officer and Principal School Medical Officer	Ronald W. Elliott, M.D., M.SC., D.P.H.
Deputy County Medical Officer	J. Lyons, M.B., CH.B., M.R.C.S., L.R.C.P., D.P.H.
Senior Administrative Medical Officers	P. H. Brewin, M.B., CH.B., D.P.H. D. E. Jeremiah, M.B., B.S., D.T.M. and H., D.P.H. C. S. Smith, M.B., B.S., M.R.C.S., L.R.C.P.
Venereologist (part-time) ...	J. A. Burgess, M.D., CH.B., D.P.H.
Pædiatrician (part-time)	C. C. Harvey, B.SC., M.D., B.S., F.R.C.S., M.R.C.P.
Obstetrician (Joint appointment with Hospital Services)	J. C. MacWilliam, L.R.C.P., L.R.C.S., L.R.F.P.S., D.OBST.R.C.O.G.
Medical Officer for the Child Guidance Service	Eileen Atkinson, M.B., CH.B., D.OBST.R.C.O.G., D.P.M.

Divisional Medical Officers—

Division No.	
1 (Skipton)	M. Hunter, M.B.E., M.D., CH.B., D.P.H.
3 (Keighley)	V. P. McDonagh, M.B., CH.B., D.P.H.
4 (Shipley)	J. Battersby, M.B., CH.B., D.P.H.
5 (Horsforth)	A. Telford Burn, M.B., B.S., D.P.H.
7 (Harrogate)	N. V. Hepple, M.D., B.S., B.HY., D.P.H.
9 (Wetherby)	R. G. Smithson, M.D., CH.B., D.P.H.
10 (Goole)	S. K. Appleton, M.D., CH.B., D.P.H., D.T.M.
11 (Castleford)	J. M. Paterson, M.B., CH.B., D.P.H.
12 (Pontefract)	J. F. Fraser, M.B., B.S., D.P.H., D.OBST.R.C.O.G.
13 (Morley)	Vacant
15 (Batley)	J. F. Caithness, M.B., CH.B., D.P.H.
16 (Rothwell)	A. L. Taylor, M.D., CH.B., D.P.H., L.D.S.
17 (Spenborough) ...	W. M. Douglas, M.B., CH.B., D.P.H.
18 (Brighouse)	F. Appleton, M.B., CH.B., D.P.H.
19 (Todmorden) ...	N. E. Gordon, M.B., CH.B., D.P.H.
20 (Colne Valley) ...	E. Ward, M.R.C.S., L.R.C.P., D.P.H.
22 (Wortley)	J. Main Russell, M.B., CH.B., B.HY., D.P.H.
23 (Hemsworth) ...	J. S. Walters, M.C., M.B., CH.B., D.P.H.
25 (Barnsley)	R. Barnes, B.A., M.R.C.S., L.R.C.P., D.P.H.
26 (Wath upon Dearne)	D. J. Cusiter, M.B., CH.B., D.P.H., D.T.M. and H.
27 (Doncaster)	J. Ferguson, M.B., CH.B., D.P.H.
29 (Thorne)	G. Higgins, B.SC., M.B., CH.B., D.P.H.
31 (Rotherham) ...	J. M. Watt, M.D., CH.B., D.P.H., D.C.H., D.OBST.R.C.O.G.

Assistant County Medical Officers and School Medical Officers—

Division No.	
1 (Skipton) ...	... *Helen M. Dean, M.B., CH.B., D.P.H. *Ruth R. Stoakley, M.B., B.CH., B.A.O., D.P.H. P. J. Burke, M.B., CH.B., D.P.H., D.I.H.
3 (Keighley) ...	... *Doreen E. Gledhill, M.B, CH.B. J. I. Bennet, M.B., CH.B.
4 (Shipley) ...	... *Gwendolen Buckle, M.B., B.S. Adaline N. Ambler, M.B., CH.B.
5 (Horsforth) ...	... *Kathleen A. S. Brosnan, M.B., B.CH., D.OBST.R.C.O.G., D.P.H. *Helen M. Mitchell, M.B., CH.B. G. W. Brown, L.R.C.P., L.R.C.S., L.R.F.P. and S. Joan M. Murdoch, L.M.S.S.A.
7 (Harrogate) ...	... *Gertrude M. Polson, B.SC., M.B., CH.B., D.OBST.R.C.O.G. *Sheila F. Schofield, M.B., CH.B., D.P.H., D.C.H. P. A. G. M. Ashmore, M.R.C.S., L.R.C.P. A. W. I. Hall, M.B., B.CHIR.
9 (Wetherby) ...	... *Elizabeth M. Hargreaves, M.B., CH.B., D.P.H. J. G. McHugh, M.B., CH.B., D.C.H.
10 (Goole) ...	... *Muriel J. Lowe, M.B., B.S., M.R.C.S., L.R.C.P., D.P.H., D.C.H. Eileen M. R. Bell-Syer, M.B., B.S.
11 (Castleford) ...	... *J. M. B. Carr, M.B., CH.B., D.P.H. Bessie J. Catton, M.B., CH.B.
12 (Pontefract) ...	... *J. E. Lee, M.R.C.S., L.R.C.P., D.P.H.
13 (Morley) ...	... *Barbara Briggs, M.B., CH.B., D.P.H. Irene Hargreaves, M.B., CH.B. Mary K. Shaw, M.R.C.S., L.R.C.P.
15 (Batley) ...	... *Freda M. Cox, M.R.C.S., L.R.C.P. Rosemary J. E. Saword, M.B., CH.B.
16 (Rothwell) ...	... *Ruth M. Bowker, B.A., M.B., CH.B., D.P.H. Sheila M. Dick, L.R.C.P., L.R.C.S.
17 (Spenborough)	... *Shirley Jessop, M.B., CH.B., D.P.H. Denise E. Robertshaw, M.B., CH.B.
18 (Brighouse) ...	... *Marie P. Milligan, B.SC., M.B., CH.B., D.P.H. D. B. Reynolds, M.R.C.S., L.R.C.P., D.P.H.
19 (Todmorden)	... *Gladys V. Bradshaw, M.B., B.S., D.OBST.R.C.O.G., D.P.H. W. C. McKerr, M.B., CH.B., B.A.O.
20 (Colne Valley)	... *W. P. B. Stonehouse, M.A., M.R.C.S., L.R.C.P., D.P.H. Charlotte N. Capes, M.B., CH.B., D.P.H. A. A. Kenyon, M.B., CH.B.
22 (Wortley) ...	... *F. C. Armstrong, M.B., B.CH., D.P.H. Elise M. Hendry, M.B., CH.B., D.CH.
23 (Hemsworth)	... *Edith E. Cromb, M.B., CH.B., D.P.H. Josephine Hayes, M.B., CH.B. C. H. Merry, M.R.C.S., L.R.C.P.
25 (Barnsley) ...	... *C. G. Oddy, M.B., CH.B., D.P.H. Stella G. A. Henriques, M.B., CH.B.

Assistant County Medical Officers and School Medical Officers—continued

26 (Wath upon Dearne)	*J. D. Hall, M.R.C.S., L.R.C.P., D.P.H. S. K. Pande, M.B., B.S.
27 (Doncaster)	*P. O. Nicholas, M.B., CH.B., D.P.H., D.C.H. Margaret T. Burton, B.A., L.M.S.S.A., L.M. Christina M. Dornan, M.B., B.CH., B.A.O. A. K. Rakshit, M.B., B.S.
29 (Thorne)	Vacant
31 (Rotherham) ...	*M. E. O'Neill, M.B., CH.B., D.P.H. Margaret J. Hallinan, M.R.C.S., L.R.C.P.

119 General Medical Practitioners who act as Child Welfare Centre Medical Officers and are employed on a sessional basis. This is the equivalent of 19·1 whole-time Assistant County Medical Officers.

* Senior Assistant County Medical Officer and School Medical Officer.

Chest Physicians—(Joint Appointments with Hospital Services)—

SHEFFIELD REGION

D. H. Anderson, V.R.D., M.D., B.CH., B.A.O., D.P.H.
J. J. Danaher, M.B., B.CH., B.A.O.
F. C. N. Holden, M.D., B.S., M.R.C.S., L.R.C.P.
A. C. Morrison, M.D., CH.B., D.P.H.
J. D. Stevens, M.D., B.SC., M.R.C.S., L.R.C.P.

LEEDS REGION

R. A. Bruce, D.M., M.A., B.M., B.CH., M.R.C.P.
J. Charley, M.D., B.S., M.R.C.P., M.R.C.S.
G. F. Edwards, M.B.E., M.B., B.S., M.R.C.P., M.R.C.S.
H. Grunwald, M.D. (Vienna)
W. D. Hamilton, M.B., B.CH., B.A.O., D.P.H.
W. H. Helm, M.R.C.S., M.R.C.P.
G. Henry, M.B., B.CH., B.A.O.
D. A. Herd, L.R.C.P., L.R.C.S., L.R.F.P.S.
J. W. Jordan, M.D., B.S., L.R.C.P., M.R.C.S.
B. T. Mann, B.SC., M.D., CH.B., D.P.H.
Marjorie S. Oxley, M.B., CH.B., T.D.D.
J. K. Scott, M.B., CH.B., M.R.C.P., D.P.H.
D. K. Stevenson, M.B., CH.B., M.R.C.P.
J. Viner, M.B., CH.B.
J. Y. Walker, M.B., CH.B., D.P.H.
R. N. Walker, M.B., CH.B., D.P.H.
A. Weleminsky, M.D. (Prague)

Other Medical Specialists in the School Health Service (Regional Hospital Board and University Appointments)—

OPHTHALMIC

S. K. Banerjee, D.O.
H. C. Black, M.B., B.CH., B.A.O., D.O.M.S.
R. Hawe, M.B., CH.B., B.A.O., D.O.L.
M. A. C. Jones, M.B., CH.B., F.R.C.S., D.O.
S. M. Kamaluddin, M.B., B.S., D.O.M.S.
B. A. Marshall, M.B., CH.B., D.O.M.S.
N. L. McNeill, M.B., B.S., M.R.C.S., L.R.C.P., D.O.M.S.
K. H. Mehta, M.B., B.S., M.R.C.S., L.R.C.P., D.O.
K. K. Prasher, M.B., B.S., D.O.
S. Robertson, M.B., CH.B., D.O.M.S.
J. Roche, M.B., CH.B., D.O.
T. S. Severs, M.D., B.S., M.R.C.S., L.R.C.P.
E. S. Tan, M.B., CH.B., D.O.M.S.
C. W. Thornhill, F.R.C.S., L.R.C.P. and L.M., L.R.C.S.I. and L.M., D.O.
J. L. Wood, M.R.C.S., L.R.C.P.
P. M. Wood, M.B., CH.B., F.R.C.P., D.O.M.S.
L. Wittels, M.D. (Vienna), D.O.

ORTHOPAEDIC

J. H. Annan, M.B., CH.B., F.R.C.S.
H. N. Burwell, M.B., CH.B., F.R.C.S.
A. J. S. Bell-Tawse, M.A., M.B., F.R.C.S.
R. W. L. Calderwood, F.R.C.S.
G. F. Hird, F.R.C.S., L.R.C.P.
G. Hyman, M.B., CH.B., F.R.C.S.
P. Kilburn, M.B., CH.B., F.R.C.S., M.CH.ORTH.
W. H. Maitland-Smith, M.B., CH.B., F.R.C.S., M.CH.ORTH.
A. Naylor, M.SC., M.B., CH.M., F.R.C.S.
Miss M. A. Pearson, M.B., CH.B., F.R.C.S.
H. Petty, M.B., CH.B., F.R.C.S., L.R.C.P.
E. R. Price, M.B., B.S., F.R.C.S., M.R.C.P.
I. M. Whitwam, M.B., CH.B.
J. Wishart, M.B., CH.B., F.R.C.S.

E.N.T.

P. H. Beales, M.B., B.S., F.R.C.S.
R. D. Dunsmore, M.B., B.S., M.R.C.S., L.R.C.P.
W. M. S. Ironside, M.B., CH.B., F.R.C.S.
H. Morus-Jones, M.C., M.B., B.S., F.R.C.S., L.R.C.P., D.L.O.
S. Kavanagh, L.R.C.P.I. and L.M., F.R.C.S., D.L.O.
K. M. Mayhall, M.A., M.B., B.CHIR., F.R.F.P.S., M.R.C.S., L.R.C.P., D.L.O.
J. E. Rees, M.R.C.S., D.L.O.
W. L. Rowe, M.B., CH.B., F.R.C.S.
C. Smith, M.B., B.S., F.R.C.S., L.R.C.P., D.L.O.

PAEDIATRIC

M. W. Arthurton, M.D., M.R.C.S., M.R.C.P., B.S., D.C.H.
M. F. G. Buchanan, M.B., CH.B., F.R.C.P., D.C.H.
R. R. Gordon, M.C., M.D., M.R.C.P., D.C.H., D.R.C.O.G.
J. M. Littlewood, M.B., CH.B., M.R.C.P., D.C.H.
J. D. Pickup, M.D., CH.B., D.C.H.
L. J. Prosser, M.B., CH.B., D.C.H.
R. J. Pugh, M.B., CH.B., M.R.C.P., M.R.C.S., D.C.H.
A. P. Roberts, M.B., B.S., M.R.C.P., M.R.C.S., D.C.H.

CARDIAC

J. R. Fountain, M.D., M.R.C.P., M.B., CH.B.
L. J. Prosser, M.B., CH.B., D.C.H.
P. C. Reynell, D.M., B.CH., M.R.C.P.
W. S. Suffern, M.D., CH.B., M.R.C.P., M.R.C.S.

DERMATOLOGICAL

W. E. Alderson, M.A., B.M., B.CH

PSYCHIATRISTS

P. J. Crowley, M.A., M.D., D.C.H., D.P.M.
Elizabeth Gore, M.D., CH.B., D.OBST.R.C.O.G., D.P.M.
Stephanie M. Leese, B.SC., M.B., B.S., M.R.C.S., L.R.C.P., D.P.M.
J. D. Orme, M.R.C.S., L.R.C.P., D.P.M.

NURSING AND MIDWIFERY

County Nursing Officer	Doris Walker, S.R.N., S.C.M., H.V.CERT.
Deputy County Nursing Officer...	Mary G. Edwards, S.R.N., S.C.M. (Part I), B.T.A., H. V. CERT., H.V. TUTOR'S CERT.
Area Nursing Officer	Winnie Taylor, S.R.N., S.C.M., H.V.CERT., Q.I.D.N.S.
Non-Medical Supervisors of Mid-	Norena M. Everitt, S.R.N., S.C.M., M.T.D.
wives	Winifred Williamson, S.R.N., S.C.M., M.T.D.
Health Visitor Tutor	Rona E. Chambers, S.R.N., S.C.M. (Part I) H.V.CERT., H.V. TUTOR'S CERT.

17 Divisional Nursing Officers.
359 Health Visitors and School Nurses (42 part-time).
5 Orthopædic Nurses and Physiotherapists (2 part-time).
6 Tuberculosis Visitors.
4 Venereal Diseases Social Workers (Qualified Health Visitors).
311 Home Nurses and Home Nurse/Midwives (17 part-time).
203 Midwives (3 part-time).
5 Matrons and 27 other nursing staff at 5 Day Nurseries.

MENTAL HEALTH SERVICE

Psychiatric Social Worker-Tutor	Maria Farrow, A.A.P.S.W.
Senior Mental Welfare Officers	R. Aspinall
	Margaret M. de la Cour
	A. Emmerson
	J. H. Hope
	J. G. Jarvis
	Dorothy W. Lynes
	S. Parkinson

46 Mental Welfare Officers.
2 Trainee Mental Welfare Officers.
Organiser of Training ... Frances E. Woolley, DIP.N.A.M.H.
18 Supervisors in Mental Health Training Centres.
96 Assistant Supervisors and other assistant staff.
5 Home Teachers for (Mentally) Subnormal Children (2 part-time).

CHILD GUIDANCE SERVICE

Psychologists ... ... D. G. Pickles, M.A.
H. B. Valentine, M.A.
6 Psychiatric Social Workers (4 part-time).

SPEECH THERAPY SERVICE

Chief Speech Therapist ... Vacancy.
13 Speech Therapists (3 part-time).

DENTAL SERVICE

Chief Dental Officer, Principal School Dental Officer — D. Davies, M.B., CH.B., B.D.S.

Orthodontic Consultant ... Rachel Sclare, DIP.ORTH.R.C.S.(Eng.), L.D.S.

Senior Dental Officers ... W. A. Allen, B.D.S.,
J. M. Enderby, L.D.S.
M. R. Hollings, F.D.S., B.CH.D.
H. Taylor, L.D.S.
G. A. Thompson, B.CH.D.

School Dental Officers—

I. F. Ash, B.CH.D., L.D.S.
Freda Bartholomew, B.CH.D., L.D.S.
G. H. Bulcock, L.D.S.
Olivia D. S. Burgess, B.D.S.
Joan Cader, B.D.S.
J. R. Clayton, B.CH.D., L.D.S.
K. R. Cowell, B.CH.D., L.D.S.
Joan M. Davison, L.D.S.
E. Doherty, B.D.S.
W. H. Dyke, L.D.S.
P. F. A. Eltome, L.D.S.
K. S. Erskine, L.D.S.
J. D. Franks, L.D.S.
Mary M. Gibson, L.D.S.
R. K. L. Gilchrist, B.CH.D., L.D.S.
J. G. E. Gill, L.D.S.
Kathleen M. Golding, B.D.S.
R. F. Grainger, B.CH.D., L.D.S.
M. Hattan, L.D.S.
S. Henry, L.D.S.
Asenath M. Holburn, L.D.S.
F. Kershaw, L.D.S.
B. Kirkland, B.D.S.
Valerie P. Lindsay, L.D.S.
F. Lister
Margaret Lord, B.D.S.
A. S. Metcalfe, L.D.S.
E. S. Midgley, L.D.S.
S. Mitchinson, L.D.S.
J. Naftalin, L.D.S.
Joyce Neden, B.D.S.
M. S. Ormesher, B.D.S.
D. B.Owen, L.D.S.
R. S. Raistrick, F.D.S., H.D.D.
G. B. Reid, L.D.S.
Jessie Rothera, L.D.S.
F. H. Sanderson, L.D.S.
Susanne E. Schloss, L.D.S.
B. Sleight, B.CH.D.
P. Smith, L.D.S.
D. J. Stocks, L.D.S.
E. Thornton, L.D.S.
P. W. Thornton, L.D.S.
J. Todd, L.D.S.
J. L. Traynor, B.CH.D., L.D.S.
H. M. Yuile, L.D.S.

8 part-time

6 Dental Auxiliaries

Senior Dental Technician ... ... J. O. Ford

9 Technicians
1 Boy Dental Apprentice
62 Dental Surgery Assistants

PUBLIC HEALTH INSPECTORS

Chief County Public Health Inspector ... D. Greenwood, M.A.P.H.I.
County Public Health Inspectors ... ... J. D. Clayton, A.R.S.H., M.A.P.H.I.
D. Jagger, M.A.P.H.I.

2 Milk Sampling Officers

ADMINISTRATIVE AND CLERICAL

Senior Administrative Officer ... ... G. Richardson, D.P.A

Sectional Clerks ... ... J. H. Milne, D.P.A.
H. Beatson
W. J. Battye
R. S. Marshall
T. Myton, D.P.A.
T. R. Schofield, D.P.A.

Senior Clerks ... ... E. Brown
D. Marshall, D.P.A.
J. Spruce, D.P.A.

25 Divisional Senior Clerks
320 Other Clerical Staff (including part-time staff)

DOMESTIC HELPS

2,817 Domestic Helps

ANALYSTS

County Analyst ... ... R. Mallinder, B.SC., F.R.I.C. (part-time).
Deputy County Analyst ... ... J. C. Harrel, F.R.I.C. (part-time).

PART I

VITAL STATISTICS

Area and Population

Births

Deaths

VITAL STATISTICS

Area and Population:

The area and population of the aggregates of Municipal Boroughs and Urban Districts, Rural Districts and the Administrative County are appended:—

	Municipal Boroughs and Urban Districts	Rural Districts	Administrative County
Area (acres)	380,315	1,226,599	1,606,914
Population:			
Census, 1961 ...	1,187,034	464,707	1,651,741
Estimated (mid-1963)	1,210,910	485,310	1,696,220

Number of Municipal Boroughs, 13; Urban Districts, 55; Rural Districts, 21; Total 89.

Summary for 1963:

The live birth rate was 18·2; the stillbirth rate per 1,000 total births 18·7; the live premature birth rate per 1,000 live births was 66. The death rate from all causes was 12·0; from heart and circulatory diseases 4·53; cancer 1·94; respiratory diseases 1·52; tuberculosis, respiratory 0·057; tuberculosis, other forms 0·008; diphtheria 0·001; whooping cough 0·001; measles 0·003; meningococcal infections 0·004; per 1,000 population. Infant mortality was 23·0; and maternal mortality 0·45 per 1,000 total births.

A comparison of the figures for the past 74 years is given in the following table:—

Year	Live Birth Rate	Stillbirths per 1,000 total births	Death Rates							
			All Causes	Infective and Parasitic Diseases	Tuberculosis, Respiratory	Tuberculosis, Other Forms	*Respiratory Diseases	Cancer	Maternal Mortality per 1,000 total births	Infant Mortality
1890–1909	28·9	†	16·7	1·89	1·19	0·52‡	3·20	0·77‡	†	147
1910–1919	22·5	†	14·5	1·26	0·84	0·41	2·58	0·98	†	112
1920–1929	20·2	†	12·4	0·56	0·68	0·25	2·08	1·20	†	82
1930–1939	15·5	46	12·1	0·30	0·48	0·13	1·24	1·46	4·70	62
1940–1949	18·1	31	12·2	0·16	0·39	0·09	1·43	1·73	1·95	47
1950–1954	15·7	25	11·9	0·09	0·19	0·03	1·23	1·89	0·82	31
1955	15·3	26	11·7	0·07	0·11	0·01	1·17	1·90	0·67	26
1956	16·4	23	11·8	0·07	0·11	0·02	1·22	1·89	0·52	27
1957	16·6	24	11·7	0·07	0·08	0·01	1·22	1·87	0·51	26
1958	16·7	23	11·9	0·05	0·09	0·01	1·29	1·97	0·43	24
1959	16·5	20	11·6	0·04	0·07	0·01	1·26	1·99	0·36	24
1960	16·9	22	11·5	0·06	0·06	0·01	1·15	1·98	0·73	22
1961	17·2	20	12·1	0·05	0·06	0·00	1·44	1·98	0·27	25
1962	17·8	18	12·0	0·04	0·05	0·01	1·47	2·00	0·20	23
1963	18·2	19	12·0	0·04	0 06	0·01	1.52	1·94	0·45	23

* Combined death rate from bronchitis, pneumonia and other respiratory diseases excluding tuberculosis and influenza.

† Figures not available.

‡ This rate is for the 10 years 1900-1909.

Live Births:

The number of live births registered was 30,803 representing a crude birth rate of 18·2 per 1,000 population. Further reference appears on page 86.

Deaths:

There were 20,318 registered deaths allocated to the Administrative County, the highest total recorded since 1929, representing a crude death rate of 12·0 per 1,000 of the population compared with 12·0 in 1962 and an annual average of 11·8 in the period 1958–62. The number of deaths assigned to the separately classified causes varies from year to year: vascular lesions of the nervous system, coronary disease and angina, pneumonia, bronchitis and accidents made the major contribution to the increase in mortality; these deaths were only partially offset by decreases from total cancer and congenital malformations.

The age-sex composition of the population varies from area to area and crude death rates, although related to actual occurrences, do not provide an accurate comparative mortality index. To enable truer comparisons of the mortality between different areas to be made, weighting or comparability factors are applied to the crude rates. The death rates from all causes for the past five years, adjusted by the appropriate factors, for the aggregates of Boroughs and Urban Districts, Rural Districts, the Administrative County, also the rates for England and Wales are given below.

Year	Boroughs and Urban Districts	Rural Districts	Administrative County	England and Wales
1959	13·0	11·6	12·7	11·6
1960	12·9	11·9	12·6	11·5
1961	13·7	12·8	13·4	12·0
1962	13·4	12·6	13·3	11·9
1963	13·6	12·5	13·3	12·2

Stillbirths and Infant Mortality:

STILLBIRTHS:

Registered stillbirths numbered 586 equivalent to a rate of 18·7 per 1,000 total births, a slight increase compared with the previous year; further reference appears on pages 87 and 91.

PERINATAL MORTALITY:

This is a measure of the hazards to the developing fœtus during the later months of pregnancy and the baby in its first week of life. The term is used to describe the combination of stillbirths and deaths in the first week of life with the resultant rate expressed per 1,000 total births. The rate pursued its downward trend to a new record low level of 31·1 but this was only 0·4 lower than in the previous year: clearly there is room for further improvement. Divergent rates are recorded for different parts of the County and this group mortality is discussed further on page 90.

INFANT MORTALITY AFTER ONE WEEK:

At ages 1 week up to 1 year there were 317 deaths equivalent to a rate of 10·3 per 1,000 live births, fractionally higher than in the previous year (10·1) but comparing favourably with the annual average rate of 10·7 in the last decade.

Total deaths during the first year of life were 707, representing a rate of 23·0 per 1,000 live births. Minor fluctuations have been recorded in certain years but since the turn of the century a decreasing trend has been apparent. The rate for 1963 was the second lowest on record and further reference is made on page 87.

PRINCIPAL CAUSES OF DEATH:

The most prominent causes, or cause groups, of death in descending order were, heart and circulatory diseases (7,682), malignant neoplasms (3,291), vascular lesions of the nervous system (3,138), diseases of the respiratory system (2,661), accidents, suicide and violence (1,019). In aggregate these causes accounted for 17,791 deaths equivalent to 87·6 per cent. of the total mortality; their relative frequency during the past five years appears below:—

Percentage contribution of the five principal cause groups of death to all causes:

	1959	1960	1961	1962	1963
Malignant neoplasms	17·1	17·3	16·4	16·7	16·2
Vascular lesions of nervous system ..	15·7	16·1	15·2	15·4	15·4
Heart and circulatory diseases	37·2	37·9	37·3	38·1	37·8
Diseases of respiratory system ..	12·4	10·2	13·6	12·7	13·1
Accidents, suicide and violence ..	4·8	4·8	4·5	4·6	5·0

The number of deaths classified according to cause and age appears below:—

	Under 4 weeks	4 weeks and under 1 year	1 and under 5	5 and under 15	15 and under 25	25 and under 35	35 and under 45	45 and under 55	55 and under 65	65 and under 75	75 and over	Total
1. Tuberculosis, respiratory	—	—	—	—	—	3	12	12	35	20	14	96
2. Tuberculosis, other	—	—	1	—	1	2	—	1	4	1	3	13
3. Syphilitic disease	—	—	—	—	—	—	1	2	8	13	8	32
4. Diphtheria	—	—	1	—	—	—	—	—	—	—	—	1
5. Whooping cough	—	2	—	—	—	—	—	—	—	—	—	2
6. Meningococcal infections	—	4	2	—	—	—	—	—	—	—	1	7
7. Acute poliomyelitis	—	—	—	—	—	—	—	—	—	—	—	—
8. Measles	—	—	3	2	—	—	—	—	—	—	—	5
9. Other infective and parasitic diseases ...	—	4	—	2	—	1	2	5	7	4	4	29
Total–Infective & Parasitic Diseases excl. Tub.	—	*10*	*6*	*4*	—	*1*	*3*	*7*	*15*	*17*	*13*	*76*
10. Malignant neoplasm, stomach	—	—	—	—	—	4	11	46	111	167	163	502
11. Malignant neoplasm, lung, bronchus ...	—	—	—	—	1	4	26	107	225	244	97	704
12. Malignant neoplasm, breast	—	—	—	—	—	4	14	51	81	63	68	281
13. Malignant neoplasm, uterus	—	—	—	—	1	1	14	21	41	43	34	155
14. Other malignant and lymphatic neoplasms	—	1	8	12	14	28	58	147	345	476	466	1,555
15. Leukæmia, aleukæmia	—	1	7	8	2	6	3	7	22	22	16	94
Total—All forms of Cancer	—	*2*	*15*	*20*	*18*	*47*	*126*	*379*	*825*	*1,015*	*844*	*3,291*
16. Diabetes	—	—	1	—	—	1	1	3	26	53	59	144
17. Vascular lesions of nervous system ...	—	1	—	—	3	12	19	111	375	898	1,719	3,138
18. Coronary disease, angina	—	—	—	—	—	6	77	333	969	1,394	1,327	4,106
19. Hypertension with heart disease	—	—	—	—	—	1	5	6	41	112	177	342
20. Other heart disease	—	—	2	1	9	16	40	93	183	508	1,484	2,336
21. Other circulatory disease	—	—	—	1	3	5	10	36	83	214	546	898
Total—Heart and Circulatory Diseases	—	—	*2*	*2*	*12*	*28*	*132*	*468*	*1,276*	*2,228*	*3,534*	*7,682*
22. Influenza	—	1	1	—	—	1	—	5	8	16	43	75
23. Pneumonia	30	75	22	6	4	3	16	26	92	217	576	1,067
24. Bronchitis	—	33	9	—	1	2	14	57	272	434	516	1,338
25. Other diseases of respiratory system ...	1	8	—	3	—	1	6	20	42	52	48	181
Total—Diseases of the Respiratory System incl. Influenza and excluding Tuberculosis	*31*	*117*	*32*	*9*	*5*	*7*	*36*	*108*	*414*	*719*	*1,183*	*2,661*
26. Ulcer of stomach and duodenum ...	—	—	—	—	1	—	8	3	26	40	52	130
27. Gastritis, enteritis and diarrhœa	6	24	1	—	—	1	4	1	8	28	28	101
28. Nephritis and nephrosis	—	—	—	2	4	6	11	17	26	38	31	135
29. Hyperplasia of prostate	—	—	—	—	—	—	—	—	7	25	55	87
30. Pregnancy, childbirth, abortion	—	—	—	—	2	5	7	—	—	—	—	14
31. Congenital malformations	96	40	12	4	7	3	4	5	7	4	1	183
32. Other defined and ill-defined diseases ...	326	32	31	12	15	19	43	102	175	281	512	1,548
33. Motor vehicle accidents	—	1	14	21	69	34	15	26	36	18	20	254
34. All other accidents	2	19	16	20	24	26	35	39	55	69	247	552
35. Suicide	—	—	—	—	7	17	28	47	46	40	22	207
36. Homicide and operations of war	—	—	—	—	1	—	3	—	—	1	1	6
Total—Accidents, Suicide and Violence	*2*	*20*	*30*	*41*	*101*	*77*	*81*	*112*	*137*	*128*	*290*	*1,019*
Total—All Causes	461	246	131	94	169	212	487	1,329	3,356	5,495	8,338	20,318

TUBERCULOSIS:

It is regrettable that there was a small increase in mortality compared with the two preceding years; there were 109 deaths in 1963, 91 in 1962 and 108 in 1961. Reference to the annual average of 121 deaths in the quinquennium 1958–62, however, suggests that the increase may be nothing more than a temporary fluctuation in the general downward trend. The corresponding death rates per 1,000 population were 0·06 in 1963, 0·05 in 1962, 0·07 in 1961 and 0·07 for 1958–62. The decline in mortality in post-war years has been remarkable and while the progress made suggests that the disease is coming under control it does not mean that effort can be relaxed. Indeed, the theme chosen for World Health Day in 1964 is " No Truce for Tuberculosis ", the object being to warn governments and peoples of the continuing widespread dangers of the disease and to inform them of the modern methods of control of infection.

Mortality from the respiratory forms of the disease numbered 96 representing a death rate of 0·06 compared with 80 (0·05) in 1962 and an annual average of 110 (0·07) for 1958–62. Ten years ago mortality for males and females was high in the 15–34 years age group; both have been much reduced and males of 55 years and over now make the major contribution. Many adults, infected in earlier life, must still retain the possibility of break-down as a result of factors such as malnutrition and other stresses. Present trends suggest that as the older population passes on the number of cases occurring as a result of new infections will progressively decrease. Diligent application of all measures at our disposal, chemotherapy, contact tracing, B.C.G. vaccination, diagnostic radiological services, improvement in nutrition and environment must continue unabated if eradication is to be achieved.

Deaths from other forms of tuberculosis totalled 13, equivalent to a death rate of 0·01 per 1,000 population compared with 11 (0·01) in 1962 and an annual average of 11 (0·01) in the period 1958–62. Half the male mortality related to the 55–64 years age group and 3 of the 5 female deaths were at ages 75 years or over. Now that mortality from the disease has reached low levels minor fluctuations can be expected from year to year but they are of no significance.

INFECTIVE AND PARASITIC DISEASES:

Deaths assigned to this group remained at the same level of recent years; in total they amounted to 76 compared with 74 in 1962 and an annual average of 75 in the period 1958–62.

Compared with the previous year there were reductions in mortality from the residual group " other infective and parasitic diseases " which fell from 41 to 29 and poliomyelitis from 1 to nil; these improvements were offset by increases from syphilitic disease from 23 to 32, meningococcal infections 4 to 7, measles 3 to 5, whooping cough 1 to 2; diphtheria claimed the same mortality—1.

The outstanding variation was the increased mortality recorded for syphilitic disease. The majority of deaths related to persons aged 55 years or over and it is satisfactory that for the past decade there has been no death under one year from the disease. The case fatality ratio for meningococcal infections remains high; four of the deaths were of infants under 1 year which, when related to the 6 notifications at this age, underlines the need for prompt diagnosis and treatment. Notifications of measles were more numerous but the case fatality ratio remained

low at 0·03 per cent. Both the deaths from whooping cough related to infants under 1 year, a boy of 7 months and a girl of 3 months; neither had been immunised. The single death from diphtheria was of an unimmunised girl of 2 years.

CANCER:

In this group there were 3,291 deaths equivalent to a death rate of 1·94 per 1,000 population compared with 3,353 deaths (2·00) in 1962 and an annual average of 3,275 deaths (1·98) in the period 1958–62. Despite world wide research programmes which are being prosecuted the disease continues to exact a high toll in the older part of the population; indeed, one death in every six was certified to this cause at the rate of 63 persons each week. The number of deaths during the past six years classified by sex and principal site is given in the following table:—

Year		Stomach	Lung, Bronchus	Breast	Uterus	Other Malignant and Lymphatic Neoplasms	Leukæmia, Aleukæmia	Total all Sites
1958	M.	307	467	2	—	823	57	1,656
	F.	228	82	315	178	721	32	1,556
	T.	535	549	317	178	1,544	89	3,212
1959	M.	318	556	1	—	839	46	1,760
	F.	250	62	263	161	729	30	1,495
	T.	568	618	264	161	1,568	76	3,255
1960	M.	295	505	3	—	905	48	1,756
	F.	225	77	316	152	707	40	1,517
	T.	520	582	319	152	1,612	88	3,273
1961	M.	300	564	6	—	804	44	1,718
	F.	213	103	309	146	761	33	1,565
	T.	513	667	315	146	1,565	77	3,283
1962	M.	274	584	1	—	871	54	1,784
	F.	248	95	304	126	728	68	1,569
	T.	522	679	305	126	1,599	122	3,353
1963	M.	275	611	2	—	869	48	1,805
	F.	227	93	279	155	686	46	1,486
	T.	502	704	281	155	1,555	94	3,291

The relative contribution to mortality made by the separately classified sites remained unchanged; cancer of the lung and bronchus was the most frequent diagnosis followed by cancer of the stomach, breast and uterus.

Mortality from cancer of lung and bronchus now represents a major health hazard; in 30 years the deaths from these sites has increased eight fold in men and between three and four fold in women. The 704 deaths were the highest total yet recorded with male excess mortality again in evidence in the ratio of 6½:1. A third of the total male cancer deaths were from these sites with mortality heaviest at ages 55 to 74 years.

Few people are now unaware of the positive correlation between cigarette smoking and lung cancer. Our health education programmes, however, continue to be pursued vigorously and these received valuable impetus from the publicity

given to the United States Public Health Service Report which strongly reinforced the findings of the Royal College of Physicians. It has often been said that no one can buy good health, but in the case of lung cancer it appears possible and indeed easy to buy ill-health and pay dearly for it. It is recognised that tobacco is not the sole source of carcinogens in the air; atmospheric pollution by coal and other fuels contribute, and research continues in these fields but the evidence which has been amassed so far can leave little doubt that the campaign against cigarette smoking must now occupy a prominent place in preventive medicine. The sale of cigarettes to children has always been deprecated and I welcome the Children and Young Persons Act, 1963, operative from 1st February, 1964, under which greatly increased penalties are prescribed for the offences of selling tobacco or cigarette papers to persons under the age of sixteen.

The number of deaths assigned to malignancy of stomach, breast and uterus was in keeping with the experience of recent years with no trend discernable. Mortality from leukæmia continued at a relatively high level and investigation of the hazard associated with radiation is being pursued as is the survey conducted by Dr. Stewart of the Department of Social Medicine at Oxford University into the ætiology of childhood cancers.

Vascular Lesions of the Nervous System:

This group accounted for 3,138 deaths which represent a death rate of 1·85 per 1,000 population. Although slight variations occur from year to year an upward trend is apparent; indeed, since 1950, mortality has increased by 24 per cent. Mortality increased progressively with age; at ages under 45 years deaths numbered 35, at ages 45–54 years 111 (3·5 per cent. of the total deaths from this cause), 375 in the 55–64 years age group (12·0 per cent.), 898 at ages 65–74 years (28·6 per cent.) and 75 years or over 1,719 (54·8 per cent.). At ages up to 65 years there was a slight excess of male mortality but thereafter female deaths predominated being especially heavy at ages 75 years and over.

Heart and Circulatory Diseases:

The upward trend in mortality continued, the number of deaths reaching the highest total yet recorded. In total, 7,682 deaths were classified to the group compared with 7,651 in the previous year and an annual average of 7,367 in the quinquennium 1958–62; the resultant death rates per 1,000 population were 4·53, 4·56 and 4·46 respectively. The age-sex distribution followed the pattern of recent years; 16·6 per cent. of the deaths were of persons in the 55–64 years age group, 29·0 per cent. at ages 65–74 years and 46·0 per cent. of persons 75 years or over. At ages under 75 years there was an excess of male mortality, particularly in the 55–64 years age group, while at ages 75 years and upwards female deaths predominated.

The number of deaths and mortality rates per 1,000 population during the past 6 years are given in the table below:—

Year	Coronary disease, angina		Hypertension with heart disease		Other heart disease		Other circulatory disease		Total	
	No. of Deaths	Death Rate	No. of Deaths	Death Rate	No. of Deaths	Death Rate	No. of Deaths	Death Rate	No. of Deaths	Death Rate
1958	3,367	2·07	508	0·31	2,765	1·70	844	0·52	7,484	4·59
1959	3,238	1·98	413	0·25	2,582	1·58	823	0·50	7,056	4·31
1960	3,516	2·13	415	0·25	2,351	1·42	905	0·55	7,187	4·35
1961	3,595	2·17	405	0·24	2,523	1·52	932	0·56	7,455	4·50
1962	3,928	2·34	423	0·25	2,414	1·44	886	0·53	7,651	4·56
1963	4,106	2·42	342	0·20	2,336	1·38	898	0·53	7,682	4·53

Coronary disease and angina again claimed higher mortality than any other disease; 4,106 deaths or 22 per cent. of the total mortality were classified to these causes. There was the usual excess male mortality at ages under 75 years which was appreciably high at ages 45–54 years.

The number of deaths classified to the other diseases in the group remained at a high level; a slight downward trend is discernable in mortality ascribed to "other heart disease", but as this is a residual group and the component diseases are not separately classified it is not possible to deduce if significant changes are taking place.

Diseases of the Respiratory System:

This group—influenza, pneumonia, bronchitis and other diseases of the respiratory system—caused 2,661 deaths compared with 2,542 in 1962 and provided a mortality rate of 1·57 and 1·52 per 1,000 population respectively.

The number of deaths classified to these causes during the past 6 years appears in the following table:—

Year	Influenza	Pneumonia	Bronchitis	Other diseases of the Respiratory System	Total
1958	62	718	1,186	197	2,163
1959	291	790	1,111	160	2,352
1960	30	682	1,061	160	1,933
1961	327	939	1,278	173	2,717
1962	78	980	1,281	203	2,542
1963	75	1,067	1,338	181	2,661

It was not an influenza year and no outbreak was recorded. Mortality was closely related to incidence and the majority of the 75 deaths were of persons aged 75 years or over.

Although pneumonia continues as a major cause of death there is no correlation with notifications; it is usually a secondary rather than a primary cause. Mortality was heavy at the extremes of life; 9·8 per cent. of the deaths were of infants under 1 year, 20·3 per cent. at ages 65–74 years and 54·0 per cent. of persons aged 75 years or over.

For a number of years mortality from chronic bronchitis, aptly referred to as the " English disease ", has averaged around 1,100 deaths per annum; in 1963 it increased to 1,338, the highest annual total recorded since 1951. The age/sex distribution closely followed the pattern of recent years, mortality was relatively high in infants under 1 year, of minor magnitude to 44 years and thereafter progressively increasing. Overall there was excess male mortality in the ratio of 3:1.

That chronic bronchitis is a serious medical and social problem has been recognised for many years. The disease accounted for 6·6 per cent. of the total mortality and was third most common cause of death among males at ages 35 years and over. Apart from mortality, the loss to the country from morbidity is formidable. The evidence incriminating cigarette smoking continues to amass as does the environmental factor of air pollution. Medical Officers of Health are persisting with the task of curtailing atmospheric pollution through application of the measures of the Clean Air Act and, as referred to elsewhere our propaganda efforts to wean the cigarette smoker from his addiction and deter the younger generation from acquiring the habit goes on unabated.

MATERNAL MORTALITY:

A setback was recorded in mortality from the group pregnancy, childbirth and abortion. In all, 14 deaths were reported, the highest annual total since 1960, the equivalent death rate per 1,000 total births being 0·45. The major increases were occasioned by deaths from sepsis and toxæmia and further reference is made on page 108.

VIOLENCE:

Mortality from this group, accidents, suicide and other violent causes increased to the highest total yet recorded. A total of 1,019 deaths was registered compared with 924 in the previous year and an annual average of 909 in the period 1958–62. The number of deaths from the separately classified causes was—motor vehicle accidents 254 (254 in 1962), other accidents 552 (483), suicide 207 (178), and homicide and operations of war 6 (9).

In recent years, with the co-operation of Medical Officers of Health, statistics relating to accidental deaths in the home have been compiled; the relative frequency of these deaths and others assigned to the various violent causes are given in the following table:—

Year	Motor Vehicle Accidents	Accidents in the Home	All other Accidents	Suicide	Homicide and Operations of War	Total Accidents, Suicide, Homicide
1958	205	237	256	186	3	887
1959	204	264	252	186	13	919
1960	241	255	209	192	11	908
1961	266	248	202	183	7	906
1962	254	292	191	178	9	924
1963	254	329	223	207	6	1,019

Deaths from motor vehicle accidents continued at a high level. The age/sex distribution followed the pattern established in recent years with the toll heavier among males in the ratio of 3:1 and a preponderance of deaths in the 15–34 years age group. It cannot be emphasised too frequently that these accidental deaths constitute a major problem, indeed 48 per cent. of all male deaths at ages 15–24 years were caused by motor vehicle accidents.

The number of deaths ascribed to other accidents increased to the highest total yet recorded with home accidents making the major contribution. Fatalities in the home far exceed the number of deaths from certain causes which create public apprehension but, whether it be apathy, or whatever the reason, public opinion seems oblivious to this toll of lives which, to a great extent is preventable. An impressive list could be made of the measures which could be taken to make the home safe, but the human element is paramount and no precautions can be effective unless the co-operation of the people themselves is forthcoming. Mortality in itself is formidable and, in combination with non-fatal home accidents, the justification of intensification of our propaganda measures is clearly underlined.

The principal causes of fatal home accidents are indicated in the table appended:—

Cause of Death		Age at Death—Years							
		Under 1	1-4	5–44	45–54	55–64	65–74	75 and over	All Ages
Accidental poisoning by solid and liquid substances ...	M.	—	1	1	2	3	2	3	12
	F.	1	—	—	2	3	4	1	11
Accidental poisoning by gases and vapours	M.	—	—	4	—	2	2	9	17
	F.	—	1	2	1	1	3	12	20
Accidental falls	M.	—	2	2	1	6	6	36	53
	F.	1	—	—	1	4	26	114	146
Accidents caused by burns and scalds	M.	2	1	2	1	4	1	3	14
	F.	—	—	2	—	3	4	10	19
Inhalation of food or vomit ...	M.	4	—	3	—	—	—	—	7
	F.	3	—	2	—	—	—	1	6
Accidental mechanical suffocation	M.	4	—	1	—	1	—	—	6
	F.	2	4	—	1	—	—	—	7
Other and unspecified accidents	M.	—	1	2	—	—	—	1	4
	F.	—	—	—	1	1	2	3	7
Total	M.	10	5	15	4	16	11	52	113
	F.	7	5	6	6	12	39	141	216

Fatalities were more numerous at the extremes of life; 5·6 per cent. of the deaths were at ages under 1 year and 58·7 per cent. of persons of 75 years or over.

Accidental falls made the major contribution, being responsible for 199 deaths or 60 per cent. of the total fatal home accidents. Females were more vulnerable, especially at ages 75 years and over. Approximately half of the total falls were recorded as " unspecified ", which is a reflection of the high proportion of elderly people living alone.

The second highest cause was accidental poisoning by gases and vapours which contributed 37 deaths. Elderly people were most frequently concerned, the majority dying from coal gas poisoning. Temporary loss of recent memory and an impaired sense of smell were probably the underlying causes of many of these tragedies which underlines the urgent need for the general introduction of a non-toxic domestic gas.

Burns and scalds were the third highest contributor with 33 deaths. Fatalities from burns continued at the high level of 28 deaths: coal fires were incriminated in 14 cases with electric fire, gas fire, smoking in bed one each and unspecified burns 5, a house on fire caused the death of a man of 50 years but more tragic were the deaths of 5 children between the ages of 11 months and 7 years whose caravan accidentally caught fire. Scalds caused 5 deaths; in 3 instances hot bath water was the agent, and kettles of boiling water in 2, one of the latter deaths being a boy of 9 months.

Accidental poisoning by solid and liquid substances took the next highest toll. Twenty-three deaths were recorded, the majority associated with overdoses of barbiturates or their derivatives.

Mortality from inhalation of food or vomit, 13 deaths, and accidental mechanical suffocation 13, continued at a high level. Thirteen of these deaths were of infants under 1 year of which 7 were due to the inhalation of food or vomit, 3 from unspecified asphyxia, 2 from overlaying whilst in bed with parents and one due to asphyxia following the collapse of a carrycot.

The remaining accidental deaths were of minimal proportions, the majority being due to unspecified causes.

The number of successful suicides increased to 207, the highest annual total recorded since 1957. Slight fluctuations are apparent from year to year and the increase is not significant. The distribution by age, sex, and agent employed is given in the following table:—

External Agent		Age at Death — Years								
		Under 15	15-24	25-34	35-44	45-54	55-64	65-74	75 and over	All ages
Domestic gas poisoning ...	M.	—	4	3	10	10	11	9	5	52
	F.	—	1	3	3	11	6	10	2	36
Other poisoning	M.	—	1	2	3	4	8	7	2	27
	F.	—	1	5	6	12	8	7	3	42
Hanging or strangulation ...	M.	—	—	1	2	2	6	1	2	14
	F.	—	—	—	1	1	1	1	1	5
Drowning	M.	—	—	—	—	3	3	1	—	7
	F.	—	—	1	1	1	—	1	2	6
Firearms	M.	—	—	1	—	—	2	—	1	4
	F.	—	—	1	—	—	—	—	1	2
Cutting instruments	M.	—	—	—	1	1	—	1	—	3
	F.	—	—	—	—	—	—	1	—	1
Jumping before or lying in path of trains	M.	—	—	—	—	1	—	—	—	1
	F.	—	—	—	—	—	—	—	—	—
Jumping from high places ...	M.	—	—	—	1	—	1	—	1	3
	F.	—	—	—	—	—	—	—	—	—
Other agents	M.	—	—	—	—	1	—	1	—	2
	F.	—	—	—	—	—	—	—	2	2
Total—all agents ...	M.	—	5	7	17	22	31	20	11	113
	F.	—	2	10	11	25	15	20	11	94

In total, domestic gas was the agent most frequently employed being incriminated in 88 cases equivalent to 43 per cent. of total suicides. If, as some contend, suicide is the result of sudden impulse, the high level from coal gas poisoning may be due partly to its wide availability and ease of application. Should, however, there be a reduction in the toxic content of domestic gas there may well be a diminution in total suicides for a period until another vehicle of similar accessibility comes into vogue.

Other forms of poisoning claimed 69 deaths; 63 from barbiturates or their derivatives and the remainder from a variety of poisons ranging from cyanide to narcotics. Increased mortality was apparent among females who for the first time had a predilection for poisoning than any other agent.

Hanging (19), drowning (13), and firearms (6) retained the same numerical sequence and as in recent years there was a slight male excess. Asphyxia due to polythene bags again claimed two deaths, both females aged 76 and 79 years.

Seasonally, incidence was high during the periods April to June and August to October; with a peak in June and the usual peak in April absent.

Loneliness and social isolation are known to be contributory influences to the incidence of suicide; although details are not available of the number of suicides who were living alone at the time of death, of the females, 19 spinsters and 27 widows were recorded.

CHILD MORTALITY:

Deaths of children aged 1–4 years increased to the highest annual total recorded since 1951; 131 were registered compared with 102 in the previous year and an annual average of 95 in the period 1958–62. The equivalent death rates per 1,000 children in the age group were 1·18, 0·93 and 0·91 respectively. Reference to the table appended indicates that control, or near control, over the once traditional childhood diseases has left accidents, pneumonia, cancer and congenital malformations as the causes most numerous.

In the period covered by the table it will be seen that accidental deaths have fallen, but the rate of decline in recent years has been slow. Of the 30 deaths in 1963, 14 were as a result of motor vehicle accidents and 10 from home accidents. Of these latter deaths 4 were due to asphyxia associated with a variety of agents, 2 from falls, 1 each from burns, aspirin poisoning, fumes and carbon dioxide poisoning, and an unspecified accident.

Cancer retained its relative importance with 15 deaths, 7 of which were ascribed to leukæmia. In perspective, at these ages, a ninth of the deaths all causes were from this disease.

Deaths from diarrhœa decreased from 11 to 1 but this gain was offset by deaths classified to bronchitis which increased from 1 to 9 and pneumonia from 17 to 22.

Cause of Death	Annual Averages for Quinquennia							1960	1961	1962	1963
	1911–15	1927–31	1935–39	1940–44	1945–49	1950–54	1955–59				
Measles	439	107	27	18	10	4	2	—	4	1	3
Whooping cough	167	67	29	20	11	5	1	1	—	—	—
Diphtheria	110	47	51	32	5	1	—	—	—	—	1
Other infective and parasitic diseases, excluding tuberculosis	54	45	18	13	7	9	7	5	3	3	2
Tuberculosis, respiratory	47	13	5	4	4	1	—	—	1	—	—
Tuberculosis, other	201	82	37	39	30	11	2	1	—	—	1
Cancer	3	5	4	6	4	9	9	7	11	13	15
Heart and circulatory diseases	4	3	2	1	1	—	1	1	1	1	2
Influenza	6	43	10	11	4	2	2	—	2	—	1
Pneumonia	457	321	121	85	42	19	14	9	14	17	22
Bronchitis	150	42	10	17	9	6	6	5	10	1	9
Other diseases of respiratory system	49	15	6	5	3	2	2	2	—	3	—
Diarrhœa and other digestive diseases ...	248	45	38	23	17	4	4	2	3	11	1
Congenital debility, malformations	12	9	7	10	12	13	12	12	10	12	12
Accidents	82	54	50	47	38	27	23	29	25	26	30
Other causes	323	119	52	45	30	23	12	23	21	14	32
All causes	2,352	1,017	467	376	227	136	97	97	105	102	131
Death rate per 1,000 living in the age group	17·13	10·62	5·09	4·17	2·23	1·29	0·99	0·92	0·98	0·93	1·18

PART II

DIVISIONAL ADMINISTRATION

DIVISIONAL ADMINISTRATION

Twenty-three health divisions have continued to operate throughout the year and details of each division are given in the following table.

At the time of the inception of the scheme of divisional administration it was extremely difficult to get suitable and adequate accommodation for office purposes, and one of them—the Divisional Health Office, Mortomley Hall, High Green (Division No. 22)—was established in premises some 250 years old, with naturally high maintenance charges. Office accommodation in certain other divisions has since become available in more suitable premises and transfers have been effected, but for the first time a purpose-built Divisional Health Office has been erected, photographs of which appear on pages 49 and 50, and this replaces the old office at High Green. The new office is in grounds in which have been erected an Old People's Home and a Branch Library.

Div. No.	County Districts	Population (Estimated Mid. 1963)	Acreage	Divisional Medical Officer, Senior Clerk and Divisional or Area Nursing Officer	Address of Divisional Health Office
1	Barnoldswick U.	10,180	2,764	Dr. M. Hunter	Water Street, Skipton Tel. Skipton 2438/9
	Earby U.	5,130	3,519	Mr. K. A. Knowles	
	Silsden U.	5,250	7,101	Miss F. Stevenson	
	Skipton U.	13,190	4,211		
	Bowland R.	4,720	83,327		
	Sedbergh R.	3,750	52,674		
	Settle R.	13,730	152,087		
	Skipton R.	23,970	146,071		
		79,920	451,754		
3	Keighley B.	56,670	23,611	Dr. V. P. McDonagh Mr. A. S. Sanderson Miss J. Butterworth	3, Bow Street, Keighley Tel. Keighley 2244/5
4	Baildon U.	12,640	2,831	Dr. J. Battersby	P.O. Box 24, Town Hall, Shipley Tel. Shipley 51363
	Bingley U.	23,350	11,418	Mr. F. G. Falkingham	
	Denholme U.	2,560	2,536	Miss M. Tattersall	
	Shipley U.	29,860	2,184		
		68,410	18,969		
5	Pudsey B.	36,660	5,323	Dr. A. Telford Burn	The Green, Horsforth Tel. Horsforth 2252
	Aireborough U.	28,220	6,856	Mr. A. Hartley	
	Horsforth U.	15,590	2,706	Miss D. Topley	
	Ilkley U.	18,520	8,610		
	Otley U.	11,750	2,934		
	Wharfedale R.	7,100	39,378		
		117,840	65,807		
7	Ripon City	10,650	1,812	Dr. N. V. Hepple	Municipal Offices, Harrogate Tel. Harrogate 5031
	Harrogate B.	57,480	8,320	Mr. L. R. Wilkinson	
	Knaresborough U.	9,570	2,494	Miss M. L. Griffin	
	Nidderdale R.	16,320	75,009		
	Ripon and Pateley Bridge R.	13,540	124,861		
		107,580	212,496		
9	Tadcaster R.	29,090	72,987	Dr. R. G. Smithson	Hallfield Lane, Wetherby Tel. Wetherby 2738
	Wetherby R.	24,430	64,424	Mr. F. H. Atack Mrs. C. C. Howels	
		53,520	137,411		

Div. No.	County Districts	Population (Estimated Mid. 1963)	Acreage	Divisional Medical Officer, Senior Clerk and Divisional or Area Nursing Officer	Address of Divisional Health Office
10	Goole B.	18,820	1,267	Dr. S. K. Appleton	6/7, Belgravia, Goole Tel. Goole 936/7
	Selby U.	10,600	3,848	Mr. R. Towell	
	Goole R.	8,990	36,776	Mrs. C. C. Howels	
	Selby R.	6,730	32,909		
		45,140	74,800		
11	Castleford B.	40,300	4,394	Dr. J. M. Paterson	" Castledene," Pontefract Road, Castleford Tel. Castleford 4201
	Normanton U.	18,490	3,067	Mr. C. R. Pickering	
		58,790	7,461	Miss M. E. Thomas (Resigned 31.12.63)	
12	Pontefract B.	27,970	4,865	Dr. J. F. Fraser	Baghill House, Walkergate, Pontefract Tel. Pontefract 3291
	Featherstone U.	14,850	4,424	Mr. W. Carver	
	Knottingley U.	12,280	2,835	Mrs. W. Taylor	
	Osgoldcross R.	8,570	33,954		
		63,670	46,078		
13	Morley B.	42,200	9,494	Dr. G. Ireland (Commenced 9.3.64)	Windsor House, Morley Tel. Morley 4281/2
	Ossett B.	15,510	3,333	Mr. A. Wright	
	Horbury U.	8,760	1,280	Miss A. M. Seelig	
	Wakefield R.	21,300	21,344		
		87,770	35,451		
15	Batley B.	40,040	4,457	Dr. J. F. Caithness	Market Place, Batley Tel. Batley 666
	Heckmondwike U.	8,630	696	Miss K. Lister	
		48,670	5,153	Mrs. W. Taylor	
16	Garforth U.	16,110	4,020	Dr. A. L. Taylor	Oulton Lane, Rothwell Tel. Rothwell 2326/7
	Rothwell U.	26,350	10,698	Mr. S. Hobson	
	Stanley U.	17,470	4,866	Miss A. M. Seelig	
		59,930	19,584		
17	Spenborough B.	37,370	8,251	Dr. W. M. Douglas	Elm Bank, Bradford Road, Cleckheaton Tel. Cleckheaton 2331/2
	Mirfield U.	13,110	3,394	Mr. P. Marshall	
		50,480	11,645	Mrs. W. Taylor	
18	Brighouse B.	31,540	7,873	Dr. F. Appleton	Mill House, Huddersfield Road, Brighouse Tel. Brighouse 796
	Elland U.	18,400	5,946	Mr. G. O. Richardson	
	Queensbury and Shelf U.	9,450	2,795	Miss C. J. Barker	
		59,390	16,614		
19	Todmorden B.	17,050	12,789	Dr. N. E. Gordon	Abraham Ormerod Medical Centre, Todmorden Tel. Todmorden 382
	Hebden Royd U.	9,260	7,084	Mr. H. Marshall	
	Ripponden U.	4,950	13,289	Miss D. M. E. Goldthorpe	
	Sowerby Bridge U.	17,320	5,763		
	Hepton R.	3,710	21,758		
		52,290	60,683		

Div. No.	County Districts	Population (Estimated Mid. 1963)	Acreage	Divisional Medical Officer, Senior Clerk and Divisional or Area Nursing Officer	Address of Divisional Health Office
20	Colne Valley U.	21,210	16,054	Dr. E. Ward	" Woodville,"
	Denby Dale U.	9,600	10,165	Mr. G. A. Beatson	Scar Lane,
	Holmfirth U.	18,560	17,648	Miss M. P. Bramley	Golcar
	Kirkburton U.	18,530	13,847		Tel. Milnsbridge 933/4
	Meltham U.	5,550	5,906		
	Saddleworth U.	17,480	18,485		
		90,930	82,105		
22	Hoyland Nether U.	15,830	1,998	Dr. J. Main Russell	Mortomley Hall,
	Penistone U.	7,200	5,593	Mr. T. D. Lund	High Green,
	Stocksbridge U.	11,390	4,630	Mrs. M. Craig	nr. Sheffield
	Penistone R.	7,410	29,002		Tel. High Green 292
	Wortley R.	50,390	48,698		
		92,220	89,921		
23	Hemsworth U.	14,620	4,163	Dr. J. S. Walters	Adiscombe
	Hemsworth R.	52,780	29,019	Mr. G. Ellis	House,
				Miss J. Crossfield	Barnsley Road,
		67,400	33,182		Hemsworth
					Tel. Hemsworth 377/8
25	Cudworth U.	9,140	1,746	Dr. R. Barnes	33 Queen's Road,
	Darfield U.	6,910	2,018	Mr. L. S. Wrigg	Barnsley
	Darton U.	14,500	4,717	Mrs. C. Dyson	Tel. Barnsley 2247/8
	Dodworth U.	4,110	1,857		
	Royston U.	8,590	1,423		
	Wombwell U.	19,120	3,838		
	Worsbrough U.	15,180	3,420		
		77,550	19,019		
26	Conisbrough U.	17,840	1,593	Dr. D. J. Cusiter	Dunford House,
	Dearne U.	26,950	3,888	Mr. P. Goddard	Wath upon Dearne
	Mexborough U.	16,840	1,452	Miss V. Dunford	Tel. Wath 2251/2
	Rawmarsh U.	19,740	2,600		
	Swinton U.	13,990	1,718		
	Wath upon Dearne U.	15,300	2,677		
		110,660	13,928		
27	Adwick le Street U.	18,400	3,605	Dr. J. Ferguson	Station Road,
	Bentley with Arksey U.	23,310	4,950	Mr. C. W. Vallance	Doncaster
	Tickhill U.	2,600	5,580	Mrs. A. Corless	Tel. Doncaster 61571
	Doncaster R.	70,100	75,093		
		114,410	89,228		
29	Thorne R.	36,090	38,419	Dr. G. Higgins	Council Offices,
				Mr. J. T. Howitt	P.O. Box 4,
				Mrs. A. Corless	Thorne
					Tel. Thorne 3130
31	Maltby U.	14,300	4,788	Dr. J. M. Watt	" Edenthorpe,"
	Kiveton Park R.	20,210	20,070	Mr. A. Hill	Grove Road,
	Rotherham R.	62,380	28,739	Mrs. A. Brooks	Rotherham
		96,890	53,597		Tel. Rotherham 3131/2

DIVISIONAL HEALTH OFFICE, MORTOMLEY HALL

Meetings of Divisional Medical Officers have been held each month (except August) in accordance with recognised procedure. Liaison with general practitioners has been maintained through the Standing Sub-Committee on Co-operation which met on three occasions during the year to consider the following matters.

February

(a) Health Visitors and General Practitioners.
(b) General Practitioner participation in Maternity and Child Welfare Services.
(c) Notification of Commencement of Labour by Midwives.
(d) Registration of Congenital Abnormalities.
(e) Alum-Adsorbed Tetanus Toxoid.
(f) Prolonged Absence from School.
(g) Use of Disposable Surgical Gloves.
(h) Maternity Co-operation Card.
(i) Use of Pethilorphan by Midwives.

May

(a) Disposable Surgical Gloves.
(b) Ambulance conveyance of R.A.F. wives to Nocton Hall Maternity Home, Lincolnshire.
(c) Child Guidance Service—Revised Arrangements.
(d) Suggestions of Working Party of Medical Officers and Chest Physicians with regard to (a) Routine Tuberculin testing of school entrants and contacts of positive 13 year olds, and (b) Ascertainment of Tuberculosis in the elderly.
(e) Supply of Health Education posters and leaflets through Divisional Medical Officers.
(f) Enuresis Alarms.
(g) Driving Licences—Procedure for medical assessment of fitness to drive.
(h) Fees for visits to arrest hæmorrhage following dental extraction undertaken by County Dental Officers.

October

(a) Active Immunisation against Tetanus after A.T.S.
(b) The Use of the Home Nursing Service in the West Riding Administrative Area.
(c) Discharge of Patients from Hospital and Arrangements for After-Care.
(d) Vaccination against Poliomyelitis—revised schedule and payment of fees.
(e) Ten Year Plan. Modification of the West Riding Plans for the future development of Health Services.
(f) Incontinence Pads.
(g) Reactions from Triple Antigen—Storage of Antigens.
(h) Midwives' Code of Practice—Causes of Stillbirth—Certification.
(i) Telephone Directory Entries.

PART III

EPIDEMIOLOGY

Notification of Infectious Disease

Vaccination and Immunisation

TUBERCULOSIS

VENEREAL DISEASES

EPIDEMIOLOGY

Incidence and Notification of Infectious Disease:

Smallpox, cholera, diphtheria, membranous croup, erysipelas, scarlet fever, and the fevers known by any of the following names, *typhus, typhoid, enteric, or relapsing,* are compulsorily notifiable under Section 144 of the Public Health Act, 1936; *chicken-pox* is notifiable under Section 147 of the same Act in some West Riding County Districts; *food poisoning* under Section 26 of the Food and Drugs Act, 1955. The following communicable diseases are compulsorily notifiable under the regulations stated in parentheses—*measles and whooping cough* (Measles and Whooping Cough Regulations, 1940); *meningococcal infection, acute poliomyelitis—paralytic and non-paralytic, and acute encephalitis—infective and post-infectious* (Acute Poliomyelitis, Acute Encephalitis and Meningococcal Infection Regulations, 1949); *ophthalmia neonatorum* (Ophthalmia Neonatorum Regulations, 1926, 1928 and 1937); *puerperal pyrexia* (Puerperal Pyrexia (Amendment) Regulations, 1954); *tuberculosis* (Tuberculosis Regulations, 1952); *malaria, dysentery and acute primary and influenzal pneumonia* (Public Health (Infectious Diseases) Regulations, 1953); *plague* (Notification of Case of Plague (General) Regulations, 1900); *anthrax* (Public Health (Infectious Diseases) Amendment Regulations, 1960). The contagious diseases of syphilis, gonorrhea and soft chancre (classed under the term venereal diseases) and scabies are not compulsorily notifiable.

The following summary shows the number of notifications in 1963 of each notifiable disease, being the number of cases originally notified and the final numbers after revision of diagnosis.

Age Group	Scarlet Fever		Whooping Cough		Acute Poliomyelitis (paralytic)		Acute Poliomyelitis (non-paralytic)		Measles		Diphtheria		Dysentery		Meningococcal Infection	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Numbers originally notified ...	400	360	442	485	2	1	—	—	10,151	9,751	3	3	503	494	13	17
(All ages)	760		927		3		—		19,902		6		997		30	
Final numbers after correction																
Under 1 year	2	3	53	57	—	—	—	—	366	394	—	—	16	7	5	1
1—2 years	16	9	51	59	1	—	—	—	1,089	1,005	—	—	17	15	—	4
2—3 „	22	17	62	55	—	—	—	—	1,408	1,358	—	1	27	25	2	1
3—4 „	33	35	40	54	—	—	—	—	1,331	1,382	—	—	10	19	2	2
4—5 „	47	49	44	68	—	—	—	—	1,493	1,404	—	—	20	18	2	—
5—9 „	210	192	164	165	—	—	—	—	4,116	3,881	—	1	76	47	2	1
10—14 „	54	47	17	18	—	—	—	—	251	225	3	1	20	21	—	1
15—24 „	11	3	3	4	—	—	—	—	46	52	—	—	12	36	—	3
25 and over	1	4	3	3	—	—	—	—	19	21	—	—	59	94	—	1
Age unknown	2	—	3	2	—	—	—	—	25	16	—	—	3	3	—	—
Total (all ages)	398	359	440	485	1	—	—	—	10,144	9,738	3	3	260	285	13	14
	757		925		1		—		19,882		6		545		27	

Age Group	Acute Pneumonia		Smallpox		Acute Encephalitis (infective)		Acute Encephalitis (post-infectious)		Typhoid Fever		Paratyphoid Fevers		Erysipelas		Food Poisoning	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Numbers originally notified ...	355	323	—	—	1	2	4	—	3	1	18	10	32	49	83	68
(All ages)	678		—		3		4		4		28		81		151	
Final numbers after correction																
Under 5 years	70	68	—	—	—	—	2	—	—	—	4	1	—	—	9	8
5—14 „	47	30	—	—	1	2	1	—	—	—	9	5	1	1	27	8
15—44 „	67	77	—	—	—	—	1	—	2	1	3	3	7	10	16	14
45—64 „	95	67	—	—	—	—	—	—	1	1	—	1	15	25	2	3
65 and over	72	72	—	—	—	—	—	—	—	—	1	—	6	11	—	—
Age unknown	—	2	—	—	—	—	—	—	—	—	1	—	2	—	1	5
Total (all ages)	351	316	—	—	1	2	4	—	3	2	18	10	31	47	55	38
	667		—		3		4		5		28		78		93	

The table below affords a comparison with the preceding eight years:—

Disease	*Number of corrected notifications*								
	1955	1956	1957	1958	1959	1960	1961	1962	1963
Scarlet Fever	1,633	1,496	1,277	1,949	2,441	1,536	911	652	757
Whooping Cough	3,112	4,265	2,089	1,226	953	3,227	838	241	925
Acute Poliomyelitis (paralytic)	244	35	78	99	12	6	34	7	1
Acute Poliomyelitis (non-paralytic)	86	28	17	53	8	—	6	3	—
Measles	29,357	3,281	28,352	6,183	24,480	4,636	29,225	11,485	19,882
Diphtheria	—	—	—	2	3	—	—	1	6
Dysentery	1,310	2,685	1,377	2,513	1,169	954	1,166	920	545
Meningococcal Infection	39	71	64	48	30	23	32	20	27
Acute Pneumonia (primary or influenzal)	1,121	1,098	1,324	909	1,007	530	801	578	667
Smallpox	—	—	—	—	—	—	—	2	—
Acute Encephalitis (infective)	2	3	8	5	1	5	1	2	3
Acute Encephalitis (post-infectious)	4	2	5	2	1	1	6	4	4
Typhoid Fever (excluding Paratyphoid)	5	1	—	—	4	—	2	2	5
Paratyphoid Fevers	25	14	3	3	7	1	11	11	28
Erysipelas	263	186	179	173	167	136	78	57	78
Food Poisoning	346	572	290	135	256	358	58	56	93
Ophthalmia Neonatorum	15	13	7	9	6	5	6	3	5
Puerperal Pyrexia	136	98	77	84	66	61	68	51	69
Tuberculosis:									
Respiratory	1,033	866	802	763	627	547	550	469	467
Other Forms	205	184	132	117	115	75	89	64	75
*Malaria	2	2	—	1	—	—	1	1	—
Anthrax	—	—	—	—	—	2	1	1	2
†Chicken-pox	370	474	359	712	434	900	278	578	996

*All the cases of malaria shown in the above table were believed to be contracted abroad.

†Chicken-pox is compulsorily notifiable only in certain County Districts, and the figures given do not, therefore, represent the full number of cases occurring in the Administrative County.

Tetanus Immunisation:

The increased use of triple vaccine, which gives simultaneous protection against tetanus, whooping cough and diphtheria, ensures that children now receive protection against tetanus at an early age. Many of the children now at school did not receive protection against tetanus in infancy, however, and it is the County Council's policy to give tetanus protection to these children at the same time as giving a diphtheria immunisation booster dose by using the combined diphtheria/tetanus antigen.

The total number of children who completed a primary course of protection against tetanus during 1963 was 33,401 and, of this number, 21,021 were born in the years 1962 and 1963. A secondary, or reinforcing, injection was given to 7,122 children, 6,128 of whom were in the 6—10 years age group.

When a patient has received anti-tetanus serum at a hospital, it is the accepted practice for the hospital authorities to give the patient a letter advising him to go either to his own general practitioner or to the local health authority for active immunisation. This is done to avoid the increased danger of anti-tetanus serum reactions after a future injury.

Tetanus immunisation is being offered to coal miners by the Medical Service of the North Eastern Division of the National Coal Board and the Health Committee has agreed that the vaccine required in the West Riding be made available to Coal Board Medical Officers. Dr. T. D. Spencer, Divisional Medical Officer of the Yorkshire Division of the National Coal Board, states that, although the immunisation campaign did not get into its stride until about the middle of the year, everything is going satisfactorily and notification is passed to the general practitioner when a man's immunisation has been completed. The total completed immunisations during 1963 were 4,238 and Dr. Spencer expects much larger figures during following years.

Scarlet Fever:

Although corrected notifications increased over the previous year by 105 to 757, the total was the second lowest reported and compared very favourably with an annual average of 1,688 in the decennium 1953—62. Nationally, incidence also remained low at 0·37 per 1,000 of the population compared with the County's 0·45. Seasonal incidence followed the usual pattern, being highest in the first and last quarters of the year. Age distribution also conformed to the experience of recent years; notifications were most numerous in young children, 83·9 per cent. being aged under 10 years.

The disease continues to be mild; only exceptional cases are admitted to hospital and deaths are rare.

Whooping Cough:

Following the record low incidence of 241 cases in 1962 it is regrettable that notifications increased to 925; this total is, however, the third lowest recorded and represents a mere 25·5 per cent. of the annual average for the years since notification began. Seasonally, notifications increased as the year progressed and relatively high incidence continued throughout the first quarter of 1964.

Age—sex incidence continued to follow what are now the usual trends; 11·9 per cent. of the notifications related to infants under 1 year, 46·8 per cent. in the 1—4 years age group and 35·6 at ages 5—9 years with a slightly higher incidence among girls persisting throughout.

Two deaths were recorded, both children under 1 year of age who had not been immunised. As indicated in the following table, in recent years there has been a decrease in the number of deaths but a high risk to infants under 1 year persists.

Period	Under 1 year			1—4 years			5 years and over			Total		
	No. of notifications	No. of d'ths	Fatality Ratio per cent.	No. of notifications	No. of d'ths	Fatality Ratio per cent.	No. of notifications	No. of d'ths	Fatality Ratio per cent.	No. of notifications	No. of d'ths	Fatality Ratio per cent.
1954–6	952	11	1·15	4,908	4	0·08	4,769	1	0·02	10,629	16	0·15
1957–9	418	6	1·44	2,007	2	0·10	1,843	1	0·05	4,268	9	0·21
1960–2	458	3	0·66	1,996	1	0·05	1,852	–	—	4,306	4	0·09
1963	110	2	1·82	433	–	—	382	–	—	925	2	0·22

IMMUNISATION AGAINST WHOOPING COUGH:

With the increased use of triple antigen, most young children now receive protection against whooping cough at the same time as they are protected against diphtheria and tetanus. The single whooping cough vaccine is, however, still available if special circumstances make it undesirable to use the combined antigen.

During the year 21,663 children received a full course of immunisation against whooping cough and since facilities were first introduced in 1952 a total of 174,852 children have been immunised under the County scheme. The number of children protected in the 0—4 years age group is 89,150, representing 82·7 per cent. of the total population in this age group.

Of the 907 notifications of whooping cough in the 0—14 years age group, 246 concerned children who had been immunised against this disease.

Poliomyelitis:

Only one notification of poliomyelitis was confirmed during the year—a paralytic case, of a boy of 22 months. The boy had fairly severe paralysis of the left limbs and although no poliomyelitis virus was isolated from the case or from his family, clinically the case was said by the consultant to be definite. He had received one injection of Salk vaccine and two doses of oral vaccine a year previously. The general practitioner, however, considers that the boy made a complete recovery which indicates that some protection may have been afforded by the incomplete immunisation.

A further paralytic case was discovered in December but notification was not made until 22nd January, 1964. This case was an unvaccinated 4 year old boy who had left foot drop. Complement fixation test was negative but Type 2 Poliomyelitis virus was isolated from a fæcal specimen. Although the case was very mild and subsequently recovered, the consultant, whilst considering that the virus isolation may have been coincidental, confirmed the diagnosis of poliomyelitis.

VACCINATION AGAINST POLIOMYELITIS:

The more stablised type of oral vaccine which became available in July, 1962, is now in very general use and the number of doses administered in 1963 was 114,908. " Salk " vaccine continues to be available for any doctor who wishes to use this type but the demand for it is now very small, 3,088 injections only being given during the year.

The oral vaccine is regarded as safe, reliable and effective and general practitioners are encouraged to take a full part in its use for routine vaccination.

The total number of persons protected against poliomyelitis in the County, taking into account both " Salk " and oral vaccine, at 31st December, 1963, is as follows:—

Age Group	*Total Protected*	*Percentage Protected*
Under 1 year	3,396	22·8
1— 2 years	17,261	60·8
2— 3 years	15,723	57·2
3—21 years	386,486	83·3
21—30 years	113,701	57·7
Others	77,771	35·6
Total all groups	614,338	64·6

Measles:

The epidemic incidence continued to show a biennial rhythm. During 1962, notifications had remained low until the last quarter when they began rising steeply to reach around 1,000 per week in December. Incidence continued high until the end of July, thereafter gradually declining so that by the year-end the epidemic was spent.

Measles is primarily a disease of childhood and few children escape much beyond their entrance to school without contracting the illness; indeed, 56·5 per cent. of the notifications related to children under 5 years of age. Fortunately, by far the majority of cases were mild and, as indicated in the following table, the case fatality ratio remains low:—

Year	Number of notifications	Number of deaths	Fatality ratio (deaths per 100 notifications)	Year	Number of notifications	Number of deaths	Fatality ratio (deaths per 100 notifications)
1950	15,763	9	0·06	1957	28,352	5	0·02
1951	25,194	17	0·07	1958	6,183	1	0·02
1952	13,938	7	0·05	1959	24,480	6	0·02
1953	19,853	9	0·05	1960	4,636	—	—
1954	5,558	3	0·05	1961	29,225	8	0·03
1955	29,357	4	0·01	1962	11,485	3	0·03
1956	3,281	1	0·03	1963	19,882	5	0·03

Research into the production of a measles vaccine continues. Some progress has been made and trials of new vaccines, alleged to give less reaction than previous antigens, are to be carried out in various parts of the country during 1964.

Diphtheria:

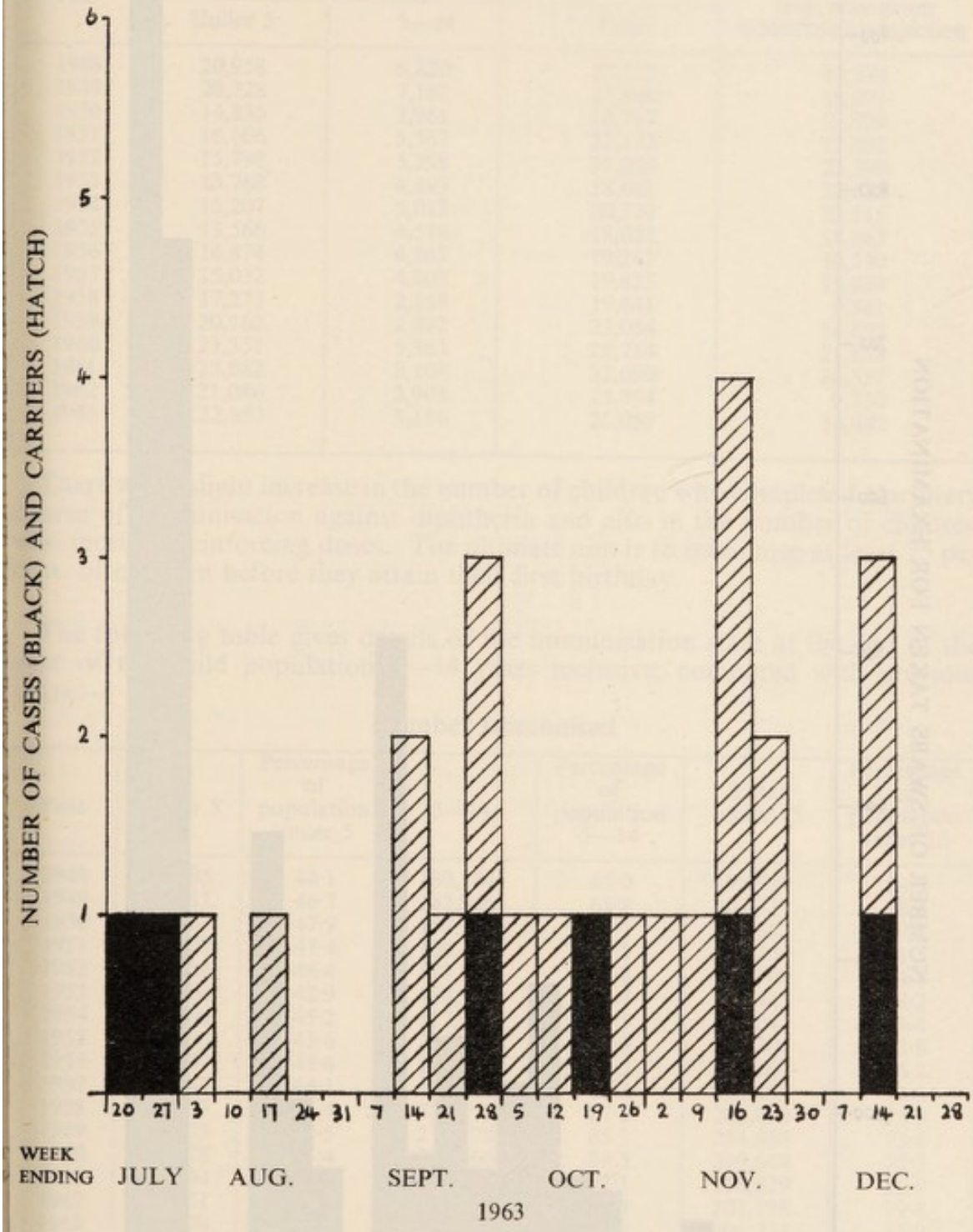
Six notifications were confirmed, all in Keighley M.B. in the latter half of the year. Dr. McDonagh, the Medical Officer of Health, has kindly supplied the following report:—

> " Towards the end of July two cases of mild diphtheria due to an atypical coryne bacterium occurred. The first case was discovered accidentally following a child's admission to hospital ' in status epilepticus ' when a throat swabbing was taken because of a mild tonsillitis and found to be positive K.L.B. The second case was sent into hospital by a general practitioner with the clinical diagnosis of faucial diphtheria, later confirmed bacteriologically. The first child attended the Keighley Training Centre and, as a result, all the children attending were swabbed and Schick tested. The non-immunes were immunised. The second case happened to be a brother of a girl attending the Training Centre. Initial swabbing of members and staff of the Centre produced negative results, but repeat swabbing resulted in several carriers being discovered, three of whom were from the neighbouring Skipton Division. Intensive mass swabbing was then carried out in the surrounding schools and among the home and street contacts of the known cases, as a result of which three more cases and twelve carriers were discovered and admitted to the Infectious Diseases Hospital. The cases were mild and it is felt would have been impossible to diagnose in the absence of knowledge of presence of the organism in the area. Swabbing of the schools was continued until the Christmas holidays and the graphs on pages 61 and 62 show the findings. During December the organism caused the death of an unimmunised child aged two years and following routine swabbing three carriers were discovered. It is interesting to observe that these carriers were the mother and two siblings of the infected child. A complete sweep through the school attended by the other child drew blank. At the end of the year there had been a total of six cases (including the fatal case) and sixteen carriers among Keighley residents and three carriers from the Skipton Division."

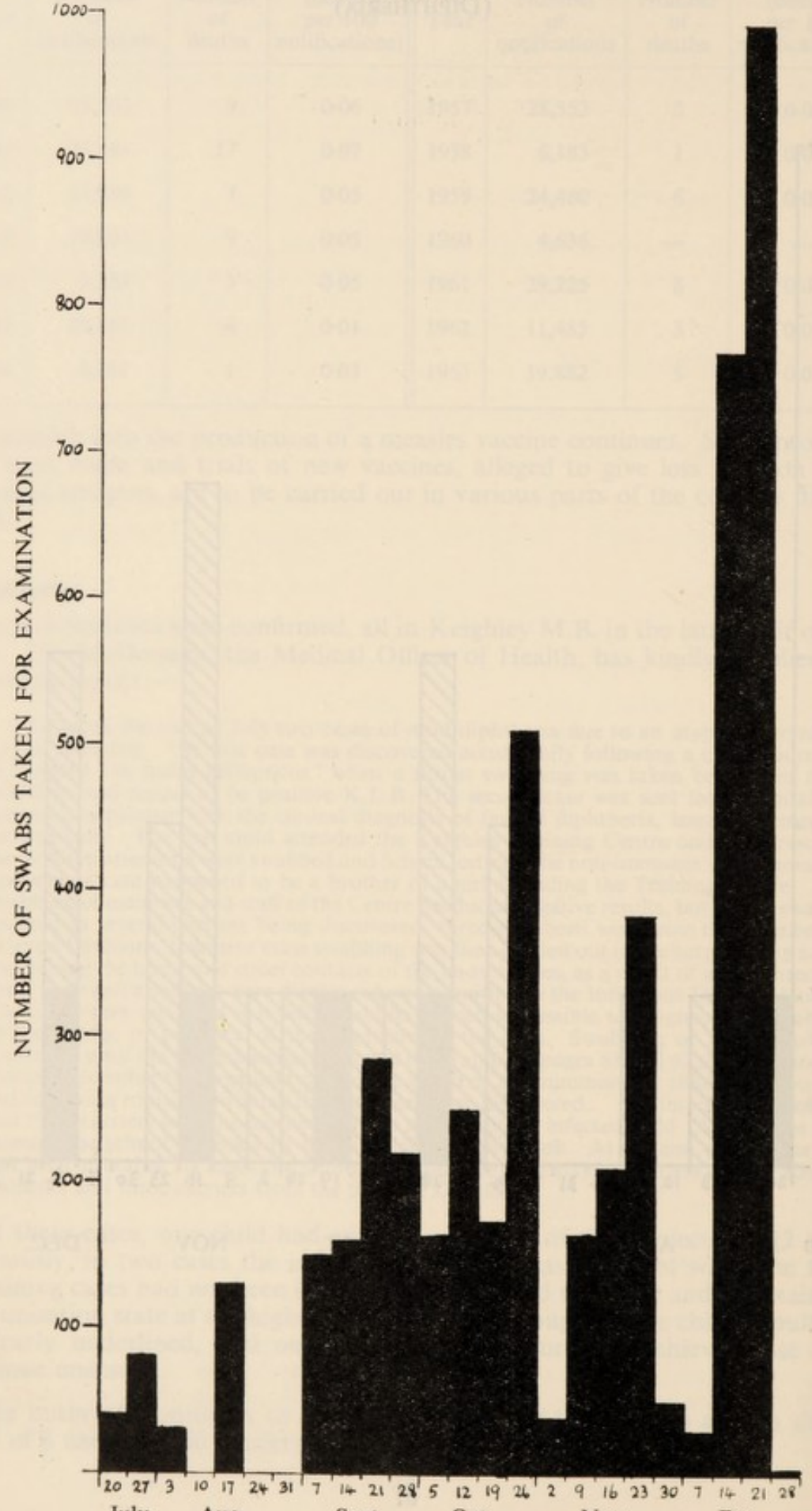
Of these cases, one child had received a course of three injections 12 years previously, in two cases the immunisation state was in doubt while the three remaining cases had not been immunised. The need to secure and maintain the immunisation state at the highest possible level throughout the child population is clearly underlined, and our propaganda measures to achieve these ends continue unabated.

The outbreak continues to the time of writing (April, 1964) and to date a total of 8 cases and 50 carriers have been discovered.

NUMBER OF CASES AND CARRIERS
(DIPHTHERIA)



NUMBER OF SWABS TAKEN
(DIPHTHERIA)



DIPHTHERIA IMMUNISATION:

The number of children who received immunisation during 1963, together with figures for previous years, are shown in the following table:—

Year	Number of children who completed a full course of immunisation			Number of children who were given a reinforcing injection
	Under 5	5—14	Total	
1948	20,958	6,220	27,178	19,274
1949	20,728	7,162	27,890	18,071
1950	14,836	3,961	18,797	13,929
1951	16,606	5,567	22,173	17,092
1952	15,798	5,298	21,096	23,390
1953	13,768	4,893	18,661	22,614
1954	15,207	5,013	20,320	22,515
1955	13,566	4,516	18,082	18,663
1956	14,874	4,367	19,241	18,130
1957	15,032	4,803	19,835	15,034
1958	17,273	2,368	19,641	9,541
1959	20,162	2,892	23,054	14,852
1960	23,351	5,363	28,714	21,653
1961	23,982	8,108	32,090	20,557
1962	21,086	2,908	23,994	9,730
1963	22,853	3,186	26,039	14,642

There was a slight increase in the number of children who completed a primary course of immunisation against diphtheria and also in the number of children who received reinforcing doses. The ultimate aim is to immunise at least 75 per cent. of children before they attain their first birthday.

The following table gives details of the immunisation state at the end of the year of the child population 0—14 years inclusive, compared with previous years:—

Number Immunised

Year	Under 5	Percentage of population under 5	5—14	Percentage of population 5—14	Total under 15	Percentage of population under 15
1948	59,795	44·1	139,194	65·0	198,989	56·9
1949	64,811	46·7	143,966	65·8	208,777	58·4
1950	66,484	47·9	150,179	67·1	216,663	59·7
1951	66,077	47·4	150,177	70·1	216,254	61·5
1952	60,885	46·4	177,875	74·8	238,760	64·7
1953	54,304	42·9	198,151	81·4	252,455	68·2
1954	55,990	45·2	217,052	87·5	273,042	73·4
1955	53,180	43·6	224,126	88·3	277,306	73·8
1956	53,147	43·6	233,120	90·2	286,267	75·2
1957	54,572	44·1	231,100	89·2	285,672	74·6
1958	58,457	46·4	226,593	87·3	285,050	73·9
1959	64,878	50·5	219,178	85·1	284,056	73·6
1960	73,078	55·4	226,566	88·5	299,644	77·3
1961	83,024	61·7	234,805	92·1	318,829	81·9
1962	86,851	63·1	220,347	88·4	307,198	79·4
1963	89,374	63·7	217,400	85·8	306,774	77·9

Dysentery:

The number of corrected notifications continued to decrease from 1,166 in 1961 and 920 in 1962 to 545, the lowest annual total recorded since 1953. As indicated in the following table, incidence was appreciably higher in the first half of the year which conforms to national experience.

	Male	Female	Total	Percentage of annual total
First quarter ...	88	108	196	36·0
Second quarter ...	89	95	184	33·7
Third quarter ...	55	49	104	19·1
Fourth quarter ...	28	33	61	11·2

Notifications by sex and age groups during the past seven years were as follows:—

	Males				Females				Persons			
	All ages	0—	5—	10+	All ages	0—	5—	10+	All ages	0—	5—	10+
1957	733	245	215	273	644	209	142	293	1,377	454	357	566
1958	1,236	380	421	435	1,277	361	387	529	2,513	741	808	964
1959	597	191	168	238	572	173	146	253	1,169	364	314	491
1960	478	181	105	192	476	155	97	224	954	336	202	416
1961	592	206	159	227	574	177	136	261	1,166	383	295	488
1962	446	158	142	146	474	152	142	180	920	310	284	326
1963	260	90	76	94	285	84	47	154	545	174	123	248

Decreases are reflected at all ages, being pronounced in the female 5—9 years age group. This may augur well for the future for as yet there is still no appreciable reduction in incidence among females at older ages.

Since notification commenced in 1919 the character and incidence have undergone various changes. By far the majority of cases in recent years have been of the Sonne variety which is generally mild with a low fatality rate. Of the cases confirmed bacteriologically in 1963 all were of this type.

Improvements in the general level of hygiene will contribute to a decline in incidence; evidence continues to accumulate that the most simple but also the most effective method of preventing the spread of the infection is the thorough washing of the hands after every visit to the lavatory.

Meningococcal Infection:

The number of corrected notifications was slightly higher than the figure for 1962, which was the lowest yet recorded. There was a corresponding increase in the fatality ratio.

Year	Number of notifications	Number of deaths	Fatality ratio (Deaths per 100 notifications)
1950	55	14	25·5
1951	57	13	22·8
1952	50	6	12·0
1953	37	12	32·4
1954	41	15	36·6
1955	39	10	25·6
1956	71	9	12·7
1957	64	13	20·3
1958	48	7	14·6
1959	30	6	20·0
1960	23	4	17·4
1961	32	5	15·6
1962	20	4	20·0
1963	27	7	25·9

Six of the notifications were of infants under 1 year and 13 in the 1—4 years age group. All the cases appear to have been sporadic with no connection apparent. The disease continues to be one of the residual problems in the control of infectious disease. Although modern treatment has reduced the fatality rate appreciably, as indicated previously, a high proportion of the deaths occurs at early ages when the making of a correct early diagnosis is often difficult.

Smallpox:

Following the outbreak in Bradford and district, reported in my Report for 1962, there was a welcome return to freedom from the disease. The risk of re-invasion from the many endemic foci in the world remains. The Ministry of Health have modified the procedure to be followed if further outbreaks occur, in the light of experience gained during 1962 in Yorkshire and elsewhere.

VACCINATION AGAINST SMALLPOX:

The following table shows the number of vaccinations and re-vaccinations performed during the years 1960—1963:—

	Vaccinations						Re-Vaccinations					
Year	Under 1	1	2–4	5–14	15 or over	Total	Under 1	1	2–4	5–14	15 or over	Total
1960	6,857	946	480	419	780	9,482	2	5	39	212	1,264	1,522
1961	5,250	2,053	720	502	746	9,271	2	14	79	280	1,497	1,872
1962	9,919	7,385	12,540	35,411	43,806	109,061	37	143	3,210	26,818	81,493	111,701
1963	1,683	2,562	626	519	332	5,722	3	36	88	313	416	856

The columns " under 1 " have been broken down for 1963 into three-monthly groupings as follows:—

	0–3 months	3–6 months	6–9 months	9–12 months
Vaccinations	384	471	383	445
Re-vaccinations ...	—	1	—	2

No reports of cases suffering from complications due to vaccination were received.

Acute Encephalitis:

Corrected notifications of infective encephalitis numbered three and of post-infectious encephalitis, four. The cases arose in widely separated districts and had no apparent connection.

Of the post-infectious cases, three related to children and were associated with mumps, the fourth being a thirty-one year old man with rubella.

Enteric Fevers:

TYPHOID FEVER:

The annual number of notifications of typhoid fever has fluctuated within the range of nil to 27; in 1963, the diagnosis was confirmed in five cases.

During February/March an outbreak occurred at the Swiss ski resort of Zermatt. Several West Riding residents were on holiday there at that time but fortunately only two cases resulted.

Intending visitors to Switzerland, especially all members of West Riding school parties, were recommended to receive T.A.B. vaccination. Although this vaccination was not part of our normal programme the West Riding Health Committee authorised me, in cases of emergency, to purchase the vaccine for the inoculation of children proceeding to Switzerland from County schools. A number of school parties did holiday in Switzerland with no untoward results. The possibility of widespread dissemination of the disease resulting from an unrecognised case or symptomless excreter employed in a school canteen was brought to the notice of all chief education officers by the Ministry of Education. The desirability of bacteriological investigation of anyone working in a school canteen who had recently been in Zermatt was recommended and the necessary local action was undertaken by divisional medical officers in consultation with divisional education officers. Again, no further cases or carriers were reported.

The three remaining cases were not related; a 59 year old woman who had previous history of gallbladder disorder, a 17 year old merchant seaman who it is presumed was infected either whilst on his ship or during a holiday in Hampshire, and a 25 year old man. Extensive investigations of all the cases failed to reveal the sources of infection.

PARATYPHOID FEVERS:

There was a marked increase in notifications than had been reported in recent years. The diagnosis was confirmed in 28 cases, all Salm. paratyphi B, compared with an annual average of 12 in the period 1951—62.

The hazard associated with imported bulked egg and egg products has been recognised for some years and in May the Ministry of Health alerted Medical Officers of Health of their suspicions that Chinese bulked egg was incriminated in outbreaks elsewhere in the country. At this time cases of phage type Taunton were reported in York C.B. and the other Ridings. A York bakery which supplied confectionery over a wide area of Yorkshire came under suspicion and it appears probable that many cases could be attributable to that source. Shortly afterwards cases were reported in various parts of the Administrative County and 12 cases of phage type Taunton were confirmed, all with histories of eating confectionery, especially cream cakes, manufactured by the York bakery. All the consignments of Chinese egg were withdrawn by the Company and the outbreak subsided.

A maid who had been engaged in the handling of food at the County Council's Bewerley Park Camp School took ill shortly after Easter and, although in discomfort, continued working for some days. She was subsequently found to be a urinary and fæcal carrier of phage type Taunton.

One hundred and eleven West Riding schoolchildren were in attendance at the school during the period 22nd April to 24th May and they were subsequently

investigated bacteriologically. Eight were found to be infected. It appears coincidental that the maid had bought cakes from a shop supplied by the York bakery.

Of the remaining cases, four were in the same family and were due to phage type Battersea. In spite of intensive investigations the source of infection was not discovered. Two brothers, normally resident in the North Riding, who were on holiday on a farm were found to be infected with phage type 3B. It is considered that they were infected prior to their holiday and investigations were undertaken by the Medical Officer of Health of their usual place of residence with, unfortunately, inconclusive results. The other cases were sporadic with no association with known cases or carriers.

The number of outbreaks in which imported liquid egg was incriminated underlined the hazard involved, and I welcome the introduction on 1st January, 1964, of The Liquid Egg (Pasteurisation) Regulations, 1963. These regulations require the pasteurisation of liquid egg to be used in food intended for sale for human consumption, other than shell eggs broken out on the food manufacturer's premises and used within 24 hours.

Food Poisoning:

Where reference is made to notified or ascertained cases of food poisoning the following definitions apply:—

A family outbreak comprises two or more cases confined to members of the same family.

Other outbreaks relate to two or more connected cases in persons of different families.

A single or sporadic case is one which was not, so far as could be ascertained, connected with other cases or excreters.

Information as to incidence has been obtained from details of statutorily notified cases and the reports of Medical Officers of Health on outbreaks and associated investigations. Confirmed notifications numbered 93 and a further 27 cases were ascertained during the course of investigations, resulting in a total of 120 incidents compared with 282 in 1962 and an annual average of 363 in the period 1958-62.

The main microbial causes are given in the following table:—

Presumed Causal Agent	Family Outbreaks		Other Outbreaks		Sporadic Cases	Total Cases
	Number	Cases Involved	Number	Cases Involved		
Salmonella Typhimurium	9	20	1	4	29	53
Other Salmonellæ	—	—	—	—	9	9
Cl. Welchii	—	—	1	18	1	19
Staphylococci	1	3	1	9	—	12
Other organisms	—	—	—	—	2	2
Not discovered	2	6	—	—	19	25
All agents	12	29	3	31	60	120

Although in total the number of incidents decreased markedly compared with the previous year there was no appreciable reduction in those due to salmonellæ. The sources and vehicles of infection of salmonellosis continue to be serious problems. As referred to previously, stringent application of The Liquid Egg (Pasteurisation) Regulations, 1963, should result in the curtailment of infection from one source, meanwhile studies into the source of contamination of both animal and human foods are being maintained. It is considered that infected rodents and poultry are prime sources with human carriers playing an important secondary role with infected implements and machinery used in the preparation of food also contributing.

Salmonella typhimurium was responsible for 44 per cent. of all incidents and, commenting on an outbreak in the Wortley Rural District, Dr. Russell, Medical Officer of Health, writes:—

" Salmonella typhimurium was isolated from a man from Oughtibridge, who had been admitted to Lodge Moor Hospital suffering from diarrhœa/enteritis. On follow-up it was discovered that his local general practitioner had had a number of cases of unexplained diarrhœa in the village during the previous fortnight. Specimens from these persons and their families were submitted for examination. The Laboratory reported that all the families except one, were positive for salmonella typhimurium. In the family which was negative one adult male was employed in a food producing factory. Although bacteriologically negative his symptoms appeared positive, and his return to work was discouraged until three successive negative specimens were obtained. Concurrently, all general practitioners practising in the Oughtibridge, Wharncliffe Side and Worrall areas co-operated in the supplying of information on all cases of diarrhœa occurring in the previous four weeks. Specimens from these persons, however, proved negative.

Extensive enquiries were made in the homes of the positive cases but no food common to all was found. All employees in every food vending shop in the village submitted fæcal specimens which proved to be negative.

Points of interest arising were:—

1. The original notification was accompanied by one from an adult male in Elsecar. Only one case was reported, and after careful investigation in Hoyland and in Wentworth, where the man worked, no source at all could be traced, nor were there any other cases.

2. The organism from the Oughtibridge specimens was referred to the Central Public Health Laboratory, Colindale, who reported phage type 12a. At the same time the Elsecar specimen produced typhimurium, phage type 1A. These were in no way related to the recent outbreaks in Chesterfield and in Sheffield which were due to phage type U.72. An outbreak of phage type 12a occurred in Cardiff about three years ago and there were a few cases in Liverpool in 1962, but there has been no recent outbreak of any significance. In Cardiff the final opinion was that pig products were responsible for it, and it was probably imported with feeding stuffs.

3. Dr. H. Bevan-Jones of the Central Public Health Laboratory, Colindale, visited the district during the investigations and, in company with the Director of the Public Health Laboratory in Sheffield, and one of my staff, visited a selected group of homes to try and obtain further information, but none was available.

4. An interesting sequel in one or two cases was observed when patients developed an acute arthritis, principally the knees and the ankles. There were three such cases, including the person employed in the food production establishment. At the same time general practitioners reported that they had met one or two cases of ' rheumatic arthritis ' in youngish people, and as a result of discussions about this food poisoning they enquired and found that each case gave a history of diarrhœa on one day approximately fourteen to eighteen days previously. Specimens from two cases of post-diarrhœal arthritis were examined at the Laboratory with a view to isolating some virus which might be of interest. These proved negative. Dr. Bevan-Jones from Colindale was interested in this aspect, and mentioned that this was a possible sequel with certain virus infections.

This was a small circumscribed outbreak of food poisoning caused by salmonella typhimurium, phage type 12a, which, unfortunately, came to the notice of the department too late to do any real work in connection with finding the source of the infection. The Sheffield Public Health Laboratory have had no more specimens producing this organism since, and had none before the cases at Oughtibridge. In all there were seven cases of food poisoning and twelve carriers."

Cases due to Cl. welchii totalled 19 and, reporting on the only outbreak involving 18 cases in Ripon and Pateley Bridge Rural District, Dr. Hepple, the Medical Officer of Health, writes:—

" On Wednesday, 9th October, 1963, school meals which included stewed meat were sent from a school kitchen to five village schools. The meals in containers arrived at the schools between 11 and 11-30 a.m. and were consumed between 12 noon and 12-45 p.m. In the the early hours of the morning of 10th October, eighteen consumers from three schools had abdominal pain followed by diarrhœa which lasted for several hours. Some stew which remained at the school principally affected was examined by the Northallerton Public Health Laboratory and a good growth of non heat resistant Cl. welchii was obtained. The sample meal kept in the kitchen gave negative results.

Stools from eight of those affected were collected on 11th October and all contained heat resistant Cl. welchii.

I am assured that the stew was newly prepared on the morning of the 9th October and that there was no question of old stock, gravy, etc., being added.

The interesting things about this outbreak are first, the uneven incidence in the consuming schools:

(a)—9/20
(b)—6/43
(c)—3/43
(d)—Nil/18
(e)—Nil/20

and secondly the apparent change in the heat resistance of the organism as a result of human passage."

Carelessness makes a major contribution to the incidence of food poisoning and, while observance of the Food Hygiene Regulations have assisted in the reduction of incidence, dissemination could be reduced further if high standards of kitchen and personal hygiene were practised by all persons engaged in the preparation and handling of food.

Ophthalmia Neonatorum:

The disease is defined in the Regulations as " a purulent discharge from the eyes of an infant commencing within 21 days from the date of its birth ". It is imperative that when cases arise treatment should be administered promptly if impaired vision or total blindness is to be prevented. During the past 25 years the number of notifications has fallen considerably; in 1963 only 5 cases were notified, each case responding to treatment with no impairment of vision.

Puerperal Pyrexia:

Revised regulations defining puerperal pyrexia as "any febrile condition occurring in a woman in whom a temperature of 100·4°F. (38°C.) or more has occurred within fourteen days after childbirth or miscarriage" came into operation in 1951. Since then notifications have averaged 99 per annum compared with 69 in 1963.

Anthrax:

Since notification of the disease in humans was introduced on 1st Decembe 1960, six cases have been notified; two in 1960, one in 1961, one in 1962, an two in 1963. All the cases were sporadic and had no connection.

The first of the cases in 1963 was of a young farm worker who developed cutaneous lesion on the 5th February and was admitted to hospital on the 10t February where the diagnosis was confirmed. On the 4th February a Form A was issued under the Anthrax Order in respect of two carcasses, later confirme as anthrax, at the farm where the man worked. A further Form A was serve on the 17th February in respect of another animal which again was confirme as suffering from anthrax. In view of the occurrence of anthrax amongst anima on the farm at which he worked it seems almost certain that the patient cor tracted his disease from contact with infected animals. The patient made complete recovery and was discharged from hospital on the 22nd February.

The second case, a fatal one, was of a 45 years old man, who was employe by a firm of wool scourers and carbonisers in Huddersfield C.B. He was th second of three cases which occurred at this mill, the other two being Count Borough residents. On the 19th September he went on holiday to relatives i County Offaly, Eire. Two days later he is said to have been ill and on th following day a spot appeared on his neck which later became a vesicle. H returned home on the night boat arriving early on the 23rd September. By th time the spot had become an ulcer, surrounded by considerable swelling. O arriving home he was seen by his nephew who worked at the same firm, wh considered that the lesion was similar to that shown on the Home Office anthra pamphlet which had been distributed at the mill. By the time a local genera practitioner was called, the man was very toxic and he was admitted to hospita where the diagnosis of anthrax was confirmed bacteriologically. The man rallie somewhat during the next two days but he eventually died on the 27th Septembe

The man was engaged on the opening of bales of skin wool from Turkey an China and feeding them into a cutting machine. The Chief Inspector of Factorie was notified of the case and, as the mill concerned was situate in Huddersfiel C.B., the follow-up there was undertaken by the Medical Officer of Health that Authority.

The procedure for referring all cases of suspected anthrax at factories, war houses and docks where materials with an anthrax risk are handled for immedia medical advice is clearly underlined and it was unfortunate that the man pr ceeded on holiday after acquiring the infection and did not seek treatment unt his return home.

Influenza:

The disease is not statutorily notifiable and the most reliable index of morbidit remains the variations in the weekly returns of new claims to sickness bene issued by the Ministry of Pensions and National Insurance, supplemented b information regarding school and industrial absenteeism, notifications of pne monia and deaths attributed to influenza.

Incidence remained low throughout the year with no outbreak of any si nificance reported.

TUBERCULOSIS

Deaths from Tuberculosis:

There were 109 deaths from tuberculosis (96 respiratory and 13 non-respiratory) representing a death rate of 0·065 (0·057 respiratory and 0·008 non-respiratory), which corresponds with the England and Wales death rate of 0·063 (0·056 respiratory and 0·007 non-respiratory). Details of deaths are given in the following table:—

Classification	Age at Death in Years																				Total		Grand Total
	0—		1—		5—		15—		25—		35—		45—		55—		65—		75—				
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M.	F.	
Respiratory ...	–	–	–	–	–	–	–	–	1	2	11	1	10	2	29	6	20	–	9	5	80	16	96
Non-respiratory	–	–	1	–	–	–	1	–	1	1	–	–	1	–	4	–	–	1	–	3	8	5	13
Totals ...	–	–	1	–	–	–	1	–	2	3	11	1	11	2	33	6	20	1	9	8	88	21	109

Notification of Tuberculosis:

There were 523 primary notifications of tuberculosis arising during the year and 19 supplemental notifications, a total of 542 as compared with 533 (512 primary and 21 supplementary) notifications in 1962. Details of the new cases are summarised in the following table:—

	AGE PERIODS													Total all Ages
	0–	1–	2–	5–	10–	15–	20–	25–	35–	45–	55–	65–	75–	
FORMAL NOTIFICATIONS:														
Respiratory, Males	–	1	5	4	6	15	19	39	43	50	71	34	21	308
Respiratory, Females ...	3	1	6	5	3	18	11	24	31	19	11	9	5	146
Non-Respiratory, Males ...	–	1	1	4	1	2	3	5	3	5	5	1	1	32
Non-respiratory, Females ...	–	–	–	1	3	1	7	11	5	7	–	1	1	37
														523
SUPPLEMENTAL NOTIFICATIONS:														
Respiratory, Males ...	–	–	–	–	–	–	–	–	–	–	3	6	1	10
Respiratory, Females ...	–	–	–	–	–	–	–	–	–	–	1	–	2	3
Non-respiratory, Males ...	–	–	–	–	–	–	–	–	–	–	2	1	–	3
Non-respiratory, Females	–	–	–	–	–	–	–	1	–	–	–	1	1	3
														19

The sources of information of the supplemental notifications were Local Registrars (5 respiratory and 2 non-respiratory), transferable deaths from the Registrar General (4 respiratory and 2 non-respiratory), and posthumous notifications (4 respiratory and 2 non-respiratory).

Register of Cases:

After adjustments for removals, recoveries and deaths, the total number of notified cases of tuberculosis on our register at the end of the year was 8,896, a decrease of 225 compared with the previous year. The following table summarises the revision of the registers in the respective divisional areas:—

Div. No.	Number of cases on register 1st January, 1963				Number of cases added to register				Number of cases removed from register				Number of cases remaining on register 31st December, 1963					
	Respiratory		Non-Respiratory		Respiratory		Non-Respiratory		Respiratory		Non-Respiratory		Respiratory		Non-Respiratory		Total	Per 1,000 Population
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F		
1	216	135	29	31	12	12	1	3	41	29	12	5	187	118	18	29	352	4·4
3	219	111	21	29	34	12	4	4	26	15	3	5	227	108	22	28	385	6·8
4	194	115	12	22	21	5	1	2	22	15	2	3	193	105	11	21	330	4·8
5	336	225	44	55	26	15	1	4	36	19	2	3	326	221	43	56	646	5·5
7	237	174	27	40	16	9	—	1	15	11	2	2	238	172	25	39	474	4·4
9	79	60	13	13	10	7	1	—	10	8	—	1	79	59	14	12	164	3·1
10	142	109	17	24	3	4	—	—	10	8	1	2	135	105	16	22	278	6·2
11	207	135	15	14	13	4	—	1	10	3	—	1	210	136	15	14	375	6·4
12	225	156	38	49	14	16	1	2	9	13	—	2	230	159	39	49	477	7·5
13	122	72	10	28	17	6	1	2	26	15	1	6	113	63	10	24	210	2·4
15	62	49	38	16	9	6	5	2	16	6	2	2	55	49	41	16	161	3·3
16	100	82	17	13	13	7	—	1	13	16	2	1	100	73	15	13	201	3·4
17	54	27	10	13	6	3	1	2	14	9	—	3	46	21	11	12	90	1·8
18	192	130	11	3	17	9	2	2	30	20	—	1	179	119	13	4	315	5·3
19	166	114	19	19	23	13	3	3	28	20	3	3	161	107	19	19	306	5·9
20	175	105	22	31	17	12	4	4	30	17	1	7	162	100	25	28	315	3·5
23	240	176	26	33	16	11	1	2	15	17	—	—	241	170	27	35	473	7·0
Leeds R.H.B.	2,966	1,975	369	433	267	151	26	35	351	241	31	47	2,882	1,885	364	421	5,552	4·8
22	355	216	76	55	27	16	2	6	38	30	3	—	344	202	75	61	682	7·4
25	228	160	37	28	28	16	1	—	14	15	—	—	242	161	38	28	469	6·0
26	380	243	45	56	24	15	1	1	25	11	1	2	379	247	45	55	726	6·6
27	344	300	84	62	31	31	2	1	42	39	2	2	333	292	84	61	770	6·7
29	108	93	33	23	14	8	1	—	13	14	1	—	109	87	33	23	252	7·0
31	242	145	35	31	18	11	5	2	29	13	1	1	231	143	39	32	445	4·6
Sheff. R.H.B.	1,657	1,157	310	255	142	97	12	10	161	122	8	5	1,638	1,132	314	260	3,344	6·3
West Riding	4,623	3,132	679	688	409	248	38	45	512	363	39	52	4,520	3,017	678	681	8,896	5·2

Care and After-Care of the Tuberculous:

The ancillary services provided by the County Council are briefly summarised as follows:—

Extra nourishment, consisting of up to two pints of milk daily, continues to be available for domiciliary patients suffering from active tuberculosis; a total of 746 patients were granted free milk during the year and 466 persons were still on the register at 31st December.

Domiciliary open-air shelters, beds, mattresses and bedding are provided to facilitate the segregation of the tuberculous patient who resides at home, but, due to better housing conditions, there is now little demand for the foremost.

During 1963, 1 patient, whose condition did not permit his return to normal competitive employment, was admitted to the training settlement at Sherwood. There were two discharges throughout the year, 1 at Sherwood and 1 at Papworth leaving 8 patients still in residence at the 31st December—at Papworth (1) and at Sherwood (7).

CARE COMMITTEES:

Any review of Care and After-Care Services would be incomplete without reference to the work undertaken by Tuberculosis After-Care Committees. The work of a Care Committee is directed at easing the problems, both financial and otherwise, with which the tuberculous patient and his family have to contend. Because of their composition, the Committees are well-fitted for this task, for, in addition to laymen who are sympathetic towards the problems of the tuberculous, there are, serving with the Committees, persons who have specialised knowledge, *e.g.*, Divisional Medical Officers, Chest Physicians, representatives of the National Assistance Board, etc., who are able to advise patients in need of help of the facilities available from statutory sources. This " expert " advice tends to conserve the Committees' funds and ensures that help is given only to those patients and their families who are outside the scope of help provided by the statutory bodies. There are ten such Care Committees active in the West Riding area, three of which serve areas which include a county borough. The Care Committees provide services in thirteen divisional areas and cover approximately half of the County population. Their work is actively encouraged by the County Council who provide grants in aid to supplement the financial resources of the Committees; the grants for this year amounted to £1,090. These grants are distributed amongst the Committees according to the population served and the amount of expenditure upon benefits to patients. Many of the Committees have extended their activities to include the after-care of patients suffering from other chest diseases and heart conditions, and this extension of activity has resulted in an increased demand upon the resources of the Committees.

B.C.G. Vaccination:

Details of B.C.G. vaccination given to the various categories under Section 28 of the National Health Service Act are shown below:—

(a) CONTACTS.—A further 1,799 contacts were vaccinated 5 of them being unsuccessful. Full details are shown in the following table:—

	AGE GROUPS												All Ages
	Under 1 year Months				Years								
	0–	1–	3–	6–	1–	2–	3–	4–	5–	10–	15–	20–	
Vaccinated:													
Male	117	110	79	54	51	71	44	41	121	157	34	21	900
Female	136	86	81	36	58	69	37	37	110	144	45	60	899
TOTAL	253	196	160	90	109	140	81	78	231	301	79	81	1,799
Result of Vaccination: Successful:													
Male	96	99	69	49	44	67	35	32	103	94	32	21	741
Female	112	73	74	32	48	59	32	34	97	73	42	56	732
TOTAL	208	172	143	81	92	126	67	66	200	167	74	77	1,473
Unsuccessful	4	–	–	–	–	–	–	–	1	–	–	–	5
Not finally ascertained ...	41	24	17	9	17	14	14	12	30	134	5	4	321

(b) SCHOOL CHILDREN.—Fourteen thousand five hundred were vaccinated under the County scheme, and the following is a summary of the work in the 23 divisions involved.

Acceptances:

Number of children offered tuberculin testing and vaccination if necessary	28,758
Number found to have been vaccinated previously	546
Number of acceptances	20,044
Percentage of acceptances	71·0

Pre-vaccination tuberculin test:

Number of children tested	18,901

Result of test:

	Heaf Test	*Mantoux Test*		
Positive	... 3,283	213		
Negative	... 12,140	2,697		
Not ascertained	547	51	Total	18,901
Percentage positive	21·3	7·3	...	19·1

Vaccination:

Number vaccinated—

Following negative Heaf Test ...	... 11,843		
Following negative Mantoux Test ...	... 2,657	Total ...	14,500

Tuberculin test twelve months after vaccination:

Number tuberculin tested after 12 months ...		... ...	2,022
Result of test—			
Positive	1,854		
Negative	118		
Not ascertained	50	Total ...	2,022

(c) STUDENTS ATTENDING UNIVERSITIES, TEACHER-TRAINING COLLEGES, TECHNICAL COLLEGES OR OTHER ESTABLISHMENTS FOR FURTHER EDUCATION.—Ninety-six students were tested, and of the sixty who were found to be negative fifty-eight were vaccinated.

Mass Radiography:

Sixty thousand three hundred and fifty-four persons from the Administrative County were examined by the Mass Radiography Service, 41,382 by units of the Leeds Regional Hospital Board and 18,972 by units of the Sheffield Regional Hospital Board. It will be seen from the tables below that 88 (0·11 per cent. of the total examined) cases of active tuberculosis and 292 (0·48 per cent.) cases of inactive tuberculosis were discovered; there were also 1,201 (1·99 per cent.) non-tuberculous abnormalities found, 602 (50·12 per cent. of the total non-tuberculous abnormalities) of which were cases of pneumoconiosis. When separated into the two hospital regions, the percentage of cases of pneumoconiosis was 60·91 in the Sheffield Region and only 5·56 in the Leeds Region.

A.—Leeds Units

Survey undertaken in Division No.	Number Examined	Abnormalities Discovered			
		Tuberculosis		* Other	Total
		Active	Inactive		
1 (Skipton)	3,721	1	11	42	54
3 (Keighley)	4,206	11	15	28	54
5 (Horsforth)	5,805	5	27	23	55
7 (Harrogate)	939	1	6	3	10
9 (Wetherby)	3,658	—	2	6	8
10 (Goole)	4,158	3	13	19	35
12 (Pontefract)	3,275	2	2	3	7
16 (Rothwell)	2,162	2	2	7	11
17 (Spenborough)	3,624	4	11	26	41
18 (Brighouse)	4,374	10	6	34	50
19 (Todmorden)	197	1	1	5	7
20 (Colne Valley)	5,263	10	21	38	69
Totals	41,382	50	117	234	401

B.—Sheffield Units

Survey undertaken in Division No.	Number Examined	Abnormalities Discovered			
		Tuberculosis		* Other	Total
		Active	Inactive		
22 (Wortley)	452	–	—	1	1
25 (Barnsley)	4,718	2	47	236	285
26 (Wath upon Dearne)	874	–	8	31	39
27 (Doncaster)	9,162	33	81	580	694
29 (Thorne)...	2,256	1	33	65	99
31 (Rotherham)	1,510	2	6	54	62
Totals	18,972	38	175	967	1,180
Totals for the County Area ...	60,354	88	292	1,201	1,581

*Details of the 1,201 " Other " abnormalities are as follows:—

	Leeds Region	*Sheffield Region*
1. Abnormalities of bony thorax and soft tissues—congenital	3	18
2. Abnormalities of bony thorax and soft tissues—acquired	4	19
3. Tumours of the bony thorax; primary and secondary	—	—
4. Congenital malformation of the lungs	3	—
5. Bacterial and virus infection of the lungs ...	28	25

6. Other infections of the lungs	4	—
7. Bronchiectasis	35	27
8. Honeycomb lung	1	—
9. Emphysema	11	19
10. Pulmonary fibrosis—non-tuberculous	16	88
11. Pneumoconiosis	13	589
12. Spontaneous pneumothorax	—	—
13. Benign tumours of the lungs and mediastinum ...	8	5
14. Carcinoma of the lung and mediastinum ...	7	11
15. Metastases in the lung and mediastinum ...	1	2
16. Enlarged mediastinal and bronchial glands—non-tuberculous	2	—
17. Sarcoidosis and collagenous diseases	8	3
18. Pleural thickening or calcification–non-tuberculous	12	54
19. Abnormalities of the diaphragm and œsophagus—congenital and acquired	10	16
20. Congenital abnormalities of heart and vessels ...	7	2
21. Acquired abnormalities of heart and vessels ...	47	82
22. Miscellaneous	11	7
23. Inquiries not completed	3	—
	234	967

Co-operation with Chest Physicians:

Following up the joint meeting with Chest Physicians which took place in 1961 and which was reported on in the Report for that year, a further meeting was held in November, 1962, the main subject under discussion being ways and means of eradicating tuberculosis, with particular reference to tuberculosis in the elderly, the follow-up of strongly positive reactors in the school leaving group, and the routine tuberculin testing of entrants to school.

Arising out of the report on the above meeting a joint working party of Divisional Medical Officers and Chest Physicians met to consider the problem in greater detail and the following principles were agreed:—

(1) The routine jelly testing of school entrants is a worthwhile procedure and in the case of positive reactors to the test, contacts, including the child's immediate family, neighbours and particularly elderly grandparents should be followed-up.

(2) A trial scheme would be introduced in one or two Divisions for the follow-up of strongly positive reactors in the thirteen year old with a view to the investigation of contacts.

(3) That the aid of general practitioners be enlisted in bringing to attention certain cases in the aged which might merit investigation.

The above recommendations were subsequently agreed by the Standing Sub-Committee on Co-operation with General Practitioners and with regard to the elderly, the offer was made for health visiting staff to collect sputum specimens from those elderly patients who had a history of chronic chest trouble, priority to be given to those where, because of the patient's condition and home circumstances, collection by a doctor would be difficult and time consuming.

VENEREAL DISEASES

Contributed by Dr. J. A. Burgess, Consultant Venereologist.

The statistics given in the first half of this report have been prepared from figures kindly provided by the physicians in charge of the special clinics at which West Riding Administrative County residents attended during 1963. They indicate the trend of new infections but do not represent the true incidence of venereal diseases and other conditions in the County. Venereal diseases are not notifiable in this country, hence the figures given are those only of patients who were registered at special clinics.

Table A.

New patients.

Year	Syphilis	Gonorrhœa	Other Conditions	Total of New Patients
1938	346	650	503	1,499
1939	403	678	593	1,674
1940	299	499	497	1,295
1941	331	552	587	1,470
1942	423	479	735	1,637
1943	487	654	1,344	2,485
1944	413	560	1,383	2,356
1945	473	767	1,419	2,659
1946	723	1,140	1,859	3,722
1947	573	729	1,511	2,813
1948	463	550	1,403	2,416
1949	435	383	1,360	2,178
1950	357	304	1,447	2,108
1951	247	171	1,212	1,630
1952	219	211	1,275	1,705
1953	214	182	1,228	1,624
1954	178	152	1,189	1,519
1955	175	135	1,168	1,478
1956	155	99	1,143	1,397
1957	152	125	1,078	1,355
1958	124	138	1,129	1,391
1959	112	405	1,352	1,869
1960	83	338	1,550	1,971
1961	85	286	1,669	2,040
1962	69	244	1,623	1,936
1963	74	272	1,734	2,080

The number of new patients increased by 144 from 1,936 to 2,080. Syphilis in the above table includes early infectious, late acquired and congenital syphilis. Cases of syphilis increased by 5 to 74; the general trend of this disease in the County since the year following the end of World War II has been downwards. New cases of gonorrhœa increased by 28 to 272. The highest number of patients with gonorrhœa was recorded in 1946; the lowest in 1956. From 1959 to 1962 the trend was downwards, but in the year under review a slight increase occurred.

"Other conditions" include chancroid, lymphogranuloma venereum, granuloma inguinale, non-gonococcal urethritis (males only), yaws, other conditions requiring treatment, conditions not requiring treatment and undiagnosed conditions. During 1963 " other conditions " increased by 111 from 1,623 to 1,734.

Since 1957 the trend of this group has been upwards. Of all new patients 83 per cent. were classified as " other conditions ". The corresponding percentages for syphilis and gonorrhœa in 1963 were 4 per cent. and 13 per cent.

Table B.

Early and Congenital Syphilis.

Year	Early Acquired Syphilis	Congenital Syphilis under 1 year	Total Early Syphilis
1949	158	7	165
1950	76	4	80
1951	58	4	62
1952	19	1	20
1953	9	1	10
1954	7	—	7
1955	6	1	7
1956	9	—	9
1957	1	—	1
1958	5	—	5
1959	12	—	12
1960	—	—	—
1961	4	—	4
1962	4	1	5
1963	5	—	5

A very few cases of early acquired (infectious) syphilis continue to be found in West Riding Administrative County residents. In some of the larger county boroughs there has been a small but definite increase in the last few years so that any rise in number in the Administrative County will have to be watched closely. In the past eight years there has been only one case of congenital syphilis in infants under one year of age. The disease can be prevented by the adequate treatment of infected expectant mothers. This entails the thorough examination and blood testing of every antenatal patient. The excellent results obtained were due, largely, to the good team-work of doctors, serologists, midwives, health visitors and social workers in examining, testing and following up these cases. (See also table G.).

Table C.

Analysis of New Cases (quarterly and stage of disease).

Quarter ended	Acquired Syphilis				Congenital Syphilis				Gonorrhœa		Other Conditions	
	Early		Late		Under 1 year		Over 1 year					
	1962	1963	1962	1963	1962	1963	1962	1963	1962	1963	1962	1963
31st March ...	—	3	18	22	—	—	3	—	59	65	388	385
30th June ...	3	—	12	10	—	—	2	5	58	61	390	426
30th September	—	1	12	16	1	—	2	7	62	81	366	496
31st December	1	1	13	9	—	—	2	—	65	65	479	427
	4	5	55	57	1	—	9	12	244	272	1,623	1,734

Table C gives the numbers of new cases of both acquired and congenital syphilis in the early and late stages; also gonorrhœa and other conditions during each quarter of 1963. The corresponding figures for 1962 are included for comparison. Apart from congenital syphilis under 1 year of age there was a very slight increase in syphilis and an increase of about 10 per cent. in gonorrhœa and other conditions. There were more cases of gonorrhœa and other conditions in the second half of the year than in the first six months.

Table D.

Distribution of New Cases by Treatment Centres.

Special Treatment Centre	Syphilis	Gonorrhœa	Other Conditions	Total
Barnsley Clinic, Queen's Road	4	11	130	145
Bradford St. Luke's Hospital	2	21	131	154
Burnley Victoria Hospital	—	—	5	5
Dewsbury General Hospital	7	30	85	122
Doncaster Royal Infirmary	8	57	272	337
Goole Bartholomew Hospital	2	2	10	14
Halifax Royal Infirmary	3	14	77	94
Harrogate General Hospital	5	9	110	124
Huddersfield Royal Infirmary	8	16	80	104
Keighley Victoria Hospital	7	27	94	128
Leeds General Infirmary	7	35	283	325
Oldham & District General Hospital ...	—	1	6	7
Rotherham Moorgate General Hospital	8	21	117	146
Sheffield Royal Hospital	1	3	21	25
Sheffield Royal Infirmary	1	—	11	12
Sheffield City General Hospital	2	2	1	5
Wakefield Clayton Hospital	7	22	262	291
York County Hospital	2	1	39	42
	74	272	1,734	2,080

The addresses of special clinics at which new patients attended during 1963 and the number of cases of each disease diagnosed are given in Table D. These figures exclude patients who were transferred after diagnosis from one clinic to another, also patients who had defaulted from treatment in a previous year and returned during the year under review for treatment of the same disease.

New cases from the Administrative County attended at 18 different special clinics during the year. Thirteen of these centres were in West Riding county boroughs, two in Lancashire and three in West Riding municipal boroughs.

Compared with the previous year increases in the number of patients with gonorrhœa were found at Barnsley, Dewsbury, Doncaster, Halifax, Huddersfield, Rotherham and Wakefield. "Other conditions" increased in number at all clinics except Harrogate, Keighley, Rotherham, Sheffield Royal Hospital, and Wakefield.

Table E.

New Cases—Sex Distribution.

	Males	Females	Total
Syphilis	37	37	74
Gonorrhœa	187	85	272
Chancroid	—	—	—
Lymphogranuloma Venereum	—	—	—
Granuloma Inguinale	—	—	—
Non-gonococcal Urethritis	342	—	342
Yaws	—	1	1
Other Conditions requiring treatment	337	310	647
Not requiring treatment	471	261	732
Undiagnosed at 31st December, 1963	6	6	12
	1,380	700	2,080

The above table shows the sex distribution of new cases of syphilis, gonorrhœa and other conditions. Syphilis was evenly distributed between the sexes but of those with gonorrhœa 68 per cent. were males. The 272 cases of gonorrhœa represent a smaller number of individuals because some patients acquired the disease on more than one occasion during the year. There were no patients with chancroid, lymphogranuloma venereum or granuloma inguinale. There was one case of late latent yaws in a West Indian woman. Yaws is not a venereal disease but one of the treponematoses, with a relatively high incidence in the West Indies and Africa.

Non-gonococcal urethritis is the collective term for a group of conditions excluding gonorrhœa, in which there is inflammation of the male urethra. Many cases, but by no means all, follow sexual exposure. Trichomoniasis and inclusion blennorrhœa are probably the commonest venereal causes of non-gonococcal urethritis in men.

Compared with the previous year non-gonococcal urethritis decreased in number by 9 while other conditions requiring treatment and conditions not requiring treatment increased by 79 and 32 respectively.

DEFAULTERS:

The V.D. social workers as part of their duties in special clinics follow u defaulting patients; that is, those who cease to attend before they are cured venereal disease. This is done either by letters (enclosed in plain envelopes) the patients, or, if these are unsuccessful, by visits and private talks. No recor are available of the number of letters sent. Table H gives details of the patien visited in the follow-up of defaulters from special clinics.

Table H.

Defaulters.

Total number of defaulters	Returned to clinic after visiting	Failed to return	Removed, unable to locate	Trans-ferred	Number of ineffective visits	Number of re-visits
232	151	37	16	28	448	331

PART IV

LOCAL HEALTH SERVICES

Care of Mothers and Young Children

Midwifery

Health Visiting

Home Nursing

Ambulance

Health Education

Recuperative Home Treatment

Provision of Nursing Equipment

Laundry Service for Incontinent Patients

Liaison

Chiropody

Domestic Help

Mental Health

Vital Statistics:	Administrative County	England and Wales
Live Births		
Number	30,803	
Rate per 1,000 population	18·2	18·2
Illegitimate Live Births per cent. of total live births ...	4·9	
Stillbirths		
Number	586	
Rate per 1,000 total live and still births	18·7	17·3
Total Live and Still Births	31,389	
Infant Deaths (deaths under 1 year)	707	
Infant Mortality Rates		
Total infant deaths per 1,000 total live births	23·0	20·9
Legitimate infant deaths per 1,000 legitimate live births ...	22·7	
Illegitimate infant deaths per 1,000 illegitimate live births	27·6	
Neonatal Mortality Rate (deaths under 4 weeks per 1,000 total live births)	15·0	14·2
Early Neonatal Mortality Rate (deaths under 1 week per 1,000 total live births)	12·7	
Perinatal Mortality Rate (stillbirths and deaths under 1 week combined per 1,000 total live and still births) ...	31·1	
Maternal Mortality (including abortion)		
Number of deaths	14	
Rate per 1,000 total live and still births	0·45	0·28

Births:

There were 30,803 live births registered compared with 29,792 in 1962 and an annual average of 28,242 in the quinquennium 1958-62; the corresponding crude birth rates per 1,000 population being 18·2, 17·8 and 17·0 respectively. Since 1954, apart from a slight decrease recorded in 1959, the number of births and rate have progressively increased. The number of births is the highest annual total recorded since 1947 and the rate the highest since 1948; the increase in the rate of 0·4 per 1,000 population for 1963 as compared with the previous year suggests that the peak in the upward trend has not yet been reached.

Comparisons of crude rates of single districts or aggregates are not strictly valid since no regard is made to the varying sex-age structure of the respective populations. To overcome this difficulty an area comparability factor, which makes due allowance for the proportion of women of child-bearing age in each local population, is applied to the crude rates. The live birth rates for the past

six years adjusted by the factors applicable for the aggregates of Boroughs and Urban Districts, Rural Districts, the Administrative County, also the rates for England and Wales, are given below:—

Year	Boroughs and Urban Districts	Rural Districts	Administrative County	England and Wales
1958	16·4	18·0	16·9	16·4
1959	16·2	17·6	16·7	16·5
1960	16·7	17·8	17·1	17·2
1961	16·9	18·5	17·4	17·6
1962	17·7	18·2	17·8	18·0
1963	18·4	18·2	18·3	18·2

The rising trend in the live birth rate was accompanied by a rise in the illegitimacy rate. The number of live births registered as illegitimate was 1,524 or 4·9 per cent. of the total live births. Between the world wars the proportion was around the level of 4 per cent.; during the last war there was a steep rise with a peak of 7·3 per cent. in 1945, followed by an irregular decline to 3·6 per cent. in 1957. Since 1959 the proportion has progressively increased to the highest level recorded since 1946. Reference to the cases dealt with under the Authority's scheme appears on page 117.

The number of stillbirths registered was 586 which corresponds to a rate of 18·7 per 1,000 total births. The rate is fractionally higher than in the previous year (18·5) when a low record was established; it is the second lowest rate and may be nothing more than a temporary fluctuation in the downward trend. Reference to the national rate of 17·3, however, indicates that reductions are possible and indeed probable. The high ratio of illegitimate stillbirths was again in evidence at the rate of 5·6 per cent. of total stillbirths and compares unfavourably with a ratio of 5·3 in 1962 and 5·0 in the period 1958-62.

Infant Mortality:

The number of deaths of infants under 1 year was 707 equivalent to a rate of 23·0 per 1,000 live births, the second lowest rate ever recorded for the Administrative County. Compared with the previous year the rate reduced by 0·3 per 1,000 live births and was 0·8 lower than the annual average for the period 1958-62 but it continues to be higher than the national rate of 20·9 indicative that there is still ample room for improvement before an irreducable minimum is achieved.

Since the turn of the century, apart from minor fluctuations, as indicated in the subjoined table, there has been a progressive decline in the rate:—

Period	Average Infant Mortality Rate		Year	Infant Mortality Rate	
	England and Wales	Administrative County		England and Wales	Administrative County
			1956	24	27
1901-1910	128	135	1957	23	26
1911-1920	100	109	1958	23	24
1921-1930	72	80	1959	22	24
1931-1940	59	61	1960	22	22
1941-1945	50	50	1961	21	25
1946-1950	36	40	1962	22	23
1951-1955	27	29	1963	21	23

The following table classifies the number of deaths and death rates by sex and age in the first year of life during the period 1959-63.

	Number of Deaths					Deaths per 1,000 Live Births				
	1959	1960	1961	1962	1963	1959	1960	1961	1962	1963
Male Infants—										
Under 4 weeks	256	249	293	297	269	18·5	17·3	19·9	19·2	17·0
4 weeks—3 months ...	67	37	50	42	43	4·8	2·6	3·4	2·7	2·7
3—6 months	30	21	38	50	42	2·2	1·5	2·6	3·2	2·7
6—12 months	35	27	34	40	43	2·5	1·9	2·3	2·6	2·7
Total under 1 year ...	388	334	415	429	397	28·0	23·3	28·3	27·8	25·1
Female Infants—										
Under 4 weeks	183	193	177	170	192	13·9	14·2	12·8	11·8	12·8
4 weeks—3 months ...	32	42	48	26	45	2·4	3·1	3·5	1·8	3·0
3—6 months	22	39	30	35	49	1·7	2·9	2·2	2·4	3·3
6—12 months	24	20	33	35	24	1·8	1·5	2·4	2·4	1·6
Total under 1 year ...	261	294	288	266	310	19·8	21·6	20·8	18·5	20·7
All Infants—										
Under 4 weeks	439	442	470	467	461	16·2	15·8	16·5	15·7	15·0
4 weeks—3 months ...	99	79	98	68	88	3·7	2·8	3·4	2·3	2·9
3—6 months	52	60	68	85	91	1·9	2·1	2·4	2·9	3·0
6—12 months	59	47	67	75	67	2·2	1·7	2·3	2·5	2·2
Total under 1 year ...	649	628	703	695	707	24·0	22·5	24·6	23·3	23·0

Compared with the previous year, improvements were recorded in the neonatal period and at ages 6—11 months; these gains were only partially offset by increases at other ages which resulted in a reduction of the rate by 0·3 per 1,000 live births. Although significant improvements in male mortality rates were achieved, males in the neonatal period continued to be most vulnerable.

Deaths in the neonatal period numbered 461 or 65 per cent. of total infant mortality; the resultant neonatal mortality rate at 15·0 per 1,000 live births was the lowest recorded. The number of deaths and death rates at various ages in the neonatal period are indicated below:—

	Number of Deaths							Deaths per 1,000 Live Births						
	1957	1958	1959	1960	1961	1962	1963	1957	1958	1959	1960	1961	1962	1963
Under 1 day ...	237	216	211	227	238	235	231	8·8	7·9	7·8	8·1	8·3	7·9	7·5
1—7 days	200	175	157	157	170	160	159	7·4	6·4	5·8	5·6	6·0	5·4	5·2
1—4 weeks ...	72	70	71	58	62	72	71	2·7	2·6	2·6	2·1	2·2	2·4	2·3
Total under 4 weeks	509	461	439	442	470	467	461	18·9	16·9	16·2	15·8	16·5	15·7	15·0

Mortality of infants in the first day of life continued to exceed the total for the remainder of the neonatal period. Deaths under one week constituted 85 per cent. of the neonatal and 55 per cent. of the total infant mortality; improvements in mortality have been achieved at older ages but deaths in the first week of life have been the most resistant to reduction during the past generation. The number of infant deaths assigned to the groups of diseases comprising the International Short List appears on page 33 but to afford a clearer appreciation of the contributory causes a detailed analysis is appended:—

Ætiological Group	Cause of Death (and International Classification number)	Age at Death						
		Under 1 day	1 day and under 1 week	1 week and under 1 month	1 month and under 3 months	3 months and under 6 months	6 months and under 1 year	Total under 1 year
ALL CAUSES	All Causes	231	159	71	88	91	67	707
Prenatal and Natal Group (including congenital malformations)	Congenital malformations (750-759)	35	35	26	26	7	7	136
	Total causes mainly of prenatal and natal origin other than congenital malformations	190	111	15	6	2	1	325
	Immaturity alone, or primary to diseases other than of early infancy (774, 776) ...	95	34	8	1	—	—	138
	Attributed to maternal toxæmia (769)	4	4	—	—	—	—	8
	Ill defined diseases of early infancy (773)	1	9	1	2	—	--	13
	Postnatal asphyxia and atelectasis (762)	60	31	1	2	—	--	94
	Intracranial and spinal injury at birth (760)	23	21	4	1	1	—	50
	Other birth injury (761)	1	—	—	—	—	—	1
	Erythroblastosis (770)	6	4	2	—	1	1	14
	Hæmorrhagic disease of newborn (771)...	—	7	—	—	—	—	7
Postnatal Group	Total causes mainly of postnatal origin	4	13	27	50	76	50	220
	Gastro-enteritis (including diarrhœa of newborn) (571, 764)	—	—	6	9	5	10	30
	Pneumonia and bronchitis (490-493, 763, 500-502)	2	13	15	32	48	28	138
	Other diseases of respiratory system (470-475, 510-527)	—	—	1	—	6	2	9
	Causes classified as infective (001-138): others mainly infective in origin (340, 391-393, 480-483, 765-768)	—	—	5	4	5	7	21
	Whooping cough (056)	—	—	—	—	1	1	2
	Influenza (480-483)	—	—	—	—	—	1	1
	Otitis media and mastoiditis (391-393)	—	—	2	—	—	1	3
	Septicæmia, sepsis of newborn (053, 765-768)	—	—	3	—	2	1	6
	Meningococcal infections and non-meningococcal meningitis (057, 340) ...	—	—	—	4	2	2	8
	Causes classified as infective not mentioned above (remainder 001-138) ...	—	—	—	—	—	1	1
	Accidental mechanical suffocation from vomit, food, foreign body, or in cot (E921-E925)	—	—	—	3	10	—	13
	Lack of care, neglect (including foundlings), infanticide (E926, E980-E985) ...	2	—	—	1	—	1	4
	Other violent causes (remainder E800-E999)	—	—	—	1	2	2	5
Unclassified	Other remaining causes	2	1	2	6	6	9	26

It is recognised that the causes of death immediately after birth are more akin to the causes of stillbirth and differ from the causes operating later in the first year of life.

Of the deaths during the first week of life 95 per cent. were due to conditions present before, or during birth. The major contributions to mortality at these ages, in descending order were, immaturity 129 (33 per cent. of the total deaths under 1 week), postnatal asphyxia and atelectasis 91 (23 per cent.), congenital malformations 70 (18 per cent.), and birth injuries 45 (12 per cent.).

At ages 1 week up to 1 year pneumonia and bronchitis continued to dominate the picture with 123 deaths (39 per cent. of the total deaths at these ages), followed by congenital malformations 66 (21 per cent.), gastro-enteritis 30 (9 per cent.) and infective diseases 21 (7 per cent.).

Perinatal Mortality:

In modern usage this term describes the combination of stillbirths and deaths in the first week of life and provides an index of the loss of infant life due to conditions associated with pregnancy and events during labour and delivery. The mortality rate is expressed per 1,000 total births and the subjoined table gives the perinatal mortality rate, also the death rate for infants aged one week up to one year for the past 11 years:—

	1953	1954	1955	1956	1957	1958	1959	1960	1961	1962	1963
Perinatal mortality (per 1,000 total births)	39·8	41·1	40·8	39·5	39·7	36·7	33·7	35·9	34·2	31·5	31·1
Infant deaths at 1 week and over (per 1,000 total births)	13·4	12·1	11·1	10·1	9·9	9·9	10·2	8·5	10·1	9·9	10·1

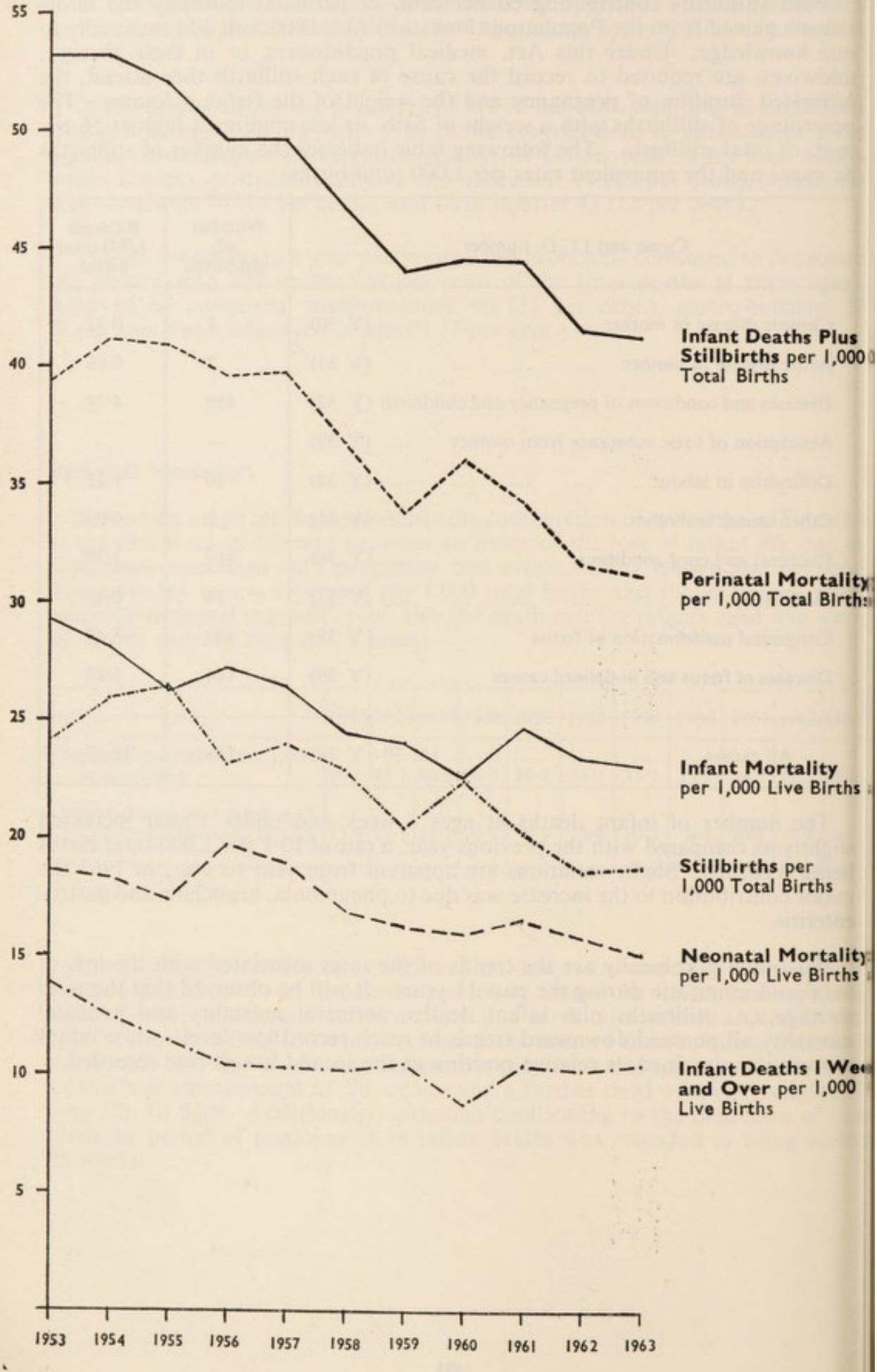
The perinatal mortality rate continued its downward trend to the lowest rate yet recorded of 31·1. As mentioned previously, immaturity, postnatal asphyxia and atelectasis, congenital malformations and birth injuries contributed 86 per cent. of the deaths under 1 week. A high proportion of these infants lived a few hours only and the involvement of prematurity is clearly underlined; indeed, a third had a birthweight of 3lb. or less and a further third with birthweights of over 3lb. to 5½lb. Additionally, although conforming to the definition of live birth the period of gestation of 18 infant deaths was recorded as being under 28 weeks.

With stillbirths contributing 60 per cent. of perinatal mortality the information gained from the Population (Statistics) Act, 1960, will add materially to our knowledge. Under this Act, medical practitioners, or in their absence, midwives, are required to record the cause of each stillbirth they attend, the estimated duration of pregnancy and the weight of the fœtus if known. The percentage of stillbirths with a weight of 5½lb. or less continued high at 56 per cent. of total stillbirths. The following table indicates the number of stillbirths by cause and the equivalent rates per 1,000 total births.

Cause and I.C.D. number	Number of stillbirths	Rate per 1,000 total births
Chronic disease in mother ... ... (Y 30)	7	0·22
Acute disease in mother ... ... (Y 31)	2	0·06
Diseases and conditions of pregnancy and childbirth (Y 32)	130	4·14
Absorption of toxic substance from mother ... (Y 33)	—	—
Difficulties in labour... ... ... (Y 34)	40	1·27
Other causes in mother ... ... (Y 35)	1	0·03
Placental and cord conditions ... ... (Y 36)	119	3·79
Birth injury ... ... (Y 37)	14	0·45
Congenital malformation of fœtus ... ... (Y 38)	109	3·47
Diseases of fœtus and ill-defined causes ... ... (Y 39)	164	5·22
All causes ... ... (Y 30—Y 39)	586	18·67

The number of infant deaths at ages 1 week and under 1 year increased slightly as compared with the previous year, a rate of 10·1 per 1,000 total births being recorded. Slight variations are apparent from year to year, in 1963 the major contribution to the increase was due to pneumonia, bronchitis and gastro-enteritis.

Illustrated graphically are the trends of the rates associated with the loss of fœtal and infant life during the past 11 years. It will be observed that the total wastage *i.e.*, stillbirths plus infant deaths, perinatal mortality and neonatal mortality all pursued downward trends to reach record low levels, while infant mortality maintained its relative position at the second lowest rate recorded.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Infant Deaths Plus Stillbirths per 1,000 Total Births
Perinatal Mortality per 1,000 Total Births
Infant Mortality per 1,000 Live Births
Stillbirths per 1,000 Total Births
Neonatal Mortality per 1,000 Live Births
Infant Deaths 1 Week and Over per 1,000 Live Births

Perinatal Mortality and the Rising Birth Rate:

In October was published the First Report of the British Perinatal Mortality Survey by the National Birthday Trust. This detailed examination of the factors causing babies to be lost from stillbirth and death in the first week of life has provided for the first time a clear guide to the preventive measures most likely to be effective in reducing the perinatal mortality rate. In this respect, the nation lags behind other European countries and, regrettably, the West Riding Administrative Area has for many years shared with the north-west of England a higher-than-national average rate.

Coincident with the emphasis on reducing the avoidable infant deaths, there has been a steady rise in the total births in the Riding and a corresponding increase in the demands placed on the maternity services. Predictions as to the future pattern of birth rate are notoriously fallible when based on past trends, but further increases in maternity demand are expected.

Graphs are reproduced on pages 94 to 106 which show the position from 1957 to 1963 for the West Riding as a whole, in the areas related to the Leeds and Sheffield Regional Hospital Boards, and finally by Divisional Areas.

A table is also included to show the differing uses of hospital and domiciliary facilities in divisions throughout the Riding. For comparison, the divisions are arranged in the table in descending order of success in combating perinatal mortality over the past five years. It must, however, be noted that problems outside Local Authority control are responsible for some variations seen.

It will be noted that the hospital services have expanded their number of confinements at a rate which has generally absorbed the increase in total births, while the total number of home confinements has hardly changed over the past six years. Nevertheless, there are still areas in the West Riding where the hospital confinement rate is well below the 70 per cent. recommended by the Maternity Services (Cranbrook) Committee in 1959, and there is every reason to believe that the single most-effective means of avoiding perinatal deaths is to increase the provision and usage of hospital maternity beds for those mothers known beforehand to constitute special risk.

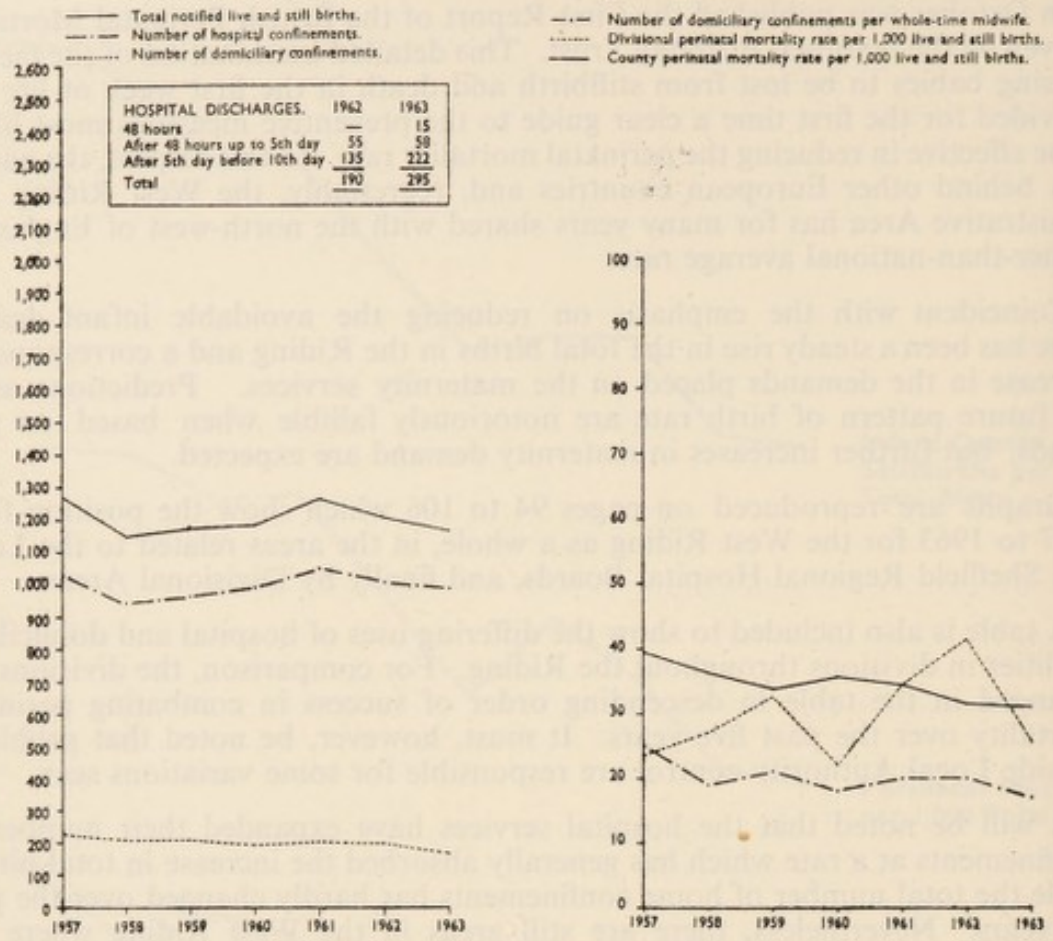
For the future, our emphasis will be on trying to ensure the best possible antenatal care to patients, and, by close co-operation with our hospital colleagues through Regional Hospital Boards and Local Maternity Liaison Committees, making the best use of those beds available for confinements needing specialist supervision.

The domiciliary midwives will continue to carry out the management of suitably-selected home confinements and may expect to do more postnatal nursing as the expedient of early discharge of patients from hospital (to increase bed occupancy) becomes more prevalent and more acceptable to patients anxious to return home to their families.

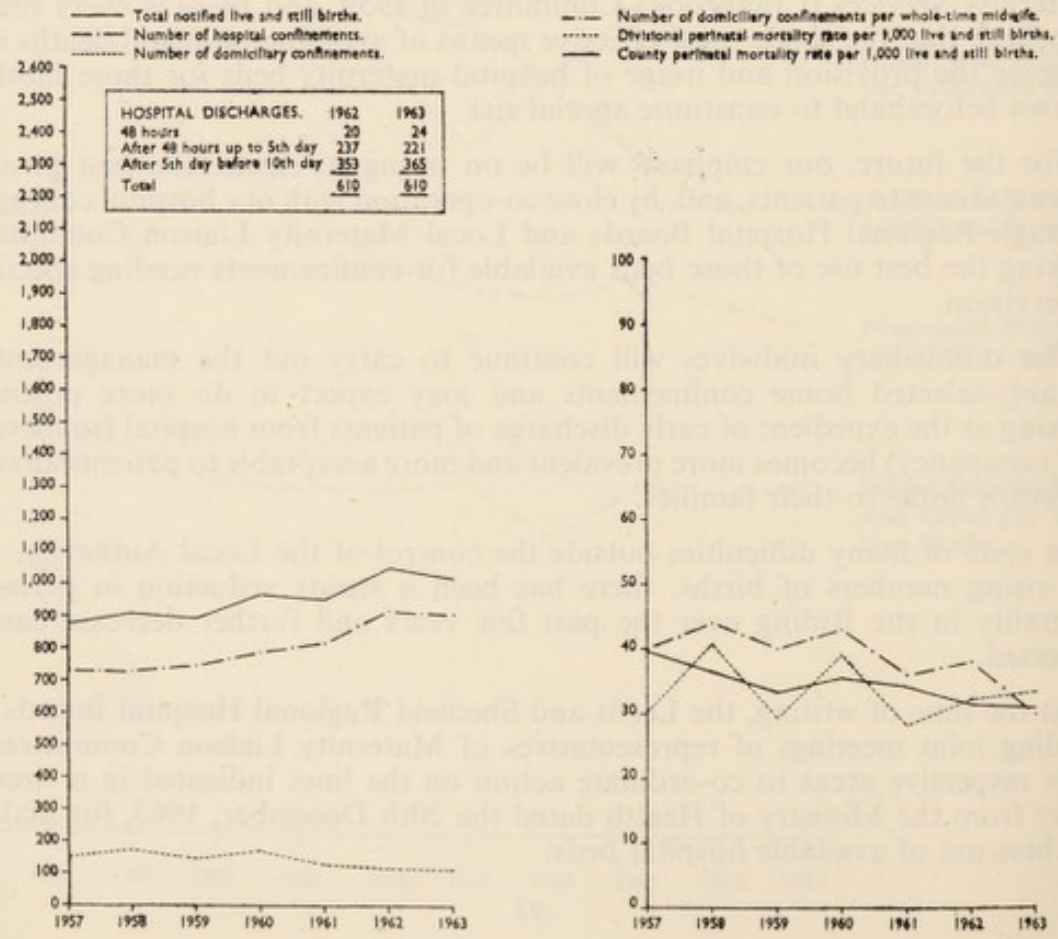
In spite of many difficulties outside the control of the Local Authority, and the rising numbers of births, there has been a steady reduction in perinatal mortality in the Riding over the past few years and further decrease can be expected.

At the time of writing, the Leeds and Sheffield Regional Hospital Boards are holding joint meetings of representatives of Maternity Liaison Committees in their respective areas to co-ordinate action on the lines indicated in a circular letter from the Ministry of Health dated the 20th December, 1963, for making the best use of available hospital beds.

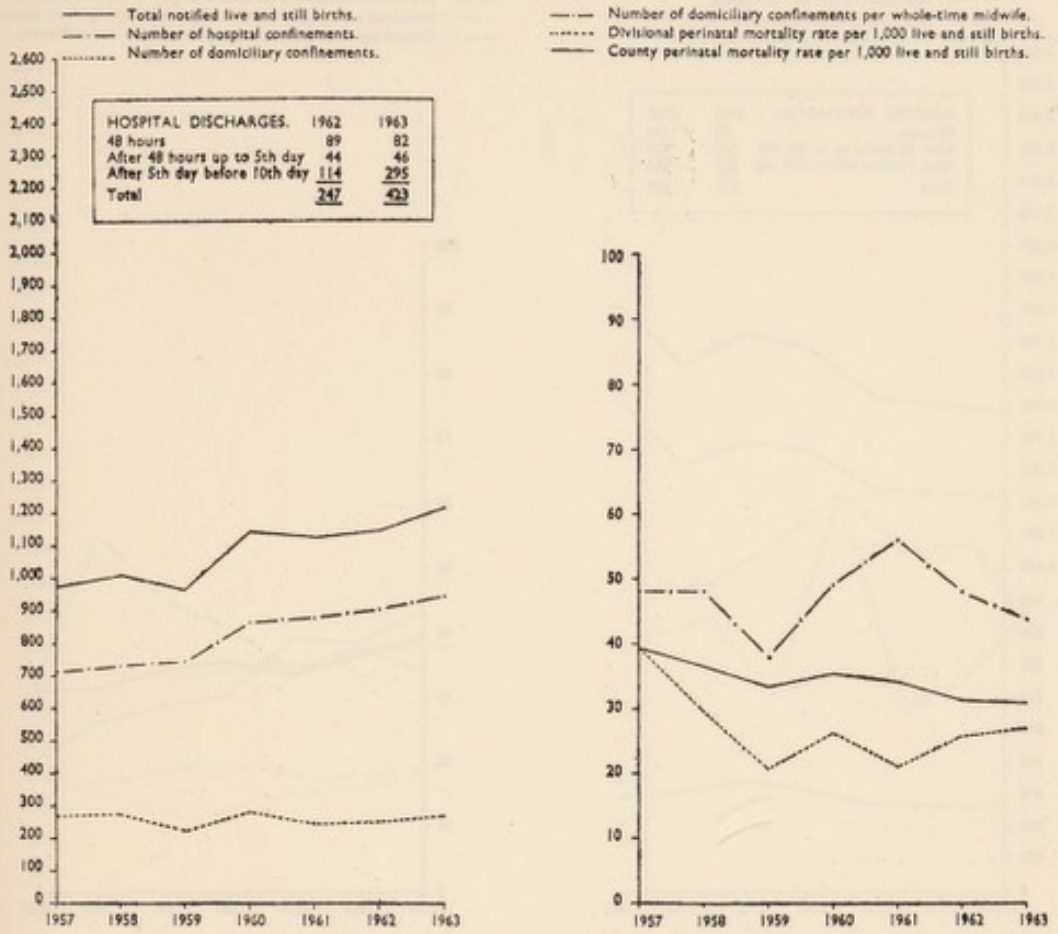
SKIPTON (No. 1) DIVISION



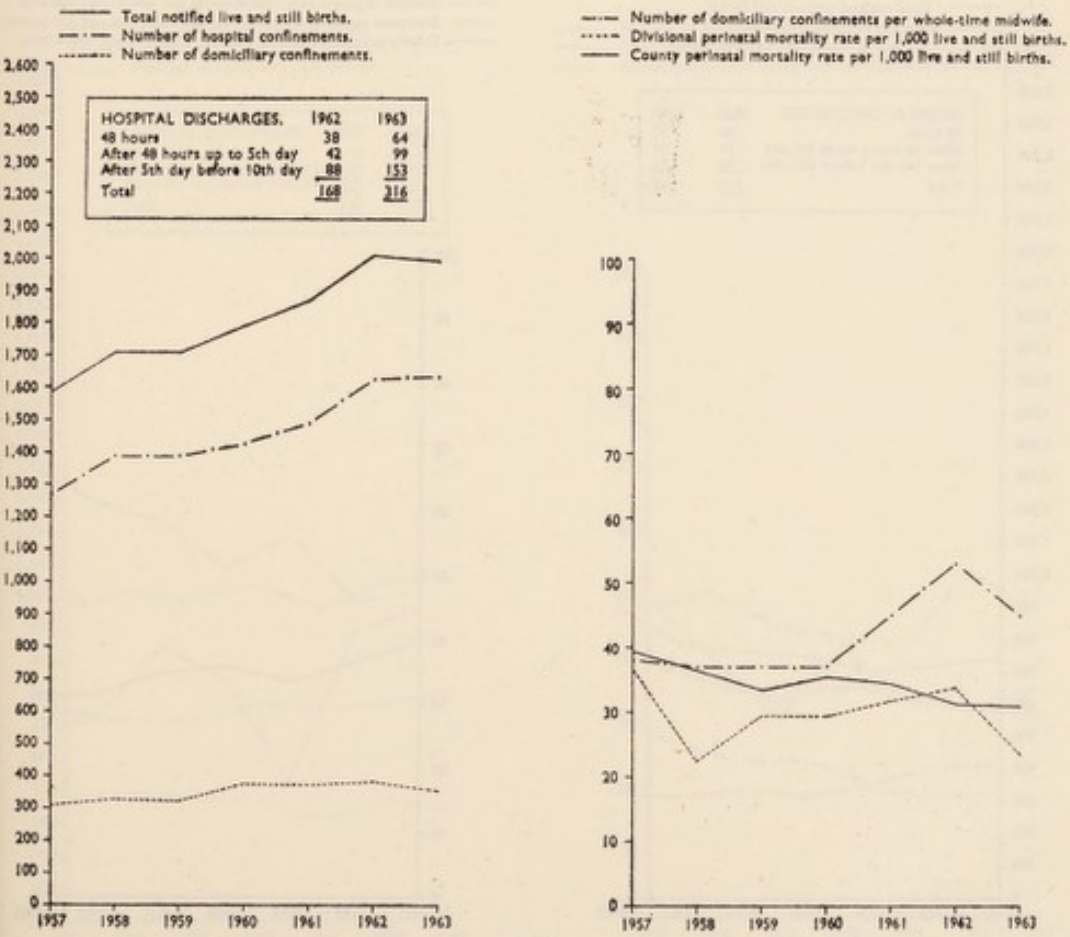
KEIGHLEY (No. 3) DIVISION



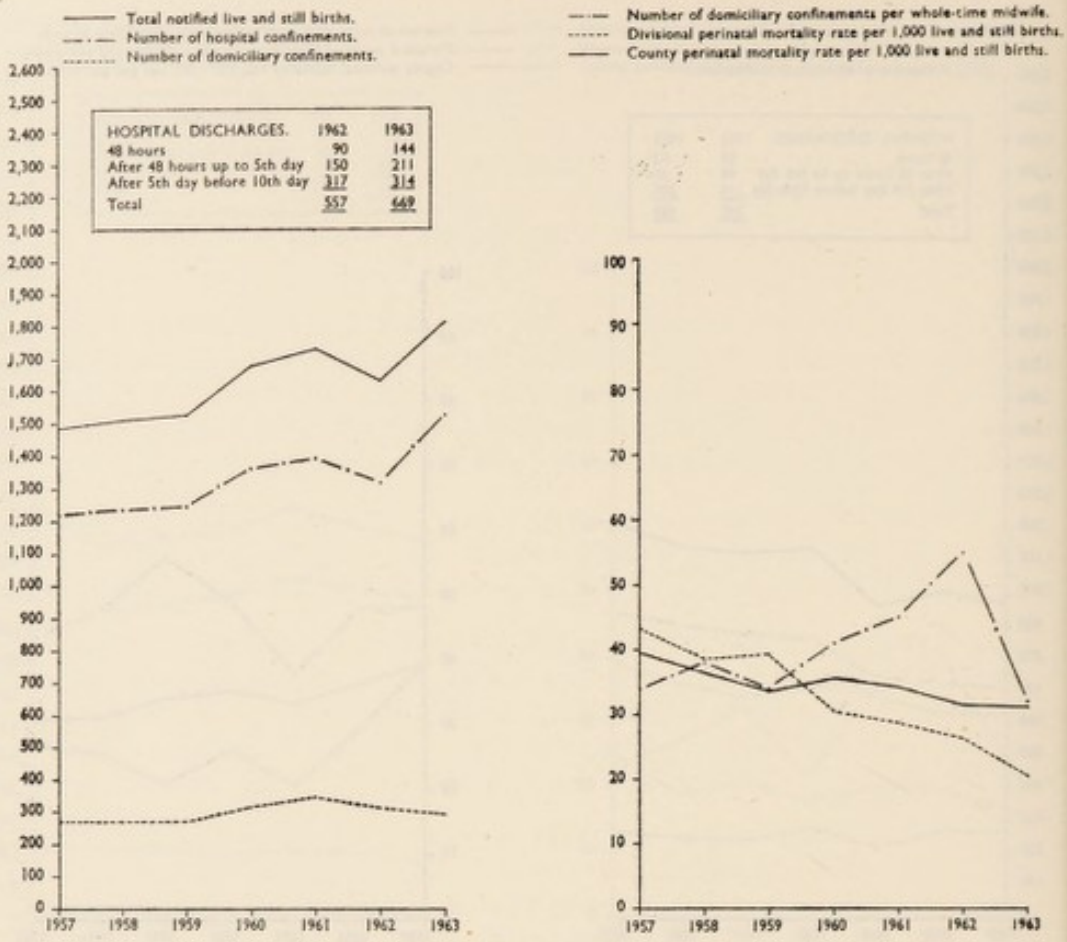
SHIPLEY (No. 4) DIVISION



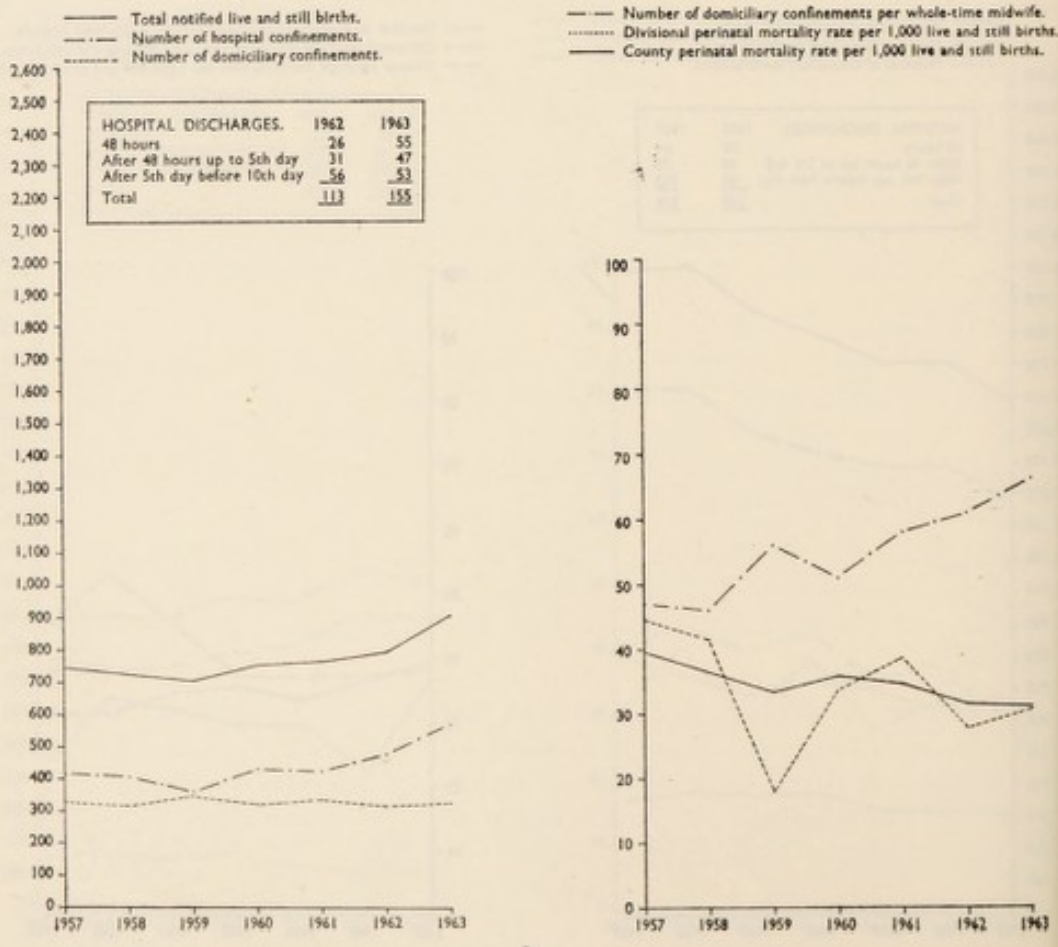
HORSFORTH (No. 5) DIVISION



HARROGATE (No. 7) DIVISION



WETHERBY (No. 9) DIVISION



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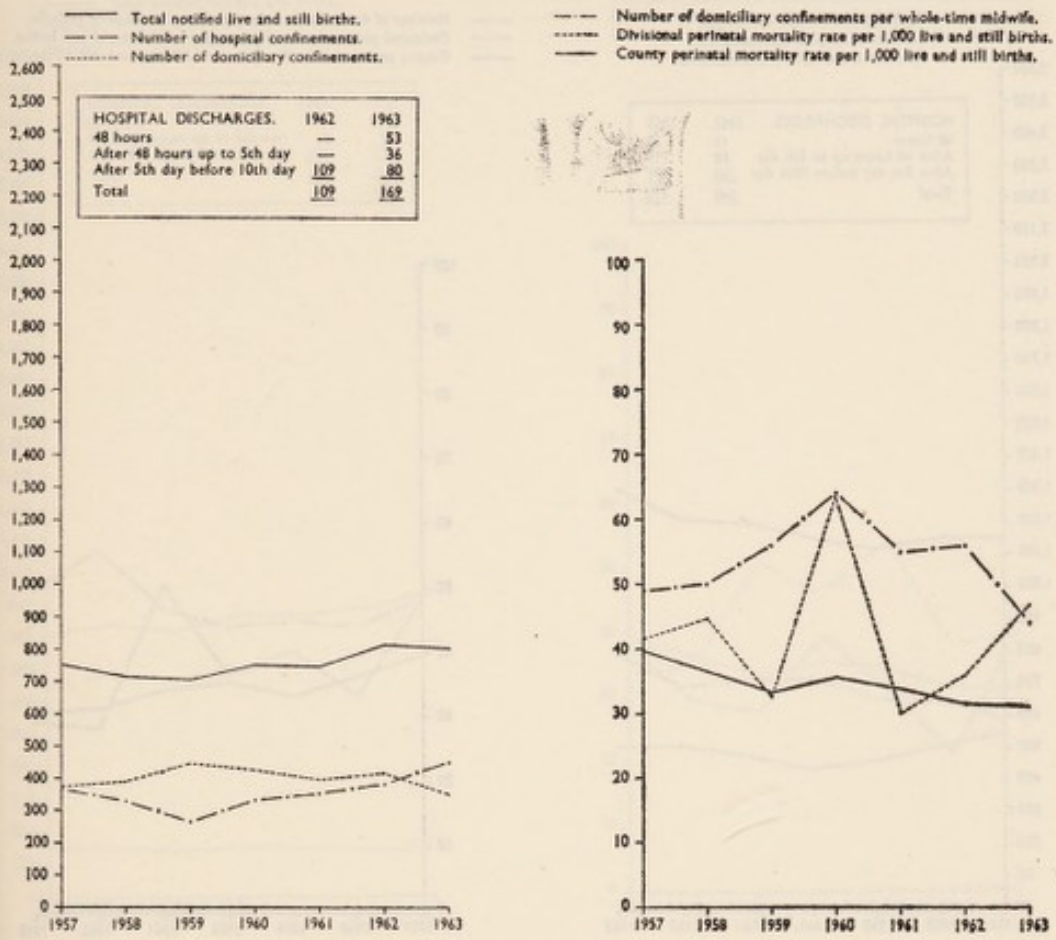
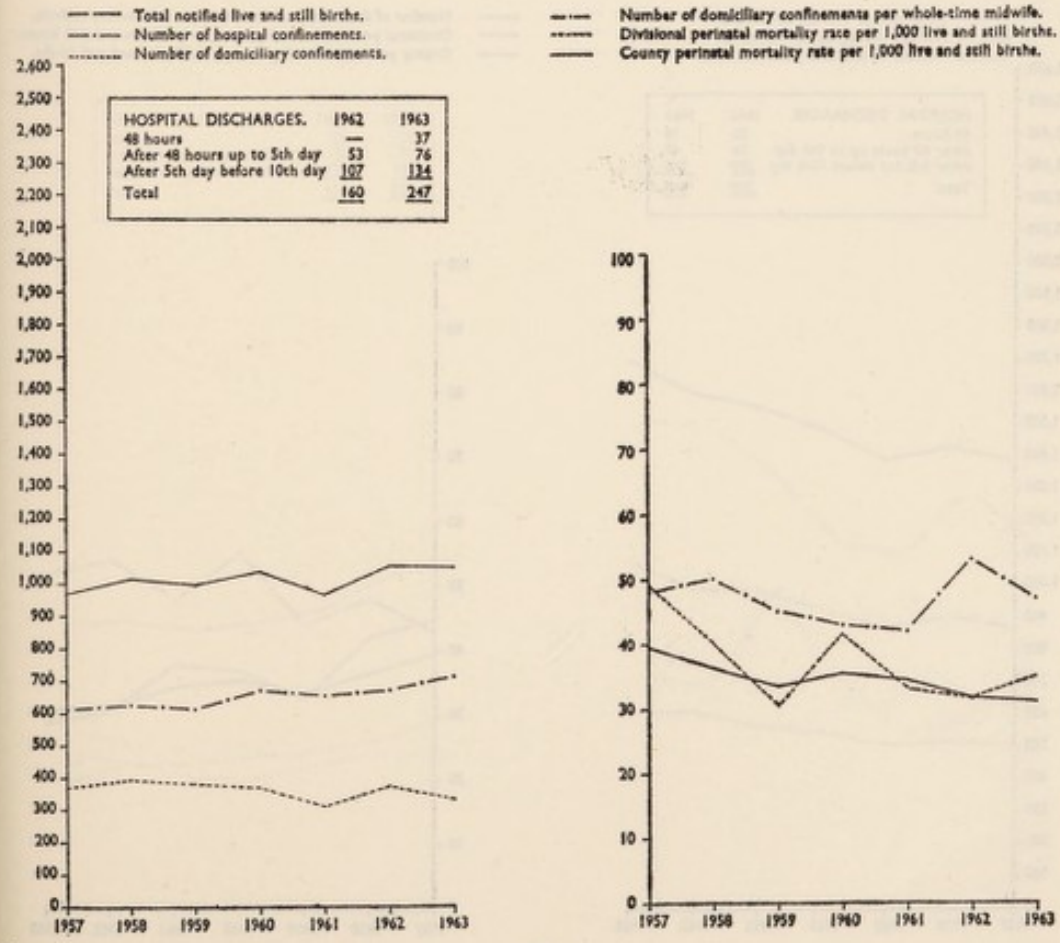
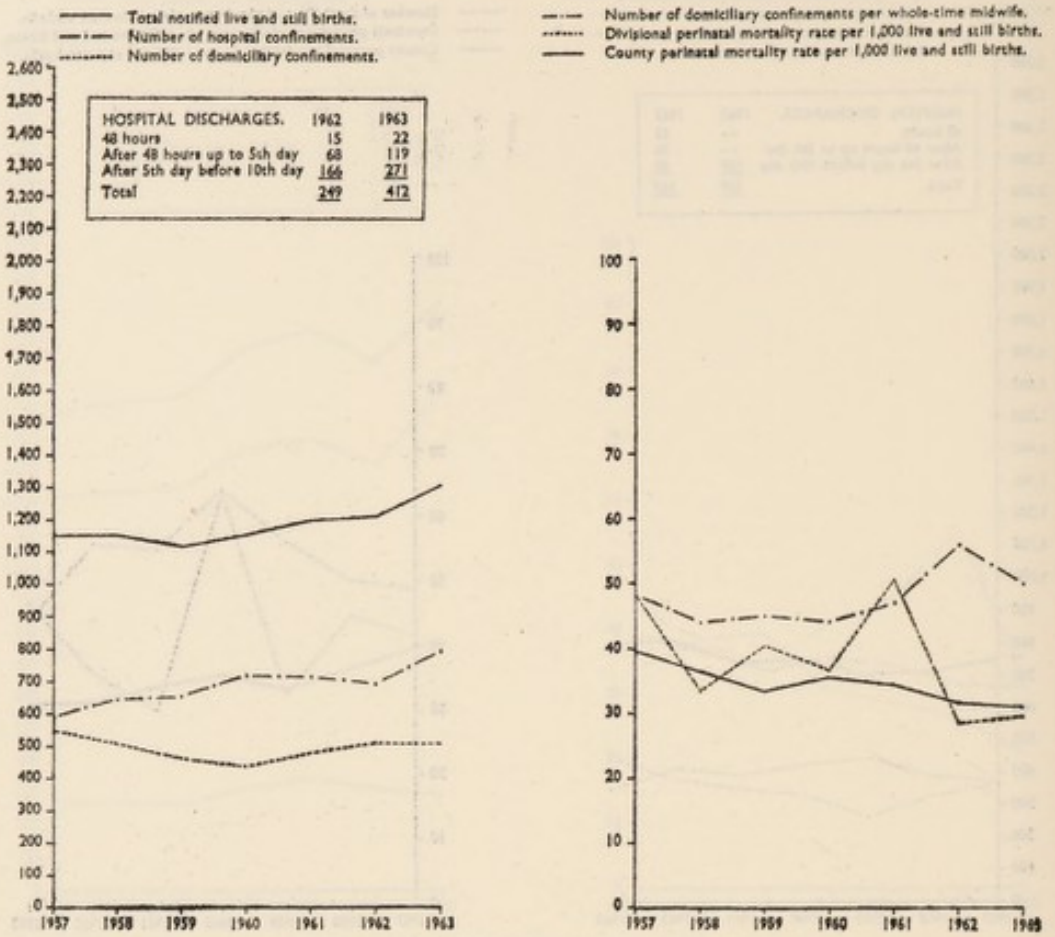


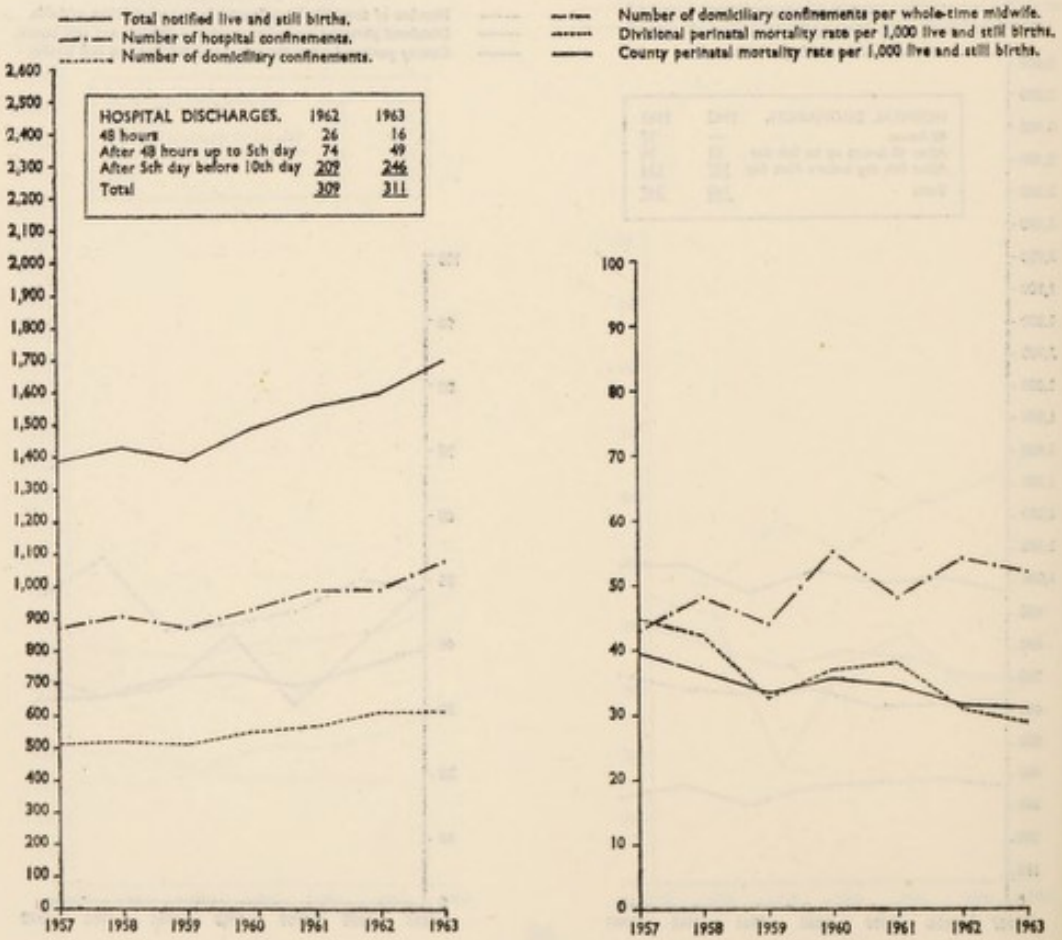
CASTLEFORD (No. 11) DIVISION



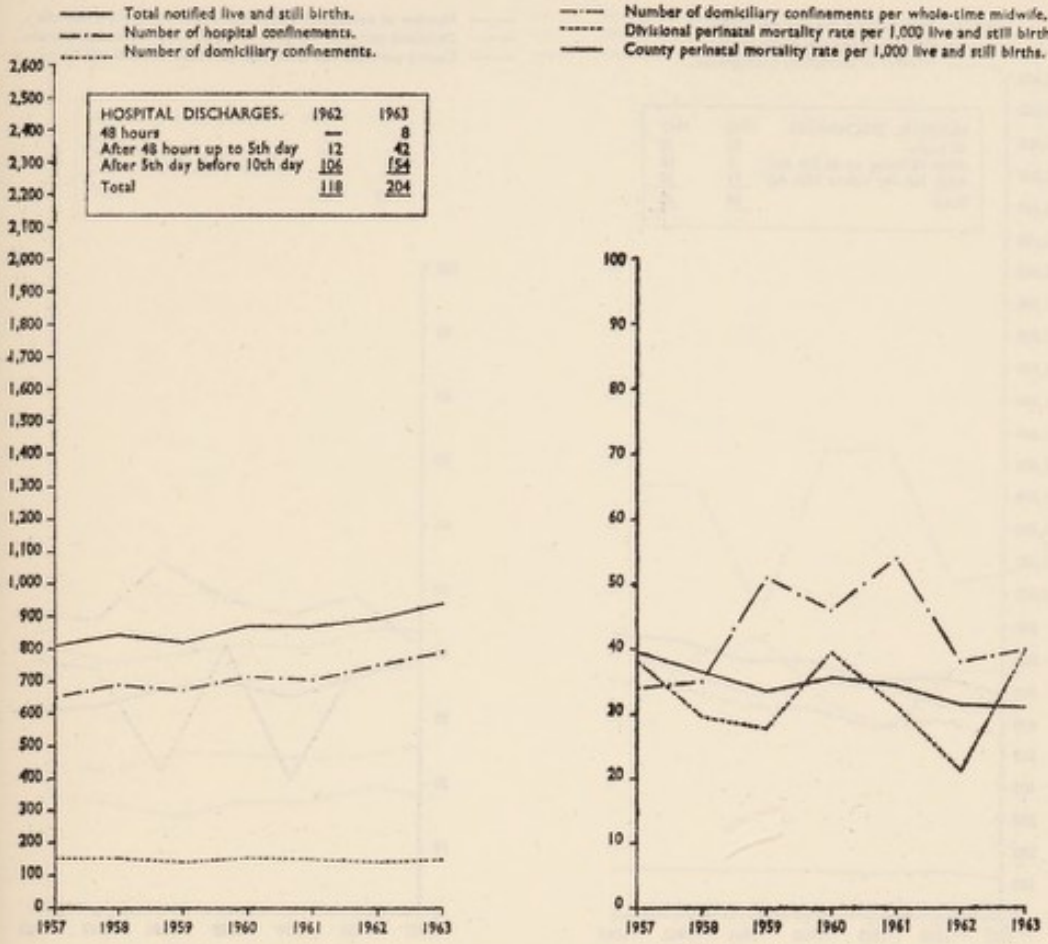
PONTEFRACT (No. 12) DIVISION



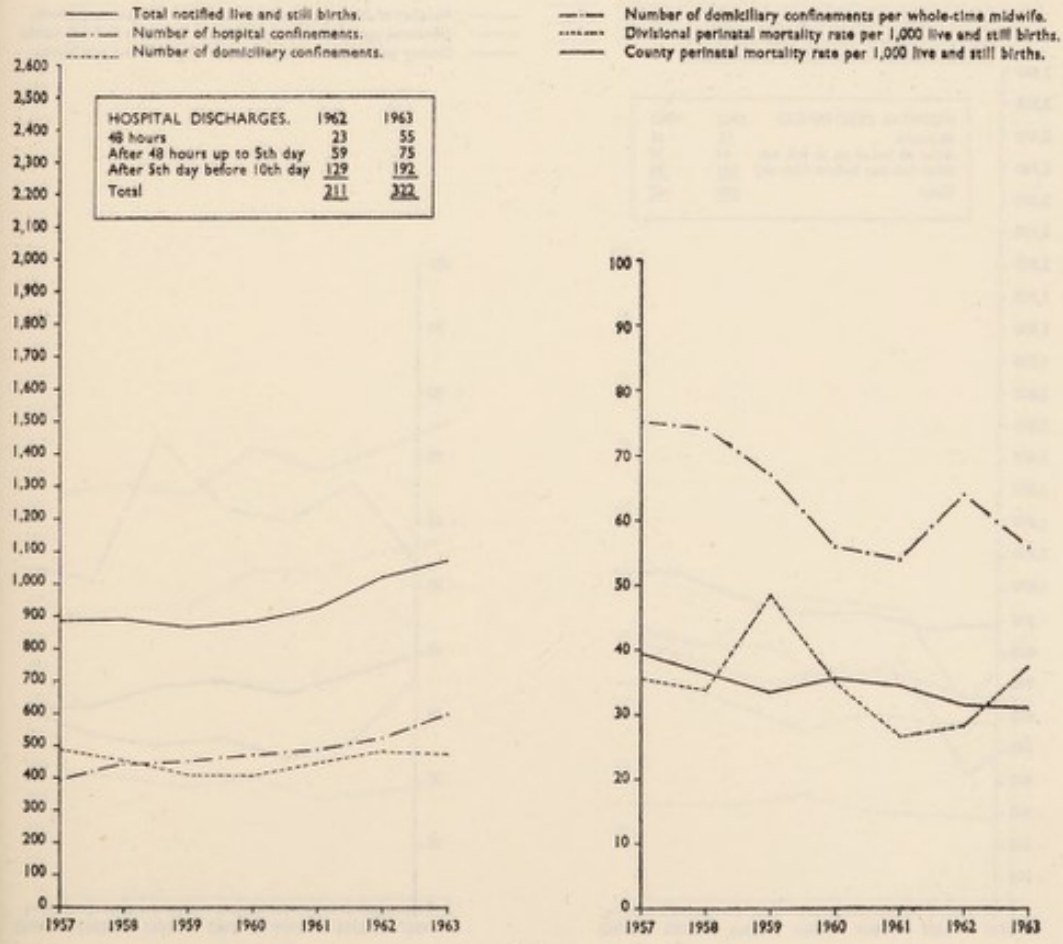
MORLEY (No. 13) DIVISION



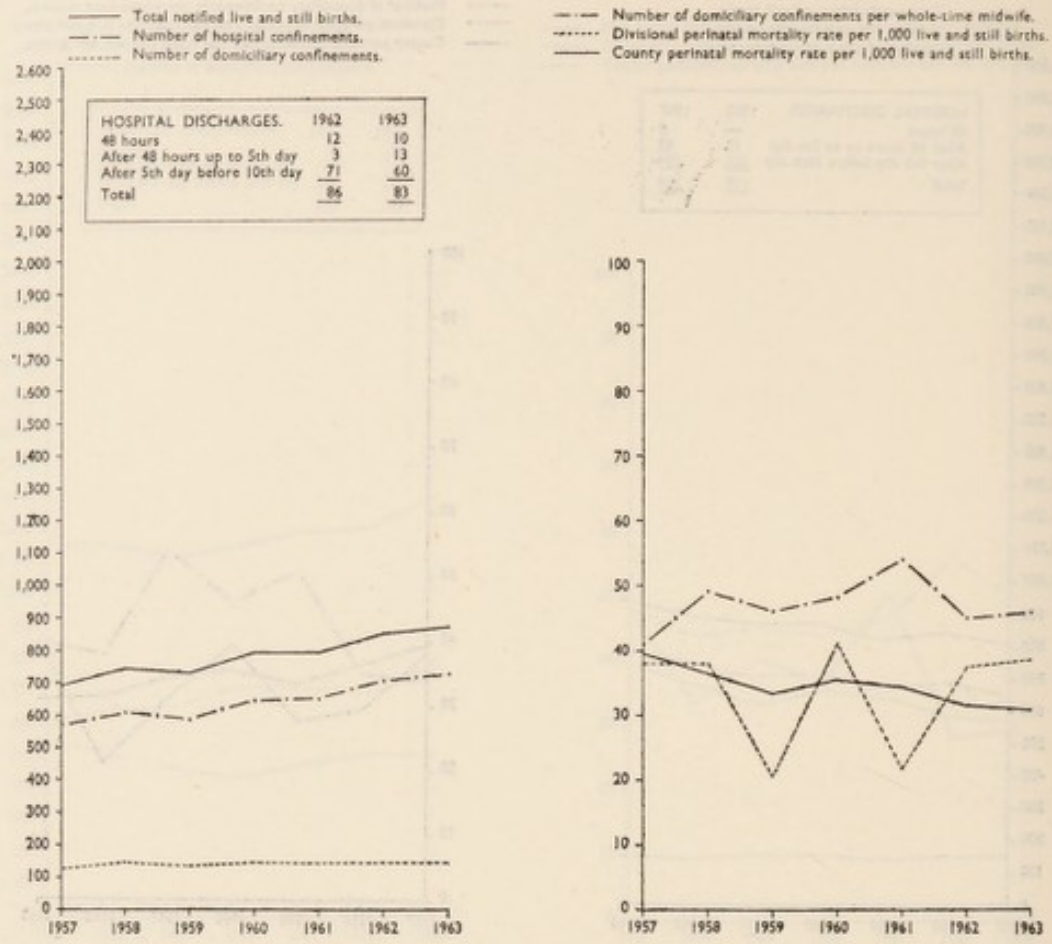
BATLEY (No. 15) DIVISION



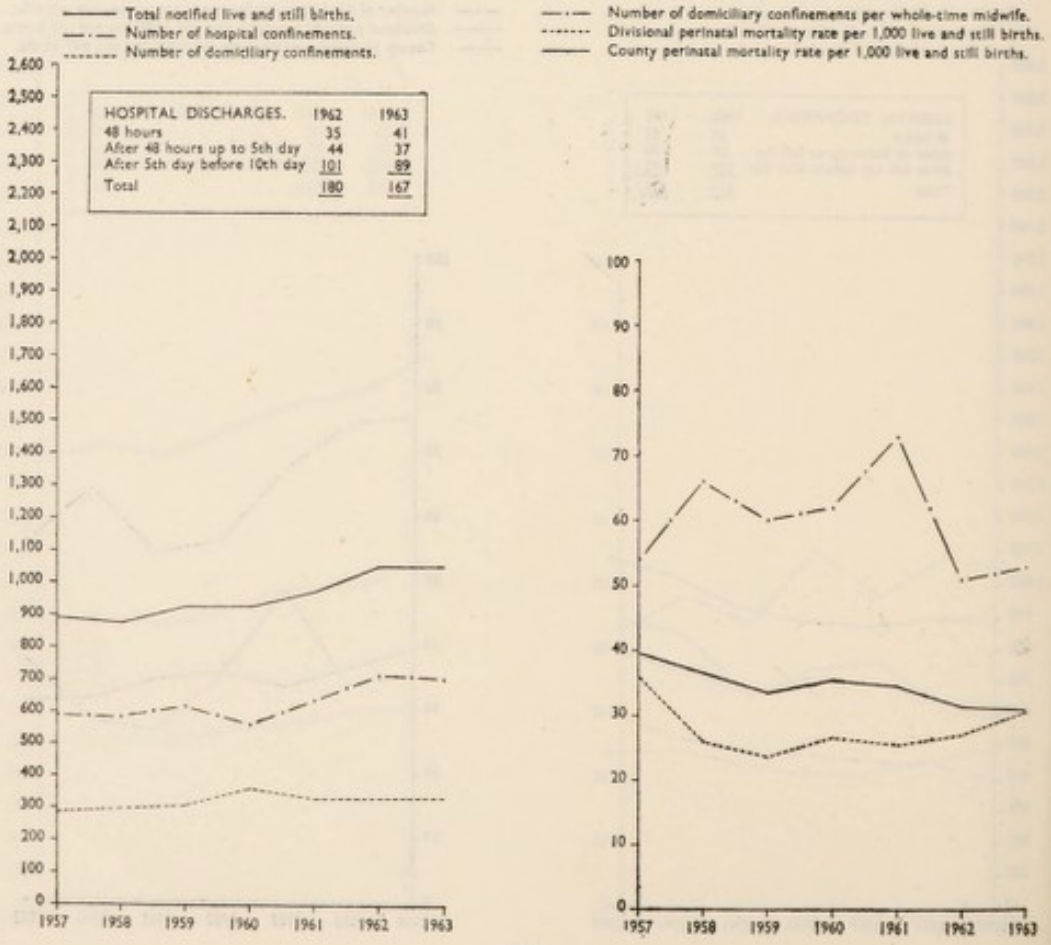
ROTHWELL (No. 16) DIVISION



SPENBOROUGH (No. 17) DIVISION



BRIGHOUSE (No. 18) DIVISION



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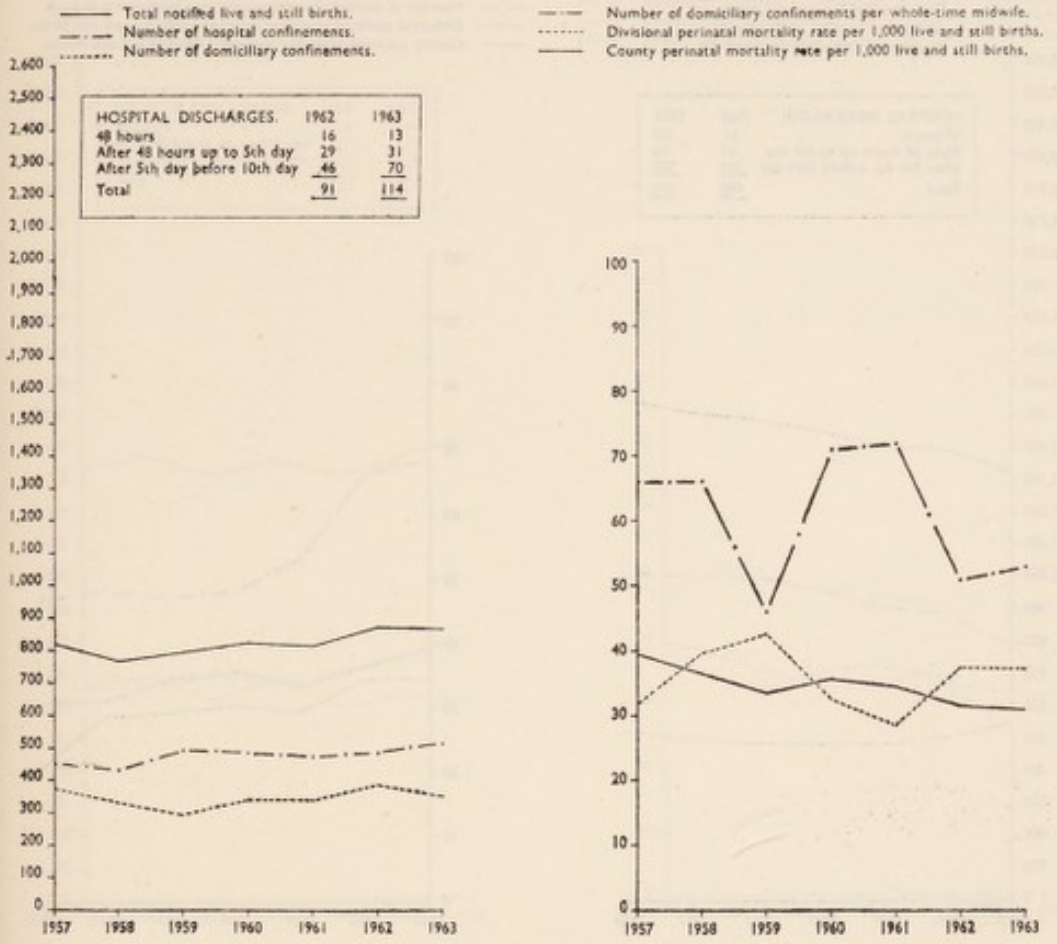
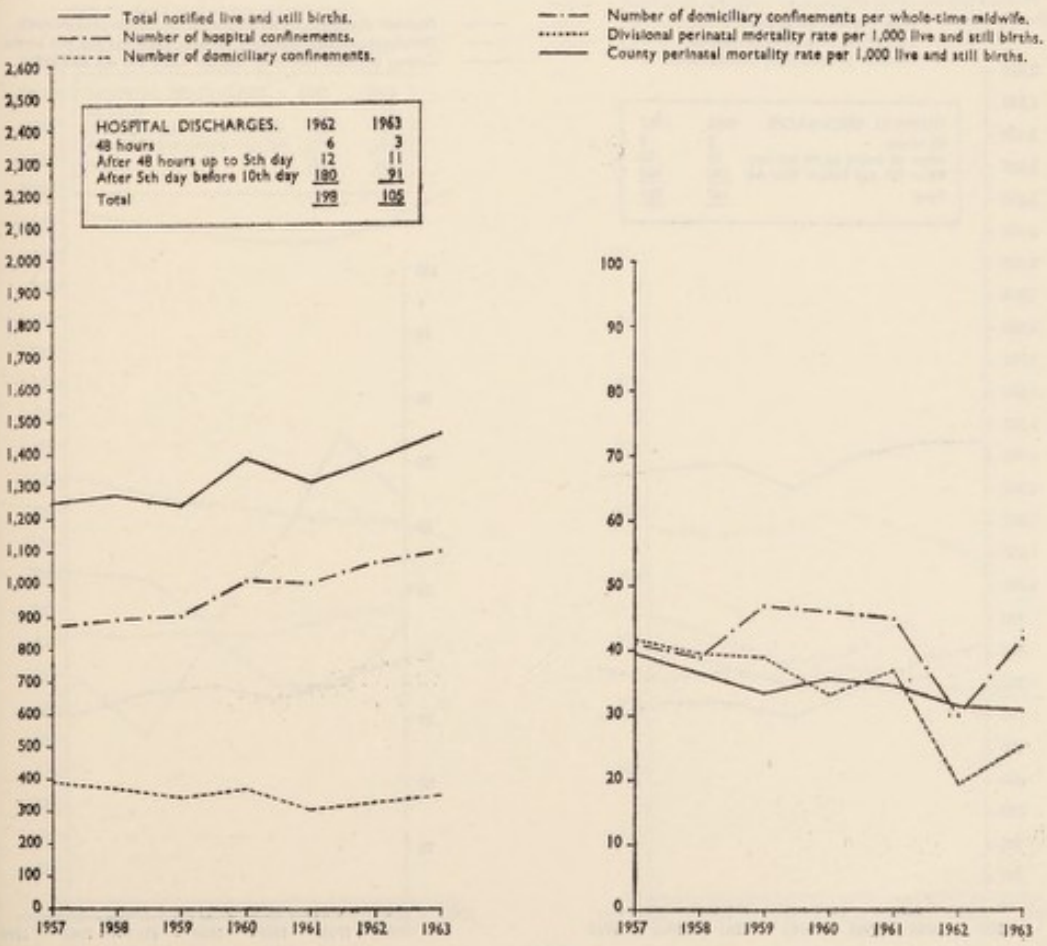


COLNE VALLEY (No. 20) DIVISION



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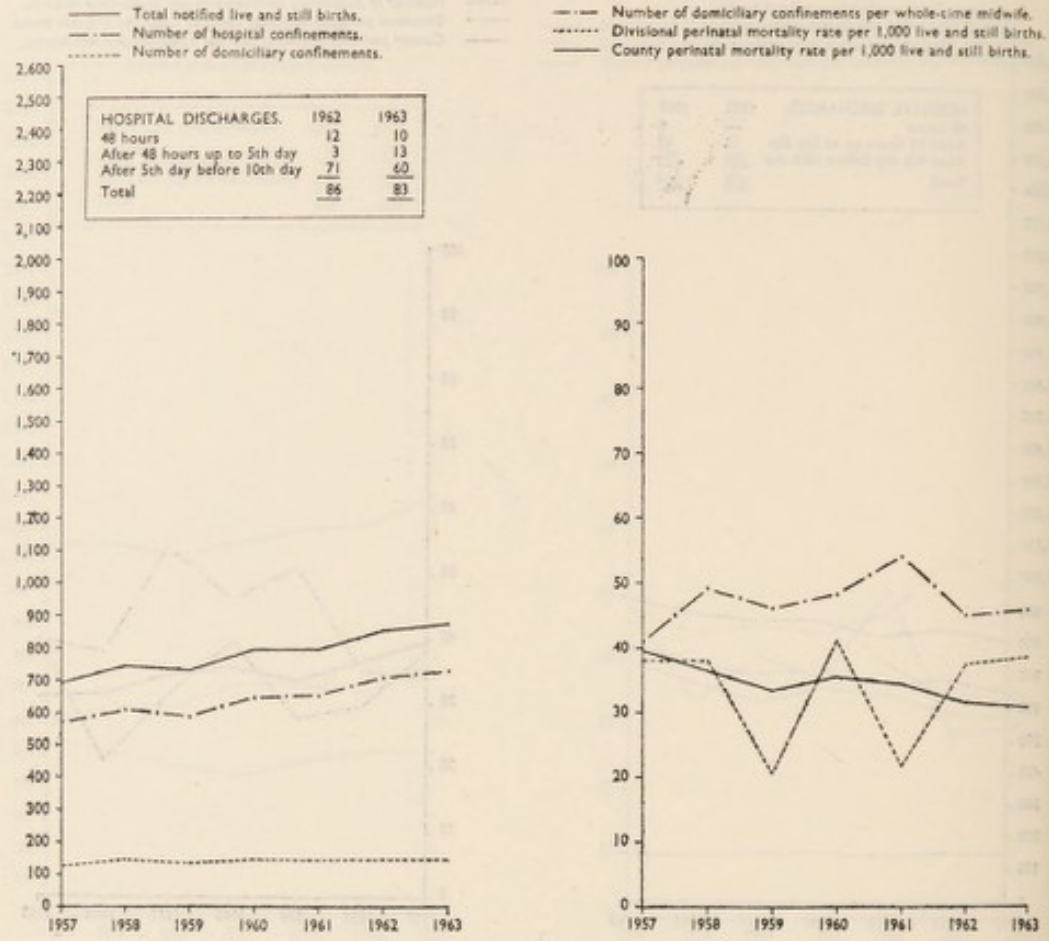

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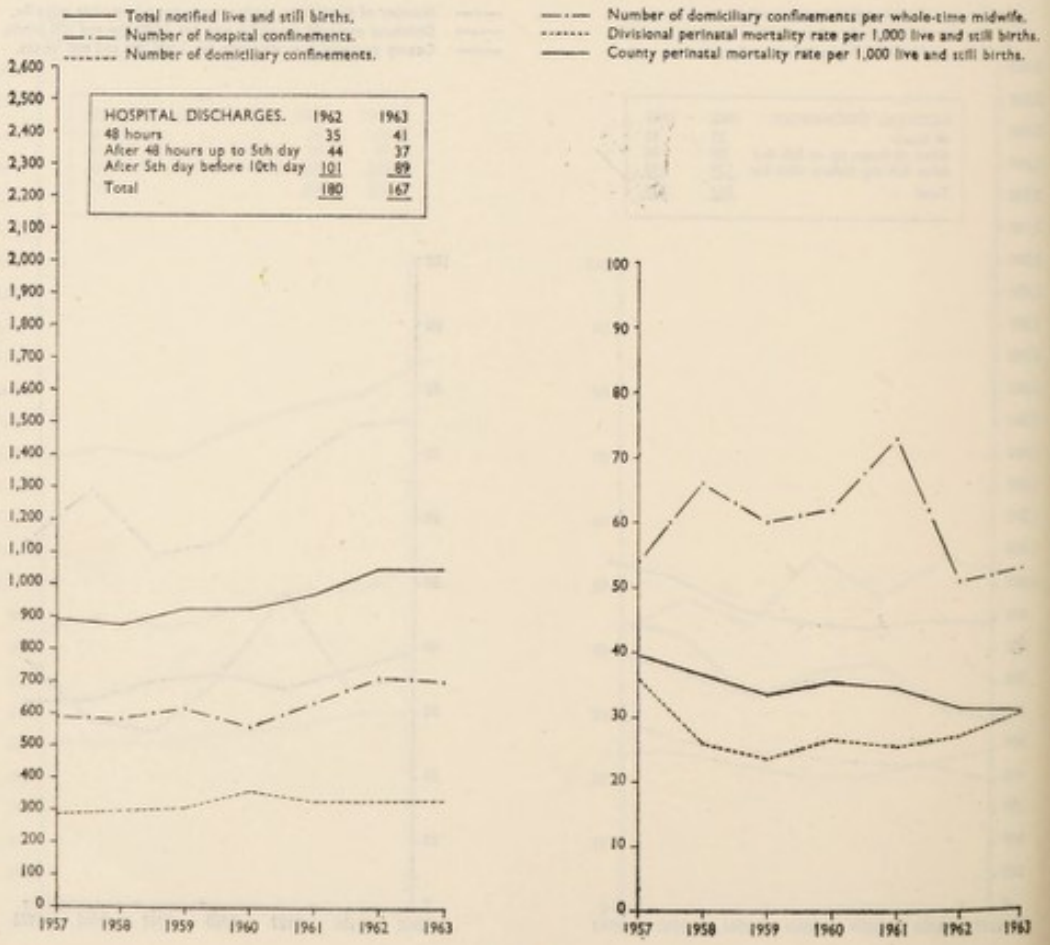
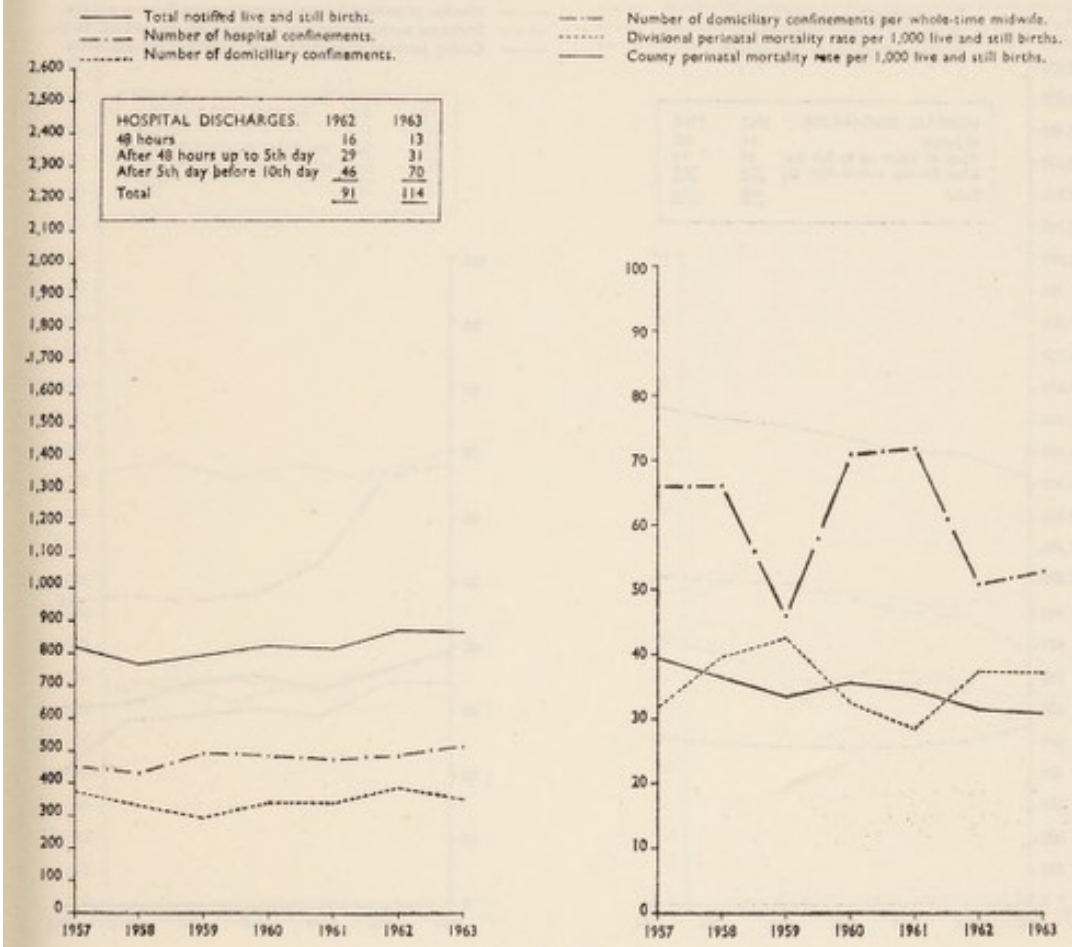


TODMORDEN (No. 19) DIVISION



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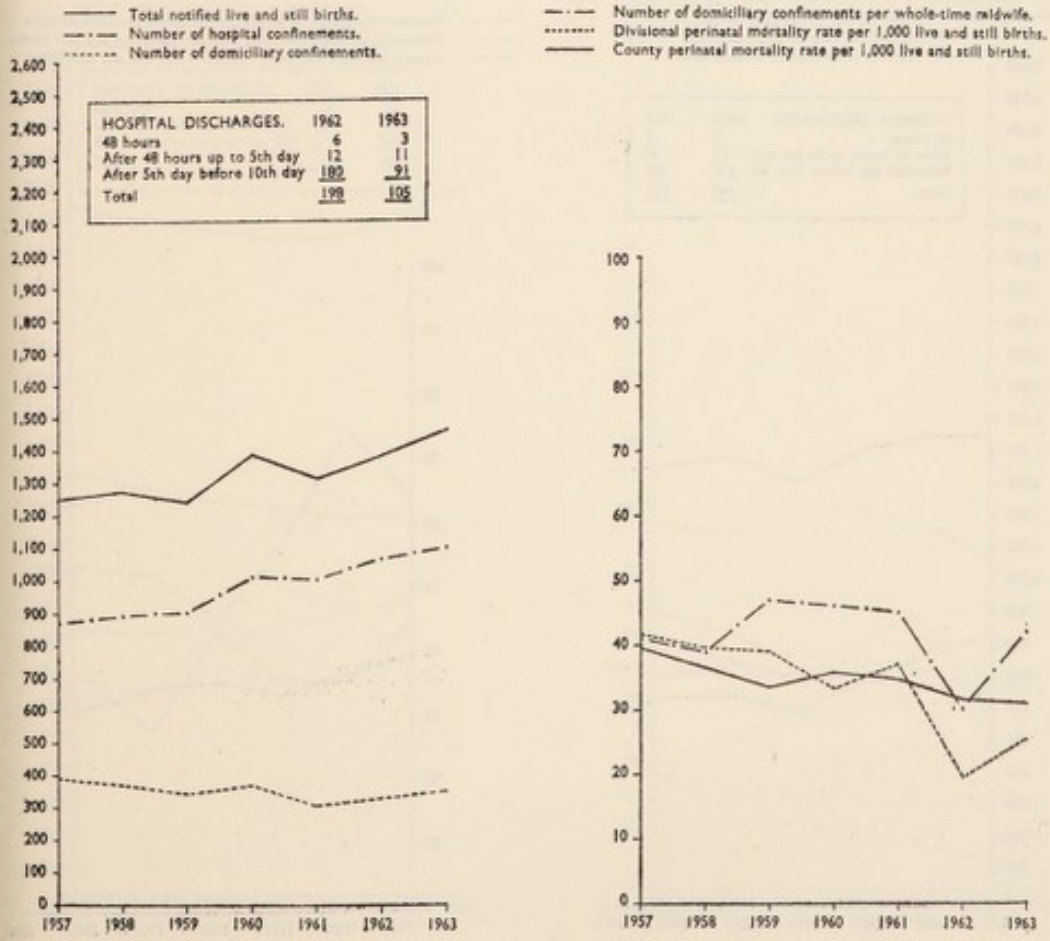

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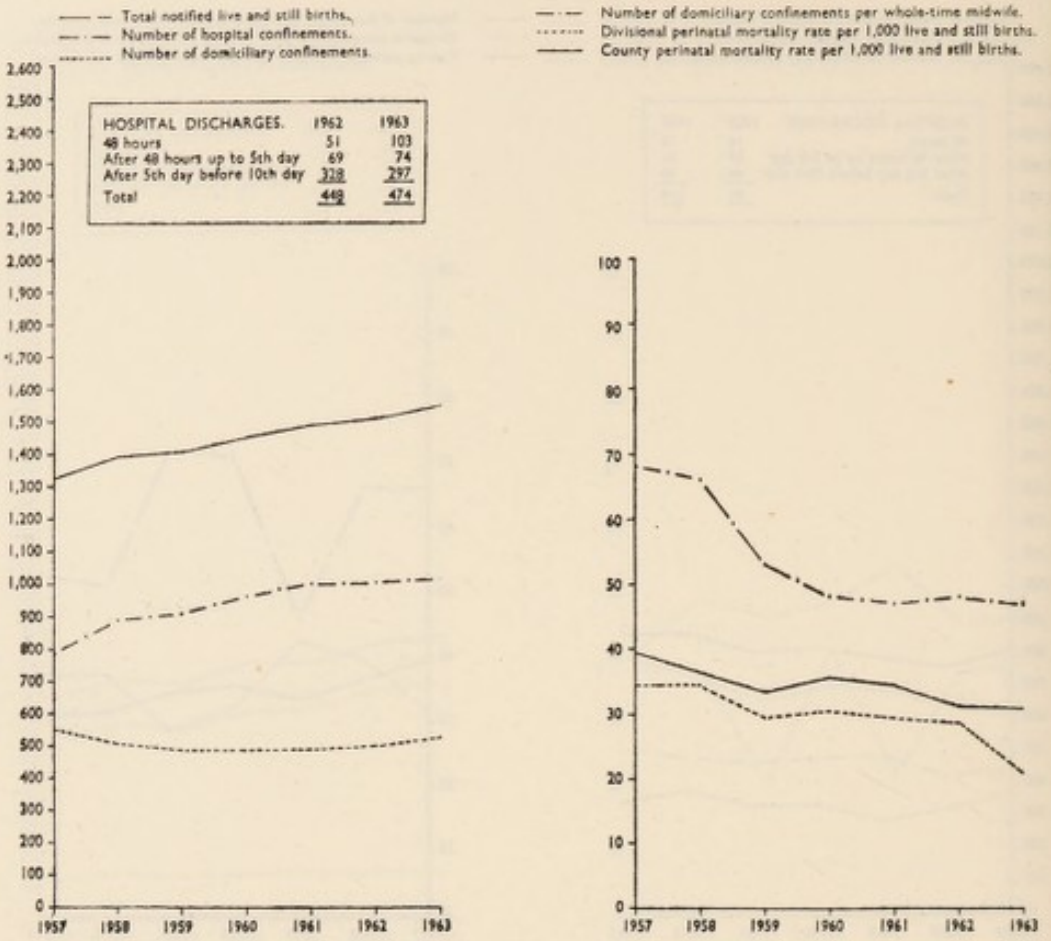

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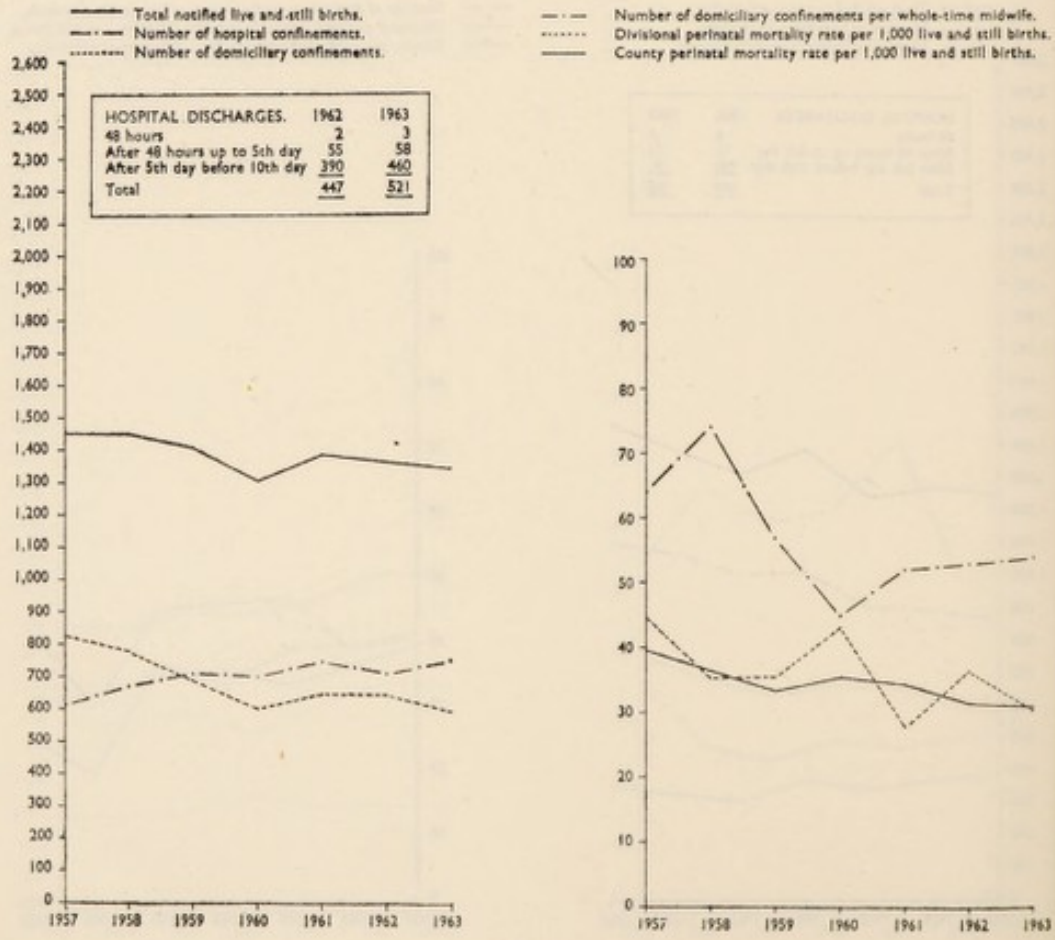

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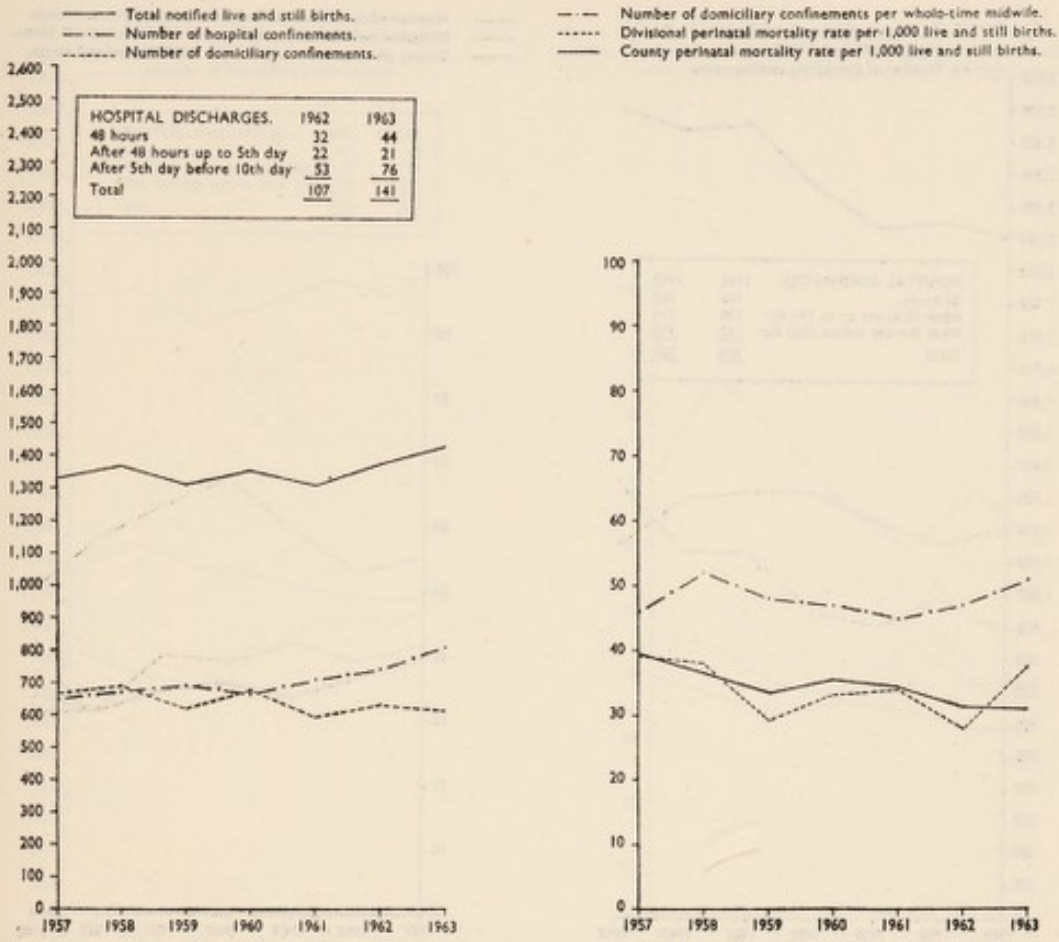
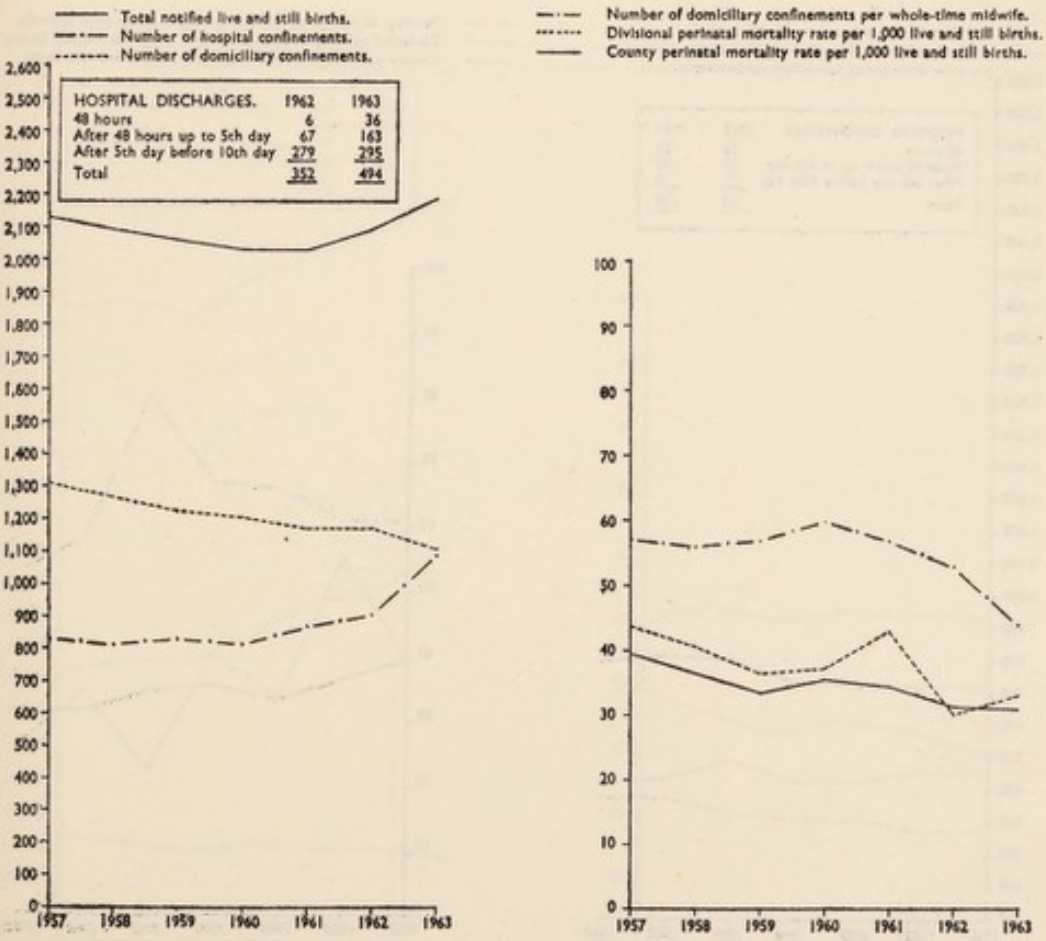


WATH UPON DEARNE (No. 26) DIVISION



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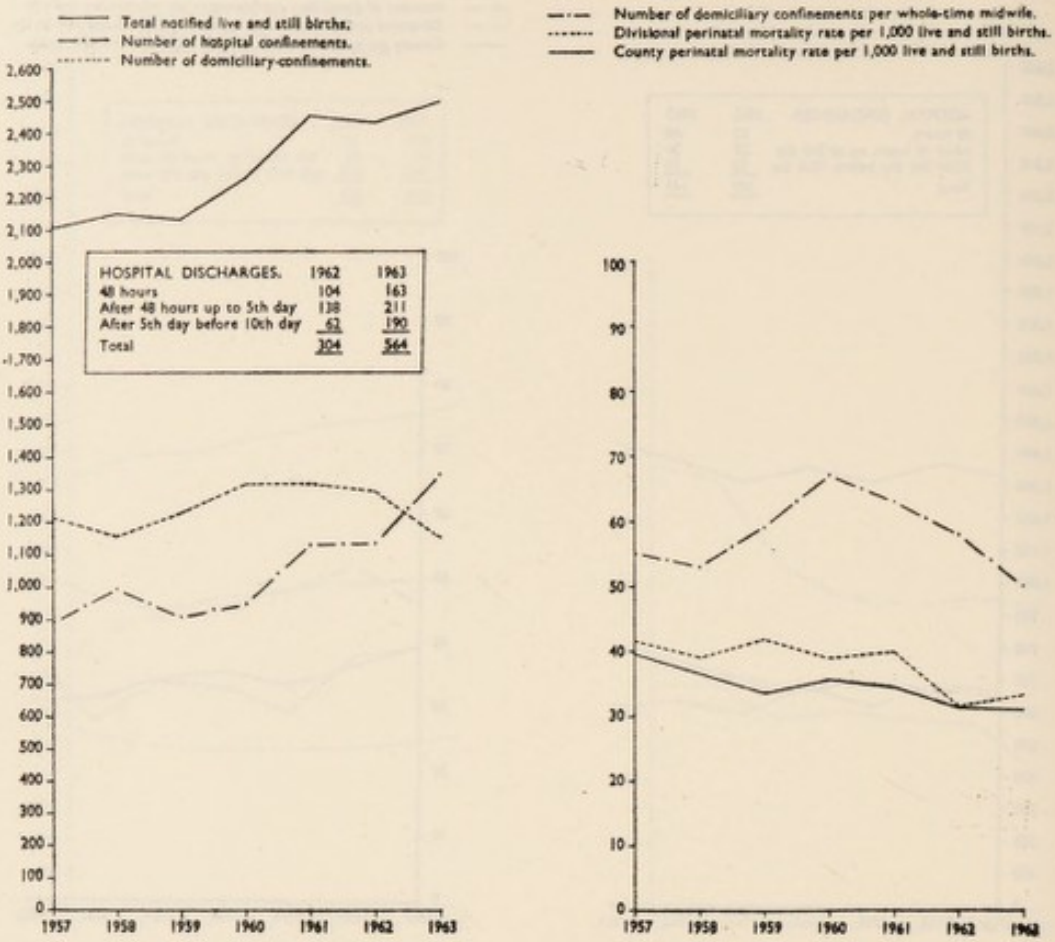

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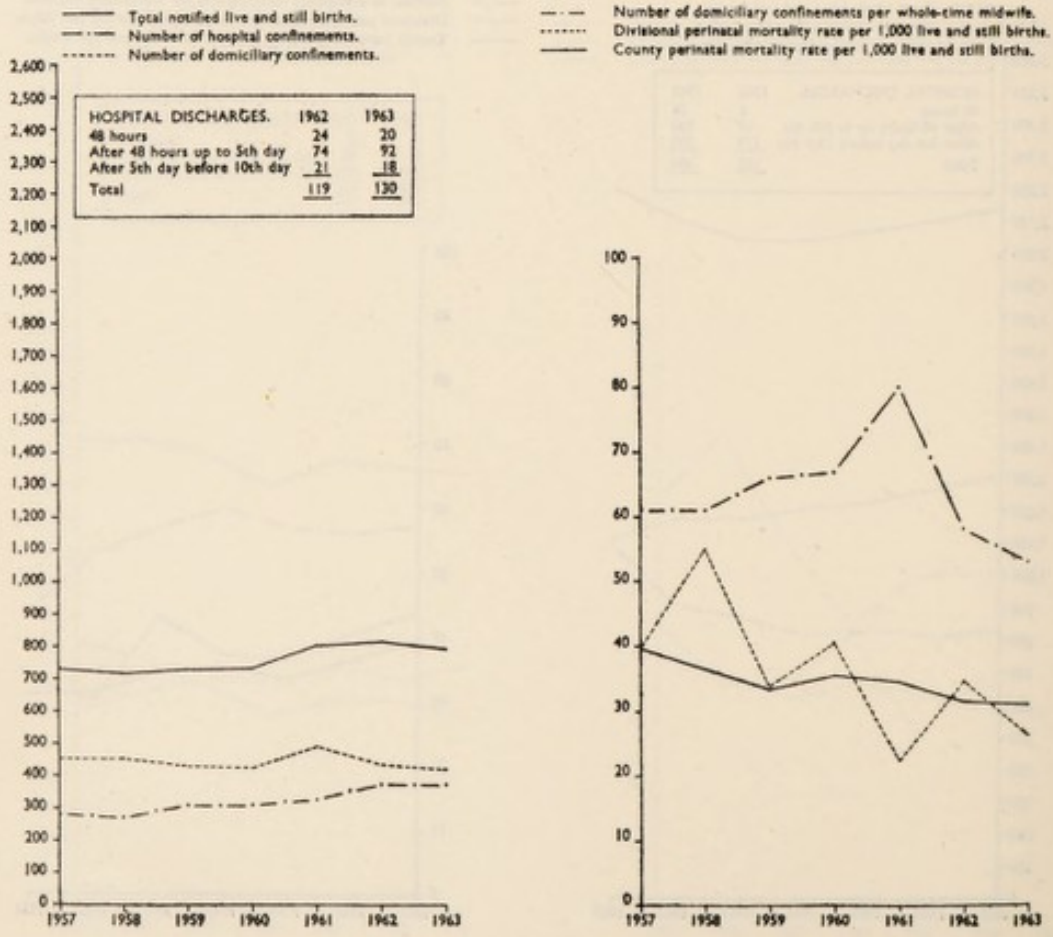
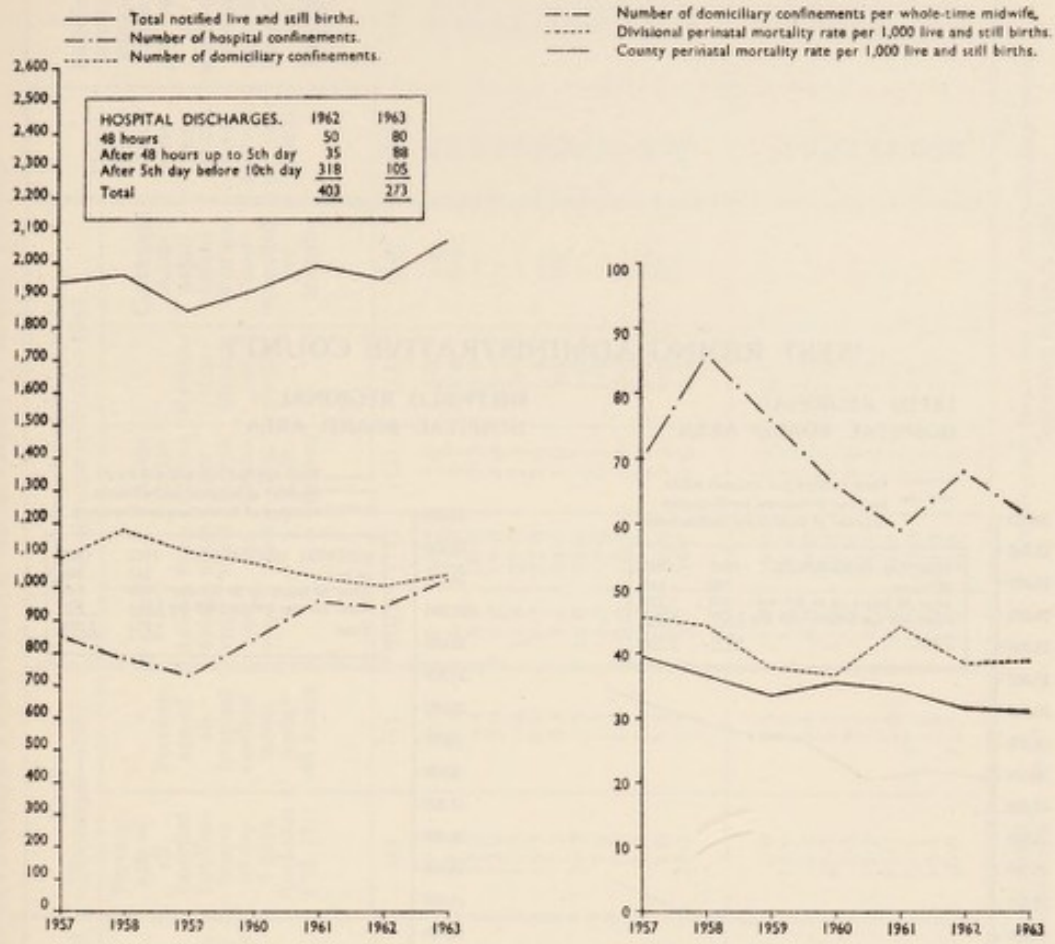
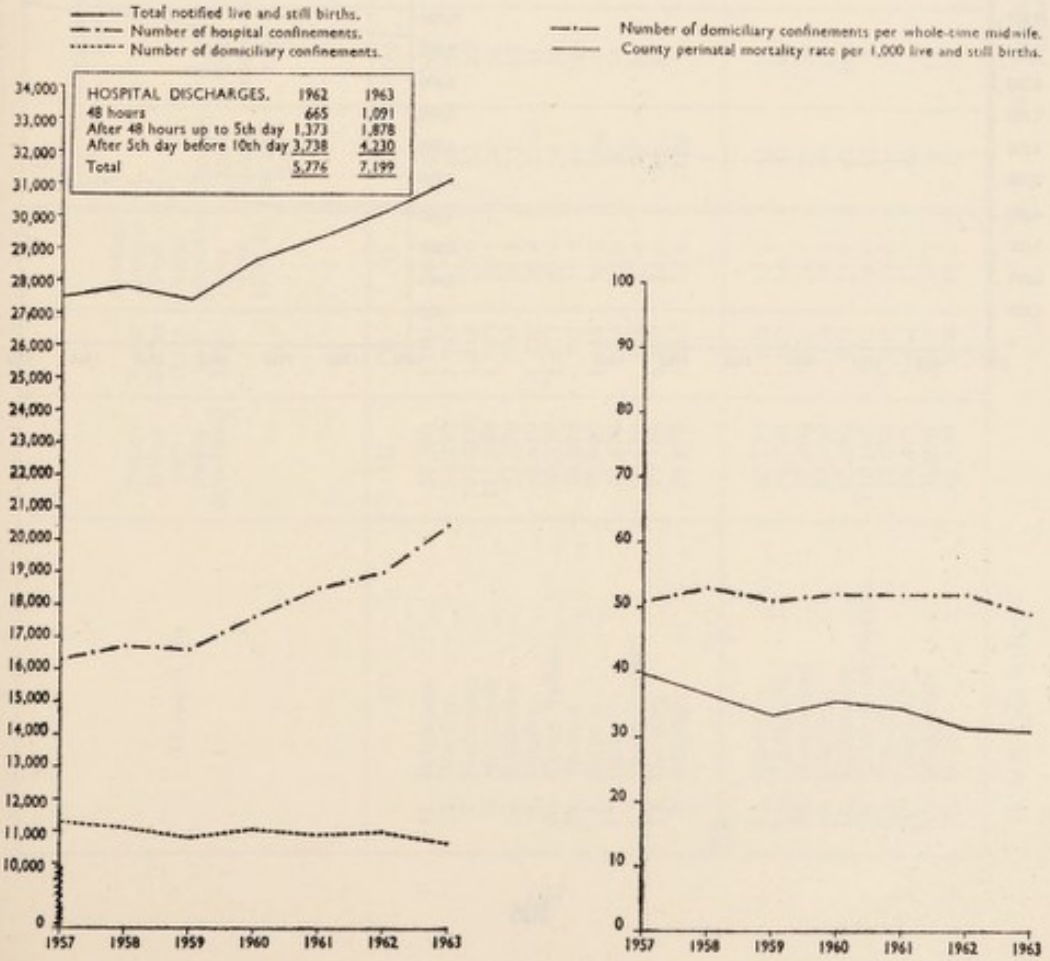


ROTHERHAM (No. 31) DIVISION

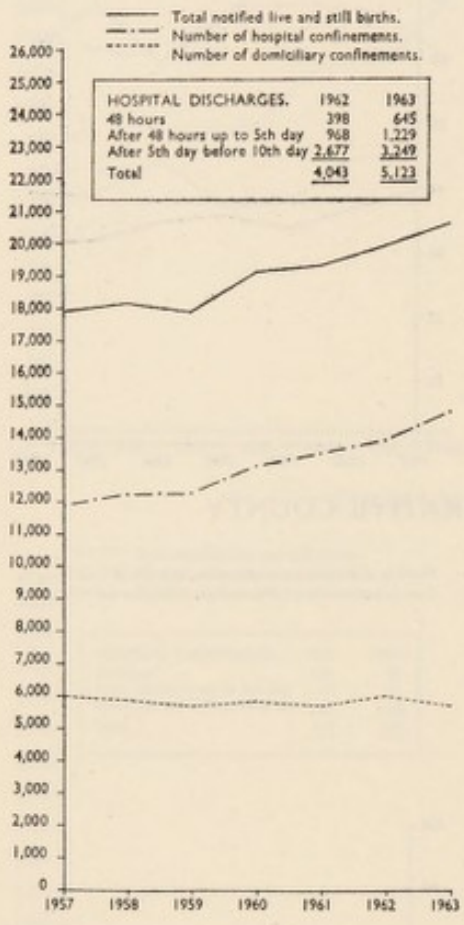


WEST RIDING ADMINISTRATIVE COUNTY



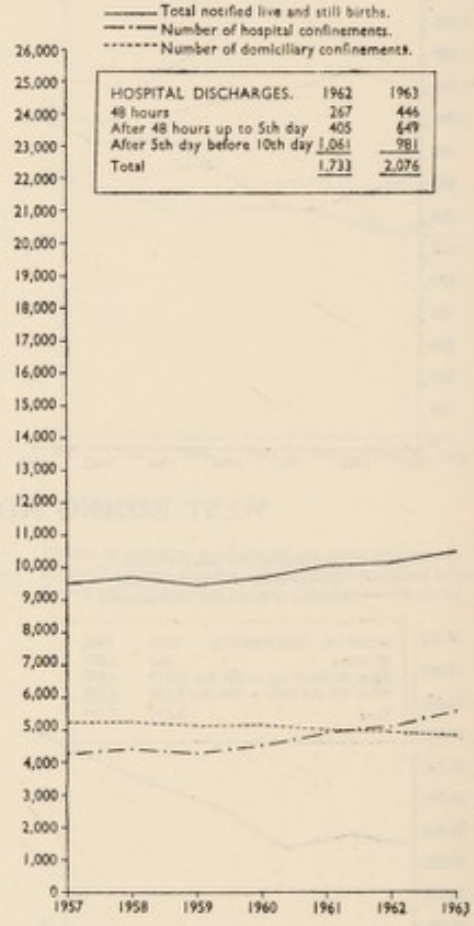
WEST RIDING ADMINISTRATIVE COUNTY

LEEDS REGIONAL HOSPITAL BOARD AREA



HOSPITAL DISCHARGES.	1962	1963
48 hours	398	645
After 48 hours up to 5th day	968	1,229
After 5th day before 10th day	2,677	3,249
Total	4,043	5,123

SHEFFIELD REGIONAL HOSPITAL BOARD AREA



HOSPITAL DISCHARGES.	1962	1963
48 hours	267	446
After 48 hours up to 5th day	405	649
After 5th day before 10th day	1,061	981
Total	1,733	2,076

DIVISIONS PLACED IN ORDER ACCORDING TO AVERAGE PERINATAL MORTALITY RATE 1959-63

Division No.	Population (estimated mid-1963)	Total Births (Live and Still)	Average Annual Perinatal Mortality rate 1959-63	Total Confinements—1963			Early Discharges—1963		Work done by each equivalent whole-time midwife—1963					Domiciliary deliveries per whole time midwife per year (1963)	* Estimated average working hours per week per whole-time midwife excluding deliveries and travelling (1963)
				Consultant Unit percentage	G.P. Unit percentage	Domiciliary percentage	Percentage of all hospital confinements under 5 days (includes Col. (9))	Percentage of all hospital confinements under 48 hours	Antenatal visits per week	Postnatal visits per week	Antenatal clinics per month (including G.P. clinics)	Relaxation clinics per month	Combined Antenatal/ Infant Welfare Clinics attended per month		
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)
18. Brighouse	59,390	1,041	26·8	67	Nil	33	11·1	5·8	8·3	19·2	3·0	2·0	1·0	53	16·9
22. Wortley...	92,220	1,545	27·8	45	20	35	17·4	10·1	10·0	23·0	2·7	1·4	0·4	47	18·7
7. Harrogate	107,580	1,818	28·6	52	32	16	23·3	9·4	8·8	20·0	0·7	0·9	—	32	14·8
5. Horsforth	117,840	1,997	29·7	28	54	18	10·0	3·9	9·0	19·0	4·0	3·5	—	45	18·7
9. Wetherby	53,520	907	29·9	53	10	37	17·7	9·6	13·8	27·0	2·3	0·6	—	66	21·2
4. Shipley	68,410	1,222	30·4	37	41	22	13·5	8·6	9·7	23·0	2·0	1·4	—	44	18·1
20. Colne Valley	90,930	1,473	30·4	54	21	25	1·3	0·3	9·4	14·1	1·0	3·4	0·1	42	14·2
29. Thorne	36,090	797	31·3	47	Nil	53	29·7	5·3	14·0	24·0	2·5	1·0	—	53	20·2
1. Skipton...	79,920	1,165	31·4	85ø	?	15	7·4	1·5	5·0	9·0	0·5	1·3	—	17	8·0
15. Batley	48,670	944	32·0	50	35	15	6·3	1·0	6·0	16·8	1·6	0·7	—	40	12·7
17. Spenborough	50,480	878	32·4	39	44	17	3·2	1·4	10·0	17·0	2·5	2·5	1·0	46	16·4
25. Barnsley	77,550	1,423	32·5	46	11	43	8·0	5·4	9·6	18·0	3·2	1·6	0·7	51	16·7
3. Keighley	56,670	1,012	32·6	89ø	?	11	27·1	2·7	5·7	24·6	6·6	2·7	—	30	22·1
XX—															—XX
13. Morley	87,770	1,694	33·3	42	21	37	6·0	1·5	11·0	19·0	2·5	2·5	5·2	52	18·9
11. Castleford	58,790	1,047	34·5	29	39	32	15·9	5·2	8·0	18·0	2·0	1·0	—	47	14·5
23. Hemsworth	67,400	1,355	34·7	26	30	44	8·1	0·4	6·0	23·0	5·0	2·3	—	54	19·6
16. Rothwell	59,930	1,079	34·8	43	13	44	21·7	9·2	11·0	22·0	2·5	1·3	—	56	18·2
19. Todmorden	52,290	863	35·7	60	Nil	40	8·5	2·5	7·0	17·0	3·3	1·8	—	53	15·2
26. Wath upon Dearne ...	110,660	2,192	36·0	45	5	50	18·3	3·3	8·0	16·6	4·0	3·0	—	44	16·5
12. Pontefract	63,670	1,301	37·0	31	30	39	17·7	2·8	9·0	21·0	3·0	1·0	—	50	17·2
27. Doncaster	114,410	2,494	37·1	48	6	46	27·9	12·2	10·0	20·0	2·0	1·5	—	50	16·6
31. Rotherham	96,890	2,073	39·2	31	19	50	16·3	7·8	10·4	33·0	2·8	1·8	—	61	24·2
10. Goole	45,140	800	41·8	37	19	44	20·0	11·9	10·0	20·0	5·0	1·0	—	44	18·5

ø G.P. Unit included

XX County Average Annual Perinatal Mortality Rate — 33·2

* The average hours per week are calculated on the following assumed basis:—
One antenatal visit (average time) = 22 mins.
One postnatal visit (average time) = 31 mins.
One antenatal or relaxation session = 3 hours

The Standard Co-operation Card for Maternity Patients:

The Ministry of Health issued these cards during the year. The intention is to increase the availability of clinical information about patients who, in the course of one pregnancy, may receive advice and care from midwife, general practitioner and hospital specialist at different times.

It is intended that the patient should carry this card and produce it for completion whenever examined.

All West Riding midwives have been instructed to complete the card and issue it to patients they see on all occasions. Through Maternity Liaison Committees, discussion has taken place on their simultaneous use by general practitioners and hospital staff. Unfortunately, the majority of the hospitals in the area are either already using their own cards and are consequently reluctant to change over, or they are so busy that their clerical staff are inadequate to deal with the problem.

Use by general practitioners is said to be increasing, particularly in the completion of continuation notes, but initiation of the cards, with the necessity to include a full and detailed history of all previous pregnancies, is felt by most to be too time-consuming as they have, in any case, to duplicate this in their own records.

General adoption of the cards has thus unfortunately not been obtained.

Maternal Mortality:

The number of deaths increased to the highest total since 1960. In all 14 deaths were registered—five from sepsis, three toxæmia, one abortion and five other complications—compared with six in the previous year and an annual average of 11 in the quinquennium 1958-62. The equivalent rates per 1,000 total births were 0·45, 0·20 and 0·40 respectively.

The table appended provides a comparison of the national and county death rates from various causes in the past five years.

Cause of Death	1959		1960		1961		1962		1963	
	Admin. County	England and Wales	Admin. County	England and Wales	Admin. County	England and Wales	Admin. County	England and Wales	Admin. County	England and Wales
Maternal sepsis (not associated with abortion) ...	0·04	0·06	0·14	0·04	—	0·04	0·10	0·05	0·16	
Toxæmias of pregnancy and puerperium (not associated with abortion) ...	0·14	0·07	0·10	0·08	0·07	0·07	0·03	0·06	0·10	0·22
Other complications of pregnancy, childbirth and the puerperium	0·18	0·18	0·31	0·19	0·21	0·16	0·03	0·17	0·16	
Abortion (with or without mention of sepsis or toxæmia)	—	0·06	0·17	0·08	—	0·07	0·03	0·07	0·03	0·06
Total Maternal Mortality...	0·36	0·38	0·73	0·39	0·27	0·33	0·20	0·35	0·45	0·28

Ante and Postnatal Services:

Three thousand five hundred and fifty-seven sessions for ante and postnatal examination work were held in the Authority's clinic premises during the year at which 7,090 women attended for antenatal examination and 969 for postnatal examination, the total attendances made being 31,179 and 1,082 respectively. The figure of 31,179 attendances at antenatal sessions is a reduction of 3,824 on that for 1962 and is in keeping with the trend of recent years for more patients to receive antenatal care from their own doctors.

The domiciliary midwives have continued to hold antenatal mothercraft and relaxation classes for both institutionally and domiciliary booked cases and details of these for the year are as follows:—

No. of sessions:

(a)	separate...	4,392
(b)	combined with antenatal clinics	65
	Total	4,457

No. of women attending:

(a)	institutionally booked...	3,070
(b)	domiciliary booked	2,442
	Total	5,512

Total number of attendances:

(a)	institutionally booked...	17,534
(b)	domiciliary booked	12,441
	Total	29,975

It is in the antenatal field where the trend in recent years for general practitioners to work more closely with the local health authority is clearly seen. During 1963, 15 general practitioners or partnerships were undertaking antenatal work for their own patients in the Authority's clinic premises free of charge, but with the domiciliary midwife in attendance. Under this arrangement a total of 588 sessions were held.

As regards special antenatal sessions held in general practitioners' surgeries 62 domiciliary midwives attended a total of some 1,621 special sessions during the year held by some 117 general practitioners.

Dental Treatment of Expectant and Nursing Mothers and Pre-School Children:

The Chief Dental Officer reports:—

Although there was an increase in the number of expectant and nursing mothers referred for dental examination and a 10 per cent. increase in the number examined, almost exactly the same number of patients were treated by the county dentists as in 1962 (769 compared with 777). There was, however, a change in the pattern of treatment provided similar to that noticed in the School Dental

Service (and, indeed, also in the National Health Service). Less extractions were carried out (3,140 compared with 3,515) but the number of fillings increased by no less than 40 per cent. (1,732 compared with 1,222). The number of dentures, both partial and complete, was reduced. This trend towards the conservation of the natural teeth has been manifest for some years.

Once again there has been a drastic reduction in the work carried out by private practitioners under the County Council's scheme, amounting almost to 50 per cent. Although expectant and nursing mothers who cannot be treated at local authority clinics continue to be referred to private practitioners, their treatment is now largely carried out under the National Health Service but no records are obtained as to whether they actually receive treatment and, if so, what is its nature.

The increase in the number of dental clinics providing treatment and the changed regulations allowing completely free treatment under the National Health Service have reduced the need for the County Council's scheme. This scheme, believed to be unique, fulfilled a useful purpose when clinics were few and far between and when a statutory charge was imposed on patients requiring dentures under the National Health Service. At the end of the year, the County Council were considering concluding the scheme which seems to be no longer required.

It is to be noted that no more than 3 per cent. of women eligible for this service took advantage of it, but there appears to be no evidence to suggest that there is any pressure on the priority dental service which it is unable to meet. This means either that the priority classes are getting treatment under the National Health Service or that some of the mothers are not sufficiently interested to take the necessary care of their own teeth and those of their children. The doctors and nurses in the maternity and child welfare clinics try to persuade patients to obtain treatment but, while there is still an overwhelming demand for treatment in the School Dental Service, it does not appear possible to attempt to develop the maternity and child welfare dental service.

The work carried out for pre-school children by School Dental Officers remained low, being almost exactly the same as in the previous year.

Expectant and Nursing Mothers:—

	By County Dentists	By Private Practitioners	Total
Number of cases referred	1,037	241	1,278
Number of cases examined	972	231	1,203
Number of cases found to require treatment	857	227	1,084
Number treated	769	205	974
Number made dentally fit	702	177	879
Number of extractions	3,140	1,539	4,679
Number of fillings	1,732	265	1,977
Number of general anæsthetics	366	112	478
Number of scalings	433	63	496

Number of complete dentures	486	195	681
Number of partial dentures	179	55	234
Number of X-rays	62	12	74
Number of crowns/inlays	14	16	30
Number of root treatments	3	1	4
Number of cases treated with silver nitrate	0	0	0

The following work has been carried out during the year for pre-school children —

Number inspected	1,076
Number treated	1,042
Number of attendances	1,512
Number of extractions	1,746
Number of general anæsthetics...	664
Number of teeth filled	435
Number of fillings	464
Number of teeth treated with silver nitrate ...	148
Number of dressings	64
Number of scalings	0
Number of X-rays	15
Number of gum treatments	0
Number of dentures fitted	2

Infant Welfare:

At the end of the year, there were 237 static and 3 mobile clinics in operation at which 534,642 attendances were made—an increase of 4,951 over the previous year. An analysis of the total attendances shows that some 84 per cent. of children born during the year, 65 per cent. of those born during 1962 (between one and two years old), and 12 per cent. of those born during 1958 to 1961 (over two and under six years old), attended centres during the year.

There was further progress during the year in the provision of new clinics, seven clinics being completed at Guiseley, Birdwell, Cudworth, Goldthorpe, Wickersley, Thurcroft and Baildon. This brings the total of new clinics erected since 1955 to 40. Six additional clinics at Otley, Conisbrough, Kilnhurst, Skipton, Garforth and Thorne were in the course of erection at the end of the year or contracts for their erection had been approved. The programme for 1964/65 and 1965/66 provides for further clinics at Brighouse, Stocksbridge, Uppermill, Scissett, Hoyland, Mexborough, Holmfirth, Harrogate, Kiveton Park, Swillington, Settle, Castleford, Ilkley, Shipley and Ackworth.

In addition to the normal building programme, progress was made during the year in the proposal to erect a number of all purpose " mini " clinics as envisaged under the Ten Year Development plans. These small clinics will be provided in selected localities with populations of up to approximately 5,000 and will be used for a variety of health and welfare purposes, including, where possible, use by general medical practitioners for surgery purposes. The first of these " mini " clinic projects will be provided during 1964 at Southowram in the Brighouse Division and the design incorporates housing accommodation for a member of the nursing staff.

Dr. C. C. Harvey, Consultant Pædiatrician, in his report on the past year, writes:

" Pædiatrics is steadily emerging from the hand-to-mouth existence of the past, when we were in constant struggle against the weight of numbers of infective and malnutrition disorders. There have been superficial thinkers who forecast that children's medicine was a shrinking practice. The wish may in some cases have been father to the thought, in the mind of planners who would gladly have appropriated the time, space, funds and hospital beds of children's work.

The most recent developments are towards a reversal of this notion. We turn from victories over infection and starvation only to face the unresolved hard core of infant mortality and persisting handicap. It requires not fewer doctors and beds and research to score the ultimate walk-over, but increased time and manpower, and even more beds in highly specialised departments with complex team-work, to do the right thing as we can now see it in focus, for many problems which can now be tackled, but which formerly could only be written off.

The Birthday Trust Survey is already making clear that much better antenatal care will be needed to reduce the hazards to the baby, which are now more clearly identified. More available time on the part of better trained doctors, with more leisure to reflect on their problems, will pay further dividends for both mother and child. It is now thought that a pædiatrically-trained doctor could, with advantage, be present in the baby's interest at breech and cæsarean births. When genetic counselling is needed, many hours of meticulous work by a highly-skilled team of doctors, biologists and technicians may be required to guide a single young couple. But how rewarding the outcome has been in several such problems already.

The unexpected birth of a spina bifida, which may happen for any midwife or doctor any day, now sets in train the most urgent team-work of pædiatric and orthopædic surgeon and neurologist, which in some cases will yield great rewards in paralysis avoided, hydrocephalus controlled and intelligence sustained.

Asphyxia during birth may create a problem of brain damage which, instead of being written off, will now exercise all the resources of pædiatrician, psychologist, physiotherapist and other remedial instructors, and later skilled teachers.

Dietary control of phenylketonuria and other metabolic disorders, including juvenile diabetes mellitus, calls for increased time and laboratory and ward space, as the survivors increase in numbers and thrive.

The skilled care of such and many other categories of handicapped child is snowballing in the specially-equipped centres to a degree which will soon demand multiplication of decentralised opportunities for treatment.

Then there are disease states in which once-for-all treatment may be strikingly successful, such as operative surgery. But an immense resource of skill, patience and technical experience is needed to bring such a child to the point where surgical relief can safely be carried out, often after years of vigilant study by a team.

The Perinatal Period:

The Birthday Trust Survey has taught us to pay special regard to an inadequate or diseased placenta, whenever a baby is born unexpectedly small for the duration of pregnancy. One such weighed only 4 lb. instead of over 6 lb. when born at 36 weeks after a toxæmic pregnancy. The placenta was small and full of clots. Follow-up of this baby has been a sad tale of cataracts in both eyes and mental subnormality.

Complacency was shattered during the year by a sudden outbreak of virulent antibiotic-resistant pyocyanea infection in a hospital maternity department.

Rhesus sensitized babies are delivered only in the larger hospital centres, and again this year a high proportion have needed no immediate exchange transfusion. They are all followed through till they are evidently normal toddlers with normal hearing.

An unusual oddity during the year was a white bloodless arm in a newborn baby, due apparently to arterial spasm at shoulder level caused by birth fracture of the clavicle. The limb made an almost complete recovery.

Infant and Pre-School Health:

Every year I deplore the ingrained clinic custom of deferring from month to month the immunising of children who are said to be chesty. I know that in some cases this story is merely a mother's excuse for her own negligence. But an exudative tendency is in my view a reason for priority rather than for procrastination, especially to secure protection against whooping cough, which has recently been very prevalent.

Many doctors seem to miss an obvious diagnosis of whooping cough because the child is not actually whooping. The whoop is not necessary for diagnosis, especially during epidemics.

Feeding problems come my way less often than in former years, yet there are still pædiatricians who allege that some babies cannot digest fat, and prescribe the half-skim milks which we have got rid of in our own territory. Midwives on refresher courses face needless confusion through such dicta. Posseting in a thriving baby is not an indication for starvation and, indeed, lack of protein may lead to liver incompetence. Underfeeding is, in effect, the only real feeding problem we have to deal with.

The skin tuberculin test in young children is more than ever important now, because it is less often positive. Three instances in the absence of known contact this year were:—

(1) A girl, 1¼ years, sent into hospital with a virus respiratory infection. Her positive Heaf test led to a chest X-ray showing a primary tubercle complex. But for the chance hospital admission for the other infection this might have proceeded to meningitis before discovery.

(2) A mongol boy, aged 5 years, was sent up with indolent glands in neck. But his positive Heaf test led to a chest X-ray which showed a massive right lung tubercle infection.

(3) A three-year old waif with a pleural effusion for which the diagnosis based on the skin test was later confirmed by laboratory culture of bacilli.

Circumcision of boy babies is regrettably coming back as a furtive fashion with parents, abetted by younger doctors who qualified since Gairdner's classic paper fourteen years ago, which discredited the operation as unnecessary in the light of the natural progressive cleavage of tissue planes up to four years old. One six-week old baby was sent up to me to be circumcised for ' urinary obstruction ', notwithstanding his observed ability to make a Force Six fountain.

The most worrying feature of the year's work has again been the outrageous frequency of accidental poisoning of young children, which parental prudence could have prevented in most cases. One tragedy in the year was a fatal Pink Disease traced to old stock in a village shop in the south of England of so-called cooling powders containing mercury. The formula was one which the manufacturers withdrew ten years ago.

Two cases of lifelong thyroid deficiency came to light at the inexplicably late ages of 2¾ years and 2¼ years. The one never attended the clinic, and the other had been regarded by the mother as just slow in failing to walk.

Our early diagnosis of *MUSCULAR DYSTROPHY* has reached new levels of precision in the research of Dr. V. Dubowitz in Professor Illingworth's Department at Sheffield University. Dr. Dubowitz's enzyme and biopsy studies are giving us definite guidance both for diagnosing and excluding Duchenne dystrophy, from the earliest age.

Tailpiece. Parents spent £40 on their toddler for Christmas, yet all he will play with is empty ' Elastoplast ' tins."

Phenylketonuria:

During 1963, 29,484 babies were tested either in clinics or in the home during the fourth week of life, or as soon as possible afterwards, using the ' Phenistix ' test. Each baby had only one routine test. No true cases of phenylketonuria were detected during that time, though 10 children were reported and investigated in hospital for abnormal ' Phenistix ' results in the field. All proved free of the disease.

Results from the beginning of testing in March, 1960, to December 31st, 1963 were:—

Total number tested 105,735

Ratio of true cases of phenylketonuria to children tested 1:17,622

Details of the cases investigated in 1963 are given in the table below:—

Initials	*Date of Birth*	*Age in weeks when urine tested*		*Who found positive result*
		Negative result obtained	*Positive result obtained*	
(a) *Positive urine results obtained in the field (and confirmed positive by the laboratory) but child became negative soon after and did not need dieting*				
P.C.	14- 1-63	—	3	Health Visitor
M.L.	21- 9-63	—	3	Health Visitor
M.J.	18-10-63	—	3	Health Visitor
(b) *Positive urine results obtained (and confirmed by laboratory blood tests) and child regarded as a case of Phenylketonuria requiring diet*				
Nil				
(c) *Positive urine result obtained in the field, not subsequently confirmed in the laboratory*				
S.Wa.	12- 5-63	—	5	Health Visitor
S.Wh.	7- 7-63	2 Hospital	4	Health Visitor
T.M.	16- 9-63	—	4	Health Visitor
T.D.	17- 9-63	—	7	Health Visitor
G.H.	19- 9-63	—	4	Health Visitor
D.F.	4-11-63	—	8	Health Visitor
A.W.	6-11-63	1 (Pathologist) 3 (Health Visitor)	1	Midwife (Hospital)

Ortolani Testing for Congenital Dislocation of the Hip:

From 3rd December, 1962, domiciliary midwives, health visitors and clinic doctors have performed the ortolani test on babies coming into their hands for the first time. On any suspicion of hip joint abnormality, the child's general practitioner and the divisional medical officer have been informed, with the intention of early referral to a specialist.

The following results have been reported for tests carried out from 3rd December, 1962, to 31st December, 1963.

(a) Cases referred to specialist, confirmed as congenital dislocation of the hip and splinted... 22

(b) Cases referred to specialist and said not to be congenital dislocation of the hip 45

(c) Cases referred to specialist, not splinted but given further review appointments 21

Further details are given below of the confirmed cases (a)

Initials		Date of Birth	First suspicion of abnormality (age in days)	Abnormality noted by	Approximate age when diagnosis confirmed
M.	F.				
	CG.	16- 8-63	11	Health Visitor	10 weeks
	CD.	15- 1-63	56	Assistant County Medical Officer	9 weeks
TAJ.		22- 8-63	14	Health Visitor	14 weeks
	KR.	28-11-63	11	Health Visitor	8 weeks
	BAH.	13- 4-63	60	Health Visitor	13 weeks
	SG.	29- 5-63	27	Mother	10 weeks
PW.		9-10-63	9	Health Visitor	5 weeks
	K.	6- 8-63	77	Senior Assistant County Medical Officer	17 weeks
KD.		16-10-62	50	Clinic Medical Officer	17 weeks
	LB.	25-12-63	35	Clinic Medical Officer	6 weeks 2 days
	SB.	11-12-62	18	Health Visitor	10 weeks
	JPP.	12- 7-63	13	Health Visitor	4 weeks
	SA.	24- 4-63	3	Health Visitor	4 weeks
AR.		27- 2-63	35	Clinic Medical Officer	10 weeks
	TB.	29-10-63	21	Health Visitor	8 weeks
	JW.	8- 2-63	122	Mother	22 weeks
SW.		10- 5-63	11	Health Visitor Clinic Medical Officer	3 weeks
	LO.	18- 6-63	15	Health Visitor Clinic Medical Officer	3 weeks
	JR.	19- 8-63	16	Health Visitor Clinic Medical Officer	3 weeks
	JT.	13-10-63	28	Health Visitor Clinic Medical Officer	7 weeks
PG.		13-12-63	30	Assistant County Medical Officer	8 weeks
	CAO.	5- 6-63	153	Assistant County Medical Officer	22 weeks

It will be noted that in some of these cases there has been delay in obtaining treatment after the ortolani test has been found positive.

Some of this delay is due to the variability of the response to the test, when done on the same patient even by the same observer. Staff engaged in the testing have had to be warned that after they have obtained a " positive " they must press for specialist referral in spite of subsequent negative findings by colleagues. The " click " is not invariably present, but once noted is often significant.

Initial fears on the part of field staff that damage might result from hip abduction movements in young babies have been overcome by films and talks from nursing officers and doctors and in some areas by demonstrations from orthopædic specialists.

The benefits in terms of children saved from prolonged medical care and sometimes permanent handicap are shown to justify doing the ortolani test as routine on all young babies.

Incidence of Congenital Abnormalities:

Local authorities were asked by the Ministry in January, 1963, to make a continuous record of congenital abnormalities arising in the newborn to prevent a repetition of the serious consequences of the late recognition of the thalidomide epidemic. A stop-gap scheme was to be introduced as a temporary measure, pending the arrangements for a national scheme of registration which was sent out from the Ministry ten months later.

The main features of the West Riding stop-gap scheme were that all children up to one year of age were to be examined by a doctor at least once and—where possible—twice (at two months and nine months of age respectively). A record was made of all congenital defects found. Children who failed to attend clinics during the first nine months of life were followed up, and arrangements made to obtain permission for either the clinic doctor or the general practitioner to examine them at home.

Full results will not be available until late 1964 when the last of the children born in 1963 will have reached one year of age.

When the national registration scheme became known, it was decided to run down the West Riding stop-gap scheme in such a manner that it would provide records of all congenital defects noted over a period of one year and then stop. Exceptionally, those divisions engaged on simultaneous compilation of an " at risk " register are to continue with both the stop-gap and the national scheme. The latter began in the West Riding on February 1st, 1964.

The " At Risk " Register:

There is some evidence which suggests that children, who eventually become handicapped for one reason or another, could be diagnosed earlier and treated to better effect if they were known to be " at risk ". The factors believed to place a child at risk are contained in the family history, the state of maternal health, past obstetric history, perinatal factors and postnatal illnesses.

Such earmarked children need close attention to be paid to their progress from birth onwards to detect early signs of deafness, visual defect, cerebral palsy and mental defect.

In the West Riding, such a register of children was begun in the Skipton and Thorne Divisions in April, 1963, on an experimental basis, and, later in the year, the Doncaster and Horsforth Divisions followed suit.

So far, there would seem to be no serious difficulty in compiling a register, but the administrative load of work in keeping it up-to-date and the efficiency with which it will enable handicapped children to be brought under observation at an earlier date than formerly remain unknown factors. To reduce the number of records required, those divisions engaged on the " at risk " register have succeeded in combining its administration with that of the registration of congenital abnormalities.

Welfare Foods:

The arrangements for the distribution of welfare foods from Child Welfare Centres, Divisional Health Offices and, to a lesser extent, by private householders and the retail trade, have continued during the year. The following table shows the extent of the distribution of welfare foods during 1963 and also, for comparative purposes, for the year 1962.

Period	National Dried Milk (Tins)		Cod Liver Oil (Bottles)		Vitamin A & D Tablets (Packets)		Orange Juice (Bottles)	
	1962	1963	1962	1963	1962	1963	1962	1963
January-March	35,098	32,050	8,895	9,158	8,716	8,433	52,654	64,821
April-June ...	34,346	32,502	7,034	6,717	7,640	7,687	64,411	78,621
July-September	33,663	31,865	6,974	6,380	7,651	7,603	68,782	81,837
October-December	32,473	30,908	8,605	8,698	7,579	7,719	62,088	71,219
Totals	135,580	127,325	31,508	30,953	31,586	31,442	247,935	296,498

At 31st December, 1963, there were 309 distribution centres in the County for he issue of welfare foods, of which 230 were Child Welfare Centres.

llegitimate Children:

Of the total of 1,524 live illegitimate births, 1,149 were dealt with as indicated n the table below; 1,078 of them were of West Riding domicile, the remaining 1 being non-County cases. Two hundred and twenty-four County cases were ccommodated during the ante or postnatal period in moral welfare homes nder the scheme of the authority.

		West Riding Cases	Non-County Cases	Total
Number of cases dealt with during the year:				
Referred by Moral Welfare Organisations ...		210	47	257
Ascertained by Staff of the Health Department		636	14	650
Referred by other services		232	10	242
Totals		1078	71	1149
Analysis of cases:				
Married	with previous illegitimate children	106	1	107
	without previous illegitimate children	161	3	164
Unmarried	with previous illegitimate children ...	143	4	147
	without previous illegitimate children	626	63	689
Widowed or Divorced	with previous illegitimate children ...	19	—	19
	without previous illegitimate children	23	—	23
Totals		1078	71	1149

Ages:			
Under 15 years of age	8	1	9
15—19 years of age	357	38	395
20—24 years of age	334	18	352
25—29 years of age	182	6	188
30—39 years of age	173	8	181
40 years of age and over	24	—	24
Totals	1078	71	1149
Disposal:			
Cases settled—Marriage	47	2	49
Baby died	40	1	41
Grandparents taking baby ...	52	—	52
Baby adopted	196	42	238
Baby fostered	31	5	36
Mother keeping baby	687	19	706
Cases referred elsewhere	4	1	5
Cases not finally settled	21	1	22
Totals	1078	71	1149

Accommodation was provided for the 224 cases in moral welfare homes as outlined below:—

	Ante and Post natal	Ante natal only	Post natal only	Governing Body
Aberdeen—Mother and Baby Home ...	1	—	—	Voluntary Committee
Bradford—Oakwell House	15	2	2	Bradford Corporation
Bradford—St. Monica's Home ...	13	4	3	Church of England
Bristol—St. John's Maternity Home ...	1	—	—	Church of England
Colchester—Hostel of Good Shepherd	1	—	—	Church of England
Halifax—St. Margaret's House	32	—	—	Church of England
Harrogate—St. Monica's Home ...	16	—	—	Church of England
Huddersfield—Queen Street Mission ...	3	—	—	Methodist Church
Huddersfield—St. Katharine's Hostel ...	14	—	—	Church of England
Kendal—St. Monica's Maternity Home	1	—	—	Church of England
Leeds—Browning House	23	—	1	Voluntary Committee
Leeds—Mount Cross, Bramley... ...	8	—	—	Salvation Army
Leeds—St. Margaret's Home	19	1	—	Roman Catholic Church
Lincoln—The Quarry Maternity Home	5	—	—	Church of England
London—St Michael and All Angels ...	1	—	—	Church of England
Manchester—Salford Mission Home ...	2	—	—	Methodist Church
Manchester—St. Agnes' House... ...	1	—	—	Church of England
Pontefract—" The Haven "	15	—	—	Church of England
Sheffield—St. Agatha's Hostel	25	—	—	Church of England
Sutton-on-Hull —Sutton House ...	1	—	—	Church of England
York—Heworth Moor House	14	—	—	Church of England
	211	7	6	

Premature Infants:

According to the nationally agreed definition a premature infant is one which weighs 5½ lb. or less at birth, irrespective of the length of gestation. There were 2,355 premature births of which 2,024 were live and 331 still. Of the premature live births 19 per cent. were born at home and 81 per cent. in hospitals. Of those born at home, 80 per cent. weighed more than 4 lb.

The Fate of Premature Babies born in the Year 1963 to Mothers normally resident in the West Riding Administrative County Area wherever the Birth took place

Total adjusted live births—30,803 Number of live premature births—2,024 Number born dead—331 Percentage of premature live births to total live births—6·6

Weight Group	Number of Premature Births						Number Dying														Number Surviving over 28 days					Percentage Survival 1963	Percentage Survival in previous years				
	Born Alive					Born Dead	First Week							Second Week							over 14 up to 28 days											
lb.	A	B1	B2	C	Total		1	2	3	4	5	6	7	8	9	10	11	12	13	14		A	B1	B2	C	Total		1962	1961	1960	1959	1958
5—5½	169	7	289	358	823	42	8	5	3	3	—	1	—	1	—	1	—	1	—	1	2	162	6	280	349	797	96·8	97·0	95·4	97·2	96·4	95·7
4½—5	95	1	154	227	477	33	19	1	7	1	1	1	1	—	—	—	—	—	—	—	1	94	1	142	208	445	93·3	94·1	92·1	94·8	92·9	92·9
4—4½	42	—	77	165	284	49	12	6	3	—	—	—	1	—	—	1	—	1	—	—	2	40	—	69	149	258	90·8	89·1	90·3	88·7	86·9	89·9
3½—4	26	—	48	76	150	39	16	11	3	1	1	—	1	1	2	—	—	—	—	—	—	17	—	37	60	114	76·0	85·6	77·1	84·1	84·8	79·3
3—3½	14	—	22	64	100	50	19	6	5	1	1	—	—	—	—	—	—	—	—	—	1	12	—	14	41	67	67·0	67·0	68·2	72·6	60·9	65·9
2½—3	18	—	14	49	81	47	28	6	4	4	—	—	1	—	—	—	1	2	—	—	1	9	—	4	21	34	42·0	41·0	39·3	44·3	40·4	40·9
2—2½	7	—	16	32	55	36	26	7	—	1	1	—	1	1	—	—	—	—	—	—	—	4	—	5	9	18	32·7	29·8	19·4	43·9	27·9	26·1
1½—2	7	—	4	25	36	20	28	1	2	—	2	—	—	1	—	—	—	—	1	—	—	—	—	—	1	1	2·8	3·2	15·2	2·3	4·2	10·9
1½ and under	4	—	1	13	18	15	17	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	3·0	—	—	—
Total	382	8	625	1009	2024	331	173	44	27	11	6	2	5	4	2	2	1	4	1	1	7	338	7	551	838	1,734	85·7	86·2	84·6	87·1	84·7	84·7

268 15

290

A —Born in Domiciliary Practice.
B1—Born in Private Nursing Home.
B2—Born in Maternity Home.
C —Born in General Hospital.

The weight groups in the first column of this table should be read as under :—
" 5—5½ lb." means " Over 5 lb. up to and including 5½ lb."
" 4½—5 lb." means " Over 4½ lb. up to and including 5 lb."
The remaining weight groups should be read in the same way.

Children Neglected or Ill-treated in their Own Homes—Prevention of Break-up of Families:

Throughout the Administrative County, there were 98 formal meetings of the Co-ordinating Committees established under the Chairmanship of the Divisional Medical Officer for the area to co-ordinate the activities of the many statutory and voluntary organisations concerned in the welfare of children. In 13 Divisions meetings were held quarterly or at more frequent intervals and, in 9 Divisions, meetings were held less frequently than quarterly. No formal meetings were held in the remaining Division as it was felt that the circumstances of individual cases were such that they could best be dealt with in small informal meetings of the appropriate officers.

The Co-ordinating Committees include in their membership officers of the local Health, Welfare, Education and Children's departments, representatives of the housing authorities and representatives of the various voluntary agencies. A typical Committee would probably include the following members:— Divisional Medical Officer, Divisional Welfare Officer, Assistant Children's Officer, Education Welfare Officer, Mental Welfare Officer, Divisional Nursing Officer, Health Visitor, Probation Officer, District Council Housing Manager, Public Health Inspector, National Assistance Board representative, N.S.P.C.C. Inspector.

The co-ordination of these resources can give valuable assistance with problem families to prevent their break-up and, although in many cases little or no improvement is achieved, further deterioration may be prevented.

The arrangements, made by the County Council following the issue of the Joint Circular of the Ministry of Housing and Local Government (17/59) and the Ministry of Health (4/59) and after consultation with housing authorities, to safeguard the interests of housing authorities in selected cases where there was a danger of the families being evicted, broken-up and the children being taken into care have continued.

The Special Sub-Committee established by the County Council to consider the cases of families in which applications for assistance have been made by housing authorities continued to meet regularly and at the end of the year 108 families remained under review. The action taken by the Committee has helped to prevent the eviction of families from their homes and has enabled the work of rehabilitation to continue. In this connection Dr. Hunter, Divisional Medical Officer (Skipton) writes:

> " This scheme has proved most valuable and has, undoubtedly, saved several families from eviction—a measure which has achieved nothing in the past, for once this type of family has been broken-up the parents rarely have the ability, support, or resources to resume family life. Their children, usually numerous, have then to be maintained in Children's Homes for years and years. This is a costly procedure, and only to be undertaken when everything else has failed. The scheme has also produced a sort of ' partnership agreement ' between the housing authorities and the local health authority, and a considerable degree of co-operation which certainly did not exist previously."

Work with problem families usually continues over a long period of time and Dr. Appleton, Divisional Medical Officer (Brighouse) reports:

> " The knowledge of a family by the Health Visitors, the Education Welfare Officer and the Divisional Medical Officer, often extends over a long period of years, and, indeed, it has been our experience that intimate knowledge of these families is only acquired over a period of years. Increasingly, the National Assistance Officer is called in for useful information, and the Housing Managers often tell us vital facts.

Much of our work, however, is done outside the meetings. When a case has to be dealt with, it is often a matter of great urgency and cannot wait until a meeting of the Committee can be called. Our relationship with the Children's Officer, with the Probation Officer, with the National Assistance Officer and with the N.S.P.C.C. Inspector is very good indeed."

Divisional Medical Officers agree that the Co-ordinating Committees are extremely useful because of the interchange of views possible between officers from different departments and authorities dealing with a particular case. Dr. Smithson, Divisional Medical Officer (Wetherby) writes:

" Dealing with problem families is uphill work but one is firmly convinced of the benefit of having an occasional opportunity to exchange information on such families with other workers in the field.

It is noteworthy that whereas originally one member of the staff of the National Assistance Board represented the four separate offices working in Division No. 9, each office now wishes to have an opportunity of attending our Committee to discuss cases falling within its purview."

Towards the end of the year the Special Sub-Committee agreed to retain the services of the Oldham Family Service Unit to work with a problem family in the Saddleworth district for a period of one year. This family had been a source of concern to the Co-ordinating Committee since 1956 and despite every effort no progress had been made, in fact of late there had been a deterioration in conditions so that break-up of the family appeared imminent. The outcome of the Family Service Unit's efforts will be awaited with interest.

Day Nurseries:

There are five day nurseries in operation, which provide more than adequate accommodation to meet the established need, for reasons of health and associated socio-medical conditions, of the areas in which they are situated. The County Council's policy is to admit only the following categories:—

(a) The young child whose mother is ill or having a baby.
(b) The illegitimate child whose mother is required to work.
(c) The young child of the widow who must educate and support her family unassisted.
(d) The young child of the mother whose husband is ill.

Details of places provided and attendances are given in the following table:—

Division Number	*Day Nursery*	*Number of Places Provided*	*Average Daily Attendance*
3	Keighley	50	31
4	Shipley	50	38
7	Harrogate	40	25
15	Heckmondwike	40	30
18	Brighouse	40	27

The situation has remained under periodic review by the Day Nurseries Sub-Committee.

All the day nurseries are classified as training nurseries and have provided practical training facilities for students resident in the West Riding undertaking courses for student nursery nurses organised by the County Boroughs of Leeds and Bradford.

Financial responsibility was accepted for the accommodation of five children in day nurseries administered by the County Boroughs of Halifax and Huddersfield and at the end of the yea. five children were in attendance at day nurseries administered by the County Boroughs of Halifax, Huddersfield and Sheffield.

MIDWIFERY

At the end of the year, there were 424 midwives employed in the Administrative County, as follows:—

260 by the County Council (including 57 home nurse/midwives).
153 by Hospital Management Committees.
11 in private practice.

There were 10,546 deliveries attended by County Council midwives, of which 9,784 cases had contracted with medical practitioners for the provision of maternity medical services. One thousand seven hundred and eighty of these were attended by a general practitioner. In 762 cases, a doctor was not booked but, in 38 of these cases, a doctor was in attendance.

The number of cases delivered in institutions but attended by domiciliary midwives on discharge was:—

	Cases
Up to and including the fifth day	2,969
After the fifth but before the tenth day ...	4,230
Total ...	7,199

Staff Situation:

The establishment is 280 whole-time midwives, and 260 (whole-time equivalent of 229·5) were in employment at the end of 1963. These are made up as follows:—

Whole-time midwives	200
Part-time midwives	3
Home nurse/midwives	57
Total ...	260

STAFF CHANGES:

Including home nurse/midwives there were 32 new appointments, 17 resignations, 5 retirements and 3 midwives transferred to health visiting.

As local supervising authority we are being asked more frequently to arrange courses for midwives wishing to return to hospital or domiciliary practice after a gap of several years. This is often due to families growing older and thus allowing the midwife to take up her career again.

In-Service Training:

42 domiciliary midwives attended an in-service training course at Grantley Hall, including 7 from Rotherham, Leeds, Wakefield and Bradford County Boroughs and 2 from hospitals—1 St. Helen Hospital, Barnsley and 1 at her own expense from Huddersfield.

The course proved to be lively and stimulating as there was a preliminary session on the art of teaching. During the course a film was shown demonstrating the psychoprophylactic and hypnotic methods of preparation for childbirth, followed by a talk on the varying breathing techniques used in labour. Psychoprophylaxis has developed from Dr. Grantly Dick Read's methods but is rather more complicated, requiring a good deal of concentration from the mother-to-be and her husband.

Portable Incubators:

Although several hospitals have portable incubators they have not yet been provided by the County Council in connection with their arrangements for the care of the premature baby as the issue of an improved design of incubator is still awaited from the manufacturers.

Maternity Liaison Committees:

The Non Medical Supervisors of Midwives attend several of these meetings in different parts of the County and have been able to spread ideas from one area to another. Some examples are:—

(1) The ortolani test for congenital dislocation of hip was first suggested in Wakefield and later extended to all midwifery and health visiting staff.

(2) Early discharge after delivery is a debatable point but through these committees many difficulties have been overcome. The notification to the local authority when these patients are booked allows the midwives to visit and offer home helps if necessary and give any advice needed regarding home preparations and requirements. The hospitals are kept informed of the midwives' off duty, which knowledge can save time at weekends and holiday periods.

(3) From suggestions and comments by the Doncaster and Rotherham Committees a scheme has been evolved by the County Ambulance Officer and his staff to obviate as much as possible any risk of infection to mother and baby. Special direct journeys are made with double manned ambulances, and sterilised cotton cellular sheets for mother and baby are used only once before being laundered and disinfected. These blankets can also be used for the inward transfer of emergency cases when considered necessary by the midwife or ambulance attendant.

(4) Co-operation cards are being used more, though their acceptance is slow in many areas.

Cars:

One hundred and eighty-one midwives use their own cars in their work and twelve midwives use cars provided by the County Council.

Emergency Obstetric Units:

There were 26 reported calls on this service, mostly for difficulties connected with the third stage of labour. The units were supplied by the under-mentioned hospitals:—

St. Helen Hospital, Barnsley.
St. Luke's Hospital, Bradford.
The General Hospital, Halifax.
The General Hospital, Harrogate.
The Royal Infirmary, Huddersfield.
The Maternity Hospital, Leeds.
Montagu Hospital, Mexborough.
Jessop Hospital, Sheffield.
The General Hospital, Wakefield.

Analgesia:

The provision of apparatus for the administration of trilene, as an alternative to gas and air, continued and there are now 289 trilene inhalers and 296 gas and air machines which were in use or held in reserve. The number of patients receiving trilene has continued to increase—7,708 in 1963, compared with 7,559 in 1962—and there has been a corresponding reduction in the number receiving gas and air from 822 in 1962 to 167 in 1963.

In addition, pethidine was administered alone or in combination with either gas and air or trilene.

The following table indicates the extent to which analgesics as a whole were used within each divisional area.

Div. No.	Area	Percentage receiving Analgesia					
		Pethidine alone	Gas and air alone	Gas and air with Pethidine	Trilene alone	Trilene with Pethidine	Total
1	Skipton	4	1	1	25	55	86
3	Keighley	12	2	5	15	58	92
4	Shipley	4	—	1	19	68	92
5	Horsforth	1	—	—	35	57	93
7	Harrogate	9	1	—	27	47	84
9	Wetherby	3	—	4	31	51	89
10	Goole	14	—	1	45	30	90
11	Castleford	2	—	—	58	27	87
12	Pontefract	13	—	3	17	61	94
13	Morley	5	—	—	29	54	88
15	Batley	5	—	—	26	51	82
16	Rothwell	8	—	—	21	61	90
17	Spenborough	1	—	—	44	46	91
18	Brighouse	1	1	1	29	59	91
19	Todmorden	5	—	—	21	66	92
20	Colne Valley	9	2	6	28	43	88
22	Wortley	28	—	—	22	23	73
23	Hemsworth	10	—	—	29	46	85
25	Barnsley	9	5	1	30	42	87
26	Wath	11	1	1	27	40	80
27	Doncaster	8	—	—	23	57	88
29	Thorne	24	—	—	14	50	88
31	Rotherham	27	1	2	15	31	76
	Leeds Hospital Board Region	7	—	1	29	52	89
	Sheffield Hospital Board Region	16	1	1	22	42	82
	West Riding Administrative County ...	11	1	1	26	47	86

HEALTH VISITING

The emphasis in 1963 was still on liaison between domiciliary nursing staffs and general practitioners. There have been many more requests from general practitioners to have health visitors working with them and more requests from them to work in County premises and this would appear to be an ideal centre from which to start. There are still many variations in the way this liaison works. On the lower end of the scale the health visitor visits the general practitioner once a fortnight and this increases to weekly and twice weekly until we get to the top of the scale where the health visitor works within the practice of the general practitioner and visits his patients as she would if they were on her area. This may mean greater distances to travel and more health visitors needing cars but this will, I am sure, give a much better community service.

Owing to shortage of qualified health visiting staff a working party consisting of three Divisional Medical Officers, one Divisional Nursing Officer and three Health Visitors—Dr. Brewin and Miss Walker also attended—was set up to study the work of the health visitor and to consider which duties could be safely handed to less qualified staff. After many meetings it was decided that quite a number of duties could be delegated to either less qualified staff or, in the case of antenatal care, to the midwives. Amongst the duties which could be entirely given over to auxiliaries were clinical duties—care of equipment, maintenance of records and day to day management of the clinic; attendance at immunisation sessions; giving ultra violet light treatment; weighing infants, though this practice is disappearing in many areas.

It was thought that auxiliaries could be very useful in the School Health Service, attending the school medical inspections except in the case of entrants which the health visitor should attend; hygiene inspections and normal routine follow-up; attendance at specialist clinics; routine audiometry testing (after some training).

In relation to the health visitors' duties in the clinics it was agreed that voluntary workers and part-time or full-time clerks should be employed to the maximum to relieve professional workers in clinics and that work in connection with food sales should, wherever possible, be undertaken by clerical staff.

Testing babies for phenylketonuria and for congenital hip dislocation has gone on throughout the year, the former taking up a lot of time on re-visits to the home.

An analysis of the work undertaken by health visitors during the year is given below:—

Analysis of Visits		*No. of visits*
Expectant mothers		10,170
Children born in 1963	125,222	
Children born in 1962	90,659	
Children born in 1958-61	134,325	
		350,206
Tuberculous households		7,188
Visits by whole-time tuberculosis visitors		8,345
Other infectious diseases		3,179
Persons over the age of 65 years		45,084
Mentally disordered persons		1,679
Discharged from hospital (other than maternity)		4,159
School health		16,617
Home helps		114,172
Ineffective visits		41,090
Total ...		601,889

Clinics and School Sessions			*No. of sessions*
Maternity and child welfare			28,287
Ultra violet light			1,130
Health Education—			
a. Clubs		294	
b. Parent teachers		30	
c. Schools		1,665	
d. Antenatal relaxation classes		1,652	
Other health education activities		576	
			4,217
Specialist—Chest			51
Other			3,171
School health			20,559
	Total ...		57,415

In 1963 the Ministry of Health revised the form of the Annual Return L.H.S. 27, therefore, the analysis of visits differs slightly from previous years. The total number of first visits to babies born in 1963 cannot correspond with the total number of live births, because babies born in late December, 1963 were not visited until January, 1964 and there is no compensatory gain from the previous year as babies born in late December, 1962 and visited in 1963 will be shown in the figures for 1962.

This year it has been possible to show the number of visits to people over the age of 65 years and also to home helps. These visits, particularly those to the aged, take a great deal of the health visitors' time. Much advice and help are needed in this problem and there is a great need for voluntary help to assist in combating loneliness in the aged group of the community.

More visits to expectant mothers were shown and the total number of visits to children under the age of 5 years increased by 20,721, though visits to older children were less.

Sessions on health education have increased by 1,388 and work in clubs, schools and antenatal classes seems to have absorbed the health visitors' time. A full report will, however, be found on page 143.

Staff Situation:

The present staffing establishment for health visiting, school nursing and tuberculosis visiting is 391 whole-time officers. At the end of the year 364 staff (equivalent of 338·4 whole-time officers) were employed in these services, an increase of 17·6 on the previous year, and were made up as follows:—

Qualified health visitors (11 part-time) combining the duties of health visiting and school nursing	261
Assistants to the health visitor (31 part-time), without the health visitor's certificate, combining duties in the public health and school health services, 12 of whom undertake health visiting under a dispensation granted by the Ministry.	94

Whole-time school nurses	2
Home nurse/midwife undertaking health visiting, home nursing and midwifery duties.	1
Whole time tuberculosis visitors.	6
	364

There were 71 new appointments (33 of these were unqualified), 29 resignations (9 unqualified), 10 retirements, 6 transfers to other services and 6 unqualified health visitors transferred to student health visitors.

Mrs. C. C. Howels was appointed Divisional Nursing Officer to Wetherby and Goole. Miss A. M. Seelig and Miss J. Crossfield, Divisional Nursing Officers, Morley/Rothwell and Hemsworth, respectively, both returned triumphant, in July, from the course on Public Health Administration at the Royal College of Nursing.

Miss M. E. Thomas, Divisional Nursing Officer, Castleford, resigned to take up the post of Deputy Nursing Officer in Blackburn.

Post Certificate Training:

30 health visitors attended approved courses organised by the Health Visitors Association and the Royal College of Nursing and many letters of appreciation were received.

46 members of staff attended in-service training on health education, at Grantley Hall, in May, 1963. The course was arranged to refresh health visitors' minds on certain basic points needed to impart knowledge to others. Miss M. Hellier, L.A.M., A.T.C.L., L.G.S.M., and Miss P. Royston, B.A., M.Ed., Vice Principal at the Ilkley College of Housecraft, were most helpful at encouraging and assessing the quality of work done. In addition there was Dr. A. G. Mearns, M.B.E., B.Sc., M.D. (Glasgow), B.Sc. (P.H.), D.P.H., F.R.S. (Edinburgh), Senior Lecturer and Examiner in Social Medicine at the University of Glasgow. Dr. Mearns spoke on health education in schools, the approach and practical appreciation.

On 5th and 6th September a short course on early ascertainment of the deaf was held at Outwood Clinic in the Rothwell Division, by kind permission of Dr. Taylor, Divisional Medical Officer. 24 health visitors attended and gained proficiency certificates. A great deal of help was given by the Divisional Nursing Officer and health visitors in the area, in collecting up groups of children in different age groups for the purpose of testing.

Student Health Visitors:

The following report is submitted by Miss R. E. Chambers, Health Visitor Tutor, at Leeds:—

> "There was an encouraging rise in applications to take the health visitors' training course in 1962-63. Twenty-one candidates were selected to train at Leeds University, representing 47 per cent. of the class. This numbered 44, all of whom took the examination for the Royal Society of Health in July. There were three failures, two being sponsored

by the County Council, but everyone was qualified by December, 1963. Another student attended the training centre at Bradford and was successful at her first examination attempt.

A noticeable feature of this course was the concentration of students at the upper end of the age range, of whom many found studying, travelling and home commitments a fairly heavy burden. The teaching staff realised that this group had much to give in the way of experience, not only as midwives, home nurses and assistants to health visitors, but also as older and responsible citizens. However, the majority had had no opportunities for study and written work of the required standard for some years. The tempo of work was, therefore, slower and the arrangement of studies and teaching methods required modification. This was essential in order to reassure and encourage those who were a little out of practice in some skills.

Miss A. M. Coleman was appointed as a Health Visitor Tutor at Aberdeen in 1963 but not before she had rendered valuable assistance, especially with those students who needed individual and additional coaching.

There were many people concerned with voluntary and statutory organisations who gave a great deal of time, enthusiasm and help to the students in practical ways. They are too numerous to mention individually, but thanks are extended to them and their colleagues who helped to make this side of training possible.

During the year, experience was provided for senior public health nursing students, attending courses at the Royal College of Nursing, always stimulating and of interest to the staff.

We welcomed Miss M. Clancy, Health Visitor Tutor to Leeds City, who joined the staff in August, 1962.

Professor Bradshaw gave a prize which was awarded to a West Riding student, Miss D. E. Yeadon."

Recruitment:

In July, 1963, and because the Royal Health Society was now accepting health visitor students who were state registered nurses with 3 months obstetric training in place of Part I midwifery, it was decided that there might be a source of recruitment amongst members of the staff and others who had had no opportunity to take Part I midwifery. Enquiries were, therefore, made from the Central Midwives Board as to whether this could be done as a post certificate course and to the Royal Society of Health to see if such students were acceptable. When agreement was reached on this point steps were taken to contact approved obstetric training schools. The response from the hospitals was most gratifying and by the end of 1963 planning was completed and in January, 1964 approval by the Committee was given to the scheme.

At present 5 students are taking obstetric training, 4 having been accepted by Leeds University and 1 by Bradford Technical College for future health visitor training.

Cars:

Two hundred and twenty-eight health visitors use cars in connection with their duties.

HOME NURSING

Staffing:

The situation in relation to home nursing is much the same as in 1962; no shortage on the home nursing front but there is still some reluctance on the part of applicants to come forward and do the combined home nurse/midwifery work. This may be due, partly, to the number of midwifery cases in rural areas being low and at the same time the home nurse/midwife is tied to 24 hours duty per day.

The number of nurses employed at the end of 1963 was about the same as in 1962.

The establishment is 290 whole-time nurses, and 311 (whole-time equivalent of 273·6) were in employment at the end of 1963. These were made up as follows:—

Home nurses, S.R.N. (14 part-time)	243
Senior relief home nurses, S.R.N.	2
Home nurse/midwives, S.R.N. (1 part-time) ...	53
Home nurses, S.E.N. (2 part-time)	9
Village nurse/midwives, S.E.N.	4
	311

There were 37 appointments, 30 resignations, 7 retirements and 4 transferred to other services.

Training:

The West Riding training scheme for home nurses continued to flourish under the expert guidance of Mrs. Taylor the acting tutor for this course.

Two courses were held during 1963, the first one commencing in May, 1963 when 13 students took the course and 12 passed the examination. The second course started in September; there were 11 students and of these 10 passed the examination.

This year two senior nurses, Mrs. B. Hucknall, Wath on Dearne area, and Mrs. P. Moulds, Thorne area, attended the William Rathbone College, Liverpool, to learn something on methods of teaching student home nurses.

Group Lectures:

Professor J. C. Goligher, Professor of Surgery, University of Leeds, attended three centres in the West Riding to talk to home nursing sisters on the after-care of patients who are discharged from hospital after having had an operation for ileostomy or colostomy. The centres were Bingley, Tadcaster and Wath on Dearne. The lectures were well attended and the home nurses were most appreciative.

Refresher Courses:

A successful course was held at Grantley Hall in July, 1963 when 38 West Riding students attended. In addition to these there were five students from adjacent County Boroughs. This course was arranged to help home nurses to keep abreast with new thoughts and ideas and to give them a glimpse into new treatments and methods in hospital care of heart cases, cancer, diabetes, diseases of the blood and the care of the aged.

In addition to lectures and discussion groups there were demonstrations and films on the right and wrong way of lifting, with practice for the students, revision of nursing techniques and a chance to discuss problems with both lecturers and colleagues.

Study Days:

During March and April, 1963 two periods of study were arranged between ward sisters from Pinderfields General Hospital, Wakefield and home nurses from adjacent areas—Pontefract, Castleford, Rothwell, Morley and Batley.

In the first place 15 ward sisters went out with fifteen home nurses. The following week the same home nurses visited Pinderfields Hospital, spending the whole morning learning something of new procedures and equipment. In the afternoon Miss O. Copeland, O.B.E., Regional Nursing Officer and Miss F. H. Heaney, Public Health Nursing Officer, Ministry of Health, opened the discussions by each giving a fifteen minutes talk. Much information came out of the group discussions and it seemed a good way of discussing mutual problems, particularly those of good patient care both within and without the hospital. The outcome of this project is that the domiciliary nurse has a much easier access to this particular hospital and from the County angle, maps of the West Riding health divisions have been supplied to each ward with the names and telephone numbers of Divisional Medical Officers and Divisional Nursing Officers so that nursing or medical staff can have direct contact when necessary; this should lead to a better liaison than heretofore but it was agreed by both hospital and public health nursing staffs that it would be useful to have a health visitor or home nurse attached to the hospital.

Cars:

Two hundred and eighty-four home nurses use cars in connection with their work and, of these, eighty-two are provided by the Authority.

Day and Night Nursing Service:

1963 provided the first full year's working of the scheme approved in 1961 for the provision of a day and night nursing service for cancer and other types of patient. So far as cancer patients are concerned, the scheme is operated jointly with the Marie Curie Memorial Foundation who meet the cost in full; the cost of providing the service for other types of case is met by the County Council as an extension of the Home Nursing Service.

The object of the scheme is to provide a day or night nursing service without charge to the recipient for a temporary period, usually in an emergency or during the terminal stages of illness, to provide relief to relatives who may be under considerable strain resulting from caring for the patient over a long period. Trained nurses, persons with nursing experience, or " sitters-in " can be employed.

All Divisions are not yet using the service partly because of lack of demand or inability to recruit suitable staff, but during the year, the service was in operation in 10 Divisions and 50 cancer patients were provided with night nursing facilities. In the great majority of cases the service was only necessary for periods of short duration but there were a few instances where, the patient, considered to be in the terminal stage of illness, survived for a longer period than was anticipated and the nursing service continued with the approval of the Marie Curie Foundation.

The night nursing service, although one which is not called upon frequently, is a well worthwhile service which can be a great help to, and is much appreciated by, relatives who are under considerable mental and physical strain in caring for patients who have been nursed at home over a long period of time.

Summary of the Work of Home Nurses:

The total number of cases dealt with by the home nurses increased by 1,070 in 1963; 28,196 cases as compared with 27,126. In consequence the number of visits has also increased by 22,258, the total number being 757,303.

Visits to tuberculous patients are decreasing slightly whilst those for maternal complications have increased. There have been a few home visits to children under the age of 5 years but the bulk of the home nurses' work is still in the over 65 age group and this work, though very valuable, is also time consuming and does not always need the skills of a State Registered Nurse.

Types of cases attended	*No. of cases attended*	*No. of visits by Home Nurses*
Medical	20,982	599,491
Surgical	6,151	129,161
Infectious diseases	82	825
Tuberculosis	344	22,311
Maternal complications	528	4,585
Others	109	930
Total ...	28,196	757,303
Age Groups		
0—4	1,119	8,989
5—64	12,201	272,767
65 years or over	14,876	475,547
Total ...	28,196	757,303
Patients included in the above who have had more than 24 visits during the year	7,770	542,329

The following statistical details relate to patients whose treatment was completed during the year:—

Classification of Cases by Disease:

Disease	*No. of Cases*
Tuberculosis	272
Other infectious diseases	158
Parasitic diseases	30
Malignant and lymphatic neoplasms	1,458
Asthma	73
Diabetes mellitus	490
Anæmias	1,493
Vascular lesions affecting central nervous system	1,506
Other mental and nervous diseases	408
Diseases of the eye	95
Diseases of the ear	367
Diseases of heart and arteries	1,657

Diseases of veins	441
Upper respiratory diseases	541
Other respiratory diseases	1,903
Constipation	1,006
Other diseases of digestive system	1,390
Diseases of urinary system and male genital organs	873
Diseases of breast and female genital organs	464
Complications of pregnancy and puerperium	438
Diseases of skin and subcutaneous tissues	1,187
Diseases of bones, joints and muscles	608
Injuries	1,425
Senility	1,073
Other defined and ill-defined diseases or disabilities	932
Diseases not specified	405
Total	20,693

Nursing Treatment:

Type	*No. of Cases*
Injections only	6,541
General nursing	6,148
Enemas	1,211
Dressings	4,729
Bed baths	623
Wash-outs, douches, etc.	320
Changing of pessaries	104
Preparation for diagnostic investigation	430
Others	587
Total	20,693

The total number of cases receiving injections was 7,123 but, in 582 cases, the injections were given during the course of a general nursing visit.

Injections:

Type	*No. of Cases*
Insulin	323
Drugs for anæmia, debility, etc.	1,984
Antibiotics	3,582
Drugs for cardio-renal diseases	792
Others	442
Total	7,123

Referral of Cases:

Source	No. of Cases
General practitioners	16,606
Hospitals	2,567
Health Department staff	1,013
Others	507
Total ...	20,693

Disposal of Cases:

	No. of Cases
Convalescent	11,758
Transferred to hospital	3,503
Died	3,517
Others	1,915
Total ...	20,693

The antibiotic drugs form the greater part of the injection therapy of the home nurse and although the number of cases for injection only has risen slightly during 1963 the actual percentage of total cases undertaken has dropped from 29 per cent. to 23 per cent. whilst the number of visits for injections only appears to have dropped to 14 per cent. of the total number of visits.

The type of work the home nurse is at present undertaking is fairly static; that is, she is dealing with a large amount of medical cases, very few surgical cases and amongst the former the majority are geriatric patients. Good work, however, is being done in this respect and home nurses are greatly appreciated and respected wherever they may go.

Survey of the Home Nursing Service:

The following is a report on a survey of the service undertaken during the year by Dr. Brewin, Senior Administrative Medical Officer.

The content of home nursing has been changing in the past few years, and it has been difficult to assess, for administrative purposes, what constitutes the normal working day of the average nurse on the district. It has also been asked whether some of the work might be done by other agencies, including the use of less-qualified staff, without loss of efficiency.

After a five-day pilot study to decide the method to be used, a survey was carried out in three divisional areas having different characteristics. These divisions (referred to as Division 'A', Division 'B' and Division 'C') were selected because they represent respectively rural, semi-rural and industrial parts of the West Riding Administrative Area. Recording covered the activities of both home nurses and home nurse/midwives.

All nurses in each division were asked to compile a diary of all the activities they carried out during working days. Saturdays and Sundays were given the same representation in the survey as were week days.

The contents of the diaries were classified by the Divisional Nursing Officers into previously-agreed categories, and office personnel analysed the results. Any ambiguities were checked back with the nurse concerned within a short time of her record being made.

DURATION OF SURVEY:

The main part of the survey took place from October 23rd to December 6th, 1962, but, due to absences through illness, holidays, etc., some diaries were still being compiled up to January 11th, 1963, when recording was stopped.

BROAD DEFINITIONS OF CATEGORIES USED:

General nursing care	Generally making the patient comfortable, including baths, blanket baths.
Dressings	Self-explanatory.
Injections	Self-explanatory.
Miscellaneous nursing	Supervision (observation). Testing of urine (diabetics). Plus any task which could not be classified to one of the previous headings.
Miscellaneous non-nursing ...	Advice re equipment. Advice to relatives and callers. Telephone answering and calling other agencies.

RESULTS:

Table 1

(a) *Staff engaged and days worked in the survey, together with the population figures for the survey areas.*

	Division 'A' (rural)	Division 'B' (semi-rural)	Division 'C' (industrial)	Total for Survey
Home nurses in survey	10 (including 1 relief and 1 bathing attendant)	13 (including 1 part-time and 1 relief)	22 (including 1 part-time and 3 relief)	45
Days worked by home nurses ...	227	343	599	1,169
Home nurse/midwives in survey ...	10	4 (including 1 part-time relief)	—	14
Days worked by home nurse/midwives	219	93	—	312
Population resident in area involved in the survey	105,820	116,630	109,920	332,370

(b) *Contributions (in days worked) by individual members of staff.*

Home nurses' participation:

30 nurses each recorded	28 working days.
3 nurses each recorded	27 working days.
9 nurses each recorded	23 working days.
1 nurse recorded	20 working days.
1 nurse recorded	14 working days.
1 nurse recorded	7 working days.

Home nurse/midwives' participation:

3 home nurse/midwives each recorded ...	28 working days.
9 home nurse/midwives each recorded ...	22 working days.
1 home nurse/midwife recorded	21 working days.
1 home nurse/midwife recorded	9 working days.

Table 2

The Average Working Day for a Home Nurse.

	Division 'A' (rural) (based on 227 nurse days)		Division 'B' (semi-rural) (based on 343 nurse days)		Division 'C' (industrial) (based on 599 nurse days)		All home nurses in the survey (based on 1,169 nurse days)	
	Mean hrs.	mins.	Mean hrs.	mins.	Mean hrs.	mins.	Mean hrs.	mins.
a. Time spent on general nursing	2	40	1	59	1	55	2	5
b. Time spent on dressings ...		22*		38		31		32*
c. Time spent on injections ...		31*		37		47		41*
d. Time spent on miscellaneous nursing tasks		21		28		6		16
e. Time spent on travelling ...	1	19	1	34	1	19	1	23
f. Time spent on bags and miscellaneous non-nursing tasks...		26		31		43		36
g. Time spent on survey clerical work		33		25		18		23
h. Time spent on normal clerical work		23		17		12		16
Total time spent on nursing (a + b + c + d)	3	50	3	42	3	20	3	32
Total time worked (a + b + c + d + e + f + g + h)	6	32	6	29	5	53	6	11

* The one bathing attendant in the survey is excluded from these figures.

Table 3

The Average Working Day of the 14 home nurse/midwives engaged in the survey.

(Two divisions taken together because of small numbers involved.)

	Home nurse/ midwives from Division 'A' (rural) and Division 'B' (semi-rural)	
	Mean hrs.	mins.
a. Time spent on general nursing	1	11
b. Time spent on dressings		10
c. Time spent on injections		21
d. Time spent on miscellaneous nursing tasks		13
Time spent on travelling	1	20
Time spent on bags and miscellaneous non-nursing tasks		36
Time spent on survey clerical work		15
Time spent on normal clerical work...		12
e. Time spent on antenatal clinic sessions		3
f. Time spent on relaxation clinic sessions		4
g. Time spent on antenatal attention in the home		16
h. Time spent on attendance in labour		22
i. Time spent on postnatal attention in the home		43

Total time spent on midwifery duties (e + f + g + h + i)	1	28
Total time spent on nursing duties (a + b + c + d)...	1	55
Total time worked in all	5	45

Midwifery figures are based on:—

312 working days.
244 antenatal visits.
24 patients seen in labour.
437 postnatal visits.

Table 4

The time spent on average at one visit by home nurses and home nurse/midwives.

Nursing task for which patient was visited	Time taken on average per visit					
	Home Nurses			Home nurse/ Midwives	All staff engaged in survey	
	Division 'A' (rural)	Division 'B' (semi-rural)	Division 'C' (industrial)	Division 'A' (rural) and Division 'B' (semi-rural) combined	Mean	Standard Deviation
	hrs. mins.	hrs. mins.	hrs. mins.	hrs. mins.	hrs. mins.	hrs. mins.
General nursing care	27	27	28	31	28 based on 6,064 visits	4
Dressings ...	18	19	25	20	21 based on 1,842 visits	11
Injections ...	10	13	13	11	12 based on 4,412 visits	3
Miscellaneous nursing care...	16	20	12	19	17 based on 1,305 visits	7

Table 5

The time spent on average at one visit by Home Nurse/Midwives on each type of midwifery task.

Midwifery task for which Patient was visited	Time taken on average per visit
	Home nurse/ Midwives of Division 'A' (rural) and Division 'B' (semi-rural)
	hrs. mins.
Antenatal attention in the home	22
Attendance in labour	2 30
Postnatal visits in the home	31

Table 6

The average number of patients given treatment daily by each home nurse and home nurse/midwife.

Main treatment given	No. of treatments daily on average by each			
	Home Nurse			Home nurse/ midwife
	Division 'A' (rural)	Division 'B' (semi-rural)	Division 'C' (industrial)	Division 'A' (rural) and Division 'B' (semi-rural)
General nursing care	6·0	4·4	4·1	2·4
Dressings	1·3*	2·0	1·2	0·5
Injections	3·2*	2·8	3·7	1·9
Miscellaneous nursing care ...	1·3	1·4	0·5	0·7
Total patients visited on average for nursing care daily by each home nurse and home nurse/midwife ...	11·4	10·5	9·6	5·5

Antenatal attention in the home	0·8
Attendance in labour	0·1
Postnatal attention in the home	1·4
Total patients seen on average daily by each home nurse/midwife for maternity care	2·3

* The one bathing attendant is excluded from these figures

Table 7

Home Nurses' and Home Nurse/Midwives' averaged views on the proportion of their home nursing work which could be equally well performed by other staff.

(Based on a review of each of the 1,922 patients treated during the survey).

	Home Nurses' views (averaged)			Home nurse/ midwives' views (averaged)
	Division 'A' (rural)	Division 'B' (semi-rural)	Division 'C' (industrial)	Division 'A' (rural) and Division 'B' (semi-rural)
% of patients who could be equally well treated at child welfare clinics or general practitioners' surgeries. ...	4·3	15·3	22·1	9·0
% daily average nursing time which would be so taken over (calculated).	1·0	6·4	7·9	3·8
% of patients who could be equally well treated by a male nurse. ...	24·6	39·0	31·9	34·6
% daily average nursing time which would be so taken over (calculated).	21·2	38·7	30·7	29·1
% of patients who could be equally well treated by a State Enrolled Nurse.	44·0	51·7	28·6	64·4
% daily average nursing time which would be so taken over (calculated).	41·3	46·7	36·8	67·6
% of patients for whose treatment on average the present staff regard themselves as irreplaceable. ...	39·5	28·5	36·7	19·6
% of their daily average nursing time which could **not** be taken over by anyone else.	46·5	32·2	40·8	20·7

Table 8

Miscellaneous findings.

(*a*) *Travelling time of non-motorists.*

Only 10 staff in the survey were non-motorists and the mean figure for their daily travelling time was 1 hr. 37 mins. (representing 235 working days). For all staff in the survey, the mean time was 1 hr. 23 mins.

(*b*) *Return visits to seriously-ill patients.*

The number of return visits by all staff in the survey when engaged on home nursing tasks was 158, and the total number of visits to patients was 13,623 (in 1,481 working days).

The percentage of patients re-visited the same day was 1·16.

COMMENT:

Tables 1—8 need little qualification. A municipal borough in Division 'A', which has a known higher proportion of elderly than elsewhere in the survey area, may have affected figures for general nursing care given in that division.

In some areas, temporary staff shortages have led general practitioners to relieve the nursing load, and they may not have restored it since new nurse appointments were made.

Nurses have pointed out that, during the survey, they tended to stay on duty in their own districts whereas normally they might have been also relieving other nurses on holiday in adjacent districts, with a consequently greater work load.

In addition, no diary entries were made of time spent " on call " and this does not appear in the tables of figures representing their daily work load.

Disposable sterile syringes were in use for all injection procedures.

SUMMARY:

Figures are given which define the scope and extent of the work of 59 home nurses and home nurse/midwives, based on diary entries made on 1,481 nurse days.

These might serve in future:—

1. To decide what establishment of nurses is needed to carry a given work load;

2. To decide whether the work load is evenly distributed between staff, and to check on complaints of overwork by individuals;

3. To decide future policy regarding use of auxiliary staff to assist home nurses, and

4. To decide future policy regarding coverage of rural areas for nursing and domiciliary midwifery.

AMBULANCE SERVICES

I am indebted to Mr. V. Whitaker, O.B.E., County Ambulance Officer, for the following information and report:—

	Year ended 31st December		Variation on 1962	1962 compared with 1961
	1962	1963	Increase	Increase
Admissions	48,077	51,449	3,372	1,252
Discharges	26,790	28,905	2,115	1,059
Transfers	11,456	12,290	834	447
Out-patients...	404,618	438,405	33,787	13,013
Accident patients	13,439	14,633	1,194	827
Total of Direct Services	504,380	545,682	41,302	16,598
Total of Direct Services plus Agency and Hospital Car Services ...	542,939	584,537	41,598	22,486
Mileage of Direct Services... ...	3,214,998	3,454,041	239,043	55,621
Total Mileage (including Agency and Hospital Car Services) ...	3,602,390	3,869,299	266,909	93,368

This year has been notable for the large increase in the number of patients conveyed. The increase over 1962 is three times that of the average increase over the previous four years.

The steep rise in respect of out-patients again emphasises the Hospital policy of increasing their out-patient services in order to relieve bed space.

The doubling of the increase in admissions and discharges over the previous year's increase is an indication of the Hospital policy of shorter stay for in-patients.

In order to meet this heavy increase in demand, the vehicle fleet has, during the year, been increased from 150 to 162 by the introduction of 12 Hillman Estate Car/Ambulances. The staff establishment has been increased from 460 Driver/Attendants to 488.

The Estate Car/Ambulances carry one stretcher and two sitting cases. Their use has improved the service to the stretcher emergency cases and so relieved the larger capacity ambulances for work involving a larger number of patients.

The design of the new ambulances ordered this year shows two major changes —sliding doors on the off and nearsides and a sliding door in the bulkhead dividing the patient and driver's compartments. The first is a safety factor and whilst the second obviates the driver alighting into the roadway, it also allows ease of communication and attendance between the crew and the patient.

Construction of new staff, office and garage accommodation at Maltby has commenced. Plans are approved for a new station at Bentley and new staff and office accommodation at Pudsey.

Owing to the termination of the lease of the premises, Morley Station has been transferred to and amalgamated with Birkenshaw Station.

An extensive modernisation scheme has been approved for the service radio network which, when completed, will provide the best possible results in the use of radio for Ambulance Service Control.

In the National Competition for Local Authority Ambulance Services, a team from the Service came second, winning the Middlesex Shield.

PREVENTION OF ILLNESS, CARE AND AFTER-CARE

Health Education:

" When desperate ills demand a speedy cure,
Distrust is cowardice, and prudence folly."

Recent events have proved how true is this quotation from Samuel Johnson's " Irene ".

Every ill demands action and the speed required depends upon the severity of the condition, but in many instances, either the severity goes unrecognised or is deliberately ignored. Personnel concerned with health education are only too well aware of these facts which provide some of the many frustrations associated with their work. Examples can be found in many fields but none more surely than in those of cigarette smoking and home safety.

Since 1961, the home safety exhibition that tours the County has included stands displaying a wide range of flame-resistant materials such as winceyette, poults and satins suitable respectively for nightwear, dressing gowns and party dresses. Detailed information has also been given to the public regarding prices and availability of such materials. However, upon application to the shops, many people have been told that such materials were no longer stocked because the demand had been insufficient to warrant it. Evidence of this inability to obtain these specially treated materials has been experienced by our own supplies department which requested tenders from some sixteen firms, six of whom quoted but only two provided samples of flame-resistant garments. Shopkeepers give the reason for the small demand as being the extra cost involved which is estimated to be at least fifty per cent. more than that of ordinary material. The result of the shopkeepers refusal to stock the special materials is that some firms, which have spent considerable sums of money on perfecting the process of flame proofing, have been forced to abandon their production of it. Consequently, it has been necessary to limit our stands and teaching to the one remaining product that is guaranteed to be flame-resistant and which is not suitable for garments such as dressing gowns and party dresses, items likely to be so very dangerous in the vicinity of fires. Thus we have come full circle and in addition to the disappointment caused by such a retrograde step we are aware that having aroused interest in this very important matter and also having gained the confidence of a large number of people, their inability to procure these materials tends to make them sceptical of our health teaching. They feel, quite rightly, that if a matter is of such paramount importance to safety, especially of young children, it must surely require comparable recognition and action.

Another subject that suffers through indecisive action is that regarding the causal relationship between cigarette smoking and ill health. We find there is much distrust shown, not only because the adolescent distrusts restrictions imposed by adults; or because adults distrust their ability to do without cigarettes; but in the general approach to this problem. Advertisements in favour of cigarettes are still prominently and attractively displayed on hoardings, in magazines and on television. Adults in charge of youths, who should themselves be setting good examples, continue to smoke in their presence and apparently make little or no attempt to curtail the habit. Consequently, we find that in discussions on this topic, some of the most frequent questions posed include " If cigarette smoking is so injurious to health, why is it that the people at the top take no action about selling cigarettes?". Is it because they have such implicit faith in humans that they hope they will stop smoking or is it because they do not believe the findings of the Report on Smoking and Health?

It seems obvious that our labours to conserve and improve the health of the community are not always assisted by a too liberal approach to problems and that desperate ills do demand speedy action.

Nevertheless, despite the frustrations and difficulties, more health education has been undertaken to an ever increasing number and range of people, in addition to consolidating projects already started.

During 1963, programmes concerned with smoking and health were again given priority especially in schools and youth clubs and the mobile unit of the Central Council for Health Education continued its programme in the County. During the forty-five days of their stay, the graduates visited a large number of schools and were well received by both staff and pupils. In addition to visiting schools and youth clubs the graduates lectured and showed the films at factories, rotary club meetings, prison and borstal institutions and to groups of farmers at a cattle market. It is too early to assess the value of their visit but it is hoped that at least some indication of this will be available within the next year. Prior to the visit by this special unit questionnaires were completed by some 800 school children roughly half of whom heard the graduates lecture and saw the films " Smoking and You " and " Spotlight on Smoking ". Some three months later all the groups of children were asked to complete a second questionnaire and the over-all results are at present being assessed by the Central Council for Health Education. Although the presentation of the questionnaires was undertaken by a member of the County staff, the project forms part of a national enquiry into the smoking habits of eleven year old children and it is, therefore, not possible to report on it. Suffice to say that on the children's own admission a high percentage of eleven year olds have become accustomed to cigarettes. Thus the policy of this Authority as revised in 1962 to send to the parents of seven year old children a letter with information concerning the dangers of cigarette smoking would appear to be well justified.

One headmaster followed up the visit of the mobile unit with a written questionnaire which resulted in answers such as:— " I was shocked ", " We have had a warning our parents never had ", " I will not smoke when I am older and I shall try to encourage my father to stop ". A youth leader reported that as a result of the unit's visit to his youth club three of the members had decided to give up smoking.

Whilst the visits of the mobile unit provided a valuable boost to our programmes it did not replace the work undertaken by the medical and nursing staff on this subject. In every division lectures have been given, illustrated by graphs, flannelgraphs, films and film strips, posters have been displayed and suitable leaflets distributed on this vital matter, and it is envisaged that such activities by the staff will be continued for some considerable time. Every effort is made to ensure that suitable visual aids are available to any member of the staff undertaking teaching on this and, indeed, on all matters relating to health.

It is only natural that as demands increase, so must the equipment, and two new sound projectors bought bring the total number of sound projectors to ten, eight of which are decentralised and two are kept in central office for use by central office staff, those divisions in close proximity to central office and for replacement in case of breakdown. All ten projectors have been in constant use throughout the year and there have been many occasions when no projector was available. Dr. Ward, Divisional Medical Officer (Colne Valley), refers to this in his report stating:—

" Film strips and sound films are in great demand and the presence of a second strip projector in the division has been greatly appreciated and put to full use. The use of sound projector, however, creates a difficult problem as it is shared with two other divisions—Todmorden and Brighouse. This is a far from satisfactory arrangement as all three divisions are using it to an increasing extent. The result is that frequently it is required on the same day in two divisions, and whilst one from Central Office is sometimes available, this is not always the case. The problem too of transport is a great time consumer and is expensive. It would seem that sharing at least with only one division would relieve the situation."

Another division that suffers for want of a projector is Goole from where Dr. S. K. Appleton reports:—

" I believe that health education by films can be expanded when this division has its own projector. At present the shared projector is not available fifty per cent. of the time and a good deal of health visitor time is wasted in collecting the outfit from Thorne, Pontefract or Wakefield."

A considerable amount of health education in schools has been undertaken in this division and continues to increase as can be seen from this further extract from Dr. Appleton's report:—

" The course of health education for senior girls at the Goole County Secondary School was completed at Easter as scheduled. At a meeting between the headmaster, the health visitor concerned, and myself, it was agreed that the syllabus had been satisfactory but by fourteen years of age many children had formed bad habits and some of these, such as smoking, would be difficult to reverse.

Starting with the winter term, 1963, therefore, the lectures, suitably modified, are being given to the six junior classes. By repeating the lectures and demonstrations to different classes they can be fitted into two mornings a week. A somewhat similar series of talks is being given to a small group at the Goole St. Thomas Roman Catholic School."

Other divisions that report additional health education in schools include Spenborough where a total of 363 lectures were given. These covered lecture courses to senior girls at all secondary modern schools and a modified course to pupils at the day E.S.N. school.

Dr. Gordon, Divisional Medical Officer (Todmorden), also reports more health education in schools being undertaken by his health visiting staff and states that:—

" Throughout the year talks have been given by the health visitor to almost all infant and junior schools in this division. In addition to Calder High School, we have regular teaching sessions at Ryburn Secondary Modern School, Sowerby Bridge."

An entirely new approach in the schools was the setting up of the complete home safety exhibition in the library at Wickersley Secondary Modern School for a week in October. The children were asked to comment on any dangers not high-lighted and the response was interesting and illuminating. The headmaster felt that the venture had been well worth while. This exhibition, consisting of models of every room in a house, as well as a model garden complete with pool, has been in constant demand throughout the year and has been seen by many thousands of adults and children in agricultural shows, schools and special exhibitions as far afield as Gargrave, Conisbrough, Penistone, Emley, Wetherby, Shipley, Heckmondwike, Aireborough, Wath, Sowerby Bridge, Goole and Pontefract. In order to satisfy demands for home safety material, a set of six peg-board displays has also been made available and has been used in many areas.

There has been a greater demand for leaflets, bookmarks and quizes and the number distributed have been in the region of:—

Leaflets	150,000
Bookmarks	33,500
Quizes	1,300

The main increase here has been in the distribution of bookmarks which is accounted for by the provision of specific ones, particularly those relating to the dangers of smoking, to the County Librarian who has kindly agreed to endeavour to further health education by making them available in county libraries. With the provision of new visual aids, such as display materials, the demand for posters has decreased considerably during the past year and the total of posters and dayglos strips distributed amounted to approximately 4,800, some 12,000 fewer than in 1962, whilst the number of flannelgraphs requested was 38, a decrease of 22. We hope in the near future to be able ourselves to produce many visual aids geared more closely to the needs of the area and the specific problems involved. Requests for such aids are frequently received from the staff who find some of the nationally produced ones unsuitable for their own specific purposes.

As the number of mothers' clubs continues to increase so does the amount of health education at them undertaken by the medical and nursing staffs. These talks cover a variety of topics all relating to health matters. One such club, opened at Wath in June, meets every fortnight and has a regular attendance of between 30 and 40. Dr. Cusiter, Divisional Medical Officer (Wath), also reports that one mothers' club in his area occasionally shares its meeting with the psychiatric club, a move which has proved very successful and which has been appreciated by the mental health staff. Such a move can indeed be interpreted as good practical health education.

A request was received from one mothers' club for a lecture and film on the subject of venereal diseases and a similar request has been recently received from a youth club leader at the instigation of members of the club. This is a subject for which we have received few requests for talks to date but some health visitors do include it under the over-all heading of " Infectious Diseases." Other health visitors also refer to the subject when dealing with sex education but the content of the syllabus depends to a large extent on what the head of the school considers suitable and is prepared to accept. From Colne Valley, Dr. Ward reports:—

> " No special talks have been given on this subject though mention has been made when talking to school leavers under the heading ' Infectious Diseases and Social Relationships '. An attempt was made to introduce some such talks under the title of ' Training to Live ' in the Uppermill Secondary Modern, but this was not acceptable to the staff, though it was suggested the subject would be discussed at Parent/Teachers Association and the opinion of parents sought. Nothing has, as yet, been heard as to the result of this."

In an effort to prevent further spread of venereal diseases posters giving details of special clinics, including address and telephone number, have been displayed at police stations.

Thus we slowly progress in our efforts to enlighten the public on healthy living. Amongst the many problems yet to be overcome, one can include those of distrust and prudence where urgent matters are concerned.

Recuperative Home Treatment:

Three hundred and eighty-nine applications for recuperative home treatment were received as compared with four hundred and twenty-seven in the previous year. Two hundred and seventy-five—seventy-six men and one hundred and ninety-nine women (five with children)—were admitted to one or other of the undermentioned homes. The remaining 114 applications (29·1 per cent.) were cancelled.

Binswood Short Stay Home, Didsbury, Manchester; Blackburn and District Convalescent Home, St. Annes on Sea; Boarbank Hall, Grange over Sands; Brentwood Recuperative Centre, Marple, Cheshire; Spero Holiday Scheme;

Elizabeth Fry Home, York; Evelyn Devonshire Convalescent Home, Park Hall, Buxton; Hunstanton Convalescent Home, Hunstanton, Norfolk; Metcalfe Smith House, Harrogate; Semon Convalescents' Home, Ilkley; Shoreston Hall, Seahouses, Northumberland; Tudor Convalescent Home, Bridlington.

The County Council have agreed in principle to the acquisition of premises suitable for adaptation for use as a convalescent home, but although several properties have been inspected these have either proved unsuitable or it has been necessary to abandon negotiations because of failure to reach agreement on a price acceptable to the District Valuer.

Provision of Nursing Equipment in the Home:

16,234 items of nursing equipment were issued to patients being nursed in their own homes, an increase of 1,075 over the 15,159 items issued in 1962. The following schedule shows the wide range of equipment which is now made available.

Item	Number on loan	Number available for issue	Total	Number of issues during year
Bath lift	—	1	1	—
Bath seat	5	—	5	5
Bedding: blankets, pillows and cases, sheets, etc.—pieces	923	354	1,277	1,061
Bed blocks	17	144	161	36
Bed cradles	239	129	368	512
Bed pans	1,128	630	1,758	3,085
Bed rests	503	229	732	1,222
Bed tables	10	9	19	13
Bedsteads: hospital, with self-lifting pole, and other	239	16	255	339
Chairs: geriatric, relaxing, high rest, "Amesbury" play, stairway (carrying) etc.	26	9	35	32
Colostomy sets	2	6	8	2
Commodes: chair and other	458	4	462	822
Cushions: air and "Dunlopillo"	34	21	55	143
Enuresis alarms	237	17	254	856
Fracture boards	44	3	47	56
Hemiplegic Exercisers	2	2	4	3
Hot water bottles	5	60	65	13
Ileostomy sets	3	5	8	3
Lifting hoists	17	2	19	25
Lifting pole and chain	13	6	19	10
Mattresses: air, biscuit, "Dunlopillo," hair, water, "P.C.P.," spring-interior	323	24	347	490
Open-air shelters	6	5	11	5
Pressure rings: air and foam rubber	611	493	1,104	1,576
Rubber/plastic sheets	1,109	502	1,611	2,624
Sputum mugs	55	213	268	61
Urinals: male and female	647	685	1,332	1,628
Walking aids: 'Amesbury,' 'Bonaped,' 'Zimmer,' 'Companion,' crutches,tripod, walking sticks	467	166	633	667
Wheel chairs: bath, folding, junior, self-propelled, spinal, stairway, etc.	411	70	481	882
Miscellaneous: feeding cups, steam kettles, breast pumps etc.	36	73	109	63
	7,570	3,878	11,448	16,234

During the year, a Departmental Working Party was appointed to review the range of nursing equipment, not only under the Care and After-Care Scheme but

also in the Home Nursing Service, with the object of determining the adequacy and suitability of the equipment in the light of advances which have been made in the design of certain items and in the materials used in their manufacture, *e.g.*, disposable items. The Working Party met on a number of occasions but their findings and final recommendations were not completed at the end of the year.

Laundry Service for Incontinent Patients:

There was no extension of this service during the year, facilities being available in only six divisions of the County.

The provision of disposable pads as an alternative to a laundry service, and of waterproof protective pants for the ambulant incontinent patient are being supplied in greater numbers. This service, although regarded as a " second-best " to the laundry service is, nevertheless, much appreciated by patients, relatives, and the home nurse.

Liaison with the Hospital Service and General Practitioners:

In 1963 the Minister of Health was still concerned about liaison between hospitals, general practitioners and public health authorities; so much so that a circular was sent out to both hospitals and health authorities with a recommendation that a delegated officer be appointed by the local authority in order to foster this relationship and to be responsible for the communications between hospitals, general practitioners and local authority personnel. This could be an ideal situation if public health nursing staff could be made available to do this type of work. There is, at the moment, a greater awareness of domiciliary care amongst hospital personnel and this is the time when much can be done to work together with the medical and nursing staffs within the hospital.

There has been little evidence during the past year of consultant physicians and surgeons discharging their patients at an earlier date to the care of the general practitioner and home nurse; this, I am sure, would be most welcome and would give a stimulus to all personnel whether medical or nursing. There has, however, been an increase in the number of domiciliary nursing personnel visiting hospitals for liaison and more requests have been received by Divisional Medical Officers for help.

GERIATRICS:

Work in this field is certainly growing and most health visitors find it an absorbing occupation, though time consuming.

Care and after-care of the geriatric patient was first started at Knaresborough Hospital and it would seem from the following report sent in by Dr. Hepple, Divisional Medical Officer, Harrogate, that the special health visitor is giving more time to this work and, in particular, to helping general practitioners in finding somewhere to place their cases:—

> " Visits are made by the special health visitor each day to the Knaresborough Hospital for the purpose of collecting messages from the general practitioners who require accommodation for geriatric patients. Princess Road Hospital, Ripon, is visited approximately once or twice weekly for the same purpose.
>
> The work is of a full-time nature and more time is now spent at the hospitals discussing admissions and after-care of discharges with matrons, ward sisters, welfare officers, relatives, or with matrons of other private establishments.

There have been no special developments of note during the past year but I would say more time is being used to assist general practitioners with other aspects of geriatric care, *e.g.*, admissions to private accommodation, nursing homes, etc. and arrangements for care of geriatrics whilst their relatives are on holiday during the summer months."

In Rotherham, Moorgate Hospital is visited twice weekly and monthly meetings with the Geriatrician are held to review cases awaiting admission.

Liaison has been established during 1963 with the Almoners' Department of the Oldham and District General Hospital in relation to the geriatric patients and Dr. Ward, Divisional Medical Officer, Colne Valley, states that a health visitor visits the Almoners' Department regularly to discuss geriatric cases, and this arrangement appears to be working satisfactorily.

Dr. Appleton, Divisional Medical Officer, Brighouse, sent in the following report:—

" The Divisional Nursing Officer attends regularly at St. John's Hospital, and background reports are discussed with the Almoner by the Divisional Nursing Officer, and some priority is given to these cases for admission. Previously we were relied on for social histories and for assessing the relative needs of patients for admission. We have found recently, however, that there is an increasing tendency for cases to be admitted for medical reasons and social reasons take second place. Where the only illness is old age, inability and incapacity, social cases tend not to be admitted. The hospital is very disinclined to admit cases where active medical treatment is not required.

Sometimes the Divisional Welfare Officer is more successful at getting cases admitted than we are, for he has a bargaining power. If he will accept a case into Part III accommodation from the hospital, the hospital will accept a case on which there are urgent social grounds and, with no control over the admission of cases to County Welfare Homes, we are able to do less than we could.

Before admission, all cases are now seen by either the Consultant at out-patients, or as domiciliary visits. Although medical grounds are extremely important some of the cases could well be admitted to the wards of general hospitals, although it must be admitted that the medical wards of these hospitals are already overweighted with people of pensionable age.

It is felt that a further step might well be the establishment of a geriatric clinic in our clinic premises, attended periodically by the Geriatric Consultant, and in-between by our own staff, who would be in attendance at his visit.

The provision of a day hospital has given us increased scope for co-operation. Patients are dressed and persuaded to be ambulant who otherwise would remain in bed."

Dr. Caithness, Divisional Medical Officer, Batley, has sent in the following report:—

" While no health visitor in this division has an official appointment as a hospital liaison officer, there is a direct liaison in relation to geriatric patients in two hospitals.

As in former years, all applications received at Staincliffe Hospital for admission to geriatric beds are referred to the Health Department for completion of an environmental report. As far as possible all these reports are done by one health visitor, although a few may be completed by other health visitors in her absence. The use of one health visitor only for this work is considered desirable in order to provide a uniformity of opinion in the last paragraph of the report in which the health visitor indicates the degree of urgency for admission to hospital. In addition to receiving the names of patients requiring admission direct from the hospital, a small number of environmental reports are initiated in this office as a result of requests direct to this office by general practitioners.

In this work the health visitor maintains frequent two-way contact with the consultant's secretary, both with regard to first visits to these cases and, more important, in repeating requests for admission to specially urgent cases.

121 environmental reports were completed during the year. Of these, 17 were reported as suitable for Part III accommodation, although the original request had been for admission

to a geriatric unit. Three patients died before admission to hospital could be arranged. Follow-up visits made equals 294. Total visits concerning hospital admission to geriatric patients equals 415. (The follow-up visits are made to those cases which were not deemed to be immediately urgent in order to assess any change in circumstances and also, unfortunately, to a number of very urgent cases where admission to hospital had not been immediately possible).

In many of these cases, consultation is made with general practitioners (from time to time to discuss whether a patient is really a case for a geriatric bed or, alternatively, for Part III accommodation). The health visitor also arranges for other social services *e.g.*, home helps, home nurses, while the patient is waiting admission to hospital, if these services are not already in use.

The above figures are confined entirely to cases awaiting admission to hospital. Large numbers of visits are paid to other elderly patients who are in need of care and attention and, in view of her liaison work with the geriatric units a high proportion of the other visits are placed in the hands of this one health visitor."

From reports received from Divisional Medical Officers it would seem that there are very few hospitals where there is no liaison with local authorities either directly or indirectly in relation to the care of the geriatric patient.

DIABETICS:

During 1963 diabetic liaison work was started in the Doncaster area and Dr. Ferguson, Divisional Medical Officer, has sent in the following report, written by the liaison health visitor, Miss M. Elliott:—

" Liaison work at Dr. Milligan's Diabetic Clinic was started in February, 1963. The out-patient clinic for diabetics only is held every Thursday afternoon and approximately 20—24 patients attend—of these an average of 12—14 are from Doncaster Rural and Thorne area, and there are usually 1 or 2 new patients each week.

Approximately 250 patients from the County area attended this clinic during 1963 (this number is not the total of diabetics in the Division as many mild cases or easily stabilised and well controlled cases are in the care of their own general practitioner).

The cases referred to the Doncaster Royal Infirmary are cases that—

(1) are difficult to stabilise/control,

(2) present complications, or

(3) are sent by the general practitioner for initial stabilisation and then later are discharged to his care.

During the clinic I am present when each case is seen and treatment is discussed. Afterwards I have a talk with the patient and discuss any problems (usually dieting ones) and if necessary make arrangements for a home visit. Fortunately most of the patients do not require home visits; the ones who do are mostly elderly patients who are in difficulties with their diets. Visits are always paid to new patients after their first attendance at the clinic if they have special diets and treatment ordered. Subsequently home visits are paid if necessary, depending upon individual circumstances.

The last few months home visits have also been paid at weekly intervals for as long as necessary to patients who are not stabilised in order to attempt better control without bringing the patient back to the infirmary each week. These visits are only paid at the direct request of Dr. Milligan.

After each clinic the medical wards are visited, and other wards if necessary, to visit any diabetic in-patients and discuss with them any problems they may have, a follow-up home visit is done after discharge in the case of newly discovered diabetics, and if found to be necessary with the other ones.

Defaulters are not followed up—Dr. Milligan feels it is not necessary, taking none attendance as indication that the patient is well—they attend without an appointment when they are feeling ill etc.

I have had very good co-operation from the district nurses at all times, and any information I have needed about family backgrounds etc., has been readily supplied by health visitors, nurses etc.

The patients have appreciated having someone with whom they could discuss their problems whether at the out-patients department or in their homes without feeling they are taking up the time of the doctors and nurses. Very often, too, when home visiting I have found other members of the family, and neighbours, all assembled to discuss various points about diabetes and ask many questions."

In Castleford the work has increased and it was found necessary to appoint an additional health visitor to this service.

Colne Valley area is still doing the liaison with the Consultant at Huddersfield Royal Infirmary and Dr. Ward, Divisional Medical Officer, reports:—

" All new patients are visited regularly until they fully understand how to live with diabetes and all the young diabetics and the elderly living alone, or with other complications are also visited regularly. Any patients in receipt of National Assistance are advised to apply for the extra dietary allowance which can be given.

This visiting also extends to Divisions 17 and 18. This work takes approximately 3 days weekly. Many visits take place in the evening."

MATERNITY:

Liaison between maternity hospitals and local authorities is slowly improving and the trend is for further improvement, particularly with the 48 hour discharges. The hospitals in Wakefield have a good liaison service and here is a report sent in by Dr. Ireland, Divisional Medical Officer, Morley, and written by Mrs. A. Gillies, Health Visitor:—

" Two hospitals namely, Manygates and the General Hospital, are each visited weekly.

The information collected includes the name and address of the baby, date of birth, and the birth weight.

Time spent in the hospital is only about thirty minutes per visit, but considerable time is spent telephoning Health Visitors in the areas of the babies' homes. Some Health Visitors can be contacted at clinics but most have to be contacted in the evening. Any information about family background and home conditions is passed on to the hospital concerned. The Health Visitor is informed when a baby is going to be, or has been discharged. This part is most important especially when babies have been kept in hospital some time and the Health Visitor does not have to rely on the mother letting her know when a baby comes home.

Recently a ' follow-up ' clinic has started at Manygates Hospital on Monday mornings at 10-00 a.m. As it is only just starting it does not last very long, but it should soon prove to be very helpful.

The Health Visitors will be able to have information passed on quickly and accurately about babies in their area, instead of asking the mother about the visit. Time spent in this clinic so far has been less than one hour, but it will probably take longer once the clinic is firmly established.

When visiting both hospitals, information about other babies is heard, and passed on to the appropriate Health Visitor."

The work done with Professor Craig is still successful and Miss B. S. Smith, Health Visitor, Morley, has sent in the following report:—

" Liaison with the Premature Baby Unit has continued at Leeds Maternity Hospital. This occupies two half days a week at the hospital, one to do a ward round with Professor Craig, the second at a follow-up clinic. All babies with any abnormalities or disease are followed up, as well as those who are premature. Reports as to home conditions are obtained from the health visitors, and the babies discharge notified, with any special points as to continuing care.

Since January, it has been agreed to assist Professor Craig with a research project into infection in the neonatal period. This involves the completion of a form on every baby discharged to the West Riding, at the end of the fourth week of life.

In December last year, liaison was started between the West Riding and the Department of Pædiatrics. This involves a ward round at the General Infirmary with Professor Craig and attendance at his clinic, seeing children with emotional problems. Most of the children seen are of school age, and information obtained from, and given to the Divisional Medical Officers. As this work has only just started, it would be difficult to assess at present."

The future trend seems to be early discharge from hospital and this will need greater liaison between the services and it will be interesting to see how it works out.

CHILDREN:

In this sphere of work the Pædiatrician usually contacts the Divisional Medical Officer either for background history or an environmental report.

Dr. Caithness, Divisional Medical Officer, Batley, sends in the following report:—

" Information is sought from time to time from the Consultant Pædiatrician in order to assist in the ascertainment of handicapped children. Similarly, the Consultant requests information on children attending his clinics, with special reference to (a) home circumstances, (b) previous action by this department, particularly in relation to intelligence tests."

CHEST DISEASES:

Liaison with chest physicians continues both directly and indirectly, the latter being the method used more frequently now than direct liaison. The health visitor responsible for after-care of tuberculous patients only needs to attend the clinic for the purpose of getting or giving information and this can quite frequently be given over the telephone and thus conserves the health visitor's time.

Dr. Cusiter, Divisional Medical Officer, Wath upon Dearne, reports:—

" Two health visitors attend the chest clinic at Mexborough Montagu Hospital. One of these attends a regular weekly chest clinic session, and the other attends one session per week to discuss cases with the Consultant and peruse the records."

Dr. Ward Divisional Medical Officer, Colne Valley, sent in this report:—

" All the health visitors in this division are also tuberculosis visitors and they visit the chest clinics to obtain information from the patient's case records or to discuss any cases with the chest physician or sister.

They do this as the need arises, and co-operation between the two departments is very good."

Chiropody Treatment:

It was felt necessary to review this service during the year because of recent developments, notably changes in the scale of payments to chiropodists and the national scheme for the registration of chiropodists.

As will be seen from the statistics appearing later in this report, a considerable amount of work is undertaken in chiropodists' surgeries, mainly in connection with the schemes administered on the County Council's behalf by voluntary associations and, under the Whitley Council approved rates of payment, the cost to the County Council of treatment given in the chiropodist's own premises

at 9s. 0d. per case is considerably greater than the cost of treatment given sessionally in the premises of the voluntary association or a clinic where the standard rate of payment is £2 5s. 0d. per session of three hours during which period a total of nine patients can be treated.

During the year it became evident that under the statutory machinery for the registration of chiropodists, the majority of chiropodists working in the scheme were being accepted for registration. The Minister has already intimated to local health authorities that, as the purpose of the state registers is to provide evidence of a universally-recognised standard of professional competence and conduct regulations will be made prescribing state registration as the sole condition of employment or of continued employment in the National Health Service.

Hitherto local health authorities have only been permitted to employ directly chiropodists who had undertaken a prescribed form of training and examination and because of this restriction the County Council in their wish to provide as wide a service as possible enlisted at the outset the aid of voluntary associations already operating schemes and encouraged new schemes by voluntary associations, under which chiropodists not possessing the prescribed qualifications could be employed.

As all registered chiropodists will be eligible for employment directly by the County Council, and as many voluntary associations would be quite willing to surrender their schemes which, in some instances, have been onerous to administer, it was felt that the time might be opportune to extend the scope of the direct service in areas where good clinic facilities were available and reasonably convenient, thus integrating the chiropody service into the other clinic services at the same time achieving an appreciable financial saving.

The following recommendations were accordingly submitted to the Health Committee towards the end of 1963 and their decision is awaited:—

(1) Where conveniently possible, treatment should be provided sessionally in clinic premises or the premises of voluntary associations.

(2) Where circumstances permit and a direct service can be introduced integrating the chiropody service with other clinic services schemes at present administered by voluntary associations be discontinued providing always that this does not decrease the amount of service already available and that no voluntary scheme be discontinued contrary to the wishes of the voluntary association concerned without reference to the Health Committee.

(3) Provision for an establishment of whole-time chiropodists.

At the end of the year, there were 110 voluntary associations taking part in the scheme and in addition, a direct service was available at 60 clinics and at the premises of 33 chiropodists.

The total number of patients treated during the year was 37,874, compared with 34,962 in 1962, 31,526 in 1961 and 19,918 in 1960. The total number of treatments given was 173,851, compared with 162,032 in 1962, 141,410 in 1961 and 69,439 in 1960.

Of the 37,874 patients treated, 36,802 were in the aged category which represents some 16·0 per cent. of the estimated population of men over sixty-five years of age and women over sixty. It is to be expected that this percentage will continue to increase as and when the service can be expanded in certain areas.

The pattern varies widely over the County as a whole; in the Skipton, Castleford, Brighouse, Todmorden, Barnsley and Wath Divisions the percentage of the aged receiving treatment during the year was 28·2, 22·5, 26·0, 21·4, 24·9 and 21·5 respectively, whereas in the Horsforth, Harrogate, Goole and Pontefract Divisions the percentage was as low as 7·3, 7·2, 7·1 and 6·2 respectively. In four Divisions, the percentage was between 10 and 15 and in nine Divisions between 15 and 20.

The extent to which domiciliary treatment was provided during the year on medical grounds continues to give rise to some concern in some areas. Again the pattern varies widely but in ten Divisions more than 30 per cent. of the aged persons receiving treatment were doing so on a domiciliary basis.

The following is a statistical summary showing the extent to which treatment was given during the year under the agencies of the voluntary associations and directly by the County Council.

	Voluntary Association Schemes	*Direct Service by County Council*	*Total*
Number of sessions held:			
In voluntary association premises ...	4,744	—	4,744
In clinic premises	—	3,858	3,858
	4,744	3,858	8,602
Number of patients treated:			
In chiropodists' surgeries:			
Pensioners	8,858	2,912	11,770
Physically handicapped	81	70	151
Expectant mothers	9	5	14
In voluntary association or clinic premises:			
Pensioners	8,727	6,729	15,456
Physically handicapped	109	99	208
Expectant mothers	6	11	17
Domiciliary treatment:			
Pensioners	5,560	4,016	9,576
Physically handicapped	304	377	681
Expectant mothers	1	—	1
Total number of patients treated ...	23,655	14,219	37,874

	Voluntary Association Schemes	*Direct Service by County Council*	*Total*
Total number of treatments given:			
Pensioners	107,523	62,303	169,826
Physically handicapped	1,868	2,104	3,972
Expectant mothers	30	23	53
	109,421	64,430	173,851
Number of patients treated per session:	8·2	8·0	8·1
Percentage of total patients treated receiving domiciliary treatment	24·8	30·9	27·1
Percentage of aged population receiving treatment (men over 65 years and women over 60 years)	10·1	5·9	16·0

DOMESTIC HELP

The year commenced with an establishment of 1,100 equivalent whole-time domestic helps but during the early summer months it was found that the rate of usage of domestic helps was unexpectedly high for the time of the year, due to an increase in the demand for the service which was greater than had been anticipated, and it appeared that it might not be possible to build up a reserve of hours to meet the demand peak during the winter months.

A review of the service was undertaken which revealed that in many Divisions the needs of the service were only being contained within the establishment of domestic helps by reducing the amount of service given per patient to permit a service to be given to a greater number of patients. It was found that in many areas the stage had been reached where in the majority of cases (largely the aged) the service had been reduced to an average of 2 to 3 hours per week per case and that any further reduction would render the service quite ineffective. The reduction mentioned also had the effect of creating for the first time for some years a waiting list of cases.

As a result of the situation existing and having regard to the anticipated needs of the service during the worst winter months the County Council, in January, 1964, approved an increase in the establishment of equivalent whole-time domestic helps from 1,100 to 1,125 from the 1st January, 1964, and a further increase to 1,175 with effect from the 1st April, 1964.

With regard to future trends, the Domestic Help Service is one which has continued to expand year by year and it is quite impossible to forecast the eventual maximum needs. At present the service caters for only some 5 per cent. of the aged population over 65 years of age and if the true needs of this category were known it is probable that the service is required by a greater number.

The service is one in which many influences are at work—the increasing number of old people in the community, the trend towards earlier hospital discharge by the provision of more community care services, the desirability of keeping the aged in their own homes as long as possible, and the increasing birth rate which may lead to more home confinements with the consequent impact on the Domestic Help Service.

All these factors demonstrate the need to keep the service under constant observation in an attempt to determine as early as possible when the stage is being reached which calls for a review of the establishment. This is not easy to do and the difficulty becomes greater when unknown influences arise such as epidemic sickness and abnormally severe winters which take their toll in the form of a general increase in the incidence of illness in the aged.

So far as 1963 is concerned, 1,078·8 equivalent whole-time domestic helps were employed compared with 1,009·5 for 1962 and 954·6 in 1961. Sixteen thousand and seventy-two cases received 2,356,083 hours' help through the service, an increase of 644 cases when compared with 15,428 cases in 1962. The help provided for the aged represented 79·9 per cent. of cases (1962—79·0 per cent.) and 86·2 per cent. of the total hours (1962—85·0 per cent.).

Classification of Cases Assisted	*No. of Cases*	*Hours employed*
Over 65 years of age	12,848	2,031,066
Under 65 years of age:		
Chronic sick and tuberculous ...	1,360	189,331
Mentally disordered	34	4,028
Maternity	1,096	64,187
Other	734	67,471
	16,072	2,356,083

MENTAL HEALTH

The number of patients referred to the Authority during the year was 4,696, and of these 284 were subnormal or severely subnormal. Since 1913 the number of yearly referrals in this category has always been in the region of 300, and at the end of the year there were 3,212 subnormal patients actually under care. The rapid development of the training centre programme has done much to support the mentally subnormal in the community but nevertheless where a member of a family is mentally subnormal the family frequently require supportive care as much as the family of the mentally ill. In the latter field the number of referrals for after-care in the year was 2,080. Already there is evidence that an increased number of mental welfare officers will be required to deal with this increasing case load.

It is pleasing to note that the training centre programme is nearing completion and that before very long all the comprehensive training centres will have kitchen facilities. The payments to adult trainees scheme has been approved and there has been an increase in the number of special care units provided. The Parent/Teacher Associations have flourished and their support, together with that of other local associations and interested bodies is much appreciated.

A full staff training programme by way of in-service training and by the use of outside bodies has been undertaken, and in this field it is remarkable how much has been achieved so quickly.

In the West Riding, as elsewhere, there is need for more after-care facilities for the mentally ill. The provision of further day centres for the mentally ill will need attention in the future. It is more than likely that day centres will tend to keep patients in the community who would otherwise have to be admitted to hospital. The purpose of a day centre for the mentally ill is to prevent further deterioration by providing a meeting place and some occupational, educational or diversionary interests for patients not on active hospital treatment but whose condition is such that it is possible for the patient to live at home. Many of these patients are unemployable and on National Assistance—some may not normally be able to live at home because of other relatives having to go out to work and it being difficult for them to be left alone. Such patients would certainly benefit by a day centre and the relatives would be relieved by knowing that the patients are being carefully looked after socially. There are other cases where a few hours of relief from the care of patients during the day makes the limits of toleration by relatives bearable.

But most important and not the least of benefit to patients themselves is the opportunity for discussion and advice on personal problems and difficulties with Mental Welfare Officers who are in attendance.

Quite often the opportunity of expressing difficulties to a sympathetic hearing inculcates self confidence and helps in rationalising what at times appears completely overbearing to the patient. There is in addition the development of group support among psychiatric patients discharged from hospital. Experiences related and shared in a friendly atmosphere mean so much to the development of a good social spirit among the members attending. A start has been made with the provision of day centres at Snaith and Harrogate.

Many patients do attend the occupational therapy wards of the psychiatric hospitals but travel difficulties are involved, and too much dependence on the

hospital service is not good for the patient. Dr. White, Consultant Psychiatrist, Stanley Royd Hospital comments on this:—

> ". . . Although facilities exist for rehabilitation of psychiatric patients under the resettlement schemes of the Ministry of Labour, in actual fact these are not sufficiently tailored to the needs of psychiatric patients. Many of our patients could work effectively in protected employment or might require this facility as a preliminary to working up to normal occupational level, but it is virtually impossible to obtain this service for them. The local mental welfare officer does his best but he is preoccupied with many problems and in my view there should be a central office or organisation dealing with occupational problems arising from all over the region, with a close liaison with a panel of sympathetic employers, Remploy and the Disablement Resettlement Officer Service of the Ministry of Labour. In effect we would then pass over the problem of occupation for a particular patient to the central office where because of the highly specialised nature of their work, they would have a much better chance of obtaining appropriate employment for the patient than would the individual mental welfare officer."

At the Divisional Medical Officers' Conference in November the compiling of a register of persons willing to accommodate mentally ill persons was discussed, and in two divisions a start had already been made by the end of the year. There will always be persons who will be unsuitable for hostel accommodation but who can manage perfectly well if the right lodgings can be found for them. The matching up process can be a long and trying job but a beginning has been made and an extension of this service is certainly desirable.

Training Centres:

The following is a list of the training centres in operation at the end of 1963, with details of the places provided:—

Centre	*Junior*	*Adult Male*	*Adult Female*	*Special Care*	*Total*
Adwick le Street	38	25	25	—	88
Airedale (Castleford) ...	40	30	30	4	104
Brighouse Junior	27	—	—	—	27
Ecclesfield	42	26	21	6	95
Harrogate	30	25	25	6	86
Heckmondwike	36	20	12	—	68
Hemsworth	60	20	20	—	100
Horsforth Comprehensive ...	30	25	25	6	86
Horsforth Junior	27	—	—	—	27
Keighley	20	15	15	—	50
Kirkburton	30	25	25	6	86
Maltby	40	30	30	4	104
Ossett Junior	27	—	—	—	27
Rawcliffe	30	25	25	4	84
Rothwell	30	16	14	4	64
Wath upon Dearne... ...	40	25	25	—	90
West Ardsley	30	25	25	6	86
Wombwell	36	25	40	—	101
TOTALS ...	613	357	357	46	1,373

The extensions at Keighley and Wath are almost complete and the figures for these centres will then be:—

	Junior	*Adult Male*	*Adult Female*	*Special Care*	*Total*
Keighley	30	25	25	—	80
Wath	40	25	25	10	100

At Keighley the extension is a new adult wing in the same grounds as the present centre and at Wath the special care unit is an adaptation to the present building.

The Skipton Training Centre will probably open in September next and will have 66 places, being 24 junior, 36 adult and 6 special care.

Premises opened in 1963

Kirkburton Training Centre, Turnshaw Avenue, Kirkburton.
Rothwell Training Centre, Holmsley Lane, Woodlesford.
West Ardsley Training Centre, Westerton Road, West Ardsley.

Extensions completed in 1963

Adwick le Street Training Centre, Village Street, Adwick le Street—outside adult workshop and kitchen extension.
Airedale Training Centre, Kershaw Avenue, Airedale, Castleford, adult extensions and special care unit.
Ecclesfield Training Centre, Westwood Road, High Green, Nr. Sheffield, adult extensions, special care and kitchen.
Hemsworth Training Centre, Wakefield Road, Hemsworth—adult wing.
Maltby Training Centre, Addison Road, Maltby—adult extensions, special care unit and kitchen.
Wombwell Training Centre, Summer Lane, Wombwell—adult wing.

It will be recalled that before this year school dinners have been provided from the School Meals Service and this has meant that the meals have had to be carried to the centres. In accordance with the policy to prepare meals where they are required kitchen and canteen facilities have been provided at the new training centres, and kitchen extensions built at the other training centres. At the end of the year kitchens were in operation at West Ardsley, Rothwell, Kirkburton, Hemsworth, Wombwell, Ecclesfield and Adwick le Street Training Centres and early in 1964 kitchens were to open at Horsforth, Wath, Airedale, Harrogate, Maltby and Keighley. Provision has been made in the 1964/65 estimates for kitchens to be built at Rawcliffe and Heckmondwike. The School Meals Officer of the Education Department and the School Meals Organisers have been very helpful in the establishment of the kitchens and the new arrangements are working very smoothly indeed. It will be recalled that the adult wings of the training centres are open for 48 weeks in the year and the kitchen facilities have certainly helped in this direction.

We had two ' official ' openings during the year. On the 29th May, 1963, County Alderman W. M. Hyman, Chairman of the West Riding County Council, opened the Harrogate Training Centre and on the 23rd September, 1963, the Rt. Hon. J. Enoch Powell, M.B.E., M.P., Minister of Health, opened the West Ardsley Training Centre. Both the occasions were most impressive and the Supervisors and Staffs of these Training Centres are to be congratulated on making the days so successful.

The West Ardsley Training Centre is typical of the comprehensive training centres provided by the Authority. The centre has 86 places with separate workshops for men and women and classrooms for children; there is also accommodation and facilities for six patients in need of special care.

From the entrance hall the children's wing is to the left, comprising two classrooms with ample storage and cloakroom facilities, and access is also obtained to the special care unit, which has independent bathing and toilet

facilities necessary for this type of patient. The adult workshops are planned in the rear, each with separate access, grouped around an internal courtyard which has been designed as a small garden sheltered from the strong winds to which the site is occasionally subjected. To the right of the entrance hall is planned the assembly and dining hall, served by a large kitchen with the most modern equipment to provide lunches. From the assembly hall access is also gained to the men's workshops, which also have separate external access, and these workshops have ample facilities for a wide range of activities, together with covered outdoor workspace and stores. Equal facilities are also given to the women's workshops, but as the scope of the work to be carried on will be of a different nature, the equipment supplied will vary accordingly. Externally, a large playground is provided with a special children's play space with swings, a roundabout and a sand pit.

The centre is constructed of brick, with a flat timber roof, outbuildings being faced in Western Red Cedar boarding to give an effect of contrast, and a high standard of internal finishes has been provided. The buildings are centrally heated from a coal fired boiler with automatic stoker, with warm air circulators and radiators.

The centre was designed in the office of the County Architect, A. W. Glover, Esq., F.R.I.B.A., the General Contractors being Messrs. J. Ledgard & Son Ltd., Leeds.

Adjacent to the training centre and in course of erection is a residential hostel for 30 subnormal adults. These adults will either enter outside employment whilst living under the sheltered conditions of the hostel or attend the training centre.

INDUSTRIAL WORK:

Industrial work commenced at the training centres in 1962 and at the end of 1963 thirty jobs had been initiated. The following jobs have been undertaken for the County Supplies Department:— firewood splitting, bean bags, hardboard sketching boards, clay modelling boards, blackboards, curtains, whip stocks, wash leathers, dolls cots, flour bags, feather flicks, dish mops, children's blackboard cleaners, teachers' blackboard cleaners, counting and bundling paper, interleafing of paper, wooden blocks, file covers and file binding. Work undertaken for outside firms include the manufacture of concrete washers, composition plant pots, seed boxes, dismantling TV sets, table making and the binding of aprons. In addition the trainees have been responsible for the maintenance of grounds, laundry work and supplementary cleaning in the centres.

The ready co-operation of the County Supplies Department and the favourable response from outside firms would appear to ensure a steady flow of work suitable for the trainees to undertake. With the contracts now available a varied programme can be undertaken and the changes rung so that the work does not become too repetitive. The development of industrial work in training centres is an aspect of growing emphasis but is not to supersede the equally desirable aspects of educational, recreational and social training. The need for a balanced programme, including all these aspects, continues to be the desired aim.

More thought is being placed on training designed to enable trainees to acquire simple skills which may lead to them becoming partly or wholly self supporting members of the community. Methods of training are by imitation and repetition, by visual aids, by the use of specially designed apparatus fitted to standard machinery and by the simplification of the work into stages con-

sisting of operations involving the use of jigs and templates. In this respect greater stress is being made on the preparation for work and life in the community rather than primarily for providing work at varying levels of skill. As the two requirements are entirely different it may be that at a later stage consideration will seriously have to be given to providing sheltered workshop arrangements for a more permanent population. This can only be when it has been decided that further training in respect of some trainees would not make them socially more competent. This decision is always a difficult one in view of the very slow learning rate of the subnormal. Any hasty premature full-time work experience may bring other important developmental aspects of living to a standstill. It is not the intention to create cheap human robots for the benefit of industry. This does not contribute to the national economy and is certainly disastrous to the full development of the well-being of the individual.

As the industrial work in the centres has expanded it became apparent that a scheme for the payment of patients engaged on this work should be initiated. It is emphasised that the payments to patients should depend not only on the industrial and standards of workmanship but also on general factors including attendance and taking into account personal disability.

The main recommendations approved by the County Council are:—

(a) A scheme of payment to trainees engaged in productive work at training centres being introduced as from the 1st April, 1964, at an estimated cost during the first year not exceeding £16,000.

(b) That whilst it is intended that each work scheme shall be self-supporting as far as possible the paramount consideration is the provision of a social service and towards that end all work activities will be undertaken with the well-being of the patients in mind.

(c) That in the first year of the scheme within the cost limit indicated in (a) above a minimum payment of 5s. 0d. per week varying to a maximum payment of 15s. 0d. per week be made to patients engaged on productive work.

(d) That payments shall be made to patients during reasonable periods of absence where the absence is due to circumstances beyond their control, and payments shall be made during holiday periods when centres are closed.

(e) That in addition to contract work which may be arranged, the laundry work required in the centre, the provision of additional cleaning assistance and the care of the centre grounds be regarded as work to be undertaken by the adult patients.

SPECIAL CARE UNITS:

The special care unit is designed for those trainees who are too severely handicapped to fit into the routine of the junior or adult sections of training centres. Some of them have gross physical handicaps.

The introduction of special care units has afforded welcome relief to a number of harassed parents who, in some cases, have struggled for a number of years to bear at home the heavy burden of a severely handicapped child. These units are open for 48 weeks in the year and the patients receive individual care. The staff are very carefully selected, for the work calls for a great deal of devotion and care. The patients are from all age groups and include those who are physically and mentally handicapped, many of them being also doubly incontinent.

Activities in these units are still experimental but a pattern is emerging which indicates their usefulness to the community. Those admitted in the first instance do not readily fit into a group for routine activity at the centre. There are indeed two types of case. The first type are those members of the group who are so physically handicapped that they require every care and attention for their social needs. The other type are those of good physical mobility but because of gross mental defect are unable to follow any simple programme of training or activity and are distracting to any group suitable for training. In the main these are noisy or violent to their fellows unless under close supervision. A fair proportion of the latter group eventually do graduate to other parts of the centre.

Even in a few cases of the first type by the introduction of simple routines of toileting and feeding by virtue of the regularity of these procedures their management has become markedly easier both in the centre and at home. But most important these simple physical effects have resulted in it becoming possible for staff and parents to come closer emotionally to the trainee with improvement in mutual human relations. Many can thus be spared from becoming hospitalised and can remain in the community, to their benefit in the vital years of development. At the end of the year eight special care units were in operation and two further units at Maltby and Wath became operative early in 1964.

The position at the 31st December, 1963 was as follows:—

Airedale. This unit has four places and is 13ft. 6in. x 11ft., 148½ sq. ft. At the present time four children are in the unit, one boy and three girls. The boy, aged 10 years, is an epileptic and ambulant, one girl, aged 10 years, is a spastic and is a chair case, and the other two girls are both ambulant.

Ecclesfield. The unit has 6 places and is 15½ft x 16ft., 248 sq. ft. Five children are in attendance, three being ambulant. There are four cot cases suitable for attendance now on the waiting list.

Harrogate. The unit has 6 places and is 18ft. x 12ft., 216 sq. ft. Four children are in attendance, two cot cases and two chair cases.

Horsforth. The unit has 6 places and is 15ft. x 13ft., 195 sq. ft. Six children are in attendance, only one being fully ambulant. In addition two children are on the waiting list for admission.

Kirkburton. The unit has 6 places and is 17ft x 12ft., 204 sq. ft. Only recently opened.

Rawcliffe. The unit has 4 places and is 13ft. x 10ft., 130 sq. ft. Four children are attending, one being a cot case, two being chair cases, and one ambulant. One case from Goole area and several from the Thorne Division are suitable for admission when places are available.

Rothwell. The unit has 4 places and is 13¼ft. x 11½ft., 152 sq. ft. The unit has just opened. Two cases have so far been admitted and it is anticipated that the full complement of four cases will be reached soon.

West Ardsley. The unit has 6 places and is 15ft. x 13ft., 195 sq. ft. Five children are in attendance, two of them being quite helpless, one an epileptic, one a chair case and one is ambulant.

The main comments from the Divisional Medical Officers are that the units are too small for the type of case being admitted, the staff establishment, even for the care of six children, should be increased to two, and there are already waiting lists of patients for admission to the special care units.

The Architect based his requirements for the special care units at 35 sq. ft., per person. At all the centres bathrooms, lavatories and utility rooms adjoin the special care units, making compact units.

When the centres were being planned it was envisaged that the children to be catered for in the special care units would be severely subnormal, too low grade to benefit from instruction in the classrooms. It was expected that the majority of these children would be ambulant. However a different situation has arisen. More and more cot cases are seeking to be admitted to the special care units on a full time basis. It has been envisaged that these cases would only be taken into the centres as a temporary measure, pending their admission to hospitals for the mentally subnormal. It must be stated, too, that some of these children are extremely young, and it is apparent that the special care units are also functioning as nursery units. In most areas the need is far greater than could possibly have been forseen. With the shortage of hospital beds, and the relief the service is providing for those unfortunate and often distressed parents, it would be harsh to discriminate.

Special care units have only lately become a feature of training centres and the Ministry of Health Local Authority Building Note, issued in November, 1963 gives guidance on a unit for the care of children with special difficulties. The purpose of such a unit is to provide for the care of children who are unsuitable for the ordinary classes of the training centres, either because they are both severely subnormal and grossly physically handicapped, or because they have major behaviour problems. The note suggests an area of 40 sq. ft. per child with a maximum of 12 children to a room. A covered veranda providing out door playing space as an extension to the room is useful, and where possible, a special entrance with easy access for transport should be provided and all doors should be wide enough to take wheel chairs. A utility room of about 60—80 sq. ft. equipped to deal with soiled clothing is considered essential.

However, it is gratifying to find that the units are performing such a remarkable service and functioning to capacity. Within the next few years it should be possible to read the pattern presented by the training centres and the hospitals in caring for this new class of children who are at present being brought into the training centres and if the present trend continues then it will be necessary to assess the problem as presented at each training centre with a view to additional accommodation being provided.

Training of Teachers and Instructors:

Four in-service training courses, each lasting for 4 days, were held at Grantley Hall during the year. The courses included visits of observation to the occupational departments of the Scalebor Park and High Royds Hospitals and to nursery schools, and the speakers have included Advisers of the West Riding Education Committee in various subjects, a Supervisor of a Training Centre, a Senior Mental Welfare Officer, the Deputy County Nursing Officer and a representative of the Nottingham Handicraft Company. The courses have been arranged by Mrs. Woolley, Organiser of Training.

The seven officers who commenced attendance on the National Association for Mental Health's diploma course for teachers of the mentally handicapped in 1962 were all successful and were awarded their diplomas in July, 1963, and a deferred student from 1962 was also successful in obtaining the diploma. Four of these officers had attended the Sheffield course for teachers of junior centres, and three instructors had attended the Birmingham course for officers engaged in training adults. The officers are to be congratulated on obtaining

the awards. In this field, which has expanded so rapidly, there is a great need for trained as well as experienced officers and, of course, there is every opportunity for promotion for these officers, who sometimes find attending the courses a hardship, particularly if they have family commitments.

The Authority again made provision for ten officers to attend the Diploma Courses commencing in September, 1963, and eight officers were accepted, three on the Birmingham course for officers engaged in training adults, two on the Sheffield course for teachers in junior centres and three on the two year course held in Bristol. The Bristol course is designed for young entrants into the training centre service and they are expected to have obtained at least three subjects at ' O ' level in the G.C.E. examinations.

In addition to the above courses regular meetings are also held at either County Hall or one of the Training Centres for the different categories of officers employed in the centres.

At the end of the year the staff was 1 Organiser of Training, 18 Supervisors, 96 Assistants and 5 Home Teachers of the Mentally Handicapped. Forty-one of these officers were qualified. There were four vacancies for assistant supervisors and seven for home teachers. There are now only two group training classes staffed by teachers of the mentally handicapped and these will close when the Skipton Training Centre opens. It has been decided that the establishment of 12 home teachers will remain for the time being and there is evidence there is a need for the right type of teacher to work with those patients who have been discharged from psychiatric hospitals.

The County's Training Centres have again been selected by the National Association for Mental Health for students attending the diploma courses to undertake their practical training.

Holidays for Patients:

The Whitby party of 50 patients together with staff again had two weeks holiday at St. Hilda's Home from the 10th to the 21st June. This is the third year a holiday has been spent at Whitby and it is highly popular with the trainees, and much appreciated by the parents. It is indeed a difficult task to select from over subscribed lists and it seems that an extension of this service may have to be considered in the future.

A smaller party of trainees were on holiday at Orton Park, Carlisle, from the 19th to the 30th August. Orton Park is a hostel for mentally subnormal children provided by the Cumberland County Council and Dr. J. Leiper, County Medical Officer of Health, makes our party most welcome.

The children from the Todmorden district who attend the Stansfield View Hospital daily for training were again included in the hospital party who went on holiday to Skegness. The Halifax Area Hospitals Management Committee are most kind, for in this district of the County which is at the moment without a Training Centre, the children attend for daily training throughout the year.

Patients in Employment:

At the end of the year the number of subnormal patients shown as receiving home visits and not attending training centres was 1937, and of this number more than 700 were in full or part-time gainful employment, and more than 600 were considered to be suitably and adequately employed at home.

Mental Welfare Officers:

At the beginning of the year the establishment provided for 7 Senior Mental Welfare Officers and 46 Mental Welfare Officers. There were 7 vacancies, being one Senior Mental Welfare Officer and 6 Mental Welfare Officers. During the year three Mental Welfare Officer have resigned, one has been promoted to fill the Senior appointment, 10 Mental Welfare Officers (including two trainees) have been appointed. There has thus been a good deal of stability in most of the County districts. In view of the rapidly expanding service it was apparent that in some areas the case loads of the Mental Welfare Officers were far too heavy and the establishment was increased from 46 to 50 in March. At the end of the year there were four vacancies for Mental Welfare Officers and these appointments were filled early in 1964.

IN-SERVICE TRAINING COURSES FOR MENTAL WELFARE OFFICERS:

The Psychiatric Social Worker/Tutor appointment is a joint one with the National Association for Mental Health, the tutor being available for National Association for Mental Health educational work for a total of four months per annum. Her work with the County Council is mainly in the field of training.

A full and intensive training programme has been carried out during the year and details are given below.

Three-day in-service training courses were held at Grantley Hall during the year. One course was on " The expanding scope of community care ", another " Picking up the Thread again ". The speakers at the first course were senior officers of the Authority and at the second one included Mr. A. Bainton, Governor, H.M. Prison, Wakefield, Dr. J. A. R. Bickford, Physician Superintendent, De la Pole Hospital, the Personnel Manager of a large Industrial Works and an Area Disablement Resettlement Officer, of the Ministry of Labour. It is, of course, not possible for all the Mental Welfare Officers to attend during the same period and in some cases the courses were duplicated. At the beginning of the courses visits of observation were arranged and these included visits to Residential Homes of the Authority, H.M. Prison, Wakefield and the Industrial Rehabilitation Unit, Leeds.

TEACHING GROUPS FOR MENTAL WELFARE OFFICERS:

In addition to the in-service training courses the teaching groups for the Mental Welfare Officers have continued throughout the year. The members of the seven groups met on one afternoon per fortnight. The aims of these groups are the teaching of basic principles and practice of social case work and professional attitudes by the seminar method using workers' own case material for this purpose. The newly appointed officers have met in Wakefield to be acquainted with the County Service, the various departments with whom co-operation is necessary, and to introduce them to the in-service training programme.

NATIONAL ASSOCIATION FOR MENTAL HEALTH TRAINING COURSES:

In the week commencing 18th March, seven officers attended Part III of the Refresher Course for Mental Welfare Officers 1962/63, five officers attended the Induction Course held at the Albert Mansbridge College, Leeds, from the 22nd April—3rd May and six officers attended the Induction Course held at the Green Park Hotel, Harrogate, from the 18th to 29th November.

Five Mental Welfare Officers commenced attendance on the Refresher Course for Mental Welfare Officers, 1963/64 which commenced on the 2nd September.

This course is organised by the National Association for Mental Health in association with the University of Leeds department of adult education and extra mural studies. This course is held in three parts, the first being residential for four weeks, the second part consists of twenty weekly case work seminars and the third part is residential for a week in April, 1964. Two Senior Mental Welfare Officers attended the course for Officers senior in status working in Local Authority Welfare and Mental Welfare Services, Part I, from the 21st October to 1st November and held at the Albert Mansbridge College, Leeds.

Other Courses of Training:

Two Mental Welfare Officers commenced attendance at the two year Younghusband course held at the College of Commerce in Leeds. Provision was made for officers to attend the special one year course for experienced officers organised by the National Insitute for Social Work Training and the Psychiatric Social Workers' course, but no officer was accepted for training in 1963.

The training programme for the Mental Welfare Officers is quite formidable and is, of course, carried out at the expense of some day to day work of the officers concerned. This is necessary if the County Council is to provide a service to meet the ever increasing demands. Indeed most gratifying acknowledgments have been received from the Medical Superintendents of the Psychiatric Hospitals regarding the good liaison which has been achieved and on the ability of the Mental Welfare Officers in the performance of their duties.

Duties of a Mental Welfare Officer:

A Mental Welfare Officer is responsible for carrying out the statutory duties as laid down in the Mental Health Act 1959, and the carrying out of the duties relating to the prevention of illness, and the care and after-care of patients. To carry out these duties it is essential for Mental Welfare Officers to maintain a close working arrangement with hospitals, general practitioners and other agencies. The Mental Welfare Officer undertakes community care work and attends at case conferences, hospital and psychiatric out-patient clinics by arrangement, and if necessary, accompanies Consultants on domiciliary visits. He is available to assist the general practitioners on mental health matters. He co-operates with other social agencies who play a part in patients' care and rehabilitation. He is expected to assist in the formation and running of social clubs for the mentally ill.

In cases where a patient's illness produces an undue burden and severe emotional stress within the family—or where the family because of emotional difficulties of their own is not able to give the patient the support he needs—the Mental Welfare Officer has not only the patient himself to deal with but also has to concern himself with one or more members of his family.

Meetings of Senior Mental Welfare Officers:

Nine meetings of the Senior Mental Welfare Officers have been held during the year and items on the agenda have included the use of ambulance transport, transport of patients to psychiatric social clubs, the notification of the discharge from hospital of subnormal patients, the compiling of a register for accommodation purposes, the hospital treatment of alcoholism (Ministry of Health Circular 10/62) and the unit established at Scalebor Park Hospital, the consideration of gainful employment for the mentally ill, the formation of local associations for mental health, affiliated to the National Association for Mental Health, venture clubs, M.D.C. Circular No. 47.

Psychiatric Social Clubs:

Club	*No. of members*	*Premises*	*Meetings*	*Opened*
Castleford Club	30	Child Welfare Clinic, Sagar Street, Castleford	Wednesday evening	September, 1961
The Contact Club	35	Child Welfare Centre, Valley Road, Liversedge	Tuesday evening	October, 1963
The Glen Social Club	30	Somerset House Clinic, Shipley	Tuesday evening	September, 1961
Harrogate Social Club	50	Training Centre, High Street, Starbeck, Harrogate	Tuesday evening	April, 1963
Maltby Club	20	Training Centre, Addison Road, Maltby	Thursday evening	April, 1963
Morley Social Club	20	Central Clinic, Morley	Thursday evening	January, 1962
Normanton Club	18	Child Welfare Clinic, Church Lane, Normanton	Monday evening	May, 1962
Rock Club, Wath upon Dearne	40	Child Welfare Clinic, Church Street, Wath upon Dearne	Fortnightly Thursday evening	August, 1961
The White Rose Social Club	16	Temperance Hall, Skipton	Fortnightly Thursday evening	November, 1962

Non-County clubs attended by West Riding patients

4 U Club, Halifax	January, 1961
Huddersfield Social Club	November, 1962

Castleford and Normanton Clubs

The Castleford and Normanton Clubs are now well established and have proved most successful and popular.

The Contact Club, Liversedge

This club serves the needs of patients resident in Spenborough B., Mirfield U., Batley B., and Heckmondwike U. The club opened with a gala night on the 15th October and since then has met weekly. A small committee of members has been elected and plans made for further activities. Between the opening night and the Christmas party, eight meetings were held and there have been 168 attendances, an average of 21 each week. The Contact Club is essentially therapeutic and a Consultant Psychiatrist attends almost every week and takes a great interest in the club activities. Mental Welfare Officers are present each week and have the use of an interviewing room. Generally the first part of the evening is devoted to some group activity and a topic for discussion is selected.

The Glen Social Club, Shipley

The Glen Social Club, Shipley, has met a real need, and it is a flourishing club. The average attendances have increased to 25–30 members per evening. At this club the subnormal patients fit in very well. With the help of the officers in the area, four members have been successfully placed in employment after being out of work for long periods because of mental illness. The programme has been varied and has included holiday slides in colour, and films from the amateur group and other agencies which have proved very popular, lectures and trips into the Yorkshire Dales and the Morecambe illuminations. Friends from the Blind Welfare Association continue to provide concert tickets each month, and the members thoroughly enjoy these outings.

Harrogate Social Club

The Social Club now has an average attendance of 20. Of the number on the club books 27 patients have received hospital treatment previously, and three have returned for further treatment in hospital. The members can be categorised as follows:— In employment 3, in receipt of national assistance 19, in receipt of sickness benefit 2, pension 2, maintained by relatives 4 and independent means 1. The social activities include dominoes, cards, beetle drives, discussions, play readings, art, table tennis, with dancing from 9 p.m. to 10 p.m. The Castleford Club was entertained to a supper and social on the 29th October and the club members visited the pantomime as guests of the Harrogate Happy Wanderers.

Maltby Club

This club opened in April and although the numbers attending have not been high, the Medical Superintendent at Middlewood Hospital arranged the conveyance of 12 hospital patients to each meeting of the club. The lively interest the members of this party took in the programmes that had been arranged, contributed in no small way to the success of the club. There has been a good deal of building activity at the Maltby Training Centre during the year and this has interrupted the meetings.

Morley Social Club

The Morley Social Club has seventeen members and the average attendance is ten. The members appreciate the facilities and the very friendly atmosphere which exists. A successful New Year's party was held on January 10th, attended by 48 members, former members and friends.

The Rock Club, Wath upon Dearne

During the year the club moved from the Clinic at Rock House, Swinton, to more central premises at the new clinic in Church Street, Wath—a large airy building with very pleasant surroundings much appreciated by the members. The club has an average attendance of 38 and when joining with other groups as many as 120 have been catered for. Ages ranging from 17 years to 62 years. Discharged patients, after a period in hospital, are often sensitive and introduction into groups, with any degree of success, has proved difficult. Since mental illness is frequently the result of conflict with the person leading to a disturbance of relationships with others, in a group such as a social club opportunities are offered to resolve these conflicts. In the club he is free to form any relationship with anyone according to his needs and thus increase his ability to make contact with others. Selection of members in this club resulted in an equal distribution of males and females but after a few months of fortnightly meetings the pattern

showed that it was almost entirely female. A monthly letter is sent out to members giving the programmes, and this letter can rightly be regarded as sufficiently inviting to encourage attendance without domiciliary follow-up. To many this is the only letter they receive so that apart from the personal link with the club the letter is also an additional contact with the world of real people. The father of a 30 year old schizophrenic commented one evening after a few absences from the club, " Whatever happens don't stop sending her a club letter, she still regards herself as a member and looks forward to it ". Although entertainment at the club is organised—*e.g.*, film shows, concerts, cookery demonstrations—every effort is made to avoid regimentation of activities. Accordingly, each evening is divided into two parts, the first half devoted to activities and the second half social. The Wombwell Townswomen's Guild have assisted the club from the beginning. This help is greatly appreciated and it has proved that in a club of this kind a good staff to patient ratio is essential. After 2½ years the club continues to flourish and the following comments by Dr. Cusiter are made:—

" (i) It has proved that with some of the patients that the periods of re-admission to hospital have not been so frequent.

(ii) Also that some patients use the club as a ' jumping off ' point for other social groups of a less protected nature, *e.g.*, evening classes and operatic societies, etc.

(iii) Selection appears to be necessary to avoid a silting up of the club by a chronic residue.

(iv) The club meetings are held alternate Thursday evenings, 7 p.m. to 10 p.m., and it is often very difficult to get some of the patients to leave even at 10 p.m., they appear to hang on to every bit of companionship possible.

(v) One sees patients improving in their relationships, becoming more cheerful, friendly and co-operative. The assumption is that group activities, outings, etc., have played a great part in achieving this improvement."

The White Rose Social Club, Skipton

The White Rose Social Club which has met at the Temperance Hall, Skipton, since November, 1962 will transfer to the new Butts Clinic, Barnoldswick early in the new year. The activities undertaken during the year were as follows—holiday slides, bingo, beetle drive, flower arrangement, Townswomen's Guild Drama Group, games evenings, country rambles, potato sculpture, painting session, demonstration on poodles, dancing, interclub evenings, pantomime outing, illuminations outing and the Christmas party. The average number attending has been eleven.

Other Clubs

The facilities of the Therapeutic Social Club, named the 4U Club at Halifax, which is administered by the County Borough, have again been available to patients from the surrounding County areas. Approximately 50 patients from Health Divisions 18 and 19 have attended during 1963. About 12 patients from Health Division No. 20 have attended the Social Club run by the Huddersfield County Borough Health Department. The patients who have attended regularly have improved and become more sociable and now take a very active part in the club.

Two social clubs for the mentally subnormal were in operation in 1963. One is held at the Health Office, Cragdale, Settle, on Friday afternoons and is supervised by a Mental Welfare Officer, and the other is for the adult trainees of the Hemsworth Training Centre. The latter commenced in October, it is held on Wednesday evenings and the activities include dancing, records, films, and canteen facilities.

Day Centres:

Club	*No. of members*	*Premises*	*Meetings*	*Opened*
Harrogate Therapeutic	50	101, Station Parade, Harrogate	Monday Wednesday Thursday Friday afternoons	October, 1963
Snaith Day Centre	7	Pontefract Road, Snaith	Daily afternoons	December, 1963

Harrogate Therapeutic Club

This venture began on an experimental basis in October, 1963. It meets on four afternoons a week, and a psychiatrist attends at three of these sessions. Since the club opened, 78 patients have been interviewed of whom 59 were considered to be suitable for group therapy. The average weekly attendance at present is 22 but the club can deal with 50 patients per week. Three patients have been referred by doctors from other areas and several local general practitioners have visited the club. Dr. D. E. Munro, Consultant Psychiatrist, Clifton Hospital, has these comments on the club.

> " There is a good liaison between our psychiatric team in the mental hospital, the mental welfare officers and the general practitioners and this has been considerably assisted by the starting of the Psychiatric Therapeutic Club which now undertakes the care and maintenance of the chronic psychotics who need support in the community. It also provides an immediate opinion on acute psychiatric cases and one of our staff has undertaken the special care of the phobic anxieties which were felt received too little attention at the busy out-patient clinic in the General Hospital. Because of the ever increasing degree of integration and psychiatric services provided there has been a steady increase in the referrals to the out-patient clinics and by admissions to Clifton Hospital. The Psychiatric Social Club, organised by Mrs. Lynes and her staff, is of great assistance in supporting the chronic psychotics and assists in keeping them under constant supervision."

Snaith Day Centre

Every effort has been made to establish a day social centre in the former group training premises at Snaith. The centre eventually opened on the 9th December but as only one patient attended it was decided to close and re-open the following week, afternoons only. Seven patients have now attended to date. Many difficulties have been met but nevertheless it is felt there is a need for this centre, but we will require much enthusiasm and patience before it is finally established. At the moment the centre has been staffed by Mental Welfare Officers and the activities have been confined to games, table tennis, play reading and discussion.

Psychiatric Out-patient Clinics:

The following is a schedule of psychiatric out-patient clinics serving the West Riding:—

Skipton General Hospital
Keighley and District Victoria Hospital
Salt's Hospital, Shipley
Bingley Hospital
Farfield House, Farsley
Harrogate General Hospital
Ripon and District Hospital
County Hospital, York

St. James's Hospital, Leeds
War Memorial Hospital, Selby
St. Bartholomew Hospital, Goole
The Nerve Clinic, Beancroft Road, Castleford
Pontefract General Infirmary
Staincliffe General Hospital, Dewsbury
Brighouse C.W.C., Atlas Road
Halifax General Hospital
Huddersfield Royal Infirmary
St. Luke's Hospital, Bradford
Sheffield City General Hospital
Royal Infirmary, Sheffield
Royal Hospital, Sheffield
Barnsley Beckett Hospital
Montagu Hospital, Mexborough
Doncaster Royal Infirmary
Moorgate General Hospital, Rotherham
Doncaster Gate Hospital, Rotherham

In addition to the general hospitals, out-patients clinics are held at the psychiatric hospitals serving the County. Some of these clinics have several sessions a week and at most of them a Mental Welfare Officer from the Authority attends. It is at the psychiatric out-patient clinic that the services of the psychiatrist and social worker are on common ground. Dr. Watt has rightly pointed out the difficulties encountered by the trend, and indeed sometimes the necessity, towards shorter periods of hospital care.

He notes that the heavy pressure to which Middlewood Hospital is being constantly subjected to by reason of the demands made upon it from the densely populated area it covers frequently results in acute bed shortages. This is particularly the case so far as elderly patients are concerned. In order to cope with day to day demands for beds, patients are detained in hospital for a minimum period only. A steady flow of after-care patients continues to be referred; many of these patients are persons with whom the Mental Welfare Officer has had no previous contact as admission to hospital, usually on an informal basis, has been arranged by the family doctor. Clinical follow-up is exceedingly rare; the procedure which the consultant usually adopts upon a patient's discharge is the dispatch of a letter to the general practitioner (with a copy to the Mental Welfare Officer) outlining the patient's condition on admission, the treatment given, the condition on discharge and recommendations with regard to the prescription of future drugs—there is invariably a final observation that the case has been referred to the Local Health Authority for after-care and that the Consultant would be pleased to help should his services be required in the future.

There are sometimes difficulties in arranging appointments at the out-patient clinic nearest the patient's home.

To overcome some of the difficulties Dr. Watt has suggested that notification with regard to after-care patients should be referred to the Mental Welfare Officer in sufficient time to enable the officer to visit the patient in hospital and so establish a working relationship before discharge takes place; that more clinical follow-ups should be arranged; that more day hospital and in-patient facilities, particularly geriatric beds therefore should be provided; that an extension of day hospital facilities would be of great help.

It was always envisaged that the seven Mental Health Areas would develop independently and there are different patterns regarding the out-patient clinic facilities.

The Local Health Authority's out-patient clinic at Brighouse continued to function throughout the year. Eighty one new patients were referred and attendances during the year totalled 425. Obviously, from the Psychiatrist's point of view, it is helpful if there are beds attached to an out-patient clinic, but the doctors do say that the patients appreciate being told to come to Brighouse, away from the hospital atmosphere, and it is easier for people who are working to attend. Dr. Herridge, Consultant Psychiatrist, is now in charge of the clinic and he has made the following comments.

" The Brighouse Psychiatr c Clinic is run by Storthes Hall Hospital every Monday on local authority premises at the School Clinic. This rather unusual arrangement is a valuable one, since it allows the closest co-operation between the Mental Welfare Service, which is based at this Clinic, and the Consultant Psychiatrist who runs the Clinic.

The purpose of the Clinic is twofold. The first is that local General Practitioners can refer patients who seek their advice about psychiatric illness for a specialist opinion. There is no waiting list, and it is often possible to avoid, by prompt action, a crisis which would otherwise require in-patient treatment. Patients remain under the care of their own doctors whilst attending the Clinic, and a valuable liaison has been built up in this way between General Practitioners, Psychiatrist and the Mental Welfare Service.

The second function is to follow up and supervise patients from the Brighouse area who have been in-patients in Psychiatric hospitals. This augments the already excellent community care services provided by the Mental Welfare Officer, and again prevents a number of avoidable re-admissions. With the increasing modern emphasis on community rather than institutional care this function is a vital and increasing one.

Finally a number of people who appear before the Courts charged with various offences are referred by the Probation Officers to the Clinic. Here community treatment under a Probation Order is often preferable to formal punishment, and psychiatric reports are frequently sent to the Magistrates' Court from the Clinic. Since the majority of these offenders are young people it is gratifying to observe that the Courts usually act on the recommendation made."

References to the training of Mental Welfare Officers is made elsewhere in the report. A good deal of thought has been given to the question of the training of Social Workers in the past few years and a good deal of criticism is still being made at the lack of the training facilities provided and the dearth of professional case workers. This is likely to continue and, therefore, it is encouraging to have the following comments made on the service which we have provided. Dr. F. T. Thorpe, Medical Superintendent, Middlewood Hospital—

" I have mentioned the matter to Dr. A. Kelly, Consultant Psychiatrist, attending the Doncaster Royal Infirmary, and we both feel that the Mental Health Service in the West Riding is progressing satisfactorily and is doing much to meet the needs of the area. We have a good liaison with the Mental Welfare Officers, who meet us once a month at Middlewood to discuss after-care problem cases, and Dr. Kelly tells me he is very much impressed with the new facilities for Part III accommodation."

Dr. P. F. Fletcher, Physician Superintendent, Stanley Royd Hospital—

" Your Mental Health Services have been working very efficiently during the past year and the liaison with this Hospital and its out-patients clinics has been most satisfactory. Each year there is a growing understanding of mutual problems and of willingness to co-operate. All my consultant colleagues have expressed satisfaction and asked me to convey their thanks, but Dr. J. M. White is writing to you direct on one or two particular points, although I know that he is satisfied in general."

Dr. W. A. L. Bowen, Physician Superintendent, Bootham Park—

" . . . I think that things are going very well as far as liaison with the West Riding Mental Health service is concerned."

Dr. J. Valentine, Physician Superintendent, Scalebor Park—

" . . . Personally, I am very satisfied with the service provided in our own catchment area . . . "

Dr. W. Fraser, Clifton Hospital—

" I should like to say that your Mental Health Officers have been most helpful and co-operative. Can I put in a plea for the provision of more geriatric beds in our catchment area. The incidence of mental illness in the Nidderdale, Knaresborough, Harrogate and Ripon areas appears to be very high. In 1963 we had 408 admissions from those areas, *i.e.*, a rate of 5 per 1,000 of the population compared to a national figure of around 3 per 1,000."

Dr. R. McDonald, Medical Director, High Royds Hospital—

" . . . Firstly, there seems to be a serious shortage of Part III accommodation beds in the area, and from time to time we have patients here who would be more suitably housed in such accommodation . . . Apart from these, I think that our liaison with the Local Authority is very good, and I note that a new ' After-care Club ' is shortly to open at Ilkley, which I am sure we will find helpful for some of our patients."

Dr. A. L. G. Smith, Medical Superintendent, Storthes Hall Hospital—

" . . . Dr. Hughes and myself have discussed the matter and we are in fact agreed that we have received an excellent service, and on all occasions, co-operation, from your officers . . . "

Case Conferences:

Success of work in the fields of prevention, care and after–care will very largely depend on a sound assessment of a patient's total medical, social and emotional situation and on an understanding of the range of problems and difficulties encountered by the patient and his family. This can best be achieved by a close working together of hospital and community services and by the building up of a comprehensive and unified service. Case conferences which are now held in all big Psychiatric Hospitals and which are attended by doctors, nurses, occupational therapists, etc., from the hospitals and by staff from the Local Authority, provide a very valuable forum for collaboration. In some cases Disablement Resettlement Officers of the Ministry of Labour or from other community services attend.

The central aim of these discussions is to create continuity of care. The Local Authority workers bring to these conferences their knowledge of patient's family, his social setting and work situation and the part these are likely to play in his rehabilitation. The hospital workers describe the patient's condition, his response to treatment, the likelihood of his recovery and discharge. With these complementary assessments in mind a therapeutic plan is devised and translated into action. Although we have still a long way to go and there is much room for individual experimentation—it is felt that we are on the whole moving on right lines.

Hostels:

It is expected that the hostel for eight subnormal children at Harrogate will be opened in July next, and the one for 30 subnormal adults at West Ardsley later in the year. The hostel at West Ardsley for post-psychotic cases will be

ready in 1965. Most of the patients who have been referred as in need of hostel care have been accommodated at the hostels provided by the County Boroughs in the County, and voluntary bodies.

Development of Psychological Service:

The work of Psychologists in Child Guidance and Allied Services has been reviewed during the year and the following recommendations relating to the Mental Health Service have been approved:—

That during the 3 year period 1964—67 the establishment of psychologists be increased to 9—the equivalent of 2 to work in the mental health sphere.

That the scheme for the development of mental health facilities be extended to include the use of psychologists.

That the appointment of psychologists should, in future, include work in the mental health sphere with the subnormals etc., as well as in the child guidance service, the apportionment of time being decided individually according to specific interests.

That the services be extended later in the light of experiences in the Mental Health sphere and as additional psychiatric help becomes available in the child guidance clinics—the position to be reviewed when the full staff of nine psychologists has been recruited and assimilated.

It is essential that there should be a period of experiment at certain centres and areas but it would be advantageous if a proportion of each psychologist's time was available through the County for requested I.Q. reviews etc., at the training centres and the suggested districts for initial trials are Castleford, West Ardsley (to include the Hostels), Harrogate (to include the Hostel), Swinton, High Green and Doncaster.

The School Dental Service is now extended to junior trainees and ultimately ancillary services comparable to those enjoyed by school children will be available for the junior trainees in the training centres.

Already a measure of success has been achieved by admitting children who are educationally subnormal and have behaviour problems to the junior wings of the training centres. These are children in the 4–6 years age group.

Statistics:

The number of patients referred to the Local Health Authority during the year, together with the number of patients under local health care at 31-12-1963 are shown on the tables at the end of the Section.

SUBNORMAL PATIENTS:

The number of subnormal patients in the West Riding area on the waiting list for admission to hospital was 79, and of these 27 were considered to be in urgent need of hospital care. The hospitals are quite full and though overall there has been a slight reduction in the numbers requiring hospital care the picture is still unfavourable, and it is apparent that additional accommodation is urgently required. The provision of local health authority beds by way of hostels has caused some confusion. It is apparent that many consultants refuse to accept patients for hospital care because they do not require treatment, and literally translated this has meant that a severely subnormal middle aged patient

who has been devotedly cared for at home, presents a tremendous problem when the parents die or become too old to continue the care. This is not the type of patient for whom we have designed our hostels, and it is grossly unfair to ask the County Welfare Officer to deal with the problem. The County Welfare Officer has nearly reached the stage when his Part III accommodation is being used for the purpose for which it was designed and to ask us to return to the position where every Public Assistance Institution contained a ward for the severely subnormal is indeed a retrograde step and must not be allowed to happen. The long term permanent hostel care problem will have to be faced by the Local Authority.

The position regarding the severely subnormal child has also caused difficulties. It is quite clear that the helpless cot case requiring specialist medical and nursing care is a matter for the hospital authorities and not for the Health or Children's Department.

During the year 175 subnormal patients were given short stay care, 166 of these at National Health Service hospitals. The Consultants in charge of the hospitals were most kind and the relief afforded to the families is much appreciated. This is particularly so when a family is able to plan a holiday knowing that the relation will be well cared for. On the occasions when short stay care has been provided because of illness in the family then this is asked for instantly and help given in these cases has invariably been good.

There was one admission to guardianship during the year, a psychotic boy of 17 years, and the total number of patients under guardianship at the end of the year was eight. 71 patients were admitted to hospitals for the mentally subnormal as permanent cases, 31 being under the age of 16 years; 55 were admitted informally, 9 by order of the Courts and 7 on the application of Mental Welfare Officers or nearest relatives.

Mentally Ill Patients:

Mental Welfare Officers were concerned in the admission of 2,275 patients to psychiatric hospitals; 1,260 of these were informal admissions, 4 were by Court orders, 324 were Section 25 cases, 34 were Section 26 cases and 653 were Section 29 cases. There were 2,080 referrals for after-care.

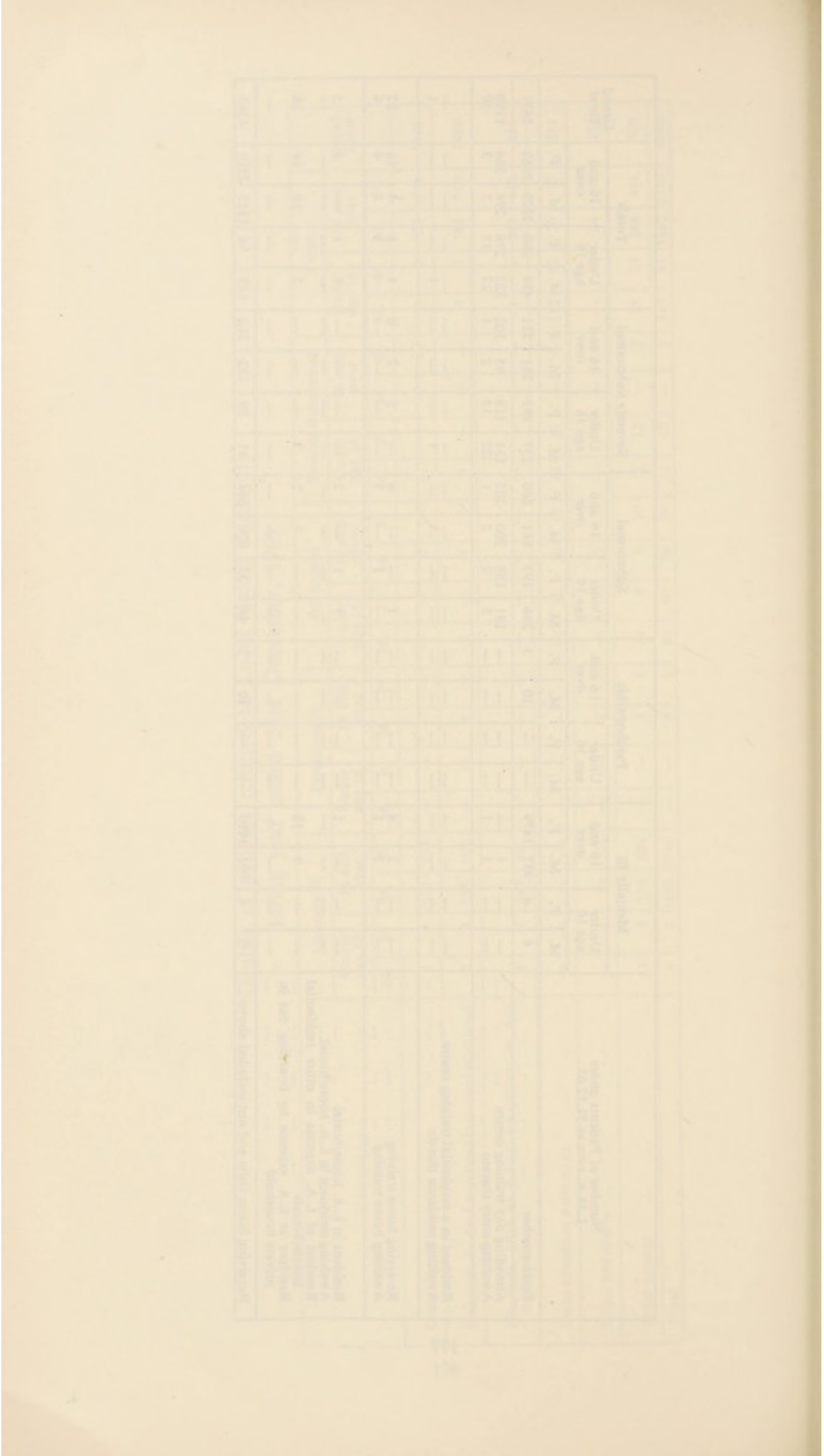
There has been comment and criticism at the apparent excessive use of Section 29 of the Act. There is some truth that the Section is being used to obtain a hospital bed which would not otherwise be available, and that we are still a long way off discovering a routine persuasive method of dealing with all unwilling people. What is interesting is the percentage of patients being detained over three days against their will. Section 29 when being operated deals with circumstances being investigated by a large number of people whereas the other Sections are confined to cases where careful consideration has been given by a smaller band of experienced psychiatrists and others. There are two points to be noted —the deprivation of a person's liberty is a serious matter and may have lasting repercussions, and again the right to curtail a patient's freedom excessively at the outset and thereby limit clinical judgement. From the patients point of view every possible means must be taken and every step provided so that the patient's insight does not have a traumatic experience. It may be that the provision of psychiatric beds, particularly in the wards of general hospitals which are not far away from the patient's home will go a long way to solving these problems.

During the year five medical practitioners were approved for the purposes of Section 28 of the Mental Health Act, 1959.

Number of patients referred to Local Health Authority during year ended 31st December, 1963.

Referred by	Mentally Ill				Psychopathic				Subnormal				Severely Subnormal				Totals				Grand Total
	Under age 16		16 and over		Under age 16		16 and over		Under age 16		16 and over		Under age 16		16 and over		Under age 16		16 and over		
	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	
General practitioners	3	1	520	954	—	—	—	—	—	—	2	—	—	1	—	—	3	2	522	954	1481
Hospitals, on discharge from in-patient treatment	2	3	555	908	—	—	4	—	1	—	4	2	1	—	—	—	4	3	563	910	1480
Hospitals, after or during out-patient or day treatment...	1	1	247	412	—	—	—	—	—	—	—	—	—	—	—	—	1	1	247	412	661
Local education authorities	—	—	—	—	—	—	—	—	68	32	20	17	44	30	—	—	112	62	20	17	211
Police and courts	—	—	79	74	—	—	2	—	—	—	3	—	—	—	—	—	—	—	84	74	158
Other sources	3	3	238	398	—	—	3	1	11	8	5	10	11	12	—	2	25	23	246	411	705
Total	9	8	1639	2746	—	—	9	1	80	40	34	29	56	43	—	2	145	91	1682	2778	4696

Number of Patients under L.H.A. care at 31.12.63	Mentally Ill				Psychopathic				Subnormal				Severely Subnormal				Totals				Grand Total
	Under age 16		16 and over		Under age 16		16 and over		Under age 16		16 and over		Under age 16		16 and over		Under age 16		16 and over		
	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	
Total number	6	4	957	1479	—	—	10	3	246	195	881	860	237	191	281	321	489	390	2129	2663	5671
Attending day training centre	—	—	1	—	—	—	—	—	191	158	200	202	131	118	95	102	322	276	296	304	1198
Awaiting entry thereto	—	—	1	1	—	—	—	—	5	2	2	1	22	13	2	1	27	15	5	3	50
Resident in a residential training centre... ...	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Awaiting residence therein	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	1	—	—	—	1
Receiving home training	—	—	2	4	—	—	—	—	1	—	—	6	—	1	2	6	1	1	4	16	22
Awaiting home training	—	—	1	1	—	—	—	—	—	1	—	3	—	—	—	—	—	1	1	4	6
Resident in L.A. home/hostel	—	—	—	1	—	—	—	—	1	1	—	2	—	—	—	—	1	1	—	3	5
Awaiting residence in L.A. home/hostel... ...	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Resident at L.A. expense in other residential homes/hostels	—	—	9	12	—	—	—	—	—	—	1	2	2	—	—	—	2	—	10	14	26
Resident at L.A. expense by boarding out in private household	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Receiving home visits and not included above ...	6	4	943	1460	—	—	10	3	48	33	678	644	81	59	182	212	135	96	1813	2319	4363



PART V

ENVIRONMENTAL HYGIENE

Food and Drugs

Sanitary Circumstances

Atmospheric Pollution

ENVIRONMENTAL HYGIENE

Re-organisation of the Public Health Inspectors' Section of the Department started early in the year and by December appointments had been made to complete the establishment which is now Chief Public Health Inspector, two County Public Health Inspectors and two Sampling Officers.

The full impact of additional staff was not particularly felt in the year under review but at the time of writing a much wider and interesting field of activities is being undertaken. This is noticeable particularly at the moment with regard to brucellosis and school swimming pools both of which will be referred to in more detail later.

Another activity recently embarked upon has been the inspection of nursing homes in conjunction with the medical and nursing staff of this department.

The continued co-operation of County District Officers has been enjoyed and efforts are being made to achieve more regular contact in the districts on matters of common interest and concern.

Food and Drugs Act, 1955:

THE MILK (SPECIAL DESIGNATION) REGULATIONS, 1960:

At last has begun the task of sorting out dealers licenced by the County Council and introducing a system of regular inspection and sampling. As envisaged many dealers have been found to be operating from unsatisfactory premises and not all have taken too kindly to being told this after being allowed to operate in this way for some considerable time. A number of the larger dairy concerns are not blameless in their distribution methods either and appear quite willing to drop milk at thoroughly unsatisfactory points. At the moment persuasion is having good effect on the cessation of these practices and it is hoped that legal powers will not have to be resorted to.

There is no doubt that the additional work involved in the supervision of dealers has matched all estimates and that the administrative side of the problem is even more than bargained for. The turnover of dealers' businesses and the subsequent licencing is surprisingly high and a continuing source of work.

The following table gives details of dealers licences at the end of the year (excluding licenced pasteurised and sterilised milk establishments which are set out later):—

Number of Licence Holders	Bottling T.T. Milk (Raw)	Dealing in pre-packed milk			
		T.T. (Raw)	T.T. (Pasteurised)	Pasteurised	Sterilised
2,911	19	333	702	874	2,385

Given below are details of licenced establishments for the pasteurising and sterilising of milk.

PASTEURISED MILK:

Airedale Co-operative Society Ltd., The Dairy, Thomas Place, Shipley.
Crawshaw, J., Blake Lea Dairy, 103, Arksey Lane, Bentley, near Doncaster.
Doncaster Co-operative Society Ltd., Dairy Department, York Road, Doncaster.
Doxey, C., Armthorpe, near Doncaster.
Goole Co-operative Society Ltd., Centenary Road, Goole.
Harrison, R. H., Manor Farm, Conisbrough, near Doncaster.
Mawer's Dairy, Glentworth House, Skellow, near Doncaster.
Pontefract Industrial Co-operative Society Ltd., Dairy Department, Horsefair, Pontefract.
Rotherham Co-operative Society Ltd., The Dairy, Progress Drive, Bramley, near Rotherham.
Salmon, P., Ashbrooke, Littlethorpe, Ripon.
Stocksbridge Co-operative Society Ltd., Shay House Lane, Stocksbridge, near Sheffield.
West Marton Dairies Ltd., West Marton, Skipton.
Whittaker's Wholesale Dairies Ltd., 77, Tenter Balk Lane, Adwick le Street, near Doncaster.
Wholesale Dairies (Rotherham and District) Ltd., Claypit Lane, Rawmarsh, nr. Rotherham.

STERILISED MILK:

Wholesale Dairies (Rotherham and District) Ltd., Claypit Lane, Rawmarsh, nr. Rotherham

During the year the following pasteurising plants ceased operations:—

Count, G. W., The Dairy, St. Mary's Gate, Tickhill, Doncaster.
Oates, J. E. & E., Thorne Dairies, 3, North Eastern Road, Thorne, near Doncaster.

With the additional staff it has been possible to step up the frequency of visits to the processing plants and although once again the general standard of operation has been good there is no doubt that frequent supervision is necessary.

Only minor improvements and alterations were made to premises except for one large dairy where a major scheme of reconstruction is under way. It is becoming increasingly obvious that a number of smaller dairy concerns are becoming uneconomical units which may lead to their closure in the not too distant future or their absorption into larger companies. During the year homogenised milk was introduced into the County area. From a sales point of view this seemed to be pushed at the public rather too quickly without the creation by advertising of a public demand and did not achieve the success hoped for by the dairy concerns. From a sampling point of view equal success to ordinary pasteurised milk was achieved in tests for keeping quality and pasteurisation. Dairy laboratories were finding, however, that on extended keeping quality tests the homogenised milk was not faring as well as the ordinary pasteurised milk and to combat this the homogenised milk is now usually submitted to a higher pasteurising temperature than normal.

More attention is now also possible to dealers buying raw tuberculin tested milk in bulk and bottling it on licenced premises. Although the quantity of milk is not high these premises are receiving particular attention with the aim that samples and bottle counts should give as high a standard as those from pasteurising plants.

Wherever possible improvements are obtained by persuasion and advice but it became necessary during the year to prosecute a bottler who persistently allowed foreign matter to be in his milk. The Court acknowledged the seriousness of the offence and imposed a fine of £100 plus costs.

Details of samples obtained by the County Public Health Inspectors (and Sampling Officers for a minor portion of the year) from dealers in the County area, with results of examinations, are given below:—

T.T. (Raw)		Pasteurised					Sterilised	
Methylene Blue Test		Phosphatase Test		Methylene Blue Test			Turbidity Test	
Satis-factory	Unsatis-factory	Satis-factory	Unsatis-factory	Satis-factory	Unsatis-factory	Void	Satis-factory	Unsatis-factory
209	9	652	3	627	5	23	31	—

Thanks are due to Dr. Little, Director of the Public Health Laboratory, Wakefield, and his staff, once again for dealing with an increasing number of samples and for the willing help and advice given. The kind co-operation of the other Directors of Laboratories in and around the County who have kept us informed of samples submitted to their respective laboratories from the County Area and helped to avoid unnecessary duplication of work is also appreciated.

Supply of Milk to Schools:

A small percentage of milk supplied to schools still has to be, of necessity, raw tuberculin tested and sampling has been concentrated on this.

Samples are submitted for examination by the methylene blue test and for biological examination for tuberculosis and brucella abortus.

Two samples failed the methylene blue test but were satisfactory on follow-up samples. One sample was found positive on cream culture for brucella abortus; the supply was immediately stopped and an alternative one provided.

The bottler mentioned earlier who was prosecuted was a supplier of school milk and his contract was terminated.

Sampling of Milk at Hospital Farms:

The farms at Stanley Royd Hospital, Wakefield, and Stansfield View Hospital, Todmorden, have now installed pasteurising plants. They were the last remaining hospital farms where samples were taken, on behalf of the Ministry of Health, of raw tuberculin tested milk.

Brucellosis:

Until December, 1963, only very limited sampling for biological examination for brucellosis had been undertaken by the County Public Health Inspectors but the appointment of additional staff created an ideal opportunity for a survey in the County to be carried out. It has been found that approximately fifteen per cent. of samples obtained are positive on cream culture and when it is realised that all samples taken were on retail delivery the true incidence may well be considerably higher.

The work being done at County level stimulated the interest of County District Officers and it has become apparent that sampling will have to be co-ordinated to prevent unnecessary duplication.

There is a dual responsiblity for sampling for brucellosis, that of the local authority under the Milk and Dairies (General) Regulations, 1959, and the duty of the County Council under Section 31 of the Food and Drugs Act, 1955.

In view of the fact that many local authorities are keenly interested in this sampling and that, due to producer retailers being Ministry licenced, they have better local knowledge of suppliers in the district, it is considered that the majority of this work might well be undertaken by them. This department will, of course, take samples where the local authority is unable to do so and, as a matter of routine, those samples of raw tuberculin tested milk obtained for the statutory test from dealers will also be submitted for examination for brucella infection by the ring and culture techniques.

Primarily, each local authority should be responsible for the sampling of producer retailers operating from premises within their own district, but it is realised that people from without the district may be retailing milk in the district and require sampling. The Department will assist in preventing the unnecessary duplication of sampling of these persons by examining copies of all sample reports and advising local authorities when this is found to be happening. Discussions with a number of local authorities, on these lines, have already been held.

A co-ordinated and co-operative effort by all interested parties is the only way any impact can be made at the present time in view of the absence of any eradication scheme. There is no doubt that present legislation gives very little help to authorities in their attempts to ensure a safe supply of raw milk.

Whilst the Ministry of Agriculture, Fisheries and Food and the Ministry of Health recognise the serious problem the following quote from a Ministry of Agriculture letter is of very little assistance to the man in the field busily engaged in sampling, serving pasteurisation orders and trying to ensure proper segregation of infected animals:—

> "As you know, the Ministry of Health regularly advise journals and magazines in the appropriate field about the hazards of drinking raw milk and that, if only raw milk can be obtained, it should be boiled before drinking."

The scheme for free vaccination of calves has also, apparently, been a failure, not only because of lack of interest on the part of farmers but also due to the fact that whilst vaccination will reduce the clinical symptoms of the disease in the cow the animal can still secrete the causative organisms and excrete them in the milk.

Report of Analyst:

All County Inspectors of Weights and Measures are also appointed sampling officers for the purpose of the Food and Drugs Act and the work of sampling is under the control of the Chief Inspector, Mr. A. Wolfenden. Details of the work carried out under the Act are referred to in the Annual Report to the County Council of Mr. Mallinder, the County Analyst, who has kindly consented to their inclusion in this report.

" During the year, 3,098 samples were submitted by your Inspectors under the Food and Drugs Act, 1955, as set out below:—

	Total Samples	*Adulterated or Below Standard*	*Percentage Adulterated or Below Standard*
Milk	1,430	40	2·8
Milk ' Appeal to Cow ' ...	9	—	—
Milk, Channel Islands	223	2	0·9
Milk, Hot	1	—	—
Milk Bottle	2	2	100·0
Foods and Drugs	1,433	69	4·8
All samples	3,098	113	3·6

Notes on adulterated or irregular samples

Milk. Out of 1,430 samples of ordinary, homogenised and sterilised milk, 40 were unsatisfactory; 23 samples were low in fat, the worst deficiency being 32 per cent. 17 samples were adulterated with water in amounts varying between 0·4 and 50·2 per cent.

Channel Islands Milk is required to contain at least 4 per cent. of fat; most samples contain much more than this. Out of 223 samples only 2 were below standard. These results reflect the special care exercised by producers of this designated supply.

Milk Bottles. Hundreds of milk bottles are scrutinised by your Inspectors every year; very seldom do they find a dirty bottle. Two milk bottles were submitted for examination and identification of deposits. One contained mould and dust, the other a layer of hardened paint. Dairies are continually finding evidence of misuse of their bottles, and occasionally a residue which is difficult to remove will pass undetected.

Sausages. Although there are no legalised minimum standards for the meat content of sausages, Public Analysts continue to require 50 per cent. in beef sausages and 65 per cent. in pork sausages. The great majority of manufacturers comply with these requirements. All 46 samples of beef sausages were satisfactory, containing between 50·6 per cent. and 84·2 per cent. of meat, the average being 64·6 per cent. There were 53 samples of pork sausages varying in meat content between 56·0 and 91·7 per cent., average 71·2 per cent. Only 4 samples contained less than 65 per cent. of meat. Sausages are permitted sulphur dioxide preservative up to a limit of 450 parts per million, provided that its presence is suitably declared; 13 samples of beef sausages and 2 of pork sausages contained preservative without this declaration and were therefore irregular.

Potted Meat. 26 samples were analysed and only 2 contained less than 70 per cent. of meat; one of these contained only 46·1 per cent. of meat, the rest of the sample being water and seasoning. Another sample contained sulphur dioxide in contravention of the Preservatives in Food Regulations.

Tinned Milk Puddings are quickly gaining popularity. 15 samples were examined, 2 were unsatisfactory in that they were made of skimmed or partially skimmed milk instead of whole milk.

Preserves. The Food Standards (Preserve) Order, 1953, lays down standards of composition for jam, marmalade, fruit curd and mincemeat. Two samples of marmalade were deficient in ' soluble solids ' (mainly sugar); the effect of this irregularity would be to impair the keeping qualities. Six samples of lemon curd were substandard; two being deficient in soluble solids, three in fat, and one being discoloured owing to scorching during preparation.

Vinegar. 2 samples labelled as ' Pure Malt Vinegar ' were simply coloured and flavoured solutions of acetic acid; one was so diluted with water that it contained only 3·6 per cent. of acetic acid. For such artificial preparations to be described as ' Non-brewed condiment ' they must contain at least 4 per cent. of acetic acid.

Vitamin Preparations. Out of many samples examined only two were below standard, probably due to prolonged storage; hence the need for quicker turn-over of stock.

Whisky. 20 samples were analysed. Only one was below standard.

Cream Cakes. When the word ' cream ' without qualification, is applied to confectionery, the cream must be actual dairy cream. Three samples of so called cream cakes were found to be filled with synthetic cream made from vegetable fat.

Labelling. A can labelled ' Plum Peeled Tomatoes ' contained a mixture of tomatoes, beans, peas and carrots: it had evidently been sent out with the wrong label.

Another misdescription was brought to light when a sample of ' Delicious Ice-Cream Sandwiches ' was examined. These confections were thin biscuits packed with meringue filling.

Hundreds of labels of pre-packed articles were examined for compliance with the Labelling of Food Order.

Barley sugars with added minerals were claimed to build up a complete protection against radio-active fall-out and also to protect children's teeth. In addition to making these sweeping assertions, the label was faulty in that it did not state precisely the proportions of these minerals and protective substances.

Three samples of Cranberry Sauce bore a label stating that the eating of this sauce was a happy way to add vitamins and minerals to meals. Such general claims are forbidden; exact proportions must be stated.

Fruit cocktail—being a mixture of diced fruits must carry a declaration of ingredients. One sample was irregular on this score.

Tinned bilberries were found to contain artificial colouring: this should have been declared.

Drugs. In view of the prodigious increase in the number of drugs now freely available with and without a prescription, your Inspector has increased the sampling rate and widened the scope of his purchases of pharmaceutical products. Some 77 samples of modern drugs, besides many traditional remedies, were examined. Only minor irregularities were discovered. There were technical errors in the labelling of two cough syrups and one sample of fever cure; this last sample was also deficient in its principal active ingredient, dilute nitric acid.

Foreign Bodies. In addition to the two unsatisfactory milk bottles mentioned under ' Milk ' there were several instances of foreign matter in food. The following examples, mostly arising out of complaints by members of the general public will suffice:—

A packet of butter in which was a splinter of wood about an inch in length.

A tin of prunes among which were numerous small beetles, showing that the prunes had not been adequately washed.

Three samples of bread containing iron stained oil, evidently from some part of the dough-handling machinery.

A bottle of medicine containing vegetable debris and a small fly.

There was also a portion of fried fish in which was a small moth."

The County Council's scheme operated in conjunction with District Council Public Health Inspectors continued throughout the year. In accordance with regulations made under the scheme, the County Council pays the fees of the County Analyst for all samples of milk taken by the inspectors, conducts all legal proceedings and defrays consequential legal expenses. The number of samples submitted for analysis was 218 of which four were found to be below standard, all being deficient in fat. All the samples were slightly sub-standard and cautions were issued to the vendors by the Clerk of the County Council in two cases and no action taken in the others.

Sanitary Circumstances:

Fluoridation of Water Supplies:

As reported last year, in December, 1962, the Health Committee considered Ministry of Health Circular 28/62 and approved in principle of the making of arrangements with Water Undertakers for the addition of fluoride to water supplies which are deficient in it naturally. Subsequently, Water Undertakers

and County District Councils were circulated by the Clerk of the County Council with a view to securing this objective.

It appeared that the majority of Water Undertakers and Local Authorities would be agreeable to the measure and following the intimation in Ministry Circular 12/63 that the Minister of Health was prepared to give general approval to the making of arrangements for the addition of fluoride to public water supplies without further reference to him, the County Council agreed to the following addition to their Scheme under Section 28 of the National Health Service Act, 1946:—

> "As a measure for the prevention of illness, the Council propose to make arrangements with any statutory water undertakers serving the Council's area for fluoride to be added to the public water supplies to the level appropriate for the prevention of dental decay, provided that, as set out in Ministry of Health Circular 28/62, the technical aspects are first approved by the Minister of Housing and Local Government and are made subject to such supervision as that Minister may deem necessary. The level considered appropriate for this is one part per million, expressed as F, plus or minus ten per cent."

A wealth of information and technical data was issued throughout the year but at the time of writing no scheme for the actual application of the principle had reached fruition.

Plumbo-Solvent Water Supplies:

The periodical examination of water from those public supplies in the West Riding which are known, or suspected, to possess plumbo-solvent properties has been carried out.

Two samples of water were collected from each supply (a) after standing all night and (b) after standing for thirty minutes in a lead service pipe, and the samples were examined for the presence of lead. Two hundred and forty-four samples were examined and in each case the result of the examination was notified to the Medical Officer of Health or other appropriate officer of the County District concerned.

It is generally considered that a water supply which is plumbo-solvent to the extent of taking up to 0·1 parts per million is unsatisfactory, and that the plumbo-solvency of such a water should be neutralised.

Eight samples contained lead in excess of 0·1 parts per million. Appropriate action was taken with the authority concerned and repeat samples obtained. All supplies were satisfactory by the end of the year.

Private Supplies of Water to Special and Other Schools:

Supervision of private supplies has again been undertaken. Details of the samples obtained are appended:—

School	Source of Supply	Bacteriological Examination		
		Number of samples obtained	Sat.	Unsat.
Grantley Hall Adult College, near Ripon	Land springs	15	11	4
Hatfield Levels School, Thorne, near Doncaster	Bore, 202 feet deep	7	7	—
Ingleborough Hall Special School, Clapham, Settle	Lake water	6	5	1
Netherside Hall Special School, Grassington, near Skipton	Land springs	10	9	1

With the exception of Hatfield Levels School all premises are provided with chlorinating equipment. Trouble was experienced with the equipment at Grantley Hall and after a number of breakdowns a major overhaul of the apparatus was carried out. Following this, satisfactory samples have been obtained. Sample failures from other premises were immediately followed up and repeat samples proved satisfactory.

The samples from Ingleborough Hall Special School were again obtained by the Chief Public Health Inspector, Settle Rural District Council, to whom thanks are due for his co-operation.

RURAL WATER SUPPLIES AND SEWERAGE ACTS, 1944–61:

Details of applications for grants made during the year:

County District or Other Body	Description of Scheme	Date of Application	Estimated Amount of Scheme
			£
Bradford Corporation	Brunthwaite Water Supply scheme	29th July	2,000
Calderdale Water Board	High Lee Green Area Water scheme	19th November	4,355
do	Cotton Stones and Mill Bank Area Water scheme	7th February	3,438
do	Lane Bottom and Upper Wood Nook Area Water scheme	19th November	2,045
Claro Water Board	Hessay Mains Extension Water scheme	9th August	1,750
do	Bilton and Ingmanthorpe Water scheme	5th September	5,250
Craven Water Board	Hob Hill, Stanbury, Keighley Water scheme	8th March	829
do	Grassington, Hebden, Linton and Threshfield Water Supply scheme	23rd December	61,311
Denby Dale U.D.	Denby Dale Water Filtration scheme	4th January	161,000
do.	Emley Sewerage and Sewage Disposal scheme	18th November	34,026
Doncaster and District Joint Water Board	Clayton with Frickley Water scheme	26th March	8,200
Doncaster R.D.	Norton (Campsall and Sutton) Sewerage and Sewage Disposal scheme	14th May	35,858
do.	Eastern Region Sewerage and Sewage scheme	2nd August	560,000

County District or Other Body	Description of Scheme	Date of Application	Estimated Amount of Scheme
			£
Hepton R.D.	Edgehey Green (Heptonstall) Sewerage scheme	21st May	42,350
Kirkburton U.D.	Town End, Lepton, Sewerage scheme	4th March	34,367
Maltby U.D.	Enlargement and reconstruction of Wood Lea Sewage Disposal Works and construction of new trunk sewers	18th February	340,000
Osgoldcross R.D.	Hillam and Monk Fryston—Enlargement of sewage works	10th December	5,000
Penistone R.D.	Crowedge Sewerage and Sewage Disposal scheme	2nd August	38,000
Ripon & Pateley Bridge R.D.	Burnt Yates and Scarah Bank Sewage works—Amended scheme	21st November	47,233
Settle R.D.	Scosthrop Sewerage scheme	24th April	1,200
do.	Settle, Giggleswick and Langcliffe Sewerage scheme	26th September	123,000
Skipton R.D.	Threshfield Sewers Extension scheme	18th November	1,448
Tadcaster R.D.	Towton Sewerage and Sewage Disposal scheme	24th April	10,171
Wakefield R.D.	Crofton Sewerage scheme	29th October	60,450
Wetherby R.D.	Wellington Place, Sewer Extension scheme	1st February	625
do.	Tockwith Road, Long Marston, Sewer Extension scheme	26th July	728
do.	Bowcliffe Hall, Bramham, Sewer Extension scheme	29th November	1,570
do.	Follifoot Road, Kirkby Overblow Sewer Extension scheme	10th December	479
Wharfedale R.D.	Pool and Arthington Sewerage and Sewage Disposal scheme	5th March	102,973
do.	Arthington Sewerage scheme	14th January	16,469
Wortley R.D.	High Bradfield Farms Water Supply scheme	22nd April	28,500

A good number of schemes were again submitted and it is proving satisfying to be able to spend more time on the examination of them. This work inevitably leads to closer liaison and co-operation with the officers in the County Districts. Comments have again been forwarded to the County Planning Officer to enable joint observations to be passed to the County Council's Consulting Engineer.

SCHOOL SWIMMING POOLS:

Resulting from the increase in staff it will now be possible to give closer supervision to swimming pools in County Establishments. Up to the present time, whilst notification has been received of the installation of pools and the department has issued copies of "Medical Administrative Instructions for Learners' Pools at Schools" no practical supervision and sampling has been carried out of either learner pools or properly installed indoor pools by this department.

The first task will be a survey of all existing pools to ascertain full details of facilities available. This will be followed by consultations with the Education Department to institute a standard system for the operation of pools, the keeping of records of chlorine dosage and residuals, pH test readings and other details. Regular sampling will also be ensured.

It is hoped to have things moving by the commencement of the open air swimming season and to be able to give more details in next year's report.

Pharmacy and Poisons Act, 1933:

The Act and complementary Poisons Rules are complex in their provisions and, although the duties under this legislation may be only a small part of the work of the department, enforcement requires diligent concentration. It is not merely a question of enforcing rules for the sake of it but it is the elimination of potentially dangerous unorthodox sales which may help to avert tragedies.

It is the duty of the County Council (as a " local authority " under the Act) to administer the Act and Rules relating to the sale of Part II poisons. The requirements of the Act and Rules include such matters as:—

(a) Listing the premises and authorised persons
(b) Storage of poisons
(c) Form of containers
(d) Labelling
(e) Recording of particulars of sales
(f) Special restrictions on certain substances

Apart from the first-mentioned which is dealt with by the Clerk of the County Council, the duties devolve on the County Public Health Inspectors who carried out 225 visits of inspection. Some irregularities were discovered and advice was given in all cases where necessary or it was requested.

Housing (Rural Workers) Acts, 1926–42:

Supervision has continued of those cottages for which grants have been given under the above Acts. Following the annual inspection of each property a detailed report regarding structural conditions, tenancies and rents was forwarded to the Clerk of the County Council who informed the owners of any matters in need of attention.

Atmospheric Pollution:

The Authority's scheme, operated in conjunction with the Department of Scientific and Industrial Research and officers of the County Districts, has continued efficiently.

Further implementation of the scheme proceeded and at the year-end 34 District Councils were participating involving 34 combined daily smoke filters and sulphur dioxide instruments, and 8 daily smoke filters only. The results obtained with the instruments operating appear below:—

Situation of Instrument	Smoke			Volumetric SO_2		
	Average Daily Suspended Impurity*	Highest Value	Lowest Value	Average Daily Concentration SO_2*	Highest Value	Lowest Value
	Microgrammes per cubic metre			Microgrammes per cubic metre		
Keighley — First Floor of Public Health Department in built-up area in centre of town	105 for 11 months	1,024	8	111 for 10 months	580	19
Keighley—Branshaw View, 20ft. above ground in classroom on south-west side of building, ¼ mile south-west of town centre. Surrounding district residential	149 for 9 months	796	0	151 for 9 months	717	18

*For period of full year unless stated otherwise.

Situation of Instrument	Smoke			Volumetric SO_2		
	Average Daily Suspended Impurity*	Highest Value	Lowest Value	Average Daily Concentration SO_2*	Highest Value	Lowest Value
	Micrograms per cubic metre			Micrograms per cubic metre		
Bingley—Health Department, Town Hall, Bingley, 1/5th mile outside town centre, surrounding district park land	98	604	6	128	978	9
Otley–First Floor of Council Offices, in town centre, mainly manufacturing	71	370	4			
Pudsey 2 (Stanningley)—"Southville", Sunfield House, 20 ft. above ground on East side, surrounding district mainly industrial	135	860	4	186	1,080	13
Pudsey 3 (Farsley)—Farfield House, Farfield Avenue, 20ft. above ground on north side, surrounding district residential	156	1,072	16	197	1,225	34
Pudsey 4 (Calverley)—M. & C. W. Clinic, Chapel Street, 20ft. above ground on west side, surrounding district parkland and residential	143	1,048	8	173	1,181	24
Ripon—Health Department High Skellgate, in centre of country town	101 for 4 months	361	34			
Wetherby—Council Offices, residential, surrounded by open country from ½ to ¾ mile distant	87	475	3			
Goole—Health Department, Municipal Offices, Stanhope Street, surrounding area commercial, residential and shipping	135	780	15	107	591	17
Castleford—First Floor of Divisional Health Office, in residential area of industrial town	253	1,840	44			
Normanton—In storeroom, first floor of Town Hall in centre of town. Surrounding district commercial, residential and a few small factories	188 for 11 months	764	8	224 for 11 months	500	63

*For period of full year unless stated otherwise.

Situation of Instrument	Smoke			Volumetric SO_2		
	Average Daily Suspended Impurity*	Highest Value	Lowest Value	Average Daily Concentration SO_2*	Highest Value	Lowest Value
	Micrograms per cubic metre			Micrograms per cubic metre		
Horbury—Ground floor lobby of Town Hall, facing east 12ft above ground, surrounding district residential and manufacturing	244	1,708	24	215	1,588	13
Morley—Public Health Inspector's Department, Commercial Street, surrounding district residential, commercial and manufacturing	204	1,028	23	213	731	46
Ossett—Croft House—on first floor landing on north-east side of building. Surrounding district residential and commercial	225 for 2 months	784	4	244 for 2 months	905	61
Batley—Public Health Department, Market Place, in centre of mixed residential, commercial and manufacturing district	189	1,628	19			
Spenborough—Divisional Health Office, Elm Bank, manufacturing area	116 for 10 months	508	16	161 for 10 months	689	25
Elland—Council Offices, 20ft above ground in manufacturing area	214	920	21	225	1,294	15
Elland (Holywell Green)—In garage of private house, in main residential area of manufacturing district	128	716	12	115	753	0
Hebden Royd (Mytholmroyd)—Redacre Sewage Works, residential and manufacturing area, open country to north	96 for 11 months	564	13	109 for 11 months	783	6
Hebden Royd (Hebden Bridge)—On second floor landing of Council Offices, in centre of mixed residential, commercial and manufacturing district	130 for 11 months	443	1	168 for 11 months	723	25
Todmorden—In first floor room on south side of Medical Centre, surrounding district mixed residential, commercial, manufacturing and open country	167	976	19	190	1,321	34

*For period of full year unless stated otherwise.

Situation of Instrument	Smoke			Volumetric SO_2		
	Average Daily Suspended Impurity* Microgrammes per cubic metre	Highest Value	Lowest Value	Average Daily Concentration SO_2* Microgrammes per cubic metre	Highest Value	Lowest Value
Colne Valley—Town Hall, Cross Street, Slaithwaite, in mixed residential and textile manufacturing district	174	668	36	151	804	17
Denby Dale—Public Health Inspector's Office, surrounding district mixed residential, manufacturing and open country	132	460	22	136	449	37
Holmfirth—On second floor landing of Council Offices, surrounding district open country, residential, commercial and manufacturing	152	552	29	163	641	37
Kirkburton–Council Depot, Highroyd, Lepton, 11 ft. above ground, surrounding district residential. Huddersfield C.B. 4 miles to the east	184	1,056	11	121	671	Alk.
Meltham—Public Health Inspector's Office, Town Hall, surrounding district residential, manufacturing and open country	168 for 11 months	676	24	145 for 11 months	639	17
Saddleworth–Sewage Works, Shaw Hall Bank, Greenfield, surrounding district residential, manufacturing and commercial	106	631	14	75	668	0
Wortley (Grenoside)–Health Dept., Council Offices, surrounding area industrial and manufacturing	100	513	9	142	678	12
Wortley (Oughtibridge)—County School, Church Street, surrounding district industrial and manufacturing	63	287	1	110	525	Alk.
Hemsworth—Divisional Health Office, Adiscombe House, in residential area	227	1,112	16	140	608	16
Darton—Council Offices, in semi-residential colliery district. Coke by-product plant 1 mile to the S.E.	180	1,008	28	157	545	42

*For period of full year unless stated otherwise.

Situation of Instrument	Smoke			Volumetric SO_2		
	Average Daily Suspended Impurity*	Highest Value	Lowest Value	Average Daily Concentration SO_2*	Highest Value	Lowest Value
	Micrograms per cubic metre			Micrograms per cubic metre		
Wombwell—The Gables, semi-residential colliery district	219	1,472	24			
Worsbrough—Savile House—8ft above ground in outbuilding, rear of Council Offices. Surrounding country open and low density residential	136 for 8 months	612	16	92 for 8 months	336	23
Conisbrough–Denaby Clinic, in room facing north. Surrounding district residential—high density	197	1,164	32	179	1,012	57
Conisbrough—The Priory, in staff dining room facing west. Surrounding district residential—low density	158 for 9 months	1,188	17	137 for 9 months	1,128	28
Rawmarsh—Public Health Inspector's Office, in centre of residential and industrial area	268	1,204	0			
Bentley with Arksey—Health Department, Chapel Street, semi-residential colliery district	202	1,308	24	148	1,063	51
Doncaster (Barnby Dun)—Barnby Dun School, in residential area 5 miles north-east of Doncaster C.B.	119	1,184	0	101	744	0
Doncaster—Askern—In Askern Clinic 6 miles south of Doncaster with open country to the south, residential to the north-east, heavy industry to north-west	116	924	0	130	856	0
Thorne—Council Offices, in semi-residential colliery district	126	700	25			
Kiveton Park—The Chelmsford Mining and Technical Institute, Dinnington, surrounding district open parkland with built up area to the south and west	135 for 7 months	708	4	131 for 7 months	698	7

*For period of full year unless stated otherwise.

Consideration of minor expansion of the scheme is proceeding in certain County Districts. The selection of sites for proposed instruments, as hitherto, will be undertaken in co-operation with the staff of the D.S.I.R. and County District Officers and I should like to thank the officers concerned for their continued assistance.

PART VI

MISCELLANEOUS

Future Developments in the Health Service

Welfare of the Epileptic and Spastic

Certification and Treatment of Blind and Partially Sighted Persons

National Assistance Act, 1948

Residential Accommodation

Disabled and Old Persons' Homes

Persons in need of Care and Attention

Registration of Nursing Homes

Notification of Births

Nurseries and Child-minders Regulation Act, 1948

Medical Arrangements for County Children's Homes and Residential Nurseries

Medical Examination for Superannuation

Road Traffic Act, 1960

West Riding Distress Fund

FUTURE DEVELOPMENTS IN THE HEALTH SERVICE

Introduction

The past two years have been marked by the publication by the Ministry of Health of Reports on the three main branches of the National Health Service. ' A Hospital Plan for England and Wales ' sought to rationalise the hospital service, introduced the concept of the district hospital and laid down a ten-year plan for the development of the service. ' Health and Welfare: The Development of Community Care ' recorded the ten-year development proposals for Local Health and Welfare Authorities and stimulated their further development. ' The Field of Work of the Family Doctor ', the report of the Sub-Committee, under the chairmanship of Dr. Annis Gillie, of the Standing Medical Advisory Committee of the Central Health Services Council examined the work of the family doctor and advises on the future scope of the development of general practice.

Each and all of these reports draw attention to the need for a continual re-examination of present services and to their future development either by the re-deployment of existing resources or by augmenting those resources. The most marked and common theme of the three reports, however, is the insistence on the need for co-operation between the three branches of the service and in particular the recognition of the important position of the family doctor, viz:—

' A Hospital Plan '	" The effectiveness of the general practitioner can be greatly enhanced by the development of supporting services, whether provided by the hospitals or by the local authorities."
' Health and Welfare '	" The development of these (health and welfare) services is, therefore, bound up with the future of the general practitioner service; the one will interact with the other and both in future must be considered together."
' The Gillie Report '	" We do not consider that a change in the administrative structure is an essential pre-requisite to the development of the Service. On the contrary any such change would come better as a sequel of functional unification in some degree. The central position of the family doctor, mobilising for his patient all the resources of hospital and local health and welfare services, give him a unique opportunity to bring this functional unification about."

Concurrently with the publication of these reports the services provided by the County Council have been under close examination and there has been significant experimental development in the field of co-operation with general practitioners. In the proposals approved in the Authority's ten-year plan there are provided the buildings and staff adequate for future development. Certain aspects of this development will involve protracted negotiations in anticipation of which it becomes necessary to seek from the County Council decisions of policy. Similarly approval in principle is required to other changes, some in emphasis only, incorporated in this report. It will be necessary to refer to the School Health Service, the responsibility of the Education Committee, because of the joint use of buildings and staff. There will not, however, be any material reference to the Mental Health Service where the present development is nearing completion and where a period of consolidation is envisaged.

Co-operation with General Practitioners

The pattern of our co-operation with the general practitioner is of first importance in that it will profoundly influence the County Council's building programme and will affect our staffing requirements.

Surgeries. Criticisms have been made of the surgery accommodation provided by general practitioners; some are affected by proposals for urban re-development; some are part of the homes of practitioners who now desire some degree of personal liberty and would prefer separate surgery accommodation. Certain improvements have been effected and limited buildings have been erected and financed from the ' General Practitioner Loan Scheme '. Generally, however, the individual practitioner, anxious to improve his facilities, is faced with capital expenditure which he is unable to finance himself and for which he can expect no increased income.

In this situation approaches have been made by a number of general practitioners for the use of our clinic premises, in a variety of ways, for surgery accommodation. Notably, of course, has been the establishment of the Cleckheaton Health Centre which is now in course of erection. More recently has been the Committee approval for a practitioner to use part of the Dodworth clinic as a surgery, for which he was prepared to pay an economic rent. It is variants on the latter scheme, rather than of Cleckheaton, which are the subject of present enquiries, from Southowram, Cottingley, Ackworth, Rossington, Mexborough, Hebden Bridge, Hemsworth, Haworth and Settle. These will undoubtedly be multiplied if a satisfactory solution can be produced and publicised. Meanwhile certain of the projects are already in jeopardy due to delay, to the absence of policy decisions, to details of cost, etc.

Health Centres. In the event of the County Council wishing to build special ' ad hoc ' surgery accommodation either in a new building or as an addition to an existing clinic that new building will be a health centre and that clinic will similarly become a health centre under the provisions of Section 21 of the National Health Service Act. These considerations affect a number of the present enquiries.

The County Council has authority to build one specified health centre only, that at Cleckheaton, and the Ministry of Health rejected the proposal that other health centres would be provided as the opportunity occurs. It would be necessary, therefore, to submit further proposals as required by Section 20 of the Act seeking authority either for each individual project or in more general terms; in the latter event it would probably be necessary to seek general authority subject to the approval of the Minister in each individual case.

Clinics. Where surgery accommodation can be provided in our existing clinic premises, with or without minor modifications, the problem of re-designation is unlikely to arise. Already this has been done at Dodworth and it is anticipated that it will be repeated at the first of the proposed mini-clinics at Southowram. No doubt the County Council would wish this method to be pursued wherever practicable.

Insofar as new building projects are concerned the Architect has been asked that the design should have regard to the possibility of future general practitioner participation so as to facilitate any later adaptations and extensions for that purpose.

Mini-Clinics. Reference has been made to the proposed mini-clinic at Southowram. Present indications are that these buildings will be ideally suitable for our own local services and as surgery accommodation for sessional use by practitioners or for more extensive use by a single practitioner and it may be in this sphere that the most rapid development can be made.

The possibility is also envisaged that the new mini-clinic might form the nucleus of a larger project providing multiple accommodation for general practitioners, in which event it would become a health centre. In such an event a policy of standardisation, if not of uniformity, may be necessary in order to avoid excessive costs, subject to the practitioners being made aware of the relatively higher cost which will be involved by departing from these standards.

The policy of co-operation now being pursued involves providing the general practitioner with the supportive services of health visitor, midwife and home nurse (to which reference is made later in this report) to providing him, where he desires it, with facilities to hold his own antenatal and infant welfare clinics. If, in addition to these facilities he asks for surgery accommodation there would appear to be some justification for the erection of a mini-clinic even if no formal local authority clinics are to be held. The premises would be available as headquarters for the local County staff and for any other health and welfare activity in the area; in such a situation not more than half their cost should be charged for any general practitioner use.

Rentals. In contrast with Cleckheaton, where the rentals are highly subsidised, it has been possible at Dodworth to let the surgery accommodation at an economic rental, due largely to joint use of certain facilities and accommodation. It is believed that this will also be possible at the Southowram mini-clinic, and it will be the aim in all the projects under consideration.

The question of rentals is, of course, an overriding consideration for the general practitioner since any additional expenditure is a direct charge on his personal income; he will require some assurance therefore that the rental to be charged will not show any appreciable variation from his present expenditure. Where the economic rent would appear to be excessive from this point of view it is suggested that the Health Committee would be prepared to negotiate in the light of the particular circumstances having due regard to their continuing responsibility for the maintenance of rooms which would be commonly occupied, *i.e.*, waiting rooms, sanitary accommodation etc., and subject to the County Council receiving a rental reflecting not less than the cost of the *exclusive* facilities provided.

G.P. Premises. Applications may arise where general practitioners prefer to finance their own surgery accommodation but wish to build adjacent to the local clinic on the County site. This alternative version is fully in accord with the policy of co-operation and it is suggested that the County Council might authorise the sale or long-term lease of the necessary land, wherever practicable.

Attachment of Nursing Staff. Of necessity the home nurse works under the clinical direction of the general practitioner; with the great majority of expectant mothers now booking a doctor this is becoming largely so with the midwife; the health visitor is available, either by telephone or in person, for consultation on problems of mutual interest.

There would, therefore, seem to be adequate evidence of full co-operation between the general practitioner and the nursing staff. This admirable picture is, however, marred by many practical difficulties and some experimental work has been undertaken with a view to a more satisfactory solution.

It has been customary to allocate each of our field nursing staff to a defined area so that she may assume responsibility for the needs of all the population within that area, with due economy of time and expense in travelling. The practices of general practitioners do not conform to that pattern; they run in parallel and overlap and in general cover a more scattered area, although the majority of patients will be limited to within a reasonable travelling distance of a particular surgery. In consequence of this different approach any member of our nursing staff will cover an area served by a number of doctors, and each practice is served by a number of nurses of each category. This complex pattern may ensure that there are means of co-operation but it is an obvious sphere for simplification to obviate the irritation and frustration which occurs, and to enable the general practitioner to assume his role as the leader of the domiciliary team.

With this in view a number of schemes for attaching the health visitor to the family doctor have been introduced for experimental purposes. Because of the different structure the initial thoughts were that the health visitor would deal with the practice problems arising in her own area and would act as liaison officer for the remaining part of the practice, liaising with her colleagues for the outside patients. This arrangement, albeit an improvement, is still inadequate in that it has been found that the doctor prefers to deal directly with the health visitor concerned, failing which he is unlikely to make use of the liaison service. The preferable arrangement is for the health visitor's attachment to a practice to be to the patients of the practice, a radical change of structure for the health visiting service. It will inevitably involve greater travelling expenses, but these should be more than offset by the improved liaison to the benefit of the community as a whole.

Difficulties are likely to arise where the area of a practice extends outside the Administrative County, but there are at the present time some 700 general practitioners with practices wholly within the County area and the policy would be to concentrate firstly on those 700 practices and then to seek to overcome the difficulties by negotiations with remaining general practitioners and with the Local Health Authorities concerned.

The extent to which the health visitor would be attached to a practice will be dependent upon many circumstances, viz:- the size of the practice and the availability of staff; where the practitioner elects to conduct his own infant welfare sessions or other preventive health clinics the health visitor would be in attendance, otherwise she would continue to undertake similar duties arranged by the County Council; in the same way it may be possible for general practitioners to undertake certain routine school health duties, particularly in infant and primary schools which, in the less urbanised areas, are more likely to be identified with a particular practice.

To enable this transition to take place it will be necessary for the attached health visitor to shed some of her less onerous duties; school medical inspections, particularly in the secondary schools, specialist school clinics, certain supervisory duties in the home help and chiropody service are obvious spheres and the more time-consuming case work involved with problem families and the like. These

duties will be undertaken by other health visitors or until such time as an adequate number of qualified staff are available by the newly approved grade of ' auxiliary ' and, where necessary, the social workers who are shortly to be introduced into the service.

The success of the pilot schemes which have been inaugurated leave no doubt as to the improved service resulting from the health visitor-general practitioner attachment.

It has been demonstrated that such a re-organisation is practicable despite the complexities of the health visiting service. It should be more easily practicable to adopt the same structure for the home nursing and midwifery service, again subject to an examination of the appropriate case load.

The home nurse at present works under the clinical direction of the general practitioner who is unaware of her commitments to his colleagues in the area, or of the relative importance of her other work, and may be dissuaded from referring cases for her attention under the erroneous impression that she is fully occupied. This situation is particularly likely to arise immediately following a period of staffing difficulty, due to sickness, resignations and retirements; it will not arise if the home nurse is wholly attached to a general practice, of sufficient size, since the practitioner will be fully aware of the extent of her duties and can thus deploy her services as may be required. It will therefore be the aim to make such attachments wherever practicable.

Midwifery presents its particular problems, not necessarily insuperable. Taking the average picture, a group practice of 8,000 patients will provide some 140 confinements in a year, 50 of which will be domiciliary, providing an adequately satisfactory load for a full-time midwife. The actual load in any particular practice is, however, governed by many factors; the availability of hospital beds and their turnover, the attitude of the individual doctors to maternity work etc. Again it cannot but be helpful if a midwife can be attached to such a practice, working in concert with the doctors and health visitors in antenatal care, attending the domiciliary confinements, and responsible with the doctors for postnatal care in the home following either domiciliary or hospital confinement. To gain this unity of purpose in maternity care it is proposed to seek for the attachment of midwives wherever conditions are suitable and the proposal mutually acceptable.

The adoption of this concept as the declared policy of the Health Committee will lead to rapid development and will be welcomed by the body of general practitioners serving the County area. Indeed one possible embarrassment arising from its adoption may be the practitioner's inability to provide accommodation for his ' supportive workers ' or community health team, a difficulty which could increase the demand for surgery accommodation in or associated with our clinics.

The Future Role of the Health Visitor

An acceptance of the policy of the fullest possible co-operation with general practitioners will have its most immediate and significant impact on the health visiting staff. In the process of re-shaping our services to meet the more pressing contemporary needs care has to be taken to ensure that the more valuable aspects of her traditional duties are not neglected and that due attention is given to the needs of the school health service.

With these considerations in mind it is nevertheless suggested that the activities of the health visitor should now be re-directed, as the opportunity occurs, with primary emphasis on the following broad themes:

(a) Co-operation with General Practitioners.
(b) Health Education.
(c) Pre-symptomatic diagnostic tests.

(a) Co-operation with General Practitioners. Ideally the health visitor will be a full-time attachment to a group practice or partnership with a list of 6,000 or more. The doctors concerned would be undertaking their own antenatal and infant welfare sessions, making use of the County clinics for that purpose, and would probably be undertaking the routine school medical inspection of the children from their practice attending the local primary school. Within such a practice the health visitor will undertake antenatal duties—in co-operation with the midwife—infant visiting and infant welfare clinics, assist or under the direction of the doctor undertake immunisation and vaccination, attend with the doctor at school medical inspections, visit and investigate the needs of the adult sick, visit the aged and deal with their needs particularly in regard to home helps and chiropody, and supervise the home helps attending patients within the practice. This is not a wholly exhaustive list but is sufficient to indicate that in her new guise the health visitor will be undertaking her traditional duties but for a defined group rather than for a geographical area and with emphasis varying from time to time to meet the more pressing needs of the moment.

When fully occupied in this way the health visitor would not be available for certain school medical inspections nor for attendance on the doctor at specialist school clinics; she would, however, be available for consultation, by the nurse undertaking these duties, in respect of school children in her practice. Such duties would be carried out either by health visitors not wholly attached to general practitioners or in many cases by the new ' auxiliary ' grade of public health nurses.

The attached health visitor, although working under the day to day direction of the general practitioner within her overall functions, will nevertheless continue to operate under the administrative control of the divisional medical officer and in close concert with her other colleagues in the health department.

In seeking approval for this re-orientation of the health visitor's duties, duties which will inevitably involve more extensive travelling, it will be appreciated that this is a long-term objective and that for the interim period there will be many variations on the theme; the work of a number of health visitors will remain largely unchanged whilst others may be attached to practices in a part-time capacity only, being otherwise employed on their normal duties.

(b) Health Education. It is axiomatic that the health visitor is, in her many duties, an exponent of health education to all who come under her care or seek her advice. This teaching of individuals needs to be, and is, supplemented by group teaching of expectant and nursing mothers, school children, parents, parent-teacher associations and other cohort groups. Health visitors undertaking this work, particularly group teaching, need to have the use of modern materials and equipment, which is being made available in increasing volume. They also need to be aware of changes in technique, of new aids as they become available and finally of the need to directing their teaching on a contemporary

common line (*i.e.*, the value of a campaign against smoking, for immunisation, on home safety etc., is increased immeasurably when it is being promoted on a repetitive theme throughout the County rather than as selected by the individual health visitor). It is for this reason that importance is attached to the proposed appointment of a health education officer and equally important that she should be recognised as a member of the nursing staff.

(c) Pre-symptomatic Diagnostic Tests. This aspect of the work of the health visitor is comparatively new but has proved itself of significant importance. Cases of phenylketonuria are being found by the routine testing of the urine of babies during their fourth week of life; when found at so early an age dietary treatment can be established and permanent mental handicap avoided. The Ortolani test for congenital dislocation of the hip is being performed on every baby coming into the hands of the midwife, health visitor or clinic doctor for the first time; for cases found in this way corrective treatment can be applied with relative simplicity and so avoid the years of splinting and repeated operation to which some children have been subjected in the past. Routine audiometric surveys of school entrants reveal defects of hearing which, if otherwise unrecognised, can be a serious handicap to a child's education.

In these three tests alone the health visitor is making an invaluable contribution to the health and well-being of the community. It is of the utmost importance that this work should continue and that similar tests should be added as and when their value has been satisfactorily determined.

The Nursing " Auxiliary "

The County Council have approved proposals to augment the health visiting staff by 50 nursing " auxiliaries " and it is hoped to make the first 30 of these appointments in the coming financial year.

The term " auxiliary nurse " is used as a generic term to include grades of nursing staff who do not possess the health visitor's certificate or the appropriate dispensation but are engaged on ' health visiting' duties to relieve the more highly qualified staff. It is not intended for use as a designation since each nurse will be entitled to the designation appropriate to her qualifications. At the present time some 80 " auxiliary " nurses are employed within the health visiting establishment. If, therefore, a further 50 were to be appointed this would provide a total of 130 against 260 qualified health visitors and would be too great a degree of dilution.

The first objective must be to build up the qualified staff and to make the most effective use of the " auxiliaries " for that purpose. It is proposed, therefore, that auxiliaries should be recruited with the firm objective of health visitor training after a preliminary period of service and secondment for obstetric training at one of the courses recently approved. The short-term obstacle will be that the recruitment of auxiliaries will be largely restricted to areas adjoining obstetric training courses and with sufficient health visiting staff to undertake pre-training instruction. The long-term advantage will be the increased numbers of qualified health visitors without whom it will not be possible to achieve the stated objectives of the health visiting service.

In this role the employment of " nursing auxiliaries " is regarded as an expedient and must of necessity remain so until the health visiting staff is considerably strengthened. When that stage has been reached it will be more practicable to review the field for the continued employment of these workers. It may be sufficient at this stage to envisage some " auxiliaries " being involved in attachment to general practice. Such practices are not tailored in size to correspond with the supporting staff and the addition of an auxiliary may well be justified in some cases to augment the services already provided by any or all of the attached health visiting, home nursing and midwifery staff.

Social Workers

The field of activity of a social worker in the County health services, other than in mental health and the control of venereal diseases, remains largely unexplored. Hitherto such work as has been done has been primarily the duty of the health visitor who however has been unable to tackle the problem in depth because of her other commitments; a situation which will continue in the transformation of her duties as already outlined; furthermore, because of these circumstances the health visitor has been denied the opportunity of developing the specialised skills of intensive case work.

The view that such workers can make a valuable contribution to the County health services, not only by relieving the health visitor of such duties but also by the exploration of problems which are likely to reveal previously undisclosed needs, was supported by the County Council in its Ten-Year Plan and by the approval of a new establishment of 25 social workers; it is confirmed in the Ministry of Health review of the local health and welfare authorities' proposals for the development of community care. Of particular significance in the many references to social workers in this review (Cmnd. 1973) is the following:—

" 25. Where a child shows signs of disturbance or backwardness, or a member of the family is mentally or physically handicapped, or the standards of a home are grossly inadequate or the mother is widowed, deserted or unmarried, personal or family problems can arise which it is the social worker's function to analyse and help in solving. The maternity and child welfare services can be the means of bringing these problems to light at an early stage, and families needing such help are increasingly being referred by the doctor, or more particularly by the health visitor, to the appropriate social worker.

26. A few authorities employ social workers within the maternity and child welfare services themselves, and in some areas they are attached to child welfare centres; but it is not the most efficient and economical use of social workers to limit their activities in this way. What is wanted is that maternity and child welfare staff should always be able to call on the appropriate social worker when necessary."

Financial provision has been made to enable recruitment of these officers to commence forthwith and it becomes necessary to determine in what way this is to be achieved.

The social workers will be seriously handicapped in their contribution to the service without professional qualifications; in their absence they will tend to become adjuncts only to the existing services and their own particular contribution will be lost. At the same time it must be recognised that at this point in time the supply of qualified social workers is limited whereas the opportunity for their employment ranges over a wide variety of service. New courses of training have been opened following the Report of the Working Party on Social Workers but these are too new and too few to fill the existing gaps. Furthermore, it is essential that the social workers should be integrated with the health department team, whereas few existing social workers have experience of such team work.

Co-incidentally a new ' Younghusband ' training course for social workers has commenced at the Leeds College of Commerce and a tentative approach has been made for the County Council to assist in the field work which is an essential part of the course of training.

In this situation it was thought desirable to discuss our mutual problems with the principal tutor, Mr. Haggett, from which the following solution has emerged.

In the first stages our recruiting will be restricted to welfare assistants having the necessary academic and personal qualifications which would make them eligible for admission to a ' Younghusband ' course of training; initially this would mean that all entrants would be approved for admission to the Leeds training course. As welfare assistants they would be employed in selected divisions undertaking duties assigned by the divisional medical officer and in close co-operation with other members of the divisional field staff; not only would they be making a useful contribution towards the work of the department but also familiarising themselves with the organisation of the County services generally and with the needs arising from their own observations; in addition to their service in the field there would also be attendance at a series of in-service lectures on specialised aspects of the service. After the inaugural period of service the welfare assistants would be seconded for training to the Leeds ' Younghusband ' course, on the terms and conditions approved at the July, 1961 meeting of the County Council, on the successful conclusion of which they would be employed as qualified social workers.

Whilst training, the students will be required to undertake a certain amount of case-work in the field under the guidance of a qualified senior social worker. If the Leeds course is to operate effectively and to develop there will be the need to provide this training in the County area and, therefore, for the appointment by the County Council of one or more senior social workers who will of course be carrying out other specialised duties in the County service. It is unlikely that this need can be fully established before 1965 and probably later but it is an integral part of the programme for the future training of the County staff. If therefore the proposals for the recruitment of social workers is approved it is obviously desirable that there should be approval in principle to the future senior appointment(s) subject to a further report when the need arises.

The Assistant County Medical Officers

The establishment of 73 assistant medical officers consists of 57 whole-time assistant county medical officers and some 100 or more medical practitioners providing a sessional service to the equivalent of a further 16 assistant county medical officers.

The assistant medical officers are engaged equally in the school health service; for various reasons the school health service is staffed by the whole-time medical officers whereas the sessional medical practitioners are almost wholly engaged in the maternity and child welfare services. For this reason matters affecting the whole-time staff are customarily referred to the Divisional, School Health and Dental Services Sub-Committee to ensure that the Education Committee may consider any recommendations. The work of the assistant county medical officers is at present under review and in due course a report will be presented to that Sub-Committee.

Meanwhile it will be obvious that the changes which are envisaged in this report will inevitably affect the medical staff. If general practitioners are to take part in the school health and maternity and child welfare services, the whole-time staff will be relieved of such duties. With this relief they will become available for other duties; those which remain and others which are arising from developments both in the school health and health services. So far as the health services are concerned it is perhaps only necessary to mention the need for the early ascertainment of deafness in young children, research into problems of immunisation, cancer, leukæmia, prematurity and congenital abnormalities, the follow-up of pre-diagnostic testing, closer co-operation with general practitioners on mutual problems; these are duties which have arisen over the past few years and have so far been undertaken by the existing staff although not without strain at times. There is need for research on the establishment of geriatric clinics but additional medical staff is required for this purpose. Similarly there is need for a great deal more research in the mental health problems in the community, particularly for the subnormal patients in the training centres and future residential hostels.

It will be apparent, therefore, that more routine duties are likely to be replaced by duties of a more exacting nature which in many instances will call for specialised knowledge. With the many changes, in knowledge and technique, which are now taking place it will be necessary to ensure that the medical staff are kept up-to-date by regular attendance at refresher courses and that the specialist interest and knowledge is made available to their colleagues throughout the service. This will also involve a greater fluidity of movement, for consultation purposes, than has hitherto been customary.

Summary and Recommendations

It has become necessary to review the County health services in relation to the changes and developments taking place throughout the whole health service and to determine what changes have become necessary if the County Council is to contribute in full to the ultimate well-being of the community. The services deployed by the Health Committee will be of maximum benefit only if used in co-operation with the family doctors of that community. The changes outlined in this report will, without abrogating the County Council's responsibility, lead to an integration of the services at the only point at which integration is of vital importance, in the care of the individual patient. An acceptance of this policy will not lead to an overnight revolution and many years of patient negotiation and implementation are to be expected before the ultimate purpose is achieved. Nevertheless, a recognition of the intent and the success of initial schemes will

do much to remove the remaining traditional suspicions of the general practitioners and breed further developments with greater rapidity than can be at present envisaged. It is for these reasons that the following recommendations will be submitted to the Health Committee for approval.

1. That subject, where necessary, to the approval of the West Riding Executive Council and of the Ministry of Health, the County Council will on application and where practicable provide surgery accommodation in health centres or in County clinics for general practitioners on the general list of the West Riding Executive Council at negotiated rentals having due regard to the economic rent.

2. That where desired and practicable the County Council will lease or sell on approved terms land forming part of the site of a County clinic to enable general medical practitioners to erect thereon surgery accommodation.

3. That wherever practicable the County Council clinic premises shall be made available to general medical practitioners free of all charges for the purpose of holding antenatal or well baby clinics for patients on their respective lists and subject to normal surgeries not being conducted during such use of the premises.

4. That the County Council approves the policy of attaching health visitors to the practices of general medical practitioners either in a part-time or full-time capacity as may be appropriate having regard to the size of the practice and the nature of the duties undertaken and subject to the County Medical Officer being satisfied that such an attachment can be effected without detriment to the remaining County service. The County Council further approves in principle the extension of this policy by the attachment of home nursing and midwifery staff to general practices subject also to the County Medical Officer having due regard to the case-load involved and to the maintenance of the County service elsewhere than in the practice(s) involved.

5. That with a view to recruiting the authorised establishment of social workers the County Council approves:-

   (a) The recruitment of welfare assistants acceptable for admission to an approved 'Younghusband' course of training, primarily by arrangements with the Leeds College of Commerce.

   (b) The secondment of welfare assistants to approved training courses on the terms and conditions approved by the County Council in July, 1961.

   (c) The future appointment, in conjunction with the Leeds College of Commerce, of one or more senior social workers subject to further report when the need arises.

6. That the County Medical Officer shall review the establishment, recruiting, training and duties of the assistant county medical staff in relation to the future development of the health and school health services and submit a report thereon to the Divisional, School Health and Dental Services Sub-Committee.

THE WELFARE OF THE EPILEPTIC AND SPASTIC

The following are the particulars of known epileptics and spastics :

	Number	
Adults	*Epileptics*	*Spastics*
Provided with accommodation under Part III of the National Assistance Act, 1948:		
(a) in homes for epileptics	73	
(b) in homes for spastics and other handicapped persons		27
(c) in County establishments and establishments where County Council has " right of user "	45	
Registered under the County Council's scheme of Welfare Services for Handicapped Persons (General Classes) and not shown above	127	139
Children		
Number ascertained as handicapped:		
(a) Approximate number attending ordinary schools	Not known	68
(b) Attending special schools	26	96
(c) Receiving home tuition	—	1
(d) Attending Training Centres for the Mentally Subnormal	81	59

The register of handicapped persons, including epileptics and spastics, under the approved scheme has been kept up to date and the information recorded includes the medical classification and assessment of their suitability for employment. Again much thought has been given during the year to furthering the County Council's approved scheme under Sections 29 and 30 of the National Assistance Act, 1948. A few centres are being operated through the County Council and the agency of voluntary organisations in the County Boroughs and these generally serve handicapped persons in the contiguous West Riding areas. Handicraft centres have been established at Harrogate, Morley, Pontefract, Wombwell, Ripon, South Kirkby, Rossington, Thurcroft, Skipton, Woodlands and Hoyland Common. In addition local branches of the National Spastics Society are now operating in several districts of the West Riding, at York, Leeds, Bradford, Halifax, Dewsbury, Huddersfield, Barnsley, Sheffield, Pontefract, Castleford and Goole.

There were ten full-time handicraft instructresses working in the County during the year. From this agency over 1,020 handicapped persons were actively engaged in home handicraft work and a number were epileptics and spastics.

There are numerous avenues for the disposal by sale of the articles produced; some are disposed of by private arrangements of the persons concerned, and assistance is afforded to others to obtain orders and sales. Voluntary organisations and many persons of goodwill have been helpful in providing means of sale and their assistance is gratefully appreciated.

Again advice to handicapped persons on their various problems and assistance and liaison with other statutory bodies is effected through nine divisional welfare officers.

Financial assistance was given to handicapped persons (including a number of spastics) in respect of internal and/or external adaptations to their homes or in respect of the provision of additional facilities designed to secure their greater comfort or convenience.

The County Council made grants to organisations providing voluntary services for handicapped persons and grants were made to the Spastic and Epileptic Societies.

CERTIFICATION AND TREATMENT OF BLIND AND PARTIALLY SIGHTED PERSONS

The following table gives particulars of new registrations during 1963 of blind and partially sighted persons (other than handicapped school children).

	Disability (B.—Blind, P.S.—Partially Sighted)									
	Cataract		Glaucoma		Retrolental Fibroplasia		Others		Total	
(i) Number of cases registered during the year in respect of which Section F recommends:	B.	P.S.	B.	P.S.	B.	P.S.	B.	P.S.	B.	P.S.
(a) No treatment	115*	†52	8	2	—	—	120	45	243	99
(b) Treatment (medical, surgical, optical or Ophthalmic Medical supervision)	138=	106‡	33	17	—	—	56	54	227	177
(ii) Number of cases at (i) (b) above which received treatment ...	95	70	26	14	—	—	44	47	165	131

* Includes 15 cases of cataract with glaucoma.

† Includes 1 „ „ „ „ „

‡ Includes 14 „ „ „ „ „

= Includes 27 „ „ „ „ „

RESIDENTIAL ACCOMMODATION

(National Assistance Act, 1948)

Under the scheme for residential accommodation the County Medical Officer is responsible for the general medical oversight of the following:—

Establishment	*Superintendent/Matron*	*Telephone Number*	*No. of Residents*	
			Men	*Women*
The Shroggs, Skipton Road, Steeton	Miss E. M. Wolstenholme	Steeton 3213	—	20
Farfield Hall, Bolton Road, Addingham	Mrs. H. Otter	Bolton Abbey 241	11	19
Neville House, Neville Crescent, Gargrave	Mr. and Mrs. M. Carling	Gargrave 349	13	21
Sharow View, Allhallowgate, Ripon	Mr. and Mrs. E. Brook	Ripon 238	43	30
The Beeches, Leeds Road, Tadcaster	Mr. and Mrs. H. G. Jenner	Tadcaster 2113	71	40
*11, Stockwell Road, Knaresborough	Miss W. M. Brown (Matron) Mr. T. K. Hayward (Secretary)	Knaresborough 2283	54	34
Wharfedale Lawn, Westgate, Wetherby	Mrs. A. Lofthouse	Wetherby 2446	—	23
The Grove, 80, High Street, Starbeck	Miss A. Smithson	Harrogate 83980	—	19
Fircroft, Wighill Lane, Tadcaster	Miss L. E. Wilkes	Tadcaster 3204	9	18
Hillworth Lodge, Oakworth Road, Keighley	Mr. and Mrs. D. Moor	Keighley 4014	64	129
Thornton View, Thornton View Road, Pasture Lane, Clayton, Bradford	Mr. and Mrs. F. Innis	Queensbury 2007/8	100	100
Woodville, Spring Gardens Lane, Keighley	Mrs. G. H. French	Keighley 2428	9	11
Crow Trees, Leeds Road, Rawdon	Mrs. H. M. Lewis	Rawdon 2908	—	20
Burley Hall, Burley in Wharfedale, near Ilkley	Miss E. S. Atkinson	Burley in Wharfedale 2334	7	20
Park House, 41, Lister Lane, Bolton, Bradford	Mr. and Mrs. G. H. Fletcher	Bradford39913	22	—
Glenholme, Green Lane, West Vale, Greetland	Mr. and Mrs. H. H. Senior	Elland 2985	20	20

* County Council have " right of user."

Establishment	*Superintendent/Matron*	*Telephone Number*	*No. of Residents*	
			Men	*Women*
Stoneswood, Oldham Road, Delph	Miss M. C. Murphy	Delph 300	8	12
Thornhill Grange, Rastrick ...	Mr. and Mrs. W. Corbett	Brighouse 810	9	34
Longlands, Leeds Road, Lightcliffe, near Halifax ...	Miss A. Dickinson	Halifax 68254	8	12
Scaitcliffe Hall, Burnley Road, Todmorden	Miss L. Holt	Todmorden 114	10	14
Stanley View, Park Lodge Lane, Wakefield	Mr. and Mrs. F. W. Radley	Wakefield 2188	126	93
Beech Towers, Halifax Road, Staincliffe, near Dewsbury	Mr. and Mrs. N. W. Jones	Dewsbury 4051/2	156	148
Walton House, Shay Lane, Walton, near Wakefield ...	Mrs. D. Wright	Wakefield 5242	—	20
Turnsteads, Whitcliffe Road, Cleckheaton	Mrs. J. E. L. Thwaites	Cleckheaton 2972	—	23
Brook Lodge, Brook Street, Selby	Mr. and Mrs. J. E. Whitworth	Selby 15	57	68
Northgate Lodge, Skinner Lane, Pontefract	Mr. and Mrs. C. Borrill	Pontefract 3351/2	100	64
Mill Garth House, Mill Hill Lane, Pontefract	Mr. and Mrs. J. T. Fenton	Pontefract 3593	11	33
Wadworth Hall, Wadworth, near Doncaster	Miss M. Bakewell	Doncaster 53272	9	18
Haynes House, Haynes Road, Thorne	Mr. and Mrs. L. Gillard	Thorne 3395	16	19
Don View, 22, Thellusson Avenue, Scawsby, near Doncaster	Mr. and Mrs. W. R. Howell	Doncaster2257	15	23
Owston View, Carcroft ...	Mr. and Mrs. A. Brearley	Adwick le Street 3368	15	17
Rolleston House, High Street, Maltby	Mr. and Mrs. G. T. Nutt	Maltby 2118	16	25
Highfield, North Anston ...	Mr. and Mrs. C. Bungay	Dinnington 2593	14	20
Oaklands, Oakdale, Worsbrough Bridge	Mr. and Mrs. F. E. Rodgers	Barnsley 5529	12	29
Netherfields, Sheffield and Halifax Road, Penistone ...	Mr. and Mrs. C. Stoney	Penistone 2144	37	29
Wombwell Grange, Park Street, Wombwell	Mrs. K. M. Smith	Wombwell 2186	—	18
Mortomley House, High Green	Mr. & Mrs. G. A. Smith	High Green 323	18	27

REGISTRATION AND INSPECTION OF DISABLED AND OLD PERSONS' HOMES

(National Assistance Act, 1948)

The following premises, which are inspected in conjunction with the officers of the Welfare Department, are registered as Disabled and Old Persons' Homes.

Establishment	*Number of Residents*	*Type of Home *(Part I, II or III)*
Congregation of Sisters of Charity of our Lady of Good and Perpetual Succour, St. Anne's Convent, Burghwallis, Doncaster	23	I
Mrs. Bessie Fox, Moor Lane House, Moor Lane, Gomersal... ...	10	I
Harrogate Old People's Home, 66-68, Cold Bath Road, Harrogate ...	36	I
Skelldale Housing Society Ltd., Borrage House, Borrage Lane, Ripon	12	I
Ernest Ayliffe Home for the Deaf and Dumb, Fulford Grange, Rawdon	32	II
North Regional Association for the Blind, " Oaklands," Huddersfield Road, Holmfirth	30	II
Keighley & District Institute for the Blind, 13-15, Scott Street, Keighley	27	II
Mrs. M. L. Harris, The Woodlands, Farrer Lane, Oulton	21	I
Methodist Homes for the Aged, " Glen Rosa," Grove Road, Ilkley...	32	I
Methodist Homes for the Aged, Berwick Grange, 5, Otley Rd., Harrogate	34	I
Highfield Home for the Blind, Soothill Lane, Batley	14	II
Catholic Women's League, Clitherow House, 49, Valley Dr., Harrogate	16	I
Miss L. W. Miller, " Greylands," Forest Moor, Knaresborough ...	7	I
Mrs. I. Brearley, S.R.N., Haversham Court, Ben Rhydding Road, Ilkley	22	III
Mrs. D. Wood, Gratton Home for Aged Ladies, 11, East View Terrace, Otley	18	I
Mrs. A. C. Shepley, Batley Hall, Upper Batley	10	I
Harrogate Guild of Help (Avondale Trust Ltd.), " The Avondale," Cold Bath Road, Harrogate	20	I
Mrs. K. D. Clarke, " Newlands," 58, Harlow Moor Drive, Harrogate	7	I
Yorkshire Association for the Disabled, St. George's House, Otley Road, Harrogate	88	II
Mr. William Kneen, The Gables, Norland, Sowerby Bridge	11	I
Mrs. M. Fell, Oakfield, Thwaites Brow, Keighley	5	I
Mrs. B. M. Veall, Lansdown, 46, Kent Road, Harrogate	9	I
Mr. John McCormick, " Burnlee House," Park Head, Holmfirth ...	17	I
Mrs. Minnie Satariano, " Downside," 15, Otley Road, Harrogate ...	15	I
Mrs. Queenie Mona Marsh, Portland House, 14, Leeds Rd., Harrogate	6	I
Mrs. P. C. Rayfield, The Grange, Woodlesford, near Leeds	5	I
Mrs. Alice McConney, Elm Bank, 242, Park Lane, Keighley ...	8	I
Mrs. June Valentine Minogue, Straygarth, 42, York Place, Harrogate	17	I
Mr. Douglas Kneen, Thorpe House, Triangle, near Halifax	15	I
Mrs. Doreen May Thompson, Brooklands, Harper Lane, Yeadon ...	6	I
W. H. and R. E. Higgins, Housley Manor, Housley Hall Lane, Chapeltown	14	I
Pentecostal Eventide Housing Association, Brooklands, Bakewell, Pentecostal Eventide Home, Bradford Road, Wrenthorpe	30	I
Mrs. Hester Walker, Granville House, Exley Road, Keighley ...	9	III
Mrs. A. G. Turner and Miss G. Carradice, Ghyll Court, The Wells Walk, Ilkley	12	I
Mrs. K. M. Pay, 60, Franklin Road, Harrogate	5	I
Mr. F. Vasey (Kildare Lodge Ltd.), Kildare Lodge, 23, Park Drive, Harrogate	9	I
Miss Beatrice Anne Hartley, Hartwell Home, Raincliffe, Thorpe Hesley	22	I
Mrs. Freda Mary Hodge, The Redlands, 21, Grove Road, Harrogate	6	I
Keighley and District Institution for the Blind, Home for the Blind, Westfield, Bromley Road, Bingley	16	II
Mrs. Kathleen Gregg, Huntingdon House, 15, Farnley Road, Menston	3	I
Mr. C. & Mrs. N. A. M. Gould, Hartrigg Guest House, Buckden, via Skipton	10	I
Mr. J. Richardson, Pentecostal Eventide Home, Aismunderby Close, Quarry Moor Lane, Ripon	18	I

Establishment	*Number of Residents*	*Type of Home *(Part I, II or III)*
Mrs. Dorothy Pearson and Mrs. S. H. Mottram, Thornlea Villas, Holme House Road, Cornholme, Todmorden	6	I
Mrs. L. Lawrence, Fearby House, 77, High Street, Starbeck, Harrogate	5	I
Mr. Geoffrey Noble and Mrs. Brenda Ainsworth, Bankfield Guest House, Hollins Lane, Sowerby Bridge	11	I
Mrs. S. M. Frankland, Brintcliffe Old Persons' Home, 1, St. Mary's Avenue, Harrogate	5	I
Mrs. Emma Band, Scott Bank, Hollins Lane, Sowerby Bridge ...	3	I
Mrs. M. L. Rennison, Lyndon Rest Home, 30, Ripon Road, Harrogate	8	I
Mr. A. P. Wallis and Mrs. S. E. Wallis, The Vicarage Rest Home for the Elderly and Disabled, Cornholme, Todmorden	10	I & III
Pudsey Voluntary Committee for the Welfare of the Blind, Lynnwood Centre and Residential Home, 18, Alexandra Road, Pudsey ...	9	II
Mrs. O. P. Urwin and Mr. T. D. Urwin, " Christony ", Beech Grove, Sutton in Craven...	12	I
Mrs. L. McLaughlin, 22, Chelmsford Road, Harrogate	4	I
Mrs. M. A. Macpherson, The Mansion, Grimston Park, Tadcaster ...	10	I
Alderson House Ltd., Alderson House, 2, Alderson Square, Harrogate *Incorporated by Royal Charter*	5	I
Lister House, Sharow, near Ripon	70 approx.	III (and Hospital cases)

* Part I—Homes for Old Persons
Part II—Homes for Disabled Persons.
Part III—Homes for Old and Disabled Persons.

In 1956, all County District Councils were informed that the County Council were prepared to consider the making of contributions (now made under Section 56 of the Local Government Act, 1958) towards the expenses incurred by them in the development of services for aged persons accommodated on Council estates subject to the submission of schemes containing full details of the proposals.

During the period July, 1957, to January, 1964, 245 schemes have been approved by the County Council, affecting 61 District Councils.

I am indebted to Mr. F. B. Armstrong, County Welfare Officer, for supplying most of the foregoing information in this part of the Report.

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

Medical Officers of Health are empowered, under Section 47 of the National Assistance Act, 1948, to initiate proceedings for persons suffering from grave chronic disease or being aged, infirm and living in insanitary conditions to be compulsorily removed to hospital or Part III accommodation. In urgent cases action may be taken under the National Assistance (Amendment) Act, 1951.

Reports of Medical Officers of Health indicate their reluctance to enforce these powers; the proceedings, resented by every official concerned are, however, unavoidable in certain instances. Unfortunately it was necessary to remove one man and three woman to hospital; also one man and two women to accommodation provided under Part III of the National Assistance Act, 1948.

REGISTRATION OF NURSING HOMES

(Public Health Act, 1936 — Sections 187-195, Mental Health Act, 1959 — Section 15 (1))

There were 3 new registrations, 6 cancellations and 3 amended registrations, making a total of 31 homes registered providing 35 beds for mental cases, 5 beds for maternity cases and 451 beds for other cases. Forty-four visits of inspection were carried out. The following schedule gives brief details of the nursing homes in the area on the 31st December.

Name and Address of Nursing Home	*No. of Beds Registered*			*Other Information*
	Mental	Maternity	Other	
Brooklands Nursing Home, Long Preston ...	—	—	10	
Sunnybank Nursing Home, Braithwaite, Keighley	—	—	9	
Elmhurst Nursing Home, Hall Bank Drive, Bingley	—	—	6	
Thornfield Nursing Home, Micklethwaite, Bingley	—	—	11	
Chevin Hall Nursing Home, Chevin Hall, Otley	35	—	—	
Fairholme Nursing Home, Hebers Ghyll Drive, Ilkley	—	—	14	
Jesmond Nursing Home, New Street, Farsley	—	—	7	
Marie Curie Nursing Home, "Ardenlea", Ilkley	—	—	33	
Oak Bank Nursing Home, Outwood Lane, Horsforth	—	—	10	
St. Joseph's Convalescent Home, Outwood Lane, Horsforth	—	—	45	Generally hospital convalescent cases
Alexandra Nursing Home, 7 Alexandra Road, Harrogate	—	—	3	
Beech Grove Nursing Home, 1 Beech Grove, Harrogate	—	—	8	
Cavendish Nursing Home, 17 Cavendish Avenue, Harrogate	—	—	11	
Clova Nursing Home, Clotherholme Road, Ripon	—	—	21	
Courtfield Nursing Home, 3 St. James Drive, Harrogate	—	—	14	
Duchy House Clinic, 9 Queen's Road, Harrogate	—	5	30	Operating theatre, X-rays, pathological investigations
Ellangowan Nursing Home, 26, Queen's Road, Harrogate	—	—	8	
Heatherwood Nursing Home, 17, Duchy Road, Harrogate	—	—	10	
Hereford Nursing Home, 16 Hereford Road, Harrogate	—	—	21	
Kingsley Nursing Home, 38 Ripon Road, Harrogate	—	—	12	

Name and Address of Nursing Home	*No. of Beds Registered*			*Other Information*
	Mental	Maternity	Other	
Norman Lodge Nursing Home, 58 Kent Road, Harrogate	—	—	25	
Strathroy Nursing Home, 115 Franklin Road, Harrogate	—	—	8	
The Pines Nursing Home, 57 Harlow Moor Drive, Harrogate	—	—	14	
Ure Lodge Nursing Home, Ure Bank Terrace, Ripon	—	—	21	
Westfield Nursing Home, Killinghall, Harrogate	—	—	7	
Windermere Nursing Home, 1a Westcliffe Grove, Harrogate	—	—	1	
Cheshire Foundation Home, Spofforth Hall, Spofforth	—	—	21	
Kenmore Nursing Home, Whitcliffe Road, Cleckheaton	—	—	15	
Cheshire Foundation Home, White Windows, Sowerby Bridge	—	—	35	
Cross Brook Nursing Home, Burnley Road, Todmorden	—	—	8	
Woodend Nursing Home, Atherton Street, Springhead	—	—	13	

Comment was made in the Report for the year 1961 of the inadequacy and weakness of the legislation in the Public Health Act, 1936 for the inspection and registration of private nursing homes and details were given of standards which had been drawn up by a sub-committee comprising members of the headquarters staff and two divisional medical officers whose areas contained the majority of private nursing homes in the County. These standards could, however, only be used by the department's inspecting staff as a guide—they were not the Authority's standards— and could have little force in a court of summary jurisdiction in the event of an appeal by the proprietor against the Authority's refusal to register a particular nursing home.

The introduction of the Nursing Homes Act, 1963, came, therefore, as a welcome measure. This Act, authorised the Minister to make regulations as to the conduct of nursing homes and was followed by the " Conduct of Nursing Homes Regulations, 1963 ", which became operative on the 27th August, 1963. The Regulations dealt in detail with the provision of facilities and services, limitation of numbers of persons in nursing homes and offences. A departmental working party reviewed the standards formulated in 1961, made certain amendments and additions in light of the new Regulations, and these standards were approved by the County Council. They are being applied in respect of all new applications for registration and they will be aimed at with regard to existing nursing homes, many of which, it is believed, fall short of the standards in certain respects.

The standards have been circulated to the proprietors of all existing nursing homes and their attention drawn to the 1963 Regulations. Where it is not found possible to achieve reasonable standards after a sufficient period of time has been allowed, the circumstances will be reported to the Committee.

The standards adopted are as follows:—

(a) *Staff*

A qualified nurse (S.R.N.), or a midwife in the case of a maternity home, should be on duty at any time of day or night. In the case of small nursing homes with no acute cases, a qualified nurse on the premises and on call may, depending on the circumstances, be considered as adequate supervision.

The overall staffing should be adequate to meet the needs of the types of case being nursed, and the following minimum requirements are given as a guide.

Equivalent whole-time nursing staff	
Acute cases. (i.e. homes normally admitting acute medical and/or surgical cases).	Two to every three beds occupied.
Non-acute and geriatric long-stay.	One to every three beds occupied.
Maternity.	Two to every three beds occupied, one half of the staff to be qualified midwives.
Domestic Staff	Adequate to ensure a high standard of cleanliness and catering at all times.

(b) *Accommodation for Patients*

Bed Space. Subject to adequate ventilation, 80 square feet of available floor space per patient in single or multi-bedded rooms, with a minimum ceiling height of 8 feet. (See special standard for maternity homes — page 217).

Suitable arrangements should be available for the isolation of infectious cases.

Day Room Accommodation. This must be provided but, as no rigid standard can be laid down because of different circumstances experienced in nursing homes, particularly with regard to the types of case accommodated, the accommodation should be sufficient to allow 25 square feet per ambulant patient.

(c) *Furniture and Furnishings*

See attached schedule.

(d) *Medical and Nursing Equipment*

See attached schedule.

(e) *Sanitary Accommodation and Washing Facilities*

Sanitary Accommodation. Each floor occupied must have one W.C. exclusive to patients, and the scale of accommodation should provide for a minimum of one W.C. exclusive to patients per every eight patients per floor.

Bathrooms One per every fifteen patients.

Wash-basins One per bedroom with adequate piped hot and cold water.

Sluices Minimum of one.

(f) *Lighting and Ventilation*

Lighting — both natural and artificial — and ventilation should be adequate.

Heating The heating system should be such as to maintain a minimum room temperature of 65°F. at all times or, where infants are present, 70°F. The minimum day room temperature should be 70°F.

(g) *General Condition of Home*

The home should be kept in good structural repair, clean, and reasonably decorated.

(h) *Fire*

The fire precautions should be adequate and comply with any recommendations made by the Fire Officer.

Accidents Precautions against accidents should be adequate and special attention should be paid to floor surfaces and rugs which should be non-slip, the necessary provision of handrails, and the provision of adequate and efficient fire-guards.

(i) *Kitchens*

The facilities should be adequate for the number of patients and comply with the requirements of the Food Hygiene Regulations. In the case of nursing homes admitting maternity cases, there should be a separate milk kitchen.

(j) *Food*

There should be an adequate supply of suitable and properly-prepared food for every patient.

(k) *Laundry*

There should be adequate facilities for the regular laundering of linen and articles of clothing.

(l) *Soiled dressings, etc.*

There should be adequate facilities for disposal by incineration of soiled dressings and other similar articles.

(m) *Medical and Dental Treatment*

Any necessary arrangements should be made for the provision of medical and dental services, whether under Part IV of the National Health Service Act, 1946, or otherwise.

(n) *Drugs*

There should be suitable arrangements for the safe-keeping and handling of drugs in accordance with the Dangerous Drugs Regulations.

(o) *Interviewing of Patients*

Authorised officers of the local health authority must be permitted to interview at any time, in private, any patient received into the home.

(p) *Patients' call system*

There should be an electric call bell at each patient's bed head, in the bathroom, W.Cs. and day room, and the system should be in working order at all times, day or night.

(q) *Lifts*

Where a passenger lift is provided, it should conform to the appropriate British Standard and all safety requirements. It should be single speed, not exceeding 50 feet/min., and be automatically self-levelling.

Special Standards for Homes admitting Maternity Cases

In addition to the standards for nursing homes generally, a nursing home for maternity cases should provide accommodation on the basis of 90 square feet bed space per patient or 110 square feet where the child is with the mother.

Where the number of beds per room exceeds one, there should be a separate delivery room, the floors, walls and furniture contained therein being capable of being washed down and thoroughly cleansed. Wherever possible, the floor should be impermeable. Adequate piped hot and cold water and elbow taps should be provided. Where deliveries are carried out in single-bedded rooms, the standards for delivery rooms should be applied.

There should be a single room for isolation purposes, with separate sluice, sanitary accommodation, and bath or shower.

Where both maternity and other types of case are accommodated in the same home, the accommodation, facilities, and staff should not be interchangeable.

EQUIPMENT — NURSING HOMES

It is suggested that the minimum scale of equipment should be as follows:—

Beds

All beds should have spring interior or rubber mattresses and, if not provided with overall mackintosh or polythene covers, the following provision should be made:—

1 mattress cover per bed.
1 long polythene or rubber sheet.
1 short mackintosh sheet (for midwifery cases only).

	Surgical, Acute Medical and "Care" Cases.	*Maternity Cases.*
Linen (per bed)		
White sheets	2½ pairs.	2½ pairs.
Draw sheets	6 (3 if laundered on premises).	6
Bedspreads	5 to four beds.	5 to four beds.
Pillows	5	3
Pillow cases	5 to every 2 pillows.	5 to every 2 pillows.
Blankets	3 if eiderdown provided. 4 without eiderdown. 6 if blankets old and thin.	3 if eiderdown provided. 4 without eiderdown. 6 if blankets old and thin.

Towels	5 (42 in. x 24 in.) or 2 large and 3 small bath towels.	5 (42 in. x 24 in.) or 2 large and 3 small bath towels.
Linen (per cot)		
	—	2 cot mattress covers. 12 small sheets. 1 polythene or rubber sheet. 6 washable blankets. 3 bedspreads to 2 cots.
Nursing Equipment		
Bedpans	1 per four beds with minimum of 1 per floor.	2 per four beds with minimum of 1 per floor.
Thermometers	1 with glass per floor.	1 with glass per bed.
Medicine glasses and tooth mugs	Adequate number.	Adequate number.
Hot water bottles ...	As necessary.	1 per bed. 1 per cot.
General		
Feeding cups	As required.	As required.
Minim measure	1	—
Urinals	1 per male patient.	—
Commodes	1 per 3 beds.	—
Jugs, bowls, kidney dishes	As required.	As required.
Soiled dressings	Receptacles as required.	Receptacles as required.
Syringes, hypodermic ...	As required.	As required.
Clinistix or apparatus for urine testing	As required.	As required.
Enema apparatus ...	As required.	As required.
Dressing trays or trolleys	As required.	As required.

Storage for Linen

Separate place, cupboard or chest; should always be available to the staff on duty.

Nursing Equipment

Dressings

Separate cupboard; should always be available to staff on duty.

Storage for Drugs

Lock-up cupboard for general use with inner locked cupboard for schedule 'A' drugs.

Sterilising Equipment

There should be adequate facilities and equipment for the sterilisation of bowls, instruments, syringes, dry dressings, etc.

Incinerator

There should be adequate facilities for the disposal by incineration of soiled dressings, etc.

Miscellaneous

Each W.C. should be provided with a lavatory brush and jar.

NOTIFICATION OF BIRTHS

(Public Health Act, 1936, Section 203)

Notifications were received relating to 21,141 live and stillbirths occurring in the Administrative County Area, and of 12,899 births occurring elsewhere to mothers who were normally resident in the County. The former figure included 2,920 births to mothers not normally resident in the County Area, and the consequent net total of births notified and attributable to the County Area was 31,120. When this figure is compared with the Registrar General's return of 31,389 births (30,803 live and 586 still births) in the County Area, the degree of error is slight and affords satisfactory evidence of the system of notification.

Prompt notification makes it possible to arrange for the early visitation of the newly-born babies by health visitors and it is satisfying to record that 29,010 first visits to children born in 1963 were made by health visitors.

NURSERIES AND CHILD-MINDERS REGULATION ACT, 1948

At the end of the year, there were 6 nurseries registered for the care of 128 children and 24 child-minders registered for the care of 137 children. Sixty-six visits of inspection were made.

MEDICAL ARRANGEMENTS FOR COUNTY CHILDREN'S HOMES AND RESIDENTIAL NURSERIES

Divisional Medical Officers have submitted periodic reports on the discharge of their responsibilities for the medical arrangements at County Children's Homes and Residential Nurseries; these provide for the medical examination of children on admission and discharge, subsequent routine and special examinations, the keeping of medical records, precautions against the spread of infectious diseases, determining the hours of rest and sleep, the general supervision of health, hygiene and dietary, and the staffing of the nurseries. Routine examinations, which are undertaken monthly in residential nurseries and six-monthly in children's homes, reveal the not-unexpected high proportion of children with physical and mental defects, and with emotional problems.

MEDICAL EXAMINATION FOR SUPERANNUATION

Prospective entrants to the superannuation scheme are required to complete a questionnaire dealing with personal and family medical history, and on the information thus obtained a decision is made as to whether a medical examination will be undertaken. The following categories are required to have a full medical examination irrespective of the information given in the questionnaire:—

(a) prospective entrants over the age of 45 years.

(b) applicants whose prospective employment is such that public safety is involved, e.g. Fire and Ambulance Service drivers.

The questionnaire and/or medical examination is regarded as a suitable basis for recommendations to heads of departments on the possible eligibility of employees for registration as disabled persons.

Applicants already admitted into a local government superannuation scheme are automatically admitted to the County Council's scheme without any form of medical screening provided that superannuable service is continuous, the employing department having the responsibility of enquiring into the sickness record of such applicants.

During the year, 1,664 health questionnaires were received. Of this number, 1,093 applicants (65.69 per cent.) were approved for admission to the superannuation scheme on the basis of the information obtained from the questionnaires.

571 applicants were referred for medical examination by reason of:—

	Number examined	*Approved*	*Not Approved*	*Deferred*
Age	151	142	5	4
History	206	172	22	12
Category (of employment, e.g. driver)	37	37	—	—
Age *and* History	140	102	28	10
Age *and* Category	12	12	—	—
History *and* Category	19	18	1	—
Age, History *and* Category	6	6	—	—
	571	489	56	26

Of these examinations, 564 were carried out by the County Council's medical officers, 4 by medical officers of other local authorities, and 3 by general practitioners. 21 specialist reports were obtained.

During the year, 73 special medical examinations were carried out by the authority's medical officers at the request of employing departments.

34 requests for medical examination were received from other local authorities.

ROAD TRAFFIC ACT, 1960

(*Section 100(6)*)

During the year, 33 cases were referred to the County Medical Officer for an opinion in respect of fitness to hold a current driving licence and therefore be in charge of a motor vehicle. Of these, 18 were considered to be medically fit and 15 considered to be unfit. When it is necessary to state that an applicant is unfit to hold a licence, there is a right of appeal against this decision and one such case arose of a man who was a controlled epileptic. The appeal was dismissed, the decision of the County Medical Officer and the Licensing Committee being upheld.

Among the diseases or disabilities specified on the form of application for a driving licence are *Epilepsy or sudden attacks of Disabling Giddiness or Fainting*. The most difficult question to be decided is often whether a person actually *Suffers* from epilepsy or not, because the Committee have no alternative but to refuse to grant the application for a licence or to allow a person involved in an accident to retain his licence, if epilepsy is proved.

Consideration has also been given to cases where accidents have occurred as a result of difficulties arising from diabetes or its treatment, often caused by carelessness on the part of the patient. If it has been ascertained that the person is basically a responsible patient, it is recommended that his licence be returned to him on his undertaking to co-operate with his doctor and pay strict attention to the regime necessary to cope with his disability.

WEST RIDING DISTRESS FUND

Grants from the West Riding Distress Fund were made in 7 cases as follows:—

4 For travelling expenses to enable relatives to visit patients undergoing hospital treatment.

1 For the provision of bedding for a problem family.

1 For the provision of clothing for a mental defective child.

1 Travelling expenses for a family to visit Scotland with a view to residential care being provided.

PART VII

THE HEALTH OF THE SCHOOL CHILD

The Annual Report of the Principal School Medical Officer

including

The Report of the Principal School Dental Officer

and

The Report of the School Medical Officer to the Keighley Excepted District

THE HEALTH OF THE SCHOOL CHILD

(Being the 56th Annual Report of the Principal School Medical Officer)

Introduction:

Few major changes have taken place in the organisation of the School Health Service during the year. Schemes introduced previously have continued including selective examinations in some of the Divisions though, so far, there has been no wide extension of the non-routine inspections and the routine medical inspection continues to be the choice of most Divisions for the 7—8 year and 11—12 year age groups.

Testing of colour vision by the Ishihara scale has now been introduced as a routine between the ages of 10—12 years as defects found may be of importance during the period of secondary education. When carried out as part of the school leavers' examination defects were found after the child had made provisional plans for future employment and much disappointment was caused if defective colour vision made the type of employment chosen an unsuitable one.

The two audiology clinics established in 1961 at Doncaster and Horsforth continue to receive a steady flow of cases. More emphasis is being placed on the diagnostic and educational advisory nature of the clinics and the work of the psychologists and teachers of the deaf in the teams is invaluable. Routine audiology is being carried out in the schools and each Division now has at least one audiometer. As the work extends the larger Divisions will require more instruments to cover both the schools and the clinics. Nurses in several Divisions attended a lecture-demonstration on the importance of audiology given by the Senior Administrative Medical Officer for the School Health Service.

The 1962 Report mentioned the difficulties in the child guidance sphere. Dr. Atkinson commenced duties on 1st March, 1963, as Psychiatrist and has been able to provide regular sessions at Skipton, Rothwell, Morley, Ossett and Keighley, besides assisting at the Pontefract Clinic. With the departure of Dr. Crowley, the Consultant Psychiatrist, for another post in Warwickshire in December, 1963, Dr. Atkinson had to take charge of the Pontefract Clinic and treatment at the Nortonthorpe Hostel. Clinics at Woodlands and Maltby have been left without psychiatric help in the absence of candidates for the vacant post. The Educational Psychologist and Psychiatric Social Worker are continuing to carry out the preliminary investigations on children referred to these clinics. Cases of an urgent nature can be referred to centres elsewhere. The general shortage of child psychiatrists shows no sign of improvement and future plans include secondment of interested Assistant County Medical Officers on courses concerning the psychiatric aspects of child health so that they can take a part in the Child Guidance Service. An extension in the services of the psychologists is also planned if the personnel agreed in a recent review of the staff complement can be recruited. The duties will include work in the sphere of mental health.

The turnover of medical staff during the year through resignations and retirements was again considerable and further retirements can be anticipated in 1964. Recruitment of staff depends very much on the attractiveness of working conditions and facilities for post-graduate study. The majority of new appointments to the Assistant County Medical Officer and School Medical Officer grade are from personnel new to the service. In order that the work can continue it is essential that the newcomers should attend such courses as those for ascer-

tainment officers for the retarded child and in the diagnosis of deafness. Other professional staff need to keep abreast of new developments in diagnostic techniques if the School Health Service is to remain progressive.

Another branch of the service being affected by shortage of staff is Speech Therapy. Due to resignations the year closed with the equivalent of eleven whole-time personnel instead of a complement of eighteen therapists. This type of situation is prevalent in many other parts of the country, matrimonial ties causing many of the departures from the staff. One can only hope to attract new staff by providing good working conditions.

Dr. Lyons continued to give invaluable help in the oversight of the School Health Service in the early months of the year. In June, Dr. C. S. Smith joined the staff as Senior Administrative Medical Officer for the School Health Service having had several years' experience in a similar post in the Midlands. In November he arranged a conference of the Assistant County Medical Officers and was able to put forward suggestions for future developments in the service.

Following the conference a questionnaire was circulated to Medical Officers asking for information on their particular interests. The replies have been most valuable in planning future developments. The afternoon session of the conference was held at the Royd Edge Residential School for Educationally Subnormal Girls where Miss E. Weekley, M.B.E., gave a stimulating address on the problems of special education and the Medical Officers were able to see the work of the school. This visit was very much appreciated.

Once again I would record my appreciation of the full co-operation given by the Chief Education Officer and his staff and by the school teachers and other workers in the sphere of child health without whose ready co-operation the School Health Service could not fulfil its purpose.

The Medical Inspection of School Children:

The number of pupils on the registers is as follows:—

	Boys	*Girls*	Total
Nursery...	238	232	470
Primary (County)	63,110	59,596	122,706
Primary (Voluntary)	21,625	20,274	41,889
Secondary Modern (County)...	29,103	26,249	55,532
Secondary Modern (Voluntary)	1,571	1,672	3,243
Secondary Grammar (County)	7,566	9,644	17,210
Secondary Grammar (Voluntary)	4,866	2,854	7,720
Secondary Technical	971	1,203	2,174
Comprehensive	8,392	8,169	16,561
Bi and Multi Lateral Secondary	615	509	1,124
Special Schools (Residential)	203	117	320
Special Schools (Day)...	297	215	512
Special Schools (Hospital)	80	44	124
	138,637	130,778	269,415

TABLE I

MEDICAL INSPECTION OF PUPILS ATTENDING MAINTAINED PRIMARY AND SECONDARY SCHOOLS (INCLUDING SPECIAL SCHOOLS)

A.—Periodic Medical Inspections

Age groups inspected (by year of birth) and number of pupils examined in each, together with classification of the physical condition of the pupils inspected.

Age groups inspected (Year of Birth)	Number of pupils inspected	Satisfactory		Unsatisfactory	
		No.	% of Column 2	No.	% of Column 2
1959 and later ...	1,052	1,048	99·62	4	0·38
1958 ...	12,766	12,681	99·33	85	0·67
1957 ...	9,504	9,463	99·57	41	0·43
1956 ...	4,131	4,117	99·66	14	0·34
1955 ...	6,909	6,889	99·71	20	0·29
1954 ...	3,653	3,646	99·81	7	0·19
1953 ...	2,214	2,193	99·05	21	0·95
1952 ...	6,042	6,015	99·55	27	0·45
1951 ...	5,119	5,092	99·47	27	0·53
1950 ...	1,866	1,844	98·82	22	1·18
1949 ...	8,570	8,476	98·90	94	1·10
1948 and earlier...	14,880	14,804	99·49	76	0·51
Total ...	76,706	76,268	99·43	438	0·57

B.—Other Inspections

Number of Special Inspections ...	20,684
Number of Re-Inspections ...	8,959
Total ...	29,643

C.—Pupils Found to Require Treatment

Number of individual pupils found at Periodic Medical Inspection to require treatment (excluding Dental Diseases and Infestation with Vermin).

Group (Year of Birth)	For defective vision excluding squint	For any of the other conditions recorded in Table III	Total individual pupils
1959 and later	13	83	94
1958	314	1,236	1,466
1957	292	805	1,033
1956	171	377	510
1955	327	488	774
1954	141	249	376
1953	106	154	227
1952	310	503	780
1951	290	321	579
1950	135	123	232
1949	369	491	860
1948 and earlier	754	806	1,539
Total	3,222	5,636	8,470

Table II

Infestation with Vermin

(i)	Total number of individual examinations of pupils in schools by the school nurses or other authorised persons	416,570
(ii)	Total number of *individual* pupils found to be infested ...	8,229
(iii)	Number of individual pupils in respect of whom cleansing notices were issued (Section 54(2), Education Act, 1944) ...	132
(iv)	Number of individual pupils in respect of whom cleansing orders were issued (Section 54(3), Education Act, 1944) ...	28

TABLE III

DEFECTS FOUND BY MEDICAL INSPECTION IN THE YEAR ENDED 31ST DECEMBER, 1963

NOTE.—All defects noted at medical inspection as requiring treatment are included in this table, whether or not this treatment was begun before the date of the inspection

Defect Code No.	Defect or Disease	PERIODIC INSPECTIONS						SPECIAL INSPECTIONS	
		Entrants		Leavers		TOTAL (including all other periodic age groups inspected)		Requiring treatment	Requiring observation
		Requiring treatment	Requiring observation	Requiring treatment	Requiring observation	Requiring treatment	Requiring observation		
4	Skin	208	435	349	490	939	1,433	460	367
5	Eyes— a. Vision ...	664	1,488	1,048	2,739	3,222	7,104	963	3,380
	b. Squint ...	281	472	37	186	462	1,157	90	374
	c. Other ...	35	75	29	156	117	382	69	71
6	Ears— a. Hearing ...	101	513	45	174	276	1,158	157	555
	b. Otitis Media	116	561	65	166	268	1,030	63	316
	c. Other ...	44	57	24	33	125	175	69	158
7	Nose and Throat ...	532	1,959	116	421	1,055	3,557	216	1,040
8	Speech	202	610	29	75	365	958	263	526
9	Lymphatic Glands ...	47	519	10	91	88	930	25	228
10	Heart	26	426	31	245	88	1,139	30	397
11	Lungs	102	721	30	273	211	1,567	105	642
12	Developmental—								
	a. Hernia ...	39	94	3	22	61	200	13	51
	b. Other ...	42	469	42	253	176	1,238	46	387
13	Orthopædic—								
	a. Posture ...	27	76	25	153	104	445	41	141
	b. Feet ...	183	433	148	376	558	1,438	171	444
	c. Other ...	72	348	97	382	246	1,136	94	372
14	Nervous System—								
	a. Epilepsy ...	16	65	17	46	53	176	16	78
	b. Other ...	137	318	34	123	258	730	57	221
15	Psychological—								
	a. Development	31	195	5	89	86	502	195	411
	b. Stability ...	35	555	19	117	120	1,132	150	662
16	Abdomen	19	86	21	79	72	313	21	94
17	Other	175	397	153	254	587	1,055	523	411

The figures contained in the tables are compiled in accordance with the annual returns required by the Ministry of Education.

As noted in Table III defects are recorded as requiring treatment whether or not the treatment was begun before the date of the inspection. A defect requiring observation is regarded as one of a minor nature which may clear without treatment. It is often difficult to be precise on the classification under the two headings as opinions vary on what constitutes a defect requiring observation only. The figures recorded as requiring treatment give a false impression of the numbers of new defects found at the medical inspection to require treatment in the present classification as many of the conditions may already be receiving treatment. A sub-division of the Ministry's return to indicate defects already receiving treatment and defects requiring treatment and newly discovered at the time of the examination would give a much better appraisal of the position. Considerable doubt has been cast in some quarters on the real value of the routine medical inspections in finding new defects other than those which would be found by routine surveys of vision and hearing.

Table IV
Treatment of Pupils

Notes

The figures given under this heading include:—

(i) cases treated or under treatment during the year by members of the Authority's own staff;

(ii) cases treated or under treatment during the year in the Authority's school clinics under National Health Service arrangements with the Regional Hospital Boards;

(iii) cases known to the Authority to have been treated or under treatment elsewhere during the year.

Figures under this section are incomplete as one has to rely on hospital discharge notifications and other agencies.

Group 1. Eye Disease, Defective Vision and Squint

	Number of cases known to have been dealt with
External and other, excluding errors of refraction and squint	1,099
Errors of refraction (including squint)	19,460
Total ...	20,559
Number of pupils for whom spectacles were prescribed ...	9,201

Group 2. Diseases and Defects of Ear, Nose and Throat

	Number of cases known to have been treated
Received operative treatment:—	
(a) for diseases of the ear	19
(b) for adenoids and chronic tonsillitis	1,256
(c) for other nose and throat conditions	62
Received other forms of treatment	432
Total ...	1,769
Total number of pupils in schools who are known to have been provided with hearing aids:—	
(a) in 1963	35
(b) in previous years	213

Group 3. Orthopædic and Postural Defects	Number of cases known to have been treated
(a) Pupils treated at clinics or out-patient departments	639
(b) Pupils treated at school for postural defects ...	7
Total ...	646

Group 4. Diseases of the Skin (excluding uncleanliness for which see Table II)	
Ringworm—(a) Scalp	7
(b) Body	11
Scabies	41
Impetigo	222
Other skin diseases	2,422
Total ...	2,703

Group 5. Child Guidance Treatment	
Number of pupils treated at Child Guidance clinics under arrangements made by the Authority	997

Group 6. Speech Therapy	
Number of pupils treated by Speech Therapists under arrangements made by the Authority	2,622

Group 7. Other Treatment Given	
(a) Number of cases of miscellaneous minor ailments treated by the Authority	10,861
(b) Pupils who received convalescent treatment under School Health Service arrangements ...	78
(c) Pupils who received B.C.G. vaccination ...	14,500
(d) Other:—	
1. Ultra Violet Light Treatment	302
2. Audiology	38
3. Cardiac	29
4. Chiropody	246
Total (a)—(d) ...	26,054

Care of the Handicapped Child:

This aspect of the School Health Service is particularly important and, in order to carry out their duties adequately, the School Medical Officers must have a wide knowledge of the various types of handicap. Individual medical officers have particular interests and it is hoped to encourage them in pursuing these. Over the next few years it is intended that in each Division one medical officer should have special experience in the ascertainment of hearing defects and another in the problems of maladjustment. The appropriate Sub-Committee have agreed to recommendations that, if places can be found, six medical officers shall be seconded on short courses on each of these branches of the work during the forthcoming year. In addition, six places have been approved on the special courses for the ascertainment of subnormality—these are needed for the new medical officers, without previous experience, joining the staff and cover approximately the losses of ascertainment officers through retirement or resignation.

The number of new ascertainments and re-examinations undertaken during 1963 was 1,652 compared with 1,830 the previous year. Details are as follows:—

Category	*No. of examinations and re-examinations*
Educationally subnormal	1,015
Physically handicapped	319
Delicate	123
Deaf	22
Partially hearing	16
Epileptic	33
Speech (requiring special school)	1
Maladjusted (requiring hostel or special school)	57
Blind	13
Partially sighted	32
Double defect	21
Total ...	1,652

Many of the children classified as handicapped may not need admission to a special school. Those with less severe physical defects can often cope with education within the ordinary school system with special help.

The following table gives details of handicapped pupils and placings in special schools and hostels during the year, and particulars of the number of children in residence in special schools at the end of the year:—

Category	New Ascertainments	New Placings in Special Schools	Total No. attending Special Schools		No. Boarded in Homes or Hostels	No. Attending Independent Schools	No. Awaiting Placement in Special Schools	No. receiving Home Tuition
			Day	Boarding				
Blind	11	11	—	49	—	—	7	—
Partially Sighted	12	12	23	32	—	—	13	—
Deaf	13	14	47	133	—	—	2	—
Partially Hearing	15	12	22	27	—	—	5	—
Delicate	48	43	10	92	1	—	17	—
*Physically Handicapped ...	38	39	42	117	—	12	23	35
Educationally Subnormal ...	293	198	712	279	—	15	412	3
Maladjusted	30	23	—	27	27	1	17	2
Epileptic	8	6	—	26	—	—	5	2
Speech Defects	2	1	2	1	—	—	1	—
Totals	470	359	858	783	28	28	502	42

* Excluding children sent to or awaiting places in hospital schools.

It has been encouraging to note that fewer children are now being referred for the first time as educationally subnormal late in their school life when placement at a special school is very difficult and the value to the child much less. Teachers are being encouraged to refer pupils for investigation if they are significantly retarded in school work at a much earlier age.

Developments in the number of day schools for the educationally subnormal, together with the special facilities at the ordinary schools should reduce the size of the waiting list within the next few years.

West Riding Special Schools

	Age range (years)	*Accommodation*
Residential Special Schools for Delicate Children		
Ingleborough Hall, Clapham	6—12	50 mixed
Netherside Hall, Skipton in Craven	11—16	40 boys
Residential Special School for Deaf and E.S.N. Boys		
Bridge House, Harewood	8—16	36 boys
Residential Hostel for Maladjusted Boys		
Nortonthorpe Hall, Scissett	9—16	25 boys
Residential Special Schools for E.S.N. Children		
Baliol School, Sedbergh...	11—16	56 boys
Royd Edge School, Meltham	11—16	54 girls
Springfield School, Horsforth	7—11	51 mixed
Whinburn School, Keighley	7—11	44 mixed
Day Special Schools for E.S.N. Children		
Heaton Royds School, Shipley...	Juniors	100 mixed
John Street School, Wombwell...	Juniors	60 mixed
Hartshead Moor School, Cleckheaton ...	All ages	100 mixed
Milton School, Swinton...	All ages	100 mixed
Castle School, Pontefract	All ages	100 mixed
Braithwaite School, Keighley	All ages	100 mixed

THE PHYSICALLY HANDICAPPED CHILD:

With the decline in the incidence of crippling defects due to poliomyelitis, cerebral palsy has become the main cause of serious physical defect in children. As a proportion of the children also suffer from impaired intellectual development, the educational problems are particularly difficult.

Particulars of educable cerebral palsied children in the County are given below. The figures include children of pre-school age.

Total No. of educable Spastics	No. accommodated in Special Schools	No. attending Ordinary Schools		No. receiving Home Tuition	No. receiving no Education
		Satisfactorily	Needing placement in Special Schools		
169	96	41	27	1	4

THE DELICATE CHILD:

The general pattern shows little change since 1962 the number of new ascertainments being 48 and few children were awaiting placement at the end of the year.

The problem of severe asthma still remains and, together with bronchitis and bronchiectasis, forms the main admissions to the Authority's Boarding Schools. Dr. Harvey, part-time Pædiatrician to the West Riding, visits Ingleborough Hall and Netherside Hall twice a year with the Senior Administrative Medical Officer for the School Health Service and an interesting case conference is held with the Head Teacher and School Medical Officer from the Division.

THE BLIND AND PARTIALLY SIGHTED CHILD:

Children who may be blind or partially sighted are examined by an Ophthalmologist of consultant status who completes the appropriate Form B.D.8. The School Medical Officer also examines the child for any additional handicaps and one of the Psychologists may also be called in to assist in ascertainment if the child is felt to have associated retardation.

THE DEAF AND PARTIALLY HEARING CHILD:

The two audiology clinics at Doncaster and Horsforth continue to receive cases from surrounding areas. The work of the Psychologists and the advice of the Teachers of the Deaf have already been referred to. The Doncaster clinic continues to be held at the Yorkshire School for the Deaf and Dr. Greenaway, the Headmaster, continues his very active interest and help in the work. Mr. Steel, Headmaster of the West Riding's Bridge House School, attends the Horsforth clinic whenever possible and his special experience of the educationally subnormal deaf child is of great assistance.

Prime emphasis continues to be made on the diagnostic and educational aspects of the audiology clinics and not on the clinical aspects so that it is unfortunate that some Ear, Nose and Throat Surgeons still wrongly regard the Authority's clinics as unnecessary duplication of facilities offered in hospitals. Problems are often brought forward by Medical Officers and Health Visitors who have an intimate knowledge of the child's home background and school environment. Whilst the hospital may be informed that the child is wearing a hearing aid only too often is this found to be incorrect locally. To make the service more comprehensive it would be of great assistance if a peripatetic service by Teachers of the Deaf could be started as in other Authorities. The liaison between the clinic, home and school can then be completed.

More Health Visitors have been trained in the methods of detecting hearing loss in young babies. Each Division now has at least one pure-tone audiometer and the importance of routine screening of all school children at the age of 6—7 years with a careful follow-up of absentees is constantly stressed.

Head Teachers are encouraged to pay particular attention to any child in the school with hearing loss or using an aid and Divisional Medical Officers now issue a leaflet of guidance including information on testing the hearing aid to ensure that it is working properly.

The importance of the early assessment of hearing loss should need little emphasis. It is of interest to note that a recent survey of the 34 pupils at Bridge House School for boys from 8—16 years who are educationally subnormal as well as hearing impaired showed that 33 had been deaf from the age of 18 months or earlier, yet 25 per cent. of the boys had not had hearing loss suspected until over the age of 5 years; one boy had reached the age of 12 years. Six of the boys had previously been referred as unsuitable for education before deafness had been suspected. These boys come from many parts of England.

Dr. Ferguson reports as follows on the *Doncaster Clinic:*—

"The number of sessions at the Audiology Clinic has again increased, and 22 such sessions were held in 1963, compared with 16 in 1962. With an increased number of cases on the register, and therefore an increasing number of re-tests, it may again be necessary to increase the number of clinics.

In the Report for 1962 I commented on the importance of parent guidance and the use of the speech audiometer at the Audiology Clinic. Further emphasis is now required to the parents, the Health Visitors, and the teachers, on the uses, the benefits and, just as important, the limitations of a hearing aid. A register of all children wearing hearing aids is being prepared and arrangements will be made for groups of mothers, whose children wear hearing aids, to attend the clinic for a talk from a teacher of the deaf and me. Health Visitors will be invited to the talks, and it is hoped that they will then be able to advise the teachers on what might be expected from a child using a hearing aid."

A statistical summary of the work carried out at the Doncaster Audiology Clinic is as follows:—

	1963	1962
No. of sessions held:	22	16
No. of individual children attending:		
(a) referred for first time in current year:	81	55
(b) also attended in previous year:	20	9
Total ...	101	64
Total number of attendances made:	101	75
Areas from which referred (i.e., number from each Division):		
Harrogate Division (7)	1	–
Goole Division (10)	2	3
Castleford Division (11)	7	–
Pontefract Division (12)	4	2
Wortley Division (22)	–	1
Hemsworth Division (23)...	12	7
Barnsley Division (25)	2	1
Wath Division (26)	11	23
Doncaster Division (27)	27	13
Thorne Division (29)	10	4
Rotherham Division (31)...	5	1
	81	55
Ages of children referred:		
Under 1	–	–
1– 2 years...	9	2
2– 5 years...	8	4
5– 8 years...	31	15
8–11 years	14	18
11 +years	19	16
Results of Clinical Investigation:		
No. of children with significant hearing loss:	40	26
No. of children without significant hearing loss:	35	29
Recommendations:		
Hearing aid recommended:	13	13
To sit in front of class:	15	13
Speech Therapy recommended:	3	6
School for Deaf recommended:	6	3
School for Partial Hearing recommended:	–	–
School for Speech Defects recommended:	–	–
Referred to E.N.T. Consultant:	17	6
Special School with Speech Therapy:	–	1

Dr. Burn reports as follows on the *Horsforth Clinic:—*

" The clinic team has met ten times during the year but in addition several children have been given a fuller audiometric investigation than is possible with the portable audiometers in the Divisions. Out of the 38 children referred to the clinic 11 were from the Horsforth Division and 27 from other Divisions.

In April a talk was given to Assistant Medical Officers explaining the purpose of the clinics and the methods used. This led to better selection of cases which have been referred and seems to have helped the clinical medical officers to deal with some cases themselves, thus saving time in treatment. Well over half the children referred had no significant hearing loss.

Assessment of some of the younger children has been improved by the use of a Free Field Audiometer, which can be used to determine more accurately the degree of loss at different frequencies.

Only seven pre-school children have been referred for investigation despite the screening which has been done by the specially trained health visitors.

The investigation of some cases by the educational psychologist has helped greatly with the general assessment of the children. From time to time difficulty in the disposal of cases occurs, when children are found to have some otological condition which requires operative treatment. Unless the child comes from the area served by hospitals attended by the consultant he has to be referred through his private doctor to another consultant. This leads to delays in treatment. Most cases requiring such treatment are found by the clinical medical officers and referred directly for treatment, but some do come to the audiology clinic."

A statistical summary of the work carried out at the Horsforth Audiology Clinic is as follows:—

No. of sessions held:	10
No. of individual children attending:	
(a) referred for first time in current year:	25
(b) also attended in previous year:	13
Total ...	38
Total number of attendances made:...	42

Areas from which referred (i.e., number from each Division):

Skipton Division (1)	1
Shipley Division (4)	8
Horsforth Division (5)	11
Harrogate Division (7)	2
Wetherby Division (9)	2
Morley Division (13)	1
Batley Division (15)	5
Rothwell Division (16)	4
Spenborough Division (17)	2
Brighouse Division (18)	2
	38

Ages of children referred:

Under 1	–
1– 2 years...	1
2– 5 years...	6
5– 8 years...	15
8–11 years	7
11 +years	9

Results of Clinical Investigation:

No. of children with significant hearing loss	15
No. of children without significant hearing loss	23

Recommendations:

Hearing aid recommended	3
To sit in front of class	4
Speech Therapy recommended	3
School for Deaf recommended	–
School for Partially Hearing recommended	4
School for Speech Defects recommended	–
For re-check	4
For Tonsils and Adenoids	1

THE EPILEPTIC CHILD:

Whilst the majority of epileptic children can be controlled by drug therapy and remain within the ordinary school system some cases still present themselves who cannot be educated otherwise than at special schools. The temporal lobe type of lesion with associated hyperactive and uncontrolled behaviour and often mental subnormality presents a severe problem even in the special school environment. Some of these pupils have to be withdrawn because of their gross behaviour disturbance, especially at adolescence.

THE EDUCATIONALLY SUBNORMAL CHILD:

The category of educationally subnormal pupils according to the definition in the Handicapped Pupils and Special Schools Regulations, 1959, (Ministry of Education) includes all " pupils who, by reason of limited ability or other conditions resulting in educational retardation require some specialised form of education wholly or partly in substitution for education normally given in ordinary schools." Circular 11/61 of the Ministry outlines the methods of special educational treatment which should be developed apart from the special schools, including diagnostic units for the young child, special classes in the ordinary schools, group or area classes etc. Much development is still required in this sphere. The current view is that not more than 1 per cent. of children need education in special schools for the educationally subnormal and priority should be given to the admission of those who are fundamentally limited intellectually, *i.e.*, with an intelligence quotient below average rather than those who are showing retardation for other conditions such as absence from school in the infant period.

The broad basis for the definition of educational subnormality gives rise to variations in the pattern of ascertainment by Medical Officers. Some take the view that a child with an I.Q. of over 75—80 is not of limited ability and do not regard the child as educationally subnormal. Others use the wider interpretation and include children within the range of average I.Q.s as educationally subnormal if they are retarded. The recorded figure for the educationally subnormal ascertained during the year is not, therefore, complete.

During the year 111 decisions were recorded by the Local Education Authority in respect of children found " unsuitable for education at school " and 104 children requiring care and guidance have been referred informally. All children leaving the special schools for the educationally subnormal are reviewed with particular care having regard to home conditions and suitability for employment.

CHILDREN WITH SPEECH DEFECTS:

As already pointed out the staffing position continues to deteriorate so far as Speech Therapists are concerned. In December, 1962, there were 13 whole-time and 3 part-time therapists. By December, 1963, the total number was reduced

to the equivalent of 11 whole-time workers—10 full-time and 3 part-time—and further resignations have occurred since. Although many factors behind this are prevalent throughout the country every effort must be made to ensure that working conditions are as satisfactory as possible for the staff. It is sometimes not fully appreciated that a modern clinic may lack the friendly informal atmosphere of a converted house and therapists find difficulty in hanging pictures on the walls in the clinics of modern design. All the therapists have the facilities of a tape recorder.

Some therapists feel a sense of isolation working in clinics on their own and rarely seeing their medical and nursing colleagues. Miss Z. Coates from the Wath Division reports, on the other hand:—

> " I have been very fortunate to be able to work with so many helpful and experienced people. There has been close co-operation between myself, Mr. Valentine, Psychologist, Dr. Orme, Child Psychiatrist, Miss Lyne, Remedial Teacher, and, of course, with the Medical Officers, Health Visitors and Dentists. Being able to discuss patients with other specialists leads to a quicker diagnosis and a greater insight into the problem. Working as part of a unit of specialists is extremely advantageous."

She also reports on the value of school visits in stimulating co-operation with the teachers:—

> " I have made numerous school visits and found them invaluable. A large majority of teachers soon become interested and, despite large classes, some are able to spare a short time daily to any child who is in need of extra help. A teacher's co-operation can be valuable in cases of patients whose home environment is not conducive to regular help from parents. I have also encouraged teachers to come to my clinics so that they can see the kind of work that is being done. I have had a number of teachers, student teachers and school girls visiting the clinics. Perhaps the number of speech therapists would increase if more of us gave talks to sixth formers on Speech Therapy as a career."

Her suggestion regarding talks by the Speech Therapists to sixth formers would be worth pursuing with the co-operation of the Heads.

Mrs. K. Harrison reports on the work in the Skipton Division as follows:—

> " Clinics continue to be held in two County Secondary Schools, three Junior Schools, also at the Child Welfare Clinics in Barnoldswick, Earby and Skipton, and the Health Office in Settle, and Ingleborough Hall Special School.
>
> Good relations and a high standard of co-operation are still enjoyed with the teachers, local health authority staff, and also with the family doctors, who during the past year have referred many patients for treatment and have sought my advice on numerous occasions.
>
> Transport has always been and will continue to be one of the major difficulties in this large rural area, but with the provision of bus travel vouchers, the collection of patients in my own car and the provision of taxis in two or more remote parts of the dales it has been possible either to interview or treat the majority of cases referred.
>
> To try and overcome the long waiting lists, time has been allotted each week to interview children coming on to the list. At this interview I have assessed the urgency of each case and discussed the problem fully with the parents. In many cases it has been found that at a second interview speech has improved and treatment is unnecessary. I feel that in the majority of cases children under the age of five years and six months do not greatly benefit from treatment and that improvement comes with normal maturation.
>
> In some cases, particularly the stammerers, treatment tends to be lengthy and is apt to drift on until the child gains no benefit. I am now trying a short course of treatment followed by three months' rest which I feel in the long run will be more beneficial. The parents are, of course, able to attend at any time to discuss new problems which may arise. By doing this, treatment is given to more children and the service is more efficient. While Speech Therapists are so scarce and the likelihood of smaller areas somewhat remote, the best way to overcome waiting lists is by careful selection of cases."

Mrs. Harrison's comments on the need for careful selection of cases are particularly valid in times of staff shortage. At the conference held in November, Medical Officers were asked to provide as much information as possible on pupils referred to the therapists and to ensure that other conditions such as throat and nose defects were cleared up.

Mrs. W. Russell worked in the Rothwell Division throughout the year and transferred to the Shipley Division from the Tadcaster area for some sessions when the former therapist left. She reports:—

" During 1963 the Speech Therapy service in Rothwell has been continued on the basis of five half-day sessions per week. In the Shipley Division the service had to be decreased from ten half-days to five sessions in September, 1963.

In the Rothwell area, there has been a gradual building-up of contacts with schools and general practitioners, which has been most valuable from the point of view of discussion of difficulties regarding patients, and also in establishing speech therapy as a treatment and consultation service.

The greatest problem in this area is that, following efforts to make speech therapy known, the waiting lists inevitably increase as teachers refer more children to the School Medical Officer, and general practitioners request therapy for pre-school children.

The Kippax, Allerton Bywater and Methley areas of the Division have received very little practical help due to lack of available sessions. Some visits to schools in these areas, however, have been made, with the aim of giving advice to teachers and parents where help could be given in the home or at school.

At Shipley and Bingley the greatest effort since September has been to maintain the regular treatment of children who had previously been spread over a greater number of sessions. Two clinics held regularly in schools up to September had to be cancelled and no school visits have yet been possible. Waiting lists are growing rapidly and there is a great need for a full-time therapist in this Division also."

Mrs. A. Woolley, who joined the staff in the Colne Valley Division during the year, reports:—

" The amount of co-operation with other branches of the County Health Services seems to vary widely according to the Divisions concerned. In my own Division I receive much help and co-operation from Health Visitors.

Most children now being admitted to the clinics have received hearing tests or will be tested in the near future. This, of course, is of much help in planning treatment for the children and in deciding whether any special help is required.

It would be an advantage if all children being referred to clinics could receive psychological testing to enable the therapist better to judge the standard of speech which may be attained, also the best method of approach to the patients."

Miss M. P. Dunkley of the Harrogate Division stresses the need for early therapy for the repaired cleft palate cases and her case history of a child with hearing loss is of interest. She reports as follows:—

" During the year 1963, 106 children with speech defects were treated in the Harrogate and Ripon area. Of these, 32 were stammerers, and 74 had articulatory defects of varying degrees of severity.

Only two of these cases were children who had had a cleft palate operation. Though nowadays the treatment of post-operative cleft palate patients is so much simpler owing to the fact that surgery is usually performed before speech has begun to develop, there is always the satisfaction of knowing that we are giving to these unfortunate little children the chance to acquire normal speech before starting school. Normally we begin treatment at the early age of two and a half years.

I would like to mention here what a great privilege it has been for me to treat some of the late Mr. Michael Oldfield's cleft palate patients. He regularly kept in touch with me about patients he referred to my clinics and always sent me a letter of thanks when a patient of

his had been discharged with normal speech. His standards were high but this made the work a real challenge.

Perhaps the most interesting cases I treated in 1963 were the children with hearing loss. There were three in all but one of these may be of particular interest.

Diane is a little girl of six years old. She first came to my notice when her teacher brought her to see me, when I was at the school taking a group of children. She told me that Diane was not speaking in class and she was painfully shy and withdrawn. I soon realised that Diane had great difficulty in hearing speech, but she was lip reading. Her own speech was very poor.

I reported the case to the Medical Officer and he immediately made an appointment for her to see the E.N.T. Specialist. His diagnosis was profound high tone deafness and a severe speech defect.

The little girl's mother was very upset when she heard the verdict and she did not seem willing to admit that Diane had a speech defect, or that she might be deaf.

The Specialist, however, suggested that, with a hearing aid and speech therapy, it might be possible for Diane to remain at normal school and so the case was referred to me. Diane is now speaking very well with the help of her hearing aid and lip reading and she is now taking her place in class without difficulty. A year ago she was a shy, withdrawn child, struggling hard to fit in with normal school life. Now she is a happy, well adjusted little girl and full of high spirits. Moreover, she is an intelligent child and, according to her teacher and Headmistress, is one of the brightest children in her class. She is also outstanding in her rhythmic work and her movements are a joy to watch.

I feel sure that Diane will cope very well in ordinary school. Her teacher is interested in her case and I have suggested ways in which she can help Diane to overcome her handicap.

I feel sure I am voicing the opinion of all Speech Therapists when I say that the value of our work in the field of education is being more fully recognised. Children with speech defects are deprived of one of the most natural forms of self expression and have often in the past been regarded as children of limited mental ability, whereas many of these children are quite intelligent, and it is most gratifying to be told by teachers that, after many children with speech defects have received treatment by the therapist, their work in class has considerably improved and a child who was previously unhappy, shy and inhibited is now a well socialised, confident pupil."

Miss G. M. Carr mentions her difficulties in securing regular attendances at clinics:—

" During early 1963 Mrs. Houghton resigned her part-time post as Speech Therapist to Division No. 15 (Batley) and I took over the work in this Division in addition to Division No. 13 (Morley).

The usual range of cases has been seen during the year. Besides the cases referred through school medicals, a small number of pre-school dyslalic and/or stammering children have been seen at the request of the mother, often through the Health Visitor or family doctor. These children are seen periodically for advice to the mother and to keep an eye on their progress. A small number of pre-school children with repaired cleft palates also attend for check-ups.

Generally speaking, attendance at weekly treatment sessions is often poor. I am trying to combat this by making school visits and trying to gain the co-operation of the schools in sending the children out when they are old enough to come a short distance by themselves. However, if they are too young, or the school is too far away, this is not possible. The Health Visitors make visits at my request to encourage the mothers to attend and sometimes the Head Teachers can help by having a word with the parents."

Mrs. C. Salmon raises the feeling of isolation although co-operation with other members of the staff is excellent. She also mentions the problem of when to discharge a case:—

" During 1963 I treated a total of 184 cases at nine different centres. Therapy is usually a weekly event but in some areas circumstances permit only fortnighly or monthly visits.

I discharged 42 of these cases. During the two and a half years I have worked for the West Riding County Council it has been my policy *never* to discharge cases because of non-co-operation (lack of attendance etc.). These cases are sent three invitations every six months and in some cases I find persevering in this way bears fruit. There were 18 cases awaiting treatment at the end of 1963.

Regularity of attendance varies from clinic to clinic and from child to child but generally the standard is good—thanks are largely due to school teachers.

Co-operation and help is now forthcoming from every quarter. Where parents are unable or unwilling to give a few minutes to daily practice, class teachers sacrifice some of their already full day to help my cases and I am most grateful to them and to the Head Teachers who can always find time to discuss any new cases and to report on the progress of those attending for treatment.

The public health staff are interested and co-operative. Forms are always filled in with all the knowledge the Assistant County Medical Officers have of the cases and Health Visitors are always willing to fill in any gaps in home environment for me.

Dr. Watt has on several occasions invited me to accompany the Health Visitors to special centres—a school for the deaf and a training centre—and, at his suggestion, I have tested the hearing of all the children on my list during 1963.

Dr. Crowley's help and advice proved invaluable to me and already I am feeling the loss of the child guidance clinics.

The Dental Officers in the Division have all shown interest in any speech defects linked with orthodontic troubles and have given advice and treatment wherever necessary.

Interest is growing amongst the general practitioners, several of whom send cases along for me to assess. (Some have even asked for leaflets and information about speech therapy).

The lack I feel most strongly is that of day to day contact with other Speech Therapists. There are so many points which would bear spontaneous discussion with a colleague whose training has been of a similar nature to one's own. I realise there are very few of us but how much more satisfying it would be if there were two Speech Therapists working from the same centre.

I would have liked to have had more time for school and home visiting but the necessity for regular sessions at so many clinics makes this difficult to arrange."

The maladjusted Child:

The staffing situation at child guidance clinics still gives cause for concern. The Local Education Authority provide the Psychologists, Psychiatric Social Workers, clerical staff and premises. It has been agreed that the establishment of Psychologists should be increased from two to nine over a three year period and their work should be extended to include duties with the mentally subnormal. The situation regarding Psychiatric Social Workers is under review and it is hoped to increase the complement of staff shortly as the present establishment of four includes a trainee. Action has not been taken previously owing to the universal shortage of qualified workers but the Leeds University hope to commence a training scheme in 1964 and this may attract personnel into the area.

The Regional Hospital Boards normally supply the services of Consultant Psychiatrists but the difficulties in this sphere were referred to in the Report for 1962. The situation has been aggravated by the resignation of Dr. Crowley. Although the Sheffield Board have advertised the post no suitable applicant has been forthcoming. The Leeds Board have indicated that the Local Authority cannot expect any further psychiatric staff whilst the hospital service remains short of personnel.

It is hoped, over a period of time, to have one Medical Officer in each Division suitably trained to carry out much of the initial screening of cases referred to the child guidance clinics. Consideration may also have to be given

to another appointment by the Education Authority similar to that of Dr. Eileen Atkinson.

The established child guidance clinics were all busy during the year and waiting lists tend to accumulate. With the departure of Dr. Crowley the clinics at Maltby, Woodlands and Dunscroft have been staffed by the Psychologist and Psychiatric Social Worker who have been able to carry out many of the initial investigations required whilst Dr. Orme has been able to advise and help.

Swinton, Ecclesfield and Barnsley Clinics—Dr. Orme reports:—

" Work in the Swinton, Ecclesfield and Barnsley areas changed considerably during 1963 because of increases in the clinic staff.

First a teacher, Miss Lyne, was appointed to run a class for maladjusted children at Swinton in conjunction with the clinic at Rock House. This class started in April and has added considerably to the therapeutic effort in the area and has already helped a number of children. The greater degree of personal attention, the close relationship possible with the teacher and the greater freedom available for both child and teacher are invaluable.

Children chosen to attend the class fall roughly into three categories—those who show extreme nervousness in ordinary school and who need to be helped over their fears in order to make the best use of their intellectual endowments; those who are too aggressive or restless to be contained in the ordinary class and who have to learn to adjust to those around them; and those who need to develop a special relationship which is missing at home in order to help them adjust to their own emotional development. A total of ten children were attending by the end of the year in different combinations from six to two half days per week. Of necessity there are ' teething troubles ' and difficulties which can only be overcome as experience develops.

In April an additional social worker (trainee), Mr. Pritchard, joined the team at Swinton and this has enabled us to deal with a greater number of cases at any time. A more effective use of casework techniques and particularly of home visiting has been possible. By sheer hard work on the part of all members of the team at Swinton, the waiting list has been reduced considerably after a bad period in the middle of the year.

At Ecclesfield and Barnsley, treatment has been helped considerably by Mr. Skinner, Psychiatric Social Worker. Unfortunately, time in these areas is very limited and Mr. Skinner has to do most of his work by home visits owing to difficulties in co-ordinating clinic timetables; the situation at Barnsley is particularly difficult. An occasional clinic at Stocksbridge has been held but this is either for pure diagnostic purposes or for follow-up of old cases; little in the way of treatment can be arranged from the Stocksbridge-Penistone areas.

A student on the Sheffield University Course in Advanced Child Care attended the Swinton Clinic from January till May and was able to take a good part in all aspects of the work. This was a stimulating experience for the clinic team too and one which suggests that greater co-ordination with training child care workers might be possible. Some student teachers from the Swinton Day Training College have also visited the clinic and lectures have been given to all the final year students.

During the autumn a group of younger children were seen—pre-school children whose behaviour gave their parents anxiety; two were not speaking, one was masturbating excessively and another was extremely aggressive. These were satisfactory to treat and having them at the same time gave rise to the suggestion of setting up a therapeutic nursery class, though this was not necessary as they did not attend the clinic long. In many of the older children we find that symptoms have been present for many years but it seems that it is very unusual for a child to be referred even from infant school. It is to be hoped that workers in maternity and child welfare clinics will become more aware of the benefits of early treatment."

Harrogate Clinic—Dr. Gore reports:—

" In 1963, 102 new cases were seen: 27 girls and 75 boys.

The sources of referral from Division No. 7 followed the pattern of previous years:—

Divisional Medical Officer	30
General Practitioners	11
Juvenile Court	2
Probation Officer	2
Parents	3
Children's Homes	3
Head Teachers	6
Other	1
	58

There were proportionately fewer cases referred from the Juvenile Court.

Our outside contacts were consolidated and extended by visits to In-Patients Units, Hospital and various schools.

Miss Blackburn's Report on Remedial Teaching

The new year began with 17 children on roll, but 2 were transferred for special schooling one on physical grounds and in this case boarding placement has been amply justified. One child was withdrawn by a parent who disliked the idea of segregation from his normal school class. This move has proved very detrimental to the boy. Two new children were admitted during the term, both of Secondary Modern age, one a serious case of school refusal. At present we have 5 girls and 11 boys, age range as follows:—

1 is 14 years
3 are 13 years
1 is 12 years
5 are 11 years
4 are 10 years
1 is 9 years
1 is 8 years

This gives 11 in the earlier age range, again indicating earlier referral, though often this is delayed until the final year in the primary school when, one feels, it would be better before then. Progress with these younger children is very well maintained and the growth in confidence, as basic difficulties are overcome, is very rewarding.

With the older children the rate of progress is slower and what one is able to do is limited. Even so, an all-round improvement has been very marked in a girl of 14 and home relationships have improved. Appreciation of our work is constantly shown by Heads of schools and parents and we continue to maintain close co-operation with home and school. The team continues to keep a very close watch on all the problems of children in the remedial group."

Shipley Clinic

This clinic urgently needs further sessions but the Leeds Regional Board have not been able to supply the necessary psychiatric cover so far.

Dr. Gore reports:—

" Twenty-nine new cases were seen during the year. Eight children were seen for regular treatment (weekly or fortnightly visits) and 12 children have had regular but less frequent treatment. In addition, 11 children were seen at intervals for review. Seventeen cases were closed and 3 children placed in Residential Establishments (Maladjusted School, Children-In-Patient Units and Wharfedale Children's Hospital respectively). Sixteen cases referred in 1963 are still waiting to be seen.

This gives a picture of the way the sessions have been used. During 1963 rather less time was lost over failure in attendance, *e.g.*, only 5 first appointments were not kept. Shortage of time, however, still remains the concern of the clinic team, as it is very difficult to deal adequately with the cases referred both from the diagnostic and treatment point of view and there is very little opportunity to meet with those concerned with the children outside their homes."

Mirfield Clinic—Dr. Leese reports:—

" This clinic is now open on Mondays and Tuesdays, both morning and afternoon, with the psychiatrist working 4 sessions, the social worker 5 sessions (one out of the clinic), the psychologist 2 sessions (less one session once a month) and the secretary 4 sessions. Dr. E. Atkinson worked one session with us for eight months but by August she came to the conclusion that half-day sessions in several clinics was not a good use of time and left us to concentrate on other child guidance clinics. As the number of sessions we spent in the clinic increased, so did the number of referrals ! We saw 98 new cases, 16 of which were seen by the psychologist only. We carried 30 cases from 1962 and have 47 carried over into 1964. On December 31st there were 14 names on the waiting list, dated from October 1963.

The new cases were in the following age and sex groups:—

	Pre-school	*5—11 years*	*Over 11 years*	*Total*
Boys	5	30	31	66
Girls	2	15	15	32

Of the new cases, the ratio of boys: girls remains approximately 2:1 as last year in the overall picture but this year has seen an increase in the numbers of younger girls—17 as compared with 2 last year—and an increase in the boys over 11 years—31 as compared with 18.

To consider the 30 cases from 1962 together with the 82 new ones seen by the psychiatrists in 1963 no fewer than 19 were from families where the parents had separated, *i.e.*, approximately 17 per cent. but only 5 of these children were in the care of the Local Authority. Two boys continued to live with their fathers who had remarried—the rest of the children stayed with their mothers. We saw 9 children in the care of the Local Authority but none who were fostered and only one who was adopted. We continue to have close contact with Westfields Reception Centre less than half a mile away, with Child Care Officers and Probation Officers and School Medical Officers. But, owing to the rural nature of our ' catchment area ', contacts with general practitioners remain by 'phone and letter and Mr. Pickles visits the members of the staffs of the schools on all too rare occasions.

During this year we have become increasingly interested in ' clumsy ' children, children whose muscular co-ordination is poor so that resulting action is awkward and often regarded as careless. I should be very glad to see all who appear to come within this group."

Rothwell, Pontefract, Ossett/Morley, Sowerby Bridge and Skipton Clinics—Dr. Atkinson reports:—

" In March, 1963, the West Riding County Council appointed me as a full-time psychiatrist for the Child Guidance Service. I was already working in three established clinics in Pontefract, Skipton and Mirfield. New clinics were then opened in Keighley—one session weekly; and Kirkburton, Ossett/Morley and Sowerby Bridge—two sessions monthly. It proved impossible to run a clinic on this basis of one day per month if any psychotherapeutic treatment was to be undertaken, so after six months' trial the clinics were re-adjusted. The Kirkburton Clinic was discontinued as there were few referrals; and the Ossett/Morley and Sowerby Bridge Clinics were held on alternate weeks. The case loads in both clinics have justified this; in fact, Morley now has a waiting list and a weekly clinic is really necessary there. At the same time my attendance at the Mirfield Clinic was discontinued; the Keighley Clinic was increased to two sessions weekly to deal with the heavy case load and this has proved to be about the correct amount of time.

A clinic was started in Rothwell in September in an attempt to ease the heavy burden on the Pontefract Child Guidance Clinic. The Pontefract Clinic has continued to be very busy. The Skipton Clinic has been rather less busy than in 1962.

In October, Mr. Skinner, Psychiatric Social Worker, started work in the Rothwell, Ossett/Morley, Sowerby Bridge and Skipton Clinics. This eased my burden considerably and enabled us to give a better Child Guidance Service but unfortunately his programme is so heavy that he is unable to do all the home visiting that we both feel to be a vitally important part of the Psychiatric Social Worker's work in the Child Guidance Service.

Mr. Pickles, of course, has continued to work as Psychologist at Pontefract Clinic, although other duties in the School Health Service have reduced his time there. In the other clinics the School Medical Officers have very kindly carried out intelligence tests when necessary and Mr. Pickles has kindly tested the occasional difficult child. We do miss, however, the contribution a Psychologist makes to the team analysis of problems.

As far as staffing of the clinics has been concerned, the remaining difficulty has been secretarial help. Various methods of dealing with this problem have been tried but it seems that the only way that the very extensive records of Child Guidance Clinics can be kept adequately is for a secretary to be attached to each clinic and this we hope for in the future.

In all the clinics at present operating, the referral rate is quite high as can be seen from the figures. This is a reflection of the need for the service. Most cases come through the School Health Service but General Practitioners, Pædiatricians, Probation Officers, Child Care Officers etc. bring cases to our notice. We are glad of their interest and the help they give us in return. With a multiplicity of clinics and limited time it is difficult to keep in touch with these people and other interested agencies as we would wish, so it is our practice to welcome any visits they care to make to the clinics to discuss cases. We find this far more satisfactory than letters. In fact, one Probation Officer visited my home on a Sunday morning to discuss a boy in whom we were both interested, as that was the only time we were both free to do so.

There has been a wide variety of cases, many of great interest, some of great difficulty in disposal—the psychotic children in particular. There is no provision for their long term care in this part of the country. Fortunately they are few in number. We still have a considerable number of social problems referred who tend to take up an excessive amount of the Psychiatric Social Worker's time and for whom we can do little. Treatment is restricted by the very heavy case loads limiting the amount of time available and by the often unsuitable premises in which we work, which limit the methods of treatment available: for example, I have no playroom at any of my clinics, so I cannot allow wet and dirty play, nor can I hold group sessions, which would be one method of dealing with the case load. This is a very difficult problem where the infrequency of clinics makes such provision as we need economically unjustifiable. Most of the cases have, however, been treated as out-patients in the clinics. Only the very worst cases, where it is felt separation of parent and child is the only possible solution, are recommended for residential treatment. There is still very inadequate provision for schools and hostels for maladjusted children, particularly for girls."

The Work of the Psychologists:

Mr. Pickles and Mr. Valentine carried out duties in their areas as in 1962. During the year Mr. Pickles completed his survey on groups of backward children attending the junior schools in the Harrogate area and was able to devote more time to the intelligence testing of the boys at Bridge House School. He also attends the audiology clinic at Horsforth. Mr Valentine continues to be an invaluable member of the team at the Doncaster Audiology Clinic and has been able to carry out mental ascertainment on a number of pupils at the Yorkshire School for the Deaf. This work of the psychologists in the ascertainment of the mental abilities of hearing impaired children is particularly important as it requires special methods of assessment in which few medical officers are trained. It is essential to know whether the child's retardation is entirely due to the deafness or whether, as in a significant number of cases, there is true intellectual impairment also.

Mr. Valentine reports as follows:—

" I continued to attend the same clinics as in previous years, namely, Swinton, Ecclesfield, Maltby and Woodlands.

I also attended the audiology clinics, held at the Yorkshire Residential School for the Deaf, throughout the year.

During visits to schools it was found that Head Teachers were often anxious to discuss the problems of children in addition to those already referred to clinics but the shortage of time made it possible only to deal superficially with these problems. There is, obviously, scope for much development of this aspect of the work and one looks forward to the appointment of more psychologists to help in this as well as in other directions.

Statistics

Children referred for full clinic investigation—number tested	134
Children seen at clinics (other than for testing)—number of interviews	61
Parent interviews at clinics...	32
School visits	143
Home visits	36

Children not referred for full clinic investigation—number tested:—

Cerebral Palsy	2
Blind/Partially Sighted	3
Deaf/Hard of Hearing (including 21 tested at the Doncaster Audiology Clinic)	27
Educational difficulties	13
Speech defects	1
Physically handicapped	1
Total	47

In addition, intelligence tests were given to 25 children residing at the Yorkshire Residential School for the Deaf."

Mr. Pickles reports as follows:—

" Psychological work is become more diversified. Relatively more time has been spent during the year in the examination of severely handicapped children and there has been an extension of work in the special schools. Child guidance commitments have remained the same, but it has been necessary to take some time from the regular programmes at the child guidance clinics to enable extra work to be done elsewhere. This may have contributed to a slight reduction in the total number of children seen as part of clinic diagnostic procedures (163 compared with 179 last year) and the pinch has been felt in other ways: it has been difficult, for example, to arrange school visits in some of the clinic areas. An almost equal distribution of time between child guidance clinic work and work in the school health service generally has been approaching; and there has been a danger of jeopardising the psychologist's contribution in clinics where the full team approach is well established and some teaching is undertaken. There is a need for an increase in psychological staff and some suggestions about future psychological work in the public health service generally have been made.

Child Guidance

As in previous years, weekly attendances were made at the child guidance clinics at Shipley, Mirfield, Pontefract and Harrogate. In these clinics, work has continued on traditional lines as a part of the team approach to problems of maladjustment in children. Most of the children attending the clinics during the year have been seen for psychological examination, in particular for cognitive and attainment testing. A wider contribution to diagnostic assessment could be made by the more frequent use of additional methods, such as projective techniques, but these are time-consuming. The psychologist can also contribute to treatment. This has been customary at Shipley and Harrogate, where fourteen children were seen regularly on a treatment basis by the psychologist during the year.

The total number of children for whom test results were available was 163, boys outnumbering girls by 114 to 49. Intelligence quotients on various tests ranged from 30 to 146, the average being 94. A slightly higher proportion of dull children was seen than in the previous year: 24 per cent. had I.Q.s below 80, compared with 17 per cent. in the previous year. Those with ability falling broadly within normal limits (I.Q. 80 to 119) constituted 66 per cent. of the total, compared with 69 per cent. in the previous year. Fewer bright children were seen. On average, the girls were of slightly lower ability than the boys.

An increase in psychological staff would make it possible in the future for psychological work in the clinics to be a little wider in scope and for liaison work with schools to become a more regular feature than has so far been possible.

Handicapped Children referred for psychological examination

This work has increased. The number of handicapped children examined was 111, compared with 73 in 1962. The largest categories were the deaf and partially hearing (36); children with specific educational difficulties (32); and children who were very backward, often not speaking, and who required special testing procedures (31).

Ideally, there should be ample time and facilities for the examination of the severely handicapped child. One four year old child, hyperactive and with severe nystagmus, but with good speech and able to make a good relationship, required five interviews, lasting approximately one hour each, before it was felt that reliable test results could be obtained: the most appropriate test proved to be a test for visually handicapped children. It was possible to see this child in the psychologist's own room in the clinic, where the furniture was appropriate and there was plenty of available material to engage his interest. The problem of examining handicapped children can be considerably increased by unsuitable conditions in clinic, school or home.

The follow-up and re-examination of these children is a responsibility which the psychologist should be able to undertake. This is important in view of the uneven development found in many severely handicapped children and the particular abilities and disabilities which may co-exist in the individual child. It would be advantageous if a more systematic review of these children could be made. Lack of time often prevents this. Once a psychological examination of a severely handicapped child is embarked upon, the development of a ' counselling ' relationship with the parent is often inevitable and, for this reason alone, subsequent interviews may be a necessity.

It seems likely that this aspect of psychological work will continue to increase. There is room for more specialisation with different types of handicap, since the frontiers of knowledge about psychological sequelæ are being extended and their investigation often calls for special psychological examination techniques. There is also a large overlap with problems of intellectual subnormality, so that psychologists working also in the special schools and training centres would be better placed to carry out effective work with handicapped children.

Audiology clinic

Eight attendances were made at the Horsforth Audiology Clinic. Eleven children were tested (8 boys, 3 girls). The ability range of these children was evenly spread, only one child appearing to be severely subnormal, and a further two having non-verbal I.Q.s below 80. This work is most interesting and it is instructive to have the opportunity of working with medical and educational specialists in this particular field.

I also much appreciated the opportunity of attending a three-day course for psychologists at the Institute of Laryngology and Otology, Grays Inn Road, London, during October.

Survey of Educationally Subnormal Children in Harrogate, Knaresborough and Ripon Areas

A detailed account of the purpose and scope of this survey was given in last year's Report. Group testing in the primary schools continued during this year and was completed by the end of September, by which time all the primary schools except one had been visited. It had originally been intended to carry the work into the secondary schools but it was felt that the purpose of the survey had been served, there was work waiting to be done elsewhere, and it was accordingly discontinued.

A considerable amount of data has been made available, since each child was given four tests during a group testing session. It has not yet been possible to analyse this in detail. Some of the follow-up work in individual examinations of selected children by the school medical officers still remains to be done. I am most grateful to Dr. Hepple for having sent on to me the results of these examinations as they have become available.

Only the broad features of the survey can be summarised here. Seventeen primary schools were visited and thirty-two visits made. The total number of children tested was 315, 211 being boys and 104 girls. The age range was from 5+ to 11+, the majority being of junior age: only 21 were below the age of 7 years. The nine year olds constituted the largest single age group.

The total number of children tested amounts to approximately 6·5 per cent. of the children on roll in the schools visited. As the selection of children was left to the discretion of the head teachers, considerable variations were found in the proportion of children referred in different schools: the proportion ranged from 27 per cent. of children at one school to 2 per cent. at another.

As is usually found in surveys of educationally backward or retarded children, boys outnumber girls. It is of interest, however, to compare the intellectual efficiency of the two sexes as measured by the principal non-verbal group test, Raven's Matrices. When this is done, the boys and girls form two distinct groups: there is a large preponderance of low scores among the girls, whereas the scores of the boys spread out over the whole ability

range approximate to a normal distribution. The girls who are making poor educational progress tend also to be of below average ability (as assessed by the group non-verbal test), whereas many more boys of average or above average non-verbal ability are handicapped by specific educational disabilities, especially in reading. This is similar to findings elsewhere and would support the possibility of there being some specific sex-linked factors related to reading disabilities.

In selecting children for further individual examination, particular, though not exclusive, attention was paid to low scores (below the 10th percentile level) on the Matrices test, and this tended to be the principal determinant in selection. On these grounds, 94 children were suggested for individual testing. Girls are as prominent in this group as boys: there were 48 girls and 46 boys. A further 19 children were suggested as needing individual examination, on grounds of suspected emotional disturbance, or outstanding discrepancies between test scores, or because some physical or sensory disability was observed during group testing.

The total number of children suggested for individual examination was thus 113, *i.e.*, approximately 35 per cent. of the sample and just over 2 per cent. of the primary school population. It has not yet been possible to compare the group test results with results obtained from individual examinations on the Stanford-Binet scale.

Attendance at Special Schools

This work was placed on a more regular footing towards the end of the year when it was requested that termly visits should be made to two of the residential schools for the educationally subnormal and more regular visits should be made to Bridge House School for deaf educationally subnormal boys. Since October, weekly visits have been made to Bridge House; and the initial work in this school has consisted of the systematic examination of all the boys in the school with appropriate non-verbal tests."

THE PSYCHOTIC CHILD:

Dr. Atkinson has made particular reference to these children in her report. Although numerically small the placement of these children is a great problem. Early reference to child guidance clinics is essential if there is to be any possibility of cure. Some are admitted to Juvenile Psychiatric Units for further investigation. The number of the units is limited and admission is usually only on a short-stay basis as an aid to diagnosis and early treatment. If improvement is not shown some of the children have to be admitted to hospitals for the subnormal if they cannot be controlled at home. The hospitals catering for psychiatric patients in the area do not accommodate young children and this is common throughout the country.

Although the child is withdrawn from reality and may appear to be functioning at a subnormal level the original level of intellect was much higher and it is not considered that a hospital for the subnormal is a proper placement.

From reports received from the psychiatrists the following was the position regarding known cases of psychosis in children in the West Riding in December, 1963:—

	Boys	*Girls*
Attending ordinary school (under observation and treatment)...	4	1
At Schools for the Educationally Subnormal	2	2
At Home:	4	1
(Receiving Home Tuition)	1	–
In Rudolf Steiner " Schools "	2	–
Attending Training Centres (Day)	3	–
In-Patients at Psychiatric Units	4	1
In Hospital for the Mentally Subnormal	1	–
Pre-School (under observation and treatment)	4	–
	—	–
Totals ...	25	5
	—	–

Buzzers for Bedwetters:

The use of enuretic alarms has been extended during the year and most Divisions have active waiting lists.

The School Ophthalmic Service:

During the year there has been difficulty in the operation of the ophthalmic service in two areas—Skipton and district and the Pontefract district. Dr. T. S. Severs has retired from full-time practice but has undertaken a small number of sessions weekly in the Skipton area. No successor has yet been obtainable by the Leeds Regional Hospital Board. Dr. J. V. Kirkwood, who undertook school clinic work in the County area, retired on the 16th November, 1963, and was succeeded by Dr. K. K. Prasher on a reduced number of sessions. As a result there has been a considerable increase in the number of children awaiting appointment. It is hoped that an improvement will be effected during 1964.

Large numbers of children continue to attend the School Ophthalmic Clinics and the number of examinations made and the number of children for whom glasses were prescribed during 1963 are given in the following table together with similar details for previous years:—

Year	*No. of children examined (including re-examinations)*	*No. prescribed glasses*
1949	12,345	7,830
1950	12,341	7,289
1951	12,514	6,970
1952	14,974	8,941
1953	17,659	9,462
1954	17,691	9,240
1955	17,265	9,926
1956	17,644	9,999
1957	17,662	9,782
1958	18,829	9,472
1959	18,784	9,411
1960	20,651	10,029
1961	20,387	9,542
1962	19,874	8,831
1963	20,559	9,201

Medical Treatment at Clinics:

As part of the Authority's arrangements under Section 48 of the Education Act, 1944, for the medical treatment of school children, the following clinics were in operation at the 31st December, 1963:—

Type of Clinic	Number	
	Provided directly by the Authority	Under arrangements with Regional Hospital Boards
Minor Ailment and other non-specialised	200	—
Dental	53	—
Ophthalmic	—	56
Speech Therapy	62	—
Ultra Violet Light	32	—
Pædiatric	5	15
Chiropody	3	—
Consultant E.N.T.	—	14
Consultant Orthopædic	—	15
Consultant Dermatology	—	1
Consultant Cardiac	—	1
Orthoptic	—	—
Remedial exercises	20	—
Audiology	2	—

Consultant E.N.T. Service:

No. of sessions held during the year ... 198

	Pre-school Children	*School Children*	*Total*
No. of individual children seen by consultant, including those continuing attendance from previous year	49	974	1,023
No. of above referred for operative treatment ...	34	449	483
No. of children:—			
(a) who obtained operative treatment during year	34	348	382
(b) treated at school clinics	—	24	24
No. of attendances at consultant clinics ...	62	1,420	1,482

Minor Ailment Clinics:

Although originally started for the treatment of impetigo, scabies and various minor ailments the pattern has now changed and much of the time is devoted to re-examination and advice on handicapped or delicate pupils.

Consultant Orthopædic Service:

Consultant Clinics

No. of sessions held during the year ... 165

No. of individual patients seen by consultant, including those continuing attendance from previous year	318	746	1,064
No. of above—			
(a) referred for operative treatment as short-stay cases only	15	44	59
(b) recommended long-stay hospital school ...	—	3	3
(c) recommended treatment by orthopædic nurse or physiotherapist—			
(i) at treatment centres	25	121	146
(ii) domiciliary	12	8	20
No. of children who obtained operative treatment during the year	3	32	35
Total number of attendances at consultant clinics	394	890	1,284

Treatment Centres		*Pre-school Children*	*School Children*	*Total*
No. of sessions held during the year ...	1,247			
Total number of patients treated (including cases continuing treatment from previous year) ...		88	561	649
Total number of attendances		1,090	5,140	6,230
Domiciliary Treatment				
Total number treated		22	1	23
Total number of visits to patients' homes ...		86	2	88
Appliances				
No. of appliances—				
(a) recommended		32	66	98
(b) obtained		29	60	89

Ultra Violet Light Clinics:

These are still well patronised in some Divisions although it is appreciated that there is considerable difference of opinion regarding their therapeutic value medically, apart from the psychological effect on the child and parent.

Number of sessions held during the year	1,205			
Number of children treated during year		175	332	507
Total number of attendances		1,615	4,760	6,375

Consultant Pædiatric Service:

Consultant Clinics

No. of sessions held during the year	222			
No. of individual patients seen—				
(a) New cases		147	189	336
(b) Cases attending from previous year ...		142	432	574
Total number of attendances at clinics		429	907	1,336

The following table gives details of the various types of defect or disease for which children were referred for consultant opinion:—

Defect or Disease			
Central Nervous System	17	17	34
Heart and Circulatory System	48	144	192
Respiratory System, including E.N.T. Defects ...	24	89	113
Speech	12	12	24
Orthopædic	9	13	22
Skin	—	2	2

	Pre-school Children	*School Children*	*Total*
Psychological	11	29	40
Mental Defect, including Educational Sub-normality	11	26	37
Congenital Deformities	15	4	19
Gastro-intestinal System	7	19	26
Epilepsy	13	36	49
Genito-urinary System	2	14	16
Glands	1	2	3
Nutritional	10	30	40
Developmental	64	59	123
Muscular Disease	3	4	7
Rheumatism	—	10	10
Habit Spasms	4	2	6
Incontinence	5	95	100
Migraine	2	30	32
Rheumatic Heart Disease	—	1	1
? Lead Poisoning	—	1	1
General Debility	—	1	1
Unclassified	24	30	54
	282	670	952

STAFFING OF THE CLINICS:

The present situation is that clinics in four Divisions are staffed from the Leeds University, in six by the Leeds Regional Hospital Board and in five Divisions Dr. Harvey is in control.

REFERENCE OF CASES:

The pattern of reference to the clinics varies in various Divisions. In two Divisions the children were mainly referred by general practitioners, in five almost entirely by the School Medical Officer.

The clinics have many advantages. The parents usually know the nurse and School Medical Officer who may be in attendance with the Pædiatrician. The siting is more convenient of access than long journeys with young children to a hospital out-patients department. The Pædiatrician is brought into closer contact with the work of the School Health Service and co-operation is stimulated.

The only disadvantage which appears to be of significance is that the child may have to be referred on to another Pædiatrician if hospital investigations become necessary. Many of the cases, *e.g.*, cardiac murmurs, enuresis and minor emotional problems can be resolved without attendance at hospital.

Dr. Cedric Harvey, the Consultant Pædiatrician attached to the West Riding staff, has a particular interest in child development clinics so that the child is well known before starting school. In his report for the year he stresses the importance of early diagnosis and the changes in the pattern of pædiatrics. Abstracts are as follows:—

> " The skilled care of many categories of handicapped child is snowballing in the specially equipped centres to a frightening degree which will soon demand multiplication of decentralised opportunities for treatment.
>
> Then there are disease states in which once-for-all treatment may be strikingly successful, such as operative heart surgery. But an immense resource of skill, patience and technical experience is needed to bring such a child to the point where surgical relief can safely be carried out, often after years of vigilant study by a team.

I have been impressed by the need for school and family doctors to ask the right questions in order to differentiate clinical conditions.

One girl was sent to me from school as a case of rheumatism in the ankles. But the question had not been asked ' Where precisely is the pain?' The answer, below the lateral malleolus only on both sides and after P.E. at school. It was ligament strain, not rheumatism. Another girl referred with the same rheumatic diagnosis pointed only to the pads beneath her heels, an area well known to orthopædic surgeons but by no means a rheumatic focus.

Yet a third was sent in by his doctor as acute rheumatism with multiple limb pains. But his pains were in muscles, not in joints, and the gradual onset of widespread paralysis led to lumbar puncture and a diagnosis of Guillain-Barre ' polyneuritis.' He recovered.

Not for several years have I been so embarrassed as recently, when asked to pronounce upon a grammar school fifth form boy, whom a part-time medical officer had forbidden games and exercise for a month pending consultation. It was a normal heart, with normal vibrating first sound. The obvious rule should be to impose no restrictions until AFTER any specialist reference which is arranged.

Postural faints continue to be misdiagnosed and treated with phenobarbitone as epilepsy, when the history of the circumstances of the attacks should make the diagnosis clear enough. Any seizure which habitually occurs in school assembly is a simple faint, not epilepsy.

We are indebted to a neurological consultant for forthright guidance for a sixth former who in the junior school had had a few minor (temporal lobe type) epileptic turns and migraine through school life. In view of his freedom from any sort of fits, with no drugs for six years, he was pronounced fit to take a motoring licence.

DEATHS FROM TONSILLECTOMY are again in the news during the year. Dr. Norman Tate (1963. Lancet. ii. 1090) reviews 87 probably avoidable deaths in the five year period 1957 to 1961. A leading article (1963. Brit. Med. J. ii. 699) points out that children normally acquire immunity to respiratory infections as they grow older. One third of 681 children on an Australian tonsil waiting list no longer needed the operation after eighteen months. The recommendation is where possible to wait and see whether natural immunity will develop, using penicillin prophylaxis against bacterial sore throats meantime.

Two recent cases of severe hearing loss have caused heart-searching. One was an alert wiry girl born after known rubella hazard in early pregnancy with a Roger heart murmur which later disappeared. She never acquired speech and her odd intent gaze suggested the attempt at lip reading but her hearing was repeatedly pronounced normal. Now at seven years old it has become clear that her handicap is of the hearing and not of the mind, and she has been re-assessed accordingly.

The other was a rhesus sensitized baby who at two days old had a shrill cry but whose serum bilirubin level after initial exchange transfusion never reached the recognised danger level. At one year old she seemed to be normal. But at six years she presents both athetoid cerebral palsy and severe deafness, selectively worse for high frequencies.

Orthopaedic Footnote

The health visitor on a suburban 'bus watched two policemen gazing with disfavour upon the exaggerated winkle-picker toes of a teenager's shoes thrust out aggressively into the gangway of the bus. At last one constable thus addressed the youth ' Tha's got a reet pair of shoes, lad. Does tha toes come to the end of the points?'

' Na ! Does tha head come to t'point of tha helmet?' "

Consultant Cardiac Clinic:

The one clinic is held in Harrogate. During 1963, 178 individual children attended and a total of 245 attendances were made.

Twenty-one individual children were referred to hospitals for further investigations and treatment. These include cases of Fallot's tetralogy; septal defects; patent ductus arteriosus; ventricular hypertrophy and transposition of the great vessels.

Apart from the routine cardiac clinic a special clinic is held periodically at the Harrogate General Hospital when the surgeon, pædiatrician and consultant cardiologist discuss problems of diagnosis and treatment. The child also continues to be seen at the routine clinic whilst awaiting treatment.

Vaccination and Immunisation:

Particulars relating to the numbers of school children immunised against diphtheria during the year and the immunisation state of the population of children of school age will be found in the Section of the Report dealing with Epidemiology, also particulars of the scheme for the vaccination of school children against poliomyelitis.

Cleanliness:

The following figures show the number of children found to be suffering from head infestation compared with previous years:—

Year	Total number of examinations made by school nurses	Number of individual children found to be infested	Percentage of school population
1948	560,631	27,361	12·4
1949	574,968	23,457	10·5
1950	523,473	20,214	8·8
1951	559,388	18,599	7·9
1952	610,201	19,772	8·1
1953	575,645	17,815	7·1
1954	549,961	13,619	5·3
1955	547,369	11,657	4·5
1956	512,868	10,379	3·9
1957	481,239	10,459	3·9
1958	523,353	9,753	3·7
1959	482,874	9,834	3·6
1960	467,937	10,341	3·9
1961	462,207	9,273	3·5
1962	421,257	8,912	3·3
1963	416,570	8,229	3·3

Nutrition:

In 1956, the Minister of Education introduced a change in the classification of the general condition of school children. The table below is, therefore, in two parts.

Year	Total number of pupils inspected	Classification					
		A (Good)		B (Fair)		C (Poor)	
		No.	% of Col. 2	No.	% of Col. 2	No.	% of Col. 2
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1948	71,858	26,077	36·3	41,876	58·3	3,905	5·4
1949	64,998	23,467	36·1	39,335	60·5	2,196	3·4
1950	61,977	26,820	43·3	33,528	54·1	1,629	2·6
1951	64,676	29,452	45·5	33,598	51·9	1,626	2·5
1952	62,156	30,506	49·1	30,635	49·3	1,015	1·6
1953	77,803	35,861	46·1	40,772	52·4	1,170	1·5
1954	79,553	40,315	50·7	38,344	48·2	894	1·1
1955	87,520	47,959	54·8	38,872	44·4	689	0·8
		Satisfactory			Unsatisfactory		
		No.	% of Col. 2		No.	% of Col. 2	
1956	89,564	87,318	97·50		2,246	2·50	
1957	83,250	81,524	97·90		1,726	2·10	
1958	84,346	83,025	98·43		1,321	1·57	
1959	88,398	87,484	98·97		914	1·03	
1960	83,630	82,892	99·12		738	0·88	
1961	82,938	82,343	99·28		595	0·72	
1962	82,395	81,950	99·46		445	0·54	
1963	76,706	76,268	99·43		438	0·57	

In view of the continued improvement in the general nutritional pattern it has been decided that routine height and weight measurements need no longer be carried out in the schools. Cases can be seen at the local clinics when periodic measurements are desirable. Several Medical Officers are interested and concerned in the problem of juvenile obesity.

SCHOOL MEALS:

The number of meals provided to school children daily according to a check made in October, 1963, was 155,468 compared with 143,907 in October, 1962. This represents 63·16 per cent. of children in attendance.

Medical Examination of Entrants to Training Colleges:

In connection with their applications for entry to Training Colleges, 1,265 students were medically examined during the year by the School Medical Officers, compared with 1,320 for the year 1962 and 1,215 for the year 1961.

Children and Young Persons Act, 1933, Employment of Children:

Under the Authority's bye-laws relating to the employment of children, 1,315 children were examined during the year by the School Medical Officers to determine their fitness for employment. The figure includes children taking part in entertainments. Four cases were found unfit.

The small number of children found to be unfit raises the question of whether it is necessary for every child to be seen by the Medical Officer or whether it could be restricted to those known to have some defect from their previous medical examinations.

Youth Employment Service:

The School Health Service maintains close liaison with the Youth Employment Service. The Youth Employment Officers visit schools to discuss with teachers and parents the type and suitability of occupations of those children about to leave school.

Prior to this the leavers will have received their final routine medical inspection and the School Medical Officer will have informed the Youth Employment Officer of those children who are handicapped in such a way that their choice of employment is limited.

After the handicapped child enters employment, the services of the School Medical Officer are still available to advise the Youth Employment Officer if any difficulty is encountered either regarding the actual occupation or from the point of view of the employer.

Protection of School Children against Tuberculosis:

TUBERCULIN TESTING OF ENTRANTS:

Routine tuberculin testing of school entrants was undertaken in six Divisions, jelly testing of school children having been instituted in the Morley Health Division in January, 1963. The Acting Divisional Medical Officer, Dr. Douglas, reports as follows:—

> " Consent forms and explanatory notes were sent to the parents of all children who were due for medical examination as school entrants and as an initial scheme the acceptance rate was encouraging. No child was to be tested unless written parental consent was received and similarly no child who was subject to eczema or plaster sensitivity would be tested without prior consultation with one of the School Medical Officers.
>
> The Nursing Staff would apply the jelly and results were to be read by the School Doctors.
>
> The technique adopted was as follows:—
>
> About a week before the child was due for medical examination the School Nurse visited the school and applied the jelly. The site chosen was between the child's shoulder blades. The tuberculin jelly was applied as an inverted ' V ' and the control jelly as a ' V ', both then assuming the shape of a diamond. The diamond was covered with a piece of ordinary sticking plaster and an explanatory letter was sent to parents. The tests were read by the School Doctor at the subsequent medical inspection. Absentees were followed up and re-tests were made in cases where the plaster had become detached in less than four days after application.
>
> Of 1,294 eligible children 935 consents were received and all these children were tested. 924 negative reactions were recorded of which 3 children had previously had B.C.G. vaccination.
>
> Eleven positive reactions were recorded but 6 of these children had had recent B.C.G. vaccination and no further action was taken. The remaining positive reactors were submitted to Heaf Gun testing and one child continued to give a positive reaction. The child concerned and its immediate family contacts were referred to the Chest Clinic and X-rayed. The Chest Physician advised further review in six months' time."

In the six Divisions a total of 5,023 children (4,022 entrants and 1,001 in the 7—8 years age group) were tested, of whom 49 gave initial positive reactions. Nineteen had had previous B.C.G. vaccination. Further investigations were carried out by referral of cases and contacts to Chest Clinics and X-ray.

Details of the testing in the various Divisions are given below:—

Health Division (a)	No. tested (b)	Negative reactions (c)	Positive reactions (d)	Of column (d)			Further investigation
				Previous B.C.G. Vaccination	Final Skin Test —	Final Skin Test +	
Castleford (Heaf Test)	612	598	14	7	—	—	6 + reactors followed up at Chest Clinic 1 primary lesion. 31 contacts seen at Chest Clinic.
Morley (Jelly Test)	935	924	11	6	4	1	1 case and family contacts referred to Chest Clinic and X-ray. Further review in 6 months.
Batley (Jelly Test)	345	345	—	—	—	—	
Spenborough (Jelly Test)							
(Entrants)	591	586	5	—	4	1	3 children and 25 contacts referred for X-ray.
(7—8 years age group)	1,001	988	13	—	11	2	
Barnsley (Jelly Test)	709	703	6	6	—	—	
Doncaster (Jelly Test)	830	830	—	—	—	—	
	5,023	4,974	49	19	19	4	

Particulars of the Authority's scheme for the B.C.G. vaccination of school children and of the number of children dealt with during 1963 will be found in the Epidemiological Section of the Report.

THE SCHOOL DENTAL SERVICE

The following is the Report of the Principal School Dental Officer, Dr. Davies.

1963 has been a year of steady, if unspectacular, progress for the dental service. Staffing has remained fairly constant, some additional clinics have been opened and for the third year in succession there has been a striking increase in the amount of treatment provided.

Staff:

At the end of the year the full-time dental professional staff consisted of the chief dental officer, the orthodontic consultant, 5 senior dental officers and 47 dental officers. In addition there were 8 part-time officers (equivalent to 2·4 full-time) and 6 full-time dental auxiliaries. On 18th September Miss M. M. Thom retired from her post as dental officer at the Harrogate clinic after 28 years' service with the West Riding.

The problem of recruitment of dental surgeons to the local authority service is not a simple one and, while a number of considerations influence the rate of entry to the service, the basic factors are always remuneration and career prospects. The local authorities, in seeking the services of dental surgeons, are in competition with other public bodies and with the attractions of private practice. It may go some way to explain the slowing up of recruitment during the year to note that 1963 saw considerable increases in remuneration to dentists in other fields which placed the local authority service at a disadvantage similar to that experienced at the inauguration of the health service which had so catastrophic an effect on staffing. The salary scales of dental officers are determined by the Dental Whitley Council and are of national application but at the end of the year the Dental Services Sub-Committee had approved changes in the staffing establishment which were designed among other things to improve the prospects of advancement for dental officers, within the provisions of the Whitley Council, on both the clinical and administrative sides.

On 27th February about 25 senior students of Leeds Dental School visited the Guiseley Clinic. This visit was in connection with the course of lectures in public dentistry now given to these students by the West Riding chief dental officer. The dental officer in charge conducted a tour of the clinic and gave an interesting talk on equipment and methods. The students were impressed by the layout of a purpose-built clinic and the high standard of equipment provided.

After a most encouraging start to a co-ordinated effort in dental health education made in 1962 the authority unfortunately lost the services during 1963 of the dental hygienists, both of whom had been employed exclusively in health education. It was decided, however, that they should not be replaced but that this type of work should be undertaken by the dental auxiliaries. Six auxiliaries took up employment with the authority towards the end of the year and it is envisaged that they will engage in educational work for a proportion of their time in association with the divisional nursing officers.

Clinics:

New dual surgery clinics were opened at Guiseley and Wath on Dearne, the latter replacing the surgery at Dunford House. Both were staffed and in use throughout the year. At Sowerby Bridge premises at Allan House became available as a dental clinic and were brought into use during December. Since 1955 the Medical Inspection room at Ryburn Secondary Modern School had been used as a dental clinic but this was not a very satisfactory arrangement, the big disadvantage being that the school is not centrally situated in the town. An additional surgery was constructed at the Bingley clinic, room being obtained by partitioning the original surgery. The second surgery is not equipped for providing a full range of treatment but is designed for the provision of orthodontic and other specialist services. Delivery was taken during the year of two new mobile dental clinics, bringing the number of these surgeries up to five. Of the latest pattern, they are as fully equipped as the fixed clinics, having dental units, ultra high-speed apparatus and X-ray machines. One is operating in the north of the county in areas between York, Knaresborough, Ripon and Pateley Bridge, the other to the west in the Hebden Bridge area. All five mobile dental surgeries and the 53 permanent clinics were in use at the end of the year.

At a time when new purpose-built clinics are now in use in every part of the Riding it is unfortunate that the Central Dental Clinic where visitors to the service, including potential recruits, are received is an old adapted building not

particularly well suited to its purpose. The Central Clinic houses, in addition to clinic accommodation, the dental laboratory and the headquarters office staff. Built about 80 years ago as a doctor's surgery and residence the clinic is situated on a busy main road at a particularly dangerous corner. Consideration may well have to be given to replacing this clinic in the not too distant future, particularly if, as a result of the Boundary Commission's recommendations, the children of Wakefield become treatable at the County Council's clinics.

Inspection and Treatment:

For the third year in succession there was an increase in the treatment provided for West Riding school children. Over the whole year there was an increase of dental staff equivalent to approximately four full-time dental officers. Two thousand, one hundred and seventy-seven more sessions were devoted to treatment than in 1962. Twelve thousand more children were inspected but only 2,000 more actually treated, 151,044 fillings were inserted compared with 130,821 in 1962, including a notable increase in the fillings inserted in temporary teeth, 14,457 compared with 7,728. There was 100 per cent. increase in the work of advanced conservation. The number of crowns and inlays constructed in 1963 was 465 compared with 226 in 1962.

The increase in staff experienced in the last three years and the installation of modern equipment particularly the ultra high-speed apparatus have altered the pattern of treatment quite markedly. The following figures are of interest:

	1960	*1963*
Number of children inspected	126,794	156,769
Number of children treated	49,310	54,380
Number of treatment sessions	18,119	23,437
Number of fillings in temporary teeth	4,332	14,457
Total number of fillings	98,940	151,044
Number of extractions	69,215	71,675

It appears from this evidence that children are receiving much more thorough treatment than formerly. When dental officers are overloaded with patients the temporary teeth tend to be ignored in order that conservation of the permanent teeth may receive priority. The temporary teeth of school children are of importance—not only are they needed by the children of up to ten years in order to chew properly but they act as guides in ensuring that the permanent teeth come through into good position.

It is gratifying to see that these teeth are now receiving some of the attention they deserve. The increase in the provision of crowns and inlays indicates the mproving quality of dental surgery provided for school children. Formerly many of these teeth would have been extracted and replaced by artificial dentures.

Mention was made in my Report for 1960 that some dental officers were gaining the impression that dental decay was no longer increasing in school children and this impression is born out in a survey carried out during the year on behalf of the Ministry of Education. Since 1948 the Ministry of Education has required some half dozen authorities, of which the West Riding is one, to undertake quinquennial investigations into the state of caries in children's teeth. These surveys concern the five year olds and twelve year olds only and the figures obtained in the West Riding in the four surveys are set out below and it will be

interesting to see whether the trend noticed is mirrored in the national picture which will eventually appear. Two interesting points are to be noted in these figures. There would appear to be no change in the situation as far as the twelve year olds are concerned during the last five years but at least deterioration seems to have been halted. Secondly, in the five year olds there would appear to have been an improvement over the past five years and even ten years.

	Number of Children Examined	*Number of Children showing no D.M.F. Teeth*	*Number of D.M.F. Teeth*	*Percentage of Children showing no D.M.F. Teeth*	*Average Number of D.F.M. Teeth per Child*
			5 year olds		
1948	5,034	1,138	22,150	22·6	4·4
1953	4,934	781	24,507	15·8	5·0
1958	3,422	395	19,505	11·5	5·7
1963	5,600	870	27,914	15·5	4·9
			12 year olds		
1948	1,876	362	5,440	19·3	2·9
1953	4,228	446	17,594	10·5	4·2
1958	4,064	130	24,705	3·2	6·1
1963	5,188	142	31,680	2·7	6·1

It would appear that the great need of and demand for dental treatment which has been so marked since the institution of the National Health Service is decreasing. The kind of dentistry carried out by the general dental service and the school dental service has increased greatly in recent years and a notable decreased demand is apparent in university towns, large areas in Southern England including many parts of London and Middlesex and in many areas throughout the midlands and the north. There can, however, be no complacency about the amount of decay experienced by school children when school entrants at five years of age still have an average of five bad teeth each. Much work remains to be done in the field of prevention. Fluoridation of drinking water is the procedure which can safely reduce decay in children's teeth by approximately half.

During recent enquiries it became known that one small area of the West Riding (and one only) has a mains water supply containing fluoride at a level of one part per million and detailed dental examinations have been carried out there which have yielded results strikingly superior to those obtained from similar investigations elsewhere in the Riding.

In this fluoride area, 42 per cent. of the children aged five to eight years were found to be free from dental decay in their temporary teeth and 32 per cent. of the children aged seven to eleven years were free from decay in their permanent teeth. The figures in a comparable area where the water contains no fluoride are 8 per cent. in both cases. The average number of permanent teeth affected by decay in eleven year old children in the fluoride area is 2·4 whereas that in the non-fluoride area is 6·3. On the recommendation of the Health Committee the County Council of the West Riding has resolved to make arrangements with any statutory water undertakers serving the Council's area for the fluoride level in public water supplies to be adjusted to that appropriate for the prevention of dental decay.

In January the Clerk of the County Council wrote to the water undertakers, County District Councils, who are not water undertakers, and water boards serving the Administrative County. Towards the end of the year fourteen replies were received from the thirty water undertakers, eleven being in favour of fluoridation and three either being not in favour or recommending no further action. Of the eighty authorities who are not water undertakers replies had been received from sixty-two, fifty-four being in favour, four not in favour and four recommending no action.

It will be seen that the local application of the Minister's policy regarding the fluoridation of water supplies raises various problems, not least of which are those which arise from the fact that most local health authorities draw their water supplies from more than one undertaking and that some water undertakers supply water to more than one local health authority area. The Minister of Health has now authorised, where appropriate, the making of arrangements to cover only parts of the authority's area and further practical progress is now possible.

Dental Health Education:

During 1962 an attempt had been made to organise, on a County basis, dental health education. Two dental hygienists were employed full-time on this work and good progress was made. Unfortunately, this scheme came to an end in the middle of 1963 when both hygienists left the service, one to enter a teachers' training college and the other to resume clinical work in the dental department of an industrial firm.

Experience had shown that the scope of our scheme was too wide and that each hygienist had the responsibility for too large an area for adequate work to be maintained. It was decided, therefore, that the post of dental hygienist should not again be filled for this purpose but that dental auxiliaries who are also trained in the techniques of health education should take over these duties and confine their activities to the medical division in which they are employed. The dental auxiliary who commenced work in October, 1962, resigned her appointment in August in order to become a tutor at the Dental Auxiliaries' Training School. Six newly qualified auxiliaries took up appointments with the County during September and October and little progress in the field of health education was possible before the end of the year. It is unfortunate that the experience gained by the hygienists should be lost to the service so abruptly and so completely but it is hoped that 1964 will see quick development of dental health education on this new basis. The means chiefly adopted to spread knowledge of dental care are talks to children in school, including the showing of films and film strips, and practical demonstrations, but also includes poster work and the distribution of leaflets in clinics. Parent-teacher associations and other groups of adults are also addressed.

Dental Health Exhibition:

A dental health exhibition was held at Bingley for one week during May. The dental clinic at Bingley is housed on the first floor of what was formerly the Technical Institute. On the same floor are four classrooms which are now used only rarely by the further education department and the Bingley youth club. It was felt, therefore, that if use of the whole floor could be obtained there would be an ideal site for a dental health exhibition on a fairly large scale. As it turned out, a large classroom on the ground floor was also made available and this was converted into a cinema during exhibition week.

The four classrooms on the first floor each contained displays illustrating the construction of the teeth, dental anatomy, the effect of sweet eating as opposed to fruit eating, correct oral hygiene techniques and a display of animal skulls and dental instruments of historical interest, together with numerous photographs. The dental suite itself was part of the exhibition and the various pieces of equipment were described and demonstrated.

The enthusiastic support of the Divisional Medical Officer and the Divisional Education Officer was obtained and every head teacher in the area expressed interest in the venture and offered their co-operation.

Transport arrangements were made in order to bring school children beyond walking distance to the exhibition and approximately four thousand school children were conveyed. The exhibition was advertised in the local press and by means of posters and was opened to the general public throughout the day and until 8-00 p.m. on three evenings during the week. The total attendance at the exhibition during the week was estimated at somewhat over five thousand.

It was felt that the exhibition was a great success and it was hoped that it would be followed up by a campaign of lectures and films in the schools by the hygienists.

As the hygienists left the Council's employment and alternative arrangements could not quickly be made it was decided to issue a questionnaire to the school children to serve a double purpose. Firstly to remind the children of the facts which they had learned at the exhibition and secondly to give some indication of the need for further dental health education in the area. At the end of the year the analysis of this questionnaire was still incomplete. The success of this venture in dental health education was largely due to the enterprise of Mr. A. S. Metcalfe, the school dental officer at Bingley, whose enthusiasm for preventive dentistry is unbounded.

Tuck Shops in Schools:

In April a statistical return was obtained showing the number of schools with tuck shops and the nature of the foodstuffs sold. A previous statement had been obtained in February of 1962 and, as the latest figures showed only a slight improvement in the position from the dental point of view, the matter was again raised with the Policy Sub-Committee of the Education Committee. The Committee were extremely reluctant to forbid tuck shops in schools but earnestly asked head teachers whether the biscuits and sweets on sale there might not be replaced by foodstuffs less harmful to the teeth.

Following this, the Education Officer sent a letter to every head teacher pointing out the unsatisfactory state of children's teeth and its relationship to sugar consumption. The statement was made that the County Council have a twofold responsibility in this matter. As the local health authority they are striving to promote better dental health. It would certainly be quite wrong if, as the education authority, they should appear to encourage the sale in schools of foodstuffs accepted as being detrimental to dental health..

It was hoped that head teachers would regard this whole matter as one of sound education and not only limit the sale in tuck shops of the more harmful types of foodstuffs but also let it be known amongst the pupils why this is being done. A list of more acceptable foodstuffs was suggested.

General Remarks:

In December, 1962, was published the first report from the Parliamentary Estimates Committee which was concerned with the dental services throughout the United Kingdom. A great deal of consideration was given to the local authority dental services and every aspect was carefully looked into. The Committee reported that, in the opinion of its members, all is not well with the school dental service and that this has been the case over a long period of years. The view was expressed that it is of the highest importance that the school dental services should be in a position to provide comprehensive dental treatment to all school children and the Committee said that only by making a serious attempt to run an efficient school dental service alongside the general dental service will it be possible at some future date to assess whether the policy of running both types of service is the right policy. This report and the circular jointly issued by the Ministries of Education and Health during 1962, which referred to the problems of recruitment and retention of dental staff, led to a close examination of the school dental service in the West Riding with a view to increased efficiency.

It was thought that the most needed reform of the West Riding County Dental Service was a change in the structure of the dental service to allow for an increased number of senior posts. This would have the effect of providing greater prospects of advancement for dental officers on both the clinical and administrative sides, of maintaining effective specialist services and of improving the administration and services as a whole. These recommendations were under consideration by the Committee at the end of the year.

Following the publication of the first report of the Parliamentary Select Committee and the subsequent debate in the House of Commons, the Chief Dental Officer of the Ministry of Health became the Chief Dental Officer of the Ministry of Education with responsibilities concerning the School Dental Services. The Chief Dental Officer, towards the end of the year, called a series of meetings of local authority Chief Dental Officers, one of which, concerning the Yorkshire authorities, was held in Leeds. This meeting, which is to be followed by others, was of the greatest value. The Ministry Dental Officers were able to give in greater detail the Minister's policy regarding the dental services and were able to spread information between the different authorities as to the ways in which common problems were being tackled.

It appears that in the future there may be a new form of school dental service. Greater emphasis is being put on regular and frequent inspection of every child and notification of defects with a view to obtaining treatment not only from the school dental service but from the National Health Service also. Very much greater emphasis is placed on preventive measures especially dental health education. The amount of dental treatment provided for school children has increased tremendously since the inauguration of the National Health Service in 1948 and the extent of dental disease has increased. The limitation and prevention of dental disease is now of paramount importance. The one measure which could, within a few years, reduce dental decay in school children by half is fluoridation but even when this is brought in other measures such as dietary care and oral hygiene will still be very necessary.

The other factor in the changing pattern of school dentistry is the use of dental auxiliaries to carry out the simpler operative tasks. In October the General Dental Council submitted to the Privy Council an Interim Report on the auxiliaries experimental scheme. This report was largely a statement concerning

the setting up of a training school and the first two years of its operation. As dental auxiliaries trained under the Scheme had been in employment only since September, 1962, the Council considered that sufficient information was not available for an opinion to be formed on the value of dental auxiliaries to the community.

In the West Riding one dental auxiliary was employed from September, 1962, until August, 1963, since when six auxiliaries have been in post. Experience has shown that these auxiliaries carry out their tasks very capably and all supervising dental officers have been impressed with the high quality of their work. The economics of training and employing dental auxiliaries will be assessed by the General Dental Council in due course and their value to the County in that sense will be decided but it can be stated now that supervising dental officers in this authority have found dental auxiliaries of great assistance in their daily work, which assistance enabled officers to concentrate on the more interesting technical tasks which previously, owing to lack of time, had to be referred elsewhere.

The only difficulty experienced in the employment of auxiliaries is the strictness of supervision at present enforced by the General Dental Council. Dental auxiliaries are not allowed to carry out the work for which they are trained if a dental officer is not actually on the premises. Arrangements can be made for auxiliaries to engage in non-clinical activities such as dental health education during the times that the dental officer is, for example, inspecting in schools or administering general anæsthetics in a neighbouring clinic, but allowance can not be made for unexpected illness or other emergency. The usefulness of auxiliaries would undoubtedly be much greater if they could be left to carry out prescribed treatment without immediate supervision.

Orthodontic Report:

The following is a Report by the Orthodontic Consultant, Miss Sclare:—

The figures for the orthodontic work carried out during 1963 show a significant increase over those of 1962 both in the amount of work actually done and in the number of children treated. One thousand, five hundred and seventy new cases were seen during the year, an increase of 217 over the previous year, while the total number of attendances increased by 2,096. In all, 4,198 children were treated and fitted with at least one appliance, 513 more than in 1962. There was a considerable rise in the number of appliances fitted. The number of removable appliances rose by 158 and of fixed appliances by 88.

Of the 61 dental officers on the staff all but 6 carried out some orthodontic treatment. Officers who show an interest in the subject are encouraged to do this work, provided it is limited to not more than one session per week. The routine work of fillings and extractions must come first.

As a result of the increasing amount of orthodontic treatment being done by the dental officers, fewer cases are now being referred for specialist treatment. This has given the dental officer specialising in fixed appliance therapy more time to try out new techniques and this would account for the increase in the number of fixed appliances used.

During the year the Orthodontic Consultant has visited a number of clinics to see how the orthodontic work is progressing and to advise and suggest a plan of treatment in difficult cases. Hitherto, dental officers have sent in models of cases to the consultant for advice and this they still continue to do but seeing the actual patient is much more satisfactory. In planning treatment from models one can only deal with the dentition, *i.e.*, the relationship of the teeth to each

other but there is more to orthodontics than the treatment of the dentition. An ideal occlusion on models may not necessarily be an ideal occlusion for a particular patient. The dentition must be made to suit the face. For example, in cases where the mandible is small and there is a protrusion of the upper teeth due, mainly, to the discrepancy in size of the upper and lower jaws, to retract the upper incisors until they come into normal relationship with the lower teeth would result in what the Americans call ' a dished-in face ' which is singularly lacking in character and is most unattractive. The extent to which a protrusion should be reduced can only be judged by seeing the patient.

Other factors such as the caries index, the health of the soft tissues surrounding the teeth, habits of speech, of swallowing, of oral hygiene and the health and temperament of the patient must be taken into consideration when deciding upon the type and extent of orthodontic treatment to be given to a patient, factors which cannot be assessed from models alone. In short, before commencing treatment the operator should be aware of all things present.

This the Orthodontic Consultant is endeavouring to teach by visiting the dental clinics and seeing the patients in the presence of the dental officer. In this way it is hoped to stimulate the interest and advance the knowledge of dental officers and so give a better service to the children. It should also help to meet the ever growing demand for orthodontic treatment. The steady increase year by year in the number of children treated is most gratifying but there are still a considerable number of children in the West Riding who remain untreated.

Once again I would like to put on record my appreciation of the co-operation of the dental technicians and of the work which they are doing, work which is an essential part of the Orthodontic Service.

Dental Inspection and Treatment Carried Out during the Year:

(*a*) *Dental and Orthodontic Work*

I	Number of Pupils inspected by Authority's Dental Officers—	
	At Periodic Inspections	149,807
	As Specials	6,962
	Total ...	156,769
II	Number found to require treatment	107,498
III	Number offered treatment	84,131
IV	Number actually treated	54,380

(*b*) *Dental Work* (other than Orthodontics)

I	Number of attendances made by pupils for treatment excluding those recorded at (c) below	151,731
II	Half-days devoted to—	
	Periodic (School) Inspection	1,295
	Treatment*	21,187
	Total ...	22,482

* Excluding anæsthetics under VI (ii)

III	Fillings—	
	Permanent teeth	136,587
	Temporary teeth	14,457
	Total ...	151,044
IV	Number of teeth filled—	
	Permanent teeth	115,496
	Temporary teeth	12,788
	Total ...	128,284
V	Extractions—	
	Permanent teeth	19,073
	Temporary teeth	52,602
	Total ...	71,675
VI	(i) Number of general anæthetics for extractions	21,560
	(ii) Number of half-days devoted to the administration of general anæsthetics by :—	
	Dentists	1,459
	Medical practitioners	40
	Total ...	1,499
VII	Number of pupils supplied with artificial teeth	935
VIII	Other operations—	
	Crowns...	356
	Inlays	109
	Other treatment	43,570
	Total ...	44,035

(*c*) *Orthodontics*:—

Number of attendances made by pupils for orthodontic treatment	16,950
Half-days devoted to orthodontic treatment	2,250
Cases commenced during the year	1,570
Cases brought forward from the previous year	2,628
Cases completed during the year	854
Cases discontinued during the year	188
Number of pupils treated by means of appliances	4,198
Number of removable appliances fitted	2,482
Number of fixed appliances fitted	242
Cases referred to and treated by Hospital Orthodontists ...	—

KEIGHLEY EXCEPTED DISTRICT

The following report on the year's work is submitted by Dr. McDonagh, the Borough School Medical Officer to the Keighley Excepted District:—

Introduction:

This report is compiled in accordance with the arrangements made by the County Council of the West Riding of Yorkshire as to the School Health Service in the Borough of Keighley and details the work carried out during the year under review.

The selective scheme of medical examination of children in the intermediate age groups has now been in operation for three years and it is thought that the advantages of the scheme are self-evident. In place of the routine medical examination of children in the intermediate age groups a questionnaire is sent to the parents which is followed by a detailed examination of those children who are considered to warrant further investigation as a result of the information provided on the completed questionnaire. The members of the staff derive a great deal of satisfaction from this more dynamic approach and there is considerable relief that much of the monotonous work of examining healthy children on a routine basis has been abolished. The routine examination of all children at the beginning and end of school life continues. Obviously the routine examination of the school entrant is vitally important and must be done carefully and meticulously. At the present time the examination of the school leaver is being used mainly as a means of evaluating our scheme of selective examination. The frequent visiting of School Medical Officers and Health Visitors to the school has meant that they have become better known to the teachers. In consequence many defects have been brought to the attention of the staff which we are quite convinced would not have been referred to them in the past. Therefore if and when we become fully satisfied that this is the ideal method it may be possible to make out a case for the discontinuation of the examination of normal school leavers. If the service is carrying out its function of finding handicaps they should be found long before the end of school life and special arrangements made for the follow-up of children who will require care and treatment in regard to their occupation after leaving school.

It will be noted in the section on Health Education that the Health Visitors are taking a more active part in school life. Whilst this is desirable it is also important that education, even of a health nature, should be carried out by precept and practice by the teachers themselves. In this connection it is important that teachers should have frequent and close contact with their medical and nursing colleagues so that they can in this way keep up to date the knowledge and information they gained as students.

It is pleasing to report that at last we have established our own Child Guidance Clinic which is held on one whole day a week in the Westgate Child Welfare Centre and the report of the Psychiatrist, Dr. Atkinson, indicates that the work is proceeding satisfactorily. However, it must be noted that a great part of the School Medical Officer's work is now concerned with emotional disturbance as this is by far the greatest trouble which afflicts children today. In addition to the emotional problems the other main concern of the School Medical Officer is the handicapped child and the School Clinic is rapidly becoming an assessment or diagnostic clinic for all kinds of handicap affecting the school child. In the future it is believed that this service will extend to cover the age range 0—18 years.

The reports of the Physiotherapist and Speech Therapist show the valuable work which is being done by them and also demonstrate how closely the School Medical Officers, Health Visitors and Clerical Staff have worked together as a team. It is only by acknowledging that it is now impossible in medicine for any one person to work in isolation that the good results referred to have been achieved. Also in this way each person has much more appreciation of the difficulties which have to be faced by their colleagues in what has now become popularly termed another discipline. If disciplines became too clearly separated, only disadvantage to the patient would result.

Medical Inspection of School Children:

The number of pupils on the registers at the end of the year is shown below together with the figures for the previous year:—

	1963	1962
Nursery	40	40
Primary	5,048	4,772
Secondary Modern	2,092	2,221
Secondary Grammar	1,374	1,448
Secondary Technical	477	479
Special Schools	98	89

Selective Scheme:

The selective scheme of medical examination of children in the intermediate age groups has now been in operation for three complete years and there is little doubt that it has been an unqualified success. Interest has centred as usual around the replies to the questionnaires, a copy of which will be found as an appendix to this report, which were issued to the parents of all children of approximately eight years of age. Seven hundred and seventeen questionnaires were distributed of which 99 per cent. were returned; none were mutilated or undecipherable. As a result of the examination of the completed questionnaires, 74 children were invited to attend for examination along with their parents and in 54 instances either one or other parent did in fact attend. Where the parent did not attend the examination was carried out by the School Medical Officer as planned. Naturally, had a formal objection been made this would not have been done but fortunately no such objections were received. In addition the School Medical Officers examined 359 eight year old children during the year and set out below are details of the defects found. It will be noted that the majority of these defects were visual, closely followed by discharging ears or other ear trouble. Since the introduction of the selective scheme all children between 12 and 13 years of age have been given a colour vision test by the Health Visitor at the same time as the routine test on visual acuity and doubtful cases referred to the School Medical Officer. Pupils are informed of any defect observed and a verbal invitation sent to parents to discuss the matter at the School Clinic. Head Teachers who have been furnished with a comprehensive list of occupations which exclude applicants who suffer from any defect of colour vision were also informed. The clinics which are held twice weekly at the School Clinic are becoming a more and more important part of the Selective Scheme. At these sessions children with defects discovered during earlier school medical inspections are examined and appropriate action taken as necessary. The majority of referrals came, as one would expect, either from the parent or the teachers, but others who referred were Consultants, General Practitioners, Health Visitors and Welfare Officers. It is thought that in this way the School Clinic is now

taking on the character of a diagnostic and assessment clinic with special emphasis on the child who has a handicap which might adversely affect his ability to derive benefit from education. This, it will be realised, is a wide field wherein we believe there is a great future for the expertly trained School Medical Officer. Later in the report will be found details of children who have been referred as maladjusted. Here again it will be noted that a large part of the work of the School Medical Officer now centres on psychological and behaviour problems. Along with the introduction of a closer working relationship between Health Visitors and General Practitioners has gone a slight change in practice in regard to the Health Visitor responsibility for the handicapped child. At the present time one Health Visitor with an assistant is responsible for the work in specific schools. However, should a child be discovered with a handicap requiring close care and attention it is the practice to refer that child to the Health Visitor attached to the patient's General Practitioner who is then responsible for the continuous supervision of his case. In this way it is thought that there is a greater degree of liaison between all concerned with the child's welfare. It is pleasing to observe that many General Practitioners are now much more appreciative of the important role that the School Medical Officer has to play in regard to handicapped children and are referring more children in order that arrangements may be made for their admission to an appropriate school where the most benefit will be derived.

Number of pupils inspected — 359

DEFECTS FOUND

Defect Code No.	Defect or Disease	Pupils Requiring Treatment	Pupils Requiring Observation
4	Skin	—	5
5	Eyes (a) Vision	20	63
	(b) Squint	2	18
	(c) Other...	—	4
6	Ears (a) Hearing	3	13
	(b) Otitis Media...	—	39
	(c) Other...	8	17
7	Nose and Throat	2	31
8	Speech	4	9
9	Lymphatic Glands	—	3
10	Heart	—	11
11	Lungs	4	30
12	Developmental—		
	(a) Hernia	—	—
	(b) Other...	—	—
13	Orthopædic—		
	(a) Posture	1	1
	(b) Feet	1	8
	(c) Other...	—	5
14	Nervous System		
	(a) Epilepsy	—	—
	(b) Other...	—	1
15	Psychological—		
	(a) Development	2	5
	(b) Stability	2	53
16	Abdomen	1	9
17	Other	2	4

TABLE I

MEDICAL INSPECTION OF PUPILS ATTENDING MAINTAINED PRIMARY AND SECONDARY SCHOOLS (INCLUDING SPECIAL SCHOOLS)

A. Periodic Medical Inspections

Age groups inspected (by year of birth), number of pupils examined in each, together with details of the physical condition of the pupils inspected.

Age Groups inspected (By year of birth)	Number of pupils inspected	Satisfactory		Unsatisfactory	
		No.	Percent. of Col. 2	No.	Percent. of Col. 2
1959 and later ...	46	46	100	—	—
1958	465	465	100	—	—
1957	185	185	100	—	—
1956	28	28	100	—	—
1955	3	3	100	—	—
1954	2	2	100	—	—
1953	8	8	100	—	—
1952	12	12	100	—	—
1951	6	6	100	—	—
1950	9	9	100	—	—
1949	291	291	100	—	—
1948 and earlier ...	489	489	100	—	—
Totals	1,544	1,544	100	—	—

B. Pupils Found to Require Treatment

Number of individual pupils found at Periodic Medical Inspection to require treatment (excluding Dental Diseases and Infestation with Vermin).

Age Groups Inspected (By year of birth)	For defective vision (excluding squint)	For any of the other conditions recorded in Table III	Total Individual Pupils
1959 and later	—	1	1
1958	8	36	43
1957	—	13	13
1956	1	3	4
1955	1	—	1
1954	—	—	—
1953	—	1	1
1952	5	3	7
1951	—	—	—
1950	2	—	2
1949	12	9	20
1948 and earlier	29	24	51
Total	58	90	143

C. Other Inspections

Number of Special Inspections	...	3,469
Number of Re-Inspections	...	1,846
Total	...	5,315

Comparative Table of Inspections carried out from 1959—1963.

Year	*Routine*	*Specials*	*Re-Inspections*
1959	2,812	2,636	1,522
1960	1,471	3,018	1,532
1961	1,641	2,865	1,464
1962	1,802	3,216	1,860
1963	1,544	3,469	1,846

Table II

Infestation with Vermin

(i)	Total number of individual examinations of pupils in schools by the school nurses or other authorised persons	12,588
(ii)	Total number of individual pupils found to be infested ...	470
(iii)	Number of individual pupils in respect of whom cleansing notices were issued (Section 54(2), Education Act, 1944) ...	3
(iv)	Number of individual pupils in respect of whom cleansing orders were issued (Section 54(3), Education Act, 1944) ...	—

Table III

Defects Found by Medical Inspection in the Year ended 31st December, 1963

Note.

All defects noted at medical inspection as requiring treatment are included in the following tables, whether or not this treatment was begun before the date of the inspection.

A. Periodic Inspections

Defect Code No.	Defect or Disease	Periodic Inspections							
		Entrants		Leavers		Others		Total	
		(T)	(O)	(T)	(O)	(T)	(O)	(T)	(O)
4	Skin	3	9	7	9	1	—	11	18
5	Eyes—a. Vision	9	24	41	149	8	6	58	179
	b. Squint	6	13	—	4	—	2	6	19
	c. Other	—	2	—	4	—	—	—	6
6	Ears—a. Hearing	—	16	—	3	1	—	1	19
	b. Otitis Media ...	2	12	1	4	—	1	3	17
	c. Other	2	2	3	1	2	—	7	3
7	Nose and Throat	1	69	2	9	—	—	3	78
8	Speech	25	18	3	2	1	—	29	20
9	Lymphatic Glands	1	5	—	—	—	—	1	5
10	Heart	—	10	—	19	—	—	—	29
11	Lungs	2	29	2	12	1	2	5	43
12	Developmental—a. Hernia ...	—	1	—	—	—	—	—	1
	b. Other ...	—	20	—	1	—	—	—	21
13	Orthopædic—a. Posture ...	1	—	4	—	—	—	5	—
	b. Feet	8	3	3	5	—	—	11	8
	c. Other ...	2	5	2	6	—	—	4	11
14	Nervous System—a. Epilepsy	—	3	—	1	—	—	—	4
	b. Other ...	—	2	—	2	—	—	—	4
15	Psychological—a. Development	—	7	—	2	—	1	—	10
	b. Stability ...	—	50	1	6	—	2	1	58
16	Abdomen	—	4	—	7	—	—	—	11
17	Other	1	7	4	13	2	—	7	20

B. Special Inspections

Defect Code No.	Defect or Disease	Special Inspections	
		Pupils Requiring Treatment	Pupils Requiring Observation
4	Skin	98	60
5	Eyes—a. Vision	234	944
	b. Squint	27	124
	c. Other	23	28
6	Ears—a. Hearing	26	112
	b. Otitis Media	32	94
	c. Other	42	48
7	Nose and Throat	44	218
8	Speech	100	108
9	Lymphatic Glands	2	16
10	Heart	10	68
11	Lungs	30	205
12	Developmental—a. Hernia	—	2
	b. Other	4	37
13	Orthopædic—a. Posture	17	19
	b. Feet	24	51
	c. Other	33	59
14	Nervous System—a. Epilepsy	4	13
	b. Other	—	20
15	Psychological—a. Development	89	145
	b. Stability	60	252
16	Abdomen	5	33
17	Other	69	59

Table IV

Treatment of Pupils

Notes

The figures given under this heading include:—

(i) cases treated or under treatment by members of the Authority's own staff;

(ii) cases treated or under treatment in the Authority's school clinics under National Health Service arrangements with the Regional Hospital Board; and

(iii) cases known to the Authority to have been treated or under treatment elsewhere.

A. Eye Diseases. Defective Vision and Squint

	Number of cases known to have been dealt with	
	1963	1962
External and other, excluding errors of refraction and squint ...	31	48
Errors of refraction (including squint)	244	247
Total	275	295
Number of pupils for whom spectacles were prescribed	206	232

During the year 228 cases of defective vision and 16 cases of squint were examined by the visiting Ophthalmic Surgeon. In addition 31 cases suffering from other conditions of the eye such as Blepharitis and Conjunctivitis were treated at the Minor Ailments Clinic.

After testing it was found that in 10 cases existing spectacles were considered to be satisfactory, in 145 cases spectacles were not thought to be necessary and 14 cases were referred to Bradford Eye and Ear Hospital.

The number of repairs to and replacements of spectacles amounted to 220.

B. Diseases and Defects of Ear, Nose and Throat

	Number of cases known to have been dealt with	
	1963	1962
Received operative treatment:		
(a) for diseases of the ear	2	3
(b) for adenoids and chronic tonsillitis	210	212
(c) for other nose and throat conditions	7	21
Received other forms of treatment	82	62
Total	301	298
Total number of pupils in schools who are known to have been provided with hearing aids		
(a) in 1962	2	
(b) in previous years	8	

Audiometric Survey:

The audiometric survey of the seven year old school child was continued during the year along with the examination of children in the " at risk " categories. As was thought last year the examination of children in the " at risk " categories produced more cases with defective hearing for a smaller number of tests carried out than did the routine examination of the seven year old. However, we still believe that both have a place in our scheme at least for the present. Of the twenty-one children referred to the Otologist for investigation eight had their tonsils removed, two had their adenoids removed and four had other forms of operative treatment. Three were referred to Bradford Eye and Ear Hospital for further investigation and the remaining four were kept under the observation of the Consultant. The table below shows the results which were obtained from testing with the pure-tone audiometer.

Children Tested by Pure-Tone Audiometry

	Number Tested	*No appreciable hearing loss*	*Referral for investigation*	*Already attending Otologist*
" At risk " categories				
(i) deafness in the family ...	3	3	–	–
(ii) prenatal causes:—				
maternal rubella	–	–	–	–
other conditions	–	–	–	–
(iii) perinatal causes *e.g.* toxæmia, anoxia, kernicterus, rhesus incompatability, prematurity, etc.	–	–	–	–
(iv) postnatal:—				
congenital defects ...	–	–	–	–
cerebral palsy	1	1	–	–
middle ear disease ...	22	10	9	9
meningitis or encephalitis	–	–	–	–
speech retardation or defect	14	13	1	1
educational retardation ...	120	111	1	1
Routine test on children in 6/7 year age group	469	462	6	6
Referred for possible hearing loss...	24	20	4	4
	653	620	21	21

C. Orthopædic and Postural Defects

	Number of cases known to have been treated 1963	1962
(a) Pupils treated at clinics or out-patient departments ...	174	176
(b) Pupils treated at school for postural defects	—	—
Total	174	176

Mr. Skinner, Physiotherapist, reports:—

" During the course of my work a number of children are referred to me, who, technically speaking, have no specific complaint for which they would normally be sent to a Physiotherapy Department. They are, in fact, cases that would in the usual course of events find their way to the Psychotherapeutic Department.

The children fall primarily into two groups. Those who suffer from extreme shyness and those with an aggressive tendency. Amongst these children we may find mild stammerers, bed-wetters and cases of obesity or general poor physical development. We have found that, by placing these children in our small classes where a combination of controlled physical movement and free expression to a basic design is practical, there often takes place a definite improvement.

The shy are encouraged, by the discovery of their latent physical abilities, to emerge from behind the protective wall they have thrown around themselves. The aggressive types, whose aggression is often to hide deep seated feelings of inferiority or rejection, tone down this trait as they also discover their own latent physical abilities.

Along with all this physical activity must, of course, run a great deal of encouragement and gentle disciplining. What one says to these children is dependent on the circumstances prevailing at the time. Spontaneity and sincerity are essential ingredients to success. The children will, as they settle into the environment of the class, confide in you and each other. From having four or five in a group with one odd one they gradually all become members of the group.

Having learnt to become members of a small group, with confidence they are ready to become members of the larger groups in normal school life. The great advantage we have in dealing with these children is that the classes are small and very personal. The child feels a member of it and not an outsider as is often the case where large groups are the rule.

Apart from the remedial classes held at the clinic, we made use of the special swimming class. Here again, we find that by succeeding in teaching a physical prowess a child's whole personality can improve."

The following shows details of the work undertaken by the Authority's Physiotherapist.

School Children	*No. of Cases*	*Attendances*
Anterior poliomyelitis	1	31
Asthma	9	109
Breathing	54	648
Bronchitis	1	19
Cerebral palsy	1	4
Curly toes	6	36
Flat feet	38	380
Hemiplegia	—	—
Kyphosis	—	—
Manipulations	12	128
Poor chest development	6	36
Postural drainage	7	96
Posture	34	375
Remedial exercises	3	50
Round shoulders	3	39
Scoliosis	1	31
Spastics	3	145
Pre-school Children		
Curly toes	3	28
Spastic	1	28

Consultant Orthopædic Clinic :
Number of sessions held 9

	Pre-school Children	*School Children*
Number of individual patients seen by consultant, including those continuing attendance from previous year ...	6	22
Number of above—		
(a) referred for operative treatment as short-stay cases only	—	—
(b) recommended long-stay hospital school	—	—
(c) recommended treatment by orthopædic nurse or physiotherapist—		
(i) at treatment centres	1	3
(ii) domiciliary	—	—
Number of children who obtained operative treatment during the year	—	—
Total number of attendances at consultant clinic	6	40
Treatment Centres:		
Number of sessions held 500		
Total number of patients treated (including cases continuing treatment from previous year)	5	174
Total number of attendances	56	2,187
Domiciliary Treatment:		
Total number treated	1	—
Total number of visits to patients' homes	5	—
Appliances:		
Number of appliances—(a) recommended	—	—
(b) obtained	—	—

D. Diseases of the Skin (excluding uncleanliness for which see Table II):

	Number of cases known to have have been treated	
	1963	1962
Ringworm—(a) Scalp	—	—
(b) Body	1	1
Scabies	7	13
Impetigo	24	30
Other skin diseases	26	40
Total	58	84

As in previous years a large part of the work carried out at the minor ailments clinic consisted of the treatment of cuts, abrasions, septic fingers and skin diseases.

E. Child Guidance Treatment:

	Number of cases known to have been treated	
	1963	1962
	26	—

Pupils treated at Child Guidance Clinics:

Arrangements were made for a number of children to attend the School Clinic for a wide range of behaviour disorders and the table set out below shows details of the pupils examined for these conditions and also for educational subnormality. Many who are referred for a behaviour disorder either of the aggressive or withdrawn type are often found to be educationally subnormal with an associated emotional disturbance. Conversely, other children are referred for retarded attainment and are found to be of average or above average intelligence but suffering from an emotional disturbance. This latter group includes several adolescents attending selected schools. In nearly every case there is a history of parental rejection or inadequacy, family disintegration or parental separation. Cases of straightforward educational subnormality are rare; there is usually an associated maladjustment. However, there have been two cases of children with I.Q.s in the subnormal range who have been provided with special educational treatment in the ordinary school, both have shown good personality development and social adjustment so that they have been able to make educational progress. The behaviour disorders which have been treated at the School Clinic have included cases of school phobia, school resistance, delinquency or incipient delinquency, rejected and emotionally disturbed children and mismanaged or inadequately managed children. Individual psychotherapy and counselling of parents has been carried out by the School Medical Officer and group therapy and physical rehabilitation by the Physiotherapist. The Speech Therapist has treated children with communication and reading where this has been indicated and Health Visitors and School Nurses have assisted in matters concerning general hygiene and home environment. From this it will be seen that all members of the staff have worked together in an excellent manner as a complete team.

These cases were seen by appointment at special sessions and it is estimated that approximately 400 hours were spent on examination and/or treatment by the School Medical Officer. This estimate does not, however, include time spent on case conferences, telephone conversations and the writing of reports. Many other cases of a doubtful psychiatric nature, e.g. nocturnal enuresis and skin conditions, were dealt with at the routine school clinics. Ninety-seven new cases were examined at the School Clinic and 81 old cases carried over from the previous year; 12 of the new cases and 9 of the old cases were referred to the Child Guidance Clinic; 4 of the old cases were already under the surveillance of a Consultant Psychiatrist.

The table referred to, taken in association with the findings of the routine medical examinations, shows that the trend referred to earlier for the School Medical Officers to spend a greater part of their time in dealing with mental health and behaviour problems continues.

New cases seen in 1963: 97

Referred by		*Reason*		*Recommendation*	
Pædiatrician	5	Behaviour disorder	51	School Clinic and Voluntary Care and Guidance	2
School Welfare Officer	2	Retarded scholastic attainment	36	School Clinic and referred to Pædiatrician	3
Head Teachers	45	Physical handicap	10		
Borough Education Officer	4			School Clinic and referred to Psychiatrist	12
Chief Education Officer	1			School Clinic and transfer from Grammar to Secondary School	1
Chest Physician	2			Home Tuition	3
Parents	16			Observation in School	3
Health Visitors	4			Special Education in Ordinary School	6
School Medical Officer	7			Change of school	1
N.S.P.C.C.	1			School Clinic and Convalescence	1
Probation Officer	5			School Clinic and Home Tuition	1
General Practitioner	1			Observation at home	1
Speech Therapist	4			School Clinic and Special School	15
				Unsuitable for Education	1
				School Clinic	47

Total time spent: 219 hrs. 30 mins.

Old cases seen in 1963: 81

Referred by		*Reason*		*Recommendation*	
Pædiatrician	4	Behaviour disorders	29	School Clinic, Care and Guidance	8
Head Teachers	19	Retarded scholastic attainment	34	School Clinic and referred to Pædiatrician	1
Borough Education Officer	1	Physical handicap	18		
Chief Education Officer	4			School Clinic and referred to Psychiatrist	9
Parents	14			Home Tuition	4
Health Visitor	2			Observation in School	3
School Medical Officer	29			Special Education in Ordinary School	2
Probation Officer	2			Observation at home and Special School	1
General Practitioner	2			School Clinic and under care of Psychiatrist	4
Speech Therapist	3			Re-ascertained as unsuitable for education	1
Magistrates	1			Special School	21
				Unsuitable for education	1
				School Clinic	26

Total time spent; 153 hrs. 30 mins.

During the year we succeeded at last in setting up a Child Guidance Clinic at the Westgate Child Welfare Centre.

Dr. Atkinson, Psychiatrist, reports:—

" The clinic was started in March, 1963, and was held for one session each week at first. However, the case load built up so rapidly that the weekly number of sessions was doubled six months later and has continued at two. This has proved a reasonable amount of time for cases referred.

Most referrals come through the School Health Service but two cases have been referred directly by General Practitioners and two by the Pædiatric Consultant and we welcome their interest in the establishment of this clinic and any further cases they may wish to refer.

There have been a variety of problems, including organic conditions, but no psychotic children. Most of the problems have been emotional, neurotic and behaviour disorders. Amongst these are the effects of adverse social conditions and in these cases we can often do little to help because we cannot alter the fundamental cause of the disturbance.

Treatment has been on the usual lines of psychotherapy of children—counselling of parents and, where possible, changing an adverse environment—3 cases have been recommended for residential treatment. The General Practitioners have been most co-operative where drug treatment was considered advisable and I thank them for this.

Mrs. Berry, Mental Welfare Officer, has acted as Social Worker and Secretary and has been of considerable assistance. Dr. Gledhill has kindly undertaken to carry out intelligence tests when necessary in the absence of a psychologist and I thank her for this and for the assistance she has given with the cases in other ways.

Finally, I would like to thank Dr. McDonagh and his staff for the support and help which have made this new venture in Keighley a success."

Location of Clinic.
Westgate Child Welfare Centre,
Oakworth Road,
Keighley.

Number of sessions held during year 52

	Boys	*Girls*	*Total*
Number of new cases seen during year	15	11	26
Number of cases referred from previous year	—	—	—
Total number of cases discharged or admitted for residential treatment	3	4	7
Number of cases carried forward	12	7	19

F. Speech Therapy:

	Number of cases known to have been treated	
	1963	1962
Pupils treated by speech therapist	202	186

Miss Barker, Speech Therapist, reports on some examples of the different types of case who attend for speech therapy other than those who suffer from a specific speech defect:—

" A child with defective S (sigmatism) was soon corrected, but he demonstrated inability to read (alexia) and corresponding difficulty in spelling. He continues to attend and make progress.

A child with acute self-consciousness about his speech which is said to have deteriorated since starting school: defective sounds are not many (dyslalia) but his co-operation is so poor assessment is difficult as yet, after three visits to the Clinic his mother reported that he had more confidence at home.

Those who fail to respond to treatment: they seem perfectly able to correct defective S (lateral sigmatism) but do not carry this over into everyday speaking. Behaviour might be withdrawn or aggressive.

An Italian child (whose parents speak no English) has no specific sound defect but his English vocabulary and language are poor. He is of low average intelligence and retarded in scholastic attainment. His failure to communicate is considered to be a major contributing factor to his retardation.

Children with difficulty in imitating speech sounds when hearing and perception and swallowing are normal (articulatory dysphasia). Two patients treated have had additional difficulty in reading and spelling: they continue to attend and their attainment improves.

Boys hoping to attend or attending the Grammar School—who have poor communication—poor diction and poor voice production.

Children at E.S.N. Schools who may not only have defective sounds (dyslalia) but also difficulty in putting such thoughts as they have into coherent conversation.

Children under the care of the Child Psychiatrist may have an infantile pattern of speech, *e.g.*,a lisp and a tendency to tongue thrust, or the use of W for R and L (dyslalia). They may also be enuretic."

The following shows details of the work undertaken by the Authority's Speech Therapist:—

Total number of sessions held during year	392
(a) Number of new cases treated during year	81
(b) Number of cases already attending for treatment from previous year	121
(c) Total number of cases treated (a + b)	202
Number of cases awaiting treatment at end of year	96
Number of visits made to schools	1
Number of home visits	—

Analysis of Cases Treated during the year:	*Boys*	*Girls*
Stammering	24	5
Defects of articulation—		
(a) Dyslalia	71	38
(b) Sigmatism	10	4
(c) Rhinolalia, due to (i) Cleft palate	2	—
(ii) Nasal obstruction	1	2
(d) Dysarthria	3	1
Aphasia	—	—
Defective speech due to (i) Educational subnormality	25	13
(ii) Deafness	—	2
Retarded speech development	1	1
Dysphonia	—	—
Other defects—Dysarthria	3	1

Analysis of Cases Discharged:	*Boys*	*Girls*
Number of children discharged	41	25
Speech normal	12	10
Speech improved	15	6
Unsuitable for treatment	—	—
Non-co-operation	7	4
Left school	6	4
Left district	1	1
Other reasons	—	—

G. Other Treatment Given:

	Number of cases known to have been treated	
	1963	1962
(a) Pupils with minor ailments	493	318
(b) Pupils who were admitted for convalescent treatment under School Health Service arrangements	7	5
(c) Other than (a) and (b) above—Ultra Violet Light	34	33
Pupils who received B.C.G. vaccination	330	232
Total	864	588

Of the 34 school children who received ultra violet light treatment at the School Clinic 9 were still under treatment at the end of the year. Through the interavailability of clinics 4 pre-school children received ultra violet light treatment and of these 2 were still under treatment at the end of the year. Altogether 90 sessions were held at the School Clinic and 794 attendances made.

Care of the Handicapped Child:

Details of the number of handicapped pupils are given in the following table:—

TABLE V

	New Ascert-ainments	Re-Ascert-ainments	New placings in Special Schools	Total No. attending Special Schools		Number awaiting placement in Special Schools	Number receiving home tuition
				Day	Boarding		
Blind Pupils	—	—	—	—	1	—	—
Partially Sighted Pupils	1	—	1	3	—	—	—
Deaf Pupils	2	—	2	2	6	—	—
Partially Deaf Pupils	2	—	2	5	—	—	—
Educationally Subnormal Pupils	12	9	15	98	2	—	—
Epileptic Pupils	1	—	—	—	—	1	—
Maladjusted Pupils	2	—	—	—	10	1	2
Physically Handicapped Pupils ...	2	—	4	1	7	1	1
Pupils suffering from Speech Defect	—	—	—	—	—	—	—
Delicate Pupils	2	—	1	—	2	—	1
Total ...	24	9	25	109	28	3	4

BRAITHWAITE DAY SPECIAL SCHOOL:

Ninety-eight children were attending the Braithwaite Day Special School at the end of the year as against 91 for the previous year. Nineteen extra district children are now attending this school, the remainder being referred from schools situate in Keighley. There is a waiting list for admission to this school.

The school is satisfying a much felt need and the teachers there are undoubtedly doing valuable work in ensuring that these handicapped children are given as much education as possible to fit them for their future life in the world.

MENTALLY SUBNORMAL CHILDREN:

Two children were reported as being " unsuitable for education in school " under the provisions of Section 57(4) of the Education Act, 1944, as amended and eight children as requiring " care and guidance ".

Nutrition:

Arrangements were continued for the issue of branded foods free of charge to appropriate cases. The distribution of such foods is made on the authorisation of the School Medical Officer who examines each case prior to an issue being approved. The following foods were distributed during the year:—

	1963	*1962*
Ferromyn Tablets	129	70
Halibut Liver Oil Capsules	56	140
Maltoline—8oz. tins ...	1	–
Minadex—4oz. bottles ...	139	115
Vitamin B Tablets	232	48
Vitamin C Tablets	40	–

Nocturnal Enuresis:

During the year six children suffering from nocturnal enuresis were provided with an Eastleigh Warning Device on loan and two were continuing under treatment at the end of the year.

Protection of School Children against Tuberculosis:

TUBERCULIN TESTING OF SCHOOL ENTRANTS:

Tuberculin testing of school entrants was introduced in order that in the case of a positive result it would lead to a search for a source of infection and at the same time secure the placing of the child under medical supervision in order to avoid the risks which follow primary infection.

The following shows details of the work undertaken under the provisions of this scheme:—

No. Invited	Refused	Absent	Previously Examined	Negative	Positive
793	85	181	23	494	10

Of the ten cases found to be positive four had been previously vaccinated with B.C.G. and the remainder were referred to the Chest Physician for supervision.

B.C.G. Vaccination of Older School Children:

The scheme for the vaccination against tuberculosis of older school children continued during the year, details of which are set out below:—

Number of Medical Officers approved to undertake B.C.G. Vaccination	3
Acceptances—	
Number of children offered tuberculin testing and vaccination if necessary, whether the offer was made during the year or previously	790
Number found to have been vaccinated previously	4
Number of acceptances	389
Percentage of acceptances	49·5
Pre-vaccination Tuberculin Test—	
Number of children tested	384
Result of Heaf Test:	
(i) Positive 54; (ii) Negative 330	384
Percentage positive	16·4
Vaccination—	
Number vaccinated	330

Infectious Diseases — Diphtheria:

Towards the end of July two cases of mild diphtheria occurred due to an atypical corynebacterium. One was in a child attending the Keighley Training Centre and the other in a school child. Intensive mass swabbing was carried out both in the Training Centre, the original school where the case arose and several other surrounding schools, as a result of which three more cases and twelve carriers were discovered and admitted to the infectious diseases hospital. The cases were mild and it is thought would have been difficult to diagnose but for the knowledge that the organism was present in the area. Swabbing of the schools continued until the Christmas holidays and recommenced afterwards. At the time of writing (April) the incident had produced a total of eight cases and 47 carriers.

As the organism would appear to be widespread throughout the schools it was clearly important that the children, especially small children, should have a good immunity. With this in mind the parent of every child appearing for the school entrance examination was asked to agree to a primary course of immunisation or a booster dose being given and this was done immediately at the end of the session.

Health Education:

Health education activities in schools have continued to develop during the year and most of the Health Visitors now undertake a routine teaching session in the Junior Schools where the syllabus consists of health subjects. In the first instance the courses were designed to last for six sessions but it is now found that a full term is required. This year we have also introduced two experimental

teaching groups in Secondary Schools both at the request of the Headmasters concerned. These classes have proved most interesting as they contain children from the lower academic streams and who therefore might become the problem family parents of tomorrow. Our aim has been to give them an insight into the difficulties of home-making; for example, budgeting on a weekly basis for a whole family; the setting up of a home including such difficult and common questions as hire purchase. The Health Visitors have also given talks on human relationships and motivations. Discussions on positive mental health and happiness and the effect of the atmosphere in the home have provoked great interest in the children.

In March the Central Council for Health Education mobile unit spent three days in Keighley during which time eight schools were visited. In addition to this the Health Visitors have tried to pay at least one visit to each school during the year to give instruction on the dangers of smoking. The emphasis has, however, continued to be placed on the ten and eleven year olds in the Junior Schools and the twelve and thirteen year olds in the Senior Schools. Posters and leaflets on this subject have been widely displayed in General Practitioners' surgeries as well as in the Authority's own premises.

Medical Examination of Entrants to Training Colleges:

Fifty students were medically examined in connection with their applications for entry to Training Colleges as compared with fifty-four in the previous year.

Children and Young Persons Act, 1933, Employment of Children:

Fifty-seven children were examined by School Medical Officers to determine their fitness for employment under the Authority's bye-laws relating to the employment of children as compared with 86 in 1962. The above figures include those children taking part in entertainments. No children were found to be unfit.

Dental Inspection and Treatment:

The arrangement as regards the dental inspection of pupils is that as far as possible:—

(a) Every pupil who is admitted for the first time to a maintained school shall be inspected by a dental officer as soon as possible after the date of admission, and

(b) Every pupil attending a maintained school or County College shall be inspected by a dental officer on such later occasions as may be practicable and necessary.

Details of the inspections and treatment carried out in connection with this service are given in the following table.

TABLE VI

	1963	1962
Number of pupils inspected—		
At periodic inspections	983	844
As specials	1,167	1,442
Total ...	2,150	2,286

	1963	1962
Number found to require treatment	1,819	1,998
Number offered treatment	1,801	1,990
Number actually treated	1,723	1,850
Number of attendances	4,799	4,763
Half-days devoted to: Periodic (School) Inspection	10	7
Treatment ...	474	468
Total ...	484	475
Fillings: Permanent teeth	3,443	3,347
Temporary teeth	41	81
Total ...	3,484	3,428
Number of teeth filled: Permanent teeth	3,386	3,280
Temporary teeth	40	74
Total ...	3,426	3,354
Extractions: Permanent teeth	1,074	957
Temporary teeth	1,237	1,569
Total ...	2,311	2,526
Administration of general anæsthetics for extraction ...	499	529
Orthodontics—		
Cases commenced during the year	36	20
Cases carried forward from previous year	42	45
Cases completed during the year	35	20
Cases discontinued during the year	3	3
Pupils treated with appliances	83	65
Removable appliances fitted	81	54
Fixed appliances fitted	—	—
Total attendances	479	368
Number of pupils supplied with artificial dentures	35	39
Other operations: Permanent teeth	997	1,385
Temporary teeth	287	293
Total ...	1,284	1,680

V. P. McDonagh
Borough School Medical Officer

HEALTH RECORD

Child's full name.....

Date of birth..... Name of Family Dr.....

Any information given below will be regarded as strictly confidential and will be seen only by the School Doctor and his staff.

Please read " he " as " she " where applicable.

1. How many sore throats has he had in the past twelve months ?

   .....

2. Has he suffered from earache or a running ear, in the last twelve months ? (Answer Yes or No)

   .....

3. Has your child suffered from defective hearing ?

   .....

4. Has he had any chest trouble in the last twelve months ? (Answer Yes or No)

   .....

5. Is he energetic ? (Answer Yes or No)

   .....

6. Underline any of the following complaints if your child suffers from them:— nail-biting, twitching of face, jerking of shoulders, nightmares, bed-wetting.

7. Has he had any illnesses (including accidents) when he has had to stay in hospital ? (Answer Yes or No)

   .....

   Nature of Illness or Injury Age Length of time in hospital

   ....

8. Is he at present under treatment for any condition? (Answer Yes or No)

   ....

   If yes, please state its nature.....

   Have you any special worries about your child ?

   .....

   .....

   .....

Signed.....Parent or Guardian

.....Date

SUMMARY

Although there have been few major changes in the School Health Service during 1963 various developments have occurred or have been planned for early development.

Screening of Hearing

All Divisions now have one audiometer and it is intended to increase the provision so that there should be no difficulty in carrying out routine hearing tests on all children after entry to school. The significance of hearing loss to the child is receiving much attention — nurses, doctors and teachers are being encouraged to watch carefully for children who may have some degree of hearing impairment.

Training of Medical Staff

New medical officers are sent on the courses for mental ascertainment after a period of instruction by an experienced member of the staff. Other medical officers are to be sent on courses dealing with the problems of maladjustment and hearing impairment. It is hoped that this policy will result in one medical officer in each Division having an interest and some special training on one of the particular problems of the handicapped child.

Child Guidance Service

The resignation of one consultant psychiatrist has resulted in depletion of staff. Plans are being developed for the increase in personnel of psychologists and psychiatric social workers. Further secondment of medical staff from the County is being considered.

Special Educational Treatment in the Ordinary School

There remains a great need for extension of special facilities in the ordinary school as outlined in Circular 11/61 of the Ministry of Education. The School Health Service has an important part to play in the ascertainment of the types of defects and special needs.