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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 1965

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

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(as at 31.12.65)

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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, 1963; 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

My report for 1964 dealt at length with a policy for co-operation with general practitioners by way of staff attachment and joint user premises. This scheme based on the policy adopted by the County Council and summarised in *Future Developments in the Health Service and Co-operation with General Practitioners* has been pursued as fast as circumstances have allowed with a reasonable degree of success and which has been reported from time to time in various publications. Information has also been given to general practitioners and our own staff through the medium of a quarterly issue of *Health Notes* as to how this general policy is being implemented. Perhaps we can now leave this part of the County policy to develop of its own momentum and I feel perfectly certain that the next few years will see even more progress. It has been remarkable to see how the general idea of a 'get together' between local health authorities and general practitioners has become so quickly accepted. Only twelve months ago there was a good deal of controversy; some little may still exist, but it has largely evaporated and there seems to be an increase in goodwill on both sides for further joint endeavours.

Health Department Reorganisation

That part of the County policy concerning co-operation with general practitioners which has still to be implemented deals with the effect of such a policy on the staffing and duties of the department. It must be obvious that such profound changes must have their repercussions on the department's staffing and training. Just as general practitioners are about to embark on new ideas in general practice, including co-operation with local health authorities, and which has resulted from their recent review, so must we in Local Government do some new thinking. We cannot expect to come out of all this unchanged if we are to fulfil our community function of joint action with general practitioners. We are part of the community service in just the same way as the general practitioners and the two must go together. If we accept this as an admirable aim we must also accept the inevitability of alteration in our own services. It will take some little time to reorganize to meet this challenge but a start has already been made in the department by way of discussions on the future duties of medical officers. A good deal of enquiry into the changing pattern of activities within the department and a tentative scheme of re-training and re-allocation of duties has been drawn up and favourably received by the medical staff. Similarly we are looking at the duties of the nursing staff and any necessary requirements for auxiliary help, including the use of social workers in the department. This in turn will need a reorganisation of administrative staff and methods. It is hoped that within the course of the next twelve months to formulate these changes in a concise report in order that the Health Committee may consider this new policy and its financial and establishment repercussions. In dealing with reorganisation on this scale we have had to ask ourselves many questions and attempt to reach logical conclusions with the experience we have so far gained and with our anticipation of changes in the future. The following are some of the points at issue:—

Owing to the change in pattern of diseases over the last 50 years during which the present pattern of working has developed, are we now carrying out a

certain amount of unnecessary work which needs a general reappraisal and possibly the bringing in of less qualified staff to release the others for more detailed work?

Can we not now after several years of experimentation reorganise our school health programme based on selective examinations, as well as cutting out such things as minor ailment clinics which are now poorly attended, and concentrate on the handicapped pupil by way of more detailed assessment?

Changes will be inevitable in any case because of the shortage of staff of all types, which is not likely to get any better particularly in this highly competitive world where more and more openings are becoming apparent for available manpower.

How far are we going to be involved with population screening tests? We have already had some experience of this with tests for phenylketonuria, congenital hip disease, and now more recently cervical cytology. Further developments on these lines are bound to affect staff and their training.

It might be thought that since we have an improved general health that attendance at infant welfare clinics would decline; the opposite is in fact true. Why is this so and how can we use this phenomena to the best advantage? Could it be that the psychological aspects of a young family are now more important than the presence of physical disease, and is there not here an avenue for our staff to explore further?

We have heard much recently about improving family social services in order to combat the development of problem families with their inherent insecurity which may lead to delinquency. All social service departments, including health, must gear themselves to this new problem, but I am sure there is a great future here for the skills concentrated in large measure in health departments if these are suitably orientated. Also the advisory services for young people need to be greatly strengthened in an attempt to prevent social deterioration.

These are some of the problems which have to be met and overcome and which have been the basis of our thoughts on reorganisation. They may well be the basis of a pattern for a new public health. The development of such ideas and the reorganisation which will then become necessary should lead to added interest in the professional life of the public health worker and to his greater value to the community.

It is along such lines that the Seeborn Committee on Local Authority and Allied Personal Social Services has directed its attention for an improved family service. It will be seen that the issues are complex. This Committee has collected evidence directly from West Riding officers and members and we have all been very glad to give assistance. It is to be hoped that although the subject is a difficult one the Committee will be able to give a balanced recommendation in spite of the speed with which they are being obliged to work.

Medical Staff

One of the more welcome investigations being carried out at the present time for the Government is that being conducted by the Royal Commission on Medical Education. This is long overdue. It has been obvious for a number of years that the preparation of the medical student for his future career is now based on old fashioned concepts which have been overtaken by the advance of

medical and social science. From the point of view of public health there has been a sad deficiency of knowledge and practically no experience of what happens in a health department as far as the newly qualified doctor is concerned. The importance of preventive medicine has only recently been given any sort of recognition in a few of our medical schools. Since preventive medicine and its allied auxiliary services play such a big and increasing part in the life of the community this must be changed. It has also become apparent that post-graduate methods must be improved, not only for those intending a hospital career or a career in general practice, but for those who want to go into public health. Some action is being taken so far as general practice and hospital services are concerned, but there is little at the moment on the public health side except on a very tentative experimental basis.

These things must be speeded up since recruitment into public health is at a low ebb. Our strongly developing links with general practice make it a necessity, for more specialisation by doctors in the public health field and lends added urgency to this problem. A few facts about the West Riding situation may be of interest:—

A recent analysis of the recruitment statistics for senior assistant and assistant medical officers between 1954 and 1966 has been carried out and the period has been divided into two. Between 1954 and 1960, 123 candidates were interviewed and 70 were appointed. Between 1961 and 1966, 83 candidates were interviewed and 62 appointments were made. Two interesting points emerge. First, the diminution in the number of candidates suitable for interview and the fewer number of appointments made, both of which show that contrary to what was experienced by most of the older members in public health the competition for posts and the choice amongst suitable candidates is much less.

Converting these figures into percentages it will be seen that in the period from 1961 to 1966, 75 per cent. of candidates were appointed, whereas only 57 per cent. of candidates were appointed in the earlier period. This illustrates the considerable lessening of choice in a period of only a few years.

The County Council has accepted its obligation by seconding assistant medical staff for training for the D.P.H. and indeed in roughly the same period of time to which the above figures relate some 40 doctors have been assisted through the County Council scheme to take the Diploma. We are attempting to follow up these doctors and see how they have fared in a public health career and we hope that this will lead us to some interesting conclusions. So far there does not seem to have been any similar shortage of candidates for senior posts.

Vital Statistics

The exactness of this science is now well appreciated from a technical point of view, but since the subject is built up of matters of life and death the deductions to be drawn from them are not always quite so clear, leaving us with a considerable feeling of uncertainty on occasion.

As long ago as 1790 Malthus was deeply disturbed by the possibility of the increasing population of the world being completely unable to feed itself; he was no doubt right as far as he could judge at that point in time. Since then, however, compensations have occurred to make his gloomy forecast less acute. Improved agricultural methods and communications warded off to some extent what appeared to be inevitable.

Very recently the subject of over-population has once again been the cause of concern, and this in spite of the report of the Royal Commission on Population in 1949. At that time the estimates of the future population were reflected in para: 248(i) which reads as follows:—

“ Total numbers will continue to grow in the near future, perhaps even for another generation. The growth will not be rapid, and the further addition to the population which can be expected is not large.”

Compared with this statement the vital statistics for 1965 illustrate once again how difficult it is to forecast population trends.

The birth rate in the Riding in 1965 was 18·2 per thousand, whilst the death rate was 11·6 per thousand—a net gain of 6·6. This net gain alone is approximately half the total birth rate in 1959, only six years previously. It is true that the West Riding is not growing as rapidly as some other parts of the country, but even here the difficulty of estimation of the future needs of the social services is apparent.

A further indication of population pressures in this country, which is already the second most densely populated of the world, is illustrated by the fact that our West Riding stillbirth rate, neonatal mortality rate, infant mortality rate, and the infant mortality rate under the age of one week, are the lowest ever achieved, and this in spite of the high birth rate. Similar trends are apparent in other areas.

On the other hand the birth rate has slightly declined within the last twelve months. Is this an indication that it will continue to decline or is this just a slight deviation in a general trend upwards? More imponderables come to mind and the picture becomes more confused when we consider the possible effect of oral contraception and intra uterine devices on the birth rate. It is estimated that already at least half a million women in this country are taking ‘the pill’. All this makes it difficult to plan ahead—in fact the population trends seem to be able to change more rapidly than we can formulate our needs for the future.

Family Planning

It is an easy step from the consideration of vital statistics to family planning. Indeed, the Ministry of Health has during the past year drawn our attention to this subject in Circular 5/66. In many ways the County Council have for years been doing what are the broad recommendations of this circular, namely, allowing the use of some of our clinic premises free of charge by the Family Planning Association for its sessions, and at the same time giving a small grant to cover the cost of the services given to cases in medical need of contraception advice. The widespread use of oral contraceptives and the advent of cervical cytology has increased the work of the Family Planning Association, and there is now pressure for further facilities to be made available to them by the County Council.

No changes in the law are envisaged so that it is up to the County Council to decide whether in fact they are already fulfilling their responsibilities or whether further expansion of the service is needed. A review of our position is also rendered necessary because of a possible extension of service to meet the needs of problem families and the fact that those services already offered to

medical need cases may need to be made free of charge to the patient. There is also the difficult question of deciding what is medical need and whether its usual meaning of physical or mental disorder shall be extended to social disturbances.

Owing to the reorganisation of the Family Planning Association branches in Yorkshire there has been a delay in arranging joint consultations between the Association and the County Council, but this is likely to be done soon after the appearance of this report.

Computers

It has now become possible to take practical steps to present health department matters to the computer. This has been mentioned in my reports in previous years as an aim to achieve, but we are now getting near to showing results. Within the next few months we shall start programming three separate activities of the health department as a first step in computer usage—more will undoubtedly follow. Our first task will be in connection with vaccination and immunisation procedures whether done by health department staff or by general practitioners. The next stage will be the programming of dental data followed by the contract work of the training centres for the mentally subnormal. The use of the computer is not only intended to ease the clerical burden, although eventually it will do so. Indeed in the early stages more clerical effort will be required in programming and in the eradication of faults as we see them develop in the two pilot vaccination and immunisation schemes which are to be done in the first instance in two divisions.

We are looking forward very much to this new type of assistance, not only to the general practitioner but to the parents of young children. I am very grateful indeed to the Treasurer and his staff for the considerable help he has given us in this field.

Infectious Diseases

A most interesting development during 1965 and early 1966 was the work of a group of doctors on the administrative measures to be taken on the control of smallpox. This Working Party was set up by the Medical Officers of Health Liaison Committee of the Leeds region and consisted of medical representatives from the Regional Hospital Board, County Councils, County Borough Councils, District Medical Officers of Health and the Public Health Laboratory Service. It was stimulated into activity by the memory of all of us in this region of the smallpox outbreak in 1962, a number of scares since, and the memorandum on the Control of Smallpox issued by the Ministry of Health in 1964. Some of the conclusions of the Working Party which were accepted by the Medical Officers of Health of the Leeds region and the other participants may be of interest:—

1. On the occurrence of a case of smallpox an advisory committee constituted as follows should be convened—

The members of this Working Party as currently constituted or amended by the Medical Officers of Health Liaison Committee.

The medical officer of health of the county borough or county district where the case has occurred, the medical officer of health of the appropriate county council, and the medical officer of health of any other county borough closely concerned.

This Committee should be available to advise the Public Health Laboratory Service and/or other authorities on—

- (a) Vaccination policy in districts adjoining an area where smallpox has occurred.
 - (b) The availability of vaccine lymph for issue to general practitioners for general vaccinations.
2. The arrangements should continue whereby the West Riding County Council Ambulance Service is responsible for admitting all patients destined for Oakwell Hospital and the Hull County Borough Ambulance Service for admitting all patients destined for Castle Hill Hospital.
 3. Medical officers of health in the region should contact the Leeds Public Health Laboratory before sending specimens to any other Laboratory.
 4. A senior medical officer from the appropriate county authority should be made available to carry out liaison between the authority primarily involved and other authorities, and with the Press if desired by the medical officer of health concerned with the incident.
 5. Whenever possible authorities should prepare an internal operational plan and exchange information about it with other authorities, at an early date.

It is hoped that by this means a concerted approach to a smallpox problem, which never confines itself to local government boundaries, will help all medical officers of health in what can be a very difficult situation. The full report gives the reasons for these recommendations which are designed to assist the hard pressed medical officer of health dealing with a smallpox outbreak at a time when he most needs help.

Since this report was issued it has also been considered by the medical officers of the Sheffield regional area who have also accepted it in principle, and the details as applicable to the Sheffield region are currently being worked out. For my part I am very pleased that we now have an agreed system on both sides of the Regional Hospital Board boundary which divides our County.

It might have been expected when the recommendation to carry out primary vaccination in the second year of life was introduced, as against the previous system which involved vaccination at a very early age in the first year, that this would cut down the vaccination rate. In fact as far as the West Riding is concerned this has not been so, and indeed the vaccination rate has continued to increase and seems to have confounded all expectations. There have been no complications from vaccination throughout the year; whether this is due to the shift of emphasis on vaccination from the first year to the second year it is too early to say. A number of years experience will be needed to enable us to be certain, but the result so far is encouraging.

Food poisoning, on which for many years we have had to report regularly an increased incidence, has shown for the last few years a downward trend. Improved handling techniques, more health education and the steady persistent work of the Public Health Inspectors are undoubtedly responsible for this

change of fortune which has taken place in spite of the increased prevalence of community feeding.

I would also like to draw attention to some work carried out by Dr. W. M. Douglas of Division 17. He was worried about the results he was obtaining in his tuberculin testing scheme using the Heaf technique and the large number of false positives he felt he was getting. He did comparative tests over a period of a year using Mantoux and Heaf techniques and feels he has now proved his point and indeed has now reverted to Mantoux testing using disposable syringes. This work is mentioned for interest to others who may be considering this problem.

Mother and Child

As a method of investigation into the wastage of infant life the Population Statistics Act, 1960 is beginning to show some results. Under this Act a doctor or midwife records for each stillbirth the cause of death, the duration of pregnancy and the weight of the child. From the results collected in this County so far it would appear that the major causes of stillbirths are placental and cord conditions, diseases and conditions of pregnancy and childbirth, followed by congenital malformations. It would seem too that some 55 per cent. of stillbirths are premature. These indications should help to direct our attention to devising methods either clinically or administratively which will improve the situation. It is only by such more detailed analysis as this that further progress can be made because the overall death rates hitherto relied upon are now becoming so low as to have lost a good deal of significance. This we have already experienced with the maternal mortality rate where a few isolated unfortunate incidents can vitally affect a statistical rate. Incidentally only 5 maternal deaths occurred in the County during 1965 and only one of these was due to toxæmia. This represents tremendous progress in the course of a generation. Now we can see the child death rates following a similar pattern as is shown on the graph on page 90.

Rapid changes are occurring in antenatal and maternity work. More general practitioners are using our clinics for their own antenatal patients. The numbers are growing each year and in each case domiciliary midwives are in attendance. This developing team spirit is very gratifying. As to the future of actual deliveries the trend continues towards hospital confinements. In the course of last year the percentage in the Leeds region rose from 74 to 76 and in the Sheffield region from 57 to 60 per cent. and at the same time the number of confinements carried out by domiciliary midwives fell by 1,028.

The time has now arrived for the serious consideration of the future of domiciliary midwifery and whether it should not now be linked with the hospital and general practitioner services in a concerted effort. This would mean domiciliary midwives working in hospitals or other maternity units, and the removal of the difficult legal bar which exists at the moment. It would seem, that this sort of development is inevitable.

Interest in congenital abnormalities in newly born babies has been intensified in recent years by the thalidomide episode, and much work has been done in an effort to prevent a repetition. One of the measures was the introduction of a congenital abnormality register on a voluntary basis. Authorities were invited to include on the birth notification form a space for the doctor or midwife to enter any observation of a congenital abnormality. We have introduced this

idea in the West Riding and the result has been an abnormality rate of any degree, minor or major, of 1.7 per cent.

In the year previous to this we had designed our own scheme which was more comprehensive than the national pattern. In our scheme *all* babies were examined at the third and again at the ninth month either by the general practitioner or a member of the local authority staff. This revealed in the experimental year an incidence of 4.4 per cent. Further details are given on page 97 of the report.

The significance of this difference is difficult to evaluate—a number of factors are involved including the voluntary nature of the present scheme, and the fact that some abnormalities do not make their appearance until later in the first year of life and would be missed in the national scheme, compared with our more comprehensive original procedure. There is, however, good reason to believe that the difference is of no significance from the point of view of the child since the abnormalities are readily detected and dealt with in the normal way, but perhaps the national scheme is adequate for its purpose as a forewarning of any sudden change in abnormality rates.

The safe conveyance of premature babies to hospital has given concern for a number of years. Now at last we are satisfied with the arrangements which have been made with the ambulance service and the hospitals to keep in readiness a new type of portable incubator. We are confident that this scheme will work and I am grateful to the County Ambulance Officer for the way in which he has adapted his vehicles, and to the midwifery staff of the hospitals and of the County for their help with regard to the storage and maintenance of the cots for emergencies.

Home Nursing

An investigation into the type of nursing equipment supplied to home nurses culminated in a comprehensive report and recommendations being agreed by the staff and the Health Committee. In view of advancing techniques and the new equipment available such a reappraisal was overdue. The report covered a wide field including uniform, equipment for the nurse's bag and the use of disposable equipment. It also entered into the field of nursing equipment for patients in their own homes and the storage of such equipment either centrally or in the divisions. This has proved to be a very useful piece of work and has involved a considerable amount of effort. Gradually the recommendations are being put into operation.

When I reported last year we were thinking of taking over the day and night nursing and care service which was originally introduced with the support of the Marie Curie Foundation. This became necessary because our scheme covered a wider range of patients than originally contemplated by the Foundation. This culminated in the County Council taking complete responsibility for the full scheme as from the 1st September, 1965.

Ambulance Training Scheme

As indicated in my last report a Ministry Working Party was due to publish its findings and this has actually taken place during the last twelve months. Pending acceptance of this report and its implications the County Council have decided to make their own temporary arrangements for the training of ambulance

staff. To this end Elm Bank, Cleckheaton, which was the Divisional Health Office until the Cleckheaton Health Centre was opened, has now been taken over as an ambulance training centre. Experiments are being carried out with courses under the control of specially appointed instructors and outside lecturers. It is hoped to gain experience for the future and to help to contribute to the success of any national scheme which may be put into operation.

Members of the health department staff are closely involved with the instruction and medical oversight of these courses and it is anticipated that much will be learned to assist in future development.

Dental Service

The County Council continues to provide a comprehensive range of very satisfactory facilities. There is, however, a cause for some slight concern in the falling off in the number of children under the age of five who come along for inspection and treatment. There has, of course, been a national decrease in the number of nursing and expectant mothers dealt with under local authority schemes since the financial disadvantage of going to a general dental practitioner has been removed. Mothers, however, appear to be getting adequate treatment, but this does not seem to be quite the case with the under fives. The reason for this is not clear but in order to investigate the matter further and to encourage more of the under fives to be treated, a special responsibility has been given in this field to one of our dental officers.

School Health

A pleasing development during the past few years has been the holding of regular conferences for assistant county medical officers. They have been well attended and most useful. The topics discussed and introduced by outside experts have been of great value in the conduct of our preventive work in the pædiatric field. This type of work has been followed up during 1965 by the formation of the Yorkshire Child Health Group under the Chairmanship of the Senior Administrative Medical Officer for School Health. The aim of the group has been to stimulate clinical discussion and improve contact between medical officers in the neighbouring authorities. These meetings are held on Saturday afternoons and have been quite successful. Members are in the main assistant medical officers of the Yorkshire authorities.

In order to decide on the future pattern of school medical inspections it was agreed to carry out a survey in some divisions on those children said to be requiring treatment or observation. An analysis of the results of this survey has shown that although a high proportion of children are recorded as having defects many of them, other than suspected defective vision or hearing loss, are already receiving treatment at the time of examination or require observation only. It would appear that providing we can ensure regular screening of vision and hearing, that a new pattern of medical service to the schools can be developed on a basis of more frequent visits by the doctor to see selected children. This would rule out a considerable waste of effort and enable more concentrated work to be done on those in need, and at the same time it would bring about a much closer contact between teacher and doctor. It is on these lines now that our thinking is being put into practical terms.

Another survey of children having bilateral average hearing loss of over 30 decibels has brought to light more cases than were originally notified, and the rate in the County now stands at 2 per 1,000 children known to have this defect, which is approximately the same as the national incidence. It is hoped to advance our work in this field and to this end the Education and Health departments are concentrating.

The Working Party report entitled *The Handicapped School Leaver* has been studied carefully as it affects the West Riding service and has led to discussions between the Youth Employment service and our own department in order to implement the recommendations. The result has been modification in documentation as between the two departments so that more useful and beneficial information can be transferred with the minimum of effort.

Staff Training

In addition to the existing training programmes two interesting new developments have taken place since the last report. Firstly advanced arrangements have been made for the opening of a new training school for health visitors in Sheffield. This will be a welcome addition to our present facilities and will enable us to make use of the training resources and recruitment potential in the South of the County, as we have done for some years for the North of the County at Leeds and Bradford.

The second development is in conjunction with the Leeds College of Commerce Social Workers Training Course. Following last year's disappointing response from candidates we have now developed a scheme for suitable school leavers to enter the health department at divisional level after being jointly interviewed by the Director of the Training Course and ourselves. The idea is for them to spend a year in the department obtaining basic knowledge as to how the department functions and then to enter the normal two year training course. During the year in the health department the staff of the training course give regular weekly tutorials. This is entirely experimental and is being enthusiastically supported by divisional medical officers and other staff concerned. In this early phase six trainees have been introduced into three of our divisions. It is hoped to continue recruitment in this way each year and some useful information should be obtained in due course. When the trained workers return to the department another phase of the experiment will begin directed to determining the correct role of such workers within the department.

Mental Health

This report contains a most interesting description of a visit made by the children from the Ossett Junior Centre for subnormals to H.M.S. Zulu at Rosyth. The story makes fascinating reading in itself but two interesting lessons can be learned from this ambitious undertaking.

These children were 20 hours away from home. They travelled to Rosyth by coach and plane and were handled with tremendous enthusiasm by the transport authorities' staff and considerable help was also given by the Edinburgh Health Department. The first lesson we learned, after much trepidation in the planning stages, was that these children could very easily stand up to the rigours of such a journey, were quite amenable and proved to be excellent guests. The crew of H.M.S. Zulu were really magnificent in their efforts. Perhaps the second lesson

is even more important in that the attitude of the public with whom the children came into contact, and they were many in this complex undertaking, showed a complete acceptance of them as though they were completely normal. This change of attitude in such a short time is probably one of the most striking developments in public relationships in recent years.

It has been pleasant to see the expansion of the industrial work in the training centres in both volume and variety of goods produced. This is another phase of mental health work which has developed far more readily and comprehensively than one could have foreseen only four or five years ago. So rapid has been the development that the Health Committee have examined the whole structure of training centre activities during the past twelve months to ensure that industrial work is not being developed at the expense of social training. They have expressed themselves satisfied and made even more generous contributions to the welfare of our subnormal patients.

There has also been a gradual broadening out of our efforts on behalf of the mentally ill. Many more social clubs have been opened and the two day centres run in conjunction with psychiatrists have proved to be useful for rehabilitation purposes. There has been improved hospital liaison and we are grateful for the policy of the Hospital Boards in providing working accommodation for mental health workers at some of the hospitals. An interesting experiment too is the liaison between the psychiatrists and mental welfare officers on the question of alcoholism, particular in the Scalebor Park area.

Environmental Health

There has been much publicity about the unhygienic practice of motorists in the absence of highway sanitation. The County Council have decided to carry out a pilot scheme on various types of highway and there have been discussions between ourselves and the Highways and Bridges Department on the best way of implementing this scheme. The greatest problem which public authorities have had on their hands for years in connection with public lavatories has been the amount of vandalism encountered. One of the greatest obstacles to be overcome in the pilot scheme will be this senseless activity. We shall watch the experiment with interest.

Fluoridation of Water Supplies

Emotions run high on this subject and have caused a hold up in the introduction of one of the most beneficial schemes that could be introduced into a civilised community. It is not intended to plough through this tangled web of argument and misrepresentation, but a few *administrative facts* may help Councillors and Aldermen who are besieged from time to time by the 'antis'.

The County Council have for years agreed to a policy for the fluoridation of water supplies. During this period the matter has been discussed on numerous occasions and each time the Council's views have remained unchanged in spite of anti-fluoridation propaganda directed intensively at members.

For the last three years the estimates have allowed for money to be available for the introduction of fluoridation and the latest confirmation of this policy was made only a few weeks before this report went to print.

The eminent bodies who agree as to the safety and value of fluoridation of water supplies on scientific grounds include the British Medical Association, the Society of Medical Officers of Health, the Royal Society of Health, The British Dental Association, the County Councils Association, the Association of Municipal Corporations, the General Dental Council, the Ministry of Health, the Department of Education and Science, and similar views have been expressed by the leaders of the political parties.

The validity of fluoridation of water supplies has been decided in the Courts in Eire and by the Privy Council on behalf of New Zealand. These were extensive actions in each case lasting many weeks and in both instances the correctness of the procedure of fluoridation was upheld.

Mr. Justice Kenny who tried the Eire case and heard evidence lasting 60 days said:—

“Having heard the evidence and read the literature, which it was agreed I should read, I am satisfied that the fluoridation of public water supplies at a concentration of one part per million will not in our temperate climate be dangerous to anybody—old, young, healthy or sick. I am satisfied that there is no reasonable possibility that it may involve an element of danger or risk to life or health to any of the citizens of this country.”

In talking of the persons who gave evidence against fluoridation the learned judge said:—

“There was a marked note of fanaticism and passionate conviction about their evidence. I got the impression that they were determined at all costs to make a case against fluoridation.”

There was a full scale debate in the House of Lords on Wednesday, the 26th January, 1966, lasting at least four hours concerning the fluoridation of water supplies on a motion by Lord Douglas of Barloch who is strongly against this measure and who moved for papers on the subject. The motion was withdrawn after complete and overwhelming evidence had been given in favour of fluoridation by leaders of the medical profession and by medical and lay spokesmen from the political parties.

The Ministry of Health issued a green pamphlet in January, 1965, giving the scientific position in answer to the claims of the anti-fluoridationists and concludes that the fluoridation process is beneficial and harmless.

Watford and the Isle of Anglesey have been having fluoridated water for many years and more recently the City of Birmingham and its surrounding areas have introduced this desirable measure. For many more years millions of people in America have been taking fluoridated water.

Of the 80 district councils in the West Riding who are not water undertakers only six have expressed a view contrary to fluoridation.

If local evidence for the benefit of fluoridation is required it exists in a small way in the West Riding. In practically every area except one small part of the Pateley Bridge district there is practically no natural fluoride in the water supply. In this specific small district, however, our own dental

officers have made a detailed investigation of the children's teeth and have found that they are immensely superior to the general average of the community.

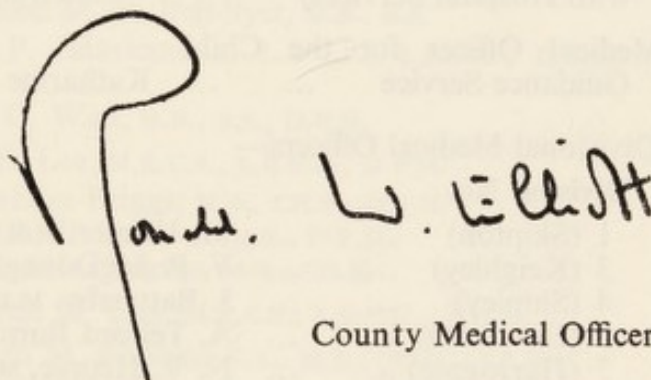
The above are facts which all members of the Council should be aware of before considering the pros and cons of the case and I hope that put in this way it will be helpful to them.

Conclusion

Once again I would like to express my appreciation to all members of the Health Department staff in particular and also to other departments for their generous help. I would also like to thank the Health Committee for their support and especially County Councillor R. Egan for his assistance during his first year as Chairman of the Health Committee.

Health Department,
Wood Street,
Wakefield.

August, 1966.

The signature is written in dark ink. It begins with a large, stylized capital 'P' that loops around. To the right of the 'P' is the word 'and' in a cursive script. Further to the right is the name 'W. L. Ellis' in a more formal, slightly cursive hand.

County Medical Officer

STAFF OF THE HEALTH DEPARTMENT

as at 31st December, 1965

MEDICAL STAFF

County Medical Officer and Principal School Medical Officer	Ronald W. Elliott, M.D., M.Sc., D.P.H.
Deputy County Medical Officer	H. W. S. Francis, M.A., M.B., B.Chir., D.P.H.
Senior Administrative Medical Officers	
Care of Mothers and Young Children and Nursing Services	P. H. Brewin, M.B., Ch.B., D.P.H.
Mental Health Service	... D. E. Jeremiah, M.B., B.S., D.T.M. and H., D.P.H.
School Health Service	... C. S. Smith, M.B., B.S., M.R.C.S., L.R.C.P.
Additional Medical Officer	... J. T. Clow, M.B., B.S.
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	... Katharine N. Maxwell, M.B., Ch.B.

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)	... Vacant—A. L. Taylor, Division 16—Acting
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)	... G. Ireland, B.Sc., M.B., B.Ch., D.P.H.
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)	... Vacant—N. E. Gordon, Division 19—Acting
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. D. G. Dick, M.B., B.S.
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., M.R.C.O.G., D.P.H. *Helen M. Mitchell, M.B., CH.B. R. Chapman, M.B., CH.B. Joan M. Murdoch, L.M.S.S.A.
7 (Harrogate) ...	...	*Isobel B. Alexander, M.B., CH.B., D.P.H. *Gertrude M. Polson, B.SC., M.B., CH.B., D.OBST.R.C.O.G. P. A. G. M. Ashmore, M.R.C.S., L.R.C.P. A. W. I. Hall, M.B., B.CHIR.
9 (Wetherby) ...	...	Irene M. Whitwam, M.B., CH.B.
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) ...	...	O. P. Markandya, L.R.C.P., L.R.C.S., L.R.F.P.S., B.M.S.A. V. G. Wad, M.B., B.S., D.P.H.
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. R. D. Hall, M.B., CH.B., D.P.H. Irene Hargreaves, M.B., CH.B.
15 (Batley) ...	...	*Freda M. Cox, M.R.C.S., L.R.C.P., D.P.H.
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., D.P.H.
18 (Brighouse) ...	...	*Marie P. Milligan, B.SC., M.B., CH.B., D.P.H. G. H. Cooper, M.B., CH.B.
19 (Todmorden) ...	...	W. C. McKerr, M.B., CH.B., B.A.O.
20 (Colne Valley) ...	...	*A. A. Kenyon, M.B., CH.B., D.P.H. *A. K. Rakshit, M.B., B.S., D.P.H. Charlotte N. Capes, M.B., CH.B., D.P.H. W. P. B. Stonehouse, M.A., M.R.C.S., L.R.C.P., D.P.H.
22 (Wortley) ...	...	*F. C. Armstrong, M.B., B.CH., D.P.H. Josephine M. Clarke, M.B., CH.B.
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. Anne M. Gill, M.B., B.CH.

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.
 D. M. Bell, M.B., CH.B.
 Margaret E. J. Bolsover, M.B., CH.B.
- 27 (Doncaster) ... J. A. Beal, M.R.C.S., L.R.C.P.
 Amy Kropacz, L.R.C.P., L.R.C.S., L.R.F.P.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.

117 General Medical Practitioners who act as Child Welfare Centre Medical Officers and are employed on a sessional basis. This is the equivalent of 21·7 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.P., M.R.C.S.
 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. McNeil, 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.
T. B. Priestley, M.R.C.S., L.R.C.P.
S. Robertson, M.B., CH.B., D.O.M.S.
J. Roche, M.A., M.B., B.CH., D.O.
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.
L. Wittels, M.D. (Vienna), 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.

ORTHOPAEDIC

J. H. Annan, M.B., CH.B., F.R.C.S.
H. N. Burwell, M.B., CH.B., F.R.C.S.
R. W. L. Calderwood, F.R.C.S.
N. Grewal, O.B.E., F.R.C.S., M.CH.ORTH.
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.
Miss P. A. I. Macleod, B.Sc., M.B., CH.B., F.R.P.S., F.R.A.C.S.
Miss M. A. Pearson, M.B., CH.B., F.R.C.S.
E. R. Price, M.B., B.S., F.R.C.S., M.R.C.P.
J. Wishart, M.B., CH.B., F.R.C.S.

E.N.T.

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.
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.
H. Morus-Jones, M.C., M.B., B.S., F.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.

PAEDIATRIC

M. F. G. Buchanan, M.B., CH.B., F.R.C.P., D.C.H.
J. M. Littlewood, M.B., CH.B., M.R.C.P., D.C.H.
C. S. Livingstone, M.R.C.P., D.C.H.
D. M. Morgan, M.B., CH.B., D.C.H.
E. M. O'Neill, M.D., 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.
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

K. Brennan, M.B., D.P.H., D.P.M.
Elizabeth Gore, M.D., CH.B., D.OBST.R.C.O.G., D.P.M.
J. D. Orme, M.R.C.S., L.R.C.P., D.P.M.

NURSING AND MIDWIFERY

County Nursing Officer	Doris Mumford, S.R.N., S.C.M., H.V.CERT.
Deputy County Nursing Officers	
Health Education	Mary G. Edwards, S.R.N., S.C.M. (Part I), B.T.A., H.V. CERT., H.V. TUTOR'S CERT.
Nursing Services	Naomi I. Harris, 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	Sarah E. Stuart, 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.
381 Health Visitors and School Nurses (56 part-time).
6 Orthopaedic Nurses and Physiotherapists (3 part-time).
6 Tuberculosis Visitors.
3 Venereal Diseases Social Workers (Qualified Health Visitors).
314 Home Nurses and Home Nurse/Midwives (14 part-time).
202 Midwives (2 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

- 49 Mental Welfare Officers
 Organiser of Training ... Frances E. Woolley, DIP.N.A.M.H.
 Peripatetic Advisory
 Instructor ... L. B. Somers
- 19 Supervisors in Mental Health Training Centres
- 118 Assistant Supervisors and other assistant staff
- 3 Home Teachers for (Mentally) Subnormal Children (2 part-time)
- 2 Wardens in Mental Health Hostels
- 3 Assistant Wardens in Mental Health Hostels

DOMESTIC HELPS

2,897 Domestic Helps

CHILD GUIDANCE SERVICE

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

SPEECH THERAPY SERVICE

- Chief Speech Therapist ... Vacancy.
- 7 Speech Therapists (4 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 Clinical 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., L.D.S.
- Area Dental Officers ... K. R. Cowell, B.CH.D., L.D.S.
 E. Doherty, B.D.S.
 P. F. A. Eltome, L.D.S.
 J. D. Franks, L.D.S.
 Valerie P. Lindsay, L.D.S.
 A. S. Metcalfe, L.D.S.
 E. S. Midgley, L.D.S.
 S. Mitchinson, L.D.S.
 Joyce Neden, B.D.S.
 F. H. Sanderson, L.D.S.
 J. L. Traynor, B.CH.D., L.D.S.
 H. M. Yuile, L.D.S.
- School Dental Officers ... J. K. Barclay, B.D.S., L.D.S.
 M. J. Boyles, L.D.S.
 R. J. S. Bulmer, B.CH.D., L.D.S.
 Olivia D. S. Burgess, B.D.S.
 J. R. Clayton, B.CH.D., L.D.S.
 Joan M. Davison, L.D.S.
 W. H. Dyke, L.D.S.
 Mary M. Gibson, L.D.S.

School Dental Officers	...	Kathleen M. Golding, B.D.S. R. F. Grainger, B.CH.D., L.D.S. Edith M. M. Hague, L.D.S. M. Hattan, L.D.S. D. H. Hoyle, B.CH.D., L.D.S. F. Kershaw, L.D.S. G. W. Lawrence, L.D.S. J. A. E. Morris, B.CH.D., L.D.S. J. Naftalin, L.D.S. F. E. Okoisor, L.D.S. M. S. Ormesher, B.D.S. D. B. Owen, L.D.S. G. B. Reid, L.D.S. Jessie Rothera, L.D.S. F. A. Rycroft, B.CH.D., L.D.S. Susanne E. Schloss, L.D.S. B. Sleight, B.CH.D. Judith M. Small, B.D.S. P. Smith, L.D.S. D. J. Stocks, L.D.S. E. Thornton, L.D.S. P. W. Thornton, L.D.S. H. G. Thorpe, L.D.S. 8 part-time.
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6 Dental Auxiliaries

Senior Dental Technician	...	J. O. Ford
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9 Technicians

1 Boy Dental Apprentice

63 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

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)

ADMINISTRATIVE AND CLERICAL

Chief 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 H. V. Brook D. Marshall, D.P.A. D. Ramsbottom J. Spruce, D.P.A. P. Ward, D.P.A.

- 25 Divisional Senior Clerks
- 385 Other Clerical Staff (including part-time staff)
- 1 Health Education Technician

VITAL STATISTICS

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-1965)		1,229,010	502,090	1,731,100

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

Summary for 1965:

The live birth rate was 18.2; the stillbirth rate per 1,000 total births 16.0; the live premature birth rate per 1,000 live births was 61. The death rate from all causes was 11.6; from heart and circulatory diseases 4.48; cancer 2.07; respiratory diseases 1.28; tuberculosis, respiratory 0.035; tuberculosis, other forms 0.005; meningococcal infections 0.002; per 1,000 population. Infant mortality was 20.7 per 1,000 live births; maternal mortality 0.16 per 1,000 total births.

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
1964	18.5	18	11.5	0.04	0.05	0.00	1.35	2.02	0.40	22
1965	18.2	16	11.6	0.04	0.04	0.00	1.28	2.07	0.16	21

* 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:

There were 31,463 live births registered equivalent to a crude birth rate of 18.2 per 1,000 population. During the period 1955-1964, apart from a slight recession in 1959 the rate progressively increased from 15.3 to 18.5. The rate of 18.2 in 1965 suggests that the peak in the upsurge of live births has been turned and we may expect the rate to remain at this level for a few years until the children of the post-war bulge era reach maturity. Further reference appears on page 84.

Deaths:

The number of deaths registered was 20,121, representing a crude death rate of 11.6 per 1,000 population. This rate, whilst fractionally higher than that of 11.5 recorded in 1964, compares favourably with a rate of 11.8 for the annual average for the quinquennium 1960-64. The number of deaths assigned to the separately classified causes varies from year to year; compared with the experience of the previous year, major increases in mortality were registered for cancer, the number of deaths assigned to this cause increased from 3,461 to 3,583, the highest total ever recorded, deaths from lung and bronchus increasing by 142 to the record high total of 827; deaths from heart and circulatory diseases increased from 7,474 to 7,753, and vascular lesions of the nervous system from 2,974 to 3,145. These increases were partially offset by reductions in mortality from respiratory diseases, accidents and violence.

As the age-sex structure of the population varies from area to area, crude death rates, although based on actual occurrences, do not provide an accurate comparative mortality index. To enable realistic comparisons of the mortality obtaining in different areas to be made, weighting or comparability factors which adjust local variations 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
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
1964	13.0	12.2	12.8	11.3
1965	12.7	11.8	12.4	11.5

Stillbirths and Infant Mortality:

STILLBIRTHS:

The number of stillbirths registered was 511 equivalent to a rate of 16.0 per 1,000 total births, both the number and the rate being the lowest recorded; further reference appears on page 85.

PERINATAL MORTALITY:

This term is used to describe the hazards to the developing foetus during the later months of pregnancy and the child in its first week of life, being the combination of stillbirths and deaths under one week with the resultant rate expressed per 1,000 total births. In the past decade the rate has pursued a downward trend and the rate of 27.3 for 1965 is the lowest yet recorded. Both components contributed to the decrease from the rate of 30.0 in the previous

year and although the rate now achieved can be viewed with some satisfaction, even lower rates were returned in certain parts of the County which indicates that the irreducible minimum has not yet been reached. This group mortality is discussed further on page 88.

INFANT MORTALITY AFTER ONE WEEK:

At ages 1 week up to 1 year there were 289 deaths representing a rate of 9.2 per 1,000 live births which compares favourably with a rate of 9.6 in 1964 and 9.8 for the annual average in the quinquennium 1960-64. The number of deaths in the first four weeks of life, the neonatal period, 438, was the lowest since 1955 and the resultant rate of 13.9 per 1,000 live births was a new low record. There were 214 deaths in the post-neonatal period (at ages 4 weeks up to 1 year) equivalent to a rate of 6.8 per 1,000 live births, the lowest registered since 1960.

Deaths in the first year of life totalled 652, providing an infant mortality rate of 20.7 per 1,000 live births, the lowest achieved. Details of the cause of death and the death rates at various periods under 1 year appear on pages 85 to 88.

Principal Causes of Death:

As in recent years the most prominent causes, or cause groups, of death in descending order were, heart and circulatory diseases 7,753; malignant neoplasms 3,583; vascular lesions of the nervous system 3,145; diseases of the respiratory system 2,247; accidents, suicide and other violent causes 937. In total these causes were responsible for 17,665 deaths or 87.7 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

	1961	1962	1963	1964	1965
Malignant neoplasms	16.4	16.7	16.2	17.5	17.8
Vascular lesions of nervous system ..	15.2	15.4	15.4	15.1	15.6
Heart and circulatory diseases	37.3	38.1	37.8	37.9	38.5
Diseases of respiratory system	13.6	12.7	13.1	11.9	11.2
Accidents, suicide and violence	4.5	4.6	5.0	5.3	4.7

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

Cause of Death	Under 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 ...	...	...	...	...	1	1	5	11	9	21	13	61
2. Tuberculosis, other ...	...	...	...	...	...	1	2	...	1	1	2	8
3. Syphilitic disease ...	...	...	...	...	...	...	...	5	8	10	10	33
4. Diphtheria ...	...	...	...	...	...	...	...	...	...	...	...	...
5. Whooping cough ...	...	...	...	...	...	...	...	...	...	...	...	...
6. Meningococcal infections ...	...	...	...	...	...	...	...	...	...	...	...	...
7. Acute poliomyelitis ...	...	...	...	...	...	...	...	...	...	...	...	3
8. Measles ...	...	...	...	3	...	...	...	...	...	...	...	3
9. Other infective and parasitic diseases ...	...	6	3	1	1	...	1	6	3	1	4	26
Total—Infective & Parasitic Diseases excl. Tub.	...	7	5	4	1	...	1	11	11	11	14	65
10. Malignant neoplasm, stomach ...	...	...	...	...	...	1	15	36	119	178	161	510
11. Malignant neoplasm, lung, bronchus ...	...	...	...	...	...	3	20	111	298	292	103	827
12. Malignant neoplasm, breast ...	...	...	...	...	...	3	31	51	61	83	73	302
13. Malignant neoplasm, uterus ...	...	...	...	...	...	2	17	37	38	36	35	165
14. Other malignant and lymphatic neoplasms ...	...	...	...	...	...	27	67	156	360	551	481	1,677
15. Leukæmia, aleukæmia ...	...	2	9	7	7	2	7	17	17	25	9	102
Total—All forms of Cancer	...	2	16	18	24	38	157	408	893	1,165	862	3,583
16. Diabetes ...	...	...	...	...	1	1	5	9	36	74	69	196
17. Vascular lesions of nervous system ...	...	...	...	4	6	4	33	97	365	914	1,721	3,145
18. Coronary disease, angina ...	...	...	...	1	2	15	86	358	1,026	1,525	1,467	4,480
19. Hypertension with heart disease ...	...	...	...	...	...	1	1	10	42	114	137	305
20. Other heart disease ...	...	1	1	1	9	13	30	77	185	416	1,260	1,993
21. Other circulatory disease ...	...	...	...	...	1	3	14	36	91	218	612	975
Total—Heart and Circulatory Diseases	...	1	1	2	12	32	131	481	1,344	2,273	3,476	7,753
22. Influenza ...	1	...	...	...	1	2	1	2	4	5	9	25
23. Pneumonia ...	25	71	16	6	5	6	10	25	75	181	491	911
24. Bronchitis ...	...	26	1	1	...	2	7	72	221	401	389	1,120
25. Other diseases of respiratory system ...	5	7	2	1	...	8	11	14	39	39	65	191
Total—Diseases of the Respiratory System incl. Influenza and excluding Tuberculosis	31	104	19	8	6	18	29	113	339	626	954	2,247
26. Ulcer of stomach and duodenum ...	...	...	...	...	...	...	3	12	24	45	56	140
27. Gastritis, enteritis and diarrhoea ...	11	14	3	...	...	...	...	5	10	22	25	93
28. Nephritis and nephrosis ...	...	1	...	3	5	3	6	10	19	26	31	104
29. Hyperplasia of prostate ...	...	...	...	...	...	...	2	...	4	14	46	64
30. Pregnancy, childbirth, abortion ...	...	...	...	...	2	1	...	...	...	...	...	5
31. Congenital malformations ...	93	47	4	8	4	3	1	9	7	2	2	180
32. Other defined and ill-defined diseases ...	298	21	18	10	25	22	46	95	216	276	513	1,540
33. Motor vehicle accidents ...	...	...	9	18	82	34	27	28	35	38	30	301
34. All other accidents ...	3	16	12	17	17	23	34	29	45	63	193	452
35. Suicide ...	...	...	...	...	11	12	24	39	46	25	19	176
36. Homicide and operations of war ...	2	...	...	...	...	...	...	1	2	2	1	8
Total—Accidents, Suicide and Violence	5	16	21	35	110	69	85	97	128	128	243	937
Total—All Causes	438	214	89	192	197	196	506	11,358	3,406	5,598	8,027	20,121

TUBERCULOSIS:

Mortality decreased further to a new record low level; there were 69 deaths compared with 84 in 1964 and an annual average of 102 in the years 1960-64. The corresponding death rates per 1,000 population were 0.04, 0.05 and 0.06 respectively. In the post-war period there has been a considerable decline in mortality; in recent years the rate of decline has quickened and whilst complete control of the disease has not yet been achieved, this stage will be reached shortly.

There were 61 deaths from respiratory forms of the disease representing a death rate of 0.04 compared with 0.05 (80 deaths) in 1964, and an annual average of 0.06 (93) in the quinquennium 1960-64. The age and sex distribution followed the pattern of recent years; remarkable reductions in mortality have been achieved amongst the young, adolescents, and early middle age groups but in the elderly, especially males, the disease remains a major health problem. When these older persons die they will be replaced by a generation of persons who have grown elderly but who harbour far less tuberculous infection. The success achieved must not be allowed to engender apathy and every opportunity will be taken to accelerate the eradication process by using all control measures at our disposal either singly or in combination to the full.

Deaths from other forms numbered 8, equivalent to a death rate of 0.005 compared with 4 deaths representing a rate of 0.002 in 1964 and an annual average of 9 equivalent to a rate of 0.005 in the period 1960-64. The number of deaths are minimal and fluctuations of this order are of no real significance.

INFECTIVE AND PARASITIC DISEASES:

Deaths assigned to this group were slightly fewer than the level of recent years; in total they amounted to 65 compared with 67 in 1964 and an annual average for the quinquennium 1960-64 of 78; the corresponding death rates were 0.04, 0.04 and 0.05 respectively.

Compared with the previous year there were reductions in mortality from measles which decreased from 5 to 3 and the residual group "other infective and parasitic diseases" from 38 to 26.

There was, however, a major increase in mortality due to syphilitic disease which was responsible for 33 deaths as compared with 23 in 1964; these deaths being of persons aged 45 years and over. Meningococcal infection remains the most fatal of common infectious diseases; mortality from the disease increased from 1 to 3; one an infant under 1 year and two in the 1-4 years age group. There was no death from diphtheria, whooping cough or poliomyelitis which is encouraging to all those taking part in our immunisation schemes.

CANCER:

In this group there were 3,583 deaths, equivalent to a death rate of 2.07 per 1,000 population compared with 3,461 deaths (2.02) and an annual average of 3,332 (1.98) in the period 1960-64. Both the number of deaths and rate are the highest recorded. Despite world wide research programmes which are being prosecuted the disease continues to take an increasingly high toll of the older members of the population; indeed of total mortality one death in every six was assigned to this cause at the rate of 69 per week.

As will be seen in the following table, the relative contribution to mortality from the separately classified sites has not changed during the past six years; lung and bronchus was the site most frequently concerned followed by, in descending order, stomach, breast and uterus.

Year		Stomach	Lung, Bronchus	Breast	Uterus	Other Mal- ignant and Lymphatic Neoplasms	Leukæmia, Aleukæmia	Total- All Sites
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
1964	M.	259	589	2	—	893	64	1,807
	F.	205	96	321	163	816	53	1,654
	T.	464	685	323	163	1,709	117	3,461
1965	M.	298	723	1	—	877	56	1,955
	F.	212	104	301	165	800	46	1,628
	T.	510	827	302	165	1,677	102	3,583

As was forecast, the slight reduction in mortality from lung and bronchus for 1964 proved to be a temporary fluctuation in the upward trend. In 1965 the number of deaths increased to 827 the highest total recorded, with male excess mortality again in evidence in the ratio of 7:1. Indeed 37 per cent. of the total male cancer deaths were from this cause with mortality heaviest in the 55 to 74 years age group.

There is no doubt that cigarette smoking is responsible for the greater part of these deaths and for the continued increase; it also contributes much to other causes of morbidity and mortality. Yet addiction to or dependence on "the weed" continues on an enormous scale. It is possible to prevent many cases of cancer of the lung which would inevitably occur among our younger generations if we could but persuade them not to acquire the smoking habit. It has been said that everyone eventually stops smoking. Mother Nature—the most permissive of parents—sees to that. Those who smoke heaviest stop earliest!

The number of deaths assigned to cancer of the stomach, breast and uterus varies from year to year with no trend apparent. Mortality from leukæmia continued at a relatively high level and research into the hazards associated with radiation and prenatal X-rays is being pursued as is the survey into the ætiology of childhood malignancies conducted by Dr. Alice Stewart of the Department of Social Medicine at Oxford University. Reference to our participation in this latter survey will be found in the research section of the report (page 180).

VASCULAR LESIONS OF THE NERVOUS SYSTEM:

This group accounted for 3,145 deaths, the highest annual recorded total, equivalent to a death rate of 1.82 per 1,000 population, being responsible for 15.6 per cent. of the total mortality. Although slight variations occur from year to year, as for other diseases associated with middle and old age, an upward trend is apparent.

Mortality increased progressively with age; there were 48 deaths under 45 years, in the 45—54 years age group 97 (3.1 per cent. of total deaths from this cause), at ages 55—64 years 365 (11.6 per cent.), at ages 65—74 years 914 (29.1 per cent.) and 75 years or over 1,721 (54.7 per cent.). At ages up to 64 years there was a slight excess of male mortality but thereafter female deaths predominated being especially pronounced at ages over 75 years.

HEART AND CIRCULATORY DISEASES:

Deaths from this group were more numerous than in any previous year. In total, 7,753 deaths were assigned to this group (38.5 per cent. of total deaths all causes) compared with 7,474 in 1964 and an annual average of 7,490 in the quinquennium 1960-64: the resultant death rates per 1,000 population were 4.48, 4.37 and 4.46 respectively. The age-sex distribution followed the pattern of recent years; 17.3 per cent. of the deaths were of persons in the 55—64 years age group; 29.3 per cent. aged 65—74 years and 44.8 per cent. 75 years and over. At ages under 75 years there was an excess of male mortality, while at ages 75 years and over 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
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
1964	4,117	2.41	326	0.19	2,108	1.23	923	0.54	7,474	4.37
1965	4,480	2.59	305	0.18	1,993	1.15	975	0.56	7,753	4.48

Coronary disease and angina again claimed higher mortality than any other disease; 4,480 or 22.3 per cent. of total mortality was classified to this cause. There was the usual excess of male mortality extending to ages up to 74 years; it was especially pronounced at ages 45—64 years; these latter deaths amounted to 35 per cent. of the total male mortality at these ages.

The number of deaths assigned to other diseases in the group continued at a high level; a slight downward trend, however, is discernable in mortality ascribed to hypertension with heart disease, and "other heart disease". So far no sound evidence has been adduced that the growing awareness of arterio-

sclerotic heart disease has resulted in it becoming a "fashionable" diagnosis and resulting in mortality from the disease being over-weighted at the expense of others in the group. Research proceeds on the various factors involved but it is premature to draw firm conclusions.

DISEASES OF THE RESPIRATORY SYSTEM:

There were 2,247 deaths classified to this group—influenza, pneumonia, bronchitis and other diseases of the respiratory system—compared with 2,341 deaths in 1964 and an annual average of 2,439 in the period 1960-64, representing death rates of 1.30, 1.37 and 1.45 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
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
1964	37	905	1,184	215	2,341
1965	25	911	1,120	191	2,247

It was not an influenza year and no outbreak was reported; the 25 deaths classified to this cause were the lowest on record.

Although pneumonia continues as a major cause of death there is no correlation with notifications and it is usually a secondary rather than a primary cause. Mortality was heaviest at the extremes of life; 10.5 per cent. of the deaths were infants under 1 year of age; 19.9 per cent. at ages 65—74 and 53.9 per cent. of persons 75 years or over.

For many years chronic bronchitis has been recognised as a serious medical and social problem. In recent years the number of deaths has averaged around 1,200 per annum and whilst the 1,120 deaths in 1965 was the lowest total since 1960, they represent 5.6 per cent. of total mortality. In fact, chronic bronchitis was the third most common cause of death among males over 45 years of age. The age-sex distribution conformed to the established pattern, mortality being comparatively high in infants under 1 year, negligible at ages to 44 years, thereafter progressively increasing. Male excess mortality continued in the ratio of 3:1 and was most pronounced in the age group 55—74 years.

Smoking and atmospheric pollution play a weighty part in the genesis of chronic bronchitis, not only killing thousands of persons a year but also condemning many others to chronic ill-health and incapacity. In endeavours to secure cleaner air, medical officers of health are persisting with the task of curtailing atmospheric pollution through the application of the Clean Air Act and, as referred to elsewhere, our health education propaganda on smoking and health continues unabated.

MATERNAL MORTALITY:

The number of deaths from this group—pregnancy, childbirth and abortion—decreased to 5, equivalent to a death rate of 0.16 per 1,000 live and still births; the number of deaths and rate are the lowest on record and compare very favourably with rates of 0.40 in 1964 and an annual average of 0.41 in the period 1960-64. Further reference is made on page 91.

VIOLENCE:

Mortality from this group, accidents, suicide and other violent causes, numbered 937 which compares favourably with a total of 1,037 in 1964 and an annual average of 959 in the period 1960-64, each separately classified cause contributing to the reduction. The number of deaths from the individual causes were motor vehicle accidents 301, other accidents 452, suicide 176, and homicide and operations of war 8.

In recent years, with the co-operation of medical officers of health, statistics of accidental deaths in the home have been compiled; the relative frequency of these deaths and others assigned to the other 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
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
1964	314	299	213	196	15	1,037
1965	301	284	168	176	8	937

Motor Vehicle Accidents:

Mortality from motor vehicle accidents decreased slightly from the record high total of 314 in 1964 to 301. The age/sex distribution followed that of recent years with excess male mortality in the ratio 2.5:1 and a preponderance of deaths in the 15—44 years age group. That these deaths constitute a major problem cannot be emphasised too frequently; it is indeed a depressing thought that of the 142 total male deaths in the 15—24 years age group, 68 resulted from motor vehicle accidents. Separate statistics of the vehicles involved are not available for the Administrative County but national records indicate that high mortality occurs in users of motor cycles.

Home Accidents:

The number of deaths attributed to other accidents (452) was slightly less numerous than in the previous year; home accidents made the major contribution and were the assigned cause of 284 deaths. Fatalities in the home far exceed those from certain diseases which create public apprehension but whether it is apathy or lack of sensationalism the public seems generally oblivious to this toll of life. Mortality in itself is formidable and in combination with non-fatal accidents the need to maintain our propaganda measures at the highest level is clearly underlined.

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

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	3	1	2	—	7
	F.	—	—	3	—	1	6	11
Accidental poisoning by gases and vapours ...	M.	—	—	5	—	3	2	15
	F.	1	—	1	—	1	10	14
Accidental falls ...	M.	—	—	1	3	4	6	50
	F.	2	—	—	—	5	23	133
Accidents caused by burns ...	M.	—	—	—	1	—	1	3
	F.	—	1	2	2	3	2	13
Inhalation of food or vomit ...	M.	5	—	3	—	—	1	9
	F.	7	—	—	—	—	—	7
Accidental mechanical suffocation ...	M.	1	1	1	1	—	—	5
	F.	2	2	2	—	1	3	10
Other and unspecified accidents	M.	—	1	4	—	—	1	6
	F.	—	1	—	—	—	—	1
Total ...	M.	6	3	17	6	10	11	95
	F.	12	4	8	2	10	34	189

Mortality was heaviest at the extremes of life; 6 per cent. of the deaths were under one year and 57 per cent. at ages 75 years and over.

Falls were the major cause, being responsible for 183 deaths representing 64 per cent. of all home accidents. Females were more frequently the victims especially at ages 75 years and over; actually more than one-third of all home accidents were as a result of falls in females 75 years and over. Many of the falls were reported as “unspecified” which is a reflection of the number of those elderly people who lived alone.

The second highest contributor was accidental poisoning by gases and vapours which caused 29 deaths. Old people were most frequently concerned, the majority dying from coal gas poisoning. Failure to light the gas after turning on was an underlying cause frequently mentioned and the extension into the County of the Gas Council's non-toxic domestic gas will, it is hoped, contribute to averting tragedies from this hitherto lethal source.

Accidental poisoning from solid and liquid substances was the third highest cause (18 deaths), barbiturates being incriminated in the majority of cases whilst an overdose of aspirin was responsible for the death of a one year old child.

Burns (16) were less frequent than in recent years, coal fires being responsible for 6 deaths, electric fires 2, and unspecified burns 8. Of these latter deaths four resulted from house on fire and one was associated with smoking.

Inhalation of food or vomit (16 deaths) and accidental mechanical suffocation (15 deaths) continued at a high level. Of the deaths due to inhalation of food

or vomit 12 were of infants under one year, and although it is encouraging that no death was due to overlaying whilst in bed with parents, one three year old child died as a result of being suffocated with a plastic bag.

Suicide:

The number of successful suicides fell to 176 the lowest total recorded since 1954 and compares favourably with 196 in 1964 and 191 for the annual average for the quinquennium 1960-64. The distribution of deaths according to 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.	—	3	2	5	8	9	7	4	38
			—	—	—	6	7	7	3	1	24
Other poisoning	...	(M.	—	2	2	4	4	4	2	4	22
			—	—	2	4	11	9	5	4	35
Hanging or strangulation	...	(M.	—	1	2	1	3	3	2	—	12
			—	—	—	1	—	1	—	1	3
Drowning	...	(M.	—	1	—	1	1	5	2	1	11
			—	—	—	—	1	1	2	1	5
Firearms	...	(M.	—	1	1	1	1	1	1	1	7
			—	1	—	—	—	—	—	—	1
Cutting instruments	...	(M.	—	—	—	—	—	—	—	1	1
			—	—	—	—	—	—	—	—	—
Jumping before or lying in path of moving vehicles	...	(M.	—	—	—	—	—	1	1	1	3
			—	—	—	—	—	—	—	—	—
Jumping from high places	...	(M.	—	—	—	—	1	1	—	—	2
			—	1	—	—	—	—	—	—	1
Other agents	...	(M.	—	1	3	1	1	3	—	—	9
			—	—	—	—	1	1	—	—	2
Total—All Agents	...	(M.	—	9	10	13	19	27	15	12	105
			—	2	2	11	20	19	10	7	71

Whilst retaining its position as the agent most frequently employed, domestic gas was less frequently incriminated than in previous years. There were 62 deaths from this agent compared with 93 in 1964 and 88 in 1963 with the usual male excess mortality continuing. It may be that the ready availability and ease of application are the underlying reasons for the high level of fatalities but, as the introduction of domestic gas with a greatly reduced toxic content proceeds, we may expect further reductions in mortality at least until another agent of similar accessibility comes into vogue.

Mortality from other forms of poisoning remained high, accounting for 57 deaths, 51 of which were from barbiturates and their derivatives, 2 from corrosive acids and 1 each from aspirin, codeine, nicotine and lysol. Deaths among females were again more numerous.

Drowning (16 deaths), hanging or strangulation (15), and firearms (8) retained the same numerical sequence and, conforming to current trends male deaths predominated. The number of deaths from the remaining causes persisted around the average for recent years.

Seasonally, mortality was heaviest in the period April—June, with a secondary peak in January, but contrary to expectations, mortality during October was comparatively light.

It is recognised that social isolation and loneliness may be incriminating factors in the incidence of suicide and although details are not available of the number of suicides who were living alone at the time of death, of the 71 females, 12 were spinsters and 24 widows.

Child Mortality:

Mortality among children aged 1—4 years decreased to the lowest annual total recorded since 1959; deaths numbered 89 compared with 98 in 1964 and an annual average of 107 in the quinquennium 1960-64. The equivalent death rates per 1,000 children living in the age group were 0.75, 0.86 and 0.97 respectively. Reference to the table appended indicates that virtual control over the once traditional childhood diseases has left accidents, pneumonia and cancer as the causes most numerous.

Compared with the previous year improvements in mortality were made from accidents which decreased from 27 to 21, congenital malformations 11 to 4, bronchitis 7 to 1, diarrhoea 7 to 3 and measles 1 to nil. Of the accidental deaths 9 resulted from motor vehicle accidents and 7 from accidents in the home. Cancer retained its relative importance, mortality increasing from 9 to 16, with leukaemia accounting for 9 deaths. Deaths from pneumonia also increased from 9 to 16 whilst deaths classified to "other infective and parasitic diseases" increased from 3 to 5.

Cause of Death	Annual Averages for Quinquennia								1960	1961	1962	1963	1964	1965
	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	1	—	
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	3	5	
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	9	16	
Heart and circulatory diseases	4	3	2	1	1	—	1	1	1	1	2	—	1	
Influenza	6	43	10	11	4	2	2	—	2	—	1	—	—	
Pneumonia	457	321	121	85	42	19	14	9	14	17	22	9	16	
Bronchitis	150	42	10	17	9	6	6	5	10	1	9	7	1	
Other diseases of respiratory system	49	15	6	5	3	2	2	2	—	3	—	2	2	
Diarrhoea and other digestive diseases	248	45	38	23	17	4	4	2	3	11	1	7	3	
Congenital debility, malformations	12	9	7	10	12	13	12	12	10	12	12	11	4	
Accidents	82	54	50	47	38	27	23	29	25	26	30	27	21	
Other causes	323	119	52	45	30	23	12	23	21	14	32	22	20	
All causes	2,352	1,017	467	376	227	136	97	97	105	102	131	98	89	
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	0.86	0.75	

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 table below. Negotiations were commenced for the amalgamation of Divisions 18 and 19, following the retirement of Dr. F. Appleton, and were still proceeding at the end of the year.

Div. No.	County Districts	Population (Estimated Mid. 1965)	Acreage	Divisional Medical Officer, Senior Clerk and Divisional Nursing Officer	Address of Divisional Health Office
1	Barnoldswick U. Earby U. Silsden U. Skipton U. Bowland R. Sedbergh R. Settle R. Skipton R.	10,000 5,100 5,350 13,140 4,780 3,760 13,880 24,020	2,764 3,519 7,101 4,211 83,327 52,674 152,087 146,071	Dr. M. Hunter Mr. K. A. Knowles Miss F. Stevenson	9, High Street, Skipton Tel. Skipton 2438/9
		80,030	451,754		
3	Keighley B.	56,140	23,611	Dr. V. P. McDonagh Mr. A. S. Sanderson Miss J. Butterworth	3, Bow Street, Keighley Tel. Keighley 2244/5
4	Baildon U. Bingley U. Denholme U. Shipley U.	13,210 24,230 2,630 29,550	2,831 11,418 2,536 2,184	Dr. J. Battersby Mr. F. G. Falkingham Miss M. Tattersall	P.O. Box 24, Town Hall, Shipley Tel. Shipley 51363
		69,620	18,969		
5	Pudsey B. Aireborough U. Horsforth U. Ilkley U. Otley U. Wharfedale R.	37,290 28,730 15,990 19,070 11,790 7,230	5,323 6,856 2,706 8,610 2,934 39,378	Dr. A. Telford Burn Mr. A. Hartley Miss D. Topley	The Green, Horsforth Tel. Horsforth 2252
		120,100	65,807		
7	Harrogate B. Ripon City Knaresborough U. Nidderdale R. Ripon and Pateley Bridge R.	59,420 11,010 10,170 16,790 13,450	8,320 1,812 2,494 75,009 124,861	Dr. N. V. Hepple Mr. L. R. Wilkinson Miss M. L. Griffin	Municipal Offices, Harrogate Tel. Harrogate 68954
		110,840	212,496		
9	Tadcaster R. Wetherby R.	30,350 26,590	72,987 64,424	Dr. A. L. Taylor (acting) Mr. F. H. Attack Miss M. P. Bramley	Hallfield Lane, Wetherby Tel. Wetherby 2738
		56,940	137,411		

Div. No.	County Districts	Population (Estimated Mid. 1965)	Acreage	Divisional Medical Officer, Senior Clerk and Divisional Nursing Officer	Address of Divisional Health Office
10	Goole B. Selby U. Goole R. Selby R.	18,680 10,720 8,900 7,130	1,267 3,848 36,776 32,909	Dr. S. K. Appleton Mr. R. Towell Miss D. M. E. Goldthorpe	6/7, Belgravia, Goole Tel. Goole 936/7
		45,430	74,800		
11	Castleford B. Normanton U.	39,990 18,420	4,394 3,067	Dr. J. M. Paterson Mr. C. R. Pickering Mrs. M. Craig	"Castledene," Pontefract Road, Castleford Tel. Castleford 4201
		58,410	7,461		
12	Pontefract B. Featherstone U. Knottingley U. Osgoldcross R.	28,830 14,980 13,770 8,860	4,865 4,424 2,835 33,954	Dr. J. F. Fraser Mr. W. Carver Mrs. M. Craig	Baghill House, Walkergate, Pontefract Tel. Pontefract 3291
		66,440	46,078		
13	Morley B. Ossett B. Horbury U. Wakefield R.	43,010 15,880 8,890 22,000	9,494 3,333 1,280 21,344	Dr. G. Ireland Mr. A. Wright Miss A. M. Seelig	Windsor House, Morley Tel. Morley 4281/2
		89,780	35,451		
15	Batley B. Heckmondwike U.	40,590 8,820	4,457 696	Dr. J. F. Caithness Miss K. Lister Miss D. Day	Market Place, Batley Tel. Batley 3141
		49,410	5,153		
16	Garforth U. Rothwell U. Stanley U.	17,920 26,610 18,520	4,020 10,698 4,866	Dr. A. L. Taylor Mr. S. Hobson Miss M. P. Bramley	Oulton Lane, Rothwell Tel. Rothwell 2326/7
		63,050	19,584		
17	Spenborough B. Mirfield U.	37,820 14,050	8,251 3,394	Dr. W. M. Douglas Mr. P. Marshall Miss D. Day	Health Centre, Greenside, Cleckheaton Tel. Cleckheaton 3501/4
		51,870	11,645		
18	Brighouse B. Elland U. Queensbury and Shelf U.	32,180 18,520 9,590	7,873 5,946 2,795	Dr. N. E. Gordon (acting) Mr. G. O. Richardson Miss C. J. Barker	Mill House, Huddersfield Road, Brighouse Tel. Brighouse 796
		60,290	16,614		
19	Todmorden B. Hebden Royd U. Ripponden U. Sowerby Bridge U. Hepton R.	16,600 9,100 5,010 16,930 3,600	12,789 7,084 13,289 5,763 21,758	Dr. N. E. Gordon Mr. H. Marshall Miss C. J. Barker	Abraham Ormerod Medical Centre, Todmorden Tel. Todmorden 2495
		51,240	60,683		

Div. No.	County Districts	Population (Estimated Mid. 1965)	Acreeage	Divisional Medical Officer, Senior Clerk and Divisional Nursing Officer	Address of Divisional Health Office
20	Colne Valley U. Denby Dale U. Holmfirth U. Kirkburton U. Meltham U. Saddleworth U.	20,980 9,720 18,720 18,690 5,660 18,150	16,054 10,165 17,648 13,847 5,906 18,485	Dr. E. Ward Mr. G. A. Beatson Miss J. L. Law	6/8, St. Peter's Street, Huddersfield Tel. Hudders- field 29526
		91,920	82,105		
22	Hoyland Nether U. Penistone U. Stocksbridge U. Penistone R. Wortley R.	15,820 7,310 11,890 7,390 51,150	1,998 5,593 4,630 29,002 48,698	Dr. J. Main Russell Mr. P. Fullwood Mrs. M. Orr	Mortomley Hall, High Green, nr. Sheffield Tel. High Green 292
		93,560	89,921		
23	Hemsworth U. Hemsworth R.	15,250 52,990	4,163 29,019	Dr. J. S. Walters Mr. G. Ellis Miss J. Crossfield	Adiscombe House, Barnsley Road, Hemsworth Tel. Hems- worth 377/8
		68,240	33,182		
25	Cudworth U. Darfield U. Darton U. Dodworth U. Royston U. Wombwell U. Worsbrough U.	9,120 6,920 15,020 4,140 8,540 19,150 16,180	1,746 2,018 4,717 1,857 1,423 3,838 3,420	Dr. R. Barnes Mr. L. S. Wrigg Mrs. C. Dyson	33 Queen's Road, Barnsley Tel. Barnsley 2247/8
		79,070	19,019		
26	Conisbrough U. Dearne U. Mexborough U. Rawmarsh U. Swinton U. Wath upon Dearne U.	17,790 26,800 16,650 19,600 14,230 15,330	1,593 3,888 1,452 2,600 1,718 2,677	Dr. D. J. Cusiter Mr. P. Goddard Miss V. Dunford	Dunford House, Wath upon Dearne Tel. Wath 2251/2
		110,400	13,928		
27	Adwick le Street U. Bentley with Arksey U. Tickhill U. Doncaster R.	18,380 23,420 2,860 76,340	3,605 4,950 5,580 75,093	Dr. J. Ferguson Mr. C. W. Vallance Mrs. A. Corless	Station Road, Doncaster Tel. Doncaster 61571
		121,000	89,228		
29	Thorne R.	37,580	38,419	Dr. G. Higgins Mr. J. T. Howitt Miss. D. M. E. Goldthorpe	Council Offices, P.O. Box 4, Thorne Tel. Thorne 3130
31	Maltby U. Kiveton Park R. Rotherham R.	14,440 22,130 63,170	4,788 20,070 28,739	Dr. J. M. Watt Mr. A. Hill Mrs. A. Brooks	"Edenthorpe," Grove Road, Rotherham Tel. Rother- ham 3131/2
		99,740	53,597		

Epidemiology

Vaccination and Immunisation

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, gonorrhoea and soft chancre (classed under the term venereal diseases) and scabies are not compulsorily notifiable.

The table below affords a comparison of the notifications during the past six years:-

Disease	Number of corrected notifications					
	1960	1961	1962	1963	1964	1965
Scarlet Fever	1,536	911	652	757	1,201	1,568
Whooping Cough	3,227	838	241	925	1,494	360
Acute Poliomyelitis (paralytic)	6	34	7	1	3	4
Acute Poliomyelitis (non-paralytic)	—	6	3	—	—	11
Measles	4,636	29,225	11,485	19,882	14,385	18,175
Diphtheria	—	—	1	6	9	—
Dysentery	954	1,166	920	545	432	934
Meningococcal Infection	23	32	20	27	17	13
Acute Pneumonia (primary or influenzal)	530	801	578	667	365	327
Smallpox	—	—	2	—	—	—
Acute Encephalitis (infective)	5	1	2	3	2	11
Acute Encephalitis (post-infectious)	1	6	4	4	2	11
Typhoid Fever (excluding Paratyphoid)	—	2	2	5	1	11
Paratyphoid Fevers	1	11	11	28	6	18
Erysipelas	136	78	57	78	72	86
Food Poisoning	358	58	56	93	114	82
Ophthalmia Neonatorum	5	6	3	5	5	11
Puerperal Pyrexia	61	68	51	69	44	47
Tuberculosis:						
Respiratory	547	550	469	467	423	357
Other Forms	75	89	64	75	73	72
*Malaria	—	1	1	—	1	—
Anthrax	2	1	1	2	—	—

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

The following summary shows the number of notifications in 1965 of each notifiable disease, being the number of cases originally notified and the final numbers after revision of diagnosis.

Tetanus Immunisation:

The total number of children who completed a primary course of protection against tetanus during 1964 was 32,587 and of this number 23,652 were born in the years 1964 and 1965. A secondary or reinforcing injection was given to 17,942 children of whom 13,653 were over 5 years and under 10 years of age.

Dr. T. D. Spencer, Divisional Medical Officer of the Yorkshire Division of the National Coal Board, reports that during 1965 a total of 6,943 Yorkshire miners completed tetanus immunisation—a rather disappointing drop over the figures for 1964. A total of about 22 per cent. of all miners in Yorkshire are now fully immunised and a very high percentage of the juvenile new entrants are now receiving the three injections with only a small number of objectors. Nearly all hospitals are giving a first dose of toxoid to men who have had injuries if they have not already been immunised and the follow-up is good. The immunisation rate of the third group—those miners who are already in the industry and are being asked to be immunised—has not been so high as in 1964 but Dr. Spencer intends to have a further campaign in the Spring of 1966. The number of miners who are blood donors and have been immunised and are having their blood used to produce human antitoxin is now 231—a modest increase over 1964.

Scarlet Fever:

The number of notifications again increased to a total of 1,568, the highest recorded since 1959, and equivalent to an attack rate of 0.91 per 1,000 population. Incidence, nationally, also increased from 0.42 in 1964 to 0.56. Seasonal incidence followed the usual pattern, being high in the first and last quarters. Age-sex distribution also conformed to the experience of recent years; 84 per cent. of the notifications were of children under 10 years with a slight excess among females.

The disease, save for exceptional cases, is mild, is readily amenable to treatment, and has been almost eliminated as a cause of death.

Whooping Cough:

After two years of relatively high incidence it is satisfactory that the number of notifications declined to 360, the second lowest total recorded. These notifications represent a mere tenth of the annual average recorded since 1940 when notification of the disease was introduced. Seasonally, notifications increased as the year progressed but at no time did the weekly total exceed 20.

Age distribution continued to follow what is now the usual pattern; 10 per cent. of the notifications related to infants under 1 year, 57 per cent. in the 1—4 years age group and 28 per cent. at ages 5—9 years. Contrary to the expected sex ratio, notifications were equally distributed.

The disease is well under control but a high risk to infants under 1 year persists. Early immunisation is encouraged and the hazard to the young baby minimised by boosting the protection of older siblings.

As will be seen from the table below, in recent years the number of deaths from the disease has declined; this, however, must not encourage apathy nor relaxation of effort to secure the highest immunisation state in our child population.

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
1964	152	—	—	761	—	—	581	—	—	1,494	—	—
1965	36	—	—	205	—	—	119	—	—	360	—	—

IMMUNISATION AGAINST WHOOPING COUGH:

During the year 25,788 children completed a full course of immunisation against whooping cough and since facilities were first introduced in 1952 a total of 222,835 children have been immunised under the County scheme. The number of children protected in the 0—4 age group is 101,203 representing 88.7 per cent. of the total population in this age group.

Of the 352 notifications of whooping cough in the 0—14 age group 135 concerned children who had been immunised against this disease.

Poliomyelitis:

Five cases were confirmed, four of the paralytic form of the disease and one non-paralytic. Each case was thoroughly investigated and brief details are appended.

The first case, a six year old girl from Darton, became ill round about 7th December, 1964, and was admitted to hospital with a provisional diagnosis of rheumatic fever. Type 1 poliomyelitis virus was isolated from a faecal specimen and the girl was transferred to isolation hospital. There was patchy paralysis of both legs (left foot drop, right hamstrings, etc.); also some back weakness and minimal paralysis in both deltoids. The girl had not been immunised or vaccinated against any disease. At the time of writing (March, 1966) she had a slight residual limp.

Case two, a "missed case" was an unvaccinated seventeen year old youth from Goole. On the 23rd March a notification was received in which the date of onset of the disease was given as 11th January with the remark "diagnosed in retrospect". Enquiry elicited that the youth had a few days off his

work as a labourer due to an "influenzal cold". When he returned to work he experienced pain and muscular weakness in the right shoulder. As the condition did not respond to usual treatment he was referred for X-ray and orthopaedic advice. The consultant concluded that the cause of the mild paresis must have been poliomyelitis. No virological investigation was undertaken. He is now fully recovered.

Like the others, the third case was also mild. An eight year old girl from Ripponden developed a febrile illness with some muscle pain and neck rigidity and the diagnosis of poliomyelitis was made on clinical grounds. Three days later the child was convalescent. She was noticed to be dragging her right leg: this weakness was transient and in a further three days she had made a full recovery. The child had received two doses of Salk vaccine in 1958, a further dose of Salk vaccine in 1961 and a fourth dose, this time oral vaccine, on her admission to school in 1962. Examination of faecal specimens from the patient for poliomyelitis virus were negative and her serum showed no rise in the agglutination titres to Echo or Cocksackie viruses.

The fourth case of paralytic poliomyelitis was an eight months old boy from Chapeltown (Wortley R.D.). He had received three doses of oral vaccine in June, July and August, 1965. Weakness of one leg and discomfort was noticed by the mother in August and poliomyelitis virus was isolated from a rectal swab. In March, 1966, the result of the typing of the culture was still awaited. The patient was treated at home and is now fully recovered.

The case of non-paralytic poliomyelitis was an unvaccinated 29 year old man from Sprotborough (Doncaster R.D.) who fell ill with a febrile illness in September. He was admitted to hospital where the diagnosis was confirmed clinically; repeated specimens submitted for virus investigation, however, were inconclusive.

As indicated in the following table, incidence in recent years has remained low and when compared with an annual average of 169 cases in the period 1946-55, it would seem only reasonable to give the credit to immunisation.

Year	Paralytic Non-Paralytic	0-14 years	15 years and over	Total
1961	P.	25	9	34
	N.P.	6	—	6
1962	P.	6	1	7
	N.P.	3	—	3
1963	P.	1	—	1
	N.P.	—	—	—
1964	P.	1	2	3
	N.P.	—	—	—
1965	P.	3	1	4
	N.P.	—	1	1
Totals 1961/65	P.	36	13	49
	N.P.	9	1	10

VACCINATION AGAINST POLIOMYELITIS:

Number of doses of oral vaccine administered during 1965—148,248. Number of Salk doses administered—231.

The total number of persons protected against poliomyelitis in the County taking into account both Salk and oral vaccine is as follows:—

<i>Age Group</i>	<i>Total Protected</i>	<i>Percentage of Age Group Protected</i>
6—12 months	5,743	37·4
1— 2 years	21,550	73·1
2— 3 years	22,768	77·2
3— 4 years	19,460	66·0
4—23 years	455,076	92·6
23—32 years	114,606	67·7
*Others 32—40 years	78,578	38·9
<hr/>		
Total all groups	717,781	74·3

*Includes also those at “special risk”

Measles:

The epidemic which began in mid-September, 1964, continued for nearly twelve months. Notifications rose to a peak of 933 in the third week of February and declined irregularly to 240 in the third week of August: thereafter incidence tailed off. In 1965 a total of 18,175 notifications were received.

Measles is primarily a disease of childhood and few children escape the infection much beyond their entrance to school; indeed, 56 per cent. of the notifications were of children under 5 years and 38 per cent. in the 5—9 years age group. Fortunately, by far the majority of cases were mild and, as indicated in the table below, the case fatality rates remain 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)
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
1957	28,352	5	0·02	1964	14,385	5	0·03
1958	6,183	1	0·02	1965	18,175	3	0·02

The importance of measles, however, is not to be gauged simply by the fatality rate. In the W.H.O. Chronicle for March, 1964, the point is taken up that there is a tendency not to take measles seriously and it was stated: “At best, it causes high fever, sore throat, and a distressing cough; at worst, there may be severe

respiratory or other complication, including the most feared measles encephalitis and its sequelæ. The social and economic consequences of such an illness, from which practically no child escapes, cannot be lightly dismissed."

Research in the field of measles vaccine has continued in certain countries for a number of years. In this country, developments led the Joint Committee on Vaccination and Immunisation to recommend that the Medical Research Council be asked to conduct trials of the protective effect of measles vaccine and the Authority's participation in an extended trial is referred to in the research section of the report.

Diphtheria:

After the set-backs in 1962, 1963 and 1964, when there were respectively 1, 6 and 9 cases, it is satisfactory to report that the County returned to freedom from the disease.

There is, however, no room for complacency for, while the disease is no longer generally epidemic in this country, small localised outbreaks continue to occur indicating that there is still a hard core of infection. The need for constant vigilance and the highest immunisation state throughout our child population remains and our propaganda efforts to secure these ends continues.

DIPHTHERIA IMMUNISATION:

The number of children who received immunisation during 1965, together with figures for previous years are shown in the following table. Due to a change to the form of return now required by the Ministry of Health, it will be noted that the age groups for the year 1965 vary from those reported in previous years.

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	
1964	24,954	3,009	27,963	20,928	
	Under 4	Aged 4 but under 8	Aged 8 but under 16	Total	
1965	25,296	2,436	1,265	28,997	21,394

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
1964	96,194	66.4	218,706	86.4	314,900	79.2
1965	101,711	68.4	216,510	84.6	318,221	78.7

Dysentery:

The number of notifications, 934, was more than twice the total for 1964 and was the highest annual total since 1961.

Contrary to the usual experience, as indicated in the following table, incidence was highest in the second quarter of the year.

	Male	Female	Total	Percentage of annual total
First quarter ...	86	70	156	16.7
Second quarter ...	296	290	586	62.7
Third quarter ...	59	46	105	11.3
Fourth quarter ...	36	51	87	9.3

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+
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
1964	214	74	47	93	218	56	38	124	432	130	85	217
1965	477	163	150	164	457	163	106	188	934	326	256	352

Compared with the previous year, notifications were higher throughout all age groups, with incidence highest in children under five years.

In recent years by far the majority of cases has been due to the Sonne organism and in 1965 of the cases confirmed bacteriologically all were of this type.

Commenting on an outbreak in Todmorden M.B., Dr. Gordon, Medical Officer of Health, writes:

" From the second week in May there was a considerable increase in the number of cases of dysentery notified in the Borough, the actual figures were:

<i>Week ended:</i>	<i>Week ended:</i>
14th May ... 18	25th June ... 36
21st May ... 57	2nd July ... 15
28th May ... 45	9th July ... 5
4th June ... 60	16th July ... 8
11th June ... 25	23rd July ... 2
18th June ... 25	

The majority of the cases were children in the infant and junior schools and the notifications represent only a proportion of the actual number of cases. Indeed, many cases were so mild that they passed unnoticed or returned to school after an absence of only a day or two. There was the usual problem of healthy carriers in the families of many of the cases investigated. In all, positive laboratory reports for Sonne dysentery were received in respect of 96 persons.

In the initial stages there was evidence of spread amongst the family contacts but cases soon started to appear in every part of the town.

One infants' school was unduly affected by this outbreak and in one week there were 55 absentees out of the 146 on roll.

Only 24 of these 55 were known to us either as cases or home contacts but all were investigated and contacts of infant school age excluded. Three food handlers were advised to stay off work pending investigation, as was a ward orderly from the local hospital for the mentally subnormal; the latter subsequently proved to be a carrier.

The organism was rather peculiar in that it was insensitive to both Streptomycin and the Sulphonamides but was sensitive to Chloramphenicol and Neomycin.

The majority of cases had abdominal pain and diarrhoea: in most cases some blood was passed. On the whole the cases were fairly mild but two required hospital admission, a male of 76 years who was severely dehydrated and a boy of nine months who appeared unduly ill.

There was nothing to incriminate any particular school, shop or catering establishment. "

Personal contact, direct or indirect, appears to be the mode of spread. A great deal of infection could be eliminated if good hand hygiene was practised; while other measures may help, the simplest and most effective method of limiting or combating the spread of infection is the thorough washing of the hands after every visit to the lavatory. The importance of training young children in the elementary rules of cleanliness is also clearly underlined.

Meningococcal Infection:

In 1950 the designation " cerebro-spinal fever " was replaced by " meningococcal infection ": since when the annual number of notifications has fluctuated but has tended to pursue a downward trend. The total of 13 notifications is the lowest yet recorded under either classification.

The number of corrected notifications and deaths since 1950 are given below:—

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
1964	17	1	5.9
1965	13	3	23.1

All the cases appear to have been sporadic with no apparent connection. As usual, notifications were more numerous in children: there were three cases in infants under one year, four in the 1—4 years age group and two at ages 5—14 years.

The reduction in incidence is particularly welcome for the disease is still a killer of young children and which, even in older patients, remains a cause of serious concern. One difficulty in control has been the protean nature of the symptoms, particularly in the young child. Once a diagnosis has been made the outlook is nowadays very hopeful.

Smallpox:

The County was again free from smallpox. The threat of importation from the many areas where the disease is endemic, however, remains, which was recognised in the choice of the theme for World Health Day in 1965, "Smallpox—Constant Alert". This served as a reminder to people everywhere of the constant threat of smallpox and to spur on the efforts to eradicate the disease throughout the world.

VACCINATION AGAINST SMALLPOX:

The following table shows the number of vaccinations and re-vaccinations performed during the years 1963-65:—

Year	Vaccinations					Re-Vaccinations				
	Under 1	1	2-4	5-14	Total	Under 1	1	2-4	5-14	Total
1963	1,683	2,562	626	519	5,390	3	36	88	313	440
1964	1,451	5,456	1,667	325	8,899	1	16	76	208	301
1965	1,112	7,193	3,232	414*	11,951	—	2	77	363*	442

*5-15 years of age

The columns "under 1" have been broken down for 1964 and 1965 into three-monthly groupings as follows:—

Year	Vaccinations					Re-Vaccinations				
	0-3 mths.	3-6 mths.	6-9 mths.	9-12 mths.	Total	0-3 mths.	3-6 mths.	6-9 mths.	9-12 mths.	Total
1964	311	373	337	430	1,451	—	—	—	1	1
1965	176	188	277	471	1,112	—	—	—	—	—

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

Acute Encephalitis:

Cases of the disease are classified as "post-infectious" if associated with or following infectious disease or smallpox vaccination; in instances when no such relationship is established the classification of "infective" is made. Confirmation of diagnosis was made in two cases; one of each classification. The post-infectious case was a 24 year old man who had meningitis.

Enteric Fevers:

TYPHOID FEVER:

In 1941, typhoid and paratyphoid fevers became separate entities for notification purposes. Since then the annual number of notifications has fluctuated within the range of nil to 27; in 1965, the diagnosis was confirmed in one case.

The patient, an Indian woman, had been admitted to hospital with pyrexia and general toxæmia. It was found that she had a heavy roundworm infestation and in addition Blood culture was positive for *Salmonella typhi*, phage type Fi, the Vi antigen titre being 1 in 1,280. All faecal specimens from the patient as well as the few contacts in the home were negative: One contact had a Widal reaction positive at 1 in 80 to 0 antigens. Because of language difficulties it was impossible to find out if the patient or contacts had had previous inoculations. The family had arrived in this country 6—7 weeks previously and as no further cases occurred it was considered probable that she had the infection on arrival in this country and much of her illness was due to the concurrent roundworm infestation. Her condition in hospital gave no cause for alarm and she made a full recovery.

School parties proceeding on holiday to countries bordering on the Mediterranean Sea and certain parts of Europe continue to be advised to receive protective inoculation against typhoid and paratyphoid fevers. The arrangement is now accepted practice and no incidents were reported.

PARATYPHOID FEVERS:

The diagnosis of *Salm. paratyphi B.* was confirmed in 18 cases compared with six in 1964 and 28 in 1963.

An outbreak involving more than 100 cases occurred in the Fylde area of Lancashire, the infection being conveyed by untreated farm bottled milk. Milk produced on the farm was supplied to four caravan sites and a number of hotels and boarding houses in the Blackpool area. It was apparent that cases were likely to occur over a wide area and Medical Officers of Health were alerted. Subsequently, they received lists from the Medical Officer of Health, Blackpool, of holiday makers who were probably "at risk" on account of having stayed at a hotel or other establishment supplied with milk from the incriminated source.

All West Riding persons "at risk", and their contacts were followed up and in all 16 cases were diagnosed.

The organism was phage type 3B var. 6 and in general the infection was mild so that few persons required hospital admission. Indeed, many had recovered clinically before faecal specimens were found to be positive. The majority of cases cleared up fairly quickly and it was found that short courses of neomycin were helpful in clearing the residual infection from the alimentary system. The two remaining cases had no connection with each other, nor the above outbreak, and made satisfactory recoveries.

The hazard associated with imported bulk egg and egg products has been recognised for a number of years and outbreaks in recent years, especially in 1963, led to the introduction from 1st January, 1964, of Regulations requiring all imported whole egg to be pasteurised. This measure has removed the uncertainty previously associated with this food.

Food Poisoning:

As in previous years information in regard to the incidence of food poisoning has been obtained from the statutorily notified cases and the reports of Medical Officers of Health on outbreaks and associated investigations. There was a welcome reduction in incidence, 82 cases being notified and 68 ascertained during the course of investigations, a total of 150 incidents, compared with 183 in 1964 and an annual average of 322 in the period 1960-64.

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		
<i>Salmonella typhimurium</i>	3	16	—	—	14	30
Other <i>Salmonellæ</i>	1	3	—	—	15	18
<i>Cl. welchii</i>	—	—	1	3	1	4
<i>Staph. aureus</i>	—	—	—	—	15	15
Other organisms	—	—	—	—	—	—
Not discovered	11	62	—	—	21	83
All agents	15	81	1	3	66	150

In addition there were 11 symptomless excretors and 63 salmonella infections not food-borne reported.

Of the known causes of the outbreaks and sporadic cases, salmonellæ were responsible for 72 per cent. (*S. typhimurium* 45 per cent.), *Staph. aureus* 22 per cent. and *Cl. welchii* 6 per cent.

No outbreak of any significance was reported.

The pre-cooking of food, especially meat and meat products, followed by imperfect cooling or storage carries an unnecessary risk of food poisoning.

Carelessness also makes a contribution to incidence and, while observance of the Food Hygiene Regulations has assisted in the reduction, 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 1965 only one case was notified which responded 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 93 per annum compared with 47 in 1965.

Anthrax:

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

The procedure of referring all cases of suspected anthrax at factories, warehouses and docks where materials with an anthrax risk are handled for immediate medical advice has continued but no positive case arose.

In September the Ministry of Health issued Circular 19/65 concerning the desirability of offering active immunisation against anthrax to workers who are particularly exposed to the risk of contracting the disease. In the West Riding there are a number of factories and industries recognised as being at risk and the Authority approved the introduction of such a scheme in January, 1966.

Influenza:

The disease is not notifiable and the most reliable index of morbidity is the variation in the weekly returns of new claims to sickness benefit issued by the Ministry of Pensions and National Insurance, supplemented by information regarding school and industrial absentees, notifications of pneumonia and deaths attributed to influenza.

No outbreak of any significance was reported and at the year-end there was no indication of the outbreaks which were to arise in various parts of the County in late January to March, 1966.

TUBERCULOSIS

Deaths from Tuberculosis:

There were 69 deaths from tuberculosis (61 respiratory and 8 non-respiratory) representing a death rate of 0.040 (0.035 respiratory and 0.005 non-respiratory), which corresponds with the England and Wales death rate of 0.048 (0.042 respiratory and 0.006 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	-	-	1	2	3	9	2	8	1	18	3	10	3	48	13	61
Non-respiratory	-	1	-	-	-	-	-	-	1	-	1	1	-	-	1	-	1	-	2	-	6	2	8
Totals ...	-	1	-	-	-	-	1	-	1	1	3	4	9	2	9	1	19	3	12	3	54	15	69

Notification of Tuberculosis:

There were 416 primary notifications of tuberculosis arising during the year and 13 supplemental notifications, a total of 429 as compared with 496 (482 primary and 14 supplementary) notifications in 1964. 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 ...	...	3	1	3	2	4	7	13	30	42	38	55	34	13	245
Respiratory, Females ...	...	-	1	5	5	3	11	7	23	22	11	8	5	-	101
Non-Respiratory, Males ...	...	-	-	1	-	2	4	4	4	6	1	2	-	3	27
Non-respiratory, Females ...	...	-	-	2	3	2	3	1	11	7	5	2	5	2	43
															416	
SUPPLEMENTAL NOTIFICATIONS:																
Respiratory, Males ...	...	-	-	-	-	-	-	-	1	1	2	2	3	2	11
Respiratory, Females ...	...	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Non-respiratory, Males ...	...	-	-	-	-	-	-	-	-	1	-	-	-	-	1
Non-respiratory, Females		-	-	-	-	-	-	-	-	-	-	-	1	-	1	
															13	

The sources of information of the supplemental notifications were local Registrars (5 respiratory and 2 non-respiratory), transferable deaths from the Registrar General (2 respiratory) and posthumous notifications (4 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 7,970, a decrease of 594 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, 1965				Number of cases added to register				Number of cases removed from register				Number of cases remaining on register 31st December, 1965				Per 1,000 Popu- lation	
	Respiratory		Non-Res- piratory		Respi- ratory		Non-Res- piratory		Respi- ratory		Non-Res- piratory		Respiratory		Non-Res- piratory			
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F		
1	174	107	19	31	6	3	—	3	13	14	1	2	167	96	18	32	313	3.9
3	220	102	26	28	15	9	3	3	65	20	16	17	170	91	13	14	288	5.1
4	203	110	9	10	20	5	—	2	30	26	2	1	193	89	7	11	300	4.3
5	311	200	38	42	23	17	—	3	73	51	8	17	261	166	30	28	485	4.0
7	231	157	25	41	23	9	—	—	5	6	—	—	249	160	25	40	474	4.3
9	84	62	16	14	2	7	3	2	23	24	8	3	63	45	11	13	132	2.3
10	124	95	16	20	6	5	1	2	8	7	1	1	122	93	16	21	252	5.5
11	210	132	15	13	9	8	1	2	22	8	—	—	197	132	16	15	360	6.2
12	215	155	36	50	16	8	2	1	15	9	1	1	216	154	37	50	457	6.9
13	99	52	9	24	9	10	—	2	14	14	1	3	94	48	8	23	173	1.9
15	62	54	39	19	17	10	6	2	19	10	9	7	60	54	36	14	164	3.3
16	83	71	15	10	10	8	—	2	18	22	—	5	75	57	15	7	154	2.4
17	40	20	8	9	6	3	1	1	9	8	4	2	37	15	5	8	65	1.3
18	176	106	13	9	26	13	4	1	15	5	1	—	187	114	16	10	327	5.4
19	164	101	18	18	9	5	1	2	27	23	5	12	146	83	14	8	251	4.8
20	170	106	25	32	6	3	—	2	45	26	3	9	131	83	22	25	261	2.8
23	228	166	25	35	14	5	1	2	23	19	2	3	219	152	24	34	429	6.3
Leeds R.H.B.	2,794	1,796	352	405	217	128	23	32	424	292	62	84	2,587	1,632	313	353	4,885	4.1
22	330	190	76	61	22	5	6	4	40	31	7	3	312	164	75	62	613	6.6
25	233	146	38	30	8	2	2	2	9	8	5	9	232	140	35	23	430	5.4
26	393	235	45	56	29	8	2	5	32	14	2	—	390	229	45	61	725	6.6
27	334	284	88	60	31	12	1	4	53	45	1	2	312	251	88	62	713	5.9
29	101	67	31	22	6	10	—	—	17	21	1	—	90	56	30	22	198	5.3
31	204	118	41	34	17	10	—	3	13	6	2	—	208	122	39	37	406	4.1
Sheff. R.H.B.	1,595	1,040	319	263	113	47	11	18	164	125	18	14	1,544	962	312	267	3,085	5.7
West Riding	4,389	2,836	671	668	330	175	34	50	588	417	80	98	4,131	2,594	625	620	7,970	4.6

Care and After-Care of the Tuberculous:

The ancilliary 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 557 patients were granted free milk during the year and 362 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 1965, 2 patients whose conditions did not permit their return to normal competitive employment, were admitted to training settlements, 1 to Sherwood and 1 to the British Legion Village at Maidstone. There were 2 discharges from Sherwood throughout the year, leaving 5 patients still in residence at 31st December, 1965—at Papworth (1), Sherwood (3) and the British Legion Village (1).

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 £985. 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.

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 1,426 contacts were vaccinated, 27 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	105	130	58	41	61	40	31	37	129	60	11	14	717			
Female	121	98	67	41	54	38	29	35	105	57	23	41	709			
TOTAL	226	228	125	82	115	78	60	72	234	117	34	55	1,426			
Result of Vaccination:																
Successful:																
Male	72	114	46	38	48	33	26	30	102	44	8	14	575			
Female	90	89	57	34	40	28	23	31	71	45	17	32	557			
TOTAL	162	203	103	72	88	61	49	61	173	89	25	46	1,132			
Unsuccessful	2	4	3	2	3	2	1	1	6	3	-	-	27			
Not finally ascertained	62	21	19	8	24	15	10	10	55	25	9	9	267			

(b) SCHOOL CHILDREN.—Fifteen thousand, six hundred and eighty-two were vaccinated under the County scheme, and the following is a summary of the work carried out.

Acceptances:

Number of children offered tuberculin testing and vaccination if necessary	28,511
Number found to have been vaccinated previously	562
Number of acceptances	21,270
Percentage of acceptances	76.1

Pre-vaccination tuberculin test:

Number of children tested	19,434
----------------------------------	--------

Result of test:

	Heaf Test	Mantoux Test	
Positive	2,336	359	
Negative	11,586	4,425	
Not ascertained	603	125	Total 19,434
Percentage positive	16.8	7.5	14.4

Vaccination:

Number vaccinated—

Following negative Heaf Test	...	...	11,545	
Following negative Mantoux Test	...	...	4,137	Total ... 15,682

Tuberculin test twelve months after vaccination:

Number tuberculin tested after 12 months	...	...	...	1,738
Result of test—				
Positive	...	...	...	1,560
Negative	...	...	...	127
Not ascertained	...	...	...	51
			Total	... 1,738

(c) STUDENTS ATTENDING UNIVERSITIES, TEACHER-TRAINING COLLEGES, TECHNICAL COLLEGES OR OTHER ESTABLISHMENTS FOR FURTHER EDUCATION.—

Eighty-one students were tested and, of the 37 who were found to be negative, 34 were vaccinated.

Mass Radiography:

Seventy-one thousand six hundred and seventy-five persons from the Administrative County were examined by the Mass Radiography Service, 48,619 by units of the Leeds Regional Hospital Board and 23,056 by units of the Sheffield Regional Hospital Board. It will be seen from the tables below that 51 (0·07 per cent. of the total examined) cases of active tuberculosis and 211 (0·29 per cent.) cases of inactive tuberculosis were discovered; there were also 1,014 (1·40 per cent.) non tuberculous abnormalities found, 505 (49·80 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 58·55 in the Sheffield Region and only 10·32 in the Leeds Region.

A.—LEEDS UNITS

Survey undertaken in Division No.	Number Examined	Abnormalities Discovered			
		Tuberculosis		* Other	Total
		Active	Inactive		
1 (Skipton)...	3,543	2	8	24	34
3 (Keighley) ...	3,855	6	13	22	41
5 (Horsforth) ...	6,865	1	17	9	27
7 (Harrogate) ...	1,150	1	—	3	4
9 (Wetherby) ...	3,855	1	1	1	3
10 (Goole) ...	3,053	—	7	23	30
11 (Castleford) ...	1,059	—	—	15	15
12 (Pontefract) ...	6,018	—	—	—	—
13 (Morley) ...	2,849	4	5	7	16
15 (Batley) ...	1,387	—	3	7	10
16 (Rothwell) ...	1,425	—	3	—	3
17 (Spenborough) ...	3,317	11	14	18	43
18 (Brighouse) ...	4,670	5	7	35	47
19 (Todmorden) ...	249	—	2	1	3
20 (Colne Valley) ...	5,324	6	14	19	39
TOTALS	48,619	37	94	184	315

B.—SHEFFIELD UNITS

Survey undertaken in Division No.	Number Examined	Abnormalities Discovered			
		Tuberculosis		* Other	Total
		Active	Inactive		
22 (Wortley) ...	7,370	5	22	171	198
25 (Barnsley) ...	2,590	2	5	134	141
26 (Wath upon Dearne) ...	1,725	—	15	102	117
27 (Doncaster) ...	5,273	3	28	250	281
29 (Thorne)...	1,982	—	20	54	74
31 (Rotherham) ...	4,116	4	27	119	150
TOTALS ...	23,056	14	117	830	961

Totals for the County Area ... 71,675 51 211 1,014* 1,280

*Details of the 1,014 " Other " abnormalities are as follows:—

	<i>Leeds Region</i>	<i>Sheffield Region</i>
1. Anatomical abnormalities—congenital	3	11
2. Anatomical abnormalities—acquired	3	21
3. Tumours of the bony thorax; primary and secondary	1	4
4. Congenital pulmonary malformations	1	—
5. Bacterial or virus pulmonary infections	24	24
6. Other infections of lungs: fungus and parasitic ...	—	—
7. Bronchiectasis	18	24
8. Honeycomb lung	—	1
9. Emphysema	2	27
10. Pulmonary fibrosis—non-tuberculous	18	49
11. Pneumoconiosis	19	486
12. Spontaneous pneumothorax	—	—
13. Benign neoplasms of lungs and mediastinum ...	3	10
14. Primary malignant neoplasms	3	9
15. Secondary malignant neoplasms	2	—
16. Hilar and bronchial adenitis	—	1
17. Sarcoidosis	11	6
18. Pleural thickening	9	43
19. Abnormalities of diaphragm and œsophagus ...	10	10
20. Cardiovascular lesions: congenital	10	1
21. Cardiovascular lesions: acquired	20	96
22. Miscellaneous	18	7
23. Pneumoconiosis and tuberculosis... ..	—	—
24. Awaiting classification	9	—
	<hr/> 184	<hr/> 830

VENEREAL DISEASES

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 1965. They indicate the trend of new infections but do not represent the true incidence of venereal diseases and other sexually transmitted diseases in the County. New cases are classified, as soon as possible, after attendance at clinics into one of three groups, syphilis, gonorrhœa or other conditions. Cases of syphilis are sub-divided according to the stage and type of the disease (e.g. primary, cardiovascular, congenital). Other conditions include sexually transmitted diseases such as trichomoniasis and inclusion blennorrhœa and various non-venereal conditions.

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
1964	67	286	1,841	2,194
1965	57	327	2,153	2,537

The total number of new patients increased by 343 from 2,194 to 2,537. Syphilis in the above table includes early acquired (infectious), late acquired and congenital syphilis. Cases of syphilis decreased by 10 to 57; 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 41 to 327. The highest number of new cases of gonorrhœa was recorded in 1946; the lowest in 1956. From 1959 to 1962 the trend was downwards, but in the last three years there has been a minor reversal of this trend.

During 1965 "other conditions" increased by 312 to 2,153. Since 1957 the trend in this group has been upwards. The figures are more than four times the pre-war level. Of all new patients 84 per cent. were classified as "other conditions". The corresponding percentages for syphilis and gonorrhœa were 2 per cent. and 14 per cent.

Table B.

Syphilis— type and stage of disease.

Year	Syphilis			
	Acquired		Congenital	
	Early	Late	Under 1 year	Over 1 year
1950	76	221	4	56
1951	58	144	4	41
1952	19	163	1	36
1953	9	155	1	49
1954	7	144	—	27
1955	6	128	1	40
1956	9	120	—	26
1957	1	122	—	29
1958	5	99	—	20
1959	12	80	—	20
1960	—	73	—	10
1961	4	67	—	14
1962	4	55	1	9
1963	5	57	—	12
1964	8	51	1	7
1965	8	45	—	4

A few cases of early acquired (infectious) syphilis continue to be found in the Administrative County. In some of the county boroughs there have been small increases in the last decade and it is likely that more cases will be diagnosed in the Administrative County residents in the next few years. It is encouraging to report that in the last ten years only two cases of congenital syphilis in infants under one year of age have been found.

These excellent results are a tribute to the doctors, serologists, midwives, health visitors, and social workers whose work in dealing with expectant mothers has been so successful in the prevention of congenital syphilis.

Table C.
Distribution of New Cases by Treatment Centres.

Special Treatment Centre	Syphilis	Gonorrhœa	Other Conditions	Total
Barnsley Clinic, Queen's Road	5	8	89	102
Bradford St. Luke's Hospital	1	53	203	257
Burnley Victoria Hospital	—	2	14	16
Dewsbury General Hospital	6	28	99	133
Doncaster Royal Infirmary	11	36	336	383
Goole Bartholomew Hospital	2	1	6	9
Halifax Royal Infirmary	2	20	93	115
Harrogate General Hospital	3	22	103	128
Huddersfield Royal Infirmary	1	23	140	164
Hull, Mill Street Clinic	—	3	21	24
Keighley Victoria Hospital	1	15	103	119
Leeds General Infirmary	8	57	303	368
Oldham & District General Hospital	—	—	4	4
Rotherham Moorgate General Hospital	4	17	172	193
Sheffield Royal Hospital	5	4	25	34
Sheffield Royal Infirmary	—	3	21	24
Wakefield Clayton Hospital	7	30	363	400
York County Hospital	1	5	58	64
	57	327	2,153	2,537

The addresses of special clinics at which new patients attended during 1965 and the number of cases of each disease diagnosed are given in Table C. 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. Twelve of these centres were in West Riding county boroughs, three in West Riding municipal boroughs, two in Lancashire and one in the East Riding.

Table D.
New Cases—Sex Distribution.

	Males	Females	Total
Syphilis	33	24	57
Gonorrhœa	224	103	327
Chancroid	1	—	1
Lymphogranuloma Venereum	1	—	1
Granuloma Inguinale	—	—	—
Non-gonococcal Urethritis	488	—	488
Non-gonococcal Urethritis with Arthritis	7	—	7
Late or Latent Treponematoses—non-syphilitic	1	—	1
Other Conditions requiring treatment	360	409	769
Not requiring treatment	532	349	881
Undiagnosed at 31st December, 1964	2	3	5
	1,649	888	2,537

The above table shows the sex distribution of new cases of syphilis, gonorrhœa and other conditions. The ratios of males to females were respectively 1·5:1, 2·1:1, and 1·8:1.

The 327 cases of gonorrhœa represent a smaller number of individuals because some patients acquired the disease on more than one occasion during the year.

The following table gives the age groups of new patients found to be suffering from gonorrhœa:

Sex	Under 20		20 to 24		25 and over	
Males	13	6%	63	28%	148	66%
Females	31	30%	34	33%	38	37%

V.D. Social Work:

The staff consists of three social workers who are all state registered nurses with health visitor's certificates. The work comes under the direction of the consultant venereologist who is adviser in venereal diseases to the County Council and is responsible to the County Medical Officer for V.D. prevention and after-care in the Administrative County. A confidential clerk-typist in the central office deals with the clerical and statistical work.

The County has been divided into three areas and each social worker traces the contacts, follows up the defaulters and is on the staff of one or more of the special clinics in her area in order to carry out the clinic social work.

Two of the areas are coterminous with the County Boroughs of Dewsbury, Doncaster, Halifax and Wakefield and two of the social workers undertake similar duties in these county boroughs. This is an excellent arrangement because the social workers cover a wide field unlimited by county borough boundaries.

The social workers have three main duties:—

(1) Social work. This is carried out mainly in the special clinics under the immediate direction of the physicians in charge. The social workers are able to speak to patients in private and help them with a great variety of problems relating to their diseases, their families, their homes and their work. No figures are available of the number of patients seen at the clinics but during the year there were 642 interviews with doctors and 1,410 miscellaneous interviews in addition to the work referred to above.

(2) Case finding. Three methods are used.

(a) The usual method is by means of the "contact slip" which the patient found to have V.D. or a sexually transmitted disease is asked to give to his or her contact with instructions that the contact should attend at a special clinic for examination.

(b) If the contact does not reside in the locality of the clinic the clinician may send information about the contact to his colleague in the area where the contact resides. In this event the social worker for the area will usually be asked to trace the contact and persuade him or her to attend a clinic for medical examination.

(c) If the contact slip cannot be used, or is unsuccessful, information about the contact is sent in confidence (using a special form and envelope) to the medical officer of health of the county or county borough in which the contact resides. The social worker employed by the local authority then deals with the contact as in (b).

The contact slip method is used at all the special clinics in the geographical county, but no figures are available of the number of contact slips issued to patients from the Administrative County. In addition some clinicians use the method described in (b) above and information about contacts is sent to the County Medical Officer from a few clinics.

Method (c) has a number of advantages and it is hoped that a standard scheme using the services of the local health department will be recommended by the Ministry of Health before long.

No statistics are available for (b). Table E shows the results obtained by contact tracing method (c). Of the few contacts reported to the County Medical Officer 80 per cent. were located by the County social workers.

Table E.

Case finding.

Total number of contacts reported	...	35				
Located and examined	...		26			
Not infected	...			13		
Infected	...			13		
Already under treatment	...				—	
Brought under treatment	...				13	
Syphilis	...					4
Gonorrhœa	...					6
Other conditions	...					3
Located	...		2			
Not examined	...			1		
Transferred to other authority	...			1		
Not located	...		7			
Insufficient information	...			4		
Unable to locate	...			3		

Antenatal Cases.

Pathologists working in the region send to the consultant venereologist the name and address of any doctor who has sent in for testing a specimen of blood from an antenatal patient giving a positive test for syphilis. The venereologist through the V.D. social worker offers assistance to the doctor in arranging the examination at a special clinic of the patient and her contacts.

Table F.

Antenatal patients with positive serological tests for syphilis.

Total number reported	Transferred to other local authorities	West Riding patients with positive tests	Not referred to Special Clinics	Referred to Special Clinics	Found to have Syphilis		Found not to have Syphilis
					New patients	Old patients	
40	10	30	12	18	2	13	3

Ten of the twelve antenatal patients were not referred to special clinics because repeat specimens of blood gave negative results. In the other two cases the family doctors preferred to undertake the treatment. None of twelve contacts of antenatal patients with syphilis were found to be infected (Table G).

Table G.

Contacts of antenatal patients found to have syphilis.

Number Examined	Found to have Syphilis	Found not to be infected
12	—	12

(3) Case holding. Known cases of venereal and sexually transmitted disease may, for a variety of reasons, cease attending before treatment has been completed or tests of cure carried out. In these cases the V.D. social workers are usually asked to communicate with the defaulters by letter or personal visit and help the patients to resume attendance (Table H).

Table H.

Defaulters.

Total number of defaulters	Returned to clinic after visiting	Failed to return	Removed, unable to locate	Transferred	Number of ineffective visits	Number of re-visits
143	107	23	6	7	269	217

PART IV

LOCAL HEALTH SERVICES

Co-operation between the Public Health Service and General Practitioners

Clinics as Surgery Accommodation

Cleckheaton Health Centre

Staff Matters

Interchange of Information

Care of Mothers and Young Children

Midwifery

Health Visiting

Home Nursing

Ambulance

Prevention of Illness, Care and After-Care

Health Education

Social Workers

Recuperative Home Treatment

Laundry Service for Incontinent Patients

Provision of Nursing Equipment

Liaison

Chiropody

Domestic Help

Mental Health

CO-OPERATION BETWEEN THE PUBLIC HEALTH SERVICE AND GENERAL PRACTITIONERS

During the year, the Department continued to expand schemes of attachment of staff and the renting of clinics to general practitioners who so wished.

Clinics as Surgery Accommodation:

The approval by the County Council to the standard rental provisions in January greatly eased the difficulties previously experienced in negotiations concerning premises.

Applications for help of this kind were received in large numbers throughout the early part of the year, until the uncertainties regarding the findings of the Review Body caused a temporary pause in the later months. Many existing County-owned clinics, particularly in the South part of the Riding, took on a new role as surgeries. In a few cases, where clinics were too small to accommodate all the general practitioners of the area who expressed interest, local agreement between them made it possible for those most in need to take up occupation immediately, on the promise to the remainder that extensions would be put in hand as a matter of urgency to allow them to follow suit as soon as possible.

The list below shows those localities where general practitioners were holding surgeries in County clinics and health centres on December 31st, 1965.

<i>Clinic</i>	<i>Type of Clinic</i>	<i>No. of General Practitioners in the practices concerned</i>	<i>Type of Surgery</i>
Birdwell	D	2	Branch
Calverley	Adapted	5	Main
Carcroft	C	2	Main
Cleckheaton	Health Centre	7	Main
Conisbrough	C	4	Main
Cottingley	Mini	5	Branch
Dalton	Adapted	3	Branch
Darfield	C	4	Branch
Dodworth	D	2	Main
Elland	Adapted	2	Main
Grimethorpe	C	1	Branch
Hemsworth	Special	3	Branch
Kirkburton	Adapted	2	Main
Mexborough	B	2	Main
Normanton	B	2	Main
Pudsey (Cringeleber)	Adapted	2	Main
Rastrick	Adapted	3	Main
Rawmarsh			
(Monkwood)	C	4	Branch
Scawsby	D	1	Main
South Elmsall	C	3	Branch
Southowram	Mini	5	Branch
Stocksbridge	D	2	Branch

Construction of new buildings, specially designed to further co-operation between public health staff and general practitioners, did not fare so well as the utilisation of existing clinics. The end of the year saw only three mini-clinics on the ground, though the use of two of them by general practitioners has given much encouragement. The delay has been principally that due to setting up a new production line for a standard building. This now accomplished, output may be expected to increase in succeeding years. The costings and increased public health function resulting from one year's experience in the new mini-clinic at Southowram is summarised below.

Southowram Clinics—successive years compared

	<i>The old clinic—1964</i>	<i>The new mini-clinic 1965</i>
Total attendances at Infant Welfare Clinics ...	925	1,929
Functions	3 sessions per week (public health)	3 sessions per week (public health)
		6 branch surgery sessions per week (3 practices)
		Daily use by Health Visitor
Running costs (one year)	£135 0s. 0d. per annum, plus rates	
		£ s. d.
		Rates ... 52 10 0
		Water ... 2 4 0
		Electricity ... 89 15 5
		Cleaning ... 139 7 6
		<hr/> 283 16 11
		Less rents for branch surgeries 60 0 0
		<hr/> Net cost ... 223 16 11
		(per annum) <hr/>

The "E" type clinic design incorporating the new principle of shared accommodation was not approved in time for any to be completed in 1965, but rapid building might be expected in later years.

Cleckheaton Health Centre:

This centre was opened by Sir George Godber in April. Although constructed before the evolution of present-day West Riding policy, it has aroused much interest and has been visited by many persons concerned with similar provision elsewhere in the country. I am indebted to Dr. Douglas, Divisional Medical Officer (Spenborough), for the following report:—

"The centre was occupied in October, 1964, and was officially opened by Sir George Godber on the 2nd April, 1965. A description of the accommodation and an outline of the services provided from the centre have been given in a previous report.

At the end of its first full year of working, it is possible to say that many of the aims of health centre development have been accomplished and that the framework which it provides for the expansion and integration of medical services is being utilised so far as possible under the present administrative structure of the National Health Service. Thus, a large number of the public have been provided with pleasant and convenient premises in which to obtain medical and social services covering a wide field of human need. The general practitioners have accommodation of a high standard in which to conduct their practices, and there has been a steady development of activities on the public health or preventive side, the point being that these are not being developed in isolation but in close co-operation with the general practitioners, the hospital service and the district council.

So far, the only involvement of hospital personnel in the work of the health centre is in the establishment of the monthly advisory paediatric clinic, an ophthalmic clinic for school children, and the attendance of a consultant psychiatrist at the socio-therapeutic contact club for mentally disturbed patients. I feel that there is opportunity for the expansion of the activities of hospital medical staff within the health centre.

The contact club has been very well attended during the year since transfer to the health centre; there has been considerable expansion in the preparation-for-parenthood course which is given to expectant mothers; in conjunction with the Welfare Officer, a weekly club for handicapped persons has been established; the family planning clinic goes from strength to strength and the location of the Registrar of Births and Deaths in an office in the health centre provides yet another convenient service for the public, and the Police conduct a Tufty Club for teaching road safety to pre-school children.

Many interesting matters have been discussed at the medical staff committee meetings which have been held at regular intervals, among these being the possibility of joint purchase of medical equipment such as an electro-cardiograph and the possible use of a laboratory technician on an experimental basis.

While these matters have not yet come to fruition, they have at least stimulated interest and discussion.

I do not think any serious snags have been encountered and I think it is true to say that the many visitors to the health centre, official and otherwise, have been impressed with the standard of accommodation, the facilities provided, and the progress made towards co-operation and integration."

Staff Matters:

During the year, a survey of possible staff attachment needs was made throughout the County and the progress made since is summarised below. It is encouraging in that former barriers of prejudice are diminishing and the advantages of informal consultations are being brought to bear on the patients' problems from both aspects of the domiciliary services.

Attachments of Field Staff to General Practitioners

	<i>No. of Health Visitors attached</i>	<i>No. of Home Nurses attached</i>	<i>No. of Midwives attached</i>
At 31st December, 1964	68	33	27
At 31st December, 1965	128	47	43

Employment of General Practitioners by the County Council in Infant Welfare Clinics

	<i>Total Doctors' Sessions</i>	<i>General Practitioners' Sessions</i>	<i>Percentage of total sessions done by General Practitioners</i>
1963	12,118	5,212	43
1964	12,492	5,496	44
1965	11,761	5,844	49

Employment of General Practitioners by the County Council in Antenatal/Post-Natal Clinics

		Total Sessions	General Practitioners' Sessions	"Midwives only" Sessions	Percentage of total sessions done by General Practitioners
1963	...	3,557	1,390	323	39
1964	...	3,253	1,267	242	39
1965	...	3,009	1,122	258	37

Rent-free Infant Welfare Sessions conducted in County Clinics by General Practitioners for their own patients with the Health Visitor in attendance

			Sessions	No. of General Practitioners involved
1963	...	...	Nil	—
1964	...	...	Nil	—
1965	...	...	46	2

Rent-free Antenatal Sessions conducted by General Practitioners for their own patients in County Clinics

			Sessions	No. of General Practitioners involved
1963	...	...	588	15
1964	...	...	902	25
1965	...	...	1,456	36

Midwives attending antenatal patients in General Practitioners' surgeries (outside clinics)

			Sessions attended	Midwives involved
1963	...	...	1,621	62
1964	...	...	1,945	67
1965	...	...	1,905	85

Interchange of Information:

In January the first issue of a quarterly bulletin "Health Notes" was produced by the Department. The intention of "Health Notes" is to keep general practitioners informed of departmental policy and other matters likely to be of importance and interest to them. It is issued, together with a Divisional Newsletter by each Divisional Medical Officer, to all family doctors in his area. During 1965 the main emphasis in "Health Notes" was the policy of co-operation

with general practitioners and its implementation. Three illustrated supplements were produced on the Cleckheaton Health Centre, on the "mini-clinics" and the E-type clinic.

The Divisional Medical Officers in their Newsletters also devoted more space to the policy of co-operation than any other topic. However, of equal importance has been the dissemination of local information on changes of staff and on new local projects.

"Health Notes" and its companion the "Divisional Newsletter" have together improved the communication between the Department and the family doctor. They are an essential part of the policy of co-operation and there is already clear evidence that these publications have played an important part in promoting it.

The Standing Sub-Committee on Co-operation continued to meet and was invaluable for exchanging views and surveying developments. A list of the matters discussed is appended.

February, 1965

1. Vaccination and immunisation records: payment for poliomyelitis records.
2. Cervical cytology.
3. V.D. diagnosis and treatment.
4. "Health Notes".
5. Surgeries and sessions for general practitioners in Health Department premises.
6. Objection to participation in future Castleford clinic.
7. Taking of blood samples and the giving of injections by nursing staff.
8. Co-operation with general practitioners and the passing on of information about school leavers with physical defects.
9. Perinatal mortality—midwives' records cards.

July, 1965

1. Payment for poliomyelitis records.
2. Interchanges of information with the school health service—
 - (a) School leavers
 - (b) Information about the mental level of child patients.
3. Perinatal Mortality—County midwives' record cards.
4. Perinatal mortality survey—Sheffield survey.
5. Cervical cytology.
6. Health Education Panels in general practitioners' surgeries.
7. "Health Notes".
8. The doctors' "Charter"—relationship with local health authority.
9. Timing of meeting.

October, 1965

1. Perinatal mortality.
2. Vaccination and immunisation—
 - (a) Poliomyelitis and triple vaccination and tetanus immunisation.
 - (b) Booster doses of poliomyelitis vaccine.
 - (c) Anthrax.
3. Research—
 - (a) Infective hepatitis.
 - (b) Influenza and poliomyelitis.
4. Medical documents for immigrants.
5. Policy of co-operation with general practitioners—
 - (a) Capital restriction.
 - (b) Commitments by general practitioners for rentals in premises not yet built.
 - (c) Local health authority clinics in general practitioners' premises.
6. Absence from school because of illness in the family other than that of the children.

CARE OF MOTHERS AND YOUNG CHILDREN

Vital Statistics:							Admin- istrative County	England and Wales
Live Births								
Number	...	...	...	...	...	...	31,463	
Rate per 1,000 population	...	...	...	...	...	...	18.2	18.0
Illegitimate Live Births per cent. of total live births							5.9	
Stillbirths								
Number	...	...	...	...	...	...	511	
Rate per 1,000 total live and still births	...	...	...	...	...	...	16.0	15.7
Total Live and Still Births	...	...	...	...	...	...	31,974	
Infant Deaths (deaths under 1 year)							652	
Infant Mortality Rates								
Total infant deaths per 1,000 total live births	...	...	...	...	...	...	20.7	19.0
Legitimate infant deaths per 1,000 legitimate live births	...	...	...	...	...	...	20.6	
Illegitimate infant deaths per 1,000 illegitimate live births	...	...	...	...	...	...	22.4	
Neonatal Mortality Rate (deaths under 4 weeks per 1,000 total live births)							13.9	13.0
Early Neonatal Mortality Rate (deaths under 1 week per 1,000 total live births)							11.5	
Perinatal Mortality Rate (stillbirths and deaths under 1 week combined per 1,000 total live and still births)							27.3	26.9
Maternal Mortality (including abortion)								
Number of deaths	...	...	...	...	...	...	5	
Rate per 1,000 total live and still births	...	...	...	...	...	...	0.16	0.25

Births:

There were 31,463 live births registered compared with 31,649 in 1964 and an annual average of 29,746 in the quinquennium 1960-64; the corresponding birth rates per 1,000 population being 18.2, 18.5 and 17.7 respectively. The decrease in the rate of 0.3 per 1,000 population for 1965 from the previous year suggests that the upward trend in the birth rate has been arrested and there is the possibility of the rate remaining around this level for a period until the children born during the post-war bulge era reach maturity.

The practice of relating births to population, although conventional and convenient, may be misleading. Comparisons of crude rates of single districts or aggregates are not basically valid since no regard is made to the varying age and sex structure of the respective populations. To surmount this difficulty an area comparability factor, which takes account of the proportion of women of child-bearing age in each local population, is applied to the crude live birth

rates. The live birth rates for the last six 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
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
1964	18.6	18.5	18.7	18.4
1965	18.3	18.1	18.4	18.0

Although the live birth rate declined slightly, the number registered as illegitimate increased to 1,872 or 5.9 per cent. of total live births. Between the two world wars the proportion was around the level of 4 per cent. per annum; during the last war there was a steep rise to 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 98.

In total there were 511 stillbirths registered, equivalent to a rate of 16.0 per 1,000 total births, the lowest yet recorded. During the past 20 years there has been an irregular decline in the rate both in the country and the County: although the County rate is now approaching the national figure there would appear to be still room for improvement.

The proportion of illegitimate stillbirths continues to be higher than the corresponding ratio among live births. Stillbirths registered as illegitimate represented 8.4 per cent. of the total stillbirths—an increase of 1.2 per cent. over the previous year—and is the highest level recorded since 1945.

Infant Mortality:

Deaths of infants in the first year of life numbered 652 equivalent to an infant mortality rate of 20.7 per 1,000 live births, the lowest on record for the Administrative County. In comparison with the previous year the rate declined by 1.5 per 1,000 live births and was 2.4 lower than the annual average during the period 1960-64. While these reductions are encouraging the national rate of 19.0 suggests that the irreducible hard core of mortality has not yet been reached.

Apart from minor fluctuations in certain years, since the turn of the century the infant mortality rate has pursued a downward trend as will be seen in the subjoined table:—

Period	Average Infant Mortality Rate		Year	Infant Mortality Rate	
	England and Wales	Administrative County		England and Wales	Administrative County
1901-1910	128	135	1961	21	25
1911-1920	100	109	1962	22	23
1921-1930	72	80	1963	21	23
1931-1940	59	61	1964	20	22
1941-1945	50	50	1965	19	21
1946-1950	36	40			
1951-1955	27	29			
1956-1960	23	25			

The relative contribution to the improvement in mortality during the past five years by sex and age is indicated in the following table:—

	Number of Deaths					Deaths per 1,000 Live Births				
	1961	1962	1963	1964	1965	1961	1962	1963	1964	1965
<i>Male Infants—</i>										
Under 4 weeks ...	293	297	269	281	255	19.9	19.2	17.0	17.4	15.6
4 weeks—3 months ...	50	42	43	52	56	3.4	2.7	2.7	3.2	3.4
3—6 months ...	38	50	42	37	39	2.6	3.2	2.7	2.3	2.4
6—12 months ...	34	40	43	34	35	2.3	2.6	2.7	2.1	2.1
Total under 1 year ...	415	429	397	404	385	28.3	27.8	25.1	25.0	23.6
<i>Female Infants—</i>										
Under 4 weeks ...	177	170	192	206	183	12.8	11.8	12.8	13.3	12.1
4 weeks—3 months ...	48	26	45	32	34	3.5	1.8	3.0	2.1	2.2
3—6 months ...	30	35	49	35	23	2.2	2.4	3.3	2.3	1.5
6—12 months ...	33	35	24	27	27	2.4	2.4	1.6	1.7	1.8
Total under 1 year ...	288	266	310	300	267	20.8	18.5	20.7	19.4	17.6
<i>All Infants—</i>										
Under 4 weeks ...	470	467	461	487	438	16.5	15.7	15.0	15.4	13.9
4 weeks—3 months ...	98	68	88	84	90	3.4	2.3	2.9	2.7	2.9
3—6 months ...	68	85	91	72	62	2.4	2.9	3.0	2.3	2.0
6—12 months ...	67	75	67	61	62	2.3	2.5	2.2	1.9	2.0
Total under 1 year ...	703	695	707	704	652	24.6	23.3	23.0	22.2	20.7

From the foregoing table it will be noted that the major reduction in mortality was in the neonatal period. Although slight improvement was achieved at ages 3—5 months this was offset by increases in the remaining periods. The male excess mortality continues: total infant male deaths were in the majority in the ratio of 1.4:1 compared with the ratio at birth of 1.1:1.

Of the infant deaths 438 or 67 per cent. occurred within 28 days of birth; the resultant neonatal mortality rate of 13.9 per 1,000 live births was the lowest recorded. The number of deaths and death rates at various ages in the neonatal period for the past seven years are indicated below:—

	Number of Deaths							Deaths per 1,000 Live Births						
	1959	1960	1961	1962	1963	1964	1965	1959	1960	1961	1962	1963	1964	1965
Under 1 day ...	211	227	238	235	231	203	200	7.8	8.1	8.3	7.9	7.5	6.4	6.4
1—6 days ...	157	157	170	160	159	196	163	5.8	5.6	6.0	5.4	5.2	6.2	5.2
1—4 weeks ...	71	58	62	72	71	88	75	2.6	2.1	2.2	2.4	2.3	2.8	2.4
Total under 4 weeks	439	442	470	467	461	487	438	16.2	15.8	16.5	15.7	15.0	15.4	13.9

The distribution of infant deaths assigned to the groups of diseases comprising the International Short List appears on page 35 but to gain a clearer appreciation of the contributory causes a detailed analysis is appended:

Etiological 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	200	163	75	90	62	62	652
Prenatal and Natal Group (including congenital malformations)	Congenital malformations (750-759)	29	32	32	33	6	8	140
	Total causes mainly of prenatal and natal origin	163	111	12	1	1	—	288
	Immaturity alone, or primary to diseases other than of early infancy (774, 776)	64	41	4	—	—	—	109
	Attributed to maternal toxemia (769)	6	2	—	—	—	—	8
	Ill defined diseases of early infancy (773)	7	9	1	—	—	—	17
Postnatal Group	Postnatal asphyxia and atelectasis (762)	56	36	3	1	—	—	96
	Intracranial and spinal injury at birth (760)	21	17	3	—	1	—	42
	Other birth injury (761)	1	—	—	—	—	—	1
	Erythroblastosis (770)	6	6	—	—	—	—	12
	Hemorrhagic disease of newborn (771)	2	—	1	—	—	—	3
Unclassified	Total causes mainly of postnatal origin	6	18	30	50	52	47	203
	Gastro-enteritis (including diarrhoea of newborn) (571, 764)	—	—	11	6	3	5	25
	Pneumonia and bronchitis (490-493, 763, 500-502)	3	13	9	34	35	28	122
	Other diseases of respiratory system (470-475, 510-527)	1	1	3	2	3	2	12
	Causes classified as infective (001-138): others mainly infective in origin (340, 391-393, 480-483, 765-768)	—	3	5	3	4	8	23
Unclassified	Influenza (480-483)	—	—	1	—	—	—	1
	Otitis media and mastoiditis (391-393)	—	—	1	1	1	1	4
	Septicemia, sepsis of newborn (053, 765-768)	—	1	—	—	—	—	3
	Meningococcal infections and non-meningococcal meningitis (057, 340)	—	2	3	1	1	3	10
	Tuberculous meningitis (010)	—	—	—	—	2	1	1
Unclassified	Causes classified as infective not mentioned above (remainder 001-138)	—	—	—	—	—	—	4
	Accidental mechanical suffocation from vomit, food, foreign body, or in cot (E921-E925)	—	1	1	5	6	1	14
	Lack of care, neglect (including foundlings), infanticide (E926, E980-E985)	2	—	—	—	—	—	3
	Other violent causes (remainder E800-E999)	—	—	—	—	—	—	4
	Other remaining causes	2	2	1	6	3	7	21

The number of deaths in the first week of life decreased from 399 in 1964 to 363 and was equivalent to a death rate of 11.5 per 1,000 live births. Of these deaths 92 per cent. were due to conditions present before, or during birth. The major contributions to mortality at these ages, in descending order were immaturity 105 (29 per cent. of the total deaths under 1 week), postnatal asphyxia and atelectasis 92 (25 per cent.), congenital malformations 61 (17 per cent.) and birth injuries 39 (11 per cent.).

Improvements in mortality under 1 day as compared with the previous year were recorded for postnatal asphyxia which declined from 67 to 56, erythroblastosis 11 to 6, and congenital malformations 32 to 29; these gains were partially offset by increases due to birth injuries which increased from 13 to 22 and immaturity from 62 to 64. At ages 1—6 days, mortality declined from 196 to 163, the major decreases recorded were birth injury which reduced from 29 to 17, immaturity from 50 to 41, and postnatal asphyxia and atelectasis from 44 to 36.

Congenital malformations continued to make the major contribution to mortality in the 1—4 weeks age group with 32 deaths (43 per cent. of total deaths 1—4 weeks), followed by gastro-enteritis 11 (15 per cent.) and pneumonia and bronchitis 9 (12 per cent.).

At ages 1 month to 1 year there were 214 deaths, with pneumonia and bronchitis 97 deaths (83 in 1964), congenital malformations 47 (41), infective diseases 15 (15) and gastro-enteritis 14 (21), being the main contributory causes.

Perinatal Mortality:

Perinatal mortality, which comprises stillbirths (from the 28th week of pregnancy) and early neonatal deaths (during the first week of life) provides a measure of the loss of infant life due to conditions associated with pregnancy and events during labour and delivery.

	1955	1956	1957	1958	1959	1960	1961	1962	1963	1964	1965
Perinatal mortality (per 1,000 total births)	40.8	39.5	39.7	36.7	33.7	35.9	34.2	31.5	31.1	30.0	27.3
Infant deaths at 1 week and over (per 1,000 total births)	11.1	10.1	9.9	9.9	10.2	8.5	10.1	9.9	10.1	9.5	9.0

Since records are available for the Administrative County, apart from minor fluctuations, the perinatal mortality rate has progressively declined. In 1965 a new low level of 27.3 per 1,000 total births was recorded. As mentioned previously, the major contribution to deaths in the first week of life were immaturity, postnatal asphyxia and atelectasis, congenital malformations and birth injuries. Many of these infants lived but a few hours and 65 per cent. of the deaths at these ages had a birth weight of 5½lb. or less clearly underlining the involvement of prematurity.

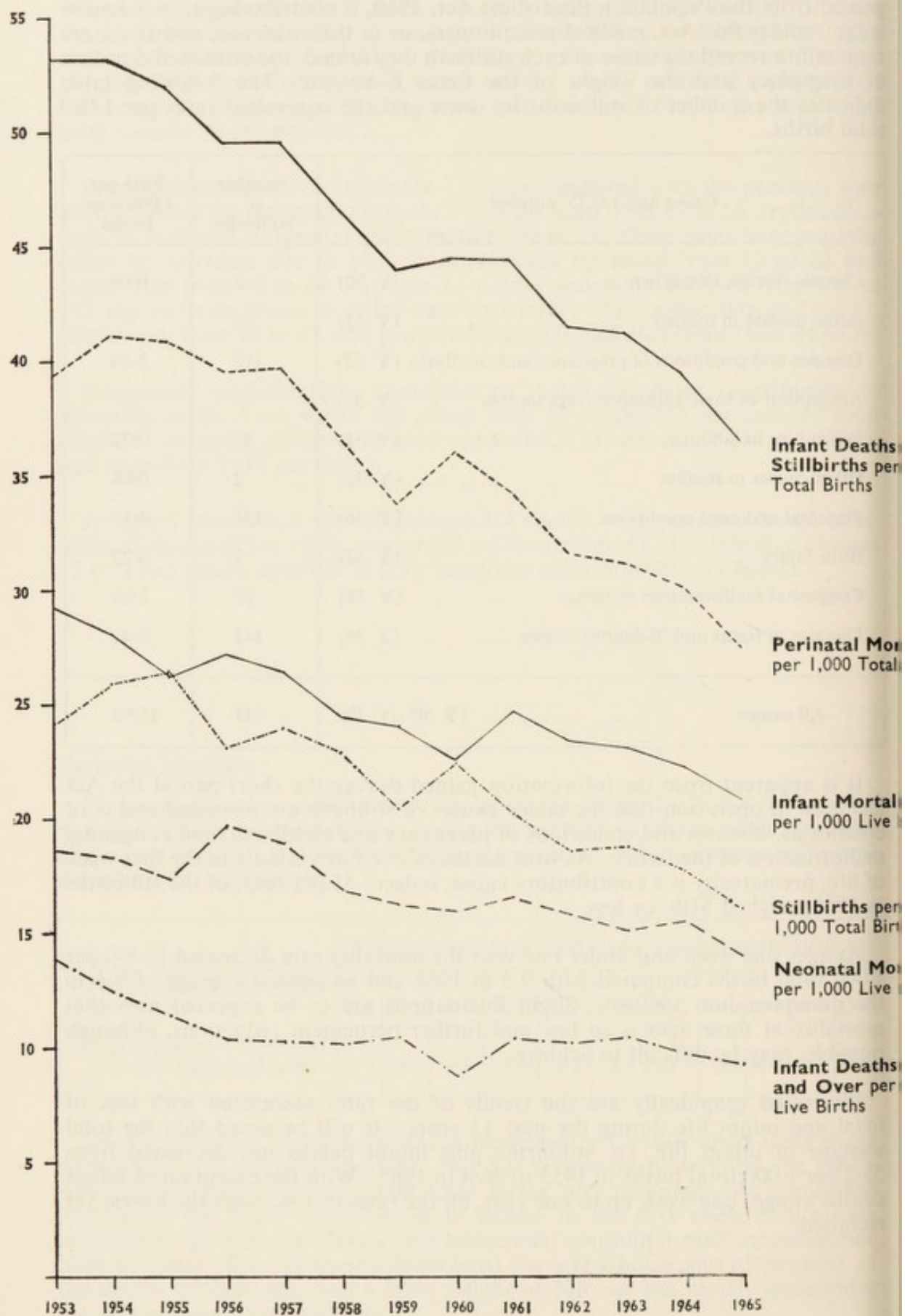
Stillbirths contributed 58.5 per cent. of the perinatal mortality. The information gained from the Population (Statistics) Act, 1960, is contributing to our knowledge: under this Act, medical practitioners, or in their absence, midwives, are required to record the cause of each stillbirth they attend, the estimated duration of pregnancy and the weight of the foetus if known. 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)	2	0.06
Acute disease in mother ... (Y 31)	—	—
Diseases and conditions of pregnancy and childbirth (Y 32)	117	3.65
Absorption of toxic substance from mother ... (Y 33)	—	—
Difficulties in labour... (Y 34)	23	0.72
Other causes in mother ... (Y 35)	2	0.06
Placental and cord conditions ... (Y 36)	134	4.19
Birth injury ... (Y 37)	7	0.22
Congenital malformation of foetus ... (Y 38)	85	2.66
Diseases of foetus and ill-defined causes ... (Y 39)	141	4.41
All causes ... (Y 30—Y 39)	511	15.98

It is apparent from the information gained during the short period the Act has been in operation that the major causes of stillbirth are placental and cord conditions, diseases and conditions of pregnancy and childbirth, and congenital malformation of the foetus. As with deaths of live born infants in the first week of life, prematurity is a contributory cause, indeed, 55 per cent. of the stillbirths in 1965 weighed 5½ lb. or less.

At ages one week and under one year the mortality rate decreased to 9.0 per 1,000 total births compared with 9.5 in 1964 and an annual average of 9.6 in the quinquennium 1960-64. Slight fluctuations are to be expected now that mortality at these ages is so low and further permanent reductions, although possible, may be difficult to achieve.

Illustrated graphically are the trends of the rates associated with loss of foetal and infant life during the past 13 years. It will be noted that the total wastage of infant life, i.e. stillbirths plus infant deaths has decreased from 53.2 per 1,000 total births in 1953 to 36.4 in 1965. With the exception of infant deaths at ages one week up to one year, all the rates in 1965 were the lowest yet recorded.



Maternal Mortality:

The number of deaths from maternal causes decreased to yet another record low level. Only 5 deaths were registered—1 from toxæmia and 4 “other complications”—compared with 13 in the previous year and an annual average of 12 in the quinquennium 1960-64. The equivalent death rates per 1,000 total births were 0·16, 0·40 and 0·41 respectively.

The table below affords a comparison of the national and County death rates from various causes for the past five years:—

Cause of Death	1961		1962		1963		1964		1965	
	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	0·10	0·05	0·16	0·03	0·09	0·04	—	} 0·19
Toxæmias of pregnancy and puerperium (not associated with abortion) ...	0·07	0·07	0·03	0·06	0·10	0·05	—	0·04	0·03	
Other complications of pregnancy, childbirth and the puerperium ...	0·21	0·16	0·03	0·17	0·16	0·14	0·16	0·12	0·13	
Abortion (with or without mention of sepsis or toxæmia) ...	—	0·07	0·03	0·07	0·03	0·06	0·16	0·06	—	0·06
Total Maternal Mortality...	0·27	0·33	0·20	0·35	0·45	0·28	0·40	0·25	0·16	0·25

Ante and Postnatal Services:

Three thousand and nine sessions for ante and postnatal examination work were held in the Authority's clinic premises during the year, at which 5,966 women attended for antenatal examination and 634 for postnatal examination, the total attendances made being 31,577 and 871 respectively. The number of sessions held and the number of women attending showed a further decrease on the figures for 1964, which is in keeping with the continuing trend for more and more patients to receive antenatal care from their own doctors or at hospital antenatal clinics.

More general practitioners are now using the Authority's clinic premises for seeing their own antenatal patients, the number of practices being 36 (81 general practitioners) compared with 25 for the year 1964. The domiciliary midwife is in attendance and 1,905 sessions were held during the year compared with 902 in 1964.

Eighty-five domiciliary midwives also attended 1,946 special sessions held in the surgery premises of some 116 doctors or practices.

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

No. of sessions:

(a)	separate ..	...	...	...	...	4,491
(b)	combined with antenatal clinics	...	...	...	...	51
					Total	4,542

No. of women attending:

(a)	hospital booked	...	...	...	...	4,117
(b)	domiciliary booked	...	...	...	...	1,617
					Total	5,734

Total number of attendances:

(a)	hospital booked	...	...	...	...	21,494
(b)	domiciliary booked	...	...	...	...	8,443
					Total	29,937

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

The Chief Dental Officer reports:—

In spite of the fact that 4 new clinics were opened during the year, there was again a drop in the number of expectant and nursing mothers treated. Approximately 30,000 births are registered each year in the West Riding and, therefore, about 45,000 women are eligible for dental treatment provided by the local authority's service. During 1965, 676 were inspected, an average of 1 per dental officer per month. The fact that for these 676 mothers 2,305 extractions were carried out and 348 full dentures and 179 partial dentures were supplied shows the nature of the treatment required by the mothers who do attend the clinics. Those girls who are most interested in the conservation of their teeth seek out a general practitioner when they leave school and continue to attend his surgery during their period of eligibility for priority treatment. As was mentioned last year, there is some evidence that mothers are receiving reasonably adequate attention from the general dental service. The condition of pre-school children gives more disquiet. A survey during the year of approximately 1,000 children aged 5 showed that, on average, they had 4 or 5 decayed teeth each and only one-quarter of the affected teeth had been treated, usually by extraction. Of 4,761 teeth found to have decayed, 909 had been extracted and only 254 had been filled.

In March, a dental officer of the Department of Education and Science reviewed the service and one of his suggestions was that a senior officer might be given the responsibility of developing the service for children under 5 years of age. It was decided that Mr. H. Taylor, Senior Clinical Dental Officer, should assume this duty and, at the end of the year, he and the Area Dental Officer responsible for dental health education had in hand plans for intensive campaigns, designed to stimulate demand, to be carried out in certain areas of the Riding commencing early in the new year. If these prove successful, the techniques used will later be applied to the whole of the County.

Expectant and Nursing Mothers:—

Number of cases examined	...	...	...	...	...	676
Number treated	...	...	...	...	...	588
Number made dentally fit	...	...	...	...	...	485
Number of extractions	...	...	...	...	...	2,305
Number of fillings	...	...	...	...	...	1,346
Number of general anæsthetics	...	...	...	...	...	288
Number of scalings and gum treatment	...	...	...	...	...	308
Number of dentures provided:	full upper or lower					348
	partial upper or lower					178
Number of X-rays	...	...	...	...	...	49
Number of crowns and inlays	...	...	...	...	...	12

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

Number inspected	...	...	...	...	...	1,222
Number treated	...	...	...	...	...	1,215
Number made dentally fit	...	...	...	...	...	1,215
Number of extractions	...	...	...	...	...	1,677
Number of general anæsthetics	...	...	...	...	...	662
Number of fillings	...	...	...	...	...	716
Number treated with silver nitrate	...	...	...	...	...	83
Number of scalings and gum treatment	...	...	...	...	...	0
Number of X-rays	...	...	...	...	...	8
Number of dentures provided	...	...	...	...	...	0

Infant Welfare:

At the end of the year, there were 239 static and 3 mobile clinics in operation, at which 570,710 attendances were made during the year—a decrease of 21,051 compared with 1964, but 36,068 more than in 1963. Attendances in 1964 were abnormally high, due in part to the attendance of children at 3 months and 9 months of age for examination under the scheme for the detection of congenital abnormalities.

An analysis of the total attendances shows that some 81 per cent. of children born during the year, 71 per cent. of those born during 1964 (between 1 and 2 years old), and 15 per cent. of those born during 1960 to 1963 (over 2 and under 6 years old) attended centres during the year.

There was further progress during the year in the provision of new clinics, 7 clinics being completed at Cottingley, Harrogate (Skipton Road), Southowram, Stocksbridge, Kirkheaton, Mexborough and Thorne. This brings the total of new clinics erected since 1955 to 53. The only clinic in the course of erection at the end of the year was that at Brighouse which also incorporates comprehensive dental facilities and a new divisional health office.

The new clinics at Southowram, Cottingley and Kirkheaton are the first of the new mini clinics and those at Southowram and Cottingley are being used very successfully by general practitioners for branch surgery purposes. Further details on the planning and use of clinics and health centres will be found in the section of the Report on "Co-operation with General Practitioners".

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

" Multiple Screening Tests

Two separate ethical considerations apply to programmes of screening.

I. For the adult public who are of an age of responsibility, to respond or not to respond to invitations to come and be screened, it may suffice to rely on propaganda and health education to discharge the responsibility of the preventive physician.

II. In contrast the young baby is at the mercy of negligent or procrastinating parents, who may even be unaware of facilities for screening tests and the importance to their child of what such tests might reveal.

For this vulnerable infant group there will always be the health visitor's anxiety about chasing up the non-attending fraction with much unprofitable expenditure of time and mileage.

Unidentified Syndromes

One of our chief anxieties is that we may be failing to recognise serious conditions which hitherto have remained undescribed or unidentified, and we do not know which of these might be amenable to preventive treatment. There are the two broad groups of the chromosome aberrations and the inborn errors of metabolism. Coupled with these there is our third perennial anxiety about unrecognised chronic poisoning by lead or mercury or aspirin or other drugs. Chromosome abnormalities are not merely museum curiosities. They may in some cases be a valuable pointer to the need for genetic counselling. Amongst the inborn errors of metabolism there are not only the phenylketonurics and similar enzyme defects, but the group of andreno-genital abnormalities which may lead to repeated newborn deaths in a family—lives which could have been saved if the condition were to be recognised and brought under treatment in the earliest days of life. The practical lesson probably is that no neonatal death should be written off without exhaustive study, and whenever a mother has lost a newborn baby without clear explanation there is a strong case for hospital delivery in future and intensive study of further newborn babies.

I have in previous years referred to the value of necropsy in stillbirths as well as infant deaths; because lessons frequently are learnt which would bring comfort and reassurance to perplexed parents and nurses. A recent case illustrates this again. A three-month-old baby died of pneumonia during an influenza epidemic. The parents might well have thought, with their lack of knowledge of virus diseases, that antibiotics ought to have saved the child's life. Necropsy revealed a mortal degree of leathery fibroelastosis of the endocardium of the left ventricle of the heart, which would certainly have proved fatal by lingering circulatory failure within a few months.

Urgent life-saving operative surgery for severe heart malformations in infancy is now becoming an everyday matter in the larger centres. It calls for exceptional resources in skilled medical and nursing and technical teamwork and in material equipment.

During the year we lost two babies within a few weeks with a severe grade of anæmia combined with uræmic grave inflammatory disease of the kidney. The association of these two aspects of disease remains obscure, and leaves us with anxiety for the future as to whether some preventable common factor is yet to be discovered (the ' hæmolytic-uræmic ' syndrome).

Hydrocephalus and Spina Bifida

The volume of work which is growing up in the main pædiatric surgical centres for this considerable group of children who are now surviving will continue to present anxious problems of staffing and management, and for education as so many more of these children are now surviving with intellect unimpaired.

Congenital Hip Dislocation

There is great cause for gratification in the number of dislocated hips which are being detected at the very outset and at the ideal age for orthopædic management with expectation of normal recovery.

Celiac Disease

The increasing control and prevention of infective diarrhoea in infancy has now permitted more ready recognition of metabolic diarrhoeas. Celiac disease, which is due to idiosyncrasy to wheat protein, should nowadays commonly be diagnosed in the first year of life rather than later, and is to be thought of in a child who is a non-thriving misery with anæmia, intermittent sickness or diarrhoea or episodes of apparent gastro-enteritis. The xylose absorption test is readily applied and can be confirmed by fat excretion tests so that a gluten-free diet may be started without delay, and months of growth retardation can be avoided. Those who have worked most with this condition advise continuing the special diet through to puberty in most cases.

Acute Respiratory Infections in Infancy

Several careful and extensive studies in different parts of the country are now showing that the great majority of the acute respiratory episodes which cause anxiety about infants are due to viruses, and in particular the Respiratory Syncytial Virus which can cause acute, and sometimes overwhelming, infection with cyanosis. It happens every year that a baby may appear for some days to have just a trivial cold, or to be suffering from a sharp chesty infection, and then suddenly become worse with extremely high fever and circulatory failure and death.

Fat Babies and their Diet

During the year I was approached by a careful family practitioner who also has considerable infant welfare clinic experience, as to whether the considerable numbers of fat babies seen at clinics would have presented any better shape if they had been fed a leaner ration. The question was whether early introduction of cereals, in which health visitors and mothers delight, is responsible for perverted growth and abnormal fattening.

I thought not, for two reasons. First, it is a fact that since before the war over a period of a few years the average weight of a two-year-old toddler in Britain had increased from 26lb. to 28lb. Credit was probably due partly to more careful balancing of infant dietary and more vigilant infant care by all infant welfare services under the threat of expected war-time starvation. Another factor, probably more important, is that the average British infant in the penicillin era suffers fewer devastating, emaciating illnesses, so that on average the heavier post-war toddler is really displaying what nature intended a healthy population to be like, after the intensity of infective illnesses had been reduced. I pointed out also that cereals are not in themselves specifically fattening. Cereals contain protein, and on the other hand milk contains carbohydrate and fat. When I want to make a baby gain weight faster I do not rely upon any specific effect of cereal, but I advise a mother to increase the number of scoops of milk powder.

There is in many of these fat babies a genetic factor which the family history would reveal

Expensive hand-outs for napkin rash at infant welfare clinics

A divisional medical officer raised with me the question of what is profitable treatment for napkin rashes now that a number of expensive steroid and barrier creams are being pressed upon us by manufacturers. My dermatologist colleagues emphasise that there is no one routine for all children. It is important to avoid soap and alkali when the baby's bottom is sore. Bacterial decomposition of urine can be reduced by meticulous laundering of napkins followed by impregnating the napkin in the final rinse with very dilute quaternary ammonium antiseptic.

Various soothing applications will relieve the skin. For some babies zinc and castor oil works well, and with others Lassar's Paste, diluted in equal parts with soft paraffin.

For other children the protective value of lanoline is admirable in the form of Unguentum Aquosum. In some babies a barrier cream seems to work.

If there are discrete small ulcers which suggest Thrush, then a specific application like Nystatin or Dequadin paint would be necessary first.

Toddlers

The commonest misfortune of older infants seems to be lack of understanding in the parent, and I still find interest and pleasure in the fact that the public regards the doctor as the appropriate guide out of disciplinary tangles of child management. Disobedience perhaps looks odd when written down as the clinical diagnosis, though there are often considerable underlying social problems in the older generation.

Families continue to be exhausted by unnecessary gross whooping cough in toddlers they have never taken for immunisation in babyhood. Mothers in many cases blame their neglect upon dogmatic anti-immunisation opinions of their husbands.

Problem Rarities

A toddler in and out of hospital repeatedly with colic and alleged bowel bleeding, in whom eventually intussusception developed of a benign lymphoma in the terminal ileum, which was resected with cure of the symptoms.

A four-year-old obstinate relapsing nephritis which needed prolonged steroid treatment, but this unluckily rendered uncontrollable the child's inherited familial obesity."

Phenylketonuria:

During 1965, 29,657 babies were tested either in clinics or at home during the fourth week of life, or as soon as possible afterwards, using the "Phenistix" test.

The test gave a positive result in 4 cases but in only 2 of these cases was the result confirmed. Details of these are as follows:—

Case 1 Boy, G.B. born 9-9-65.

Positive "Phenistix" test by health visitor at 4 weeks.

Phenylketonuria confirmed by hospital 25-10-65.

Admitted to hospital 1-11-65.

Discharged 20-2-66.

Dieting commenced 2-11-65.

Follow-up report (March, 1966):

Phenylalanine level on hospital admission 20 mg/100 mls and 1 mg/100 mls on 1-2-66. Put on diet of Albumade but refused. Changed to Minafen on which he did well. Discharge delayed because of episode of acute chest infection.

Case 2 Boy, A.H., born 31-8-65.

Positive "Phenistix" test by health visitor at 4 weeks (28-9-65).

Phenylketonuria confirmed by hospital 12-10-65.

Admitted to hospital 26-10-65.

Discharged 7-12-65.

Dieting commenced 26-10-65.

There was no follow-up report on this boy as he moved out of the Authority's area on 16-12-65.

The following are details of tests undertaken since the scheme commenced in March, 1960, to 31st December, 1965:—

Total number tested	...	...	...	...	...	165,275
Number of confirmed cases	...	...	...	...	...	9
Ratio of true cases of phenylketonuria to children tested	1	:	18,364			

Ortolani Testing for Congenital Dislocation of the Hip:

During 1965, 17 confirmed cases of congenital dislocation of the hip were discovered by hospital staff, domiciliary midwives, health visitors, clinic medical staff and general practitioners. This makes a total of 68 confirmed cases since the Ortolani test was introduced as a routine procedure in December, 1962.

Tests carried out during 1965:

(a) Cases referred to specialist, confirmed as congenital dislocation of the hip and splinted...	17
(b) Cases referred to specialist and said not to be congenital dislocation of the hip ...	31
(c) Cases referred to specialist, not splinted but given further review appointments ...	13

The following are details 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.				
R.	H.M.	18- 2-65 1- 5-65	1 18	Midwife General practitioner and health visitor	1/12 6/52
	C.B.	27- 7-65	14	Health visitor	6/52
	K.B.	4- 3-65	1	Hospital staff	3 days
D.R.G.		17-11-65	19	Health visitor	9/52
A.N.		4- 4-65	11	Health visitor	4/52
	A.P.	6- 6-64	336	Specialist	11/12
	A.J.A.	11- 8-65	approx. 33	Assistant County Medical Officer	10/52
	D.J.W.	17- 1-65	182	Medical Officer	6/12
	L.W.	20-11-65	28	Pædiatrician	6/52
	A.B.	29- 5-65	2	Pædiatrician	4½ days
	J.A.S.	11-10-64	17	General practitioner	7/12
I.L.W.		13- 1-65	14	General practitioner	11/52
	S.L.V.	27- 7-65	13	Health visitor	6/52
	C.F.	10- 9-65	1	Hospital staff	1/12
	D.L.B.	31- 3-65	182	Mother	7/12
	A.V.R.	10- 7-65	1	Hospital staff	1 day

Congenital Abnormalities:

Under the national scheme for the registration of congenital abnormalities discovered at birth and recorded on the notification of birth form, 555 babies with a total of 665 abnormalities were notified.

These figures cannot be regarded as representing a true incidence of congenital abnormalities as the scheme for notification is a voluntary one. Many West Riding births take place in hospitals situated in the county boroughs and pre-occupation with pressure of work resulting from, possibly shortage of staff and a high rate of confinement may easily lead to failure to detect or to record a congenital abnormality on the notification of birth form. In addition, incomplete inward transfers of birth notifications can be another source of inaccuracy.

The number of births registered in 1965 was 31,974, giving a percentage of 1.7 for babies with one or more congenital abnormalities. Under the previous County stop-gap scheme, in which the aim was to examine all babies on two occasions during the first year of life, congenital abnormalities were discovered in 4.4 per cent. of the babies. This serves to illustrate the limited value of the national scheme.

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 the last four years.

Year	National Dried Milk (Tins)	Cod Liver Oil (Bottles)	Vitamin A. & D. Tablets (Packets)	Orange Juice (Bottles)
1962	135,580	31,508	31,586	247,935
1963	127,325	30,953	31,442	296,498
1964	123,371	31,609	31,700	334,505
1965	111,956	33,080	29,129	376,350

At 31st December, 1965, there were 309 distribution centres in the County for the issue of welfare foods, of which 239 were Child Welfare Centres.

Illegitimate Children:

Of the total of 1,872 live illegitimate births, 1,454 were dealt with as indicated in the table below; 1,395 of them were of West Riding domicile, the remaining 59 being non-County cases. Two hundred and sixty-four County cases were accommodated during the ante or postnatal period in moral welfare homes under 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	...	238	44	282
Ascertained by Staff of the Health Department		905	5	910
Referred by other services	... ..	252	10	262
		—	—	—
Totals	... ..	1395	59	1454
		—	—	—

Analysis of cases:

Married	{ with previous illegitimate children	109	—	109
	{ without previous illegitimate children	190	2	192
Unmarried	{ with previous illegitimate children ...	172	6	178
	{ without previous illegitimate children	868	50	918
Widowed or Divorced	{ with previous illegitimate children ...	17	—	17
	{ without previous illegitimate children	39	1	40
		—	—	—
Totals	... ..	1395	59	1454
		—	—	—

Ages:

Under 15 years of age	...	...	...	...	6	—	6
15—19 years of age	...	...	...	...	561	33	594
20—24 years of age	...	...	...	...	403	23	426
25—29 years of age	...	...	...	...	218	2	220
30—39 years of age	...	...	...	...	179	1	180
40 years of age and over	...	...	...	...	28	—	28
Totals	...	...	...	...	1395	59	1454

Disposal:

Cases settled—Marriage	...	...	...	...	70	1	71
Baby died	...	...	...	...	48	2	50
Grandparents taking baby	...	...	...	...	37	1	38
Baby adopted	...	...	...	...	261	39	300
Baby fostered	...	...	...	...	39	2	41
Mother keeping baby	...	...	...	...	908	12	920
Cases referred elsewhere	...	...	...	...	4	1	5
Cases not finally settled	...	...	...	...	28	1	29
Totals	...	...	...	...	1395	59	1454

Accommodation was provided for the 264 cases in moral welfare homes as outlined below:—

	Ante and Post natal	Ante natal only	Post natal only	Governing Body
Bradford—Oakwell House	18	4	1	Bradford Corporation
Bradford—St. Monica's Home	22	1	—	Church of England
Bristol—St. Raphael's, Henbury	1	—	—	Roman Catholic Church
Eastbourne—Bell Hostel	1	—	—	Church of England
Halifax—St. Margaret's House	28	1	—	Church of England
Harrogate—St. Monica's Home	13	—	—	Church of England
Heywood—St. Anne's Maternity Home	2	—	—	Church of England
Huddersfield—Queen Street Mission	3	—	1	Methodist Church
Huddersfield—St. Katharine's Hostel	19	—	—	Church of England
Leeds—Browning House	24	2	1	Voluntary Committee
Leeds—Mount Cross, Bramley	12	2	—	Salvation Army
Leeds—St. Margaret's Home	15	—	—	Roman Catholic Church
Lincoln—The Quarry Maternity Home	7	—	—	Church of England
Mansfield—Grosvenor House	1	—	—	Church of England
Pontefract—"The Haven"	47	—	2	Church of England
Salford—St. Teresa's Mother and Baby Home	1	—	—	Roman Catholic Church
Sheffield—St. Agatha's Hostel	13	2	—	Church of England
Streatham—The Limes Mother and Baby Home	1	—	—	Church Army
Streatley—Widecombe House Mother and Baby Home	—	—	1	Church of England
Sunderland—Parker Memorial Home	1	—	—	Sunderland Corporation
Sutton on Hull—Sutton House	2	—	—	Church of England
Wiltshire—The Grange	1	1	—	Church of England
York—Heworth Moor House	12	1	—	Church of England
	244	14	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 2,210 premature births, of which 1,928 were live and 282 still. Of the premature live births, 15 per cent. were born at home and 85 per cent. in hospitals. Of those born at home, 84 per cent. weighed more than 4 lb.

**THE FATE OF PREMATURE BABIES BORN IN THE YEAR 1965 TO MOTHERS NORMALLY RESIDENT IN THE WEST RIDING
ADMINISTRATIVE COUNTY AREA WHEREVER THE BIRTH TOOK PLACE**

Total adjusted live births—31,463 Number of live premature births—1,928 Percentage of premature live births to total live births—6.1

Weight Group	Number of Premature Births					Number Dying														Number Surviving over 28 days					Percentage Survival 1965	Percentage Survival in previous years																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																					
	Born Alive				To-Born Dead	First Week							Second Week							A	B1	B2	C	Total																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																							
	A	B1	B2	C		Total	1	2	3	4	5	6	7	8	9	10	11	12	13							14	Over 14 up to 28 days																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																				
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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 101 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 11 Divisions, meetings were held quarterly or at more frequent intervals and, in 11 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 97 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.

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:—

<i>Division Number</i>	<i>Day Nursery</i>	<i>Number of Places Provided</i>	<i>Average Daily Attendance</i>
3	Keighley	50	37
4	Shipley	50	39
7	Harrogate	40	28
15	Heckmondwike	40	33
18	Brighouse	40	23

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 11 children in day nurseries administered by the County Boroughs of Halifax, Huddersfield, Sheffield and Wakefield, and at the end of the year 8 children were in attendance at day nurseries administered by these authorities.

MIDWIFERY

Institutional Midwifery:

The proportion of hospital confinements rose from 74 per cent. to 76 per cent. in the Leeds Regional Board area, and from 57 per cent. to 60 per cent. in the Sheffield Regional Board area, giving a County rate of 63·5 per cent.

The number of cases discharged early after delivery continued to rise, so that nearly 50 per cent. were sent home before the tenth day, half of these being between the fifth and ninth days.

Despite the decrease in the number of births, the number of women delivered in hospital rose. The opening of a twenty-bedded unit at the Montagu Hospital, Mexborough accounted for most of the increase in the Sheffield Regional Board area.

Division No.	Area	Population (estimated mid-1965)	Total notified births (Live and Still)	Place of Birth					
				Hospital				Domiciliary	
				No.	No. of Early Discharges			No.	%
					At 48 hours	After 48 hours up to and including 5th day	After 5th but before 10th day		
1	Skipton ...	80,030	1,224	1,108	21	95	408	116	9
3	Keighley ...	56,140	1,014	944	29	305	371	70	7
4	Shipley ...	69,620	1,269	1,085	64	84	659	184	14
5	Horsforth ...	120,100	2,009	1,719	138	75	664	290	14
7	Harrogate ...	110,840	1,746	1,476	171	254	357	270	15
9	Wetherby ...	56,940	1,039	703	116	39	94	336	32
10	Goole ...	45,430	834	502	56	35	103	332	40
11	Castleford ...	58,410	1,043	758	84	104	169	285	27
12	Pontefract ...	66,440	1,357	884	120	120	299	473	35
13	Morley ...	89,780	1,693	1,133	57	115	146	560	33
15	Batley ...	49,410	970	865	69	18	288	105	11
16	Rothwell ...	63,050	1,262	689	84	203	109	573	45
17	Spenborough ...	51,870	978	874	119	28	66	104	11
18	Brighouse ...	60,290	1,168	810	27	62	90	358	31
19	Todmorden ...	51,240	778	505	43	54	69	273	35
20	Colne Valley ...	91,920	1,603	1,277	26	83	148	326	20
22	Wortley ...	93,560	1,518	1,058	125	109	261	460	30
23	Hemsworth ...	68,240	1,231	751	70	80	447	480	39
25	Barnsley ...	79,070	1,484	939	11	48	222	545	37
26	Wath ...	110,400	2,095	1,215	137	161	236	880	42
27	Doncaster ...	121,000	2,512	1,510	176	456	154	1,002	40
29	Thorne ...	37,580	855	460	76	146	48	395	46
31	Rotherham ...	99,740	2,154	1,245	137	396	242	909	42
Leeds Hospital Board Region ...		1,189,750	21,218	16,083	1,294	1,754	4,487	5,135	24
Sheffield Hospital Board Region ...		541,350	10,618	6,427	663	1,316	1,163	4,191	39
West Riding Administrative County ...		1,731,100	31,836	22,510	1,957	3,070	5,650	9,325	29

Domiciliary Midwifery:

At the end of the year, there were 450 midwives employed in the Administrative County, as follows:—

256 by the County Council (including 54 home nurse/midwives).

185 by Hospital Management Committees.

9 in private practice.

There were 9,253 deliveries attended by the County Council midwives, of which 8,783 cases had contracted with medical practitioners for the provision of maternity medical services. One thousand four hundred and fifty one of these were attended by a general practitioner. In 470 cases, a doctor was not booked but, in 28 cases, a doctor was in attendance.

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

(i) At forty-eight hours	...	...	...	...	...	1,957
(ii) After forty eight hours, up to and including the fifth day	...					3,070
(iii) After the fifth but before the tenth day...	...	...	...	...		5,650
					Total	10,677

It will be noted that domiciliary deliveries fell by 1,028.

There was still no definite pattern in relation to early discharges; the majority being between the fifth and ninth days, and this made the domiciliary service more difficult to organise than if discharges were at either 48 hours or 10 days.

The new domiciliary midwives' records which were adopted during the year had been tested in the field and approved by the maternity liaison committees.

STAFF SITUATION:

The establishment is 280 whole-time midwives, and 256 (whole-time equivalent of 228·0) were in employment at the end of 1965. These are made up as follows:—

Whole-time midwives	...	...	...	...	200
Part-time midwives	...	...	...	...	2
Home nurse/midwives	...	...	...	...	54
				Total	256

STAFF CHANGES:

Including home nurse/midwives, there were 23 new appointments, 22 resignations, 6 retirements, 4 midwives transferred to other services and 2 died.

IN-SERVICE TRAINING:

A course was held at Grantley Hall, on the theme "Antenatal Preparation Including the Psychoprophylactic Approach". Fifty domiciliary midwives attended, including 9 from the County Boroughs of Bradford, Doncaster, Leeds, Wakefield and York, and one from the Halifax District Nursing Association. Eleven hospital midwives attended from Bradford, Harrogate, Halifax, Huddersfield, Keighley and Sheffield Hospital Management Committees.

The course proved to be lively; the physiotherapy teaching sessions were excellent, and the demonstration and discussion sessions were a great help to the midwives, giving them a new approach to the art of group teaching.

PREMATURE BABY INCUBATORS:

The tests on the new portable incubator for babies proved satisfactory and it was anticipated that deliveries would begin early in 1966.

ANALGESIA:

All midwives were equipped with trilene apparatus so that gas and air analgesia was rarely given, except when the trilene apparatus was away for its annual check and there was no spare inhaler available. Gas and air analgesia was given in 41 cases (gas and air alone in 15 cases and combined with pethidine for the remaining 26).

The percentage of mothers who received analgesia was much the same as last year with trilene being used most often.

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

Div. No.	Area	Percentage receiving Analgesia					Total
		Pethidine alone	Gas and air alone	Gas and air with Pethidine	Tri-lene alone	Tri-lene with Pethidine	
1	Skipton	8	—	—	32	45	85
3	Keighley	9	1	4	9	66	89
4	Shipley	7	2	2	18	63	92
5	Horsforth	4	—	—	28	56	88
7	Harrogate	11	—	—	29	44	84
9	Wetherby	10	2	4	33	46	95
10	Goole	3	—	—	45	37	85
11	Castleford	4	—	—	48	35	87
12	Pontefract	13	—	—	11	59	83
13	Morley	8	—	—	28	52	88
15	Batley	4	—	—	39	43	86
16	Rothwell	22	—	—	22	40	84
17	Spenborough	2	—	—	31	56	89
18	Brighouse	4	—	—	42	43	89
19	Todmorden	3	—	—	24	65	92
20	Colne Valley	8	1	—	25	58	92
22	Wortley	39	—	—	21	11	71
23	Hemsworth	12	—	—	27	53	92
25	Barnsley	15	—	—	24	43	82
26	Wath	16	—	—	22	37	75
27	Doncaster	7	—	—	25	59	91
29	Thorne	17	—	—	17	54	88
31	Rotherham	24	—	—	17	37	78
Leeds Hospital Board Region		9	—	—	29	50	88
Sheffield Hospital Board Region		18	—	—	21	42	81
West Riding Administrative County		13	—	—	26	46	85

RESUSCITATION OF THE NEWBORN:

A resuscitation tube was issued to each midwife, so that she could administer mouth-to-mouth resuscitation to a baby born in a state of asphyxia. Many of the midwives used this apparatus and were very pleased with the results.

CARS:

One hundred and ninety-one midwives used cars in connection with their duties, 16 being provided by the Authority.

EMERGENCY OBSTETRIC UNITS:

There were 28 reported calls on this service, mostly for difficulties connected with the third stage of labour. Units operate from the undermentioned 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, Mexbrough
Jessop Hospital, Sheffield
The General Hospital, Wakefield

MATERNITY LIAISON COMMITTEES:

The Non-Medical Supervisors of Midwives attended 10 maternity liaison committee meetings in the West Riding, where matters concerning the booking and discharging of patients in hospitals, and the interchange of information, were discussed.

In the Doncaster area a nursing sub-committee was formed to investigate the possibility of using the Central Sterile Supply Department for the domiciliary as well as hospital staffs. No decision was reached by the end of the year.

A meeting of representatives of all maternity liaison committees in the Sheffield Regional Board area was held in Nottingham, in October. Co-operation of all concerned with the confinement of the mothers, and the use of hospital accommodation for general practitioners and domiciliary midwives, were the main items on the agenda. The effect of the trend to hospital delivery on the district training of pupil midwives was also discussed. It was decided that the Central Midwives' Board be asked to agree that early discharge cases should be delivered in hospital by the district pupil, who would carry on the nursing care after discharge home.

HEALTH VISITING

A reasonable and varied amount of work was done by the health visitor during 1965.

Progress was made in the attachment of health visiting staff to general practice and, at the end of 1965, there were 128 health visitors attached to 163 practices, comprising 355 general practitioners, which means that just under half the qualified health visitors on the staff were working closely with general practitioners.

A great deal of planning went into this project, and it appeared to be working successfully. At the same time it is too early to judge how it affects the individual work of the health visitor.

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

<i>Analysis of Visits</i>							<i>No. of visits</i>
Expectant mothers	...	...	...	...	...	...	8,497
Children born in 1965	...	...	...	...	...	...	119,044
Children born in 1964	...	...	...	...	...	...	90,006
Children born in 1960-63	...	...	...	...	...	...	143,002
Children born 1960-1965							352,652
Tuberculous households	...	...	...	...	...	...	5,542
Tuberculous households by tuberculosis visitors	...	...	...	...	...	...	8,134
Other infectious disease households	...	...	...	...	...	...	3,049
Persons over the age of 65 years	...	...	...	...	...	...	51,837
Number of cases	...	...	...	...	...	21,613	
Number visited at request of g.p. or hospital	...	...	...	...	...	6,853	
Mentally disordered persons	...	...	...	...	...	...	1,913
Number of cases	...	...	...	...	...	545	
Number visited at request of g.p. or hospital	...	...	...	...	...	227	
Persons, excluding maternity cases, discharged from hospital (other than mental hospitals)	...	...	...	...	...	...	3,635
Number of cases	...	...	...	...	...	1,903	
Number visited at request of g.p. or hospital	...	...	...	...	...	1,166	
School health	...	...	...	...	...	...	15,684
Home Help Service	...	...	...	...	...	...	123,826
Ineffective visits	...	...	...	...	...	...	58,383
<i>Clinics and School Sessions</i>							<i>No. of sessions</i>
Maternity and child welfare	...	...	...	...	...	...	30,179
Ultra violet light	...	...	...	...	...	...	584
Health Education—							
a. Clubs	...	...	...	...	...	...	182
b. Parent/teachers	...	...	...	...	...	...	9
c. Schools	...	...	...	...	...	...	1,461
d. Antenatal relaxation classes	...	...	...	...	...	...	1,543
Other health education activities	...	...	...	...	...	...	540
							3,735
Specialist—Chest	...	...	...	...	...	...	1,325
Other	...	...	...	...	...	...	3,083
School health	...	...	...	...	...	...	20,681
Total							59,587

The total number of visits to children under the age of five years dropped by 8,918, and statistics show that health visitors did not visit more than two to three times during the first year of life. The visits to the age group 2 to 5 years showed a slight increase of 1,932.

It will be noted that the number of cases over the age of 65 years, and the number of visits to these cases, increased, the latter by 5,080. The visits to home help cases also increased by 1,488. These are likely to increase yearly, and form a large proportion of the work of the health visitor. General practitioners also found they needed help in dealing satisfactorily with this particular age group, and here they found the health visitor a helpful member of the team. The health visitor, however, should be in contact with the whole family and not one part of it, and it would seem that if she is to continue caring for the family as a whole she will need more help in carrying out her duties in a satisfactory manner.

There was a decrease in sessions spent on health education; 749 less than in 1964. This was to be expected when health visitors' time was taken up with the work in general practice.

Staff Situation:

The staffing establishment for health visiting, school nursing and tuberculosis visiting was increased in 1965 by 16, to 407, in place of 391 whole-time officers.

The increase was to allow for the appointment, or promotion, of staff to the position of fieldwork instructor, in order to comply with the rules of the Council for the Training of Health Visitors. Ten fieldwork instructors were appointed from existing staff.

Although the establishment increased, the number of personnel employed remained fairly static; there were 389 staff (equivalent of 352.7 whole-time officers) employed in these services, at the end of the year an increase of 7.4 on the previous year, and were made up as follows:—

Qualified health visitors (9 part-time) combining the duties of health visiting and school nursing.	272
Assistants to the health visitor (47 part-time), without the health visitor's certificate, combining duties in the public health and school health services, 8 of whom undertake health visiting under a dispensation granted by the Ministry.	109
Whole-time school nurse.	1
Home nurse/midwife undertaking health visiting, home nursing and midwifery duties.	1
Whole-time tuberculosis visitors.	6
	<hr/> 389 <hr/>

There were 101 new appointments (55 of these were unqualified), 70 resignations (27 unqualified), 11 retirements, 2 transfers to other services, 3 died and 12 unqualified health visitors transferred to student health visitors.

Mrs. C. C. Howels resigned from the post of Divisional Nursing Officer for Wetherby and Goole Divisions. Miss D. M. E. Goldthorpe, Divisional Nursing Officer in Todmorden, transferred to Thorne and Goole, and Miss C. J. Barker, Divisional Nursing Officer for Brighouse, covered the work of Todmorden. Miss M. P. Bramley, Divisional Nursing Officer for Colne Valley, was appointed to Wetherby and Rothwell, and Miss J. L. Law was appointed as Divisional Nursing Officer for Colne Valley, to commence in January, 1966.

Post Certificate Training:

Thirty health visitors attended approved courses organised by the Royal College of Nursing and the Health Visitor's Association. Letters of appreciation were received from many of the health visitors.

In addition, 5 health visitors attended a special course for fieldwork instructors, at Bangor, in order to prepare them for taking students in October, 1966.

Fifty-two members of staff attended an in-service training course at Grantley Hall, in July. The theme of the course was "New Aspects in Child Care". Opening the course, Miss E. E. Wilkie, B.A., S.R.N., H.V. Tutor, Chief Professional Adviser to the Council for the Training of Health Visitors, invited the health visitors to look carefully at their work and consider whether they were, in fact, meeting the needs of the present day community. A greater part of the programme was devoted to the normal emotional development of the child. In this connection Mrs. M. Farrow, A.A.P.S.W., stressed the value of routine visiting of the normal family by the health visitor, and her ability to assess the emotional environment present at all stages of child development.

The care of the subnormal child, the handicapped child and the child at risk was covered by other speakers.

Concluding the course, Mrs. M. L. Kellmer Pringle, B.A., Ph.D., spoke on the work of the National Bureau for Co-operation in Child Care, of which she is the Director. Much lively discussion took place during the course, with stimulating interchange of ideas between lecturers and health visitors.

Three courses on ascertainment of deafness were held at Cleckheaton, Otley and Airedale, by kind permission of Doctors Douglas, Burn and Paterson. Seventy health visitors, in all, attended. The help and co-operation of the Divisional Medical Officers, and the work done by the Divisional Nursing Officers and Health Visitors, was an invaluable contribution towards the smooth running of the courses.

Student Health Visitors:

The following report was submitted by Miss Chambers, Health Visitor Tutor at Leeds:—

"This year, for the first time, there was a 100 per cent. pass of the 39 students taking the course. Of these, 19 were sponsored by the West Riding County Council.

The Council for the Training of Health Visitors had strongly recommended that the ratio of students to tutors should be about 12/15 : 1. It was, therefore, decided to reduce the places from 50 to 40 in the first instance. This made itself felt in many ways, from the extra space in the lecture room to more satisfactory teaching. As always, the

students brought a wide variety of experience and ideas with them and, with the easier exchange of these, more people felt the benefit. Much was learnt from one another and there was often someone who could support and verify statements from lectures and text books through their own personal experience. An example of this was the student who had adolescent children and could, consequently, enrich discussion with a pertinent anecdote. It was found possible to pay more attention to the problem of individual students and to arrange more discussion groups and symposia, when some students prepared work and papers on a given subject for their fellows. Certain lectures were given to smaller groups, for studies which required active participation, such as social casework. This had been tried the previous year when the class was considerably larger. Unfortunately, owing to the differing needs of varying courses, it proved difficult to arrange for the health visitor students to take lectures with other groups. Attempts at this are kept to the forefront, but time is too precious to waste on implementing a theory regardless of its specific use.

As the health visitor's work increases in scope, she needs to improve her skills in communication. Many nurse training schools were already doing what they could, by means of written work and tutorials, to encourage the student nurse to use her ability to write and speak well. Under the new recommendations for educational qualifications and methods of training, there was no doubt that this would continue to spread, however, many health visitor students trained some years ago and it was necessary to help them to improve their written work and to encourage them to discuss subjects rationally and freely with their colleagues. Unfortunately, there was not time during the course to supervise the writing of English language and it was sometimes necessary to advise intending students to take a course in English before reapplying for a place in the class.

It may be remembered that in the Annual Report for 1963 mention was made of the acceptance, by the Royal Society of Health, of students who had completed 3 months obstetric training instead of Part I midwifery. Several members of the class came into this category and fitted into the course very satisfactorily. There did not seem to be any significant difference between them and their colleagues. On the contrary, they were able to make a valuable contribution to the studies generally. The majority would not have been able to take, or desirous of taking, Part I midwifery and would, therefore, have been lost to health visiting. And again, many were older women with valuable experience of family and community life. Happily, the Council for the Training of Health Visitors approved this condition as a qualification for entry to training and this state of affairs can continue.

Another factor influencing an increased number of applications from well-qualified and suitable persons was the form which advertisements took. When the tone and wording suggested that the best were required, the better candidates came forward. This allowed for more discriminating selection and, in the end, a more progressive service to offer to the public. The qualities needed were not just academic, professional or personal but a critical balance of all three, which varied from one individual to another.

The wind of change is blowing through health visitor training as it is through the actual work after qualification. Next year will see the implementation of the new syllabus, with all that this entails. A start has been made in preparation for this by discussing the new demands with lecturers and practical work organisers, and some minor changes have been made. The interim rules were issued in January, 1965, and were a guide in planning the course and examination for 1966. The latter will be set by Leeds University in the future, as the Royal Society for Health is the examining body for the last time this year.

Finally, mention must be made of all those who have helped in the practical training during the current year. These are too numerous to be specified individually but include people in many departments, ranging from the senior officer to the newest and most junior clerk. Their courtesy and helpfulness is much appreciated."

Seven students took health visitor training at Bradford Technical College, and all 7 were successful. Miss D. M. Lane, Health Visitor Tutor for Bradford, was most helpful and co-operative in dealing with students; the West Riding taking part in a good deal of practical training. During the academic year some of the students tried out the scheme which came into operation this year, that of studying a small number of normal families and writing up their case notes. This was very helpful, and gave practice to both tutors and prospective fieldwork instructors.

Recruitment:

The majority of applications for health visitor training were from persons who required obstetric training, indeed, if it had not been for this particular scheme, which the Committee approved, there would have been very few applicants, with the necessary educational background, acceptable for the course.

Cars:

Two hundred and fifty health visitors used cars in connection with their duties, one of which was provided by the Authority.

HOME NURSING**Staffing:**

At the end of 1965 the home nursing staffing situation was satisfactory. In some areas home nurses were not replaced because of the amount of sickness in the population did not justify it. There were pocket areas where shortages occurred from time to time but there were seldom any long-term vacancies.

The establishment was 290 whole-time nurses. 314 were employed at the end of 1965, 6 less than in 1964, and were made up as follows:—

Home nurses, S.R.N. (13 part-time)	...	...	251
Senior relief home nurse, S.R.N. ...	...	...	1
Home nurse/midwives, S.R.N. ...	...	...	51
Home nurses, S.E.N. (1 part-time)	...	...	8
Village nurse/midwives, S.E.N. ...	...	...	3
			<hr/>
		Total	314
			<hr/>

There were 32 appointments, 30 resignations, 3 retirements and 5 transferred to other services.

Training:

The West Riding training scheme for district nurses continued under the guidance of Miss Harris, the Acting Tutor for the course.

There were 2 courses of training in 1965, commencing in May and September. Eleven students took the course and all were successful. The help given by the senior nurses in the practical training was invaluable.

Refresher Courses:

A very successful course was held at Grantley Hall in September, 1965, when 44 West Riding students attended. In addition to these there were 3 students from adjacent county boroughs.

The course was similar to the one held in 1964 and, once again, the theme of the course was rehabilitation. The aim of rehabilitation is to help a disabled person to make the best use of his remaining abilities and to regain social competence.

Physical therapy plays a major part in rehabilitation—particularly of locomotor disabilities—and, today, physiotherapy concentrates more than ever on exercise techniques. Through the invaluable help given by Miss M. C. Johnson and Miss B. Savage, and with the co-operation of the Chartered Society of Physiotherapists, the district nursing sisters were taught the necessary exercise techniques and had ample opportunities for practice.

Lectures were also given on the care and rehabilitation of the geriatric patient, the arthritic, patients suffering from diseases of the chest and the central nervous system.

The district nursing sisters visited the Royal Baths, Harrogate, and Scotton Banks Hospital, Knaresborough.

The value of the district nurses' role in rehabilitation is inestimable.

Study Days and Group Lectures:

HOSPITAL AND DOMICILIARY STAFF INTERCHANGES:

During 1965 Clayton Hospital, Wakefield and Huddersfield Royal Infirmary were approached, and consented, to join with domiciliary nursing staff in study days comprising of a visit by ward sisters to the district, followed by a return visit of the domiciliary staff to hospital. In the afternoon Miss F. H. Heaney, Public Health Nursing Officer, and Miss O. Copeland, O.B.E., Regional Nursing Officer, opened the general discussion. Many points were discussed and one always prominent was the need for a closer and more direct contact between the domiciliary and hospital services.

Both hospital and domiciliary staff were very appreciative of these interchanges, having gained much practical knowledge and a deeper understanding of each other's work.

Eighty-two members of staff took part in these interchanges.

DAY COURSES ON THE CARE OF THE DIABETIC AT HOME:

Three hundred and seventy-three home nurses and health visitors attended 2 one-day courses, held at Rothwell Grammar School, on "The Care of the Diabetic at Home".

The lectures were arranged by Professor R. E. Tunbridge, Department of Medicine, General Infirmary, Leeds, and covered all aspects of the care and treatment of the diabetic patient.

Professor Tunbridge opened the day with a lecture on "Present-day Aims in the Treatment of Diabetes Mellitus"; a dietitian spoke on "The Problems of Dieting", and this was followed by "Insulin, the Varieties Available and Some Problems of Administration", given by Dr. J. L. James, a most able speaker.

Dr. James opened the afternoon session with a lecture on "The Place of Tablets in the Treatment of Diabetes". This was followed by a lecture on "Gangrene and Arterial Disease in the Diabetic", by Mr. J. H. Shoesmith and, to conclude a most interesting and instructive day, Mr. E. R. Earnshaw spoke on "Visual Disorders in Diabetes Mellitus".

GROUP LECTURES:

Miss E. M. Herron, District Nursing Officer, Queen's Institute of District Nursing, attended 3 centres in the West Riding to speak to groups of home nurses on "Modern Trends in District Nursing". Two hundred nurses attended the lectures held at Castleford, Cleckheaton and Doncaster.

Cars:

Two hundred and ninety home nurses used cars in connection with their duties, 83 of which were provided by the Authority.

Summary of the Work of Home Nurses:

The total number of cases dealt with by home nurses in 1965 increased by 1,721; 30,228 cases in comparison with 28,507 in the previous year.

The information received in relation to the number of visits to these cases was, however, disappointing, as they appeared to have decreased considerably. The reason for this was difficult to define, particularly as the individual case loads of the home nurses appeared to be as heavy as in 1964. Casual visits and visits in relation to loan equipment were not always recorded, even though they may have taken up to 30 minutes a visit.

It was well known that less nursing treatment was needed for the aged sick because drug therapy kept some patients ambulant, whereas previously they were put on bed rest and nursing care.

Visits to patients over the age of 65 years comprised 60 per cent. of the whole number of visits. Visits to children and tuberculous patients decreased. In the case of tuberculosis, one would expect this to happen because of modern treatment and better housing facilities.

The variety of work changed very little and home nurses thought that many patients who attended hospital out-patients departments for dressings could quite well have been done either at home or in the doctor's surgery. If the hospital medical staff could be persuaded to relieve the pressure on the hospital out-patients departments it would give a variety of work for the home nurses, and would use the skills for which they have been trained. The majority of work done by the home nurses at present could be done by less qualified people with supervision from trained persons.

Attachment to General Practitioners:

There were 47 home nurses attached to 71 practices, consisting of 156 general practitioners. This attachment made a difference to the work of the nurse. She spent some time in the surgery, at least once a day, either morning or evening. These visits were not recorded, therefore, it was difficult to make an assessment.

The Home Nursing and Care and After-care Services Equipment:

Much of the equipment used in the home nursing and care and after-care services had undergone little in the way of change since the services were introduced in 1948, although items of a new nature had been added from time to time.

In view of the availability of new materials, improved items of equipment and the introduction of new methods, a Departmental Working Party was established to review the 2 services to determine how far changes were considered necessary in the interests of efficiency and the provision of a better service to the patients. The Working Party met on a number of occasions during the past 2 years and its final recommendations are expected to be published early in 1966.

<i>Types of cases attended</i>							<i>No. of cases attended</i>	<i>No. of visits by Home Nurses</i>
Medical	...	...	...	...	...	...	22,094	598,499
Surgical	...	...	...	...	...	...	6,869	136,261
Infectious diseases	...	...	...	...	...	...	134	1,290
Tuberculosis	...	...	...	...	...	...	254	12,607
Maternal complications	...	...	...	...	...	...	568	5,486
Others	...	...	...	...	...	...	309	3,222
Total							30,228	757,365

<i>Age Groups</i>								
0—4	...	...	...	...	...	...	1,150	8,629
5—64	...	...	...	...	...	...	13,363	294,140
65 years or over	...	...	...	...	...	...	15,715	454,596
Total							30,228	757,365

Patients included in the above who have had more than 24 visits during the year	7,939	534,403
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The following statistical details relate to patients whose treatment was completed during the year:—

Classification of Cases by Disease:

<i>Disease</i>							<i>No. of Cases</i>
Tuberculosis	...	...	...	...	...	...	240
Other infectious diseases	...	...	...	...	...	...	232
Parasitic diseases	...	...	...	...	...	...	64
Malignant and lymphatic neoplasms	...	...	...	...	...	...	1,638
Asthma	...	...	...	...	...	...	56
Diabetes mellitus	...	...	...	...	...	...	448
Anæmias	...	...	...	...	...	...	1,747
Vascular lesions affecting central nervous system	...	...	...	...	...	...	1,454
Other mental and nervous diseases	...	...	...	...	...	...	403
Diseases of the eye	...	...	...	...	...	...	106
Diseases of the ear	...	...	...	...	...	...	477
Diseases of heart and arteries	...	...	...	...	...	...	1,789

Diseases of veins	...	...	...	...	...	...	...	574
Upper respiratory diseases	...	...	...	...	...	...	...	596
Other respiratory diseases	...	...	...	...	...	...	...	1,709
Constipation	...	...	...	...	...	...	...	981
Other diseases of digestive system	...	...	...	...	...	...	...	1,682
Diseases of urinary system and male genital organs	...	...	...	...	...	...	...	931
Diseases of breast and female genital organs	...	...	...	...	...	...	...	476
Complications of pregnancy and puerperium	...	...	...	...	...	...	...	564
Diseases of skin and subcutaneous tissues	...	...	...	...	...	...	...	1,233
Diseases of bones, joints and muscles	...	...	...	...	...	...	...	610
Injuries	...	...	...	...	...	...	...	1,487
Senility	...	...	...	...	...	...	...	999
Other defined and ill-defined diseases or disabilities	...	...	...	...	...	...	...	1,074
Diseases not specified	...	...	...	...	...	...	...	507
Total								22,077

Nursing Treatment:

	<i>Type</i>								<i>No. of Cases</i>
Injections	6,799
General nursing	6,103
Enemas	1,194
Dressings	5,471
Bed baths	786
Wash-outs, douches, etc.	277
Changing of pessaries	121
Preparation for diagnostic investigation	452
Others	874
Total								...	22,077

The total number of cases receiving injections was 7,332 but, in 533 cases, the injections were given during the course of a general nursing visit.

Injections:

	<i>Type</i>								<i>No. of Cases</i>
Insulin	257
Drugs for anæmia, debility, etc.	2,309
Antibiotics	3,330
Drugs for cardio-renal diseases	826
Others	610
Total								...	7,332

Referral of Cases:

<i>Source</i>								<i>No. of Cases</i>
General practitioners ...	...	...	...	...	...	...	...	17,332
Hospitals ...	...	...	...	...	...	...	...	3,155
Health Department staff ...	...	...	...	...	...	...	...	1,114
Others ...	...	...	...	...	...	...	...	476
Total ...								22,077

Disposal of Cases:

								<i>No. of Cases</i>
Convalescent ...	...	...	...	...	...	...	...	12,339
Transferred to hospital ...	...	...	...	...	...	...	...	3,873
Died ...	...	...	...	...	...	...	...	3,456
Others ...	...	...	...	...	...	...	...	2,409
Total ...								22,077

Day and Night Nursing Service:

Until August, 1965, this service had been administered in two parts:—

(a) a service for cancer patients organised and administered by the County Council on behalf of the Marie Curie Memorial Foundation, all expenses being met by them, and (b) a service for other types of patient paid for by the County Council as an extension of the home nursing service and at no charge to the patient.

The object of both schemes was to provide a day or night nursing service for temporary periods, usually in an emergency or during the terminal stages of illness, to afford some measure of relief to relatives who were under considerable strain resulting from caring for patients over a long period. Trained nurses, persons with nursing experience, or "sitters in" were employed in the service.

Early in 1965, the Marie Curie Memorial Foundation indicated to the County Council that they expected patients or relatives who were able to pay for a private service should do so and that donations to the Foundation should be encouraged. This placed the cancer patient or his relatives at a disadvantage in comparison with the patient suffering from other types of illness and provided with the service by the County Council without regard to means. The position was considered by the Health Committee and, as from 1st September, 1965, the County Council withdrew from participation in the Foundation's scheme and a day or night nursing service is now provided for any patient needing it, whatever the type of illness, at no charge as an extension of the home nursing service.

The service is not one which is called upon frequently, but it is one which can be of immense benefit to relatives who find themselves under considerable mental and physical strain through caring for patients over a long period of time.

During the year, the service was used in 15 of the 23 Divisions, 158 cases being provided with 7,993 hours of service at a cost of £2,094.

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 1964		1964 compared with 1963
	1964	1965	Increase	Decrease	Increase
Admissions	52,707	53,313	606	—	1,258
Discharges	30,066	29,669	—	397	1,161
Transfers	13,149	13,159	10	—	859
Out-patients	457,582	478,080	20,498	—	19,177
Accident patients... ..	15,641	15,355	—	286	1,008
Total patients of Direct Services... ..	569,145	589,576	20,431	—	23,463
Total patients of Direct Services plus Agency and Hospital Car Ser- vice	607,364	634,371	27,007	—	22,827
Mileage of Direct Services	3,749,286	3,813,716	64,430	—	295,245
Total Mileage (including Agency and Hospital Car Service)	4,196,919	4,309,998	113,079	—	282,405

The demand for ambulance transport has continued to rise. The principal increase has been in respect of out-patients, in which group the highest increase is from patients attending hospitals as "day patients". These are patients who attend hospital regularly as part of a planned course of treatment and are provided with treatment and care as though they were in-patients but who return home at nights. Most of them are under the care of the psychiatric, geriatric and chronic sick departments, which are an expanding section of the service.

Although the number of actual accidents has increased during the year, the number of casualties involved has fallen by 286. This is the first accident patient decrease for some years.

During the year, work commenced on the reorganisation of telephone lines and radio-telecommunications in preparation for the inauguration of the new operational control system, whereby the existing 22 ambulance stations will come under the operational control of three group controls.

The first of these groups should be in operation in April, 1966, and will comprise Keighley, Menston, Shipley, Pudsey, Birkenshaw, Todmorden, Honley and Brighouse stations, under the control of group control at Birkenshaw.

A two weeks residential training course for ambulance personnel was held early in the year at the County Fire Service Training School, Birkenshaw. It was attended by twenty staff on a voluntary basis and the instruction was given by selected service instructors and invited lecturers, including hospital specialists and doctors. The venture was a resounding success but, unfortunately, owing to limited accommodation further courses could not be held.

There is now a proposal to establish a Service Residential Training School in County premises at "Elm Bank", Cleckheaton, to take up to 20 students per

course. If this becomes a fact, it will be a great step forward in meeting the urgent need for training of ambulance personnel.

A number of instructors have been specially trained in the art of casualty simulation, by which they are able to fake injuries to casualties and thus bring more realism to first aid training.

Three Humber ambulances (of which type it is hoped to introduce a further 18 next year) have been taken into service. These vehicles are smaller, faster and more manoeuvrable than the conventional dual purpose ambulance and should help to reduce the time factor in attendance at accidents in areas difficult to cover. The one essential in these days of multiple accidents and injuries is to get an ambulance crew to an accident more quickly, if possible, than in the past in order to commence life saving measures.

The new station at Bentley was completed and occupied during the year. The provision of an ambulance station at Castleford has been held up due to difficulty in obtaining a suitable site. Negotiations are also proceeding for site purchases for a new station at Todmorden and for one to service the Birkenshaw/Morley area.

The application of mouth-to-mouth resuscitation as a more effective measure than measures previously taught in first aid has come to the fore in recent years. As an emergency measure which is of value in any life saving attempt, it must be applied with a minimum of delay mostly by lay persons. It is, therefore, important that an understanding of the method and its practical application should be taught as widely as possible. To this end, County Ambulance Service First Aid Instructors have, over the past three years, given 502 teaching demonstrations to school children, other local authority services and a wide section of the public.

Presentation of the subject on modern lines with visual aids occupies two hours, including a colour and sound film, a talk, practical demonstration and, when possible, class participation in which individuals practice on a mechanical dummy.

PREVENTION OF ILLNESS, CARE AND AFTER-CARE

Health Education:

Whenever rapid advancement takes place in any activity, it is necessary to halt occasionally, for the purposes of assessing tactics, renewing forces, planning new materials, absorbing additional staff and viewing the horizon generally. The early part of 1965 was devoted to such an appraisal of our previous efforts within the light of the recommendations of the Cohen Report, published in 1964, to which reference was made in last year's report.

With regard to cancer education, the gradual introduction of clinics for cervical cytology has resulted in some teaching being carried out by means of posters and leaflets which confirm the information given by medical and nursing staff. This educational service will increase as the appropriate facilities expand. We also envisage an extension of health education in relation to cancer as a result of the publicity given to the illness and death of Richard Dimbleby. Information of this nature, dealing with a prominent public figure, can do much

to impress the general public and so impel them to seek advice and, where necessary, take action. We are prepared to foster the reaction and provide the educational facilities required to enlighten people on the importance of seeking early medical advice.

There has been an increase in the demand for information on the subject of venereal diseases and talks supported by films and film strips dealing with this subject have been given in many parts of the County. An interesting development in this context was a request from the women police training section for a talk on venereal diseases to one of their training courses. This was given and as a result further talks were requested and the time allocated to this subject was increased in subsequent courses from one lecture period to three. It was obvious from the questions asked and the remarks passed that the knowledge of these diseases had been scanty and inaccurate, and every group to date has expressed appreciation of the talks and films.

Talks and films on venereal diseases have also been given to many youth clubs and mothers' clubs, whilst the subject is included in some syllabuses carried out in schools by medical and nursing staff. This teaching is undertaken only after consultation with the headmaster and his staff and is not done in isolation but forms part of a series of talks on human relationships and/or in the context of communicable diseases. Examples can be seen in the following extracts from reports:—

Dr. Douglas, Divisional Medical Officer (Spenborough), writes:—

“No special feature has been made of education in relation to smoking or venereal diseases during the year but these subjects have been incorporated in the general programme of talks.”

Dr. Walters, Divisional Medical Officer (Hemsworth), says:—

“Five health visitors conduct weekly lessons in the Secondary Modern Schools for the 14—15 year old girls, comprising eight sessions in all. These cover a general syllabus including smoking in all cases, and Venereal Diseases have been discussed in three schools this year. The other schools have films and talks as requested.”

In Morley division, Dr. Ireland, Divisional Medical Officer, deals with the problem of informing the public about Venereal Disease services in the following extract from his report:—

“The problem of the display of notices on venereal diseases in the public conveniences was approached from a new angle in Morley by having a stencil cut from a sheet of aluminium. This stencil stated that venereal disease was dangerous and should be treated, and also where information regarding the treatment could be obtained. The information was then painted on the walls of the public conveniences using aerosol paint sprays in various colours and I am pleased to say that in over nine months these notices have resisted many forms of desecration and in some cases no attempt to deface has been made.”

Campaigns to disseminate knowledge on the dangers of cigarette smoking have continued at divisional level. An endeavour was made early in 1965 to interest schools in forming a league of non-smokers, and to this end suitable posters and literature were supplied. The basic idea behind this scheme was to encourage a new cult of non-smoking teenagers and it was hoped that by having a nucleus of senior schoolboys and girls as leaders of this fashion, the younger members would follow suit and refrain from starting to smoke. It would appear

that after the initial enthusiasm for this scheme, interest has waned in many schools and it is obvious that any success likely to be achieved in this field requires repeated attempts and varied approaches. We still have a tremendous challenge to face in this respect.

General health education in schools undertaken by the staff of the health department has followed much the same pattern of previous years. In the Skipton division a personal letter plus a proposed syllabus was sent by Dr. Hunter to all head teachers, expressing willingness to co-operate in the co-ordination of health education programmes.

Dr. McDonagh, Medical Officer of Health of the Delegated Authority of Keighley tells us that:—

“ Health education in schools has continued to develop, and there are now approximately ten schools where health education could be described as a routine procedure, whilst many more schools are visited as necessary for isolated teaching sessions on specific subjects. Our basic aim is unchanged—in the junior schools to try to encourage an interest in the principles and practice of healthy living—and in the senior schools to concentrate on parentcraft, homemaking, citizenship, etc. In our opinion the best results have always been obtained where health education is dealt with on a routine basis, of either a weekly or fortnightly session, and we find that this is particularly so in the senior schools, since in this kind of teaching-learning situation, the relationship which develops between all concerned is more likely to encourage discussion which is all important. So far most of our efforts in the senior schools have been at the request of the headmasters and chiefly concerned with the lower intelligence groups, and this is probably the most important section of the school population, from our point of view. It should not, however, be assumed that the more intelligent children are not in need of this kind of instruction, for in our experience they are.”

This is the general pattern for health education in schools throughout the County, and the point highlighted in the final sentence warrants much thought as it is an accurate, constructive point. All too often, intelligence is mistaken for knowledge whereas no matter how intellectual a person may be, without being given information on a specific subject, he cannot be expected to know or understand that subject. As health education provides a design for healthy living, it is essential that the basic foundations laid in the pre-school years be steadily built up throughout the formative school years, according to the standard demanded by intellectual attainment.

Working upon the assumption that if health education is to be effective, it is necessary for the public to encounter the same topic in as many places as possible over a specified reasonable period, the divisions have planned programmes to cover each month of the year, bearing in mind the particular problems associated with certain months. Appropriate posters, literature, films and other such visual aids are made available from central office to each division to boost their efforts and to provide the necessary background of interest to stimulate discussion. Every area has different facilities available with which to highlight current topics—e.g. Dr. Ireland, Divisional Medical Officer (Morley), reports:—

“ We have acquired the use of a shop window in Horbury and the window is dressed every two months in accordance with the programme. We have also secured the use of two poster sites at Morley Town Hall and the windows of the divisional health office are used to advantage as they face onto a main shopping area. During the procedure of attachment of health visitors to general practitioners in Morley, doctors agreed to notice boards in their waiting rooms being used by the health visitor to display the current items of health education material.”

Dr. Caithness, Divisional Medical Officer (Batley), writes:—

“ Full use is made of the display stands in the window of the divisional health office. It is considered that this forms a valuable means of health advertisement as the divisional health office is situated in the Market Place and is seen by large numbers of people every day in the week. The display stands are dressed by the health visitors approximately once every two weeks with a wide variety of subjects, e.g. infant feeding, food values and vitamins, personal cleanliness, prevention of infection (colds, influenza, etc.) and various aspects of home safety.”

Whilst from the Horsforth Division Dr. Burn, Divisional Medical Officer, states:—

“ A home safety display was held in a corner shop on a busy main road at Pudsey. This drew large crowds and was found to be more successful than a large indoor exhibition.”

These remarks from various areas stress the importance of a focal point where the attention of the public can be arrested. Having succeeded in this primary target, it is important to provide concise, accurate information in such a way that they are impressed by the message and encouraged to take appropriate action. In our clinics, which provide such wonderful opportunities for health education of very vulnerable groups, we have endeavoured to contribute displays of interest. The value of these is emphasised in many divisional reports and I quote from but one of them, Dr. Appleton, Divisional Medical Officer (Goole), who writes:—

“ The use of glass cabinets for small displays in clinics attracts mothers and makes useful points for the staff. This is one adequate reason for maintaining a reasonable attendance at child welfare centres.”

From the opposite end of the County—Dr. Ward, Divisional Medical Officer (Colne Valley) says:—

“ A little health education work has also been done with elderly patients whilst they are waiting for chiropody treatment.”

Here again, a good display is helpful in starting discussion as well as being a point of interest and mental stimulation. Most people attending chiropody clinics are in the 60 years and over age group, a group who need to be stimulated to accept change and to appreciate the need for good dietary habits, exercise and safety factors in particular. It is better to use such ready made audiences for health education purposes than to expend valuable time and money in setting up one large exhibition in a hired hall and hope that the general public will attend.

This policy has proved expedient in relation to the home safety exhibition which is still in great demand by specific groups throughout the County. During 1965, the exhibition was erected in many primary and secondary schools where the school teachers undertook the teaching of safety aspects in conjunction with the exhibition. Competitions of various kinds were held and both central office and divisional staff assisted in judging the results. In one area, a challenge cup was presented to the school with the best entry. Home safety has always been an important part of health education and the past year was no exception as the subject was dealt with by individual advice in homes and clinics, by displays in clinics and through various types of exhibition material at church fairs, civic galas, agricultural and horticultural shows, as well as at special

functions such as the ones staged by the Welfare Department at Settle and High Bentham. The material for such displays is provided by central office and has been greatly appreciated as the following extract from one report alone shows. Dr. Main Russell, Divisional Medical Officer (Wortley) says:—

“ Home safety exhibitions were held at Hoyland, Chapeltown and Grenoside. These were very well received and in conjunction talks were given by the health visitor. A special ‘ Safety with Farm Equipment ’ exhibition was arranged by central office for the Penistone show. This display was excellent, showing the care needed to guard against accident when using farm equipment. The general public was very impressed, especially as most of those attending are members of the farming community.”

Tufty Clubs have been established in several areas and help to stress the need for home and road safety with young children.

Clubs of all descriptions—mothers, youth, church, rotary, soroptomist and others—have been helped with talks from various members of the staff who have used appropriate visual aids including films and film strips. To ensure satisfactory handling and projection of these valuable aids, those members of the nursing staff who are actively engaged in group health education have received instruction from the health education technician and are unanimous in their gratitude for such advice. This service has led to less damage occurring with films, greater use of them and more confidence in handling.

A very successful two-day course on “ Principles and Practice of Teaching and the Correct Use of Visual Aids ” was held at Outwood clinic in September. Dr. H. C. Strick and Mr. D. Gains, Warden and Deputy Warden, Adult Training College, Grantley Hall, gave the lectures and led the discussion groups. Further courses, both residential and non-residential, are planned for 1966. The medical and nursing staff are showing more positive interest in group health education and the demand for visual aids continues to increase.

Social Workers:

The County Council have approved an establishment of 25 whole-time social workers for employment generally in the Council's health services.

While it is generally accepted that social workers, as distinct from mental health social workers, have a part to play in the future development of the health services, the extent to which they can be usefully employed and the contribution they can make are yet to be determined. The County Council decided, therefore, to start with a small number of unqualified staff, place them at the disposal of certain divisional medical officers and give them a grounding in all branches of the health services administered at divisional level for a probationary period.

At the outset, an attempt was made to recruit mature adult staff with a leaning towards social work and who would be likely to prove suitable material for training for the Certificate of Social Work by taking the two-year Younghusband course. Although many applications were received, none was considered suitable and it appeared that would be social workers of this age were not the type of person we were seeking. The posts were re-advertised to attract the younger person with suitable academic qualifications but who had not been, or were unlikely to be, successful in obtaining a place at a university.

From the many excellent applications received, a choice of six trainees was made following a joint interview at which the Tutor from the Leeds College of

Commerce was present to assess the applicants' suitability for eventual admission to the social workers' training course. The six trainees started duty in three divisions in November, 1965, and arrangements were made with the Leeds College of Commerce for in-service training to introduce them to general social work. Provided satisfactory reports on the work of the trainees are received from the divisional medical officers after a probationary period, they will be sent to take the two-year Younghusband course at Leeds.

By this means, it is hoped to build up gradually a staff of qualified social workers who will have had a sound knowledge of the local health authority services before entering upon their final training.

Recuperative Home Treatment:

Three hundred and twenty-three applications for recuperative home treatment were received as compared with three hundred and ninety-eight in the previous year. Two hundred and thirteen, fifty-six men and a hundred and fifty-seven women, (two with children), were admitted to one or other of the undermentioned homes, the remaining hundred and ten applications (31.25 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; Elizabeth Fry Home, York; Evelyn Devonshire Convalescent Home, Park Hall, Buxton; Hunstanton Convalescent Home, Hunstanton, Norfolk; Metcalfe Smith House, Harrogate; Semon Convalescents' Home, Ilkley; Tudor Convalescent Home, Bridlington; West Kirby Convalescent Home, West Kirby.

Laundry Service for Incontinent Patients:

There was no extension of the service during the year, facilities being available in only six divisions of the County. The main obstacle to any extension is a geographical one. Unless the patients to be served are in a reasonably compact area with laundry facilities within easy reach, the hiring of transport for the collection of foul linen and conveyance to the point where laundry facilities are available, and the collection and distribution of clean laundry, very soon becomes uneconomic. The provision of divisional transport, which can be used to advantage for a variety of purposes, could provide the means of overcoming these difficulties and a scheme is at present under consideration.

The issues of disposable pads for the bed case and waterproof, protective pants with interliners for the ambulant incontinent have continued to increase, and, while such provision may be regarded as second best to a laundry service, the service is popular and much appreciated by both patients and relatives alike.

Ultimate disposal of the pads has not so far created any difficulty, except in a few smoke-controlled areas with houses using all-electric appliances, but, in these instances, the divisional medical officer has been able to agree collection and disposal arrangements with the District Council.

Provision of Nursing Equipment in the Home:

17,609 items of nursing equipment were issued to patients being nursed in their own homes, an increase of 800 over the 16,809 items issued during 1964. 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	15	—	15	16
Bedding: blankets, pillows and cases, sheets, etc.—pieces	747	382	1,129	1,073
Bed blocks	23	137	160	28
Bed cradles	287	120	407	569
Bed pans	1,191	564	1,755	2,976
Bed rests	565	210	775	1,216
Bed tables	11	16	27	17
Bedsteads: hospital, with self-lifting pole, and other	259	28	287	416
Chairs: geriatric, relaxing, high rest, 'Amesbury' play, stairway (carrying) etc.	19	9	28	23
Colostomy sets	2	6	8	2
Commodore: chair and other	685	11	696	1,265
Cushions: air and 'Dunlopillo'	79	21	100	99
Enuresis alarms	303	13	316	1,481
Fracture boards	67	2	69	82
Hemiplegic exercisers	1	3	4	2
Hot water bottles	7	56	63	12
Ileostomy sets	4	4	8	4
Lifting hoists	17	6	23	29
Lifting pole and chain	24	5	29	34
Mattresses: air, biscuit, 'Dunlopillo,' hair, water, 'P.C.P.,' spring-interior	369	48	417	542
Open-air shelters	3	3	6	3
Pressure rings: air and foam rubber	523	462	985	1,374
Rubber/plastic sheets	1,035	364	1,399	2,309
Sputum mugs	30	144	174	42
Urinals: male and female	706	543	1,249	1,651
Walking aids: 'Amesbury,' 'Bonaped,' 'Zimmer,' 'Companion,' crutches, tripod, walking sticks	793	186	979	1,175
Wheel chairs: bath, folding, junior, self-propelled, spinal, stairway, etc.	508	101	609	1,075
Miscellaneous: feeding cups, steam kettles, breast pumps etc.	53	71	124	94
	8,326	3,516	11,842	17,609

Liaison with the Hospital Service:

Liaison with hospitals appeared to have extended during 1965, particularly in relation to general hospitals. This is progress in the right direction. There was certainly a wider variety of categories being dealt with than in previous years.

There were 66 health visitors in direct contact with one hospital or another and these health visitors usually visited the hospital once each week. They passed any relevant information through the Divisional Medical Officer for transfer to the appropriate person who was to deal with the situation. In

addition, there were 44 health visitors doing liaison in an indirect way; this was usually done by telephone.

There were 6 divisions which had no direct personal contact with hospitals. Most of this liaison was done either by letter or by a health visitor from an adjacent division. This was a satisfactory arrangement up to a point, but there was still too much time-lag between the patient being discharged from hospital and the notification of treatment to the general practitioner and district nursing sister concerned.

Because of attachment of health visitors to general practitioners, and because of persistent shortage of health visitors, the pattern of liaison with hospitals changed. Dr. Paterson, Divisional Medical Officer (Castleford), wrote:—

“During 1965 the direct liaison with Headlands Hospital ceased to be done by a health visitor and was undertaken by an assistant to health visitor. In addition, when the attachment of 5 health visitors to general practices took place, in December, these health visitors undertook the geriatric home visiting for priority on social grounds, within the practices to which they were attached. The assistant to health visitor continued to pay the weekly visit to the hospital and pass on information to the health visitors.”

This was an excellent move and did mean that the whole medical and nursing team knew what was going on. Again, Dr. Caithness, Divisional Medical Officer (Batley), reported:—

“As in former years, special reports were submitted to the geriatric physician on the home circumstances of all patients for whom admission to the geriatric units had been requested. As stated in previous reports, this work was largely in the hands of 1 health visitor in order that a uniformity of opinion could be maintained in respect of the degree of urgency of each case. With the introduction of health visitor attachment to general practitioners, it became necessary for each health visitor to deal with her own cases. So far this has proved satisfactory.

During the year 70 reports were requested on cases awaiting admission. None of these was found suitable for Part III Accommodation. Many of these cases required several visits and, in the most urgent cases, additional reports in writing or by telephone were submitted to the hospital.

Apart from these cases, many other requests for visits to old people were received during the year and these cases occupied a considerable part of the health visitors' time. In all cases the general practitioner was consulted and the fullest possible use was made of all available social services.”

GERIATRICS:

Other work in the geriatric field is included in the following report from Dr. Ferguson, Divisional Medical Officer (Doncaster), with particular reference to the chronic sick:—

“Background reports were supplied for the majority of patients placed on the waiting list for admission. One health visitor visited the Western Hospital weekly, to check on admissions, and gave verbal reports in addition to the written environmental reports. The waiting list continued to be very long, and the hospital depended very largely on these reports in order to establish some kind of priority. These conditions may improve with the opening of a 90-bed chronic sick block in April at the Doncaster Royal Infirmary, and the appointment of a part-time geriatrician.”

Harrogate area was the pioneer area in attaching a health visitor to the Geriatric Unit in Knaresborough; the system was still working and Dr. Hepple, Divisional Medical Officer, sent in the following report:—

“The geriatric health visitor attended the Knaresborough Hospital each day to receive messages, chiefly from general practitioners, requesting the admission of elderly, sick patients to Knaresborough Hospital or Princess Road Hospital, Ripon.

Visits were made to the homes of patients for the purpose of assessing the medical and social needs, and admissions were arranged according to the requirements of the individual patients.

Good liaison continued with general practitioners, welfare officers, and the staffs of various hospitals. Assistance was given in cases where private accommodation was desired.

Owing to the extremely heavy demand for female geriatric beds in this area, it will be very difficult in 1966 to offer accommodation in hospitals to those patients whose relatives wish to go on holiday. As far as possible, however, every effort will be made to grant relatives' requests.

I feel that it would help considerably if we had accommodation for the type of patient who is not strictly a hospital case but who is, nevertheless, unsuitable for Part III Accommodation. A 'half-way house' would be invaluable, particularly in regard to summer holiday accommodation."

DIABETICS:

Although there were no new developments in the follow-up of diabetics, most cases appeared to have been visited by the health visitor doing liaison. Mrs. E. E. Driver, Liaison Health Visitor in Division No. 13, sent in the following report:—

"Eighty-three new cases were seen over the past 12 months, 25 in Division No. 13, the others divided mainly between Rothwell and Normanton.

I saw all these patients after Dr. Fletcher had examined them and advised them on their diet, urine testing, and showed them how to keep a colour chart. I visited the patients in my own area at home, where they were much more relaxed and, therefore, took instruction much easier.

I telephoned the other divisions about their particular patients and gave their own doctors' names, so that the health visitor who was attached could call to see them.

I paid 60 visits over the year."

Mrs. Driver paid 20 visits more in 1965 than in the previous year.

In Castleford and Huddersfield areas this work was proceeding satisfactorily. From Doncaster Dr. Ferguson, Divisional Medical Officer, sent in the following report:—

"Miss Fulwood, Health Visitor, visited the Infirmary for the Diabetic Clinic, but since the appointment of a new Consultant, this was not a clinic for diabetics only; general medical cases were also seen, and the Health Visitor did not sit with the Consultant, as previously. She therefore depended on the notes, rather than the Consultant."

MATERNITY:

The scheme whereby mothers and babies are discharged after 48 hours was growing, and many more mothers were going home early. Dr. Caithness, Divisional Medical Officer (Batley), sent in the following report:—

"Maternity services—the main feature of co-operation with hospital maternity services was, undoubtedly, in respect of '48-hour discharge' of patients.

This procedure increased steadily throughout the year; the following are the details:—

Seventy-one cases were investigated by the midwife. Of these, 14 were suitable.

Of the 71 cases 45 were from Staincliffe General Hospital, being 11.1 per cent. of the total Batley and Heckmondwike maternity cases admitted to that hospital.

Moorlands Maternity Home—22 cases, being 17·2 per cent. of the total Batley and Heckmondwike cases. The remaining 4 cases were 3 from Crossley Maternity Home and 1 from St. Luke's Hospital, Bradford.

Liaison with the midwives, at the time of discharge of the patient from hospital, remained satisfactory throughout the year. The midwives reported that the patients were well satisfied with this scheme and with the condition of early discharge from hospital."

PREMATURE INFANTS:

In most divisions there was a health visitor going into maternity hospitals in order to give home situation reports to the hospital before discharging the baby. This scheme progressed satisfactorily.

The following is a report sent in by Dr. Ireland, Divisional Medical Officer (Morley), and written by Mrs. A. Gillies, Health Visitor:—

" Liaison with Hospital Services. Premature Babies.

The main object of this service is to obtain ' home conditions ' of premature babies for the hospital authorities.

A weekly visit was made to the hospital ward and I contacted health visitors in the areas where the babies were to live, and they, in turn, passed on any relevant information.

I was able to tell the health visitors when a baby was getting ready for home.

Travelling caravan dwellers gave the worst worry, especially when they gave addresses like:—

The Caravan,
Joe's Field.

However, they were traced eventually. Most of this work was done by telephone.

A follow-up paediatric clinic was held alternate Mondays, in Manygates Hospital, and I was invited to attend. Again I was able to pass any worthwhile information to the health visitors concerned."

For many years Miss B. S. Smith, Health Visitor in Morley, has made weekly contact with Professor W. S. M. Craig, Paediatrician at Leeds Maternity Hospital. This is now being partially run down. Dr. Ireland, Divisional Medical Officer (Morley), sent in Miss Smith's report on her work:—

" Liaison with Leeds Maternity Hospital continued during the past year by my attendance at Professor Craig's ward round and at the follow-up clinic. However, from January, 1966 it was decided to discontinue visits to the hospital for the purpose of the follow-up clinic, in view of the fact that there were very few referrals from there to the health visitor. The service continued to maintain contact between the home and the hospital, when the baby was retained in hospital after the mother's discharge and to notify the health visitor concerned when the baby was ready to go home, and of any follow-up recommendations made.

Other liaison with the Department of Paediatrics, which included a round of the children's wards at the Infirmary and attendance at a clinic of Professor Craig, was also discontinued as from 1st January, 1966, again because very few children needed to be referred back to the Divisional Medical Officer."

From a general point of view liaison was improving. There were many reasons for this; one of them being the joint study days which ward sisters and district nursing sisters had together.

Dr. Burn, Divisional Medical Officer (Horsforth), sent in the following report:—

" In general, liaison with the hospitals admitting patients from the area was good and, as a rule, by correspondence. The attendance of Assistant County Medical Officers at

Leeds Maternity Hospital and St. James's Hospital, Leeds, and Otley General Hospital was felt to have raised the standard of liaison, perhaps more noticeably at the latter, with the Consultant Pædiatrician. One Assistant County Medical Officer attended Leeds Maternity Hospital on alternate Friday mornings; the other attended the first Wednesday morning in the month at St. James's Hospital (Geriatrics), and the second and fourth Monday mornings and the third Wednesday morning at Otley General Hospital (Pædiatrics)."

Chiropody Treatment:

With the availability of more chiropodists for employment in a direct service as a result of State Registration, more schemes formerly administered on an agency basis by voluntary associations were taken over during the year. By the end of the year, there were 93 voluntary associations taking part in the service compared with 102 at the end of 1964. In addition, a direct service was available at 110 clinics or the premises of voluntary associations and at the premises of 38 chiropodists.

The total number of patients treated during the year was 45,156 compared with 43,104 in 1964, 37,874 in 1963, and 34,962 in 1962. The total number of treatments given was 214,490 compared with 197,771 in 1964 and 173,851 in 1963.

Of the 45,156 patients treated, 44,008 were in the aged category, which represents some 18 per cent. of the estimated population of men over 65 years of age and women over 60. The pattern varies widely over the County as a whole; in the Skipton, Keighley, Castleford and Brighouse Divisions, the percentage was 32.5, 26.6, 25.5 and 25.8 respectively, whereas in the Horsforth, Goole, Pontefract and Morley Divisions the figure was as low as 10 per cent. In 3 Divisions, the percentage was between 10 and 15, in 6 Divisions between 15 and 20, and in 6 Divisions between 20 and 25.

The extent to which domiciliary treatment was provided during the year on medical grounds continues to give rise to concern in some areas. In 10 Divisions, more than 30 per cent. of the aged receiving treatment were doing so on a domiciliary basis, in 1 Division the percentage being as high as 37.3. The average for the County as a whole was 26.9.

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.

		<i>Voluntary Association Schemes</i>	<i>Direct Service by County Council</i>	<i>Total</i>
Number of sessions held:				
In voluntary association premises	...	3,705	—	3,705
In clinic premises	... ..	—	7,036	7,036
		<u>3,705</u>	<u>7,036</u>	<u>10,741</u>

					<i>Voluntary Association Schemes</i>	<i>Direct Service by County Council</i>	<i>Total</i>
Number of patients treated:							
In chiropodists' surgeries:							
Pensioners	...	...	...	...	7,678	5,424	13,102
Physically handicapped	...	...	...	...	116	135	251
Expectant mothers	...	...	...	...	14	10	24
In voluntary association or clinic premises:							
Pensioners	...	...	...	...	6,895	12,180	19,075
Physically handicapped	...	...	...	...	80	170	250
Expectant mothers	...	...	...	...	3	7	10
Domiciliary treatment:							
Pensioners	...	...	...	...	3,915	7,916	11,831
Physically handicapped	...	...	...	...	181	429	610
Expectant mothers	...	...	...	...	1	2	3
Total number of patients treated	...	...	...	...	<u>18,883</u>	<u>26,273</u>	<u>45,156</u>
Total number of treatments given:							
Pensioners	...	...	...	...	85,863	124,203	210,066
Physically handicapped	...	...	...	...	1,482	2,854	4,336
Expectant mothers	...	...	...	...	32	56	88
					<u>87,377</u>	<u>127,113</u>	<u>214,490</u>
Number of patients treated per session:					8.5	8.4	8.4
Percentage of total patients treated receiving domiciliary treatment					21.2	31.8	26.9
Percentage of aged population receiving treatment (men over 65 years and women over 60 years)					7.5	10.2	17.7

DOMESTIC HELP

Towards the end of 1965, approval was given to an increase in the establishment of equivalent whole-time domestic helps from 1,175 to 1,235 with effect from the 1st January, 1966, to compensate for the reduction in the working week from 42 to 40 hours, and to a further increase to 1,335 with effect from the 1st April, 1966, to allow both for an expansion in the service and to permit a more generous allocation of hours per case for the elderly.

At the time of writing, the whole of the domestic help service is undergoing review with particular regard to the amount of assistance being given per case, the future organisation and supervision of the service, and the terms and conditions of service and in-service training arrangements for domestic helps.

So far as 1965 is concerned, 1,102·3 equivalent whole-time domestic helps were employed compared with 1,101·2 for 1964 and 1,078·8 for 1963. Seventeen thousand five hundred and fifty-five cases received 2,407,428 hours' help through the service, an increase of 679 cases when compared with 16,876 cases in 1964. The help provided for the aged represented 81·1 per cent. of cases (1964—80·8 per cent.) and 87·1 per cent. of the total hours (1964—86·6 per cent.).

<i>Classification of Cases Assisted</i>				<i>No. of Cases</i>	<i>Hours employed</i>
Over 65 years of age	...	...	...	14,235	2,096,300
Under 65 years of age:					
Chronic sick and tuberculous	...	...	...	1,681	201,176
Mentally disordered	...	...	...	41	4,498
Maternity	...	...	...	893	43,855
Other	...	...	...	705	61,599
				17,555	2,407,428
				17,555	2,407,428

MENTAL HEALTH

Introduction:

The rapid progress in the development of industrial work, mentioned in the report for the year 1964, has been maintained and indeed increased during the year under review. The tables giving details of the numbers of articles completed in the period 1963-65, give clear indication of the growing volume and variety of the work undertaken by the adult patients in the training centres. It is apparent that there has been no falling off in the amount of work accomplished and the fact that more time has become available for social activities is due to the speedier completion of contracts with the introduction of powered machinery and increased efficiency on the part of staff and patients.

The scheme for payments to adult patients has now been in operation for over two years and an increased scale will be in operation during the 1966/7 financial year.

Special mention is made in the report of social training and of the various activities undertaken in the social life of the training centres, and attention is particularly drawn to a vivid account of an air trip undertaken by a party of junior patients to visit a naval frigate at the Scottish port of Rosyth.

Healey Croft residential hostel for subnormal patients was opened during the year and a full report is given under the heading of 'Hostels' in this report.

The Snaith Day Centre for mentally ill patients was brought into full use during the year. This centre caters for those mentally ill persons who would otherwise have to make the long journey from the Selby, Goole and Thorne districts to attend the day hospital at the De La Pole Hospital. An account of the activities of the Snaith Centre is given under the heading 'Day Centres'.

The future building programme includes the provision of extra 'Special Care' accommodation at two centres and the provision of new special care units at three of the existing training centres. Also the erection of a new training centre at Brighouse and a sheltered workshop at West Ardsley.

The Mental Health Act has now been in operation for some five years and the County's comprehensive scheme for mental health for the same period. The community care of the subnormals had, of course, been with the department since 1948 and some of the needs were known. The field of the mentally ill, however, was a new beginning and it is gratifying to know that all the consultants at the Psychiatric Hospitals in the area are pleased with the liaison and co-operation which has been achieved. It will be some years before we are able to meet all demands for the provision of hostels, foster homes and sheltered workshops. The care of the elderly presents a large and difficult problem. In the main, however, the present services ensure that patients who have received hospital treatment or have been referred for care will receive the maximum of support in their own homes.

Training Centres:

The following is a list of the training centres in operation at the end of 1965, with details of the places provided:—

<i>Centre</i>		<i>Junior</i>	<i>Adult Male</i>	<i>Adult Female</i>	<i>Special Care</i>	<i>Total</i>
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		40	20	20	—	80
Horsforth Comprehensive		30	25	25	6	86
Horsforth Junior		27	—	—	—	27
Keighley		50	25	25	—	100
Kirkburton		30	25	25	6	86
Maltby		40	30	30	15	115
Ossett Junior		27	—	—	—	27
Rawcliffe		30	15	15	4	64
Rothwell		30	16	14	4	64
Skipton		24	18	18	4	64
Wath upon Dearne		46	25	25	12	108
West Ardsley		24	23	23	6	76
Wombwell		36	25	40	—	101
TOTALS		<u>647</u>	<u>373</u>	<u>373</u>	<u>73</u>	<u>1,466</u>

The Skipton Training Centre, Keighley Road, Skipton, opened on the 8th February, 1965.

STAFF:

Approximately 30 per cent. of the training centre staff hold the Teaching Diplomas as awarded by the National Association for Mental Health and other bodies who are approved by the Training Council for Teachers of the Mentally Handicapped. This Training Council was set up by the Minister of Health in February, 1964, with the following terms of reference:—

“To promote the provision of training for the staff (including hospital staff) of training centres for the mentally subnormal, and to approve courses of training.”

Since the Training Council was established, it has approved the courses already run by the National Association for Mental Health, and six new courses started by colleges of further education, which the Council has helped to promote. The courses are of either one or two years duration, the one year course is intended mainly for older experienced staff; the two year course is designed for younger and relatively inexperienced students.

During 1965 three young students returned to the County service after completing the two year course at Bristol, and one student returned from the one year course at Sheffield. Also two male instructors successfully completed the one year course at Birmingham.

Two teachers commenced diploma courses during the year, one being accepted for the two year course at Leeds and one for the one year course at Sheffield.

In addition to the full-time diploma courses, the in-service training programme has continued and eight short courses were held at Grantley Hall during the year.

Five students from other authorities, who were on teaching diploma courses at Leeds and Sheffield, were seconded to the County Council's training centres for practical experience and teaching practice as part of their course.

The total training centre staff as at 31st December was 1 Organiser of Training, 1 Peripatetic Instructor, 19 Supervisors, 118 Assistant Supervisors, Trainees and Instructors and 3 Home Teachers of the Mentally Handicapped. 42 of these officers hold the teaching diploma.

CENTRE ACTIVITIES:

The training centres play a most important role in the lives of the trainees and their relatives. Almost every training centre has an industrious and enthusiastic Parent/Teacher Association and the practical support given by these bodies has been invaluable. Many useful amenities have been provided by these associations and the trainees are enjoying the benefit of such gifts as bicycles, greenhouses, film projectors, climbing frames etc. Members of the P.T.A. are always well to the fore when such activities as Open Days, Harvest Festivals, Guy Fawkes Parties and Field Days are being organised. This close co-operation between teachers and parents has certainly been to the mutual benefit of staff, parents and the trainees themselves.

Swimming is now a regular feature in the programmes of several training centres. The usual pattern is for the trainees to attend private sessions at the local swimming baths. They go in small parties and are always accompanied by an adequate number of teachers who are competent swimmers. This activity is much enjoyed and a number of trainees have already started swimming.

Youth Clubs are now operating successfully in several centres. These are for the trainees who attend the centre and the centre staff have voluntarily given their time in the evenings to run these clubs. Transport also is provided on a voluntary basis and the Committee have readily granted free use of the premises when application has been made.

Other forms of social training include visits to large stores in shopping centres, travelling on public transport, nature walks, visits to farms, etc.

Although many interesting projects were undertaken during the year, perhaps the most enterprising was a visit to H.M.S. Zulu by children from the Ossett Junior Centre, this project was reported on in great detail by Mrs. Ellis, Supervisor of the Ossett Centre, and her report is reproduced below:—

"The 'Zulu' Project"

The H.M.S. 'Zulu' project had very modest beginnings when a young friend of ours, a Leading Electrical Mechanic in the Royal Navy, joined the crew of H.M.S. 'Zulu', a newly commissioned Frigate about to make its first voyage on a tour of duty in the Persian Gulf area. He had a great interest in our centre and agreed to write regularly from the ship's various ports of call, describing his experiences. We developed a regular correspondence and he sent us many interesting letters on his and the ship's experiences and also several photographs and mementos of the trip. During the 18 months the ship was away his correspondence with us received the official blessing and encouragement of the Captain, Commander Pearse, R.N., which culminated in an invitation from the Captain to visit the ship when she returned home.

Fortunately, 'our sailor', as he was known to the children of the centre, flew home to register for a Petty Officer's course and we were able to discuss the invitation to the ship. This meant a visit to either Portsmouth, where the ship would dock initially, or to Rosyth, where she would proceed for a refit. Either meant a journey of some 250 miles or more, but Rosyth seemed the more convenient from the point of view of ease of access and the dates involved. Then we faced the problem of how to transport some 15 young mentally handicapped children (the oldest was 11) to Rosyth and back and this could not be done by normal road or rail travel without spending at least one night away from home. This seemed impossible to arrange without considerable difficulty and possible opposition from parents, apart from the difficulty of cost and trying to find a hotel or hostel, which would accept our group. 'Our sailor', however, came up with the idea of flying to Edinburgh and back from Yeadon which would cut travelling time enormously—subsequent enquiry from various airlines operating from Yeadon confirmed that a trip there and back in a day, with a reasonable time at Rosyth was perfectly feasible. The financial aspect then raised the inevitable doubt—the original provisional estimate was £210, a formidable sum to raise in the 6 weeks before the trip was due to take place. However, a casual mention of the project in a talk I gave to the Local Mothers' Club which resulted in an item in the local press, raised such enthusiasm and so many offers of help that I was encouraged—with some trepidation—to embark seriously on the project.

The intervention of the school holidays complicated matters further as neither of my 2 centre staff were available for the trip, but I had the willing help of my husband, who handled financial details and long distance arrangements while I was more and more involved in meetings with the many local groups who had started fund raising efforts and the difficult task of choosing 15 out of the 29 children at the centre, who could be considered suitable to make the trip.

The parents of the 15 were called together for several meetings and the Parent Teacher Association had an emergency meeting and agreed to guarantee the balance of the funds necessary for the outing and finally an overall guarantee was most generously made by the Variety Club of Great Britain. Our financial worries were thus removed.

All our arrangements had originally been made with departures from Yeadon, but a final confirmation letter from the Captain of the H.M.S. 'Zulu' changed our visit date to Friday, 20th August, when we found that no suitably timed flight from Yeadon was available. Everything was then switched to air travel from Manchester with B.E.A. via Glasgow to Edinburgh. As this entailed a much longer road trip to and from the airport, and a change of aircraft at Glasgow, I had most reluctantly to remove the three most severely handicapped children from the party and my decision was accepted with full understanding by the parents concerned.

The switch to Manchester meant a change in our travel arrangements—previously Godfrey Davis Ltd. a Leeds car hire firm had generously offered to transport the party between Ossett and Yeadon—and it was decided to use the school bus for the journey to and from Manchester, but Godfrey Davis Ltd. still insisted on being involved and arranged to bring the children to the centre for the early 5 a.m. start. Indeed, the day before the trip I received a telephone message to say that transport from Edinburgh to Rosyth would also be arranged by them.

The parents were finally notified of the complicated travelling arrangements—the children having to be collected from villages and towns within a 10 mile radius of Ossett, final telephone calls were made to Edinburgh, the various transport people and B.E.A. and the Leeds Secretary of the Variety Club of Great Britain.

The great day finally dawned and my husband and I travelled to the centre at 4-30 a.m. with some misgivings. However, the arrangements worked without a hitch—all the children arrived on time and we were on our way to Manchester—a large coach was taken together with a supply of blankets so that each child had a full seat and could be bedded down on the return home. 'Our sailor' obtained special leave to accompany us. My husband and I had had a trial run to Manchester both to time the journey and study the embarkation procedure but when we arrived with our estimated half-hour to spare we found that the second aspect of this was largely unnecessary—B.E.A. had really laid on the V.I.P. treatment for our party and we were expertly guided through the registration procedure and through to the aircraft by a B.E.A. officer and this transpired to be the drill through Glasgow to Edinburgh. Our thanks are due to B.E.A. for the excellence of the arrangements they made on our behalf.

The plane from Manchester to Glasgow was a 126 seater Vanguard with pressurised cabins and looked very large and impressive on the tarmac, but the children took all this like seasoned travellers, took their special seats and fastened their safety belts with absolute nonchalance. There were no nerves or tears on take-off or throughout the 45 minute flight to Glasgow and they showed great interest in the ground below as we flew over the Lake District and Southern Scotland. We were met off the plane and just had time for a very welcome hot drink before transferring to a smaller Herald aircraft for the short flight across to Edinburgh to arrive just after 9 a.m. in cool, but sunny weather. A quick coach run in the special airport 'bus into the centre of Edinburgh and we were met by two Mental Welfare Officers of the Edinburgh Health Department with whom we had been in contact and who had arranged our lunch and tea. An interesting walk through Edinburgh and Princess Street Gardens, taking in a childrens' concert in the open air theatre, a visit to the famous floral clock near the Scott memorial, a quick shopping expedition in a crowded store for gifts to take home, and it was time for lunch at the Playhouse Restaurant. Here we adults relaxed thankfully for a short time and the children displayed their excellent table manners, of which I am justly proud and then it was time for the big thrill—H.M.S. 'Zulu'. Godfrey Davis Ltd. had been true to their word and outside three magnificent limousines waited to take us in style to Rosyth. An interesting run over the new Forth Bridge brought us to the Dockyard Gate where our special passes were scrutinised and we were met by members of the crews of H.M.S. 'Zulu' dressed up as pirates and a sister ship, H.M.S. 'Mohawk', dressed as Red Indians. This set the pattern for the whole afternoon, which turned out to be truly riotous. We were welcomed aboard by Lt. Commander Broadbent, the Secd. in Command, other members of the crews of the two ships who took over a child each and we were given the freedom of the ship. After the first five minutes the children acted as though they had been on ships all their lives—running up and down cat ladders, operating telephones and control systems—all of which had been very thoughtfully disconnected prior to our visit—and learning to be gunners and look outs. Three hours passed all too quickly, but a further surprise waited us—a most magnificent party had been laid out in the Petty Officers' Mess and the children tucked in with great gusto. The party was wholly financed by a collection amongst the crew and the fact that the ship had only docked an hour before we arrived and our whole visit took place while a large proportion of the crew were being paid and proceeding on a well earned leave, bears tribute to the remarkable efficiency with which the visit was organised.

Our cars were now due to arrive and we parted with reluctance but not without huge parcels of sweets and fruit, mementos of our visit and fervent requests to bring more children next time.

A direct run back to the airport, where our drivers waived aside all offers of payment only to find that our return plane to Glasgow was grounded due to bad weather over the hills. Our fears of not getting back were, however, shortened, a special coach was laid on to Glasgow, where our Manchester plane had been delayed until our arrival. Again the short flight time, this time in the dark and 2,000 feet above the normal ceiling to avoid the bad weather which had developed. The children again showed no fear as we went through several pockets of turbulence and although a few nodded off, most were still most interested in the lights of the cities below. We collected our coach, the children were bedded down for the return run and the journey back to Ossett, stopping only to telephone the centre where parents waited, to explain our half hour delay in arrival, which was precisely at 12-30 a.m. some 20 hours after the children had first set out. However, I must say that they were far more active and alert than we adults at the end of it all.

My grateful thanks are due to the many people and groups who were connected with the venture and it is impossible to mention them all individually. I would however, particularly thank B.E.A. for the flight arrangements, the mental health staff at Edinburgh who helped considerably with arrangements in Scotland, the Variety Club of Great Britain for their financial guarantee and the Captain and crew of H.M.S. 'Zulu'.

Many things come to mind on later appraisal of the whole venture. We have proved that mentally handicapped children are quite capable of travelling by air, can accept a novel situation as normal children would and their range of experience has been considerably widened. The many people we met through the trip—our fellow air travellers, airline, restaurant and transport staff, holiday visitors in Scotland and the young men of the Navy showed a lively interest in the venture which was not simply morbid curiosity and there is no doubt that we have furthered our general aim of bringing the general public and mentally handicapped closer together. The children have not forgotten the trip and I believe it will remain one of the memorable events of their lives."

HOLIDAYS FOR PATIENTS:

A party of 50 trainees together with staff again spent two weeks at St. Hilda's Home, Whitby from 14-25th June, 1965. This party was made up of adults and children and was drawn from all training centres, places being allocated at approximately three per centre. This was the sixth successive year that trainees have visited Whitby and a further visit is planned for 1966.

In addition to the general holiday, children from the Horsforth Junior Centre went en bloc for a week's holiday at Whitby in the early summer. This venture was sponsored by the local P.T.A. and leave of absence was granted to the staff who accompanied the party. This project is also being repeated in 1966.

INDUSTRIAL WORK:

Early in 1963 industrial work was introduced into the adult wings of the training centres. The first jobs were of a very simple nature such as the splitting of firewood for the boys and the making and filling of bean bags by the girls. From this modest beginning progress has been rapid and over 130 differing contracts are at present being undertaken. Most of the work is on behalf of the County Supplies Department but about 20 private contracts are also being undertaken. There is, therefore, a fair variety of work. For the men, the contract work includes the making of art easels, first aid boxes, playhouse screens, sketching and modelling boards, specimen stands, mercury trays etc. The women are busily engaged on curtains, blotting pads, pan scrubs, aprons, dressing gowns, Christmas crackers, table cloths, tea towels etc.

The following table gives details of the work done on behalf of the County Supplies Department during the period 1st April, 1963 to 31st December, 1965:—

<i>Job No.</i>	<i>Description</i>	<i>1963/4</i>	<i>1964/5</i>	<i>1965/ 31-12-65</i>	<i>Total</i>
1	Firewood Splitting	475	8,704	10,405	19,584
2	Bean Bags	3,267	4,691	1,281	9,239
3	Sketching Boards	2,464	4,936	5,107	12,507
4	Modelling Boards	5,163	9,125	4,850	19,138
5	Blackboards	1,487	2,700	600	4,787
7	Curtains (Sewing yards)	2,050	17,892	28,003	47,945
11	Whip Stocks	2,552	2,742	2,745	8,039
12	Wash Leather Mops	215	975	354	1,544
17	Doll's Cots	24	65	104	193
18	Flour Bags	16,255	2,000	17,594	35,849
19	Feather Flicks	138	256	334	728
20	Dish Mops	933	975	1,985	3,893
22	Children's Blackboard Cleaners	2,831	4,000	6,750	13,581
23	Teacher's Blackboard Cleaners	3,818	4,379	5,537	13,734
26	Wooden Blocks	—	2,180	507	2,687
31	Finishing Work for County Supplies	5,324	9,926	3,413	18,663
33	Blotting Pads	6	633	477	1,116
34	Archery Screens	8	—	—	8
35	Workholder Cases	572	50,133	65,380	116,085
36	Copper Pan Scrubs	—	4,157	2,637	6,794
37	Clothes Horses	—	83	72	155
38	Inkwell Trays	—	35	25	60
39	Floor Dominoes	7	124	126	257
41	Science Section Blocks	—	60	144	204
42	Men's Aprons	12	758	233	1,003
43	Junk Boxes	—	111	101	212

<i>Job No.</i>	<i>Description</i>	<i>1963/4</i>	<i>1964/5</i>	<i>1965/ 31-12-65</i>	<i>Total</i>
44	Truck on Castors	—	192	162	354
45	Wooden Cubes	—	229	377	606
47	Women's Pinarettes	—	1,107	172	1,279
48	Test Tube Cleaners... ..	—	582	450	1,032
49	Renovation of Furniture	—	387	404	791
51	Nylon Pan Scrubs	—	3,101	3,783	6,884
52	Art Easels—Standing Model	—	95	616	711
55	Art Easels—Table Model	—	124	190	314
56	Pillow Cases... ..	—	2,448	7,850	10,298
58	Playhouse Screens	—	39	81	120
60	Pan Stands	—	36	252	288
67	Plywood Peg-boards—100 hole	—	417	435	852
68	Scatter Cushions	—	48	—	48
69	Midwives Bags (calico)	—	28	—	28
70	Plywood Peg-boards—25 hole	—	336	493	829
71	Sawing Blocks	—	30	76	106
72	Making up only—Pillow Cases	—	240	—	240
73	First Aid Boxes	—	—	95	95
74	Number Ladders	—	141	547	688
75	Hollow Wooden Blocks	—	120	144	264
76	Clothes Props	—	24	24	48
77	Specimen Stands—6in.	—	24	149	173
78	Specimen Stands—3in.	—	24	155	179
79	Mercury Trays	—	—	84	84
80	Dressing Gowns	—	45	108	153
81	Corner Flags	—	60	756	816
84	Corner Flag Poles	—	—	368	368
85	Tea Towels	—	120	2,584	2,704
86	Hand Towels	—	95	—	95
87	Christmas Crackers (boxes of 12)... ..	—	—	803	803
88	Pillow Cases—Unbleached	—	633	1,425	2,058
89	Penholder Trays	—	—	94	94
90	Drawing Material Boxes	—	—	132	132
91	Feeders—Terry Towelling... ..	—	—	958	958
93	Table Cloths	—	—	70	70
95	Battledor Type Bats	—	—	980	980
96	Doll's Clothes Horses	—	—	150	150
97	Screen Curtains	—	—	60	60
98	Cot Sheets	—	—	200	200
100	Bogey Boards	—	—	60	60
102	Training Bibs	—	—	29	29
104	Stilts 3ft. size	—	—	252	252
105	Padder Type Bats	—	—	100	100
107	Steering Wheel and Masts... ..	—	—	54	54
108	Test Tube Racks 8 hole	—	—	38	38
109	Stilts 4ft. size	—	—	168	168
110	Clothes Posts and Base	—	—	12	12
111	Wooden Mallets	—	—	75	75
112	Dusters	—	—	234	234
115	Piano Bumper Bars	—	—	12	12
116	Kit Bags	—	—	30	30
118	Winchester Boxes	—	—	68	68
119	Waste Paper Bags	—	—	6	6

In addition to the work undertaken for the County Supplies Department, a considerable amount of work has been done for private firms e.g. the making of concrete washers used in connection with road making, the stamping out of lubrication caps, wire-bending operations in connection with the manufacture of building ties, and the making of fibre plant pots for the parks' departments of local district councils.

Details of the private contracts undertaken from 1st April, 1963 to 31st December, 1965 are as follows:—

Job No.	Description	1963/4	1964/5	1965/ 31-12-65	Total
6	Concrete Washers	89,000	203,000	136,000	428,000
8	Fibre Plant Pots	19,400	36,544	9,900	65,844
9	Lancashire Witches... ..	—	—	24	24
13	Seed Boxes	1,000	1,436	957	3,393
27	Sorting of Grease Nipples etc. ...	—	—	166	166
32	Wire Bending	200,360	431,739	209,000	841,099
50	Cold Frames	1	3	—	4
53	Painting "Sooty" Effigies... ..	1,008	720	—	1,728
54	Brass Straps... ..	—	563,240	169,440	732,680
59	Sewing Wash Leathers	—	2,211	300	2,511
61	Manufacture of Tables and Trolleys	—	2	1	3
63	Renovation of Gates	—	—	8	8
64	Rubber Link Mats	—	12	1	13
65	Carpet Fringes	—	252	210	462
66	Concrete Slabs	—	—	50	50
82	Trap Doors	—	25	—	25
92	Readicut Rugs	—	—	7	7
94	Flower Pin Holders	—	—	157	157
99	Soft Toys	—	—	1,466	1,466
101	Resale of Furniture... ..	—	—	87	87
103	Fisher Plastics	—	—	383,904	383,904

A considerable amount of material for propaganda purposes in connection with health education has also been made in the training centres. The value of this work during the year 1964/5 was £132 14s. 1d. and during 1965/6 £147 1s. 9d. making a total of £279 15s. 10d.

Additionally, the girls carry out laundry work, not only for their own training centre needs but also taking on the laundry for other County establishments such as child welfare centres, etc. The boys are maintaining the grounds, cutting the grassed areas with motor mowers.

It was realised from the beginning that success in the industrial work field would, in a large measure, depend upon the ability of the Instructors to break down into simple operations the manufacturing process of the various articles. The Instructors in the training centres have shown great ingenuity in the setting up of jigs and by this means the component parts of intricate articles have all been made by the patients. In this way production has been more by "team effort" than by individual attainment and the patient has the satisfying experience of being part of a team or group which has produced worthwhile and saleable articles.

Power machinery has gradually been introduced into the centres and many of the girls are now adept operators of electrical and hand sewing machines whilst the boys competently use electric drills, morticing machines and routers.

The Chief Officer of Supplies has indicated that the standard of goods manufactured in the training centres is as good, and in some cases better, than the goods obtainable from open industry.

This remarkable progress is the result of the combined efforts of the Centre Supervisors and Instructors, the Organiser of Training, members of the central office staff, and especially to the ready co-operation of the Chief Officer of Supplies and his staff.

Whilst appreciating the therapeutic value of industrial work, it must be emphasised that the social aspect of the training centres is not being neglected and a balanced programme of work, play and social training is being carried out. The present division of the training centre week is $17\frac{1}{2}$ hours industrial work and $12\frac{1}{2}$ hours for social activities. The present flow of industrial work from the County Supplies Department, together with the private contracts, is being contained within the industrial work period with a slight margin for further contracts to be undertaken.

PAYMENTS TO TRAINEES:

The scheme for incentive payments to trainees was introduced as from 1st April, 1964. The scheme for the year under review was governed by two main factors, i.e. a ceiling of 15/- per week for individual payments and a total budget provision of £16,000. The minimum payment is 5/- per week and at the end of the year approximately 55 per cent. of the patients were receiving the basic minimum of 5/- per week, some 30 per cent. were receiving 7/6 per week and the remaining 15 per cent. were at 10/-, 12/6 or 15/- per week. A scheme for increased payments during 1966 has already been approved.

The incentive payment scheme has been much appreciated, especially by parents to whom it was a great morale boost when they realised that their son or daughter, whom they had never expected to earn anything, could bring home a weekly wage packet, however small.

Payment through this scheme is not related to productivity but recommendation for increases are made on account of the effort and enthusiasm displayed by the trainee. The trainees are paid in transparent envelopes, through which they can see the coins; they are encouraged to acknowledge receipt by either signing the wages sheet or making their mark against the amount. "Pay day" is indeed a most important occasion and is undoubtedly of value in training.

SPECIAL CARE UNITS:

The provision of special care has proved to be a tremendous help to those parents who, in some cases, have struggled for a number of years to bear at home the heavy burden of a severely handicapped child. The special care units are designed for those patients who are too severely handicapped to fit into the routine of the junior or adult sections of the training centres. In addition to mental handicap, many of the special care cases have also gross physical disabilities. Although many distressing cases are admitted to the care units, it is gratifying to know that a number of cases have made considerable progress. They are encouraged to use their limbs and some have reached the walking stage. Emphasis is placed on toilet training and human relationships; and several successes have been recorded, for which the parents have been particularly grateful.

The special care unit is open for 48 weeks in the year and special transport is provided for appropriate cases. The staff are carefully selected, for the work calls for a great deal of devotion and care.

Eleven special care units, with a total of 73 places, were in operation at the end of the year. Plans are in hand to provide three new care units of 12 places each and to increase the accommodation in two of the present units from six to twelve places, thus lifting the number of places from 73 to 121. Public demand is certainly increasing with regard to special care unit provision and parents of mentally handicapped children are more readily seeking advice about their management at home. The main concern of parents often seems to centre not so much on diagnosis or prognosis, which usually has been adequately dealt with by many agencies but rather in the kind of assistance available to the children and to the parents themselves.

Mental Welfare Officers:

The establishment is 1 Psychiatric Social Worker/Tutor (a joint appointment with the National Association for Mental Health), 7 Senior Mental Welfare Officers and 54 Mental Welfare Officers. During the year 9 Mental Welfare Officers have resigned and one has retired. Of this number 5 were appointed Mental Welfare Officers with other authorities, one transferred to the Child Guidance Service of this authority as a trainee Psychiatric Social Worker, one obtained employment in the Welfare Department of another authority and one was accepted as a student for the B.A. (Admin.) Course. 11 Mental Welfare Officers were appointed during the year. 10 of these Officers were men and it has been noticeable over the past year or so that the response to advertisements for these posts from women has been very poor (of the 53 Mental Welfare Officers in post, 39 are male and 14 female).

TRAINING COURSES:

Mr. Parkinson, Senior Mental Welfare Officer in the Storches Hall Mental Health Area, was awarded the Certificate in Psychiatric Social Work at the University of Leeds, and Mr. Hope, Senior Mental Welfare Officer, commenced this course in September. Mr. Noden, Mental Welfare Officer, completed the two year Younghusband Training Course at the Leeds College of Commerce and he was awarded the Council for Training in Social Work's Certificate in Social Work. Two Mental Welfare Officers commenced the second year of this course in September.

Ten Mental Welfare Officers attended Induction Courses for newly appointed officers in 1965. The courses, organized by the National Association for Mental Health, are residential, and last for 11 days.

The teaching groups, held on one afternoon per fortnight have continued throughout the year. They are held at Wombwell, Skipton, Brighouse, Pontefract, Harrogate. All the Mental Welfare Officers attend the groups organized by Mrs. Farrow. They are of great benefit to the officers, particularly those who are recruited to the service from the hospital service.

Grantley Hall Courses:

There were five three-day courses for Mental Welfare Officers at Grantley Hall during the year.

The first from the 6th—8th April was attended by 23 Mental Welfare Officers and the theme was "New developments in the care of the Mentally Disordered". Dr. R. D. H. Maxwell, Consultant Psychiatrist, spoke on "Developments in Investigations—Treatment of the Mentally Ill", Mr. J. Castelow, Welfare Officer at the Ministry of Health, on "Recent Developments in the Mental Health Services", Dr. R. M. J. O'Brien, Consultant Psychiatrist, on "Clinical Features of Alcoholism", and Dr. C. F. Herridge, Consultant Psychiatrist, on "New Drugs and New Dangers".

This course was repeated from the 27th—29th April and was again attended by 23 Officers.

The course 5th—7th October was on "Mental Health and the Family". It began with a visit to the Cardinal Square School, Leeds and Mr. Marks, Headmaster, spoke on "Mental Hygiene and Therapy with Educationally Sub-normal children"; Dr. R. E. D. Markillie, Consultant Psychiatrist, discussed "Family Relationships and Personality Development" and Miss M. Sedgwick, Divisional Children's Officer, spoke on "Children at Risk".

Two identical courses were held in November, from the 2nd—4th and the 16th—18th. "Mental Health and the Elderly" was the title of the courses at which the speakers included Mrs. E. Law, Tutor Organiser of the Yorkshire Council for Old People's Welfare; Mr. E. Butterworth, Lecturer in Social Studies, University of Leeds; Dr. J. A. R. Bickford, Physician Superintendent, De la Pole Hospital; Dr. O. Fleming, Clinical Assistant Geriatrics, Dr. L. Rosenthal, Consultant Physician and Dr. D. Macmillan, Director, Nuffield Centre for Hospital and Health Service Studies.

Dr. Francis, Deputy County Medical Officer, opened all the above courses and an evaluation at the close of each course was given by Dr. Jeremiah, Senior Administrative Medical Officer for Mental Health.

MEETINGS OF SENIOR MENTAL WELFARE OFFICERS:

The Senior Mental Welfare Officers continued to meet at monthly intervals throughout the year. Normally these meetings are held in Wakefield but the June meeting was held in the new Psychiatric Unit at St. Luke's Hospital Huddersfield, this particular meeting also included a tour of the hospital unit. A joint meeting with the Area Youth Employment Officers was held during the year. At this meeting the officers considered the recommendations of the Working Party set up under the chairmanship of Elfred Thomas, B.Sc., Ph.D., (Director of Education, City of Leicester) to investigate the various aspects and problems of the handicapped child.

Under the guidance of Mrs. Farrow full in-service training for Mental Welfare Officers has been maintained and at the Teaching Groups and Grantley Hall Courses they are able to keep contact with their colleagues throughout the Riding. A library of text books, on loan from the County Library, is kept in the Central Office and is available to the members of staff.

The Mental Welfare Officers attend case conferences at the Psychiatric Hospitals and are in attendance at the Psychiatric Out-patient Clinics. The Consultant Psychiatrists in the Hospital Service serving the County have said they are pleased with the service provided by the Authority and the standard of co-operation which has been achieved. Clinic facilities for the subnormal and severely subnormal have been extended and almost all cases referred for hospital care seen by the appropriate Consultant with little delay.

Hostels:

HEALEY CROFT HOSTEL, WESTERTON ROAD, WEST ARDSLEY.

Warden—Mr. R. Tyson, S.R.N., R.M.N.

Assistant Wardens—Mrs. M. Tyson, R.M.N., Mrs. L. Jarman.

Dr. Ireland, the Divisional Medical Officer, reports as follows:—

“ This hostel, completed in 1965, admitted its first residents on 14th September and by the end of the year twenty-three subnormal adults were in residence. The hostel has places for 30 residents (which includes the bed in the sick-bay) and structurally consists of three wings. Two of the wings, each two storied, contain the bedrooms and are at right angles to each other. One is for male residents and also contains the warden's flat, the other is for female residents and contains two bed sitting rooms for two assistant wardens. These two wings are joined by a common approach to the third wing, which is single storied, and contains the kitchen, dining room, lounges, games room, office and the reception area.

The resident staff consists of a warden and two assistant wardens (one of whom is the warden's wife). There is a non-resident cook, five part-time domestic assistants and a part-time caretaker (shared with the nearby West Ardsley Training Centre).

Age and Sex of Residents at Healey Croft Hostel

Sex	16+	19+	22+	25+	30+	40+	50+	60+	Total
M	2	1	—	2	3	2	1	—	11
F	2	2	1	1	1	3	2	—	12
Total	4	3	1	3	4	5	3	—	23

Residents so far admitted fall into four main groups as follows:—

- 1) Subnormal adults living in the community who have lost by death or illness their parent or guardian, temporarily or permanently (8)
- 2) Subnormal adults living in hospitals but not considered to be in need of treatment (7)
- 3) Subnormal children residing in children's homes who attain the age of 18 years and are considered to be in need of continued supervision (3)
- 4) Subnormal adults with poor physical and/or mental social conditions existing in the home and which may have resulted in anti-social behaviour (5)

Considering the number of staff and the number of residents the first two groups have proved to be the least problematical and the most suited to a hostel that is run in principle like a home where the aim is to provide a homelike and stable background. For the third group the residents from children's homes prove difficult due to the massive adjustment they have to make from a well ordered children's home, where in many cases they have been for a long time, to an adult setting. The subnormal adults admitted in social and anti-social groups prove the least suited and the problems arising from this group create some difficulty in maintaining the principle of the hostel which is to function as a substitute home and retain a certain permissiveness of outlook. Problems with this group can arise particularly when one considers that the three resident staff can have to cope with 30 residents.

The residents fall into two sections (a) working residents (9) and (b) residents attending the Training Centre (14) some of whom are capable of employment but the female residents in this category prove hard to place.

This grouping causes difficulties in organisation and administration at the hostel. For example the working subnormals partake more realistically in entertainments and recreations. They receive their pay packets, are better off financially and resist to some extent being organised and it is probably right that they should be encouraged to find their own suitable outlets. The residents attending the Training Centre tend to remain near the 'apron strings' and require encouragement and a lead in recreational activities. Bed times, meal times, etc. which have to relate to the hostel as a whole can prove difficult as seen by the analogy of a normal home situation where there are two 4—5 year olds—two 9—10 year olds. From an administrative point of view the various meal times are also affected by this grouping and breakfasts are had as follows: 5-30 a.m. for four residents; 6-30 a.m. five residents; 8-0 a.m. fourteen residents. The Training Centre residents have their evening meal at 5-0 p.m. and those returning from work at 6-0 p.m.

There have been problems during these first four months, one or two quite serious, and relating to bad placement but on the whole the hostel has tended to develop its own personality and the residents have settled down quite well.”

MEADOW BANK HOSTEL, HARROGATE.

Accommodation 8 subnormal children

Warden—Mrs. J. E. Fuller, S.R.N., S.C.M., H.V.Cert.

Assistant Warden—Mrs. N. Major.

Dr. Hepple, the Divisional Medical Officer, reports:—

"The children are at the hostel from Monday to Friday each week during the Training Centre terms, which correspond with those in the Harrogate Schools. In the holiday periods the hostel is used for short stay care. The hostel has been fully occupied throughout the year, the number of new admissions being seven. Four of the children discharged were from the Skipton area and they were admitted to the Skipton Training Centre which opened in February.

Short stay care—Eight children were admitted to Meadow Bank during the year, one of them three times, for varying periods. At Easter and Whitsuntide three children were admitted and five children during the period 25th July to 13th August. During the Christmas holiday one girl was admitted on December 29th for one week.

Health—There were no infectious diseases at Meadow Bank during the year.

Activities—These have included outings by car and walks, shopping expeditions, the usual fireworks display, birthday parties and Christmas party. The children are encouraged to help themselves and one another and do jobs round the hostel. Three school girls are regular visitors, one coming each day straight from school. These girls play with the children and they are also helpful in other ways.

Mrs. Fuller attended a residential course for the staff of hostels for mentally handicapped children held at Haywards Heath, Sussex, from the 31st May to the 4th June, 1965."

LEE GRANGE HOSTEL, WEST ARDSLEY.

This hostel is under construction and will cater for post-psychotic cases. It is anticipated that it will be ready for occupation in the Autumn of 1966.

Day Centres:

<i>Club</i>	<i>No. of members</i>	<i>Premises</i>	<i>Meetings</i>	<i>Opened</i>
Harrogate Therapeutic	52	101, Station Parade, Harrogate	Monday Wednesday Thursday Friday afternoons	October, 1963
Snaith Day Centre	20	Pontefract Road, Snaith	Daily	December, 1963

Harrogate Therapeutic Club:

The groups meet every afternoon from 2-0 p.m. to 4-30 p.m. and the relative figures are set out below:—

	<i>Sessions</i>	<i>Attendances (Patients)</i>	<i>Attendances (Psychiatrist)</i>	<i>Attendances (Mental Welfare Officers)</i>
Monday	47	680	36	47
Tuesday	20	180	—	20
Wednesday	50	1050	44	50
Thursday	50	200	—	50
Friday	50	460	—	50
	<hr/> 217 <hr/>	<hr/> 2570 <hr/>	<hr/> 80 <hr/>	<hr/> 217 <hr/>

Dr. P. J. G. Quinn, Physician Superintendent, Clifton Hospital, York, writes as follows:—

“This hospital is responsible for the psychiatric services in the Harrogate/Ripon area. As you probably know, there is a very close and happy relationship between Dr. Munro and Dr. Kerr, our Psychiatrists, and Dr. Hepple and the Mental Welfare Officers there. The local authority Therapeutic Club at 101 Station Parade, Harrogate, is a great boon and provides a very helpful follow-up service. The only problem is that the accommodation is not too satisfactory, but I understand that you are on the look-out for better premises. The local doctors have been sending quite a number of new cases to 101 Station Parade.”

Snaith Day Centre:

Staff—Mr. G. H. Purchon, Psychiatric Nurse/Therapist
Mrs. R. H. Kershaw, Instructor

Dr. Appleton, Divisional Medical Officer for the Goole area, has taken a great interest in the development of this centre and the following report is based mainly on his observations over the year's work.

Mr. Purchon commenced duty on the 1st February, 1965, and Mrs. Kershaw on the 7th February, 1966. During 1964 the centre had been operating on four afternoons a week as a day social club, staffed by Mental Welfare Officers. The area served is Goole, Selby and Thorne. Transport is provided by the County Ambulance Service and mid-day meals from the School Meals Service.

The patients attending are selected by the Consultant Psychiatrist. There are 22 names on the register and the average daily attendance is 17.

The primary function of the Day Centre is to provide an intermediate stage for those patients sufficiently recovered to leave hospital but not yet able to face the full impact of life in the community without further encouragement and sympathetic guidance.

A friendly unrestricted atmosphere has enabled each member of the Centre to feel that he is an individual in his own right and is enabled to use facets of his personality which have become blunted in many cases by up to eight years of hospitalisation. The socialisation process in which the main aim is to return the majority to the community in acceptable roles is seen to operate effectively and the patients do not feel isolated from the community.

Occupational therapy is almost as varied as the number of patients attending, the object being to find out what each patient wants to do and which activities best release his tensions. One patient is most relaxed when dismantling a piano, another in painting posters, a third when listening to the church organ, and so on. Over a period the following occupations have been made available to one or more patients: sewing, knitting, typing, gilding, painting, metal work, French polishing, piano stripping, guitar-case making, salvaging television parts, radio repairs, implement sharpening and grinding, hairdressing and woodwork. Several other interesting activities are under consideration.

There is no pressure upon the patients and they feel free to talk, relax and discuss their problems with a sympathetic and understanding staff.

Psychiatric oversight is provided by the Psychiatrists from De la Pole Hospital, who visit the centre each Wednesday lunch time to discuss any problems the patients may have, in the informal atmosphere of the Centre, and Dr. J. Amor Ardis, Consultant Psychiatrist, says,

" My impression during the time the centre has been open is that it is doing an extremely good job. Whenever I visit there seems to be a cheerful and optimistic atmosphere and most of the patients show evidence of being hopefully occupied. They appear to have a good relationship with Mr. Purchon and hence with each other. I have indeed been surprised to find so many to improve in morale and in mental health generally despite the fact that many of them suffer from intractable neurotic or physical conditions which have failed to respond to orthodox occupational therapy or indeed in many cases have failed to derive much benefit from hospital treatment."

Psychiatric Social Clubs:

<i>Club</i>	<i>No. of places</i>	<i>Premises</i>	<i>Meetings</i>	<i>Opened</i>
Castleford Club	30	Child Welfare Clinic, West Villa, Hightown, Castleford	Monday evening	September, 1961
The Contact Club	35	Health Centre, Greenside, Cleckheaton	Tuesday evening	October, 1963
The Glen Social Club	30	Somerset House Clinic, Shipley	Tuesday evening	September, 1961
The Handshake Club	40	Multiple Clinic, Leeds Road, Tadcaster	Tuesday evening	January, 1964
Harrogate Social Club	50	Training Centre, High Street, Starbeck, Harrogate	Tuesday evening	April, 1963
Ilkley Club	30	South Hawksworth Street, Ilkley	Monday evening	February, 1964
Maltby Club	20	Training Centre, Addison Road, Maltby	Thursday evening	April, 1963 (temporarily closed)
Morley Social Club	20	Central Clinic, Morley	Thursday evening	January, 1962
Rock Club, Wath upon Dearne	40	Child Welfare Clinic, Church Street, Wath upon Dearne	Fortnightly Thursday evening	August, 1961
Rothwell Club	30	Central Clinic, Oulton Lane, Rothwell	Monday evening	August, 1965
Springhead Club	25	Springhead Clinic, Cooper Street, Saddleworth	Thursday afternoon	December, 1964
The White Rose Social Club	16	Div. Health Office, High Street, 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

During the year the Castleford Club moved to new premises at the Child Welfare Clinic, West Villa, Hightown, Castleford, the Normanton Club was closed and the Rothwell Club held at the Central Clinic, Rothwell, was opened. The Castleford and Normanton clubs had served Health Divisions No. 11 (Castleford) and 16 (Rothwell) and the re-organisation gave each Division one club. The Maltby Club has been closed temporarily but it is hoped to re-open this club in 1966. The White Rose Club transferred from Barnoldswick to Skipton in April, 1965.

Club Activities:

Some of the activities undertaken by the Psychiatric Social Clubs are reported as follows:—

Two holidays were arranged for patients attending the *Harrogate* club. The first from the 23rd April to the 1st May was at Bridlington, and 23 members took part (4 being from other clubs). It was a most worthwhile venture and was followed by the second holiday to Scarborough in the Autumn, 13 patients taking part on this occasion.

Activities at the *Handshake* Club have included dances, games, film shows, coffee evenings etc. One member provided a show of slides taken by his son with the R.A.F. on Christmas Island. Visits have been made to York and Harrogate Clubs and two trips have been made to Scarborough and the Dales. The Tadcaster Round Table assist with transport.

The *Ilkley* Club continues to play a therapeutic part in maintaining people in the community who would otherwise have been admitted to hospital. One or two people are attending the Industrial Therapy Unit daily from their own homes, the idea being a first step to rehabilitation in employment.

The total membership of the *Contact* Club is now 60 with an average attendance of 23. The Psychiatrist continues to give his support and regularly attends the meetings. Special events were arranged at intervals during the year—notable amongst which was the trip to Blackpool illuminations and the now customary theatre parties. Civic recognition was accorded the Club at Christmas when the Third Annual Dinner was held, the Mayoress and Deputy Mayor of Spensborough dined as guests of the patients.

The numbers attending the *White Rose* Club are restricted due to the vastness of the Divisional area and the difficulties encountered as a result of poor transport facilities. Despite these difficulties the patients enjoy their club nights, which provide social contact they may otherwise be unable to maintain. Activities undertaken at the club consists of games including table tennis, darts, cards, dominoes etc., housey-housey and beetle drives are held and small prizes are given. Parties were arranged on three occasions last year with neighbouring psychiatric social clubs.

Membership of the *Glen Social* Club is in the region of 30. There is a predominance of female members, only about 4 are men. The club meets on Tuesday evening for two and a half hours and activities vary there being visiting speakers, demonstrations of such things as hairdressing, film shows on a wide range of subjects, and amongst the members themselves are arranged such activities as whist drives, bingo, and parties on such occasions as birthdays. Patients who live alone have been noticed to benefit most from membership, and the club at least provides a weekly opportunity for such persons to meet other people and have the assurance of human contact.

The weekly meeting of the *Castleford* Club is most successful and there is a slowly changing membership as new people join and others leave. There is a good atmosphere and members enjoy their weekly get-together. Music, games and discussion are all part of the proceedings and all take part in one or the other. There has recently been a visit to a production by the Oulton-cum-Woodlesford theatrical group, thoroughly enjoyed by all.

The *Morley Club* is held every week at the Central Clinic since it was started in 1962. Its purpose is to assist in the social rehabilitation of patients discharged from hospital and to serve as a link between the hospital and domiciliary services. The attendance fluctuates considerably and though the highest weekly number has been in the region of fifteen, this has not been maintained for many weeks at a time, and the average number has been eight. At least ten members are now working satisfactorily and have reached a point where they wish to remain at home at the end of their day's work and they no longer attend the club.

The *Springhead Club* now has 10 members, and the usual attendance is 6 to 8. These are all women and their ages range from 40 to 80 years. Recently the members asked if the activities of the club could be extended to include handicrafts. The Mental Welfare Officer arranged this and the club is now a hive of industry. Tray cloths have been embroidered, and rugs made, and one member particularly who is basically subnormal and had no idea how to hold a needle, has been taught simple sewing, and her pride the day she completed a tray cover was a joy to behold. It has been doubted if it is worth while having a club for so few members but the members themselves are emphatic that the club must continue. Furthermore, for the Mental Welfare Officer to visit the members in their own homes would take her more time than that she spends at the club. Of ten patients discharged from the Elizabeth Martland Unit, Oldham, and recommended for after-care by the Consultant Psychiatrist, 6 started work immediately and the remaining 4 were introduced to the club. Within a few weeks, 3 of these also obtained work so there was little opportunity to get additional members as the club meets in an afternoon.

The *Rothwell Club* opened in August and the average attendance has been 20 members. The officers are well pleased with the premises at Rothwell and with the good co-operation from the other users of the clinic. In addition to the usual club activities, a number of the members are skilful chess and draughts players.

The *Rock Club* has continued to thrive and towards the end of the year arrangements were being made with the Rockingham Institute of Further Education for dressmaking classes to be held for members of the club during the day at the Wath Child Welfare Centre. In July about 50 members of the club visited the factories of the Ross Group at Cleethorpes.

Psychiatric Out-patient Clinics:

The following is a list of the out-patient clinics serving the West Riding patients:—

<i>Leeds Regional Hospital Board Area:</i>	<i>Psychiatrist(s) in charge</i>	<i>Day and Time</i>
Skipton General Hospital	Dr. P. M. J. O'Brien	Wednesday: 2 p.m.
Keighley and District	Dr. C. P. Gore	Wednesday: a.m.
Victoria Hospital		Thursday: 2-30 p.m.
Shipley, Salts Hospital	Dr. G. A. Dransfield	Thursday: 2-0 p.m.
Scalebor Park Hospital	Dr. J. Valentine	Wednesday: 2-0 p.m. Saturday: 9-30 a.m. By appointment only
Otley General Hospital	Dr. C. P. Gore	Tuesday: 3-0 p.m.
Bingley Hospital	Dr. P. M. J. O'Brien	Alternate Tuesday: 9 a.m.

<i>Leeds Regional Hospital Board Area:</i>	<i>Psychiatrist(s) in charge</i>	<i>Day and Time</i>
Farfield House, Farsley	Dr. H. B. Milne	Monthly: Thursday: 2-0 p.m. (follow-up clinic only)
Harrogate and District General Hospital	Dr. D. E. Munro	Tuesday, Friday: 2-0 p.m.
Ripon and District Hospital	Dr. D. E. Munro	Monday: 2-0 p.m.
Easingwold, Claypenny Hospital (Subnormality)	Dr. J. Newcombe	Friday: 2-15 p.m.
York, County Hospital	Dr. P. J. E. Quinn Dr. W. A. L. Bowen Dr. M. W. Galley Dr. D. Robertson Dr. H. de B. Warren	Monday: 2-0 p.m. Monday to Friday 2-0 p.m.
York Bootham Park Hospital	Dr. W. A. L. Bowen Dr. M. W. Galley Dr. D. Robertson	Patients seen at short notice at request of family doctor
Naburn Hospital	Dr. H. de B. Warren	Thursday: 2-0 p.m.
York, Clifton Hospital	Dr. P. J. G. Quinn	Friday: 2-0 p.m.
Leeds St. James's Hospital	Chairman of Commit- tee of Psychiatrists	Daily: 9-30 a.m. and 2-0 p.m.
Leeds St. James's Hospital	Dr. D. P. Oakley Professor M. Hamilton Dr. J. M. White	Monday: 2-0 p.m. Tuesday: 2-30 p.m. Tuesday and Friday: 2-30 p.m.
Leeds, General Infirmary	Professor M. Hamilton	By appointment only
Leeds University Department of Psychiatry (Subnormality Clinic)	Dr. J. Newcombe	Daily
Leeds Meanwood Park Hospital (Subnormality)	Dr. P. Harvey	By appointment only
Selby War Memorial Hospital	Dr. H. de B. Warren Dr. W. A. L. Bowen	Monday: 9-30 a.m.
Goole Bartholomew Hospital	Dr. J. A. Ardis Dr. J. A. R. Bickford	Wednesday: 9-30 a.m.
Castleford, The Nerve Clinic, Beancroft Road	Dr. D. Fenton-Russell	Wednesday: 2-0 p.m.
Oulton Hall Hospital	Dr. A. J. Ralston	By appointment only
Pontefract Infirmary	Dr. D. Fenton-Russell Dr. D. P. Oakley	Tuesday: 2-0 p.m. Wednesday: 2-0 p.m.
Wakefield General Hospital	Dr. J. M. White	Wednesday: 2-0 p.m.
Wakefield, Pinderfields General Hospital	Dr. R. D. H. Maxwell Dr. P. F. Fletcher	Thursday: 9-30 a.m. Thursday: 2-0 p.m.
Hemsworth Southmoor Hospital	Dr. R. D. H. Maxwell	Monday: 2-0 p.m.

<i>Leeds Regional Hospital Board Area:</i>	<i>Psychiatrist(s) in charge</i>	<i>Day and Time</i>
Rothwell St. George's Hospital	Dr. D. P. Oakley	Tuesday: 2-0 p.m.
Dewsbury General Hospital	Dr. N. V. Wilkinson	Thursday, Friday: 2-0 p.m.
	Dr. E. P. Cadogan	Tuesday: 10-0 a.m.
Dewsbury Staincliffe General Hospital	Dr. N. V. Wilkinson	Monday: 2-0 p.m.
Halifax General Hospital	Dr. M. Segal	Tuesday, Friday: 2 p.m.
	Dr. D. H. Ropschitz	Mon., Thurs., 2 p.m.
		Saturday: 10 a.m.
Bradford, Royal Infirmary	Dr. R. W. Carty	Monday: 2-0 p.m.
	Dr. J. Todd	
	Dr. G. A. Dransfield	Wednesday, a.m.
	Dr. R. McDonald	
	Dr. J. R. M. Mackie	Friday, 2-0 p.m.
	Dr. H. B. Milne	
Bradford, St. Luke's Hospital	Dr. H. B. Milne	Tuesday: 2-0 p.m.
	Dr. J. R. M. Mackie	
	Dr. J. Todd	Thursday: 2-0 p.m.
	Dr. R. W. Carty	
Huddersfield, St. Luke's Hospital	Dr. M. Segal	Monday; 10-0 a.m.
	Dr. J. S. Hughes	Mon., Fri.: 2-0 p.m.
	Dr. A. L. G. Smith	Tuesday: 9-30 a.m.
	Dr. E. P. Cadogan	Wednesday: 9-30 a.m.
		Thursday: 2-0 p.m.
Bradford Westwood Hospital, (Subnormality)	Dr. J. Newcombe	Thursday: 2-15 p.m.
	Dr. D. A. Spencer	

<i>Sheffield Regional Hospital Board Area:</i>	<i>Psychiatrist(s) in charge</i>	<i>Day and Time</i>
Sheffield City General Hospital	Dr. M. Jeffrey	Tuesday, Friday: 9-30 a.m.
Sheffield, Royal Infirmary	Dr. F. J. S. Esher	Monday to Friday
	Dr. A. Kelly	
	Dr. F. G. Spear	
	Professor E. Stengel	
	Dr. W. L. Tonge	
	Dr. J. S. Whyte	Monday to Friday
Sheffield, Royal Hospital	Dr. F. J. S. Esher	
	Dr. A. Kelly	
	Dr. F. G. Spear	
	Professor E. Stengel	
	Dr. W. L. Tonge	Monday, Thursday: 2-0 p.m.
	Dr. J. S. Whyte	
Sheffield, Royal Hospital Psychotherapy Clinic	Dr. F. J. S. Esher	

<i>Sheffield Regional Hospital Board Area:</i>	<i>Psychiatrist(s) in charge</i>	<i>Day and Time</i>
Barnsley, Beckett Hospital	Dr. M. Jeffrey	Monday, Wednesday: 2-0 p.m.
Mexborough, Montagu Hospital	Dr. N. L. Gittleson	Monday, Thursday 2-0 p.m.
Doncaster Royal Infirmary	Dr. M. Jeffrey Dr. A. Kelly	Friday: 2-0 p.m. Tuesday: 1-30 p.m.
Rotherham, Moorgate General Hospital	Dr. R. J. Kerry	Wednesday: 2-0 p.m.
Rotherham Hospital, Doncaster Gate	Dr. R. J. Kerry	Monday: 2-0 p.m.
Rotherham, Chest Clinic	Dr. N. L. Gittleson	Tuesday: 9-30 a.m.
Middlewood Hospital	Consultants of the Hospital	Tuesday: 6 p.m. Thursday: 2-0 p.m. Saturday: 10-0 a.m. (Day Hospital)
Doncaster, Western Hospital	Dr. M. Jeffrey	Tuesday: 2-0 p.m. Thursday: 9-30 a.m.

Day Hospital

The Yews, Worrall Road, Sheffield Dr. S. L. Davies

General observations:

Mr. Parkinson, Senior Mental Welfare Officer, reports that in the Storthes Hall area the most important event of the past year was the bringing into use of the new St. Luke's Hospital at Huddersfield. This purpose-built psychiatric unit, together with extensive out-patient clinics (daily) and day hospital facilities have added greatly to the psychiatric resources of this part of the County. Since the hospital opened the patients in the Batley, Spensborough, Brighouse, Todmorden and Colne Valley Health Divisions and (to a lesser degree) the Barnsley Division—have had this hospital as an alternative to Storthes Hall Hospital. Many patients still prefer the latter to St. Luke's and as the up-grading of accommodation at Storthes Hall is still proceeding apace, this situation is likely to continue for some time. The out-patient clinic which had been held for some years in the Child Welfare Centre, Atlas Road, Brighouse, was transferred in April to St. Luke's Hospital.

The Cleckheaton Health Centre has brought mental health right into the general practitioner's orbit—it is no longer a thing apart. In recent years general practitioners have come into much greater personal contact with consultant psychiatrists due to the change in both treatment and attitudes. Where the mental welfare officers regularly accompany psychiatrists on their domiciliary visits, the trio—psychiatrist, general practitioner and mental welfare officer—have every opportunity to work together the most appropriate arrangement for any particular patient. This is a good thing and produces excellent results. Mr. Noden, acting Senior Mental Welfare Officer, notes that officers in the York area are able to take advantage of the co-operation that exists between the hospitals and local authority in that area. This enables them to attend the case conference at Naburn and Bootham Hospital and build up a

good working relationship with the psychiatrists there. One of the difficulties of the scattered rural area is that patients to the West of Wetherby have a great distance to travel to the out-patient clinics at York. The provision of out-patient clinics in York is excellent.

In the Middlewood Mental Health Area Dr. A. Kelly, Consultant Psychiatrist, states that the Mental Welfare Officers are in frequent contact with him in his work and, for example, those in the Doncaster area attend weekly at his Doncaster Royal Infirmary Clinic. This liaison is of mutual benefit. In addition, Dr. Kelly, once a month chairs a meeting with all the mental welfare officers in the areas served by his hospital where in particular, the problems and the more difficult situations in the after-care field are discussed. These meetings are well attended and very much worthwhile. In this area Dr. F. J. S. Esher holds a fortnightly meeting at Rotherham at which the problems of the mentally subnormal in the community are discussed. Dr. J. A. R. Bickford, Physician Superintendent, De La Pole Hospital, states that he is more than satisfied with the assistance provided by the mental welfare officers of the West Riding. He adds that they deal with an area so remote from the hospital with greater efficiency than would be required were it within immediate reach.

The need of the mentally subnormal in the community is far more apparent than that of the mentally ill. Thus the County has nearly completed its building programme of training centres for the mentally subnormal, it has established two hostels and it is possible to forecast the future needs with some accuracy. The impression gained from the hospital psychiatrists is that the immediate problems in the hospitals concern the elderly and the long stay patients.

Dr. J. Valentine, Physician Superintendent, Scalebor Park, writes of the difficulties experienced in finding places for elderly patients, who no longer require psychiatric care and some of whom could manage very well in ordinary Part III accommodation while a few would require a little more supervision. Also it is hard to find jobs in industry for some of the longer stay hospital patients, who have shown in the industrial unit a capacity to work well with some guidance. He feels that sheltered workshops in the community would fill a need. Dr. A. L. G. Smith, Medical Superintendent, Storches Hall Hospital, states that the needs of this community are constantly changing and he is sure we will have to be extremely circumspect in our approach to the problem of the creation of a rehabilitation workshop. Recently Dr. Smith had an opportunity of talking to the Secretary of the Federation of Industrial Therapy Organisations and he was told that already one such organisation in the South has had to drastically alter its concept as the supply of suitable psychiatric patients ceased, and rather than let the unit close down arrangements were made to accept suitable workers from other sources, i.e. Local Authority. From talks with other Medical Superintendents in the South, Dr. Smith says it would appear that this is becoming a factual problem elsewhere, in that it is becoming increasingly difficult to maintain a supply of suitable patients. This, of course, is not unexpected as obviously there will be a certain number of patients who cannot be rehabilitated to the community, and the chronic psychotic does not seem to be appearing due to the altered policy in the intensive treatment of schizophrenics and early return to the community. Despite this Dr. Smith feels sure there is a need for a project of this nature beyond the hospital.

In the past the Mental Health Service has had to deal with many of the elderly who are confused and this has led to accommodation problems at the psychiatric hospitals. The Ministry of Health issued Circular 18/65 in September on the Care of the Elderly in Hospitals and Residential Homes.

The provision of a rehabilitation workshop as mentioned by Dr. Smith has received some consideration. This is an extension of the occupational therapy, and other industries undertaken in the hospital, to workshop conditions outside the hospital. Experience has been gained at the Snaith Day Centre and provision in the estimates has been made for a workshop with 36 places for the mentally disordered.

ALCOHOLISM:

The Leeds Advisory Council on Alcoholism established an Information Centre in late 1964 and discussions have been held with the Centre and Field Officer.

An alcoholic unit has, of course, been established at Scalebor Park Hospital with Dr. P. M. J. O'Brien, Consultant Psychiatrist, in charge. A Mental Welfare Officer with this Authority has been seconded to the unit to deal with the West Riding cases. The community care involved is rather specialised, and Dr. O'Brien plans a decentralization of some of the functions of the alcoholic unit to out-patient services run by suitably experienced mental welfare officers, where these are available.

Statistics:

During the year 5,344 patients were referred to the local health authority, an increase of 100 over the previous year. Details of these, together with the number of patients under care on 31st December, are shown in the tables at the end of the Section.

SUBNORMAL PATIENTS:

The number of patients awaiting entry to hospital at the close of the year was 57, and of these 21 were considered to be in urgent need of hospital care. Fifty of these patients were severely subnormal and 25 were over the age of 16 years. There has been a reduction in the waiting list from 84 to 57 and undoubtedly this is accounted for by the increase in the community services, particularly the provision of special care units. 216 patients were provided with short stay care, 196 of them being admitted to National Health Service hospitals. 36 patients were admitted to hospital for permanent care, 31 as informal patients. The Consultant Psychiatrists at the hospitals have been most helpful, and they are ever willing to see patients at home and at the out-patient clinics. The case conferences at the hospitals have been attended by the Mental Welfare Officers concerned with the cases under discussion, and the Officers are encouraged to maintain contact with patients admitted to hospital. Ministry of Health Circular No. 24/65 on improving the effectiveness of the Hospital Service for the Mentally Subnormal stresses the importance of close links between the hospital, local authority, family doctor and voluntary services, to provide a comprehensive service covering all the needs of the subnormal and severely subnormal. Since the Healey Croft Hostel was opened it is apparent that there are many patients in hospital who could really live in the community if the facilities were available. Those who have been in hospital for a considerable time may require special attention, but Dr. Ireland in his report on the Healey Croft Hostel states that seven adult patients admitted there from hospitals have presented no real problems.

At the end of the year the total number under guardianship was 8; 7 being under the guardianship of the local health authority and one under the guardianship of a relative.

The number of subnormal patients receiving home visits and not attending Training Centres was 1,716. These were either in full or part-time employment or were considered to be suitably and adequately employed at home.

At 1st March, 1966, there were 106 children attending the Training Centres on an informal basis. On that date 37 of the children were under the age of 5 years. The Chief Education Officer is informed in all cases where children are admitted to Training Centres as informal patients. At 31st December, 1965, 13 children, whose disability was not finally assessed, were attending Training Centres on a trial basis.

MENTALLY ILL PATIENTS:

Mental Welfare Officers were concerned in the admission of 2,447 patients to psychiatric hospitals; 1,544 of these were informal admissions, 7 were by Court Order, 264 were Section 25 cases, 61 were Section 26 cases, and 571 were Section 29 cases. There has been a slight rise in the number of admissions to hospitals and a slight decrease in the number of compulsory admissions to hospitals as compared with the previous year.

There were 2,951 referrals for after-care during the year.

National Health Service Act, 1946, Section 28:

The County Council's Scheme under this Section has been amended in the Section dealing with residential accommodation, and the following paragraph added:—

“ The Authority shall make arrangements in appropriate cases for the boarding-out of patients in private households or in homes provided by Voluntary Organisations.”

Number of patients referred to Local Health Authority
during year ended 31st December, 1965.

Referred by	Mentally III						Psychopathic						Subnormal						Severely Subnormal						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			
	M.		F.	M.		F.	M.		F.	M.		F.	M.		F.	M.		F.	M.		F.	M.		F.	
General practitioners	5	6	521	1035	—	—	—	—	—	—	—	—	2	—	—	6	3	1	2	—	—	—	—	1	1582
Hospitals, on discharge from in-patient treatment	—	2	500	890	—	—	—	—	—	—	—	—	3	—	—	17	7	1	—	—	—	2	—	—	1424
Hospitals, after or during out-patient or day treatment	2	3	243	520	—	—	—	—	—	—	—	—	3	—	—	1	7	4	—	—	—	—	—	—	885
Local education authorities	—	1	—	—	—	—	—	—	—	—	—	—	44	—	—	28	31	36	37	19	—	—	—	—	196
Police and courts	—	2	87	84	—	—	—	—	—	—	—	—	1	1	1	1	4	1	—	1	—	1	—	—	184
Other sources	1	5	360	605	—	—	—	—	—	—	—	—	2	—	—	3	19	15	33	23	—	4	—	—	1073
Total	8	19	1811	3134	—	—	—	—	—	—	—	—	55	33	—	84	66	72	45	—	8	2	—	—	5344

Number of Patients under L.H.A. care at 31.12.65	Mentally Ill						Psychopathic						Subnormal						Severely Subnormal						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			
	M.		F.	M.		F.	M.		F.	M.		F.	M.		F.	M.		F.	M.		F.	M.		F.	
	5	6	1181	1848	—	—	—	—	—	9	12	—	—	—	—	—	—	—	—	—	—	—	—	—	
Total number	5	6	1181	1848	—	—	—	—	—	9	12	—	—	—	—	—	—	—	—	—	—	—	—	—	6418
Attending day training centre	—	—	26	9	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1411
Awaiting entry thereto	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	34
Resident in a residential training centre... ..	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Awaiting residence therein	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Receiving home training	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	4
Awaiting home training	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	3
Resident in L.A. home/hostel	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	31
Awaiting residence in L.A. home/hostel... ..	—	—	5	5	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	24
Resident at L.A. expense in other residential homes/hostels	—	—	12	13	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	33
Resident at L.A. expense by boarding out in private household	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	6
Receiving home visits and not included above:	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Suitable to attend training centre	—	—	12	28	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	226
Others	5	6	1126	1793	—	—	—	—	—	9	12	—	—	—	—	—	—	—	—	—	—	—	—	—	4667

PART V

ENVIRONMENTAL HYGIENE

Food and Drugs

Sanitary Circumstances

Atmospheric Pollution

ENVIRONMENTAL HYGIENE

The Public Health Inspectors Section has enjoyed a full and interesting year with a number of new duties and investigations undertaken.

The implementation of the Riding Establishments Act, 1964, has commenced and whilst our duties are only of a minor nature the work has been satisfying.

Discussions have taken place with the County Highways and Bridges Department and the County Planning Department on the provision of sanitary accommodation on trunk roads. The absence of sanitary facilities has been the cause of a good deal of publicity recently. The matter has been raised in Parliament on a number of occasions and various organisations stress this urgent need from time to time. There is no doubt that a public health problem exists due to the indiscriminate fouling of our countryside and action must be taken. Further mention of this subject is made later in the report.

A survey has been carried out on the damage to canned foods in transit between producer and consumer and shows that insufficient care is taken in handling this class of food. A full report is given later in the food and drugs section.

The co-operation of County District Officers and members of the various Departments of the County Council has been enjoyed again and thanks go to them for their help and kindness.

Food and Drugs Act, 1955:

THE MILK (SPECIAL DESIGNATION) REGULATIONS, 1963:

THE MILK (SPECIAL DESIGNATION) (AMENDMENT) REGULATIONS, 1965:

Licensed Dealers:

Licensing has now been with the Authority since 1961 and the renewal of licences for a further five year period has taken place. Progress towards better standards of storage and distribution was slow in the first three years due to lack of staff but a good amount of leeway has been made up since. One of the most surprising things about licensing is the frequency with which businesses change hands and far more time is taken up dealing with these administratively than was ever anticipated.

Mention was made last year of the setting up of depôts by the larger dairy companies so that dealers might operate from more satisfactory premises. Two such depôts have been opened during the year and others are at the planning or construction stage.

Methylene blue test failures of untreated milk continue to be higher than one would wish but repeat samples are usually satisfactory. It became necessary, however, to prosecute a producer-retailer selling from a vending machine licenced by this Authority, for persistently failing this statutory test. The defendant pleaded guilty and a fine of £5 plus costs was imposed.

From 1st October, 1965, a new special designation "Ultra Heat Treated" has been prescribed for milk which has been processed by the ultra high temperature method, i.e. heated to not less than 270°F. for not less than one second. No detailed provision for the filling arrangements are included in the 1965 Regulations but unless aseptic precautions are taken the milk will lose its long

keeping attribute and post treatment contamination will result in it failing to satisfy the colony count test. At the present time no processing by this method is in operation or planned within the Administrative County area.

The following table gives details of dealers licences at the end of the year (excluding licenced pasteurisers and sterilisers and bottling premises, details of which are given later):—

Number of Licence Holders	Dealing in pre-packed milk		
	Untreated	Pasteurised	Sterilised
3,032	449	1,125	2,500

Details of samples obtained by the department from dealers in the County area, with results of statutory tests, are given below.

Untreated			Pasteurised					Sterilised	
Methylene Blue Test			Phosphatase Test		Methylene Blue Test			Turbidity Test	
Satis- factory	Unsatis- factory	Void	Satis- factory	Unsatis- factory	Satis- factory	Unsatis- factory	Void	Satis- factory	Unsatis- factory
1,491	142	37	2,113	2	2,010	21	84	78	—

Processing Plants:

Given below are details of licenced establishments for the pasteurising and sterilising of milk.

Pasteurised Milk:

Chappell, R. M., Nether End Farm, Denby Dale.
 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.
 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.
 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 plant ceased operations:—

Airedale Co-operative Society Ltd., The Dairy, Thomas Place, Shipley.

Routine supervision has been maintained of all processing plants and in the main only minor matters have had to be drawn to the attention of management. Recording charts are not always kept as carefully as they should be and young employees show a reluctance to wear overalls and head coverings.

At one large plant both new and additional pasteurising equipment was installed. At another dairy, concern mounted over the deterioration in standards generally and a meeting was held with the Secretary and the Manager of the Company. The Department's attitude was put strongly and since that time the premises and equipment have been redecorated, there is adequate supervision of properly dressed staff and a new dairy manager is in control.

Details of samples obtained from the processing plants are given below:—

Pasteurised					Sterilised	
Phosphatase Test		Methylene Blue Test			Turbidity Test	
Satisfactory	Unsatisfactory	Satisfactory	Unsatisfactory	Void	Satisfactory	Unsatisfactory
562	—	536	—	26	36	—

Premises Bottling Untreated Milk:

Supervision and sampling at those premises where untreated milk is bottled under a licence issued by the County Council has continued. Whilst the 14 premises licenced bottle only a comparatively small amount of milk they are visited regularly and 186 samples were obtained. Of these seven failed the methylene blue test and two samples were void. Follow-up samples of each failure were taken and these proved satisfactory. Advice was given where appropriate.

SUPPLY OF MILK TO SCHOOLS:

Sampling has again been concentrated on untreated milk as it is found that pasteurised supplies can be checked by obtaining retail samples from the same processing plant. Fifty-five samples were obtained and five failed the methylene blue test. Repeat samples proved satisfactory.

All untreated milk samples were examined for tuberculosis, brucella abortus and antibiotics. All were satisfactory except three samples which were positive for brucella abortus. In each case immediate action was taken to stop the supply and alternative arrangements made.

SAMPLING OF MILK AT HOSPITAL FARMS:

The obtaining of samples from the pasteurising plant at Stanley Royd Hospital Farm, Wakefield, continued until November. During that time out of 44 samples, six failed the phosphatase test and two the methylene blue test. In November the farm reverted to the production of untreated milk only for sale by wholesale and the two samples obtained during the short period to the year end passed the methylene blue test.

At the request of the Ministry of Health sampling of pasteurised milk at Stansfield View Hospital Farm, Todmorden, recommenced in November. Five samples were obtained before the year end; all five passed the methylene blue test but only three passed the phosphatase test.

ANTIBIOTICS IN MILK:

Sampling for the detection of antibiotics in milk has continued and 1,425 examinations were carried out by the Wakefield Public Health Laboratory. Two per cent. were found to contain antibiotics and whilst it would be preferable to find none at all this figure is considered reasonable.

Follow-up action has been taken again in co-operation with the Milk Marketing Board. No repeat sample has as yet been found positive and accordingly no formal sampling has been undertaken.

The examination carried out has continued to be the modified TTC provisional method for the detection of antibiotic and other inhibitory substances in milk.

BRUCELLOSIS:

Once again keen interest has been shown in the detection of brucellosis and a total of 1,670 samples were submitted to the Wakefield Public Health Laboratory for examination. All samples were examined by ring test and cream culture and a limited number by guinea pig inoculation.

Positive evidence was found in 121 herds by cream culture and a further seven by biological examination.

Laboratory results were immediately notified to Divisional Medical Officers in order to enable them to take action within the provisions of the Milk and Dairies (General) Regulations, 1959, in their capacity as Medical Officers of Health. Follow-up action is then normally carried out by the Public Health Inspectors of the County Districts and there is no doubt that this work adds considerably to their burden.

With the co-operation of County District Officers we have endeavoured to avoid duplication of sampling for brucellosis. Also, the information given by the Directors of the Public Health Laboratories in and around the County of samples submitted to them by other authorities has been very helpful and we are indeed grateful to them.

Last but certainly not least thanks are due to Dr. L. A. Little, Director of the Wakefield Public Health Laboratory, and his staff who once again dealt with all our samples, all our queries and shared some of our worries.

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, 3,064 samples were submitted by your Inspectors under the Food and Drugs Act, 1955, as set out below:—

	<i>Total Samples</i>	<i>Adulterated or Below Standard</i>	<i>Percentage Adulterated or Below Standard</i>
Milk	1,333	50	3.7
Milk 'Appeal to Cow' ...	31	1	3.2
Milk, Channel Islands ...	220	7	3.2
Food and Drugs	1,480	56	3.8
All samples	3,064	114	3.7

Notes on adulterated or otherwise irregular samples

The percentages of adulterated and irregular samples are similar to those of recent years.

Milk. 1,333 samples of ordinary, homogenised, sterilised and hot milk were analysed; 50 were unsatisfactory: 29 were deficient in fat, the worst being 22.0 per cent. deficient. The rest of the adulterations were due to added water, the largest addition amounting to 30.5 per cent.

Channel Islands Milk must contain not less than 4.0 per cent. of fat; 7 samples out of some 200 were below standard, the worst containing only 3.6 per cent.

'*Appeal to Cow*' samples of milk are taken under supervision. 31 'Appeal to Cow' samples were taken; in one sample we found approximately 2 per cent. of added water. A repeat sample taken under extra supervision was normal in composition.

Cheese Spread. One sample was mouldy and unfit for human consumption.

Flour. 6 samples were analysed; only 1 was irregular, being deficient in creta præparata (prepared chalk).

Milk Chocolate Biscuit. A chocolate biscuit was deemed unsatisfactory because of the heavy 'gold' printing on its fancy wrapper. The bronze powder, containing copper and zinc, was very easily detached and was transferred from the fingers to the chocolate covering of the biscuit. The manufacturers quickly rectified this defect.

Meat Products (other than sausages). Out of the many samples analysed, 7 were unsatisfactory:—

2 of potted beef because they contained less than 70 per cent. of meat and also were made with starchy filler.

2 of potted meat because they were deficient in meat and one also contained preservative.

2 tins of casserole steak and one steak and kidney pie were deficient in meat.

Orange Drink. 1 sample contained an excess of saccharin.

Sausages. For many years Public Analysts have striven to uphold standards for the meat content of sausages: 50 per cent. for beef sausages and 65 per cent. for pork sausages. It now appears that these standards will be enforced by Regulations in the near future.

We have analysed 68 samples of beef sausage: all were satisfactory as regards meat content, the results ranging from 50 per cent. to 85.2 per cent., average 63.5 per cent.

63 samples of pork sausage contained between 57.0 and 83.1 per cent. of meat, average 68.4 per cent. 7 of these samples contained less than 65 per cent. of meat and were reported as unsatisfactory. The Preservatives in Food Regulations, 1962, permit sausages and sausage meat to contain sulphur dioxide up to a limit of 450 parts per million provided that its presence is suitably declared at the time of sale. 6 samples of sausage and 3 of sausage meat contravened the Regulations in that they were preserved but the fact was not notified in the correct manner.

Spirits. Some 115 samples of spirits were analysed. We found 3 whiskies, 1 rum and 3 gins had been adulterated with water, the amounts ranging from 0.9 per cent. to 21.1 per cent.

Foreign Bodies. 12 samples were submitted for identification of foreign bodies or extraneous matter following complaints by members of the public.

1 tin of bilberries contained a beetle.

There was another beetle in a tin of tomato puree.

A cockroach was found in a tin of green beans.

An earwig was embedded in the pastry of an apple turnover.

In a tin of blackberries there was a piece of paper, and a length of twine in a loaf of bread.

There was a piece of glass in a packet of butter, and some wool yarn in a biscuit.

A brass screw was found in a date and walnut cake. The screw was identical with those used in a new electrical installation in the bakery, and must have fallen into the mixture or ingredients.

Inside a sausage, the consumer was astonished to find a piece of mutton cloth. Another consumer was horrified to find a piece of an earth worm between the sausages in a half pound pack: it should in all fairness be emphasized that the worm was not inside the sausage but we were unable to find an explanation for its unwelcome presence.

Labelling. Hundreds of labels on pre-packed foods and drugs have been scrutinised: only eight were found to be irregular.

For instance, the labels on a bottle of mint sauce and on a jar of pickled beetroot both gave the list of ingredients in the wrong order of magnitude.

The label on a bottle of soft drink failed to declare the presence of saccharin.

There were out of date references to the B.P.C. on the labels of Indian Tincture and Borax and Honey, because both these preparations have been deleted from the current British Pharmaceutical Codex.

The fact that we are finding fewer irregularities on labels shows that manufacturers and packers are taking more pains to ensure that their products comply with the Labelling of Food Order."

The County Council's scheme of qualitative milk sampling 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 138 of which two were found to be below standard. One was adulterated by extraneous water and no action was taken: the other was 21.3 per cent. deficient in fat and a successful prosecution was taken, the vendor being fined £5.

EXTRANEOUS MATTER IN FOOD:

Thirty-four complaints were received and investigated during the year. A summary is given below of details of each case and the result where legal proceedings were taken. In other cases verbal or written cautions were given.

Glass in a bottle of milk—9 cases. One prosecution—fined £20.

Dirt in a bottle of milk—9 cases.

Chicken wire in a bottle of milk.

Pen nib holder in a bottle of milk.

Hair in a bottle of milk.

Milk bottle tops in a bottle of milk—5 cases.

Dirty milk bottles—2 cases. One prosecution—fined £20 and costs.

Mouldy sausages.

Brown discoloration in a loaf of bread.

Piece of metal in a steak and kidney pie.

Mouldy meat and potato pie.

Insect in loaf of bread.

Foreign body in a rum ball.

The last case was most interesting and eventually involved the Department of Zoology, Leeds University in identifying the foreign body. A lady treated herself to some rum balls from a local bakery but on biting into one quickly spat it out again complaining of a foul taste. An irregular shaped object about $1\frac{1}{4}$ inches by $\frac{1}{2}$ inch was found. It had a mottled dark grey skin or cortex and was white inside. It appeared to be part of a fish or snail, so to be sure the help of Professor Dodd of Leeds University was sought. After due deliberation it was decided that the object was part of the adipose fin of a salmon or trout. To confirm his opinion he even obtained an adipose fin from a local fish merchant for comparison.

This information still left us with the mystery of how the fin got into the rum ball. Although further extensive enquiries were made both with the baker and the purchaser no solution was found.

CANNED FOOD SURVEY:

Following a complaint that damaged canned goods were being supplied by the County Supplies Department to a school it was decided to carry out a small survey into the incidence of damage to goods arriving at the Supplies Department Food Depôt.

Before describing the survey, however, two points must be made, one is that there is no question whatsoever that goods of inferior quality or ones known to be damaged are bought by the County Council. Secondly, many of the cases of canned goods are despatched to schools without opening at the Food Depôt and the cases themselves show no signs of damage. It is only on opening the cases that the damaged cans are seen.

The survey was carried out over a three month period to allow for a turnover of stock and comprised the examination of quantities of meat, fruit and vegetables. The survey was restricted to the catering size A.10 which contains 6—7 lb of goods. This size had been found to be the main source of trouble, very little damage having been found amongst the smaller, family size, can.

Damage in the main was confined to imported cans, home products being usually satisfactory. This may well be due to additional handling at docks, etc. as little difference was noted generally in respect of packaging or the strength of the metal sheet used in the can. Cardboard cases are universally used these days and the wooden case is becoming a rarity.

The physical examination of the cans was carried out by the same person all the time to give a consistent classification into the following grades—no damage; slight damage—slight denting at up to two points; moderate damage—damage at one or more points sufficiently severe to cause some distortion of the can; severe damage—grossly misshapen and/or leaking. The number examined and placed into the appropriate grade is given below:—

No. of cans examined	No damage	Slight damage	Moderate damage	Severe damage
1,087	400	340	183	164
100%	37%	31%	17%	15%

Enquiries have been made in the trade and it is clear that this pattern is general in the large packs.

Water Supplies:

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 twenty six samples were examined and in each case the result of the examination was notified to the Medical Officer of Health and 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 0.1 parts per million is dangerous and that the plumbo-solvency of such a water should be neutralised.

Five samples contained lead in excess of 0.1 parts per million. Appropriate action was taken with the authority concerned and repeat samples obtained proved satisfactory.

PRIVATE SUPPLIES OF WATER TO COUNTY PREMISES:

Supervision of private supplies has again been undertaken. Details of the samples obtained are appended:—

Premises	Source of Supply	Bacteriological Examination		
		Number of samples obtained	Sat.	Unsat.
Aldfield C.E. School, Aldfield, near Ripon	Untreated trunk main	7	5	2
Clint Burnt Yates Endowed School, Burnt Yates, near Harrogate	Bore	8	8	—
Elsack Primary School, Broughton, near Skipton	Well	6	6	—
Grantley Hall Adult College, near Ripon	Land springs	20	20	—
Ingleborough Hall Special School, Clapham, Settle	Lake water	5	4	1
Upper Wharfedale Secondary School, Grassington	Land spring	11	10	1

Full water treatment plant is installed at Grantley Hall, Ingleborough Hall and Upper Wharfedale Secondary School. With the exception of a filter candle at Aldfield C.E. School the other water supplies have no treatment.

The unsatisfactory samples from Aldfield were due to water by-passing the filter and this was quickly remedied.

A decorator accidentally switched off the power to the treatment plant at Upper Wharfedale and caused the unsatisfactory sample.

The unsatisfactory sample from Ingleborough was due to a breakdown in the chlorinating equipment. Samples from Ingleborough were again obtained by the Chief Public Health Inspector, Settle Rural District Council, to whom thanks are due for his co-operation.

Concern arose in December over a Training College where both mains water and a private supply were in use. The private supply was used in the heating system and for hot and cold water supplies for washing purposes.

A breakdown in the water treatment plant gave rise to a badly discoloured supply which, on sampling proved very unsatisfactory bacteriologically.

Immediate steps were taken to issue instructions to staff and students regarding the use of the water. Fortunately the College was closing down for Christmas holidays and allowed for remedial work during this period.

As a result of consultations with the Water Board concerned, however, it was found possible to obtain all necessary water from them. In future the private supply will only be used in an emergency and after full treatment in the now repaired plant.

During the holiday period the distribution system was descaled and shock dosed with chlorine to clear any residual pockets of bacterial pollution.

Before the students returned checks were made at points throughout the College and in each case the supply was satisfactory.

WATER SUPPLY—PUBLIC HEALTH ACT 1936:

One application by a number of local government electors for the provision of a piped water supply under the provisions of Section 111(2) of the Public Health Act, 1936, as amended by Section 28 of the Water Act, 1945, was dealt with.

The County Council's observations, after close investigation of the matter and the examination and sampling of existing water supply, were forwarded to the Ministry of Housing and Local Government.

FLUORIDATION OF WATER SUPPLIES:

The Ministry of Health has requested that a report be made on the action taken by the Council in respect of Circulars 28/62, 12/63 and 15/65 with a view to the fluoridation of water supplies.

Fluoridation of water supplies is being increasingly practised in many parts of the world. It was first introduced in North America in 1945 and by 1964 some 50,000,000 people in the United States and Canada were drinking fluoridated water. An Act of the Irish Parliament has enabled the general introduction of fluoridation to be started in that country and Australia and New Zealand are among the many other countries in which some water supplies are fluoridated.

In this country fluoridation was introduced in certain areas in 1955/56 on a pilot scale and in 1962 the Minister of Health, indicated in Circular 28/62 that he was ready to approve, under Section 28 of the National Health Service Act, proposals from local health authorities to make arrangements with water undertakers for the addition of fluoride to water supplies which are deficient in it naturally.

The Health Committee took the initiative and considered the circular, also a report setting out the scientific investigations carried out both in America and the United Kingdom into the effect fluoridation of water supplies had on dental caries. At this early stage they agreed that approval in principle be given to the making of arrangements as outlined in the circular and authorised the necessary approach being made to 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. Following upon this the Clerk of the County Council circulated all the water undertakers and County District Councils concerned and with few exceptions they supported the proposal.

The Minister of Housing and Local Government also circulated water undertakers (Circular 37/63, 27th May, 1963) requesting them to arrange for fluoridation if the local health authorities concerned desire such action. This clarified the position and in June the Minister of Health issued Circular 12/63 in which he gave general approval for the addition of fluoride to public water supplies, without further reference to him, and he expressed the hope that all local health authorities would make the necessary arrangements to secure as soon as possible the improvement in dental health which fluoridation will bring about. The Authority endorsed their previous decision and in July, 1963, the scheme under Section 28 of the National Health Service Act was amended by the addition of the following:—

“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 1 part per million, expressed as F, plus or minus 10 per cent.”

The response by the water undertakers at this juncture was unenthusiastic due, in the main part, to a pending action against the Watford Borough Council challenging their powers as water authority to fluoridate the water supply. There followed a period of “wait and see” which lasted over a year during which time although a wealth of information and technical data was issued little progress was made. In July, 1964, however, with the failure of an appeal to the Supreme Court of Ireland to declare that the Health (Fluoridation of Water Supplies) Act of 1960 was unconstitutional and the Judicial Committee of the Privy Council upholding the decision of the New Zealand authorities to fluoridate their water supplies the position appeared more promising and when the discontinuance of the pending Watford action was announced in February, 1965, it was hoped that some positive progress would be achieved in this country.

Successive Ministers of Health had reaffirmed their confidence in the value and safety of fluoridation and on 3rd August, 1965, the Minister of Health issued Circular 15/65 which authorised local health authorities to proceed with schemes for the fluoridation of water supplies by arrangement with water undertakers and contained a full indemnity in respect of any costs or damages incurred in consequence of proceedings taken against the local authority in respect of such action. The Health Committee considered the circular and authorised the Clerk of the County Council to proceed with negotiations with the Statutory Water Undertakers serving the Administrative County to implement fluoridation subject to reimbursement of the cost thereof by the County Council. The Clerk of the County Council circulated the Committee's decision to the water undertakers and strenuous efforts were made to achieve agreement with a number of undertakers. At the year-end consideration was being given to a draft agreement with one water board but no scheme had reached fruition. Negotiations are still proceeding (April, 1966) and it is hoped that the introduction of fluoride to the water supplies to the optimum level will be effected in certain parts of the Area in the not too distant future.

Throughout the protracted discussions and negotiations the Divisional Medical Officers have given valued support: their efforts to put the matter in perspective with their District Councils also are greatly appreciated. After three years' experience to achieve this safe, effective measure for the prevention of dental decay one is left with the feeling that rarely has any health measure been the subject of so much study, research—and frustration.

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
			£
Bowland R.D.	Gisburn Sewage Disposal	11th June	29,400
Calderdale Water Board	Ivy Houses, Mill Bank Water Supply	18th March	722
do	Hargreaves Terrace, Norland Water Supply	18th March	1,100
do	Upper Greetland Water Supply	18th March	18,429
Claro Water Board	Sawley Water Supply	16th July	600
do	Bishop Thornton Water Supply	16th July	2,450
do	Felliscliffe (Tang) Water Supply	16th July	730
do	East Keswick Water Supply	28th October	1,890
Craven Water Board	Lawkland Water Supply (Part 2)	20th January	570
do	Langcliffe Place, Settle, Water Supply	9th March	4,200
do	East Marton Water Supply	8th November	2,744
Doncaster R.D.	Selby Road, Norton, Sewerage	26th July	8,660
Leeds C.B.	Bolton Plantation Reservoir to Clifton Reservoir Water Supply	22nd April	13,998
do	Timble Water Supply	22nd April	8,858
Osgoldcross R.D.	Burton Salmon Sewerage	17th March	55,000
Penistone U.D.	Penistone Sewerage and Sewage Disposal	8th March	293,500
Saddleworth U.D.	Grove Farm, House and Cottages, Diggle Water Supply	6th May	700
do	Lawton Fold, Grotton Water Supply	10th May	750
do	Pastures Lane, Scouthead Water Supply	12th January	1,050
Selby R.D.	Hambleton Sewerage and Sewage Disposal	24th September	100,320
Tickhill U.D.	Extension of Tickhill Sewage Works	12th August	33,000
Wharfedale R.D.	Pool and Arthington Sewerage and Sewage Disposal Part Scheme	16th March	3,601
	do Part Scheme	8th July	42,833
	do Part Scheme	2nd November	76,650

All schemes were examined and comments forwarded to the County Planning Officer for onward transmission, with his observations, to the County Council's Consulting Engineer.

In addition, Ministry Inquiries and Investigations of schemes were attended where held.

School Swimming Pools:

Supervision and sampling of these pools has continued with particular emphasis on visits during the summer months for checking hygiene standards.

One hundred and thirty one samples were obtained and submitted to the Public Health Laboratory. Immediate follow-up action was taken when adverse reports were received and advice and guidance given. On the whole a good standard has been maintained.

The amount of time spent giving advice generally and examining new projects has been considerable. At the height of the swimming season a member of the staff, who has made a special study of the subject, is engaged on average two to three days each week.

Listed over are the present and proposed pools with details of plant and equipment.

School	Pool		Filtration	Chlorination	Remarks
	Capacity in gallons	Type			
Aireborough Grammar	30,000	Conventional	Sand	Chlorine Gas	—
Armthorpe Junior	12,400	Conventional	Diatomaceous Earth	Not yet selected	Pool in planning stage
Bardsey Primary	870	Sunken	None	Added by hand	Chlorination and filtration equipment approved 8-12-64
Bewerley Park Centre for outdoor pursuits	12,000	Purley	Diatomaceous Earth	Automatic Chlorinator	Pool in planning stage
Bingley Grammar	46,400	Conventional	Diatomaceous Earth	Semi-automatic Hypo-Chlorinator	Pool in planning stage
Boroughbridge County Primary	6,000	Purley	Diatomaceous Earth	Drip Feed	Diatomaceous Earth filter installed 1965
Bridge House Special School, Harewood	4,000	Purley	Diatomaceous Earth	Automatic Chlorinator	Pool opened 1965
Darton Barugh J.M.I.	6,000	Purley	Canvas Bags	Drip Feed	Diatomaceous filter approved 10-8-64
Darton Kexbrough	6,000	Purley	Diatomaceous Earth	Automatic Chlorinator	Pool in planning stage
Ermysted's Grammar Skipton	29,000	Conventional	Sand	Chlorine Gas	—
Featherstone R.C.	46,000	Conventional	Sand	Chlorine Gas	—
Granby Park Harrogate	52,000	Conventional	Sand	Chlorine Gas	New School
Harrogate Woodlands	20,000	Conventional	Diatomaceous Earth	Automatic Chlorinator	Pool in planning stage
Hartwith Summerbridge	6,000	Purley	Diatomaceous Earth	Automatic Chlorinator	Diatomaceous Earth filter and automatic chlorinator provided 1965
Hebden Royd Centre, Pitt Street, Hebden Bridge	6,000	Purley	Diatomaceous Earth	Automatic Chlorinator	Pool in planning stage
Horbury C.E.	6,000	Purley	Diatomaceous Earth	Automatic Chlorinator	Pool opened 1965

School	Pool		Filtration	Chlorination	Remarks
	Capacity in gallons	Type			
Horbury Bridge C.E.	8,000	Mermaid	Diatoma- ceous Earth	Automatic Chlorinator	Pool in planning stage
Hoyland Common J.M.I., Hoyland	6,000	Purley	Canvas Bags	Drip Feed	—
Ilkley Grammar	35,000	Conventional	Sand	Chlorine Gas	—
Ilkley Menston Primary	25,000	Constructed Outdoor	Sand	Drip Feed	—
Kirk Fenton Parochial	8,000	Purley	Sand	Automatic Chlorinator	Pool in planning stage
Mexborough Grammar	18,000	Purley	Diatoma- ceous Earth	Drip Feed	Pool opened 1965
Penistone St. John's C. E.	8,000	Purley	Canvas Bags	Drip Feed	Pool not used
Rawcliffe Training Centre	8,000	Purley	Sand	Automatic Chlorinator	Pool in planning stage
Ripon Grammar	52,000	Conventional	Sand	Chlorine Gas	—
Rothwell Carlton J.M.I.	8,000	Purley	Sand	Drip Feed	Pool opened 1965
Scholes J.M.I.	8,000	Purley	Diatoma- ceous Earth	Automatic Chlorinator	Pool in planning stage
Shade Primary, Todmorden	30,000	Conventional	Sand	Chlorine Gas	—
Sherburn in Elmet	8,000	Purley	Diatoma- ceous Earth	Drip Feed	—
Ulleskelf C.E.	6,000	Purley	Canvas Bags	Drip Feed	—
Upper Poppleton C.P., York	2 pools proposed 2,000 14,000	Purley	Diatoma- ceous Earth	Automatic Chlorinator	Scheme in planning stage
Upper Wharfedale Secondary	43,000	Conventional	Diatoma- ceous Earth	Automatic Chlorinator	Pool in planning stage
North Elmsall J.M.I., Upton	21,000	Purley	Diatoma- ceous Earth	Automatic Chlorinator	—

School	Pool		Filtration	Chlorination	Remarks
	Capacity in gallons	Type			
Ward Green J.M.I., Worsbrough	12,000	Purley	Diatoma-ceous Earth	Automatic Chlorinator	—
Weston Lane C.P., Otley	7,000	Constructed Outdoor	Sand	Added by hand	Chlorinator to be provided
Whinburn Special School, Keighley	5,000	Plastic Construction	Canvas Bags	Drip Feed	Pool re-opened 1965

West Riding County Council (General Powers) Act, 1964:

PROVISION OF PUBLIC CONVENIENCES:

The provision of sanitary conveniences for motorists on trunk roads was discussed at a Divisional Medical Officers Conference early in the year and subsequently discussions have been held with members of the staff of the County Engineer and Surveyor.

A report was submitted by the County Surveyor to the Highways Committee in September suggesting that a pilot scheme covering representative highways in the County should be initiated. Authority was given for the investigation and preparation of a scheme for toilets on the lines suggested with estimates of cost.

Three routes were chosen, a major trunk road, a rural holiday traffic route and an industrial route. At the present time no convenience is in being but progress is being made.

Ideas at the present time are that permanent structures should be built, as vandal proof as possible, and the conveniences on the water carriage system. Cesspool or septic tank drainage may well have to be provided in remote spots. Washing facilities would be provided. Conveniences would be sited at approximately ten mile intervals.

Without doubt the conveniences provided must be of first class design and construction and clean at all times. The latter item is the most important of all if the conveniences are to be accepted by the public and the fouling of lay-bys and the countryside to cease. It would be a terrible tragedy if after spending thousands of pounds it was found that travellers continued to use the hedge bottom because of a dirty convenience.

Pharmacy and Poisons Act, 1933:

Three hundred and fifty six visits of inspection were made to premises listed for the sale of Part II poisons. Only minor contraventions were found and verbal warnings were given where necessary. A number of visits to open air markets was made and it became necessary to stop the sale of poisons from stalls in two of them.

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.

Over the past few years the number of properties under supervision has dwindled and next year the final inspections will be made.

The Riding Establishments Act, 1964:

Following discussions with officers of the Clerk's Department, duties commenced in April. This Department has only a minor role to play as principally inspections for licencing purposes are carried out by the veterinary profession. However, it is considered that general public health aspects of each case should be considered and an annual inspection of premises will be made. Forty six premises are now licenced and by the year-end the majority had been visited. Only minor contraventions were noted and reports were submitted to the Clerk of the County Council for his action.

Atmospheric Pollution:

The Authority's scheme for the measurement of atmospheric pollution operated in conjunction with the Warren Spring Laboratory of the Ministry of Technology and officers of the County Districts, has continued efficiently.

Further implementation of the scheme proceeded and at the year-end 37 District Councils were participating involving 46 combined daily smoke filter and sulphur dioxide instruments, and five 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		
Barnoldswick—Health Department, Fernlea, surrounding district residential and commercial with railway nearby	101 for 9 months	789	12	111 for 9 months	427	20
Keighley—First floor of Public Health Department in built-up area in centre of town	137 for 10 months	872	10	115	985	16
Keighley—Branshaw View, 20ft. above ground in classroom on south-west side of building, $\frac{1}{4}$ mile south-west of town centre. Surrounding district residential	92	552	4	75 for 9 months	480	13

*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
	Microgrammes per cubic metre			Microgrammes per cubic metre		
Bingley—Health Department, Town Hall, Bingley, 1/5th mile outside town centre, surrounding district parkland	75	402	7	148	639	32
Shipley—Health Department, Town Hall, surrounding district residential and commercial	96 for 9 months	622	12	147 for 8 months	704	25
Horsforth—Broadway, in residential area, most properties to the south in Smoke Control Areas	164 for 1 month	363	32	193 for 1 month	446	46
Otley—First floor of Council Offices, in town centre, mainly manufacturing	99	440	4			
Pudsey 2 (Stanningley)—“Southville”, Sunfield House, 20 ft. above ground on east side, surrounding district mainly industrial	100	677	9	138	619	Alk.
Pudsey 3 (Farsley)—Farfield House, Farfield Avenue, 20ft. above ground on north side, surrounding district residential	126	721	11	161	676	40
Pudsey 4 (Calverley)—M. & C. W. Clinic, Chapel Street, 20ft. above ground on west side, surrounding district parkland and residential	113	640	20	152	734	Alk.
Harrogate—Ground floor of Municipal Offices, surrounding district residential and commercial	68	347	6	96	337	20
Harrogate—Ground floor of Regional Office, Milk Marketing Board, surrounding district residential and manufacturing	102	426	9	71	437	Alk.
Harrogate—Wheatlands School, surrounding district low density housing and open parkland	58 for 11 months	256	4	65 for 11 months	308	0
Knaresborough—Knaresborough House, in parkland surrounded by mixed residential and commercial properties, open country to west.	76 for 4 months	316	8	81 for 4 months	196	12

*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
	Microgrammes per cubic metre			Microgrammes per cubic metre		
Wetherby—Council Offices, residential, surrounded by open country from $\frac{1}{2}$ to $\frac{3}{4}$ mile distant	88 for 4 months	225	14			
Goole—Health Department, Municipal Offices, Stanhope Street, surrounding area commercial, residential and shipping	106	668	13	103	354	31
Castleford—First floor of Divisional Health Office, in residential area of industrial town	234	984	8	205	601	68
Castleford—The Green, Ferry Fryston—situated 12ft. above ground on E. side of the Pavilion, surrounding district residential with open country to E.	158	876	4	90	279	8
Castleford—Technical College—in Mining Laboratory 25ft. above ground on W. side of building, open country from S.-S.W., residential and manufacturing S.E., E., N.E., N.-N.W., manufacturing S.W.-N.W.	145	912	12	174	712	44
Normanton—Nevile House. Surrounding district commercial, residential and a few small factories	169	991	16	108	580	24
Horbury—Ground floor lobby of Town Hall, facing east 12ft above ground, surrounding district residential and manufacturing	172	1,293	23	200	798	25
Morley—Public Health Inspector's Department, Commercial Street, surrounding district residential, commercial and manufacturing	149	655	12	161	583	Alk.
Morley—Spring Avenue, Gildersome in residential area	93 for 10 months	488	12	106 for 10 months	452	13
Ossett—Croft House—on first floor landing on north-east side of building. Surrounding district residential and commercial	104	885	13	196	991	30

*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
	Microgrammes per cubic metre			Microgrammes per cubic metre		
Batley—Public Health Department, Market Place, in centre of mixed residential, commercial and manufacturing district	152	748	20			
Spennborough—Health Centre, Greenside, in small park, residential and commercial area.	130	720	7	177	631	53
Elland—Council Offices, 20ft above ground in manufacturing area	199	1,094	16	231	1,392	6
Elland (Holywell Green)—In garage of private house, in main residential area of manufacturing district	149 for 2 months	358	24	173 for 2 months	396	31
Hebden Royd (Mytholmroyd)—Redacre Sewage Works, residential and manufacturing area, open country to north	84 for 11 months	526	8	115 for 11 months	567	Alk.
Hebden Royd (Hebden Bridge)—On second floor landing of Council Offices, in centre of mixed residential, commercial and manufacturing district	121 for 11 months	637	20	169 for 11 months	710	14
Todmorden—In first floor room on south side of Medical Centre, surrounding district mixed residential, commercial, manufacturing and open country	125	1,044	10	172	825	35
Colne Valley—Town Hall, Cross Street, Slaithwaite, in mixed residential and textile manufacturing district	152	497	34	151	435	32
Denby Dale—Public Health Inspector's Office, surrounding district mixed residential, manufacturing and open country	150	622	29	130	409	Alk.
Holmfirth—On second floor landing of Council Offices, surrounding district open country, residential, commercial and manufacturing	125	457	27	147	498	38

*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
	Microgrammes per cubic metre			Microgrammes per cubic metre		
Kirkburton—Council Depot, Highroyd, Lepton, 11 ft. above ground, surrounding district residential. Huddersfield C.B. 4 miles to the east	163	908	17	107	448	13
Meltham—Public Health Inspector's Office, Town Hall, surrounding district residential, manufacturing and open country	133	484	24	111	402	19
Saddleworth—Sewage Works, Shaw Hall Bank, Greenfield, surrounding district residential, manufacturing and commercial	109	732	17	96	471	0
Wortley (Grenoside)—Health Dept., Council Offices, surrounding area industrial and manufacturing	56	281	4	91	388	13
Wortley (Oughtibridge)—County School, Church Street, surrounding district industrial and manufacturing	49 for 9 months	187	3	81 for 9 months	355	Alk.
Hemsworth—Divisional Health Office, Adiscombe House, in residential area	201	961	12	127	415	25
Darton—Council Offices, in semi-residential colliery district. Coke by-product plant 1 mile to the S.E.	170 for 11 months	709	26	153 for 11 months	526	40
Wombwell—The Gables, semi-residential colliery district	258	1,564	44	104	362	26
Wombwell—The Library, Station Lane, surrounding district residential and commercial	245	1,276	48	172	591	53
Worsbrough—Savile House—8ft above ground in out-building, rear of Council Offices. Surrounding country open and low density residential	174	536	15	112	375	13

*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
	Microgrammes per cubic metre			Microgrammes per cubic metre		
Conisbrough—Denaby Clinic, in room facing north. Surrounding district residential—high density	188	724	15	166	420	34
Conisbrough—The Priory, in staff dining room facing west. Surrounding district residential—low density	157 for 11 months	852	16	129 for 11 months	457	34
Rawmarsh—Public Health Inspector's Office, in centre of residential and industrial area	243	914	18			
Bentley with Arksey—Health Department, Chapel Street, semi-residential colliery district	144	834	16	143	1,093	24
Doncaster (Barnby Dun)—Barnby Dun School, in residential area 5 miles north-east of Doncaster C.B.	136	780	12	132	500	Alk.
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	104	592	4	167	763	0
Thorne—Council Offices, in semi-residential colliery district	114	484	28			

*For period of full year unless stated otherwise.

Numerous visits were made to County Districts operating daily volumetric instruments within the County Council's Scheme to assist in matters of siting and operation of instruments.

Reflectometer reading of stains is carried out by this Department for almost all stations and the service to County Districts of calculating results for them has continued.

Station to be treated		Average daily population		Average daily sewage		Average daily sewage treatment	
Station	Population	High	Low	High	Low	High	Low
Station 1 - 1st Street	100	100	100	100	100	100	100
Station 2 - 2nd Street	150	150	150	150	150	150	150
Station 3 - 3rd Street	200	200	200	200	200	200	200
Station 4 - 4th Street	250	250	250	250	250	250	250
Station 5 - 5th Street	300	300	300	300	300	300	300
Station 6 - 6th Street	350	350	350	350	350	350	350
Station 7 - 7th Street	400	400	400	400	400	400	400
Station 8 - 8th Street	450	450	450	450	450	450	450
Station 9 - 9th Street	500	500	500	500	500	500	500
Station 10 - 10th Street	550	550	550	550	550	550	550
Station 11 - 11th Street	600	600	600	600	600	600	600
Station 12 - 12th Street	650	650	650	650	650	650	650
Station 13 - 13th Street	700	700	700	700	700	700	700
Station 14 - 14th Street	750	750	750	750	750	750	750
Station 15 - 15th Street	800	800	800	800	800	800	800
Station 16 - 16th Street	850	850	850	850	850	850	850
Station 17 - 17th Street	900	900	900	900	900	900	900
Station 18 - 18th Street	950	950	950	950	950	950	950
Station 19 - 19th Street	1000	1000	1000	1000	1000	1000	1000
Station 20 - 20th Street	1050	1050	1050	1050	1050	1050	1050
Station 21 - 21st Street	1100	1100	1100	1100	1100	1100	1100
Station 22 - 22nd Street	1150	1150	1150	1150	1150	1150	1150
Station 23 - 23rd Street	1200	1200	1200	1200	1200	1200	1200
Station 24 - 24th Street	1250	1250	1250	1250	1250	1250	1250
Station 25 - 25th Street	1300	1300	1300	1300	1300	1300	1300
Station 26 - 26th Street	1350	1350	1350	1350	1350	1350	1350
Station 27 - 27th Street	1400	1400	1400	1400	1400	1400	1400
Station 28 - 28th Street	1450	1450	1450	1450	1450	1450	1450
Station 29 - 29th Street	1500	1500	1500	1500	1500	1500	1500
Station 30 - 30th Street	1550	1550	1550	1550	1550	1550	1550
Station 31 - 31st Street	1600	1600	1600	1600	1600	1600	1600
Station 32 - 32nd Street	1650	1650	1650	1650	1650	1650	1650
Station 33 - 33rd Street	1700	1700	1700	1700	1700	1700	1700
Station 34 - 34th Street	1750	1750	1750	1750	1750	1750	1750
Station 35 - 35th Street	1800	1800	1800	1800	1800	1800	1800
Station 36 - 36th Street	1850	1850	1850	1850	1850	1850	1850
Station 37 - 37th Street	1900	1900	1900	1900	1900	1900	1900
Station 38 - 38th Street	1950	1950	1950	1950	1950	1950	1950
Station 39 - 39th Street	2000	2000	2000	2000	2000	2000	2000
Station 40 - 40th Street	2050	2050	2050	2050	2050	2050	2050
Station 41 - 41st Street	2100	2100	2100	2100	2100	2100	2100
Station 42 - 42nd Street	2150	2150	2150	2150	2150	2150	2150
Station 43 - 43rd Street	2200	2200	2200	2200	2200	2200	2200
Station 44 - 44th Street	2250	2250	2250	2250	2250	2250	2250
Station 45 - 45th Street	2300	2300	2300	2300	2300	2300	2300
Station 46 - 46th Street	2350	2350	2350	2350	2350	2350	2350
Station 47 - 47th Street	2400	2400	2400	2400	2400	2400	2400
Station 48 - 48th Street	2450	2450	2450	2450	2450	2450	2450
Station 49 - 49th Street	2500	2500	2500	2500	2500	2500	2500
Station 50 - 50th Street	2550	2550	2550	2550	2550	2550	2550
Station 51 - 51st Street	2600	2600	2600	2600	2600	2600	2600
Station 52 - 52nd Street	2650	2650	2650	2650	2650	2650	2650
Station 53 - 53rd Street	2700	2700	2700	2700	2700	2700	2700
Station 54 - 54th Street	2750	2750	2750	2750	2750	2750	2750
Station 55 - 55th Street	2800	2800	2800	2800	2800	2800	2800
Station 56 - 56th Street	2850	2850	2850	2850	2850	2850	2850
Station 57 - 57th Street	2900	2900	2900	2900	2900	2900	2900
Station 58 - 58th Street	2950	2950	2950	2950	2950	2950	2950
Station 59 - 59th Street	3000	3000	3000	3000	3000	3000	3000
Station 60 - 60th Street	3050	3050	3050	3050	3050	3050	3050
Station 61 - 61st Street	3100	3100	3100	3100	3100	3100	3100
Station 62 - 62nd Street	3150	3150	3150	3150	3150	3150	3150
Station 63 - 63rd Street	3200	3200	3200	3200	3200	3200	3200
Station 64 - 64th Street	3250	3250	3250	3250	3250	3250	3250
Station 65 - 65th Street	3300	3300	3300	3300	3300	3300	3300
Station 66 - 66th Street	3350	3350	3350	3350	3350	3350	3350
Station 67 - 67th Street	3400	3400	3400	3400	3400	3400	3400
Station 68 - 68th Street	3450	3450	3450	3450	3450	3450	3450
Station 69 - 69th Street	3500	3500	3500	3500	3500	3500	3500
Station 70 - 70th Street	3550	3550	3550	3550	3550	3550	3550
Station 71 - 71st Street	3600	3600	3600	3600	3600	3600	3600
Station 72 - 72nd Street	3650	3650	3650	3650	3650	3650	3650
Station 73 - 73rd Street	3700	3700	3700	3700	3700	3700	3700
Station 74 - 74th Street	3750	3750	3750	3750	3750	3750	3750
Station 75 - 75th Street	3800	3800	3800	3800	3800	3800	3800
Station 76 - 76th Street	3850	3850	3850	3850	3850	3850	3850
Station 77 - 77th Street	3900	3900	3900	3900	3900	3900	3900
Station 78 - 78th Street	3950	3950	3950	3950	3950	3950	3950
Station 79 - 79th Street	4000	4000	4000	4000	4000	4000	4000
Station 80 - 80th Street	4050	4050	4050	4050	4050	4050	4050
Station 81 - 81st Street	4100	4100	4100	4100	4100	4100	4100
Station 82 - 82nd Street	4150	4150	4150	4150	4150	4150	4150
Station 83 - 83rd Street	4200	4200	4200	4200	4200	4200	4200
Station 84 - 84th Street	4250	4250	4250	4250	4250	4250	4250
Station 85 - 85th Street	4300	4300	4300	4300	4300	4300	4300
Station 86 - 86th Street	4350	4350	4350	4350	4350	4350	4350
Station 87 - 87th Street	4400	4400	4400	4400	4400	4400	4400
Station 88 - 88th Street	4450	4450	4450	4450	4450	4450	4450
Station 89 - 89th Street	4500	4500	4500	4500	4500	4500	4500
Station 90 - 90th Street	4550	4550	4550	4550	4550	4550	4550
Station 91 - 91st Street	4600	4600	4600	4600	4600	4600	4600
Station 92 - 92nd Street	4650	4650	4650	4650	4650	4650	4650
Station 93 - 93rd Street	4700	4700	4700	4700	4700	4700	4700
Station 94 - 94th Street	4750	4750	4750	4750	4750	4750	4750
Station 95 - 95th Street	4800	4800	4800	4800	4800	4800	4800
Station 96 - 96th Street	4850	4850	4850	4850	4850	4850	4850
Station 97 - 97th Street	4900	4900	4900	4900	4900	4900	4900
Station 98 - 98th Street	4950	4950	4950	4950	4950	4950	4950
Station 99 - 99th Street	5000	5000	5000	5000	5000	5000	5000
Station 100 - 100th Street	5050	5050	5050	5050	5050	5050	5050

The purpose of this report is to provide information on the status of the sewerage system in the City of New York. The report is based on a survey of the system conducted in 1900. The survey was conducted by the Board of Health, and the results are presented in this report. The report is divided into two parts. The first part is a general description of the system, and the second part is a detailed description of the system. The first part is divided into three sections. The first section is a general description of the system, and the second section is a description of the system in the City of New York. The second part is a detailed description of the system, and it is divided into three sections. The first section is a description of the system in the City of New York, and the second section is a description of the system in the County of New York. The third section is a description of the system in the State of New York. The report is intended to provide information on the status of the sewerage system in the City of New York, and it is intended to be used by the Board of Health and the City of New York.

PART VI

MISCELLANEOUS

Research Projects:

**Survey of Childhood Cancers
Measles Vaccines Trial**

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

Admission to the Superannuation Scheme

Road Traffic Act, 1960

West Riding Distress Fund

RESEARCH PROJECTS

Survey of Childhood Cancers:

In previous reports mention has been made of the Authority's participation in a national survey conducted by Dr. Alice Stewart of the Department of Social Medicine at Oxford University into childhood cancers.

In an interim report Dr. Stewart writes:—

"As part of a large scale survey designed to discover the causes of childhood cancers, the West Riding (County and County Boroughs combined) has so far contributed 450 cases out of a possible total of 535. The survey still has four years to run and a rough estimate suggests that this region may eventually contribute 600 cases to a total of 5,000 from all parts of England, Scotland and Wales (1953—1967 deaths).

The survey to which Medical Officers of Health in the West Riding have made such a notable contribution was the first to show that leukaemia incidence during childhood is influenced by birth order and maternal age, and is exceptionally high among mongols (30-fold increase). It can also claim to have discovered that pre-school sibs of children with cancers are over four times as likely to develop these diseases as other individuals in this age group; and that the diverse causes of childhood cancers include obstetric radiology. These findings originally emerged from data obtained by Medical Officers of Health from mothers of cases and controls. They have since been confirmed by other means and it has also been possible to demonstrate a high level of agreement between survey reports (retrospective data) and authenticated records (contemporary data).

Recent work suggests that susceptibility to childhood cancer is often determined by events occurring at the time of conception which are also associated with a high abortion rate, particularly among males. The relevant observations include a deficiency of like sex twins (especially males) with cancer, and a deficiency of males in a small group of infant cases with a history of threatened abortion (13 females, 1 male). Only two pairs of twins with the same kind of cancer have so far been encountered in the survey, but each pair was of like sex and was presumed to be monozygous. Since there were only 65 cases affecting twins from like sex pairs, and barely a third of these were presumed to be monozygous, the cancer risk for an identical twin of a child with cancer greatly exceeds the risk for other sibs and may exceed the leukaemia risk for mongols."

The work undertaken by the medical staff is most time consuming; on average at least one day is required to successfully investigate each case and its paired control. Currently the deaths of children who died during the years 1961/64 are being followed-up and at the year end, of the 140 cases relating to the Administrative County, investigations into 101 case/control pairs had been completed satisfactorily.

Measles Vaccines Trial:

Commenting on the Authority's contribution to the Medical Research Council's measles vaccines trial, Dr. T. M. Pollock, Director of the Epidemiological Research Laboratory, Public Health Laboratory Service, Colindale, writes:—

"Since the isolation of measles virus by Enders and Peebles in 1953 measles vaccines have been developed in several countries, notably the United States of America, Britain and Russia.

Two main types of vaccines are available—killed vaccine and live vaccine. The killed vaccines currently available produce only a temporary immunity and are at present used alone. However, live vaccines produce substantial protection but have the disadvantage that they are sometimes associated with constitutional upset. A combination of killed vaccine followed by live vaccine one month later has been used to reduce the vaccination reactions sometimes caused when the live vaccine is given alone.

Early in 1964 the Medical Research Council undertook a pilot investigation in which the vaccination reactions of killed vaccine followed by live vaccine and the antibody response obtained was compared with the results with the live vaccine alone. The results with both regimes were promising and in autumn 1964 Medical Officers of Health in the West Riding and 14 other areas, the Medical Research Council, and the Public Health Laboratory Service began a large trial to determine the value of measles vaccines to control measles in the United Kingdom.

Forty-seven thousand children were allocated to receive *either* live vaccine *or* killed and live vaccine or to remain unvaccinated; vaccination was undertaken during October and November, 1964. These children have since been carefully followed up to record frequency of reactions after vaccination and the degree of protection afforded during the recent measles epidemic.

The vaccination and the follow-up has been undertaken by the staff of the County Health Department and further information has also been made available by the family doctors of the children concerned. The notification lists of children in the age group concerned are also being examined.

Three thousand six hundred children for the trial came from the West Riding. The co-operation by general practitioners and local authority staff concerned in the vaccination follow-up and heavy clerical administration has been of a high order and has been much appreciated. It is expected that the results will provide definite information about the value of vaccines in controlling measles in the United Kingdom."

Of the 3,600 children referred to above, 2,450 comprised the vaccination group and they received a dose of killed vaccine followed four weeks later by a dose of live vaccine, the vaccinations being carried out by the Authority's medical officers during October and November, 1964. The remaining children formed the "control group" and were promised vaccine when further supplies became available. In July, 1965, a supply of vaccines was made available and invitations were issued to the parents on behalf of these control group children. Of the 1,150 children eligible, 1,060 were vaccinated during September and October, following the same immunisation schedule referred to above.

Early in 1966 a report on the preliminary results of the trial after six months was published. Whereas it would appear that in the first six months a high degree of protection was afforded by vaccination, it is important to continue the surveillance of the children to assess both the quality and duration of immunity. At the moment no one can say if, or how often, booster doses may be required.

Our participation in the trial is continuing and it is hoped that our findings will assist the Medical Research Council to reach firmer conclusions for the future.

THE WELFARE OF THE EPILEPTIC AND SPASTIC

The following are the particulars of known epileptics and spastics :

<i>Adults</i>	<i>Number</i>	
	<i>Epileptics</i>	<i>Spastics</i>
Provided with accommodation under Part III of the National Assistance Act, 1948:		
(a) in homes for epileptics	65	
(b) in homes for spastics and other handicapped persons		23
(c) in County establishments and establishments where County Council has "right of user"	29	
Registered under the County Council's scheme of Welfare Services for Handicapped Persons (General Classes) and not shown above	148	174

<i>Children</i>	<i>Number</i>	
	<i>Epileptics</i>	<i>Spastics</i>
Number ascertained as handicapped:		
	not	
(a) Approximate number attending ordinary schools	known	39
(b) Attending special schools	21	90
(c) Receiving home tuition	—	2
(d) Attending Training Centres for the Mentally Subnormal	107	83

Plus 6 children suffering from both epilepsy and spasticity.

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 etc. 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. Several 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 by the County Council at Harrogate, Morley, Pontefract, Wombwell, Ripon, South Kirkby, Rossington, Thurcroft, Skipton, Woodlands, Hoyland Common, Barnoldswick, Keighley, Castleford, Batley, Horsforth, Settle, Outwood and Cleckheaton. 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 eleven full-time handicraft instructresses working in the County during the year. From this agency over 1,259 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 1965 of blind and partially sighted persons (other than handicapped school children).

	Disability (B.—Blind, P.S.—Partially Sighted)									
	Cataract		Glaucoma		Retro-lental Fibro-plasia		Others		Total	
	B.	P.S.	B.	P.S.	B.	P.S.	B.	P.S.	B.	P.S.
(i) Number of cases registered during the year in respect of which Section F recommends:										
(a) No treatment	89*	57†	13	1	—	—	93	31	195	89
(b) Treatment (medical, surgical, optical or Ophthalmic Medical supervision)	150‡	142=	32	11	—	—	77	64	259	217
(ii) Number of persons at (i) (b) above who received treatment ...	82	101	29	10	—	—	66	53	177	164

* Includes 14 cases of cataract with glaucoma.

† Includes 2 " " " " "

‡ Includes 23 " " " " "

= Includes 26 " " " " "

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:—

<i>Establishment</i>	<i>Superintendent/Matron</i>	<i>Telephone Number</i>	<i>No. of Residents</i>
The Shroggs, Skipton Road, Steeton	Miss E. M. Wolstenholme	Steeton 3213	20*
Farfield Hall, Bolton Road, Addingham	Mrs. H. Otter	Bolton Abbey 241	30
Neville House, Neville Crescent, Gargrave	Mr. and Mrs. M. Carling	Gargrave 349	34
Sharow View, Allhallowgate, Ripon	Mr. and Mrs. E. Brook	Ripon 2238	73
The Beeches, Leeds Road, Tadcaster	Mr. and Mrs. H. G. Jenner	Tadcaster 2133	11
†11, Stockwell Road, Knaresborough	Miss W. M. Brown (Matron) Mr. T. K. Hayward (Secretary)	Knaresborough 2283	87
Wharfedale Lawn, Westgate, Wetherby	Mrs. A. Lofthouse	Wetherby 2446	23*
The Grove, 80, High Street, Starbeck	Miss W. Smeaton	Harrogate 83980	19*

<i>Establishment</i>	<i>Superintendent/Matron</i>	<i>Telephone Number</i>	<i>No. of Residents</i>
Fircroft, Wighill Lane, Tadcaster... ..	Miss L. E. Wilkes	Tadcaster 3204	27
Hillworth Lodge, Oakworth Road, Keighley	Mr. and Mrs. D. Moor	Keighley 4014	170
Thornton View, Thornton View Road, Pasture Lane, Clayton, Bradford	Mr. and Mrs. F. Innis	Queensbury 2007/8	191
Woodville, Spring Gardens Lane, Keighley	Mrs. Iddon	Keighley 2428	20
Crow Trees, Leeds Road, Rawdon	Mrs. H. M. Lewis	Rawdon 2908	20*
Burley Hall, Burley in Wharfedale, Nr. Ilkley	Miss E. S. Atkinson	Burley in Wharfedale 2334	27
Park House, 41, Lister Lane, Bolton, Bradford	Mr. and Mrs. L. Gillard	Bradford 39913	22†
Moor Court, Fieldway, Ben Rhydding	Mr. and Mrs. E. Hubbick	Ilkley 4734	34
Littlelands Court, Littlelands, Cottingley	Mr. and Mrs. P. Hale	Bingley 5330	34
Manorfield House, Manor Road, Horsforth	Mr. and Mrs. F. Atkinson	Horsforth 3561	34
Glenholme, Green Lane, West Vale, Greetland	Mr. and Mrs. H. H. Senior	Elland 2985	40
Stoneswood, Oldham Road, Delph	Miss M. C. Murphy	Delph 300	20
Thornhill Grange, Hanson Road, Rastrick	Mr. and Mrs. W. Corbett	Brighouse 810	43
Heathlands, Meal Hill Lane, Slaithwaite	Mr. and Mrs. P. Morrell	Slaithwaite 2856	34
Longlands, Leeds Road, Lightcliffe, Nr. Halifax	Miss A. Dickinson	Halifax 68254	20
Scaitcliffe Hall, Burnley Road, Todmorden	Miss L. Holt	Todmorden 2814	24
Scissett Mount, Busker Lane, Scissett	Mr. and Mrs. J. G. Raby	Skelmanthorpe 3260	34
Stanley View, Park Lodge Lane, Wakefield	Mr. and Mrs. F. W. Radley	Wakefield 2188	207
Beech Towers, Halifax Road, Staincliffe, Nr. Dewsbury ...	Mr. and Mrs. N. W. Jones	Dewsbury 4051/2	304
Knowl Park House, Crow Lees Road, Mirfield	Mr. and Mrs. D. Dyer	Mirfield 2583	34

<i>Establishment</i>	<i>Superintendent/Matron</i>	<i>Telephone Number</i>	<i>No. of Residents</i>
Knowle Manor, Tennyson Terrace, Morley... ..	Mr. and Mrs. R. C. Cost	Morley 4740	34
Walton House, Shay Lane, Walton, Nr. Wakefield ...	Miss A. Smithson	Wakefield 5242	20*
Home Lea House, Wood Lane, Rothwell	Mr. and Mrs. T. Farrar	Rothwell 3218	34
Turnsteads, Whitcliffe Road, Cleckheaton... ..	Mrs. J. E. L. Thwaites	Cleckheaton 2972	23*
Brook Lodge, Brook Street, Selby	Mr. and Mrs. J. E. Whitworth	Selby 2815	68
Northgate Lodge, Skinner Lane, Pontefract	Mr. and Mrs. C. Borrill	Pontefract 3351/2	164
Parklands, Station Road, Rawcliffe, Goole	Mr. and Mrs. N. A. Sylvester	Rawcliffe 226	34
Mill Garth House, Mill Hill Lane, Pontefract	Mr. and Mrs. J. T. Fenton	Pontefract 3593	44
Newfield, Brookfield Avenue, Pontefract Road, Castleford	Mr. and Mrs. W. Powell	Castleford 4110	34
Norman House, Attlee Street, Normanton	Mr. and Mrs. A. S. Huxley	Normanton 2366	34
Fearndale, Purston Park, Featherstone	Mr. and Mrs. C. W. Hutchinson	Featherstone 642	34
Bullenshaw House, Bullenshaw Road, Hemsworth	Mr. and Mrs. R. A. Harris	Hemsworth 722	34
Langthwaite House, Barnsley Road, South Kirkby ...	Mr. and Mrs. T. Preston	South Elmsall 2510	34
Highfield House, Love Lane, Castleford	Mr. and Mrs. F. Butterfield	Castleford 3767	34
Wadworth Hall, Wadworth, Nr. Doncaster	Mrs. S. C. Kenny	Doncaster 53272	27
Haynes House, Haynes Road, Thorne	Mr. and Mrs. H. Bishop	Thorne 3395	34
Don View, 22, Thellusson Avenue, Scawsby, Nr. Doncaster	Mr. and Mrs. W. R. Howell	Doncaster 2257	38
Rose House, Church Street, Armthorpe, Doncaster ...	Mr. and Mrs. G. Bromley	Armthorpe 450	34
Owston View, Carcroft ...	Mr. and Mrs. A. Brearley	Adwick le Street 3368	34
Rolleston House, High Street, Maltby	Mr. and Mrs. G. T. Nutt	Maltby 2118	41
Highfield, Woodsetts Road, North Anston, Nr. Sheffield	Mr. and Mrs. C. Bungay	Dinnington 2593	34

<i>Establishment</i>	<i>Superintendent/Matron</i>	<i>Telephone Number</i>	<i>No. of Residents</i>
Dearnlea, Park Road, Thurnscoe	Mr. and Mrs. J. M. Raine	Goldthorpe 3094	34
Rowena House, Old Road, Conisbrough	Mr. and Mrs. J. Harrison	Conisbrough 2331	34
Winterwell House, Dryden Road, West Melton, Wath on Dearne, Nr. Rotherham	Mr. and Mrs. N. Bradley	Wath on Dearne 2096	34
Monkwood House, Whiteleys Avenue, Rawmarsh, Nr. Rotherham	Mr. and Mrs. P. Jorden	Rawmarsh 2651	34
Haworth House, Brinsworth Lane, Brinsworth	Mr. and Mrs. J. C. Milne	Rotherham 3373	34
Oaklands, Oakdale, Worsbrough Bridge	Mr. and Mrs. F. E. Rodgers	Barnsley 5529	41
Netherfields, Sheffield and Halifax Road, Penistone ...	Mr. and Mrs. C. Stoney	Penistone 2144	63
Wombwell Grange, Park Street, Wombwell	Mrs. K. M. Smith	Wombwell 2186	18*
Mortomley House, High Green, Nr. Sheffield... ..	Mr. and Mrs. G. A. Smith	High Green 323	45
Oakwood, Back Lane, Royston, Nr. Barnsley... ..	Mr. and Mrs. J. Wakeling	Royston 725	34

* Women only

† Men only

‡ County Council have "right of user"

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.

<i>Establishment</i>	<i>Number of Residents</i>	<i>Type of Home *(Part I, II or III)</i>
Congregation of Sisters of Charity of our Lady of Good and Perpetual Succour, St. Anne's Convent, Burghwallis, Doncaster ...	26	I
Mrs. Bessie Fox, Moor Lane House, Moor Lane, Gomersal... ..	22	I
Harrogate Old People's Home, 66-68, Cold Bath Road, Harrogate ...	36	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
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	13	I
Harrogate Guild of Help (Avondale Trust Ltd.), "The Avondale," Cold Bath Road, Harrogate	20	I
Mrs. A. Carter-Squire, "Newlands," 58, Harlow Moor Drive, Harrogate	9	I
Yorkshire Association for the Disabled, St. George's House, Otley Road, Harrogate	88	II
The Gables, Norland, Sowerby Bridge	11	I
Mrs. M. Fell, Oakfield, Thwaites Brow, Keighley	5	I
Mrs. M. R. Dodds, Lansdown, 46, Kent Road, Harrogate	9	I
Mr. D. Tamplin, "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. Alice McConney, Elm Bank, 242, Park Lane, Keighley	8	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	16	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	7	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
Hartrigg Guest House, Buckden, via Skipton	10	I
Mr. J. Richardson, Pentecostal Eventide Home, Aismunderby Close, Quarry Moor Lane, Ripon	18	I

<i>Establishment</i>	<i>Number of Residents</i>	<i>Type of Home</i> <i>*(Part I, II or III)</i>
Mrs. Dorothy Pearson, Thornlea Villas, Holme House Road, Cornholme, Todmorden	6	I
Mrs. L. Lawrence, Fearby House, 77, High Street, Starbeck, Harrogate	6	I
Mr. Geoffrey Noble and Mrs. Brenda Ainsworth, Bankfield Guest House, Hollins Lane, Sowerby Bridge	13	I
Mr. and Mrs. J. McAvoy, Brintcliffe Old Persons' Home, 1, St. Mary's Avenue, Harrogate	3	I
Mr. C. Band, Scott Bank, Hollins Lane, Sowerby Bridge	6	I
Mrs. M. L. Rennison, Lyndon Rest Home, 30, Ripon Road, Harrogate	10	I
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
Alderson House Ltd., Alderson House, 2, Alderson Square, Harrogate	5	I
Sue Ryder Home for Concentration Camp Survivors, Hickleton Hall, Nr. Doncaster	27	III
Mr. G. Cains, Meadow Croft, 6, South Crescent, Ripon	8	I
Mr. A. K. and Mrs. E. J. Sims, The Grange, Emley	18	III
Mrs. Hilda Mary Dobson, Carr Farm, Darley, Nr. Harrogate	3	I
Mrs. W. Milner, 92, Primrose Lane, Gilstead, Bingley	2	I
Mrs. W. G. Pickering, "Fairholme," Hebers Ghyll Drive, Ilkley	6	I
Mrs. M. Jowett, Valley View Rest Home, 4, Cross Banks, Otley Road, Shipley	5	I
Mrs. Doris Jervis, Glenayr Rest Home, 19, Franklin Mount, Harrogate	2	I
Mrs. Audrey Milnes, Maple Grange, 16, Roseville Road, Harrogate	5	I
Mr. and Mrs. A. K. Sims, Oaklands, Turnshaw Road, Kirkburton, Huddersfield	26	III
<i>Incorporated by Royal Charter</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, 1966, 358 schemes have been approved by the County Council, affecting 78 District Councils.

Following the implementation of the West Riding County Council (General Powers Act), 1964, the County Council informed all County District Councils that they were prepared to consider the making of contributions towards the expenses incurred by them in the development of services for aged persons living in privately owned or rented accommodation.

During the period September, 1965, to January, 1966, 131 schemes have been approved by the County Council, affecting 31 District Councils.

I am indebted to Mr. J. H. Bargh, 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, or physically incapacitated are living in insanitary conditions and are unable to devote themselves and are not receiving from other persons proper care and attention 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 are, however, unavoidable in certain instances. It was necessary to remove two men and three women to hospital and one man and four 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 amended registrations, 1 cancellation and 1 new registration making a total of 27 homes registered at the end of the year providing 35 beds for mental cases, 5 beds for maternity cases and 470 beds for other cases. Thirty-nine visits of inspection were made. 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	
Norwood House, High Spring Gardens Lane, Keighley ...	—	—	9	
Sunnybank Nursing Home, Braithwaite, Keighley ...	—	—	9	
Elmhurst Nursing Home, Hall Bank Drive, Bingley ...	—	—	3	
Thornfield Nursing Home, Micklethwaite, Bingley ...	—	—	11	
Chevin Hall Nursing Home, Chevin Hall, Otley ...	35	—	—	
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
Cavendish Nursing Home, 17 Cavendish Avenue, Harrogate ...	—	—	16	
Clova Nursing Home, Clothholme 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

Name and Address of Nursing Home	No. of Beds Registered			Other Information
	Mental	Maternity	Other	
Ellangowan Nursing Home, 26 Queen's Road, Harrogate	—	—	8	
Hampden House, 120, Duchy Road, Harrogate	—	—	46	
Heatherwood Nursing Home, 17 Duchy Road, Harrogate	—	—	10	
Hereford Nursing Home, 16 Hereford Road, Harrogate	—	—	21	
Kingsley Nursing Home, 38 Ripon Road, Harrogate	—	—	17	
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	
Westfield Nursing Home, Killinghall, Harrogate	—	—	7	
Cheshire Foundation Home, Spofforth Hall, Spofforth	—	—	21	
Kenmore Nursing Home, Whitcliffe Road, Cleckheaton	—	—	27	
Cheshire Foundation Home, White Windows, Sowerby Bridge	—	—	35	
Woodend Nursing Home, Atherton Street, Springhead	—	—	13	

NOTIFICATION OF BIRTHS

(Public Health Act, 1936, Section 203)

Notifications were received relating to 20,975 live and still births occurring in the Administrative County Area, and of 13,912 births occurring elsewhere to mothers who were normally resident in the County. The former figure included 3,051 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 31,836. When this figure is compared with the Registrar General's return of 31,974 births (31,463 live and 511 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 30,860 first visits to children born in 1965 were made by health visitors.

NURSERIES AND CHILD-MINDERS REGULATION ACT, 1948

At the end of the year, there were 7 nurseries registered for the care of 194 children and 43 child-minders registered for the care of 301 children. One hundred and seventy 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 diet, 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.

ADMISSION TO THE SUPERANNUATION SCHEME

The County Council, in January, 1962, adopted a revised policy with regard to medical examinations for admission to the Local Government Superannuation Scheme, whereby the requirement that all entrants to the scheme should first be medically examined was discontinued. Instead, a form of medical questionnaire dealing with personal and family history was introduced and full medical examinations were required only in certain special cases such as drivers etc., as well as where prospective entrants were over the age of 45 years.

The scheme has worked well and experience has shown that the age over which all prospective entrants must be examined could well be raised to 50 with a considerable saving in time and cost, and it has been amended accordingly.

During the year, 1,987 health questionnaires were received. Of this number, 1,384 applicants were approved for admission to the superannuation scheme on the basis of the information obtained from the questionnaires. 603 applicants were referred for medical examination by reason of:—

	<i>Number referred</i>	<i>Approved</i>	<i>Not Approved</i>	<i>Deferred</i>
Age	204	190	5	9
History	215	164	24	27
Category (of employment, e.g. driver)	75	74	1	—
Age and History	74	49	17	8
Age and Category	18	17	—	1
History and Category	14	9	4	1
Age, History and Category	3	1	2	—
	603	504	53	46

Of these examinations, 593 were carried out by the County Council's medical officers and 10 were carried out by medical officers of other authorities.

A comparison of the figures for the years 1963, 1964 and 1965 shows an increase each year in the number of staff appointed over the three years.

99 special medical examinations were carried out by the authority's medical staff at the request of the employing departments.

11 Specialist reports were obtained.

55 requests for medical examinations were received from other local authorities.

ROAD TRAFFIC ACT, 1960. SECTION 100(6)

During the year, 33 persons were referred to me for an opinion as to their medical fitness to hold driving licences. Enquiries and investigations were carried out and appropriate recommendations passed to the Clerk of the County Council for the guidance of the Local Taxation Officer.

WEST RIDING DISTRESS FUND

Grants from the West Riding Distress Fund were made in 6 cases as follows:—

- 2 For travelling expenses to enable relatives to visit patients undergoing hospital treatment.
- 2 For the provision of clothing for mentally subnormal persons.
- 1 For the supply of essential household requirements, for a mentally ill woman.
- 1 For the supplementary payment to the guardian of a severely subnormal woman.

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 58th Annual Report of the Principal School Medical Officer)

Introduction:

No major developments have taken place during 1965 though considerable thought has been given to the future trends of the service and to practicable methods of re-orientating the medical officers' duties so as to give more available time to studying the emotional problems of childhood and means of preventing various stresses throughout school life.

Difficulties continue in staff recruitment particularly in regard to speech therapists where the staffing position remained unchanged throughout the year. The recruitment of whole-time assistant medical officers has improved in some of the Divisions and doctors are being attracted into the service from general practice probably in part due to the revised scheme for subsequent secondment to the courses leading to the Diploma of Public Health. The main shortage at the end of the year was in the senior assistant grade where there are few responses to advertising in the medical press despite considerable thought being given to a more attractive type of announcement. It is hoped that future recruitment to this grade will increase from members of the staff who have obtained the D.P.H. Little further employment of general practitioners on school health service duties has been possible, but sessional employment by married women has continued to fill many of the gaps created by the shortage of whole-time staff.

In the child guidance sphere a further psychologist was appointed to take up duties on 1st January, 1966. One part-time psychiatric social worker had to resign for family reasons, but another has been appointed in the same area and will be increasing the number of sessions available early in 1966. One trainee is now fully qualified and it is anticipated that a second trainee will be seconded to the P.S.W. course during 1966. The close liaison with the Leeds University training course continues. The Sheffield Regional Hospital Board agreed to the secondment of Dr. Brennan, a consultant psychiatrist, for one session per week in the Maltby area from November 1st, 1965, thus giving some assistance when there was a vacancy created by Dr. Crowley's departure in 1963.

Regular conferences for the senior and assistant county medical officers have continued each term during the year and topics included liaison with other services; the problem of the autistic child; research within the public health sphere; and the importance of dental health in the child. These day conferences are much appreciated by the staff and stimulate interesting discussions. The issue of *Clinical Notes* continued, five numbers being circulated in 1965. Particular attention is given in the abstracts from the journals to subjects of practical interest to the doctor in the field.

During 1965 the Yorkshire Child Health Group was founded under the Chairmanship of Dr. Smith. The aim of the Group is to stimulate clinical discussions and social contacts between medical officers working in the various authorities. The Group normally holds meetings on Saturday afternoons and the West Riding staff are well represented in the membership.

Following the publication of *The School Health Service* booklet in 1964 further efforts have been made to enlighten various groups on the services which can be given for the child and the Senior Administrative Medical Officer for the School Health Service has addressed meetings of Health Visitors; Mental Welfare Officers; Training Centre Staffs; Education Welfare Officers; and students at Teachers' Training Colleges during the year.

During the year the School Health Services, in co-operation with the Chief Education Officer, assisted in the National Development Study following up children born during the week March 3rd—March 9th, 1958. Shortly after birth these children were the subject of a comprehensive investigation into the circumstances relating to the mother and the child, the pregnancy, and the birth. The present study was a logical extension to assess the present physical, educational and emotional status of the child population and to relate these assessments to the previous data.

Teachers had to complete a detailed assessment of the child's educational attainment and the survey included a social assessment questionnaire, usually completed by the Health Visitor, and a detailed medical examination in compliance with a special form including estimations of hearing, tests for crossed laterality etc. This survey took up quite an amount of professional time as approximately 460 children were seen in the West Riding area. The results of the national survey are awaited with interest.

Dr. Smith has continued to be a member of the Group Council of the School Medical Officers' Group of the Society of Medical Officers of Health and maintains close contact with the medical officers of the Department of Education and Science.

He is also a member of the Technical Advisory Panel on Child Health of the Leeds Regional Hospital Board and of the Medical Sub-Committee of the North Regional Association for the Blind. These contacts increase the liaison of the School Health Service with the consultant pædiatricians and ophthalmic surgeons in the West Riding Area.

Once again I would record my appreciation of the full co-operation given by the Chief Education Officer and his staff and by the teachers and other workers in the sphere of child health without whose ready co-operation the School Health Service could not attempt to fulfil its purpose.

The Medical Inspection of School Children:

The number of pupils on the registers is as follows:—

	<i>Boys</i>	<i>Girls</i>	<i>Total</i>
Nursery...	309	314	623
Primary (County) ...	66,041	62,521	128,562
Primary (Voluntary) ...	22,730	21,517	44,247
Secondary Modern (County)...	29,472	26,180	55,652
Secondary Modern (Voluntary) ...	1,603	1,720	3,323
Secondary Grammar (County) ...	8,971	10,455	19,426
Secondary Grammar (Voluntary) ...	3,807	2,511	6,318
Secondary Technical ...	511	631	1,142
Comprehensive ...	8,626	8,397	17,023
Bi and Multi Lateral Secondary ...	599	499	1,098
Special Schools (Boarding) ...	201	108	309
Special Schools (Day)...	353	254	607
Special Schools (Hospital) ...	77	49	126
	<hr/> 143,300	<hr/> 135,156	<hr/> 278,456

TABLE 1

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 who have received a full medical examination	Physical Condition of Pupils Inspected		Number of Pupils found not to warrant a medical examination (See Note below)
		Satisfactory No.	Unsatisfactory No.	
(1)	(2)	(3)	(4)	(5)
1961 and later ...	1,212	1,186	26	—
1960 ...	12,748	12,675	73	—
1959 ...	10,580	10,509	71	—
1958 ...	4,487	4,464	23	376
1957 ...	7,923	7,909	14	1,644
1956 ...	3,848	3,838	10	85
1955 ...	1,997	1,983	14	109
1954 ...	5,600	5,577	23	1,071
1953 ...	4,857	4,843	14	257
1952 ...	1,518	1,513	5	44
1951 ...	6,750	6,712	38	5,544
1950 and earlier ...	13,614	13,519	95	—
Total ...	75,134	74,728	406	9,130

Column (3) total as a percentage of Column (2) total ... 99.46

Column (4) total as a percentage of Column (2) total... 0.54

NOTE: As selective examinations have been carried out, Column (5) above gives the number of pupils who have been "interviewed" or "discussed" at case conferences and found not to warrant a medical examination.

B.—Other Inspections

Number of Special Inspections ...	16,623
Number of Re-Inspections ...	7,713
Total ...	<u>24,336</u>

The number of children examined during 1965 shows a slight increase on the 1964 figures:—

	<i>Periodics</i>	<i>Other Inspections</i>	<i>Number of pupils found not to warrant an examination on Selective Procedures</i>
1964	70,895	27,538	2,272
1965	75,134	24,336	9,130

indicating that this aspect of the service is being maintained.

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
1961 and later	17	124	136
1960	403	1,538	1,819
1959	416	1,342	1,649
1958	198	494	646
1957	463	846	1,224
1956	247	421	627
1955	104	152	235
1954	312	471	741
1953	267	379	623
1952	79	131	193
1951	378	450	781
1950 and earlier	926	868	1,711
Total	3,810	7,216	10,385

TABLE II

INFESTATION WITH VERMIN

- (i) Total number of individual examinations of pupils in schools by the school nurses or other authorised persons 461,862
- (ii) Total number of *individual* pupils found to be infested ... 8,999
- (iii) Number of individual pupils in respect of whom cleansing notices were issued (Section 54(2), Education Act, 1944) ... 212
- (iv) Number of individual pupils in respect of whom cleansing orders were issued (Section 54(3), Education Act, 1944) ... 46

A hard core of infested children remains, usually due to infestation of other members of the household and efforts must be maintained to obtain their co-operation in keeping clean.

TABLE III

DEFECTS FOUND BY MEDICAL INSPECTION IN THE YEAR ENDED 31ST DECEMBER, 1965

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	289	488	369	394	1,017	1,443	225	202
5	Eyes—	880	1,758	1,274	2,035	3,810	6,320	1,506	1,568
	a. Vision	408	297	49	110	691	736	218	158
	b. Squint	44	63	34	134	123	382	32	45
6	Ears—	261	556	75	181	555	1,242	222	444
	a. Hearing	169	513	59	159	319	998	63	141
	b. Otitis Media	37	78	38	38	118	223	47	32
7	c. Other	641	1,753	115	382	1,193	3,306	204	722
8	Nose and Throat	183	665	13	62	318	1,016	175	324
9	Speech	42	514	5	79	68	963	10	147
10	Lymphatic Glands	89	449	55	236	205	1,066	45	283
11	Heart	169	588	54	264	303	1,372	119	391
12	Lungs								
	Developmental—								
	a. Hernia	58	80	8	25	103	180	15	25
	b. Other	68	441	65	113	296	924	64	278
13	Orthopaedic—								
	a. Posture	21	74	40	121	113	357	27	89
	b. Feet	231	371	91	283	579	1,178	132	265
	c. Other	115	342	69	284	275	998	81	226
14	Nervous System—								
	a. Epilepsy	24	67	19	35	71	164	37	70
	b. Other	81	251	22	59	169	487	31	78
15	Psychological—								
	a. Development	22	175	24	76	93	507	249	303
	b. Stability	50	455	18	120	146	1,002	154	412
16	Abdomen	24	93	22	46	83	272	15	71
17	Other	355	836	197	306	902	1,800	228	568

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	326
Errors of refraction (including squint)	19,978
Total	20,304
Number of pupils for whom spectacles were prescribed ...	8,590

Group 2. Diseases and Defects of Ear, Nose and Throat

Received operative treatment:—

(a) for diseases of the ear	57
(b) for adenoids and chronic tonsillitis	1,535
(c) for other nose and throat conditions	54
Received other forms of treatment	283
Total	1,929

Total number of pupils in schools who are known to have been provided with hearing aids:—

(a) in 1965	74
(b) in previous years	180

Group 3. Orthopaedic and Postural Defects

(a) Pupils treated at clinics or out-patient departments	835
(b) Pupils treated at school for postural defects ...	22
Total	857

Group 4. Diseases of the Skin (excluding uncleanness for which see Table II)

Ringworm—(a) Scalp	1
(b) Body	9
Scabies	97
Impetigo	189
Other skin diseases	2,130
Total	2,426

<i>Group 5. Child Guidance Treatment</i>		Number of cases known to have been treated
Number of pupils treated at Child Guidance clinics under arrangements made by the Authority		1,112
<i>Group 6. Speech Therapy</i>		
Number of pupils treated by Speech Therapists under arrangements made by the Authority		850
<i>Group 7. Other Treatment Given</i>		
(a) Number of cases of miscellaneous minor ailments treated by the Authority		6,147
(b) Pupils who received convalescent treatment under School Health Service arrangements ...		35
(c) Pupils who received B.C.G. vaccination ...		15,682
(d) Other:—		
1. Ultra Violet Light Treatment		88
2. Remedial Exercises		13
3. Audiology		146
4. Abdominal defects		34
5. Cardiac		207
6. Chest and Heart		27
7. Miscellaneous		78
Total (a)—(d) ...		<u>22,457</u>

Medical Inspections in Schools:

Periodic routine medical inspections of all school children in certain age groups were instituted as a result of the Education Act (Administrative Provisions) 1907, and up to 1953 the Handicapped Pupils and School Health Regulations 1945 laid it down that all children must be examined on at least three occasions during school life (1) as soon as possible after entry into school; (2) in the last year of attendance at primary school; and (3) during the last year at a secondary school. Some authorities also continued to carry out an inspection of all eight year olds. Minor revisions were made in the 1953 Regulations and the 1959 Regulations made modifications to allow experimentation and Circular 352 which accompanied the Regulations stated:— “Where it is possible for the school doctor to visit schools regularly (e.g. at least two—three times a term) it may be found preferable for him to see on each occasion such children as are brought to his attention by parents, teachers, or the school nurse, instead of seeing all the children of a particular age at infrequent intervals”.

The Health of the School Child 1954/55 outlined the first experiments in “selective” examinations at Smethwick and since that time reference has been made in each edition to extensions of the selective procedure. By 1961, 30 Local Education Authorities were carrying out experiments. The first trials in the West Riding commenced in 1960 in the Keighley and Morley areas and reference was made to them in the Annual Report for 1960. The Divisional, School Health and Dental Services Sub-Committee gave approval to the extension of the scheme to other Divisions where the Medical Officer so desired in 1961.

The professional journals since that time have published many articles on the advantages and disadvantages of a selective procedure. Most authorities are agreed that the routine examination of all entrants to school should be continued. Many consider that a selective procedure could replace other routine examinations with the possible exception of the "Leavers" examination though some selective methods may also be practicable here.

It is of interest that ideas on the replacement of routine medical examinations are by no means a recent development. Dr. James Kerr, a pioneer school medical officer being appointed to Bradford City in 1893, in his book *The Fundamentals of School Health* in 1926 wrote: "Instead of an examination at long intervals, there ought to be an annual inspection by the school doctors; if this is deemed too much for the results, then the ideal school scheme would be frequent screening of the children by the teacher, who would presently value health and teach others to do so also. The teacher's first selection would again be reviewed by the school nurse, and her selection by the doctor."

Regarding routine medical examination he wrote "Half the doctor's time is taken up in detailed examination of healthy children and another quarter, perhaps, in recording trivial defects which elsewhere would be unnoticed."

In view of the generally improved pattern of medical care for the child it has been felt for some time that a general re-appraisal of the results of routine inspections was desirable. Attention has already been drawn in the Annual Reports for 1963 and 1964 to the fact that the figures recorded in the returns required by the Department of Education and Science each year gave a false impression of the number of children actually requiring treatment at the time of examination as they included the children already receiving treatment.

A survey was therefore commenced during 1964 in some of the Divisions, the medical officer recording at the time of the examination whether the child was:—

- (a) considered to require treatment
- (b) already receiving treatment
- (c) considered to have a defect requiring observation only

This survey has continued during 1965.

In addition it has been possible to analyse the types of defects referred under the various headings of the Department of Education and Science Medical Schedule Form 10M. Dental conditions were excluded from the survey, but medical officers were asked to include enuresis which was not specified on the form.

The 1964 figures for eight Divisions showed the following results:—

Age Group	Total pupils examined	Total number of defects found	Percentage referred for treatment	Percentage receiving treatment	Percentage of defects requiring observation only
Entrants	6,846	4,843	13.8	13.5	72.6
Leavers	5,160	2,160	19.4	25.3	55.3

The preliminary figures for 1965 year's survey includes three Divisions with a total surveyed as follows:—

Age Group	Total pupils examined	Total number of defects found	Percentage referred for treatment	Percentage receiving treatment	Percentage of defects requiring observation only
Entrants	3,512	2,357	14.5	9.8	75.7
Leavers	2,309	1,150	19.4	18.9	61.8

Many children show more than one defect. The returns, in some instances, did not indicate the number of individual children with defects, but in six Divisions in 1964 and in three Divisions so far in 1965 it was possible to include this:—

Age Group	Total examined	Total with defects	Percentage of children with defects
<i>1964</i>			
Entrants	4,613	2,237	48.5
Leavers	4,231	1,450	34.3
<i>1965</i>			
Entrants	3,512	1,627	46.3
Leavers	2,309	988	42.8

Variations in the percentage of children with defects reported are of interest both in the returns from different Divisions and, in some instances, it has been possible to compare returns from individual doctors working in the same Division.

In the 1964 returns the percentage of Entrants having defects varied from 34.1 to 62.8 and the Leavers group from 21.4 to 49.2.

In the 1965 survey so far the percentage of Entrants showing defects varied from 39.0 to 55.2 and the Leavers group from 33.2 to 46.8.

In 1964 comparison was made between the results of four experienced medical officers working in the same Division and carrying out three age groups as routine examinations:—

Doctor	Percentage of children reported as having defects		
	Entrants	11 year olds	Leavers
A	42.3	39.8	34.9
B	28.0	31.8	27.1
C	40.9	28.3	27.9
D	57.3	46.4	47.2

During 1965 other Divisions have been analysed:—

In one Division employing two experienced whole-time medical officers, the results are as follows:—

Doctor	Percentage of children reported as having defects	
	Entrants	Leavers
E	51	45
F	23	23

In another Division carrying out four routine inspections with two whole-time medical officers and one part-time (Doctor I) the following pattern was shown:—

Doctors	Percentage of children reported as having defects			
	Entrants	8 year olds	11 year olds	Leavers
G	57	59	52	46
H	46	41	48	42
I	68	60	68	56

It is therefore obvious that the percentage of defects recorded varies considerably with the individual doctor and this also accounts, at least in part, for the variations between the figures in different Divisions. The type of population in the individual Divisions had little significance in the results: rural and residential areas showing a higher percentage of children reported to show defects than in the Divisions surveyed with a more industrialised population.

When one turns to the individual type of defects referred *as requiring treatment* the largest percentage is for children having suspected defective vision. In the 1964 survey 19.9% of the total defects considered to require treatment of the Entrants Group; 29.3% of the eight year olds; 40.8% of 11 year olds and 45.2% of school leavers were referred for this reason. In 1965's figures analysed so far the figures for the Entrants Group were 25.2%; Leavers: 44.0%; eight year olds: 47.2%; 11 year olds: 42.5%.

The other main defects referred for treatment in the Entrants Group were nose and throat conditions including suspected hearing loss. Otherwise there was a general scatter of the types of defects referred though the number of psychological and emotional problems referred as a result of routine medical examinations was small. The references for treatment of enuresis varied considerably in different Divisions. In the 1964 survey of 16,170 children in various age groups no case of epilepsy was recorded as being found for the first time at a routine medical inspection.

In 1965 so far 7,583 children have been analysed following routine inspections and again no new case of epilepsy was found to require treatment. (One case was discovered in 1,173 selective examinations.)

The general conclusions of the survey of routine medical inspections is that, although a high proportion of children are recorded as having defects, a large percentage of these defects, other than suspected defective vision or hearing loss, are already receiving treatment at the time of examination or require observation only.

SELECTIVE EXAMINATIONS:

The aim of the selective procedure is to discuss the individual children with the teachers and nursing staff in the light of the questionnaire completed by the parents and then only invite for interview those children who appear to have some defect.

It is of interest to compare figures received for selective procedures during 1965 from two Divisions: Division A where the system had been in operation for some years; Division B where it was a recent innovation.

<i>Division</i>	<i>Total children examined</i>	<i>Total children showing defects</i>	<i>Percentage</i>
A	566	389	68.7
B	570	240	42.1

The fact that only 42.1 % of children in Division B were found to have defects suggests that selection techniques require further modifications as less than half the children were found to have any defect on examination.

Of the defects found and referred for treatment, the major conditions were suspected defective vision, hearing loss, and enuresis. Of the total defects recorded 22.4 % were referred for treatment; 18.1 % were receiving treatment and 59.5 % required observation only. Defective vision accounted for 21.2 % referred for treatment, and enuresis for a further 21.2 %.

The findings in the selective examinations therefore follow the same pattern as those in the routine procedures. Most of the defects, apart from suspected defective vision, hearing loss, and enuresis are already receiving treatment or require observation only.

The high proportion of children recorded as having defects in the various age groups leads one to echo Dr. James Kerr's views that trivial defects may be being recorded which elsewhere would pass unnoticed. The role of the school medical officer is to advise the teachers and the education authority on defects likely to affect the child's physical and emotional well-being throughout school life and to see that any necessary treatment is obtained. Insufficient attention is sometimes given to the fact that many apparent defects may actually be within the range of normality for a particular age.

The late Professor John A. Ryle in his book *Changing Disciplines* (1948) had an interesting section on the meaning of normality and normal variability. He pointed out such conditions as enlargement of the tonsils, palpable glands, postural characters and others were often within the limits of normal variability although recorded as defects. In the analysis of defects from the Divisions surveyed it was noted that there were very wide variations in the incidence of skin conditions; enlargement of lymph glands; and flat feet both from individual Divisions as a whole and from individual medical officers.

It is intended to discuss future changes in procedure with the Divisional Medical Officers, but the views of the assistant medical officers are being sought before concrete suggestions are put forward.

It is hoped to extend the screening of children's vision by nursing staff so that each child can be tested at regular intervals and defects referred for treatment without waiting for the medical inspection. Periodic screening of hearing of all school children by the nurses is also to be extended and has now become a routine throughout the County in the "Entrants" group. It is hoped to be able to repeat this at age 8-9; and 12-13 years when further staff can be recruited. Those found to have hearing loss should be seen by the medical officers at clinics so that a more detailed examination can take place than in normal school conditions.

More attention must be given to the emotional and psychological aspects of child development. In order to do this the doctor and nurse must be able to pay more frequent visits to the schools so that they become known to the staff as members of the "team" rather than occasional interlopers. Although the Annual Report for 1964 gave details of a survey of the inadequate accommodation available for medical purposes in many schools experience elsewhere has shown that there is less disorganization to the school by more frequent visits for one or two sessions than a set routine examination held annually and extending over several sessions. The more frequent visits would require additional planning, but would be worth while.

Looking into the future it would seem that the pattern of medical inspections in schools should be reviewed. If a full routine examination of all entrants to the County's schools is carried out—including late entries from private schools or other areas, the majority of relevant defects should be picked up from the physical aspect at this stage. Regular screening of vision and hearing by the nursing staff would bring these defects to light at an earlier stage as they develop. Regular visits by the doctor, at least twice a term, would enable the teacher to bring forward emotional and educational problems as they arise and the medical officer could see all children at work and at play in the school environment.

The "Leavers" examination has to take into account the child's suitability for various types of employment. It could possibly be on a "selective" basis in the light of the child's previous medical history and school reports, but may have to be continued as a routine if a forthcoming report recommends a closer connection between the School Health Service and the Factory Doctor Service.

Care of the Handicapped Pupil:

The diagnosis of the handicapped pupil is one of the most important functions of the school health service and recommendations for the child's future education must be made with considerable care having regard to environmental conditions in the home and local schools as well as the child's own level of emotional and mental development. Early diagnosis of defects is of great significance in the child's future. Preliminary plans have been agreed in principle to the setting up of main Centres for Handicapped Children. These will be associated with new Child Guidance Clinics and will enable the child to be investigated from both physical and mental aspects without the need to visit a multiplicity of clinics. Criteria for such centres are:—

- 1) Early identification
- 2) Full assessment including secondary handicaps
- 3) Prompt medical and surgical treatment
- 4) Guidance to the parents
- 5) Education of the young child in the broadest sense including remedial teaching for specific defects
- 6) Follow-up and re-assessment
- 7) Placement in the community
- 8) Full co-operation of all members of the team

It is intended that these centres should concentrate on the age range 2—7 years with facilities for long term follow-up of the more handicapped children who will require particular guidance on leaving school. Apart from the Child Guidance Clinic facilities there will be provision for the assessment of the young child with impaired hearing; the child with multiple handicaps; the child with educational problems including those who are retarded and those of normal intelligence, but with specific problems such as cerebral dysfunction. Special attention will be given to the problems of the non-communicating child including those who may be autistic.

It is hoped that more facilities will become available in the area for special post-graduate training for medical officers in the sphere of handicapped pupils. At the present time full use is made of any available courses as it is essential that the medical staff should keep abreast of new developments. At the invitation of the Spastics Society, Dr. Smith attended a special study weekend held in Manchester in 1965 where the whole sphere of handicapped pupils was discussed and recommendations for the future made. He also has an honorary lectureship at Leeds University and lectures on the handicapped child to Health Visitors in training and to the D.P.H. course.

The number of new ascertainties and re-examinations undertaken during 1965 was 1,936 compared with 1,967 the previous year. Details are as follows:—

<i>Category</i>						<i>No. of examinations and re-examinations</i>
Educationally subnormal	...	...	...	...	...	1,192
Physically handicapped	...	...	...	...	...	370
Delicate	...	...	...	...	...	117
Deaf	...	...	...	...	...	37
Partially hearing	...	...	...	...	...	30
Epileptic	...	...	...	...	...	29
Speech (requiring special school)	...	...	...	...	...	3
Maladjusted (requiring hostel or special school)	...	...	...	...	...	87
Blind	...	...	...	...	...	31
Partially sighted	...	...	...	...	...	35
Double defect	...	...	...	...	...	5
Total						1,936

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	4	9	—	55	—	—	6	—
Partially Sighted	5	7	23	36	—	—	4	1
Deaf	27	19	42	134	—	—	5	—
Partially Hearing	14	14	37	34	—	—	8	—
Delicate	49	60	17	76	1	—	12	1
*Physically Handicapped	39	34	64	112	—	11	25	42
Educationally Subnormal	293	247	831	299	—	17	386	1
Maladjusted	51	28	1	31	24	5	32	3
Epileptic	5	6	2	19	—	—	2	—
Speech Defects	—	1	2	1	—	—	1	—
Totals	487	425	1,019	797	25	33	481	48

* Excluding children sent to or awaiting places in hospital schools.

The booklet *The School Health Service* stressed once again the need for early reference for full investigation of all children suspected of educational retardation and there is an encouraging diminution in the numbers of children referred for the first time from secondary schools—at an age when special educational treatment is not going to be long enough to provide full benefit.

West Riding Special Schools

	Age range (years)	Accommodation
<i>Residential Special Schools for Delicate Children</i>		
Ingleborough Hall, Clapham	6—12	50 mixed
Netherside Hall, Skipton in Craven	11—16	40 boys
<i>Residential Special School for Deaf and E.S.N. Boys</i>		
Bridge House, Harewood	8—16	36 boys
<i>Residential Hostel for Maladjusted Boys</i>		
Nortonthorpe Hall, Scissett	9—16	25 boys
<i>Residential Special Schools for E.S.N. Children</i>		
Baliol School, Sedburgh	11—16	56 boys
Royd Edge School, Meltham	11—16	54 girls
Springfield School, Horsforth	7—11	52 mixed
Whinburn School, Keighley	7—11	44 mixed
<i>Day Special Schools for E.S.N. Children</i>		
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

A further Day Special School for E.S.N. Children was opened in 1965.

Anchorage School, Sprotbrough 7—16 100 mixed

THE PHYSICALLY HANDICAPPED CHILD:

Cerebral palsy remains one of the main causes of serious physical defect in children and the incidence is unlikely to become much less as many of the causative factors are not preventable. 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		
166	90	39	34	2	1

MINIMUM CEREBRAL DYSFUNCTION:

This syndrome is now becoming more widely recognized. It is often referred to as "brain damage" although pathological studies often fail to reveal organic evidence of defect. Causation is varied including anoxia at birth, minimal degrees of cerebral palsy etc. The child is often regarded as "clumsy" both in gait and in writing. It may be associated with crossed laterality and visual defect. On special testing by the Weschler Intelligence Scale for Children significant variations are shown between the Verbal and Performance abilities. Some authorities consider that dyslexia ("word-blindness") is a manifestation of the syndrome rather than a separate entity. The child becomes retarded educationally and may show evidence of emotional difficulties due to frustration.

Educationally, treatment is difficult and requires periods of individual tuition for the child. It is hoped that the setting up of centres for handicapped children will enable more detailed studies and research to be carried out on these children who suffer a real handicap although the apparent physical signs are slight.

THE DELICATE CHILD:

The number of new ascertainments during 1965 was 49 compared to 38 in 1964. The main problem is that of chest conditions. Few children now require admission to special schools for reasons of general subnutrition and malnutrition.

The case conferences at the Ingleborough Hall and Netherside Hall Schools continued during the year and the following report on the schools may be of interest —

Residential Schools for Delicate Children:

The West Riding County Council maintains two special schools for delicate children. Ingleborough Hall for both sexes aged 6—12 years, and Netherside Hall for boys aged 11—16 years. Children are admitted to the schools from various parts of the County usually on the recommendation of a consultant paediatrician or chest physician. Each school is attended regularly by a local

general practitioner and the children are on this doctor's National Health Service list during residence at the school. The schools are also visited regularly by assistant county medical officers from the Skipton Division and close liaison is maintained with the general practitioners. Dr. Harvey, the part-time consultant paediatrician to the West Riding, and the Senior Administrative Medical Officer for the School Health Service visit both schools twice a year when a full case conference takes place with the school medical staff, Head Teacher and School Matron.

The following table shows the type of child on roll at the schools in December, 1965:—

Clinical Diagnosis (after review)	Ingleborough Hall		Netherside Hall
	Boys	Girls	Boys
Asthma and eczema	7	—	10
Asthma	6	2	16
Asthma and bronchitis	1	4	2
Bronchitis	4	3	1
Bronchiectasis	—	—	2
Bronchitis and debility	1	—	—
Otorrhœa and debility	1	—	—
Sinusitis	—	—	1
Emphysema	1	—	—
General allergy	—	1	—
Debility	5	3	4
Soiling	—	—	1
Non-progressive muscular dystrophy ...	—	—	1
	26	13	38

There are usually active waiting lists for the admission of boys to both schools and frequently vacancies for girls at Ingleborough Hall School. There is no provision for senior girls within the West Riding and the few referred are placed elsewhere e.g. at the West Kirby Open Air School. Five pupils at each school were from other authorities: East Riding C.C. 4; Leeds C.B. 2; Dewsbury C.B. 2; Bradford C.B. 1; and Rotherham C.B. 1. Of the West Riding pupils the majority of those with chest conditions came from the more industrialized areas of the County.

One criterion for admission is the history of repeated absences from the ordinary school. In general the children with chest conditions improve considerably in the residential school environment although some continue to have acute episodes of asthma during their holidays at home and this should be overcome before discharging them back to the ordinary school. Emotional problems in the home environment are sometimes a continuing factor leading to the recurrence of asthma.

The term "debility" is a broad one and children have been included who appear to be puny and under-sized for their age. In some instances further enquiries reveal that their size is of familial rather than nutritional origin.

Although it has not been possible, due to staffing difficulties, for physiotherapists to visit the schools it has been possible for boys from Netherside Hall to visit Skipton Clinic for exercises for postural defects and breathing following a part-time appointment being made there.

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:

1965 was marked by the retirement of Dr. Greenaway as headmaster of the Yorkshire School for the Deaf. Due tribute has been paid to his great work in the sphere of the deaf child, but his considerable help and advice at the audiology clinic held at the school cannot go unrecorded. As will be seen the work has continued successfully during the year. The number of attendances at the Otley Clinic has been disappointing—this is due in part to the relative inaccessibility from other Divisions.

Visits to the Bridge House School for educationally subnormal boys who also have hearing impairment and other defects have continued by medical officers attending refresher courses on ascertainment at Leeds University and the demonstrations of the special techniques required in assessing this type of handicap have been much appreciated. Owing to an improvement in the staffing situation it has been possible to admit more boys to the school during the year.

The problem of the child with hearing impairment in the ordinary school still requires further attention. Any child with a bilateral average hearing loss of over 30 decibels is under a handicap as the normally spoken word is heard as a whisper. In an endeavour to assess the incidence of this type of condition Divisional Medical Officers were asked to complete a return of all children in ordinary schools wearing hearing aids, having a bilateral hearing loss of over 30 decibels, or being regarded as having a significant hearing loss where accurate audiometry had not been possible due to age or other factors. Up to the end of December, 1965, 538 cases had been recorded. This figure is in keeping with the generally accepted national incidence of 2 per 1,000 school children.

All these children may not be substantially handicapped in school and it will be necessary to evaluate their educational attainment and other factors such as the intelligence quotient on an individual basis. The results should give an estimation of the number of children requiring specialized help in the ordinary school and evaluate the extent of the need for a peripatetic service by qualified teachers of the deaf. There are now over 100 such teachers engaged in this work in 40 other authorities.

The National College of Teachers of the Deaf published a Memorandum of Educational Provision for Children with Defective Hearing in September, 1965, which gives a lucid account of the types of facilities required for educating the hearing impaired child.

Dr. Ferguson reports as follows on the *Doncaster Clinic*:-

"The number of sessions continue to increase and now three sessions per month are held during the school terms. 28 sessions were held during 1965 compared with 16 sessions two years ago.

Once again a satisfactory proportion of pre-school children attended the clinic, there being 19 children in this age group in 1965.

The Headmaster and Staff continue to show great interest in the clinic and give every co-operation. It has been possible to arrange for every mother with a child under school age with significant deafness to spend a day with her child, in the Nursery Department of School for the Deaf. The mother observes how the staff deal with the deaf pupils and this helps her in handling the problems of her own child until admittance to the Nursery Department can be arranged.

It has been suggested that a peripatetic teacher of the deaf should be appointed and I would urge the importance of such an appointment. The parent, child and teacher would definitely benefit from such an appointment."

A statistical summary of the work carried out at the above clinic is as follows:—

						1965	1964
<i>Number of Sessions held</i> ...	...	...	...	...	...	28	25
<i>Number of Individual Children attending</i>							
(a) Referred for first time in current year	...	...	...	...	...	75	58
(b) Also attended in previous year	...	...	...	...	...	55	40
					Total	<hr/> 130	<hr/> 98
<i>Total number of attendances made</i>	...	...	...	...		<hr/>134	<hr/> 108

Areas from which referred (i.e. number from each Division)

Division No. 10...	...	...	...	...	7	3
Division No. 11...	...	...	...	...	2	—
Division No. 12...	...	...	...	...	7	6
Division No. 13...	...	...	...	...	—	1
Division No. 23...	...	...	...	...	6	10
Division No. 26...	...	...	...	...	3	2
Division No. 27...	...	...	...	...	36	23
Division No. 29...	...	...	...	...	12	3
Division No. 31...	...	...	...	...	2	10
					<hr/>	<hr/>
					75	58
					<hr/>	<hr/>

Ages of children referred

Under 1 ... ..	...	...	...	...	...	1	—
1—2 years	...	...	...	...	...	7	6
2—5 years	...	...	...	...	...	11	11
5—8 years	...	...	...	...	...	29	15
8—11 years	...	...	...	...	...	16	19
11+ years	...	...	...	...	...	11	7

Results of Clinical Investigation

Number of children with significant hearing loss ... ..	...	78	57
Number of children without significant hearing loss ... ..	...	52	41

Recommendations

Hearing aid recommended ... ..	...	10	14
To sit in front of class ... ..	...	16	22
Speech Therapy recommended ... ..	...	8	6
School for Deaf recommended ... ..	...	11	11
School for Partial Hearing recommended ... ..	...	—	—
School for Speech Defects recommended ... ..	...	—	—
Referred to Ear, Nose and Throat clinic ... ..	...	23	26
Special School with Speech Therapy ... ..	...	—	—

Dr. Burn reports as follows on the *Otley Clinic*:—

"Referrals for this clinic have been very much lower than I would ever have expected, and I am concerned that we may be missing children who would benefit from a full investigation of their hearing.

During the year we have seen one or two cases of special interest. A child of seven, who moved into the Division three years ago, and was then wearing a hearing aid (when he could be persuaded to do so) was given a trial in an ordinary school, but because of failure to improve was transferred to a special school for partial hearing children. He did not settle here and was extremely unhappy with behaviour problems, and eventually had to be withdrawn. Further investigation during the year has shown that his hearing is normal to frequencies below 1,000 cycles and above 3,000, but there is a severe loss between these frequencies. This would account for speech difficulties from which he suffers, and for the fact that he could not tolerate a hearing aid which was amplifying the full range of frequencies. He is now back in a primary school and having speech training, and seems to be settling down.

Another child with central nervous system damage was thought to be very severely subnormal. She had no speech, suffered from a mild spastic paraplegia, and was subject to violent temper tantrums. She was admitted to a training centre where after a while it was appreciated that some of her responses were better than those expected of a severely subnormal. Repeated investigation showed that while she was somewhat retarded her main problem was severe deafness, and she is to be given a trial in a School for the Deaf, where it is hoped she will make good progress."

A statistical summary of the work carried out at the above clinic is as follows:—

	1965	1964
<i>No. of Sessions held</i>	7	12
<i>No. of Individual Children attending</i>		
(a) Referred for first time in current year	12	20
(b) Also attended in previous year	4	6
	<hr/>	<hr/>
<i>Total</i>	16	26
	<hr/>	<hr/>
<i>Total number of attendances made</i>	22	31

Areas from which referred (i.e. number from each Division)

Division No. 1	2	5
Division No. 4	—	2
Division No. 5	11	14
Division No. 9	1	3
Division No. 16... ..	2	1
Division No. 18... ..	—	1
	<hr/>	<hr/>
	16	26
	<hr/>	<hr/>

Ages of children referred

Under 1	—	—
1—2 years	—	—
2—5 years	6	1
5—8 years	4	14
8—11 years	3	6
11+ years	3	5

Results of Clinical Investigation

No. of children with significant hearing loss	13	13
No. of children without significant hearing loss	3	13

<i>Recommendations</i>						1965	1964
Hearing aid recommended	...	...	...	...	...	—	3
To sit in front of class	...	...	...	...	...	2	1
Speech Therapy recommended	...	...	...	...	...	—	4
School for Deaf recommended	...	...	...	...	...	2	1
School for Partial Hearing recommended	...	...	...	...	...	—	3
School for Speech Defects recommended	...	...	...	...	...	—	—
Referred for hospital treatment	...	...	...	...	...	3	2
Trial for school for E.S.N.	...	...	...	...	...	—	1
For T's and A's	...	...	...	...	...	1	—
For further investigations	...	...	...	...	...	2	—

THE EPILEPTIC CHILD:

A small number of children still need to be referred for admission to special schools for the epileptics because of uncontrolled fits or behaviour. Research continues in the field of new drugs to overcome these problems and it is probable that the number of uncontrolled cases will become progressively less. Much depends on the attitude of the teacher towards fits occurring in the ordinary school as to whether a child is referred as unsuitable.

THE EDUCATIONALLY SUBNORMAL CHILD:

During 1965 a survey was carried out on the apparent regression in the Intelligence Quotients of children referred as educationally subnormal. This was a retrospective study and has formed the basis for further work in this sphere.

The survey was limited to children with I.Q.s of 80 or under classified as educationally subnormal and recommended for admission to special schools. Owing to shortage of places during the period under survey many children remained at the ordinary schools. All the children included in the survey had the I.Q.s reviewed before leaving school.

638 children were included: 330 remaining at the ordinary schools; 148 were admitted to day schools for the educationally subnormal and 160 to residential schools. The schools were not limited to these in the West Riding itself. It was found on re-test that 34·8% of children remaining in the ordinary schools had a drop in I.Q. of over 3 points compared with 54·7% of those admitted to day special schools and 48·1% admitted to residential special schools.

The proportion of children with I.Q.s under 70 on the initial test who remained at the ordinary school was 27·9% compared with 41·9% of those admitted to residential special schools.

This regression in I.Q.s has been noted in surveys elsewhere and is due, in part, to the higher verbal content of the Stanford-Binet Intelligence Scales in the older age groups, the retarded child not developing so well verbally. This regression in I.Q. begins to show itself by the age of 10—11 years and is probably not due to a fundamental regression in intelligence, in most instances, but to deficiencies in the present available tests of assessment.

Causation of Educational Retardation:

Several specialists in the field of mental subnormality continue to emphasize the importance of environmental factors in causation.

With this in mind a survey was commenced in October, 1965, based on the information received from the completed Forms 2 H.P. when children are examined by the ascertainment medical officers.

This survey will be continued during 1966, but the preliminary findings are of interest:

I.Q.s up to 80

Survey 12-10-65—31-12-65

			<i>I.Q.s under 50 or not assessable</i>	<i>I.Q.s 50—70</i>	<i>I.Q.s 71—80</i>
Total:—	159 children	...	24	77	58
I.	Familial dullness: ...	...	6 (25%)	47 (61%)	29 (50%)
II.	Personal factors: ...	...	17 (71%)	14 (18%)	8 (14%)
	Prematurity ...	...	3	7	2
	Epilepsy ...	...	2	1	1
	Meningitis ...	...	1	—	—
	Subarachnoid hæmorrhage ...	...	2	—	—
	Hydrocephalus and spina bifida ...	...	2	2	—
	Mongols ...	...	5	—	—
	Toxoplasmosis ...	...	1	—	—
	Gross spasticity ...	...	1	—	—
	Mild spasticity ...	...	—	—	1
	Kernicterus ...	...	—	—	2
	Anoxia ...	...	—	2	1
	Fall on head ...	...	—	—	1
	Maternal toxæmia ...	...	—	1	—
	Birth injury ...	...	—	1	—
III.	No relevant history: ...	...	1 (4%)	16 (21%)	21 (36%)
	Dual Factors I and II ...	...	1	3	4

The early findings support the view that personal factors are of greater significance in the causation of severe mental retardation whilst a background of familial dullness is found in almost two-thirds of the general range of I.Q.s 50—70 which accounts for a large proportion of the admissions to special schools for the educationally subnormal.

References as "Unsuitable for Education" at School:

During the year 87 decisions were recorded by the Local Education Authority in respect of children found unsuitable for education at school in accordance with Section 57 of the Education Act, 1944. This does not include all children considered to be unsuitable for education as amendments to the Education Act as a result of the Mental Health Act, 1959, allow children to be admitted to a Training Centre on a "voluntary" basis without the need for formal procedures being undertaken if the parents, Education Authority, and Local Health Authority are in agreement. This particularly applies to the young severely retarded child.

and obviates the worries caused to parents following the receipt of the various formal letters which had to be served under the Section 57 procedure. The parents can still request that their child's case be reviewed and the Chief Education Officer is informed of all children admitted to Training Centres on a "voluntary" basis. 102 children were attending Training Centres after voluntary admission at the end of 1965.

References for "Care and Guidance" on leaving school:

As a result of the changes brought about by the Mental Health Act, 1959, reference for care and guidance is no longer a statutory procedure. Children who have been previously regarded as educationally subnormal are reviewed by the medical officers and recommendations are made on an informal basis—the parents being advised on how to seek help for their child if required.

Owing to the broad interpretation of the term educational subnormality referred to in the 1964 Annual Report many children were referred for examination on leaving school with relatively high I.Q.s as the routine procedure was for the Chief Education Officer to refer all children ever classified as educationally subnormal.

A survey was carried out on children referred for examination during the period 7-8-64 to 28-7-65 with the following results:

I.Q. result	Attending Special Schools		Attending Ordinary Schools	
	Referred for Care and Guidance	Not Referred	Referred for Care and Guidance	Not Referred
Under 50	11	—	1	—
50—59	27	2	2	1
60—69	22	11	18	13
70—79	6	19	10	30
80—89	2	—	5	38
90 and Over	—	—	2	5
Total	68	32	38	87

After discussions with the Education Department and the Divisional Medical Officers it was agreed that the following categories should be referred to the Divisional Medical Officer for possible examination in future:

1. All children attending schools for the educationally subnormal.
2. Children with previous I.Q.s under 80 where there is evidence of immaturity or instability.
3. Any other case where there appears to be evidence of instability or of an adverse environment and previously classified as educationally subnormal.

This has reduced the number of unnecessary examinations. 105 children were referred informally during the year.

CHILDREN WITH SPEECH DEFECTS:

The number of therapists employed by the authority during 1965 remained unchanged though one therapist had to reduce her sessional work from 1st January, 1966.

There are two main problems in regard to the shortage of speech therapists:

1. *Training*

There are more applicants than available places at the training schools and colleges. It is difficult to increase the number of places available for training owing to a shortage of suitably qualified lecturers for the work and also the shortage of clinical material available within reasonable access to the training schools.

2. *Wastage*

Early marriage appears to be a particular occupational hazard of the female therapists. Although salary scales have been increased (the current scale from 1st July, 1965 being £695—£1,140 over a long period of increments) the sessional fee is £1 18s. 6d. Many married women might consider returning to duty on a sessional basis, but find that their financial return is small when they have paid for domestic help to look after young children.

Miss M. P. Dunkley reports as follows:—

“ During 1965, 103 children with speech defects were treated in the Harrogate, Ripon and Pateley Bridge areas.

These cases include the following:—

- 21 stammerers—19 of whom were boys, and 2 girls.
- 69 children were treated for varying degrees of Dyslalia.
- 2 children were suffering from hyper nasality.
- 3 children were suffering from a degree of deafness.
- 2 children were educationally subnormal.

The remaining 6 children had retarded speech development. In the last group mentioned, 2 cases were of special interest to me.

The first was a boy of 6½ years of age, who was referred to me as not talking either at home or at school.

His teacher reported that he took quite an intelligent interest in his lessons, but he was a silent member of his class, and did not mix with the other children, either in class, or in the playground.

His mother stated that he had begun to talk at the normal time, but that his speech was unintelligible, and since starting school he had refused to talk.

When I first saw him, I got no response at all; he understood what was said to him and there appeared to be no sign of deafness.

At first I put him with a small group of boys, but it was soon apparent that he was a solitary child, and preferred to play alone.

After one or two such sessions, it was obvious that we were not getting anywhere, so I decided to give him individual treatment—where I could try to win his confidence.

Gradually he began to respond by naming objects in the room, and pictures of everyday things shown to him.

His speech was very poor indeed, but I praised every attempt made, and ignored the faulty articulation.

After three or four more sessions together, I very casually asked him if he thought it would be more fun if two or three others joined in our games. He agreed to this, and once again he joined a small group of Dyslalics.

Though at first he was a little apprehensive, he gradually came round, and before long, he was taking an active interest in his lessons.

It has been so rewarding to see the change in this boy, as his self-confidence grows.

This is a case of a child who took refuge in silence, because he was unable to communicate successfully with other children.

His speech is now so much improved that he can be readily understood.

At home he is chatting quite freely and he is making progress with his reading at school.

The second case concerns a child of 3½ years.

She was referred to me by her own Doctor at 3½ years of age, as a non-talker.

She was a premature baby and there was no babbling stage.

She dribbled excessively and oral air pressure was very weak. She still has difficulty in swallowing.

There were no general signs of motor disability, but movements of the palate, tongue and lips were limited and clumsy.

There was incomplete closure of the Naso-pharyngeal sphincter.

She understood all that was said to her—and she made intelligent use of gesture.

The mother told me that she was very jealous of her baby sister, and she had started bed-wetting when the new baby arrived.

When baby was fed, the patient insisted on having a bottle, and being nursed like the baby.

She was in fact jealous of any affection and attention shown to the baby and she retaliated by being very aggressive.

Here is a case of an emotionally disturbed little girl, who in all probability is further-handicapped by a possible isolated Dysarthria.

We have been fortunate in getting her into school, before she is five, as it is thought that it will help her to mix with other children. The family lives on an isolated farm, and the home environment is not too happy.

This is not going to be an easy case to treat; progress will be slow, but already this little girl has begun to show an interest in talking, no doubt stimulated by the fact that her little sister has now started to talk.

Some of the children who come to me with retarded speech development are often living in isolated districts, especially around Ripon.

I feel there is a need for opportunities for these children to meet others of their own age group.

Two parents of these lonely children have already suggested the idea of forming a 'Play Group' in Ripon—which I feel would be an excellent idea.

During the year, I have had the opportunity of giving talks to Young Mothers' Groups and explaining the work of a Speech Therapist to Student Health Visitors and groups of school leavers."

Mrs. N. Hepworth reports as follows:—

"Attendance at clinics is very good, on the whole. The parents co-operate very well, with one or two exceptions, and we are getting some good results. Over the last three years, only eleven children have failed to attend the Speech Therapy Clinic, on invitation.

Two appointments are usually sent, then if the child still fails to attend the records are put into a pending file, as I usually have a waiting list.

The children are being referred earlier in their school life, due to the very good co-operation from the school staff, health visitors and medical officers. Early treatment cuts out many of the reading and writing complications which are apt to follow in the wake of an uncorrected speech defect."

Mrs. E. S. Maxwell reports as follows:—

"Clinics have been held as usual at Shipley (Somerset House) on Mondays, Bingley (Myrtle Park) on Wednesdays and Baildon (Cliffe Avenue) on Thursdays.

The clinic at Shipley has been full all the time with a short waiting list, but a steady flow of admittances and discharges has been maintained. Attendance has been very good on the whole. A larger proportion than usual of the children attending this clinic regularly are mentally backward to some degree.

Bingley clinic is in a similar state to Shipley with regular attendances and a small waiting list. Absences are usually due to illness, and parents are more considerate about informing the clinic beforehand that they will be unable to attend.

Denholme school was visited at the request of the head teacher. Several children were seen and Dr. Ambler has interviewed two of them since then with a view to them having speech therapy. The main difficulty in this case is the bus service from Denholme to Bingley.

Baildon clinic has not been full all the time. Regular attendance has been maintained with co-operation of the teachers of a group of children from Sandals school. Most of these will only need to be seen occasionally for review in 1966.

Two visits to Ferniehurst school were made during the clinic hours and a large group of children with minor speech defects was seen. A short report on each child with suggestions on how help could be given in school was submitted to the headmaster. Baildon clinic has been discontinued from the end of December, 1965, owing to a reduction in sessions worked, and the children from Baildon will be transferred to Somerset House where further treatment is necessary.

Beaconsfield Children's Home, Clayton, was visited in September. One child, a boy, is now attending Somerset House once a fortnight. Ideas of speech games and encouragement of speech and language development in general, for the children of nursery age, were given to the Matron, Mrs. White. She finds that the majority of the toddlers in her care are retarded in speech development to some degree."

Mrs. B. M. Smith reports as follows:—

"During the year 99 treatment sessions were held, divided equally between the Penistone and Stocksbridge clinics. To these must be added 20 sessions spent in visiting schools and homes. All Junior and Infant Schools in the area were visited at least once during the year.

Children referred for speech therapy were seen soon after referral, and advice given to the parents as to how they could best help their child during the waiting period. All children on the waiting list were seen twice during the year, special sessions were being held for this purpose.

On December 31st there was a total of 18 children awaiting treatment. Out of 50 cases treated during the year, only 2 were closed for non-co-operation, a satisfactory state in view of the rural nature of the area."

Miss R. P. Rogers reports as follows:—

"A Speech Therapist employed by a Local Health Authority is often asked if she does not become bored with sigmatisms and dyslalics. During the year sigmatisms and dyslalics have been most welcome in my case load which has included a number of severe speech defects. Many of them have necessitated a specialist's examination before therapy could commence. However, we are most fortunate in that advice is usually given very readily and

full co-operation is achieved. It would perhaps be even more encouraging if psychological assessments of stammerers could be given, as these cases are so often both a Child Guidance and a Speech Therapy problem. There have even been cases which seemed to defy diagnosis. One of these was a three-and-a-half year old boy with an abnormally slow rate of speech and what could only be described as an exaggerated Welsh accent. He came from a Yorkshire speaking family, and his language ability was very advanced. The only true defect discovered was an inability to sing!

It has been interesting to note the distribution of speech defects over the three divisions of the County in which my clinics are situated. In one area there is a predominance of stammerers, which seems to imply that there is truth in the theory of an inherited predisposition to the condition. It is known that large families inter-marry so passing on the defect. Similarly, in another area, the majority of cases referred were of retarded speech development indicating an inherited weakness of the speech mechanism. Developmental dysphasia occurred in equal proportions in all three divisions suggesting that the condition is in fact caused by psychological or physical trauma.

This natural grouping of speech defects has led me to feel even more strongly that eventually it would be most beneficial to arrange special classes in schools for speech defective children. Most children with defective speech display some concomitant sensory and motor defects which create reading and writing difficulties. During my school visits this year it has been interesting to note the number of children, of average intelligence, with and without speech defects, to whom the visual presentation of symbols means very little. Generally, teachers of today's large classes say they are not able to give these children individual attention, and so they must try to cope with standard teaching methods. During the year a seven year old boy was referred for treatment for a stammer which had just developed. He was very bright in arithmetic, yet could hardly read or write. It would seem that such 'disabled' children would benefit both psychologically and practically from teaching methods adapted to their needs.

My first full year's work in the West Riding has been stimulating and rewarding, if a little harassed by the inevitable waiting lists. However, since the setting up of a training school in Leeds, and two salary increases awarded during the year, it is encouraging to be able to hope that the Speech Therapy Service may have more staff in the near future."

THE MALADJUSTED CHILD:

The changes in staff have been outlined in the introduction to the report. The year's work has been one of steady progress with a limited staff, but most areas of the West Riding have the facilities of a Child Guidance Clinic within a fairly reasonable travelling distance.

Harrogate Clinic—Dr. E. Gore reports:—

"Staff:

Consultant Psychiatrist ...	Dr. E. Gore, M.D., D.P.M.	} 4 sessions weekly
Clinical Psychologist ...	Mr. D. G. Pickles, M.A.	
Psychiatric Social Worker	Mr. G. E. Skinner, D.P.A., A.A.P.S.W.	
Social Worker ...	Mr. D. Pottage	
Remedial Teacher ...	Miss F. Blackburn	Full time during school terms
Secretary ...	Mrs. M. M. Ramsbottom	Part time

During the last year the staff position has remained stable. Mr. Pottage joined us in April as social worker. Towards the end of the year we were glad to meet Dr. I. B. Alexander who had been appointed Senior Assistant County Medical Officer. We have had some meetings with Dr. Polson, Dr. Hall and Dr. Ashmore during the year to discuss particular problems.

In 1965, 116 cases were referred: 41 girls and 75 boys. A large proportion of these were from Division 7 (81 cases) and the sources of referral from this Division were as follows:—

Divisional Medical Officer	...	...	...	25
General Practitioners	...	...	...	19
Head Teachers	...	...	...	21
Parents	...	...	...	9
Pædiatrician	...	...	...	1
Children's Officer	...	...	...	2
Children's Home	...	...	...	1
Others	...	...	...	3
				—
				81
				—

There has continued to be an increasing number referred by General Practitioners. Of the referrals from Division 7, 26 children were taken on for regular treatment and the parents were also seen for regular interviews with the psychiatric social worker.

We had an increased number of referrals of pre-school children, and intend to start a small treatment group of these children, whose mothers will also attend, together for talks with the psychiatric social worker.

We have continued to utilise the lunch periods, particularly on Thursdays, for meeting the people closely concerned with the children in their daily lives, such as Headteachers, Probation Officers, Children's Officers, General Practitioners, Youth Employment Officers, Mental Welfare Officers and others. This year we have had visits from eight Headteachers.

In addition, among other outside visitors we have welcomed student Health Visitors, students from the Institute of Education in Leeds, and in September, 15 Assistant County Medical Officers on an Ascertainment Course for the education of subnormals.

The Psychologist and the Social Worker have visited schools in the area from time to time, and the clinic team has taken part in the Harrogate Professional Lunch meetings, which have proved interesting and rewarding.

We have also kept up our contact (by visiting) various maladjusted schools and hospitals.

The remedial work has continued to flourish and Miss Blackburn has been invaluable during our team discussions of cases. She has furnished a separate detailed report of her work in the clinic.

We have of course been in the closest touch with Dr. Hepple during the year, and have appreciated his helpful interest in the clinic.

We were sorry to hear of the death of Dr. Smithson, but are glad to continue our association with Dr. Taylor, with whom we had already been in touch."

Mirfield, Pontefract, Ossett, Morley and Rothwell Clinics—Dr. K. N. Maxwell reports:—

"During 1965 I continued to work in the same clinics as the previous year. The only changes of staff in these clinics were as follows:—

Mrs. Spurr, Psychiatric Social Worker, joined the clinic staff at Morley. Mr. Pritchard, Psychiatric Social Worker, is now working in the Pontefract clinic in addition to Mrs. Harris. The secretarial work of the Ossett and Morley clinics is being performed by Mrs. Doreen Hunter since Mrs. Janet Mell left for family reasons.

Mirfield and Pontefract continue to have waiting lists, but at Ossett, Morley and Rothwell, children are seen very soon after referral.

During 1965 the figures for children examined at the clinics were as follows:—

	Mirfield	Pontefract	Ossett	Morley	Rothwell	Total
Number of sessions held during 1965	192	102	47	47	82	470
Number of new cases during 1965	106	67	15	19	37	244
Number of cases referred from previous years	45	52	10	8	10	125
Number of cases discharged or admitted for residential treatment	67	48	10	9	23	157
Number of cases carried forward to 1966	84	71	15	18	24	212

The Electroencephalographic examination of children attending the Mirfield clinic has been facilitated by the opening of the Department of Neurophysiology at St. Luke's Hospital, Huddersfield. A number of children with dysrhythmic records have been treated with appropriate medication with some improvement. This has required observation over a longer length of time than formerly, but is affording useful therapy in the difficult problem presented by the behaviour disturbed child."

Skipton Clinic—Dr. R. R. Stoakley reports:—

"The clinic has been held each Friday throughout the year; one day a month being devoted to cases from the Northern end of the Division, the team travelling to Settle on the first Friday of each month.

On April 2nd the clinic premises were transferred from the Gate Lodge of Raikeswood Hospital to the new clinic at 9 High Street. There is available for the use of the child guidance team every Friday, three consulting rooms, and an interviewing room; besides the large waiting room.

Mr. Mannix, the psychologist, has been with us throughout the year. Mrs. Smithson, who joined the staff in October, 1964, left for domestic reasons on 30th April. She was the first psychiatric social worker we had had in the Division, and set a very high standard of work for her successor to follow. Mrs. Smith took over on 18th June. Mr. Pottage, a trainee psychiatric social worker, has been with us since February 1st and has fitted in with the team and has been a most useful member.

There have been a total of 61 new cases referred during the year. Of these seven did not attend. Either the problem had resolved itself before the date of appointment, or the parents did not wish the child to attend the clinic.

School Medical Officers	referred	18 cases
Headmaster or teachers	"	17 "
General Practitioners	"	8 "
Parents	"	7 "
Education Welfare Officers	"	5 "
Health Visitors	"	3 "
Probation Officer	"	1 "
Moral Welfare Officer	"	1 "
Consultant Physician	"	1 "

Anyone wishing to refer a case is free to do so at any time through the Divisional Health Office, or directly by telephoning Skipton 2438 on a Friday between 9-00 a.m. and 10-00 a.m.

Case conferences have been held from time to time, and problems involving other social workers have been discussed with all concerned for the welfare of the child. One particularly useful conference was held when we were able to have with us the Education Officer, Probation Officer, Health Visitor and Mental Welfare Officer. Several of the teachers have come in to discuss cases and Mr. Mannix has been able to visit most of the senior schools and some of the junior schools.

Mr. Mannix has done remedial work with seven pupils. A few of these have visited the clinic regularly every Friday, but the others have been seen at their schools whenever Mr. Mannix could find time to visit. As the schools stretch from Bentham to Silsden, it is an impossible task to give adequate time and attention to this branch of the work, and Mr. Mannix has tried to advise the staff of the schools in the management of the problem pupils. He has carried out 42 Intelligence Tests.

Of the cases referred, some have required only one visit to the clinic—one baby was referred for an estimation of intelligence because of adoption proceedings. One boy with muscular dystrophy was referred for assessment before placing in a special school. One child from a problem family was referred, and as it was felt that further visits would not be useful or helpful to that particular child, the health visitor was asked to continue her work with the family.

In three cases the mother required re-assurance only, and the child did not need to continue attendance. One mother was aggressive and unco-operative and refused to attend again, and one grammar school boy failed to keep a second appointment.

Recommendations made during the year were:—

Two to schools for maladjusted pupils (still awaiting placement);

Two to the care of the Local Authority for placement away from home;

One to Diagnostic Centre for Autistic Children—admitted in October, 1965 to Cranage Hall, Cheshire;

One child was accepted by Dr. Errington Ellis at the Percy Hedley Centre for Spastics, Newcastle-upon-Tyne for diagnosis, and subsequently recommended for special schooling.

There are 34 cases in attendance at the clinic at the present time. Classified according to the presenting problem they are as follows:—

Educationally subnormal and irresponsible	...	...	7
Educationally subnormal and withdrawn	...	...	2
Neuroses due to adverse circumstances...	...	...	5
Difficult behaviour	...	...	4
Poor progress in school due to emotional disturbance	...	...	5
Petty thieving	...	...	3
School phobia	...	...	1
Uncontrolled temper	...	...	1
Immoral behaviour	...	...	1
Hysteria	...	...	1
Fire raising...	...	...	1
Stammer	...	...	1
Emotionally disturbed due to physical handicap	...	...	1
Asthma	...	...	1
Total:			34"

Swinton, Ecclesfield, Barnsley and Woodlands Clinics—Dr. J. D. Orme reports:—

"In the early part of the year there were few changes to report at any of the clinics in the Southern part of the Riding. Shortage of staff limited the amount of work which could be done, especially as I was also occasionally visiting the clinics at Woodlands and Maltby, previously run by Dr. Crowley. Later in the year, however, the addition of Mr. Pottage as trainee social worker at Ecclesfield and the return of Mr. Pritchard as psychiatric social worker at Swinton and Barnsley has assisted the work in those clinics so that I have been able to spend regular time at Woodlands in an advisory capacity and even to carry out a certain amount of psychotherapy there. In November and December, arrangements were made with Dr. Brennan of St. Catherine's Hospital, to attend the clinics in the Rotherham Division at Maltby and elsewhere.

Over the whole period there has been little change in the pattern of referrals, with about equal numbers coming from School Medical Officers and from Family Doctors. One gets the impression that when the School Medical Officers are hard pressed with routine examinations, fewer cases are perceived as being emotionally disturbed, presumably because there is less time for communication of anxiety about this from parents and teachers. Certainly the number of referrals from School Medical Officers has decreased.

The work of the clinic class has continued throughout the year. It must be emphasized that Miss Lyne undertakes an extremely difficult task in teaching children, many of whom are so disturbed that they cannot be tolerated in an ordinary school. There is of course an element of remedial teaching in her work, but the greater part consists of allowing emotional tensions to be expressed and then controlled so that the child becomes stable enough to return to the normal school community. Difficulties are experienced because of the shortage of space for her to work in, and because no child can attend full-time. There are thus some children who are excluded from school when they are not attending the clinic class, while others find difficulty in adjusting to two different school environments. Constant vigilance is required of such a teacher even during dinner and other times to guard against accidents caused by the disturbed behaviour of these children (such as the fire raising manifested on one occasion). It must be realised that this adds considerably to the strain and difficulty of the task, though if it could be developed there might then be less need for residential placements for other children."

Miss Lyne's Report on Remedial Teaching:—

"The Remedial Group

Thirteen children, ten boys, three girls were attending for varying numbers of sessions when the year first began. Ten had already been coming for some time and three were newcomers, one of whom only maintained attendance for three weeks.

Reasons for Attendance

Five boys for disturbed behaviour at home and school with some stealing. One boy and one girl for disturbed behaviour and stealing at home although at school behaviour was reasonable. Two boys and one girl who were withdrawn and practically non-speakers at school. One boy withdrawn and bizarre in his behaviour. One boy withdrawn and enuretic. One girl a school refuser.

All the children had some degree of educational failure varying from one only slightly retarded to four who were grossly retarded.

The range of mental ability is shown:—

I.Q.	103	99	85	79	Age Range years	8	9	10	11	12
	103	97	80	73	No. of Children	2	6	2	1	2
	100	91	80	73						

They attended: five full time; three every morning; two one afternoon; one two afternoons; one one morning, so that the sessions worked out as:—

	Monday	Tuesday	Wednesday	Thursday	Friday
Morning	6	7	6	8	7
Afternoon	4	5	3	—	6

During the year the enuretic boy was able to go back into school full time at Christmas reducing the morning session by one.

One boy attending full time was reduced to just morning attendance. Another boy attending full time was tried full time at the local day E.S.N. school from Whitsuntide.

The Work with the Group

The remedial work covers the widest possible interpretation of education as covering healthy growth both as individual and social beings physically, emotionally and mentally. These children need so much help to achieve primary satisfaction physically and emotionally before their mental growth can be effective and continuous. Most normal children have achieved this satisfaction in the first five years of life at home thus making them able to work consistently with reasonable secondary physical and emotional satisfactions at school.

These maladjusted children, however, have whole areas in which they have been deprived of that completeness of satisfaction which is the only sound basis on which a child can grow effectively and because of this so much of their energy is dissipated in a search for people and situations which they will find satisfying, rather than turning their energy to school work. It is also possible for a child whose experience has made him afraid to accept growth emotionally and socially to use success at scholastic work as a defence against making any effort to build up relationships with other people.

In the light of this knowledge, it is essential to provide as much opportunity as possible for physical activity, destructive activity and creative activity as well as mental activity and this is what we attempt to do within the limitations of the surroundings.

The child first of all goes through a testing out phase when he is given plenty of freedom so that eventually he begins to allow us to see him as he truly is. From this point on situations can be structured to help him with his problems.

These problems very often are to feel himself worth-while as a physical being first of all, to develop warmer emotional responses. If this can be achieved from then on co-operation operates and school work begins to develop in a meaningful way.

Results of Work

Working on this basis:—

Two boys attending one half day per week have maintained their progress socially and scholastically and will return to school full time. The girl attending one half day has lost ground and will need more help next year. Three full time attenders went through extremely disturbed phases. But the fact that they were still accepted, even after desperate action, had considerable effect on their ability to feel and respond to children and adults. Their energy is now being directed more often into creating learning although from time to time they become disruptive, but not nearly on the same scale as before.

The girl school refuser has shown a pronounced strengthening of personality and ability to learn. She is to be tried full time at the local comprehensive school.

One boy is to be transferred to a residential school for maladjusted boys because his home background is not stable enough to give him the support he needs.

The withdrawn, bizarre boy is now much more in contact with reality and able to work hard with understanding of what he is doing.

The boy who returned to school at Christmas continues to make good progress.

Two boys transferred to day E.S.N. school, but one will continue to attend in the afternoons.

The boy attending two afternoons has only made progress in his relationships with children and adults, he has not yet got to the point where he can turn his energies to concentrated work. His attendance will be increased next year.

When the parents can co-operate with the psychiatric social worker, the supportive effect can be seen in the child's progress. It is also very valuable to be able to consult the members of the clinic team from time to time when crises arise or development seems to have come to a standstill. Thursday afternoon is given up to school and occasionally home visiting and the keeping up of these links is invaluable in helping the child to realise the unity of the care and concern for his welfare."

REPORT OF WORK OF PSYCHOLOGISTS:

There is an increasing national demand for psychologists to staff growing school psychological and child guidance services. The demand exceeds the supply, and it proved impossible to fill existing vacancies in the County services. There were three psychologists working full time in the child guidance service during the year. Mr. Mannix, who joined the service at the end of 1964, worked at the clinics at Morley, Ossett, Rothwell, Skipton and Keighley. Mr. Valentine attended the clinics at Woodlands, Dunscoft, Maltby, Swinton, Ecclesfield and Dinnington. Mr. Pickles continued to attend the clinics at Shipley, Mirfield, Pontefract and Harrogate.

The work undertaken in the clinics varied somewhat according to the time available and the completeness of clinic teams. The psychologist's part in child guidance work extends beyond routine testing, and involves a contribution to the description of personality, the investigation of educational attainment and needs, liaison work with schools, and may involve some share in treatment. In part-time clinics working under pressure, some of these aspects may have to be curtailed. At Woodlands, Dunscroft and Maltby, which were without psychiatric direction for the greater part of the year, the full responsibility for diagnostic and treatment services was left to Mr. Valentine and Mrs. Bruce, Psychiatric Social Worker, with the support of consultation from Dr. Orme. Mr. Mannix was able to devote some of his time to giving regular remedial tuition to selected children who needed individual educational help as an aspect of the treatment of their maladjustment. Some treatment sessions were also undertaken by Mr. Pickles with children selected by the psychiatrist at some of the clinics he attended.

Liaison with schools is an important aspect of the psychologist's work. It has been mentioned in previous reports that, while as many school visits as possible are made, and contacts otherwise maintained by 'phone or letter, the development of links with the schools in the areas served by the clinics still needs to be extended. Sufficient coverage to build clinic-school contacts in the case of all children referred for child guidance is desirable, but cannot be expected until the staff of psychologists is increased. The figures show that 175 visits were made to schools to discuss children who had been referred for child guidance, and this compares with the figures of 388 maladjusted children seen by the psychologists in the clinics as part of the team investigation. Where a clinic's geographical location is favourable, headteachers and their staffs are often very glad indeed to attend case discussions in the clinic, contacts with several schools have been maintained in this way, and fruitful means discussed for helping seriously disturbed children. We are still a long way, however, from providing adequate liaison with schools, which would contribute to more effective treatment of maladjusted children, and assist in preventive work.

The figures given below show that the greater part of the psychologist's work involved diagnostic help with maladjusted children, but a considerable proportion of time was also spent in assessment and educational guidance of handicapped children. Of the total number of 671 children seen by the psychologists, 388 were children referred to the clinics primarily for behaviour, nervous or habit disturbances requiring full child guidance investigation. The number of children seen mainly for psychological assessment of handicapping conditions, such as hearing loss, visual, speech and motor defects, or serious intellectual limitation, was 283. Also included in this group were children referred for psychological assessment of learning or educational difficulties, principally difficulties in learning to read. Experience shows that a considerable proportion of children referred for educational difficulties also have association emotional difficulties, these coming to light through the examination of the child, or through the account and history given by the parent. The school may be unaware that such difficulties exist. Even when the problem is presented as one solely of poor academic progress, with no manifest disturbances of behaviour or mood in school, it is good policy to enquire most carefully into the child's history and circumstances, and the parent's own views about the problem. The participation of the psychiatric social worker is invaluable in this respect. There were several children seen during the year initially for psychological assessment of learning difficulties, who were found to require more extensive help for their emotional problems, and were thus referred for psychiatric advice and treatment.

The problem of reading difficulties is one which occupies a large part of the psychologist's time. It occurs mainly in boys. The incidence is quite large among children referred to the clinics for behaviour and nervous conditions. Of the 388 maladjusted children seen during the year, 87 or 22·4 per cent. (79 boys, 8 girls) were found on testing to be significantly retarded in reading, using stringent criteria. These were children who needed some special educational assistance as well as treatment for their predominantly disturbed emotional conditions. Special classes at two of the clinics, Harrogate and Swinton, were able to help some of these children, and remedial centres could be of assistance in a few further cases. There remained quite a number, however, for whom appropriate remedial help was not available in the areas in which they lived.

Regular attendances at residential special schools were arranged during the year. Mr. Mannix visited Whinburn and Springfield junior residential e.s.n. schools frequently for re-assessment of selected children. Mr. Valentine continued to assist at the Doncaster School for the Deaf. Mr. Pickles visited Royd Edge School for senior e.s.n. girls each term, and Bridge House School for deaf e.s.n. boys rather more frequently. Mr. Valentine and Mr. Pickles also attended the audiology clinics at Doncaster and Otley.

The amount of work to be done in clinics and schools has prevented as yet any regular extension of psychological work in training centres and hostels and this must await the appointment of additional psychologists. A few visits were made to training centres to see children at special request, usually when a child's progress in the centre suggested the possibility of transfer to a special school. Quite a number of young backward children were seen, often with no speech, who proved to be severely subnormal and in need of training centre placement. Mr. Mannix was also able to pay a few visits to the Ossett junior training centre to help in the assessment of a group of children who were showing favourable response to instruction in word recognition.

All the psychologists are now equipped to deal with assessment of the abilities of babies by the Ruth Griffiths technique. The youngest child referred for psychological testing during the year was a baby of 17 weeks, the assessment being requested in view of the possibility of adoption.

Details of work undertaken during the year are given below —

Total Number of Children seen for psychological assessment...	671
Total Number of Maladjusted Children	388
Total Number of Handicapped Children	283

The children seen fall into the following diagnostic categories:—

Nervous Conditions	...	...	...	...	...	91
Behaviour Problems	...	...	...	...	...	280
Habit Disturbances	...	...	...	...	...	38
Other symptoms of maladjustment	...	...	...	...	...	8
Hearing Defects...	...	...	...	...	...	65
Visual Defects	...	...	...	...	...	8
Speech Defects	...	...	...	...	...	19
Motor Defects	...	...	...	...	...	8
Learning Difficulties	...	...	...	...	...	84
General Backwardness...	...	...	...	...	...	111

Distribution of available I.Q.s of maladjusted children

	I.Q.											Totals
	below 50	50— 59	60— 69	70— 79	80— 89	90— 99	100— 109	110— 119	120— 129	130— 139	140 & above	
Boys	1	7	12	28	61	64	45	37	18	6	2	281
Girls	2	3	3	11	17	21	22	11	4	3	1	98
Total	3	10	15	39	78	85	67	48	22	9	3	379

Mean I.Q. 94.63

*Maladjusted Children Retarded in Reading
Discrepancy between Reading Quotient and Intelligence Quotient*

	15+	20+	30+	40+	Totals
Boys ...	17	33	21	8	79
Girls ...	3	3	1	1	8
Totals ...	20	36	22	9	87

Percentage of Total Maladjusted Children: 22.4

Visits:	Ordinary Schools	...	175
	Special Schools	...	53
	Remedial Centres	...	5
	Training Centres	...	10
	Audiology Clinics	...	15
	Other Clinics	...	4
	Children's Homes	...	2
	Home Visits	...	25

Nortonthorpe Hall Hostel for Maladjusted Boys:

It is with regret that one hears of the impending departure of the Warden and Matron, Mr. and Mrs. Gilpin, in July, 1966, for health reasons. Their interest in the boys and the establishment of a stable homely environment for the maladjusted youths has formed the basis on which many of the successes have been achieved.

The whole of the Child Guidance clinic staff including the consultant psychiatrists meet each term at a case conference under the chairmanship of the Senior Administrative Medical Officer for the School Health Service. Mr. Gilpin outlines the progress of the individual boys and this is equated with the reports from the psychiatrists and social workers. Provisional conclusions are reached as to which boys may be ready for discharge from Nortonthorpe and the psychiatrists bring forward the cases to be considered for possible admission. Subsequently a further meeting is held at the hostel with Mr. Gilpin, Dr. Smith, Mr. Skinner, the psychiatric social worker who maintains close liaison between Nortonthorpe and the other workers, and Mr. G. Richardson of the Education Department. At this meeting discharges are finalized and potential admissions are given priority according to the apparent urgency.

Although the hostel was originally intended for comparatively short stay cases the shortage of places in schools for the maladjusted has resulted in more severely disturbed boys being admitted. Some boys have remained until the normal age for leaving school as it has not been possible to modify the home background.

Boys are admitted from the age of 8 years and spend an initial period in the reception class of the hostel before going out to the local primary or secondary school. During the time the boy is resident at the hostel, the Child Guidance teams endeavour to assist in modifying the home environment so that the child can return. Unfortunately this is not always practicable. The problem is illustrated by the type of background shown in the cases of the 23 boys at the hostel in December, 1965:

Environmental Background of Pupils on roll: December, 1965

Broken home	...	...	10
Psychosis in parents	...	...	2 (fathers)
Parents "delinquent"	...	...	1
Poor home conditions	...	...	6
Parental rejection	...	...	3
Parental "over-protection"	...	...	1

For the last two years the Chief Education Officer has undertaken a survey of the ex-pupils and the Youth Employment Officers have followed the boys up after leaving school until the age of 18 years. The following outline of subsequent progress is based on these periodic reports together with information received elsewhere. It does not cover all the former pupils, but lists 93 in all although no information is available to date in 15 cases. Of these 13 are still of school age and reports would have been forthcoming had the boys shown a recurrence of severe difficulties.

I. *Discharged from Nortonthorpe whilst of School Age*

A. *Still at School*

1. *Agreed discharges by Admissions and Discharges Panel*

(a) *"Rehabilitated"*

Settled into school well ... 7

Regression: truancy, erratic behaviour,
poor attenders ... 4

No reports to date ... 5

(b) *Withdrawn for absconding etc.*

Committed to Approved Schools (in-
cluding two who only stayed a few
days) ... 6

No reports to date ... 5

2. *Withdrawn by parents*

Satisfactory reports ... 3 (one child only in
Nortonthorpe for
1 month)

Satisfactory after initial difficulties ... 2 (one boy had 1
term only at
Nortonthorpe)

No reports to date ... 3

B. *Now left School*

1. *Agreed discharges by Panel*

(a) *"Rehabilitated"*

Satisfactory employees ... 12

Satisfactory after initial difficulties ... 5

Unemployed after repeated changes of
job ... 2

Later committed to Approved Schools 2

(Subsequently—Unsatisfactory employee—1)

—In psychiatric hospital—1)

Lost sight of ... 1

(b) *Transferred to Schools for the E.S.N.*

Satisfactory in repetitive job ... 1

Unsettled: repeated changes ... 1

In psychiatric hospital ... 1

(c) *Withdrawn for absconding etc.*

Frequent changes of jobs. Now settled
(was at Nortonthorpe 1 month only) 1

Unemployed after frequent jobs ... 1

Transferred to Approved School—
now satisfactory employee ... 1

2. *Withdrawn by parents*

Satisfactory employees ... 6

Satisfactory after numerous changes ... 4

Unsatisfactory employees ... 3

Admitted to Rampton Hospital ... 1

II. *Left Nortonthorpe at 15 years of age*

(Duration of stay 1—5 years)

Satisfactory employment	...	...	7
Unsettled at first, now satisfactory (one had period in Detention Centre)			5
Still unsettled in employment	...	...	1
No report	...	...	1

Types of Employment

The following gives some indication of the types of employment taken up by some of the boys:—

Army (2); mining trainees (6); labourers (6); carpenter (1); scrap metal dealer (1); warehousemen (2); salesman (1); machine operators (2); pie-maker (1); lamp maker (1); tyre fitter (1); rolling mill worker (1); glass blowers (2); pattern maker (1); cotton carrier (1); bobbin collector (1); van boy (1); chicken dresser (1); shop assistants (2); textile worker (1); packer (1); haulage hand (1); farm worker (1); warehouse assistant (1); dyer (1); shovel maker (1).

The reports indicate the numerous difficulties encountered. Despite careful screening a number of boys prove to be unsuitable whilst at school or break down after leaving: 9 are known to have been admitted to Approved Schools. Three former pupils later proved to be so disturbed that admission to psychiatric hospitals became necessary. In a number of cases withdrawn by the parents against advice, the boys had apparently settled in to both subsequent school life and employment without difficulty. One wonders to what extent the admission to the hostel provided shock therapy to the child and parents so that the factors precipitating the maladjustment were overcome. In this preliminary survey it would appear that boys leaving the hostel directly to employment generally showed a higher incidence of successful adjustment.

Mr. Pritchard, one of the Psychiatric Social Workers, has undertaken a study of 38 boys who left Nortonthorpe Hostel from 1957 to 1959. The survey gives a longer term assessment of the adjustment to life than the more recent reviews. Of the 38 boys, 19 were "normal discharges"—i.e. no longer considered to require placement (Group A) and 19 had left without approval such as withdrawal by the parents (Group B). Of the 38 boys, 22 were interviewed, 7 could not be traced, 8 gave no reply to the request and one refused an interview. 79 per cent. of Group A were seen, but only 37 per cent. of Group B.

Adjustment to the family, socially, and overall adjustment to life were assessed. In Group A 60 per cent. showed good adjustment compared to 30 per cent. in Group B. 13 per cent. of Group A showed poor adjustment and 30 per cent. of Group B.

Of the 12 boys in both groups who had been in trouble up to entering the hostel 10 had had no further conviction for over 3 years before the survey—a "success" rate of 83 per cent.

It is of particular interest, in view of the other studies on environmental factors, that only 5 of the 22 families had resolved their problems which had had an important bearing on the decision to admit the boy to the hostel. In five cases other siblings had shown symptoms of maladjustment after the initial boy's placement.

The Warden of the hostel was asked to predict the subsequent prognosis of each boy before the survey commenced and it is notable that the prediction was correct in 15 of the 22 boys interviewed (68 per cent.) and partially correct in a further 5.

The parents were asked to comment on their opinion regarding the value of the hostel and child guidance clinic treatment. Fifteen commented that the hostel had helped considerably, but only 7 considered that child guidance had been of much value partly because shortage of staff resulted in insufficient sessions for attendance.

Educational attainment was difficult to assess as it was based on information from the parents, but 14 boys appear to have shown definite improvement. In subsequent occupations the boys generally had better work records than had been expected.

The survey demonstrated the need for a sufficient length of stay at the hostel to allow time for the boy's re-adjustment as revealed in the higher success rate in Group A.

THE PSYCHOTIC CHILD:

Further interest was stimulated in the work with the autistic and psychotic child following a one-day conference held in Sheffield in October, 1965 and representatives of the medical and nursing staffs attended together with mental welfare officers, psychologists and psychiatric social workers.

In Division 22 a survey was commenced in October, 1965 of all non-communicating children. These are referred by the nursing staff to medical officers for screening. After eliminating other defects such as hearing loss, mental sub-normality, or delayed speech, cases are referred to Dr. F. J. S. Esher, a consultant psychiatrist specially interested in the autistic child and seconded for this purpose by the Sheffield Regional Hospital Board. Pædiatric help can also be obtained from the Sheffield University when chromosome or genetic studies are required.

The Divisional Medical Officer reports on the initial stages of the survey:—

“The purpose of this survey is to find autistic children at the earliest possible stage, with the idea at the back of our minds that if they can be found early then a form of treatment similar to the present recognised form might be more successful.

A meeting was held in the Divisional Office, High Green, on the 2nd July, 1965, at which Dr. Russell and staff, Dr. Simpson Smith, Dr. Esher, Consultant Psychiatrist, and Dr. K. Holt, Consultant Pædiatrician, introduced the subject to the Health Visitors of the Division and they were shown one or two autistic children. As a result of the meeting it was decided that our survey should be one to discover the *Non-Communicating Child*. This was to avoid any idea that the Health Visitors were to diagnose early autism. As the Consultants most concerned with these children are not at all clear how early autism presents, this was thought to be a wise move. It was agreed that any child referred by the Health Visitor would be screened by the medical staff of the Division, and that any that they were unsure about would then be seen by Dr. Holt, and finally by Dr. Esher.

Two snags became apparent quite soon after this meeting. The Health Visitors had obviously fallen into the predicted trap and were not referring non-communicating children. They were, in fact, looking for, and not finding autistic children. Therefore a second meeting was called in December, 1965, to try and get them back on the right lines. Since then a total of eight children have been referred. The first of these has been seen (not diagnosed as autistic); the others will be seen in the next few weeks.

The second snag that cropped up was the impending departure of Dr. Holt to London; this has since taken place and Dr. R. R. Gordon, Consultant Pædiatrician in Sheffield, has agreed to take over his role. Now that this is settled we can get on to see the children a bit more quickly."

The cases known in the West Riding up to 16 years of age on the 31st December, 1965, were 35 boys and 16 girls as follows:—

<i>Children showing evidence of "Autism"</i>								<i>Boys</i>	<i>Girls</i>
<i>Pre-school age:</i>									
At home	...	...	...	...	...	...	...	2	—
Attending Training Centre	...	...	...	...	...	...	...	1	—
<i>School age:</i>									
At home: refused Training Centre	...	...	...	...	...	...	...	2	—
Withdrawn from Training Centre for behaviour problems	...	...	...	...	...	...	...	1	—
On home tuition as best provision	...	...	...	...	...	...	...	1	—
Attending Training Centres	...	...	...	...	...	...	...	7	4
In-patients at hospital awaiting transfer to school catering for autistics	...	...	...	...	...	...	...	—	2
At Day Schools for the educationally subnormal	...	...	...	...	...	...	...	1	1
At Day Schools for the educationally subnormal, but awaiting admission to Special School for autistics	...	...	...	...	...	...	...	2	—
At residential school for educationally subnormal	...	...	...	...	...	...	...	1	1
At Special Schools for autistics	...	...	...	...	...	...	...	3	—
At ordinary school awaiting Special School for autistics	...	...	...	...	...	...	...	2	—
At ordinary school awaiting admission to school for maladjusted	...	...	...	...	...	...	...	1	—
At ordinary school awaiting admission to psychiatric unit	...	...	...	...	...	...	...	1	—
In hospitals for the subnormal	...	...	...	...	...	...	...	1	4
Total								26	12

Children showing aggressive and over-active behaviour with no evidence of normal development

Pre-school (at home)	...	...	...	...	...	...	...	1	—
Attending Training Centre	...	...	...	...	...	...	...	2	1
At home: withdrawn from Training Centre by parents	...	...	...	...	...	...	...	—	1
								3	2

Aggressive Subnormal Epileptics

Trial ordinary school	...	...	...	...	...	...	...	1	—
Attending Training Centre	...	...	...	...	...	...	...	1	—
In hospitals for the subnormal	...	...	...	...	...	...	...	2	1
At home (discharged from Training Centre for difficult behaviour)	...	...	...	...	...	...	...	—	1
								4	2

						Boys	Girls
<i>" Borderline Psychotic "</i>							
At day school for educationally subnormal	...	...	...	...	...	1	—
<i>Under Investigation</i>							
Attending ordinary school	...	...	...	...	...	1	—

Buzzers for Bedwetters:

This service continues to increase. The apparatus is loaned to the parents from the Divisional Offices on medical recommendation.

If organic causes for enuresis are excluded this method of treatment is very effective in a high proportion of cases and the beneficial effects to the child and family are marked.

Foot Infections:

Periodic press reports of parents complaining that barefoot activities in school lead to verruca infestation of the feet continue to draw attention to this perennial problem. The medical journals during the year carried much correspondence on the topic and it was fully discussed by the School Health Services Group Council. One dermatologist approached the Authority claiming that the higher incidence of verrucæ in girls was due to the fact that boys did not carry out barefoot activities. The Chief Education Officer however reported that at Infant and Junior levels equal numbers of boys and girls take indoor P.E. in bare feet. At the secondary stage fewer boys than girls do it, but a considerable number of boys do barefoot work.

It is rather unfortunate that so much attention has been focussed on plantar warts (verrucæ) where the pathology is rather obscure. The causative factor is a virus and the incubation period is very prolonged: from several months to as much as 21 months. It is therefore very difficult to blame activities in school for the incidence of the infection as it may well be picked up in the home or elsewhere. It has also been postulated that the virus may gain access to the body via the upper respiratory tract rather than locally.

There is therefore no scientific evidence to support the claim that barefoot activities have a significant influence on the spread of plantar warts.

Treatment is somewhat unsatisfactory, many clearing spontaneously. Simple occlusion is painless, safe, and often effective and cuts down any risk of infecting others.

Fungus (tinea) infections of the feet receive less publicity, but the pathology is more clearly understood. Spread of infection is encouraged by communal bathing facilities; inadequate drying between the toes; and standing around on wet floors in bare feet. Although anti-fungicidal preparations readily overcome the condition it may often go unrecognised or unreported.

Barefoot activities on properly treated floors such as halls or gymnasia with smooth surfaces and no cracks in which epithelial debris can lodge carry little or no risk of spread of tinea infections.

To prevent the spread of tinea infections attention must be paid to the cleanliness of all areas which remain wet e.g. swimming bath surrounds and changing room floors. Bacteriologists recommend the daily use of detergents and sterilizing solutions in addition to daily cleansing with hot water.

It is hoped, shortly, to issue instructions to all P.E. instructors advising them on the general supervision of children's feet following discussions with the officers of the Education Department.

The School Ophthalmic Service:

During the year Dr. T. Priestley was appointed by the Leeds Regional Hospital Board to undertake the Ophthalmic Service in the Skipton area in place of Dr. T. S. Severs who had retired. Dr. Priestley also holds a weekly clinic in Keighley. The Regional Hospital Board also agreed that Dr. D. J. Hopkins should undertake work in the clinic at Pontefract where there was a considerable waiting list.

Details of the examinations during 1965 and a comparison with previous years are as follows:—

<i>Year</i>	<i>No. of children examined (including re-examinations)</i>	<i>No. prescribed glasses</i>
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
1964	20,248	8,904
1965	20,304	8,590

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, 1965:—

Type of Clinic	Number	
	Provided directly by the Authority	Under arrangements with Regional Hospital Boards
Minor Ailment and other non-specialised	94	—
Dental	64	—
Ophthalmic	—	59
Speech Therapy	26	—
Ultra Violet Light	16	—
Pædiatric	15	15
Chiropody	5	—
Consultant E.N.T.	—	18
Consultant Orthopædic	—	16
Consultant Dermatology	—	1
Consultant Cardiac	—	1
Orthoptic	—	4
Remedial Exercises... ..	12	1
Audiology	2	1

A number of Consultant E.N.T. Clinics and Orthopædic Clinics were closed during the year. Mr. S. Kavanagh and Mr. H. M. Jones were withdrawn from the E.N.T. clinics at Shipley and Horsforth when the new Eye and Ear Unit was opened at Bradford. In the Doncaster Division arrangements were made for Miss R. D. Dunsmore to incorporate the E.N.T. clinic with her normal out-patient sessions at Doncaster Royal Infirmary. Similarly the West Riding Clinic at the Rotherham Hospital has been discontinued and West Riding cases are now attending the hospital out-patients sessions. Patients previously seen by Mr. A. Naylor at the Shipley Orthopædic Clinic are now being seen by him at the Bradford Children's Hospital and the last session held at the Shipley Clinic was in March.

These changes are mainly due to the shortage of available time by the Consultants, the need to centralize their work and the improved facilities being provided at the hospitals and the need for more intensive investigations than were possible at the clinics. These factors are appreciated and a close liaison remains between the Divisions and the Hospital Consultants.

Minor Ailment Clinics:

The number of children treated for minor ailments continues to decline. In 1965, 6,147 children were seen; in 1964, 9,249.

Consultant E.N.T. Service:

No. of sessions held during the year ...	210		
		<i>Pre-school Children</i>	<i>School Children</i>
			<i>Total</i>
No. of individual children seen by consultant, including those continuing attendance from previous year	48	918	966
No. of above referred for operative treatment ...	21	379	400
No. of children:—			
(a) who obtained operative treatment during year	11	388	399
(b) treated at school clinics	—	12	12
No. of attendances at consultant clinics ...	56	1,310	1,366

Consultant Orthopaedic Service:

Consultant Clinic

No. of sessions held during the year	145		
	<i>Pre-school Children</i>	<i>School Children</i>	<i>Total</i>
No. of individual patients seen by consultant, including those continuing attendance from previous year ...	347	666	1,013
No. of above—			
(a) referred for operative treatment as short-stay cases only ...	12	30	42
(b) recommended long-stay hospital school	—	—	—
(c) recommended treatment by orthopaedic nurse or physiotherapist—			
(i) at treatment centres ...	20	80	100
(ii) domiciliary	20	12	32
No. of children who obtained operative treatment during the year	—	16	16
Total number of attendances at consultant clinic	540	917	1,457

Treatment Centres

No. of sessions held during the year ...	1,243		
Total No. of patients treated (including cases continuing treatment from previous year)	92	502	594
Total number of attendances	1,223	4,363	5,586

Domiciliary Treatment

Total number treated	3	1	4
Total number of visits to patients' homes	11	32	43

Appliances

No. of appliances—			
(a) recommended	68	68	136
(b) obtained	66	61	127

PHYSIOTHERAPY SERVICE:

There has been one change only in the staffing position of the Physiotherapy Service since my last annual report. Mrs. R. Spencer commenced to work one session a week at the Skipton Clinic in July. At the end of the year the staff aggregated the equivalent of 1.6 physiotherapists and two orthopaedic nurses.

Ultra Violet Light Clinics:

Clinics are still held in eight of the Divisions, but the figures for 1965 show a considerable decrease in the number of sessions and children treated.

Number of sessions held during the year 587

		<i>Pre-school Children</i>	<i>School Children</i>	<i>Total</i>
Number of children treated during the year	...	68	131	199
Total number of attendances	... ..	656	1,953	2,609

Consultant Pædiatric Service:

From the 31st December, 1965 Professor Craig withdrew the services of the pædiatricians seconded by the University of Leeds to the Morley, Horsforth and Batley Divisions. As a result the pædiatric clinics held in local authority premises had to be closed. Whilst it is regretted that this link with the University was severed little difficulty has been experienced in arranging for the children to be seen at the pædiatric out-patients' departments of the local hospitals. The numbers involved have been small.

Consultant Clinics

No. of sessions held during the year 220

No. of individual patients seen—

(a) New cases	... ..	156	233	389
(b) Cases attending from previous year(s)	...	193	426	619
Total number of attendances at clinics	... ..	487	835	1,322

The following table gives details of the various types of defect or disease for which children were referred for consultant opinion:—

<i>Defect or Disease</i>								
Central Nervous System: General	...	...	...	...	...	20	24	44
Migraine	...	...	...	...	...	6	24	30
Epilepsy	...	...	...	...	...	14	41	55
Van Recklinghausen's Disease	...	...	...	...	...	1	—	1
Heart and Circulatory System	...	...	...	...	...	55	141	196
Respiratory System, including E.N.T. Defects	...	...	...	...	...	30	99	129
Speech	...	...	...	...	...	11	13	24
Orthopædic	...	...	...	...	...	6	8	14
Cerebral palsy	...	...	...	...	...	2	1	3
Skin	...	...	...	...	...	1	—	1
Psychological: General	...	...	...	...	...	3	21	24
Head banging	...	...	...	...	...	1	—	1
Enuresis	...	...	...	...	...	3	8	11
Mental Retardation, including Educational Sub-normality	...	...	...	...	...	27	29	56
Microcephaly	...	...	...	...	...	—	1	1
Congenital Deformities	...	...	...	...	...	18	15	33

						Pre-school Children	School Children	Total
Gastro-intestinal System: General	...	...	...	...	...	6	7	13
Œsophageal Stricture	...	...	...	...	...	1	—	1
Genito-urinary System	...	...	...	...	...	2	24	26
Glands	...	...	...	...	...	1	1	2
Nutritional	...	...	...	...	...	10	20	30
Developmental: General	...	...	...	...	...	94	50	144
Soiling and Wetting	...	...	...	...	...	—	1	1
Genetic Undersize	...	...	...	...	...	1	—	1
Incontinence	...	...	...	...	...	7	81	88
Muscular Disease	...	...	...	...	...	1	2	3
Rheumatism...	...	...	...	...	...	—	1	1
Habit Spasms	...	...	...	...	...	2	6	8
Obesity	...	...	...	...	...	1	3	4
Anæmia and Debility	...	...	...	...	...	1	—	1
Prematurity	...	...	...	...	...	5	—	5
Unclassified	...	...	...	...	...	34	24	58

School Health Service Aspects—Dr. C. C. Harvey reports:—

“ Over the 20 years since the end of the second war, I think at last we are finding parents no longer apologetic and ashamed to admit that their child still has a pair of tonsils. Not many years back the reaction commonly was one of feeling guilty that the dirty objects had not been eradicated before now. Parents even seemed to be ahead of doctors and medical students in coming to terms with tonsils as organs which are doing nature's job faithfully. Hospital students, however, still need to be cured of that suspicious attitude which regards tonsils as a fount of corruption to be shorn away before the child can thrive. They still think rounded juicy tonsils are fair game for surgical enterprise, notwithstanding that the child can masticate and swallow food with zest. We often hear a plea to do something drastic about the tonsils when a child gets recurring sore throats, probably due to viruses. What these people don't admit is that children may continue to get tiresome sore throats after the tonsils have been sacrificed in vain. Nobody yet has carried out an adequate controlled trial of children with similar sorts of sore throats either operated on or left unoperated on over a period from 5 to 10 years old, for comparative study.

Innocent Heart Murmurs

So many of these have been referred again this year that at your invitation I have made a special report note for circulation in 'Clinical Notes' on these perplexities. It is to be hoped that practising doctors and also senior medical students will get more clear criteria to enable them to decide on these murmurs without the perturbation of reference to consultants.

We have an increasing number of gratifying thoroughly normal post-operative correction results of gross congenital heart malformations coming through from the cardio-vascular department at Sheffield, for conditions which would formerly have meant lingering invalidism and death in early adult life. These results usually follow after several years of careful diagnostic study both as out-patient and in-patient, with increasingly precise diagnostic judgment as experience grows.

Habit Spasms

Usually the fault with fidgeting children lies in the parents, but I do not often expect such a candid disclosure as one 6 year old boy with a natterly mother recently uttered. I asked mother whether his blinks and scuffles were worse on school days or at weekends; her son broke in vehemently, 'Saturday's no good—never allowed to have playmates'.

Fits and Faints

It takes a carefully written eye witness account in the words of parents or whoever saw an attack to make a decision, and nearly always an adequate description makes a clear diagnosis. Doctors, however, commonly fail to ask the appropriate questions:—

What time of the day or night have these episodes occurred? What was the child doing at the time? Is the pattern consistent from one episode to the next?

Slumping in a swoon, waiting for breakfast to be served, almost certainly is a low blood-sugar simple syncopal fainting, which may be aggravated by infective debility. Hunger colic is commonly associated.

Anything which happens repeatedly in school morning assembly is almost certainly not epileptic. Anything, however, which happens repeatedly when close to the television screen is highly suspicious of photo-stimulation of epilepsy.

Pædiatric Psychiatry

We were taken aback during the summer with the emergency admission to hospital of a 6 year old mean-faced little sour-puss, who had refused all drink and food and communication by speech since three of her teeth had been extracted under general anæsthetic three days earlier. We unprofitably tried coaxing her for two days, and then adopted crude direct tactics of tube feeding. She responded forthwith to this assault upon her person in a highly reasonable way and was heard the next morning ordering her own menu for breakfast. Did we do wrong? Did we by-pass some important psychiatric opportunity for getting to the bottom of whatever caused her to distrust her parents, and to conclude that they had wronged her by taking advantage of her in such a deplorable way under cover of unconsciousness? Her response to the tube feeding was not that of a hysteric, but an intelligent hunger-striker who had made her protest.

School Leaving Age

I sometimes get direct approaches at my hospital clinics from new Youth Employment Officers about children for whom the Divisional Medical Officer already has full files of copies of hospital reports. It is my practice always to leave the advising of Youth Employment Officers to the School Medical Officers, and in these cases I redirect the enquiry to the Divisional Medical Officer."

Consultant Cardiac Clinic:

Dr. N. V. Hepple reports as follows on the Cardiac Clinic at Harrogate:—

"The Clinic exists to investigate and to give authoritative advice on these defects and their management and has saved many children from unnecessary invalidism during its years of operation.

It is held weekly in the Out-Patient Department of Harrogate General Hospital and is staffed by Dr. W. S. Suffern, Consultant Cardiologist, Dr. L. J. Prosser, Consultant Pædiatrician, Dr. M. Polson, Senior Assistant County Medical Officer, a health visitor and a shorthand typist from the Divisional Office.

A full investigation, including radiography and electrocardiography, is made in each case and the results are available for the family doctor and the school medical officer involved. Advice is also given to the school and the parent about the management of the child.

During 1965, 23 new cases were seen, including children from the Wetherby and Horsforth Divisions.

There were 241 attendances made by 188 patients altogether. 12 children were seen by Mr. Wooler at two special sessions held at Harrogate; 16 children were attending the Leeds General Infirmary for further investigation or were awaiting operation during the year.

Two children attended Leeds for cardiac catheterisation and one had ligation of a patent ductus arteriosus."

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 during the year 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
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
1964	434,790	8,696	2.0
1965	461,862	8,999	3.2

In some areas a system of "Selective" inspections has been introduced as suggested in *The Health of the School Child* 1962/63.

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)
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		
1964	70,895	70,485	99.42	410	0.58		
1965	75,134	74,728	99.46	406	0.54		

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 September, 1965 was 177,512 compared with 164,507 in October, 1964. This represents 69.61 per cent. of children in attendance.

Medical Examination of Entrants to Training Colleges:

In connection with their applications for entry to Training Colleges, 1,622 students were medically examined during the year by the School Medical Officers, compared with 1,372 for the year 1964 and 1,265 for the year 1963.

Children and Young Persons Act, 1933, Employment of Children:

Under the Authority's bye-laws relating to the employment of children, 1,152 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. 18 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:

During the year several discussions took place between the Senior Administrative Medical Officer for the School Health Service and the Youth Employment Officer and his senior staff on the implementation of the working party report on "The Handicapped School-Leaver". As a result modifications of the forms issued by medical officers when examining school leavers giving information on defects likely to affect employment were introduced. It was agreed that the general form Y.C.6 (Med) need only be completed if the pupil showed some relevant defect instead of as a routine for all leavers. This has resulted in a reduction in the amount of unnecessary clerical work. The form Y.C.6 (Med) Handicapped has been enlarged to include a supplement indicating the degree of handicap in the limbs etc. which will be of assistance to the youth employment officers in placement in industry. Both forms have been introduced as an interim measure, as it is anticipated that new forms will be introduced nationally in the near future.

A joint meeting was also arranged between the senior youth employment officers and mental welfare officers. This was addressed by Mr. Miles, Dr. Jeremiah and Dr. Smith and stimulated liaison in assisting the placement of the educationally retarded child in industry.

Protection of School Children against Tuberculosis:

TUBERCULIN TESTING OF ENTRANTS:

In three Divisions of the West Riding tuberculin testing of younger children is carried out on an experimental basis. A total of 2,290 children (1,521 entrants and 769 in the 7—8 years age group) were tested, of whom 25 gave initial positive reactions. Five 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 — +	
Keighley (Heaf Test)	665	657	8	5	— 3	Referred to Chest Physician.
Spennborough (Jelly Test) (Entrants) (7—8 years age group)	715	704	11	—	10 1	2 children and 13 contacts referred for X-ray. No new cases of tuberculosis discovered.
	769	768	1	—	— 1	
Wath upon Dearne (Jelly Test)	141	136	5	—	— 5	Referred to Chest Physician. Negative on retest.
	2,290	2,265	25	5	10 10	

During the year, and not included in the above table, serial tuberculin testing of school children has been carried out in the Todmorden Division and Dr. Gordon, the Divisional Medical Officer, reports as follows:—

“Tuberculin testing of school children between the ages of 8 and 12 years, i.e., those born from 1952—1956 inclusive, was again carried out in this division of the West Riding in 1965, as requested by the Department of Education and Science.

The results are set out in the following tables:—

					Year of birth				
					1952	1953	1954	1955	1956
Number of children eligible ...	...	...	...	...	612	419	214	650	684
B.C.G. vaccination previously ...	...	...	...	...	13	10	8	32	26
Known natural positives ...	...	...	...	...	57	54	20	21	—
Acceptances ...	...	...	...	...	373	342	177	567	632
Number tested ...	...	...	...	...	335	281	160	492	553
<i>Results</i>									
Negative ...	...	...	...	...	313	268	155	480	534
Positive + ...	...	...	...	...	20	12	4	12	10
++ ...	...	...	...	...	1	—	1	—	5
+++ ...	...	...	...	...	1	1	—	—	4
++++	—	—	—	—	—
Total naturally positive ...	...	...	...	...	79	67	25	33	19
Percentage positive ...	...	...	...	...	20.2	20.0	13.9	6.4	3.6

1965 results compared with those of 1963 and 1964:—

Year of Birth	Percentage positive in		
	1963	1964	1965
1950	17.0	—	—
1951	13.0	16.1	—
1952	10.9	11.1	20.2
1953	15.2	15.8	20.0
1954	11.1	11.7	13.9
1955	—	4.5	6.4
1956	—	—	3.6

This table shows that there has been no appreciable change in the reactor rate in children born in 1954 and 1955, but there is considerable increase in the rate for 1952 and 1953. In the case of the 1952 group this figure is again influenced by the lower consent rate at this age when the tuberculin test is a preliminary to B.C.G. vaccination. The 1953 age group has been consistently above average since this survey started and I do not know any explanation of why this should be so.

Of the 58 children recorded as having +1 group reactions in 1965, 29 were conversions having been recorded as negative in previous tests. Some of these children come from schools which were last tested in 1963 using an unsatisfactory type of Heaf gun which proved to be unreliable. None of these cases were followed up.

6 children showed a +++ reaction and of these 1 was a conversion having been negative when last tested some 16 months previously. All these children and 28 of their home contacts were investigated without finding any evidence of disease or any source of infection.

A most significant feature of this survey is the marked differences in the reactor rate for children born after 1954. This supports the contention that the high percentage of reactors found here in previous years has been to a large extent due to milk-borne infection, as this part of the County became a 'Specified Area' in November, 1957."

THE SCHOOL DENTAL SERVICE

The following is the report of the Principal School Dental Officer—Dr. D. Davies

Staff:

Compared with the staffing position in 1964 the School Dental Service suffered a slight reduction in the numbers of both Dental Officers and Dental Auxiliaries and this is reflected in the nature and quantity of work done.

On 31st December the full-time dental staff in post and the authorised establishment were as follows:

	<i>Staff</i>	<i>Authorised Establishment</i>
Chief Dental Officer	1	1
Orthodontic Consultant	1	1
Senior Clinical Dental Officers	5	5
Area Dental Officers	12	18
Dental Officers	32	45
Dental Auxiliaries	6	10

In addition there were eight part-time dental officers, being the equivalent, in sessions worked, of 2.6 full-time Dental Officers. These figures represent a decrease of two full-time and two part-time Dental Officers compared with the position at the beginning of the year.

Recruitment of Dental Officers to the service during the year was reasonably satisfactory and the decrease is due to a larger number of retirements than is usual in any one year and to the sudden death of an Area Dental Officer, Mr. R. K. L. Gilchrist. Two Dental Officers left the service to enter general practice and one to enter the service of another local authority.

The number of half days devoted to the School Dental Service was 25,403 being a reduction of 952 compared with the previous year, (each full-time Dental Officer works approximately 450 sessions per year). There were 905 additional evening sessions worked.

Although there were six Dental Auxiliaries in post at both the beginning and the end of the year there was the equivalent of only three throughout the year. Two left the service very early in the year and another was absent on maternity leave. Two auxiliaries were appointed in September, but one returned to her home in London after a few weeks. Another was appointed in the middle of December.

There were a number of education successes among the staff. Three Dental Technicians obtained the City and Guilds Certificate in Advanced Orthodontic Technology (six of our Technicians now hold this certificate and one also has the certificate in Maxillo-Facial Technology). Six Dental Surgery Assistants entered for the Examination for the Certificate of the Examining Board for Dental Nurses and Assistants and all were successful at their first attempt. This was a very creditable achievement as classes in dental nursing are not available at technical colleges in the West Riding. Surgery assistants were helped by their Dental Officers and those in the Brighouse area formed themselves into a class and were instructed by Mr. W. A. Allen, Senior Clinical Dental Officer. The very satisfactory results throw credit on the skill and ability of the Surgery Assistants and also on Mr. Allen's teaching and I think reveal that the standard of dental surgery assisting in the West Riding is a high one.

Three Dental Officers attended post-graduate courses during the year. One attended a course in anaesthetics at Sheffield University and two a course in orthodontics at Keele University. The Authority's Orthodontic Consultant, Miss R. Sclare, was one of the speakers at the Keele course. In addition to this the internal courses of post-graduate instruction given by the Chief Dental Officer and the Senior Clinical Dental Officers have continued, the only new subject to be covered was the intravenous induction of anaesthesia of which mention is made later. Negotiations were commenced with the University of Leeds Dental School for the provision of a post-graduate course, in matters relating to Public Dentistry, specially for the Dental Officers of this Authority.

Clinics:

Four new dental clinics came into operation during 1965, at Skipton, Garforth, Thorne and Mexborough. All of these were dual-surgery clinics built on the same lines as other recent clinics and equipped to the same high standard. At Skipton dental treatment was formerly provided by a mobile unit, and with the opening of a fixed permanent clinic in the centre of the town, fully comprehensive treatment became available. With mobile clinics difficulty is experienced in providing general anaesthesia and those forms of treatment which require attendance over a long period of time such as the provision of dentures following extractions and the supervision of orthodontic work.

Before the Thorne Clinic was constructed such of the school children who desired school dental treatment had to travel ten miles to Doncaster. Because of this and the fact that in the Thorne area there are about five thousand children the dental clinic got off to a very vigorous start and it quickly became an institution in the town. The demand at Mexborough is equally great, but staffing problems in the area limited the work that it was possible to do there. The Garforth clinic opened more slowly, but the town is expanding rapidly and it is expected that the amount of work will increase particularly when the comprehensive school at present under construction adjacent to the clinic is finally completed. On 31st December there were 99 surgeries available to the School Dental Service and 98 were actually in use. The exception was at Rawmarsh where staffing problems made it impossible to maintain a service.

As there was no increase in the number of Dental Officers it was not possible to increase the number of mobile dental clinics which remains at five. All five were in use during the year and together they were worked for 1,068 sessions.

Inspections:

It will be noticed that the table at the end of this report differs radically from that of previous years. This table constitutes the major portion of a statistical return which is required by the Department of Education and Science at the end of the year. This return has been re-designed in order to make the statistics comparable with those of the General Dental Service and the major change is a sub-division of the figures according to the ages of the children. These are now in three groups: children aged 5—9, 10—14, and 15 and over. In previous years the number of children inspected was sub-divided into those inspected at periodic inspections and those as specials. In the new table the inspections are divided into those carried out at school and those carried out at the clinic. Not all periodic inspections are carried out at school and not all first inspections at the clinic are specials, so that these figures are not comparable with those of previous years.

During 1965 approximately 276,000 children were in attendance at maintained primary and secondary schools. Of these 179,496 were inspected during the year a reduction of approximately 4,000 on the previous year. The fact that some hundred thousand children were not inspected during 1965 does not mean that some such number were neglected. The figure merely indicates that on average children are being inspected about every eighteen months. In some areas the interval is greater than this and in others it is much less.

A new figure is included in the table showing the number of pupils who were re-inspected during the year and this shows that in some areas the Dental Officer has reduced the period between inspections to less than twelve months. The number of children re-inspected was 21,665. Of the total number inspected, 99,264 were offered treatment and 64,533 subsequently attended for treatment, 4,451 received more than one course of treatment and 176,071 attendances were made, an average of three per patient.

Treatment:

For most of the year there were two Dental Officers and three Auxiliaries less than in 1964 and this accounts for the fact that for the first time for five years there was an overall reduction in the work carried out. Compared with the 162,791 inserted in the previous year there was a drop of 2,417 in the number of fillings. The reduction, however, is so small as to indicate that the actual number carried out by each Dental Officer and Dental Auxiliary in post actually increased although it appears that the increased output due to modernisation of equipment is now levelling off.

Another indication that there was a reduction in staff is the fact that the number of general anaesthetics increased by 1,726 to 25,435 and the number of extractions increased by 4,797 including 960 more permanent teeth. There was also a disappointing reduction in the specialised work of crowns and inlays. The number of pupils supplied with artificial teeth was 486 and 735 dentures were supplied. The new table shows an interesting breakdown of dentures provided for school children. This shows that 27 children were supplied with full dentures, one of them being under the age of ten.

The demand for orthodontic treatment continues unabated. While 3,152 patients were carried over from 1964, 2,053 new cases were commenced compared with 1,714 new cases in the previous year.

The two thousand new cases represent 7.4 per cent. of the children at risk in West Riding schools. As approximately half the children accept treatment from the School Dental Service this is equivalent to about 15 per cent. of the children at risk who are patients of the school service. In the whole of England and Wales new orthodontic cases commenced in all services, the General Dental Service, the Hospital Service and the School Dental Service, totalled approximately 160,000 or 23 per cent. of the children at risk. It appears therefore that even now all the orthodontic treatment required in the West Riding is not being carried out.

During the year the intravenous anaesthetic techniques commenced in 1964 were continued and developed, in all about eight hundred patients were treated in this way, the youngest being aged four years. Patients who refuse 'gas' and

yet are considered unsuitable for local anaesthesia accept this method of induction enthusiastically as do their parents who have been agreeably surprised that intravenous anaesthesia is available in school clinics.

Work of the Laboratory:

The following items of work were undertaken in the Laboratory during 1965, including work for expectant and nursing mothers on behalf of the Health Committee.

Full Dentures	Partial Dentures	Repairs	Inlays and Crowns	Orthodontic Appliances
370	982	383	476	3,727

The total number of items was 5,938 compared with 5,777 in 1964. In addition 5,124 orthodontic study models were made.

Because of the increase in the amount and complexity of the work of the laboratory the Divisional, School Health and Dental Services Sub-Committee approved an alteration in the establishment allowing for an increase of one in the technician grade and a reduction of one in the apprentice grade. The new establishment is one chief technician, one technician in charge, nine technicians and two apprentices. Although advertisements for the vacant post of dental technician were inserted in trade journals and local newspapers it proved impossible to recruit the additional technician required. Whitley Council conditions for the employment of dental technicians allow no more than two annual increments above the base of the salary scale to be given to new entrants to the service in respect of past experience, however long, if the experience has been outside the Public Service. Such applications for the vacancy as were received were from married men with many years experience in the General Dental Service to whom the salary that could be offered was not attractive. From every point of view it is best if technicians can be trained as apprentices in our own laboratory and it was surprising that it also proved impossible to recruit an apprentice to fill a vacancy in the establishment. Because of the shortage of technicians during the year it was necessary for 1,884 hours overtime to be worked.

The Technical Advisory Panel on Dentistry of the Leeds Regional Hospital Board, of which the Chief Dental Officer is a member, discussed a suggestion of the Ministry of Health that all practical training of dental technicians might be given in approved hospital or local authority dental laboratories; that training of apprentices be reduced from five to three years and that training be concentrated at about 10—12 geographical centres throughout the country. The Panel agreed that there was a shortage of dental technicians and that it would be necessary to provide a supply and that although it would be practicable to increase training facilities it would not be possible in the region to do this on the scale suggested by the Ministry of Health. It would be impossible to provide training facilities for dental technicians for general dental practitioners.

Health Education:

Three major campaigns were organised during the year. In April a five-day campaign was held in the area served by the Penistone clinic, originally it was intended to hold an exhibition in seven of the larger schools, but in the event it was found that the distances between schools in the Penistone area are so

great that such a scheme would be quite impracticable, as the children would have to spend extremely long times on buses and in many cases bus services are infrequent and sometimes non-existent.

The plans therefore were changed and the exhibition actually visited fourteen schools. The number of children seen in schools varied enormously, approximately 1,100 being seen at the largest and eight being the total population of the smallest. The greatest co-operation was received from the head teachers, staff and senior pupils at all schools and particular pleasure was expressed by the head teachers of some of the small schools that their pupils had been included in the campaign.

The exhibition was based on three stands, each with a lecture, the first being on the value of building foods and cleaning foods, the second on tooth morphology, the progress of dental caries and the importance of regular tooth brushing, and the third on the necessity for regular visits to the dentist, with simple explanations of the basic principles of dental treatment. When infant schools were visited, a different technique was adopted and the children sat on the floor grouped round one speaker who delivered a talk lasting approximately twenty minutes in which the principles of oral hygiene were explained in as simple a manner as possible. It is estimated that approximately three thousand children were seen during the week.

In July a campaign spread over ten days was held in the Wakefield Rural District. The form of this was similar to that in the previous campaigns, in which a small exhibition and speakers were transported to some of the larger schools, and the neighbouring small schools were invited to attend. It is considered unlikely that this system will be used in the future, as complications tend to arise when the weather is bad. It seems preferable for future exhibits to be taken to every school in the area concerned. In the present instance a total of nine schools were visited by the exhibition and a further fifteen schools were present by invitation. As each school concluded its tour of the exhibition the head teacher was given pamphlets to enable any interested member of the staff to follow up the instruction given, and these booklets were invariably accepted with great interest. Eight members of the dental staff took part in this campaign and at one time it almost appeared that some malign influence was attempting to sabotage the venture for several of the staff concerned were afflicted by acute personal problems during the course of the campaign; but it is pleasing to be able to say that in spite of all difficulties it was felt that the campaign in no way suffered and thanks and congratulations are due to those of the staff who cheerfully shouldered extra burdens and thereby helped to assure the success of the operation.

A dental health campaign was held in the areas of Slaithwaite and Uppermill at the end of September and beginning of October. Three days were devoted to Colne Valley High School and one day to the Saddleworth Secondary School. Other schools in the area were seen at the rate of two or three per day depending upon the size of each school.

For the two larger schools the method adopted was that that had been used in previous campaigns in which three stands are set up with a speaker to each. The visit to the Colne Valley High School was particularly worthy of note in view of the exceptionally high degree of co-operation and assistance received from the school. Their efforts made it possible to deal with the large number of children at the school quite comfortably in the time allotted to it. For the

remaining smaller schools a different technique was adopted in which a display was set up at one end of the school hall and a large number of children were seen. In two cases this meant the entire school was seen at once, but more usually the schools divided and the infants and juniors were seen separately. A talk lasting between twenty minutes and half an hour was then given to each group. The advantage of this method is that time is available for questions and the number and variety of questions posed by each group proved most gratifying if somewhat difficult to answer in certain cases. About 3,500 children were seen during the course of this campaign.

These larger campaigns were organised by Mr. Metcalfe, Area Dental Officer, and taking part were the Dental Officers of the districts concerned and their Dental Surgery Assistants and three of the Dental Auxiliaries. In addition to these, low intensity techniques in dental health education were carried out by the Dental Auxiliaries in their own divisions throughout the year particularly as a follow-up in areas where large campaigns had previously been held. A good deal of apparatus and equipment and literature has now been accumulated at the Central Clinic much of which is borrowed on occasion by Dental Officers particularly interested in this form of preventive dentistry.

Epidemiological Survey:

The Public Dental Service is an inspection and treatment service, but in contradistinction to the General Dental Service, it is concerned not only with individual sufferers from dental disease, but with the dental state of the community as a whole. It might be expected therefore that a prime requisite would be an accurate knowledge of the extent and distribution of the diseases with which it is to deal. In fact the knowledge we have is meagre.

A number of studies have been undertaken in recent years by various bodies for specific purposes, in particular those in connection with fluoridation of water supplies and with the value of fluoride tooth paste. These have been very accurate, but have been carried out only in a few isolated areas.

The Department of Education and Science has organised in seven local authorities' areas quinquennial surveys of the prevalence of dental decay in five year old and twelve year old children. These are of interest, but of limited use practically. No information whatsoever is available as to the extent and distribution of disorders other than decay.

Ideally one would like to know the prevalence and distribution of dental disease together with the incidence in each year of age throughout school life from 5—14. In the past it has been impossible to obtain this information without undue expenditure of professional time, but with access to the County computer it may now be within sight. As a start it was decided during 1965 to make an accurate assessment of dental decay in two age groups, those entering primary school at age five and those aged fourteen, the majority of whom are in their final year at school. The first age group was chosen because the information to be obtained will reveal the amount of decay which occurs in pre-school children and how much of this remains untreated when the children become the responsibility of the school dental service. The fourteen year age group was chosen because at this age all the teeth apart from the wisdom teeth are in position and the survey will show the extent to which the 28 permanent teeth suffer from decay during school life and to what extent this is treated.

One will then be in a position to judge the effectiveness of the treatment provided and plan future policy accordingly. The children examined were unselected children at school who received treatment not only from the school dental service, but also from general practitioners in the general dental service. As the school dental service is responsible for the whole of the school population the extent to which it falls short of the ideal may be measured.

Approximately a thousand children in each of the two age groups were examined and the results are shown in the following table:

	Number of children	D	M	F	T	Average
Age 5	1,016	3,598	909	251	4,761	4.7
Age 14	1,143	4,782	1,543	5,865	12,190	10.7

D = Number of teeth decayed and untreated

M = Number of teeth extracted because of decay

F = Number of teeth filled

T = Total number of teeth affected by decay

Average = Average number of decayed teeth per child

It will be seen that at the age of five each child on average has four or five milk teeth affected by decay. The vast majority of affected teeth are untreated and of those treated the majority are treated by extraction. Only 5 per cent. of affected teeth were filled. The average child of 14 years of age has ten or eleven permanent teeth affected by decay of which five have been filled, one extracted and four remain untreated.

Dental Auxiliaries:

Since 1962 when Dental Auxiliaries became available this Authority has employed eleven for various periods of time. Regular reports on these Auxiliaries have been made to the General Dental Council and in the autumn independent assessors from the General Dental Council examined and reported on their work. It seems likely that the experiment will be terminated in 1966 and a final report be made by the General Dental Council to the Privy Council. On the nature of this report will depend whether this class of dental auxiliary is to be permanent or not.

The general opinion of Dental Officers in this Authority who have had the duty of supervising Dental Auxiliaries is that their clinical work is good and adequate and that they could make a useful contribution to the dental treatment needed by school children. It is felt, however, that the regulation preventing a Dental Auxiliary from carrying out clinic work except in the physical presence of a dental officer unduly restricts their usefulness. It means for example that Auxiliaries cannot be employed where they are most needed, where there is no full-time Dental Officer and administrative difficulties are experienced when Dental Officers are absent through sickness, or leave the service and cannot be replaced. The official pronouncement on the Dental Auxiliaries experiment is awaited with interest.

General Remarks:

From 23rd to 26th March, Mr. J. G. Potter, Dental Officer of the Department of Education and Science, visited the West Riding. In this time he reviewed the service as a whole and inspected twelve clinics.

A letter from the Department was subsequently received congratulating the Authority on the high standard of its Dental Service. It was recommended however that in some of our older clinics the equipment should be modernised. Financial provision has been made for this modernisation to be undertaken in 1966/67.

A Co-ordinating Committee comprising Chief Dental Officers of the local authorities of Lancashire and Yorkshire has recently been formed, the objects of which are to consider ways and means to further effectiveness of the local authority dental services, to establish an interchange of ideas between those responsible for the efficiency of the services in the various parts of the two Counties and to provide a forum where problems and difficulties experienced in the operation of our service may be discussed.

The Committee met twice during the year, at Manchester in March and at Wakefield in September, and matters discussed included the compilation of the new returns required of the School Dental Service, the organisation of dental health education, the attendance at clinics of unaccompanied infants and the treatment of handicapped children.

During the year Mr. F. H. Sanderson, Area Dental Officer, has taken a great interest in dental photography and has now accumulated a collection of transparencies suitable for projection. These fall into two classes, one being photographs of patients and close-ups of their dentition and appliances used in treatment. These photographs make valuable records of those patients whose treatment is spread over several months and are suitable for demonstration purposes in the instruction of new entrants to the service. The second group is more general and includes photographs of clinics and surgeries and equipment and of various activities of the School Dental Service such as school inspections and dental health education campaigns. These photographs are much in demand by those Dental Officers who give talks to dental students, dental nurses, student teachers, parent-teacher associations and women's organisations.

In March, fifth year dental students at Leeds Dental School were taken on an organised visit to the Cleckheaton Health Centre where they were able to see the high standard of accommodation and equipment provided in the West Riding Dental Service.

I should like to conclude by thanking all who have helped to maintain the Dental Service and in expressing the staff's appreciation of the interest taken in their work by the Chairman and members of the Divisional, School Health and Dental Services Sub-Committee. Thanks are also due to the Education Department teaching staff on whose helpful co-operation so much depends.

Orthodontic Report:

The following is a Report by the Orthodontic Consultant, Miss Sclare:—

It is with some pride tinged with a certain amount of sorrow, that I write this, my last report on the Orthodontic Service. I shall be retiring at the end of 1966.

I have been closely associated with this service since its inception about 26 years ago, and since 1947 have been engaged full time in it. For a number of

years practically all the orthodontic treatment throughout the Riding was given by Mr. B. R. Townend and myself. Mr. Townend held clinics at Wakefield while I divided my time between clinics at Wakefield, Brighouse and Harrogate. To these clinics parents were only too glad to bring their children from all parts of the Riding even though for many it meant long and tedious journeys. Rarely did these patients miss an appointment however bad the weather.

Gradually dental officers who showed a particular aptitude and keenness for the subject were invited to attend the orthodontic clinics for instruction in diagnosis and the treatment of cases, especially of the more complex type of case, and in due course they were able to start orthodontic treatment in their own areas. This meant that more children were able to receive this treatment and it also helped to reduce the time spent on travelling for many patients. By 1959 in addition to the three original centres a certain amount of specialised orthodontic treatment, i.e. treatment involving advanced techniques, was available at eight other centres.

Other dental officers were encouraged to treat the simpler type of case so that now, with very few exceptions, most dental officers are doing some orthodontic treatment. This is good for both patient and operator. Treatment is made available for more patients, and this particular type of dentistry relieves the monotony of fillings and extractions which inevitably form the bulk of the dental officers' work.

We have always tried to keep abreast with all the latest concepts and techniques and every type of appliance is being used in our specialist orthodontic clinics.

I would like to take this opportunity to report on the work that is being done by my colleague, Mr. G. A. Thompson, who is at present engaged four-fifths of his time in orthodontics. He is now treating a number of cases with what is known as a full banded technique. This is a highly specialised type of orthodontic treatment which we have imported from America. Very few orthodontists in this country are as yet experienced in this technique. With this type of therapy many cases which hitherto were considered untreatable can now be successfully treated. We are fortunate in being able to offer this treatment to our patients.

The West Riding County Council was one of the first Local Education Authorities to establish an orthodontic service, and for many years it has been regarded as one of the finest in the country, and because of this it has attracted young officers to our service. It is therefore essential that we do all we can to maintain and indeed improve our high standard.

If the service is to be run efficiently it requires a high degree of supervision, so that dental officers can be instructed in the best techniques and waste of time and money can be prevented. Orthodontists are not just born, they have to be trained and undergraduate education is not sufficient to make an orthodontist, even though in the last few years there has been a significant improvement in orthodontic teaching in the dental schools.

This past year I have devoted more and more time to visiting dental officers especially in South Yorkshire where there is a lack of skilled orthodontists, and to supervising the work that comes into the Laboratory. Supervision in the Laboratory ensures that the best type of appliance for each case is made, and

that no unnecessary appliances are made. This results in a considerable saving of time and of money.

Since 1959 the Orthodontic Service has developed to such an extent that if it is to continue to expand and to maintain its high reputation the number of orthodontic specialists will have to be increased. With a school population of 276,000 I would think that the minimum requirements would be three full-time specialists; one central in Wakefield, one in the North part of the Riding and one in the South.

In taking my leave I would like to put on record my sincere thanks to Mr. B. R. Townend, our former Chief Dental Officer and Orthodontic Consultant, for all his help and encouragement, to Dr. D. Davies for his support and confidence in me, to all the dental staff and to Mr. Marshall and his clerical staff for their co-operation throughout all the years of my service in the West Riding and finally to Mr. Ford and all the technicians without whose co-operation and fine craftsmanship our orthodontic service would not have reached its present standard.

Dental Inspections and Treatment Carried Out during the Year:

Attendances and Treatment

	Ages 5 to 9	Ages 10 to 14	Ages 15 and over	Total
First visit	29,240	28,906	6,387	64,533
Subsequent visits	30,971	65,079	15,488	111,538
Total visits	60,211	93,985	21,875	176,071
Additional courses of treatment commenced	1,450	2,352	649	4,451
Fillings in permanent teeth	33,459	86,468	22,356	142,283
Fillings in deciduous teeth	16,854	1,237	—	18,091
Permanent teeth filled	25,248	73,351	19,715	118,314
Deciduous teeth filled	15,038	1,154	—	16,192
Permanent teeth extracted	2,619	14,080	3,129	19,828
Deciduous teeth extracted	49,042	12,390	—	61,432
General anaesthetics	16,290	8,525	939	25,754
Emergencies	2,611	1,396	380	4,387
Number of Pupils X-rayed				2,701
Prophylaxis				18,819
Teeth otherwise conserved				2,433
Number of teeth root filled				208
Inlays				112
Crowns				384
Courses of treatment completed... ..				53,774

Orthodontics

Cases remaining from previous year	3,152
New cases commenced during year	2,053
Cases completed during year	1,123
Cases discontinued during year	264
Number of removable appliances fitted... ..	3,323
Number of fixed appliances fitted	174
Pupils referred to Hospital Consultant	—

Prosthetics

	5 to 9	10 to 14	15 and over	Total
Pupils supplied with F.U. or F.L. (first time)...	1	9	17	27
Pupils supplied with other dentures (first time)	36	308	142	486
Number of dentures supplied	54	428	253	735

Anaesthetics General Anaesthetics administered by Dental Officers ... 25,435

Inspections

(a) First inspection at school. Number of Pupils	168,180
(b) First inspection at clinic. Number of Pupils	11,316
Number of (a) + (b) found to require treatment	111,139
Number of (a) + (b) offered treatment	99,264
(c) Pupils re-inspected at school clinic	21,665
Number of (c) found to require treatment	11,772

Sessions

Sessions devoted to treatment	23,589*
Sessions devoted to inspection	1,494
Sessions devoted to Dental Health Education ...	320

*Includes 1,598 Anaesthetist sessions

KEIGHLEY EXCEPTED DISTRICT

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 examination was continued and the past year's work has more firmly convinced us this is the ideal way of carrying out the School Health functions. So much so that we now believe the time has come for serious consideration to be given to the varying of the final school leaving medical inspection. This might then consist of an interview of all school leavers by a school medical officer and a subsequent thorough examination with special reference to any known or observed handicaps and the future employment of the leaver. It is thought that this is a much more economical and efficient way of caring for the school leaver. Further, now that we have had experience of the selective scheme for five years we should have an excellent and, we hope, a full and complete knowledge of all handicapped children as they are approaching the end of their school life, and from this information we should, following the final interview, be able to make the proper recommendations.

As described in last year's report the transfer of the Child Guidance Clinic to the School Clinic took place during the year. Experience of a year's work under the new arrangement has shown that this has been carried out in an excellent fashion and that every kind of co-operation has been made available to us. Nevertheless it must be emphasised that the lack of a consultant psychiatrist is a handicap. Also, we were, during the major part of the year, without a psychiatric social worker and health visitors were employed to assist the mental welfare officer.

The situation regarding consultant psychiatrists is that as an Authority we rely on services provided by the Leeds Regional Hospital Board. However, as these specialists are in extremely short supply some Authorities have made their own arrangements with consultants to carry out this work and undoubtedly by this method have improved the child psychiatric services under their control. It will also be observed from reading the Child Guidance section of the report that the amount of work carried out at the clinic has considerably increased. This is possibly due to the close ties which now exist between the general practitioners, school teachers and the staff of the School Clinic. From this point of view alone the new arrangements are well worth while. We have found some difficulty in allocating the work on statistical grounds between what is considered to be that of a school medical officer and what might more properly be regarded as the function of the Child Guidance Clinic. While we have done our best to form a line of separation it must be appreciated that the work, whether it be School Health or Child Guidance, is nevertheless concerned with the health of the school child, and the more unified this work can become under the one roof the better for all concerned. More and more now do we find that general practitioners are referring cases of maladjustment and behaviour disorders directly to the Clinic and, of course, with the attachment of the health visitor to the general practitioner we find that we more easily obtain social and sociomedical background information which is most necessary before one can deal successfully with this kind of case.

Organised Health Education in the school continues to increase, although we have not yet as many regular teaching courses going as we would like.

Towards the end of the year the Authority agreed to accede to the request of the Minister of Health to fluoridate the public water supplies in order to diminish the amount of dental decay among school children and the remainder of the population. As has been said frequently there is abundant evidence to show that this is an effective public health measure in the prevention of dental decay.

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:—

				1965	1964
Nursery	...	...	...	40	34
Primary	...	...	...	5,070	4,812
Secondary Modern	...	...	...	2,171	2,164
Secondary Grammar	...	...	...	1,242	1,319
Secondary Technical	...	...	...	466	470
Special Schools	...	...	...	97	96

TABLE I

MEDICAL INSPECTION OF PUPILS ATTENDING MAINTAINED PRIMARY AND SECONDARY SCHOOLS (INCLUDING NURSERY AND SPECIAL SCHOOLS)

A. Periodic Medical Inspections

Age groups inspected (by year of birth), number of pupils who received a full medical examination together with details of the physical condition of the pupils inspected, the number of pupils found not to warrant a medical examination in connection with the selective medical examinations and the number of pupils found to require treatment (excluding dental diseases and infestation with vermin).

Age groups Inspected (By year of Birth)	Number of Pupils who have received a full medical examination	Physical Condition of Pupils Inspected		Number of Pupils found not to warrant a medical examination	Pupils found to require treatment (excluding dental diseases and infestation with vermin)		
		Satisfactory	Unsatisfactory		For defective vision (excluding squint)	For any other condition recorded in Table III	Total individual pupils
		No.	No.				
1961 and later	38	38	—	—	—	9	9
1960	550	548	2	—	6	141	143
1959	289	286	3	—	1	86	86
1958	13	13	—	—	1	4	4
1957	352	352	—	231	62	108	151
1956	172	172	—	58	45	52	87
1955	—	—	—	—	—	—	—
1954	—	—	—	—	—	—	—
1953	—	—	—	—	—	—	—
1952	—	—	—	—	—	—	—
1951	228	227	1	—	48	28	75
1950 and earlier	396	395	1	—	97	38	122
TOTAL	2038	2031	7	289	260	466	677

Col. (3) total as a percentage of Col. (2) total ... 99.66

Col. (4) total as a percentage of Col. (2) total ... 0.34

SELECTIVE SCHEME:

The selective scheme of medical examination of children in the intermediate age groups has now been in operation for five years and more than ever has proved to be an unqualified success. 813 questionnaires were distributed during the year, of which 763 were returned. Following an examination of the completed questionnaires 143 children were invited to attend along with their parents, in 100 instances either one or other parent did attend and in one instance the child was accompanied by another relative.

Additionally School Medical Officers examined 381 eight year old children during the year and set out over are details of the defects found. It is pointed out that the character of the defects found has not varied to any great extent in recent years.

A copy of the questionnaire will be found as an appendix to this report.

Defects Found

Defect Code No. (1)	Defect or Disease (2)	R (3)	T (4)	O (5)
4	Skin... ..	2	6	3
5	Eyes (a) Vision	44	63	56
	(b) Squint	8	15	3
	(c) Other	2	1	4
6	Ears (a) Hearing	6	8	15
	(b) Otitis Media	—	5	6
	(c) Other	4	1	1
7	Nose and Throat	3	25	35
8	Speech	4	6	—
9	Lymphatic Glands	—	—	2
10	Heart	1	1	10
11	Lungs	3	3	15
12	Developmental (a) Hernia	—	—	—
	(b) Other	3	—	1
13	Orthopaedic (a) Posture	—	1	3
	(b) Feet	—	7	3
	(c) Other	2	2	—
14	Nervous System (a) Epilepsy	—	—	—
	(b) Other	1	1	—
15	Psychological (a) Development	3	3	9
	(b) Stability	—	2	6
16	Abdomen	1	2	3
17	Other	17	17	30

R = Pupils newly referred for Investigation/Treatment.

T = Pupils already under Treatment.

O = Pupils requiring observation only.

This year it was thought worthwhile to keep a record of pupils referred for treatment for the first time at the same time noting those pupils who were already receiving treatment for defects found.

B. Other Inspections

Number of Special Inspections ...	3,053
Number of Re-Inspections ...	1,185
Total ...	<u>4,238</u>

Comparative Table of Inspections carried out from 1961—1965.

Year	Routine	Specials	Re-Inspections
1961	1,641	2,865	1,464
1962	1,802	3,216	1,860
1963	1,544	3,469	1,846
1964	2,256	3,325	1,392
1965	2,038	3,053	1,185

TABLE II

INFESTATION WITH VERMIN

(i) Total number of individual examinations of pupils in schools by the school nurses or other authorised persons ...	9,967
(ii) Total number of individual pupils found to be infested ...	508
(iii) Number of individual pupils in respect of whom cleansing notices were issued (Section 54(2), Education Act, 1944) ...	—
(iv) Number of individual pupils in respect of whom cleansing orders were issued (Section 54(3), Education Act, 1944) ...	—

TABLE III

DEFECTS FOUND BY PERIODIC AND SPECIAL MEDICAL INSPECTIONS

DURING THE YEAR ENDED 31ST DECEMBER, 1965

NOTE.

All defects, including defects of pupils at Nursery and Special Schools, noted at periodic and special medical inspections are included in the following table, whether or not they were under treatment or observation at the time of the inspection.

Defect Code No. (1)	Defect or Disease (2)	PERIODIC INSPECTIONS								SPECIAL INSPECTIONS	
		ENTRANTS		LEAVERS		OTHERS		TOTAL			
		(T) (3)	(O) (4)	(T) (5)	(O) (6)	(T) (7)	(O) (8)	(T) (9)	(O) (10)	(T) (11)	(O) (12)
4	Skin	17	9	14	6	8	3	39	18	73	29
5	Eyes— <i>a.</i> Vision ...	8	3	145	48	107	56	260	107	902	387
	<i>b.</i> Squint ...	27	2	10	1	23	3	60	6	104	20
	<i>c.</i> Other ...	5	—	3	—	3	4	11	4	15	13
6	Ears— <i>a.</i> Hearing ...	13	9	6	1	14	15	33	25	43	53
	<i>b.</i> Otitis Media ...	9	18	4	2	5	6	18	26	17	28
	<i>c.</i> Other ...	16	—	4	2	5	1	25	3	25	6
7	Nose and Throat ...	55	65	4	3	28	35	87	103	53	91
8	Speech	32	8	1	—	20	—	53	8	90	35
9	Lymphatic Glands ...	5	3	—	1	—	2	5	6	3	12
10	Heart... ..	5	9	5	6	2	10	12	25	6	49
11	Lungs	17	25	4	5	6	15	27	45	69	77
12	Developmental—										
	<i>a.</i> Hernia ...	3	1	—	—	—	—	3	1	1	2
	<i>b.</i> Other ...	2	15	—	—	3	1	5	16	9	24
13	Orthopaedic—										
	<i>a.</i> Posture ...	1	1	1	—	1	3	3	4	18	7
	<i>b.</i> Feet ...	18	9	3	6	7	3	28	18	57	15
	<i>c.</i> Other ...	22	5	1	3	4	—	27	8	38	27
14	Nervous System—										
	<i>a.</i> Epilepsy ...	2	—	1	3	—	—	3	3	11	13
	<i>b.</i> Other ...	—	3	1	1	2	—	3	4	4	10
15	Psychological—										
	<i>a.</i> Development ...	4	3	—	—	6	9	10	12	165	126
	<i>b.</i> Stability ...	8	4	3	11	2	6	13	21	67	105
16	Abdomen	7	4	1	2	3	3	11	9	6	26
17	Other... ..	19	49	7	20	34	30	60	99	68	124

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 during the year.

A. Eye Diseases. Defective Vision and Squint

	Number of cases known to have been dealt with	
	1965	1964
External and other, excluding errors of refraction and squint ...	37	55
Errors of refraction (including squint)	230	148
Total	267	203
Number of pupils for whom spectacles were prescribed	132	111

During the year 213 cases of defective vision and 17 cases of squint were examined by the visiting Ophthalmic Surgeon. In addition 37 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 7 cases existing spectacles were considered to be satisfactory, in 51 cases spectacles were not thought to be necessary and 9 cases were referred to the Bradford Eye and Ear Hospital.

The number of repairs to and replacements of spectacles amounted to 223.

B. Diseases and Defects of Ear, Nose and Throat

	Number of cases known to have been dealt with	
	1965	1964
Received operative treatment:		
(a) for diseases of the ear	—	—
(b) for adenoids and chronic tonsillitis	152	104
(c) for other nose and throat conditions	8	10
Received other forms of treatment	78	74
Total	238	188
Total number of pupils in schools who are known to have been provided with hearing aids		
(a) in 1965	—	—
(b) in previous years	11	—

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 previously the examination of children in the "at risk" categories produced more cases of defective hearing for a smaller number of tests carried out than did the routine examination of the seven year old school child. However, it is still thought that both have a place in the scheme at least for the present. Of the twenty-six children referred to the Otologist for investigation four had their tonsils removed, three had their adenoids removed and two had other forms of operative treatment. Three children were referred for further investigation, in two cases no form of treatment was advised and in twelve cases no report has so far been received. The table below shows the results which were obtained from testing with the Pure-Tone Audiometer.

Children Tested by Pure-Tone Audiometry

	No Number Tested	No appreciable hearing loss	Referral for investi- gation	Already attending Otologist
<i>" At risk " categories</i>				
(i) deafness in the family ...	1	-	1	-
(ii) prenatal causes:—				
maternal rubella ...	-	-	-	-
other conditions ...	-	-	-	-
(iii) perinatal causes, <i>e.g.</i> toxæmia, anoxia, kernicterus, rhesus incompatability, prematur- ity, etc.	-	-	-	-
(iv) postnatal:—				
congenital defects ...	-	-	-	-
cerebral palsy ...	-	-	-	-
middle ear disease ...	10	5	5	-
meningitis or encephalitis	-	-	-	-
speech retardation or defect	3	3	-	-
educational retardation ...	8	7	1	-
Routine test on children in 6/7 year age group ...	634	621	11	2
Referred for possible hearing loss...	55	47	8	-
	711	683	26	2

C. Orthopædic and Postural Defects

	Number of cases known to have been treated	
	1965	1964
(a) Pupils treated at clinics or out-patient departments	171	190
(b) Pupils treated at school for postural defects ...	—	—
Total ...	171	190

Mr. Skinner, Physiotherapist, reports:—

"The Department has been renamed during the year from Orthopædic to Physiotherapy. The change it is felt, gives a truer picture of the scope of the service offered to the Borough. The term Orthopædic, covering only a part of what we do.

The work of the Department, as in previous years, remains fairly constant. A steady flow of children being recommended for treatment from within our own Health Department and from the Orthopædic, Chest and Pædiatric Departments of the Hospital.

During the year, the amount of work done, has unfortunately fallen in quantity, due to my absence through illness. This has resulted in a larger waiting list than normal.

The Swimming Class continues to be held on Friday mornings and has fulfilled its object in assisting many children to overcome physical and mental handicaps, and become reasonably proficient swimmers. In this work we have had the able assistance of Mrs. Jackson, the Borough Swimming Instructress."

The following shows details of the work undertaken by the Authority's Physiotherapist.

<i>School Children</i>							<i>No. of Cases</i>	<i>Attendances</i>
Asthma	...	...	...	...	...	...	3	43
Athetoid	...	...	...	...	...	...	1	27
Benign Hypotonia	...	...	...	...	...	...	1	21
Breathing	...	...	...	...	...	...	59	845
Bronchitis	...	...	...	...	...	...	3	37
Curly toes	...	...	...	...	...	...	4	72
Flat feet	...	...	...	...	...	...	26	289
Manipulations	...	...	...	...	...	...	4	89
Physiotherapy Exercises	...	...	...	...	...	...	1	7
Postural drainage	...	...	...	...	...	...	3	57
Posture	...	...	...	...	...	...	55	409
Remedial exercises	...	...	...	...	...	...	5	92
Spastics	...	...	...	...	...	...	6	113
<i>Pre-school Children</i>								
Spastics	...	...	...	...	...	...	1	30

Consultant Orthopaedic Clinic :

Number of sessions held 9

*Pre-school School
Children Children*

Number of individual patients seen by consultant, including those continuing attendance from previous year ... 10 58

Number of above—

- (a) referred for operative treatment as short-stay cases only — —
- (b) recommended long-stay hospital school — —
- (c) recommended treatment by orthopaedic nurse or physiotherapist—
 - (i) at treatment centres — 24
 - (ii) domiciliary — —

Number of children who obtained operative treatment during the year — —

Total number of attendances at consultant clinic 11 77

Treatment Centres:

Number of sessions held 400

Total number of patients treated (including cases continuing treatment from previous year) 1 171

Total number of attendances 30 2,101

Domiciliary Treatment:

Total number treated — —

Total number of visits to patients' homes — —

Appliances:

Number of appliances—(a) recommended — —
(b) obtained — —

D. Diseases of the Skin (excluding uncleanness for which see Table II):

								Number of cases known to have been treated	
								1965	1964
Ringworm—(a) Scalp	...	...	...	...	...	...	...	—	—
(b) Body	...	...	...	...	...	...	...	—	—
Scabies ...	...	...	...	...	...	...	...	4	11
Impetigo ...	...	...	...	...	...	...	...	20	36
Other skin diseases	...	...	...	...	...	...	...	143	157
Total ...	...	...	...	...	...	...	...	167	204

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:

	<i>Number of cases known to have been treated</i>	
	1965	1964
	Pupils treated at Child Guidance Clinics ...	152	51

Location of clinic:

School Clinic,
147, Skipton Road,
Keighley.

Number of sessions held during the year 144

	Boys	Girls	Total
Number of new cases seen...	89	40	129
Number of cases referred from previous year ...	19	4	23
Total number of cases discharged or admitted for residential treatment ...	50	24	74
Number of cases carried forward...	58	20	78

The staff of the Clinic included the Medical Officer, an Educational Psychologist, a Psychiatric Social Worker (until her resignation in April 1965) and a Mental Welfare Officer. Owing to the part-time services of the staff all personnel have not always been able to be present at the same sessions. But at the Monday afternoon sessions, the Medical Officer, the Educational Psychologist and the Social Worker (i.e. Psychiatric Social Worker or Mental Welfare Officer) have been able to work together and confer. At the Thursday afternoon sessions the Medical Officer and the Social Worker have been able to work together. Extra sessions have been contributed by the Educational Psychologist for the purposes of making psychological examinations and by the Social Worker for home visiting. The number of sessions given by the Medical Officer has been adjusted to meet the demand, and by the end of the year it was found that four sessions per week were required. These sessions were held on Monday, Wednesday, and Thursday afternoons and Wednesday mornings. By taking these measures the waiting time for non-urgent cases has now been reduced to approximately two months.

One hundred and fifty two cases were examined and/or treated by the members of the Child Guidance Team either separately or together. It should be mentioned, however, that some of these cases would probably in ordinary circumstances have been examined by a School Medical Officer. But by bringing these children to the Child Guidance Clinic it has meant that the waiting list for children requiring ascertainment has now been cleared. It is anticipated that in the year to come the Child Guidance Clinic will not need to serve this purpose.

The seventy eight cases now on the register to be carried forward into next year are almost all cases undergoing psychotherapy or are in need of psychiatric support. Four of these cases are already receiving residential treatment which had been recommended prior to 1965. No new cases have been referred for residential treatment in the year 1965.

Referrals to the clinics have been made by Pædiatricians, General Practitioners, School Medical Officers, Health Visitors, Magistrates, Teachers and Probation Officers as well as directly by the parents themselves. Conversely the same people as well as many others, have been very co-operative in the work of the clinic and have assisted in the management and treatment of many of the cases. We are grateful to them for their help. The good liaison which exists between the various agencies and people concerned with Child Health and Welfare has been an outstanding feature of the year's work.

A wide variety of behaviour and nervous disorder has been encountered during the year, including cases of school phobia, sexual disturbances, delinquency and psychosomatic disorders. There has been a steady referral of pre-school children by General Practitioners and Health Visitors, for behaviour disorders and suspected retarded mental development which has frequently been associated with emotional deprivation. Several adolescents have also been treated for depressive states of varying degrees of severity.

The value of voluntary placement in a Day Training Centre for mentally retarded children has become apparent during the year. One child whose behaviour indicated severe mental subnormality at the age of two and a half years has now become sufficiently socially adjusted to be admitted to an ordinary school at the age of 5 years, although she will probably require education in a Day Special School for E.S.N. pupils at the age of 7 years. Similarly another child for whom the same procedure was adopted (i.e. Training Centre until age 5 years, then ordinary school) will be transferring to a Day Special School for E.S.N. pupils in September, 1966. There are two other children between the ages of 5 and 7 who are unsuitable for education in the ordinary school at this stage and are attending the Day Training Centre on a voluntary basis and the Clinic for Guidance, with a view to admission to a Day Special School for E.S.N. pupils at the age of 7 years.

There are many advantages in the practice of a School Medical Officer indulging in the work of a Child Guidance Clinic. By being in possession of intimate knowledge of local conditions and schools the entire behavioural field of the child can be surveyed. Also by working closely with other School Medical Officers poor attenders and other cases can remain under observation in school.

The inclusion of the Mental Welfare Officer in the Child Guidance Team has proved to be a very satisfactory arrangement. Not infrequently it has been found that a member of the family of a child referred is already under the care of the Mental Welfare Officer or is found to be in need of her services. In this way too the Child Guidance Clinic has become well integrated with the Mental Health Service of the Borough.

F. Speech Therapy:

	<i>Number of cases known to have been treated</i>	
	1965	1964
Pupils treated by speech therapists	—	140

G. Other Treatment Given:

	Number of cases known to have been dealt with	
	1965	1964
(a) Pupils with minor ailments	718	778
(b) Pupils who received convalescent treatment under School Health Service arrangements	6	11
(c) Pupils who received B.C.G. vaccination	415	466
(d) Other than (a), (b) and (c) above—Ultra Violet Light ...	17	31
Total	1,156	1,286

17 school children received ultra violet light treatment at the School Clinic, all of whom had been discharged at the end of the year. Through the inter-availability of clinics 2 pre-school children also received ultra violet light treatment and both of these had been discharged at the end of the year. Altogether 56 sessions were held at which 264 attendances were made.

Special Educational Treatment in the Ordinary School:

During the year eleven new cases and four old cases, making a total of 56 pupils were ascertained as being in need of Special Educational Treatment in the ordinary school.

Care of the Handicapped Child:

Details of the number of handicapped pupils are given in the following table:—

TABLE V

	New Ascertainments	Re-Ascertainments	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	—	—	—	3	1	—	—
Deaf Pupils	1	—	—	—	3	—	—
Partially Deaf Pupils	1	—	1	5	1	—	—
Educationally Subnormal Pupils	9	3	13	98	2	—	—
Epileptic Pupils	—	—	1	1	—	—	—
Maladjusted Pupils	—	—	—	—	9	—	—
Physically Handicapped Pupils ...	1	—	2	3	7	—	—
Pupils suffering from Speech Defect	—	—	—	—	—	—	—
Delicate Pupils	1	—	1	—	1	—	—
Total	13	3	18	110	25	—	—

BRAITHWAITE DAY SPECIAL SCHOOL:

Ninety-eight children were attending the Braithwaite Day Special School at the end of the year which was the same number as at the end of the previous year. Twenty-five extra-district children are now attending this school, the remainder being referred from schools situate in Keighley. There is unfortunately a waiting list for admission to this school.

The school continues to satisfy a much felt need and the teaching staff there are undoubtedly doing valuable work in ensuring that the pupils are given as much education as possible to fit them for their future life in the community.

MENTALLY SUBNORMAL CHILDREN:

One child was reported as being "unsuitable for education in school" under the provision of Section 57(4) of the Education Act, 1944, as amended, and fifteen children as requiring "care and guidance". Five children were also admitted to a Day Training Centre on a voluntary basis during the year.

Nutrition:

Arrangements were continued for the issue of branded foods free of charge in 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:—

			1965	1964
Maltoline—8oz. tins	...	...	4	8
Vitamin B Tablets	...	...	50	—
Vitapan—4oz. bottles	...	...	53	95

Nocturnal Enuresis:

During the year thirteen children suffering from nocturnal enuresis were issued with an Eastleigh Warning Device on loan and of these four 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
895	95	118	17	657	8

Of the eight cases found to be positive five had been previously vaccinated with B.C.G. and the remainder were referred to the Chest Physician for further investigation and/or observation.

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	845
Number found to have been vaccinated previously	3
Number of acceptances	470
Percentage of acceptances	55.82

Pre-vaccination Tuberculin Test—

Number of children tested...	470
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Result of Heaf Test:

(i) Positive 54, (ii) Negative 415, (iii) Not ascertained 1.

Percentage positive	9.34
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Vaccination—

Number vaccinated...	415
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Included in the above figures are 45 immigrant children who were tuberculin tested as part of a full medical examination which was undertaken as soon as possible following their admission to school.

B.C.G. VACCINATION OF SCHOOL CONTACTS:

During the year, another separate testing and B.C.G. vaccination programme was carried out. This concerned the school contacts of a boy discovered to have quite severe adult-type tuberculosis. The boy was referred to the Chest Physician by the family doctor because of a persistant cough. He is still under treatment.

The figures relating to this contact testing and vaccination programme are set out below:—

Acceptances—

Number of children offered tuberculin testing and vaccination if necessary ...	...	...	...	...	...	...	...	321
Number found to have been vaccinated previously ...	...	...	...	...	...	...	...	17
Number of acceptances ...	...	...	...	...	...	...	...	264
Percentage of acceptances	86.84

Pre-vaccination Tuberculin Test—

Number of children tested...	264
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Result of Heaf Test:

(i) Positive 22, (ii) Negative 242, (iii) Not ascertained 0. ... 264

Percentage positive	8.33
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Vaccination—

Number vaccinated...	236
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In his follow-up of positively re-acting contacts the Chest Physician has found one case of tuberculosis and in addition one case of pleural effusion and four cases of hilar adenitis are being kept under observation.

Health Education:

This aspect of the work has continued to develop and there are now approximately ten schools where Health Education could be described as a routine procedure, whilst many more schools are visited as necessary for isolated teaching sessions on specific subjects. The basic aim is unchanged, in the Junior Schools, to try to encourage an interest in the principles and practice of healthy living, and in the Senior Schools to concentrate on parentcraft, home-making and accident prevention. In our opinion the best results have always

been obtained when Health Education is dealt with on a routine basis of either weekly or fortnightly sessions, and we find that this is particularly so in the Senior Schools since in this kind of teaching-learning situation the relationship which develops between all concerned is more likely to encourage discussion. So far most of our efforts in the Senior Schools have been at the request of the Headmaster, and chiefly concerned with the lower intelligence groups, and this is probably the most important section of the school population from our point of view; it should not however, be assumed that the more intelligent children are not in need of this kind of instruction, for in our experience they are.

During the year we organised a Home Safety Essay Competition for schools, eighteen schools competed, and there were 940 individual entries. Prizes were awarded to four age groups and in addition a Challenge Cup was presented to the school with the best entry. The main purpose of the competition was to educate the school child in Home Accident Prevention, and the Health Visitors and Teaching staff of the schools concerned spent a great deal of time and effort on this aspect of Health Education.

The Health Visiting staff continue to visit schools for the purpose of giving instruction regarding the adverse effects of smoking, and in addition this subject is always incorporated in the syllabus for the routine teaching course. We have supplied posters and leaflets etc. on this subject to the schools at regular intervals.

Medical Examination of Entrants to Training Colleges:

Sixty-eight students were medically examined in connection with their applications for entry to Training Colleges as compared with sixty-five in the previous year.

Children and Young Persons Act, 1933, Employment of Children:

Forty 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 sixty-one in 1964. 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 occasion 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 IV

Attendances and Treatment

	Ages 5 to 9	Ages 10 to 14	Ages 15 and over	Total
First visit	579	834	248	1,661
Subsequent visits	563	2,338	797	3,698
Total visits	1,142	3,172	1,045	5,359
Additional courses of treatment commenced	43	116	38	197
Fillings in permanent teeth... ..	722	2,979	997	4,698
Fillings in deciduous teeth	45	—	—	45
Permanent teeth filled	632	2,779	972	4,383
Deciduous teeth filled	42	—	—	42
Permanent teeth extracted	144	716	255	1,115
Deciduous teeth extracted	1,478	453	—	1,931
General anaesthetics... ..	454	349	45	848
Emergencies	71	49	16	136
Number of Pupils X-rayed				60
Prophylaxis				98
Teeth otherwise conserved				8
Number of teeth root filled				8
Inlays				11
Crowns				7
Courses of treatment completed... ..				1,684

Orthodontics

Cases remaining from previous year ...	68
New cases commenced during year ...	66
Cases completed during year	52
Cases discontinued during year	9
Number of removable appliances fitted...	116
Number of fixed appliances fitted ...	1
Pupils referred to Hospital Consultant ...	—

Prosthetics

	Ages 5 to 9	Ages 10 to 14	Ages 15 and over	Total
Pupils supplied with F.U. or F.L. (first time)...	1	—	2	3
Pupils supplied with other dentures (first time)...	3	8	11	22
Number of dentures supplied	5	11	24	40

Anæsthetics General Anæsthetics administered by Dental Officers —

Inspections

(a) First inspection at school. Number of Pupils	5,593
(b) First inspection at clinics. Number of Pupils	504
Number of (a) + (b) found to require treatment	2,759
Number of (a) + (b) offered treatment	2,752
(c) Pupils re-inspected at school clinic	562
Number of (c) found to require treatment	287

Sessions

Sessions devoted to treatment	598
Sessions devoted to inspection	41
Sessions devoted to Dental Health Education	5

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 no major developments have taken place during 1965 much thought has been given to the future.

Medical Inspections in Schools

After a detailed appraisal of routine medical inspections it is intended to introduce more selective procedures with routine screening of vision and hearing by the nursing staff. This will enable more time to be devoted to the emotional problems of the child.

Training of Medical Staff

The policy of in-service training for medical officers to enable them to undertake some specialization of duties continues and is to be extended.

Handicapped Children in the Ordinary Schools

There is still urgent need to set up a peripatetic service by teachers of the deaf to assist hearing impaired children in the ordinary schools. More individual help is also needed for educationally subnormal children in the ordinary schools and for those with minor degrees of cerebral dysfunction.

The Child Guidance Service

This is expanding slowly as recruitment of new staff is restricted by the national needs, but all parts of the County have access to some facilities.

Speech Therapy Clinics

There has been no improvement in the staffing position and there is little hope of much additional recruitment for some time.

Although no major developments have taken place during the past month, the staff has been given to the future.

It should be noted that the staff is still in a state of transition.

After a detailed appraisal of the current situation, it is believed that the staff is in a position to handle the present situation. The staff will continue to be devoted to the emotional problems of the child.

The policy of in-service training for medical officers is being extended. The staff is also working on the problem of the child.

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