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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 1966

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

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(as at 31.12.66)

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Warren, R. A. D., B.A.

White, Mrs. D. M., B.A.

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 Nurseries 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—TO THE FUTURE

to be read in conjunction with Appendices A and B

THE REPORT

An Annual Report normally describes the activities of a year just completed. This issue dealing with the year 1966 contains the usual material but an effort has been made to separate the statistics from the commentary in such a way as to make it more readable. By and large the report reflects the steady progress which has been made in all sections of the department. Members of the Committee will be aware of the great strides which have been made in the last seven or eight years and that scarcely any of the functions of the department have escaped complete overhaul and extensions of activities. I have remarked on previous occasions on the continued accumulation of new responsibilities. This is inevitable as preventive medicine extends its influence and interests. The time has now come for us to look carefully at what we are doing and if possible to reorientate our ideas and adjust our procedures in order that the future may be more clearly planned. For this reason the introduction to the report on this occasion will be forward looking rather than a description of past events.

AT THE CROSS ROADS

The need to look at our activities is one not only for our own department but for preventive medicine as a whole in this country. Perhaps there was never a time when there was so much uncertainty about the method of approach to the future, but at the same time a complete awareness that much needs to be done and of a character quite different from what we have been doing in the past. It is not the goal which is in question but the path leading to it.

A great deal of thought is being given at the present time to the method of approach. A number of official bodies are giving their attention to matters which, at first sight, do not seem to bear directly on preventive medicine but in fact, on closer examination, it can be seen that our own branch of medicine is indeed at the cross roads. A brief description of some of the background activities will illustrate the feeling of uncertainty which exists.

Royal Commission on Local Government

In Appendix A¹ of this Report I have included that part of the evidence given to the Royal Commission on Local Government by the County Council which refers to its local health authority activities. It is an attempt to argue the case for large scale planning of preventive medicine under the banner of a type of local authority based on a two tier system of the kind of which we have many years experience in the West Riding. It attempts to show there are far too many artificial boundaries between bodies responsible for health matters. Scientific health measures pay no heed to these boundaries and it is time this was recognised by local government if a progressive scheme of prevention is to be successful and easily attained. The written facts given to the Royal Commission by a number of government departments and other interested bodies, and already published, seem

generally to be in line with this kind of thinking. This would inevitably mean the disappearance of smaller authorities as we know them now. At district council level this would be a great advantage to medical officers of health by enabling them to exercise more even control over environmental hygiene matters. At local health authority level it would lead to an easier pattern of liaison with Executive Councils and Regional Hospital Boards, and to speedier and more uniform progress of development and training of staff. Naturally these matters are of great concern to preventive medicine and a satisfactory solution to the administrative problems involved is eagerly awaited.

Royal Commission on Medical Education and the Committee of the General Medical Council on the Diploma of Public Health

The new demands of preventive medicine make it necessary to look carefully at the training of medical officers in this sphere. For many years the Diploma of Public Health has been a statutory requirement for a medical officer of health. Just as general medicine has changed so has preventive medicine and the training for both needs a complete reappraisal. This is being done at the present time and in Appendix B² is reproduced the evidence given by Dr. Francis and myself to a General Medical Council Committee dealing with this problem. The document is based on research and investigation done within the department to which I shall refer later. It seems to us that it illustrates the pressures which are demanding a new type of training in public health, with greater emphasis on administration for some, but for certain other members of public health staffs facilities should be available for training in what we call clinical preventive medicine either as a separate discipline or with more emphasis on in-service training.

The recently published recommendations as to basic medical education by the General Medical Council³ reflects this broader approach to preventive medicine at the undergraduate level. In speaking of the student it says—"He should learn about the organisation of medicine, the scope of its various specialties, the role of the general practitioner, and the role of the public health services in the promotion of health."

It continues under the heading of 'Social and Preventive Medicine': "The teaching should include systematic instruction and demonstration in the community aspects of medicine and its responsibilities; the epidemiology and the demographic, social and environmental associations of disease; and the organisation of medical care and policies for the prevention of disease and the promotion of health. It is desirable that some of these aspects should be integrated in the teaching of other clinical subjects."

This is extremely important from the point of view of preventive medicine since it means that in future we can look forward to preventive medicine being taught side by side with clinical medicine so that the inter-relationship of the two can be made clear at an early stage in medical education. Hitherto training has been almost solely restricted to curative medicine and the General Medical Council advice that there should be 'a lighter and more flexible curriculum' is very refreshing. One expects from this a greater emphasis on prevention in the future.

Committee on Local Authority and Allied Personal Social Services⁴

The committee under the chairmanship of Mr. Frederick Seeböhm may vitally affect the path by which the aims of preventive medicine are reached.

Members will recall the visit which we had from members of this committee during the year and the many discussions which took place on the local authority's social services. Subsequent written comments have been submitted to the committee from the department at the former's request. The pattern of the report, of course, is not yet known, but we have some inkling of the type of thinking which is going on from a White Paper⁵ which was issued in Scotland suggesting how in that country the local authorities' social services should be run. These suggestions would make radical changes in the administrative structure of local authorities and would tend to split a number of existing departments in order to create a new social welfare department. Many of us in public health feel that this is a very retrograde step and unnecessarily splits services which are functioning reasonably well. In the case of the health department it has geared itself to the future in a manner already described and approved by the committee and the Executive Council and set out in the report *Future Developments of the Health Service and Co-operation with General Practitioners*,⁶ on which we have now been working for the last few years with satisfactory results. Radical changes such as those suggested in Scotland would make it more difficult to carry out this policy.

General Practitioner Services

A number of reports have made it perfectly clear that the future general practitioner will play a bigger part in preventive medicine. The well known Gillie Report⁷ dealing with the future of general practice states: "The central position of the family doctor mobilising for his patient all the resources of hospital and local health and welfare services give him a unique opportunity to bring out this functional unification."

The recent 'charter' for general practitioners⁸ negotiated between the British Medical Association and the Ministry in several of its aspects introduces the general practitioner still further into the work of local health authorities as in vaccination and immunisation and cervical cytology work. This, of course, is in accordance with the general policy of the County Council but means that adjustments in our own services will be needed.

Nursing Services

The training of health visitors has been reorganised in recent years by the setting up of a council for the training of health visitors with considerable powers of control. The standards of entry to the service have increased and we shall need to think about the ultimate number of fully trained health visitors we can achieve, and how much ancillary help will be required to make good the probable reduction in the number of trained health visitors. This trend is the subject of a Ministry circular⁹ and stresses the very point I have just made that we must expect to employ more auxiliary help. This is not necessarily a bad thing since the routine duties of all members of the staff should be looked at carefully to see how much work of a less skilled nature can be delegated.¹⁰ The ultimate result could well be far better than the present situation.

Similarly the district nursing service is under the microscope. The Queen's Institute of District Nursing has recently published *Feeling the Pulse*¹¹ on a review carried out on the work of the district nurse in some selected areas.

A similar paper has emanated from Scotland.¹² How justifiably one can transfer these results to other areas is uncertain but the results of both are remarkably similar to some research carried out in this department.¹³ All these reports stress that much of the district nurse's work could be done by less skilled people.

The midwifery service must also become the subject of change very soon. Domiciliary confinements are rapidly diminishing in all parts of the country and soon we will need to devise methods whereby what remains can continue to be conducted efficiently.

Recent Government publications concerning Local Government

Both the Maud Report¹⁴ and the Mallaby Report¹⁵ envisage considerable changes in the management and the staffing of Local Government. It is obvious from a mere glance at the reports that they will have their repercussions on the preventive services if the latter remain in Local Government.

General

The report which has become so well known as the Porritt Report¹⁶ now some years old deals even more fundamentally with the local health services in that it suggests a complete removal of these from local authority responsibility and placing them under area health committees which would also control the hospitals and the general practitioner services, thus uniting the three branches of the medical services which have been split since 1948 at the inception of the National Health Service Act.

The mere listing of some of the recent trends of thought which I have done briefly above makes it clear that preventive medicine is undoubtedly at the cross roads.

WHAT ARE WE DOING ABOUT IT ?

It is impossible, of course, for anyone in charge of a health department to know all the answers to the many problems which I have just hinted at. The only solid basis on which to proceed is a firm belief in preventive medicine itself, and that whatever administrative machine is devised, prevention will be needed for its own sake. Its days are far from being over and there are signs appearing daily that its importance is increasing. The West Riding County Council have gradually adopted a policy which will, in my view, meet the needs of the future under whatever banner it is carried out.

In 1964, the County Council adopted a policy of close relationship with general practitioners⁶ and the development of health centres and staff attachment and other measures detailed in this scheme have progressed rapidly and satisfactorily.^{17 18} I am sure it did not surprise members that within a short time we presented them with a review of the clinical work and of the duties and training of staff in the health department.¹⁹ This review has been accepted by the County Council as also was the accompanying document which argued the case for a changed staffing structure to meet the findings of the review.

The review had become necessary for three reasons. First there was pressure on all members of the staff caused by the active policy of development over the last seven or eight years and which had been dealt with with very little change in

numbers or types of staff. Second, the policy of co-operation with general practitioners and their closer relationship with the department had made it necessary to look at our own duties very carefully.²⁰ Third, the change in pattern of medicine itself over the last half century demands a new approach. Change in virulence and incidence of certain diseases is an example of this trend. The disappearance of gross malnutrition is another. Many of our services were still based on arrangements made to meet problems of this kind. This especially applied to the school health service. In addition there has been technical advancement leading to the possibility of more rapidly detecting of early signs of disease or disability. For example, the earlier recognition of deafness and partial hearing,²¹ of simple tests for enzyme diseases like phenylketonuria and the recently popularised test for congenital dislocation of the hip. More such tests will undoubtedly be useful in the course of time. It was also necessary to conduct this review because of the shortage of staff both medical and nursing. The National Health Service Act itself has also had a gradual impact in that the necessity to run treatment clinics by local authorities has been removed because of the availability of hospital and general practitioner services to everyone without charge.

The review describes how a number of our services such as antenatal, school health, and infant welfare work, have been analysed statistically and it indicates that we do not now require some of the arrangements which have been practised for many years to meet needs which have now disappeared or are of lesser importance. It is anticipated that as the suggestions emanating from this review are put into operation the duties of all members of the staff will be reorientated. It will be necessary in the light of these findings to be realistic and gradually remove some of the unnecessary work or employ auxiliaries to do some of the less skilled work. Even as long ago as 1926 Dr. James Kerr, sometime School Medical Officer for London and Bradford City had this to say:²² "Half the doctor's time is taken up in daily examination of healthy children and another quarter perhaps in recording trivial defects which elsewhere would be unnoticed." We still have failed to introduce selective examinations on a large scale which even then were recommended in some form by Dr. Kerr when he said: "The ideal school scheme would be frequent screening of the children by the teacher who would personally value health and teach others to do so also. The teachers first selection would again be reviewed by the school nurse and her selection by the doctor." This is not exactly how we intend to do it but Dr. Kerr had the right idea. If we look at a number of our staffing functions we may well find similar pruning can be done which will lead to a more efficient and useful service, and incidentally more satisfactory to the staff by way of concentration of effort where it is needed.

Changes in approach which are given in full detail in the review and which I do not wish to repeat here will leave the staff more opportunity to deal with many more challenging problems which have come to light or being given more emphasis in recent years. We shall need to pay more attention to preventive mental health work whether in antenatal clinics or child welfare centres,²³ to a complete revision of school medical inspection procedures and the stimulating of a much closer relationship between the school medical officer and the teacher. I am very pleased to see that this latter is now moving rapidly towards a joint effort by teacher and doctor towards the needs of handicapped children. Both education and health departments have developed a system of closer liaison in this field. Multiphasic screening should be considered provided we can be selective and adopt tests which will have a positive benefit to the patient and not merely detect something which cannot be dealt with. Someone must tackle the

sexual problems of adolescence and the looming problem of drug addiction: both are difficult and may lead us to attempt a widening of our health education programme in this field. An extension of health education is badly needed, it is a basic need of the health services but at the same time one which is extremely difficult to pursue, and I would hope that the health committee would look favourably towards an expansion of resources in this field, and to a gradual growth in whichever direction we feel that we can be of use. The problem family needs further attention and the new Bill on Family Planning, which is likely to become an Act soon, will certainly give local health authorities considerable responsibilities which they have not hitherto borne. We need to experiment too in the furtherance of the welfare of the old person and geriatric advisory clinics may soon be a reality in the county.

All these changes in attitudes towards preventive medicine need a vigorous programme of training and re-training. This we have attempted to do over the years and have been relatively successful, but it has become obvious that medical staff will need to concentrate in future more on some of the problems which I have already indicated. Soon we can expect to receive a report from the Ministry of Health, from a Committee under the Chairmanship of Sir Wilfred Sheldon, on the activities in child welfare centres. One cannot anticipate this report but changes will be suggested and I have no doubt that preventive pædiatrics will become one of our major functions. This is an added reason for concentrating the attention of the medical staff on new problems for the future. This is particularly clear when we see how general practitioners are becoming, and will become, more interested in the tasks in the health department which have hitherto been carried out by our own medical staff. This is all to the good and will lead to a better team effort being concentrated on our mutual problems. With this in mind we intend to carry out in the reasonably near future a concentrated re-training course for our own medical staff with emphasis on new and more specialised duties.

A number of the now famous post-war educational reports have also pointed out the difficulties associated with the deprived child. This is particularly evident in the Newsom and Plowden reports.^{24 25} We feel that we can be of considerable help to the Education Department with some of these problems and the Chief Education Officer and myself have stimulated activity in this direction. Here may well be a new field of usefulness for the staff.

More recently still the Yudkin report²⁶ draws attention to the problems of ensuring adequate care for children under five, a problem in which both Education and Health departments have a vital interest and which will be more readily solved in the present atmosphere of close and cordial co-operation between the departments.

THE FUTURE

It is absolutely essential that the preventive medical services of local health authorities should be given a stimulus, one might almost say a transfusion. There is a good deal of pessimism about. The following quotation from the Mallaby report¹⁵ already referred to illustrates this:—

“In written evidence the B.M.A. stated that during the last fifteen years numbers in general practice and in the hospital service had increased very considerably, whilst recruitment to the public health service had remained stationary or had fallen.” and again

“The medical practitioner in local authority service too as a clinician is at a disadvantage compared with his colleagues in the two other branches of the National Health Service in terms of salary and prospects.”

Figures recently collected in the department show that of the 40 medical officers sponsored for the D.P.H. in the last ten years one third are now no longer in public health and another third are in positions in public health for which the D.P.H. is not necessary. It seems obvious, therefore, that preventive medicine must obtain a new image. I have tried to argue the case that apart from mundane matters of personal reward there is really no need for pessimism from a professional point of view if we really believe in the future of preventive medicine, and I have tried to indicate how we might achieve success both in the foregoing comments and in other documents referred to below and in Appendices A and B.

At this stage some encouraging examples are needed. I would refer first to the computer programme with which we are deeply committed at the moment. This could completely alter the ease of administration in and the usefulness of health departments. Already we are involved with vaccination and immunisation schemes on the computer which we hope will be fully operative from its present pilot stage to a complete county scheme within eighteen months. This is an example of how the computer can be used, not only merely as a machine for doing sums but as a management tool. We are confident that eventually not only the clerical chores of this activity will be removed by the computer but there will be a definite improvement in the vaccination and immunisation state of the county. This really is an exciting prospect. Already the Treasurer has committed a number of our services to the computer: clerical jobs in connection with the Home Help service for example; but we are more interested in its management function and already we are using the computer to form a basis for the follow up of deafness tests, and with the basic information which is being fed into the machine we shall soon have the basis for forming a register of handicapped or potentially handicapped children which will be valuable for follow up and therefore early diagnosis and for other research. The only cloud on the horizon is the scarcity of technical staff to further all these ideas, but given this the future of the computer in health administration is very bright.

On the nursing side an example which is to be encouraged is the fact that staff attachment to general practitioners has led to more interesting and productive work. Most of the staff attachments to general practitioners would confirm this and the research carried out by some general practitioners in Ashford²⁷ proves beyond doubt the increased value of the home nurse to her patient when she is attached to a general practitioner.

There are plenty of indications of the bright future for the preventive medical services. A very recent one comes from the Permanent Secretary of the Ministry of Health, Sir Arnold France, in giving oral evidence to the Royal Commission on Local Government,²⁸ where he is quoted as saying:—

“As regards the services that the local authorities give, this is very much a personal view, but my personal view is that what people want is as far as possible to remain in the community, and I think the community, though perhaps a little slowly, is beginning to adapt itself and to be prepared to accept this. That being so, I would have thought that there ought over the next ten or twenty years to be quite a concentration of effort in developing the community services to enable people to live in the community, to enable old people to live longer in their own homes and then in local authority residential homes rather than go in the earlier stage into the geriatric ward of the hospital; to enable—and this of course is now possible with the new

drugs that are available—to enable people who may from time to time in their lives be in need of psychiatric treatment to spend a great deal of time out in the community, visiting the hospital if necessary as out-patients or as day-patients, but not having large numbers of mentally ill or mentally subnormal people spending 30, 40 or even 50 years in mental hospitals.

All this is going to lead to the process which has already started of a very considerable development of the health and welfare services of local authorities. That is going to mean that there has got to be not only the more obvious things such as old people's homes, nurses to go into houses, home helps. It means that there has got to be far more provided by way of training centres for handicapped people, whether mentally or physically handicapped, to provide occupations for them. A great many of them it is now found are able to do a certain amount of work, and not just work in training centres; there are jobs to be found for them, things they can do. They may not be able to earn a full living but they can earn quite a substantial part of a living. This alters the whole interest and pattern of their lives and is something which ought to be encouraged.

Local authorities are beginning to encourage that kind of development over the whole range of services which the community is increasingly being able to accept. There is the provision of hostels for half way houses for mental hospital patients coming back into the community and going out into a job; they need care at night and need a base to operate from.

All these are services which are going to be greatly developed over the next ten or twenty years. I would not hazard a guess as to what the proportion of expenditure on the health service under the different arms would be, but I am certain that in an expanding service this one will expand no less than the others, and should do."

I am grateful to Sir Arnold France for putting these thoughts so clearly.

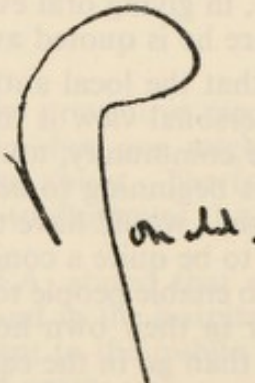
CONCLUSION

I have no doubt in my mind that preventive medicine will and must progress. I have no doubt that the very many people throughout the country who are also thinking in these terms will make sure that it will progress. What is essential, however, is that we must all be prepared for change and some of it very radical. It is sometimes difficult to accept change but this must be done.

I am very grateful to the Health Committee of the County Council for their ready acceptance of these views and for the means to further them. I am also grateful to all the staff for their forbearance, but I hope that they have been encouraged by the fact that the Perinatal Mortality Rate for 1966 in the Riding is considerably less than the national average for the first time. This is good for a northern county.

Health Department,
Wood Street,
Wakefield.

July, 1967.

 W. Ellis
County Medical Officer

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STAFF OF THE HEALTH DEPARTMENT

as at 31st December, 1966

MEDICAL STAFF

County Medical Officer and Ronald W. Elliott, M.D., M.Sc., D.P.H.
Principal School Medical Officer

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 Officers for the Child

Guidance Service ... Muriel Blackburn, M.B., B.S., D.P.M.
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 (Calder Valley) ...	N. E. Gordon, M.B., CH.B., D.P.H.
20 (Colne Valley) ...	P. M. Sammon, M.B., CH.B., D.P.H.
22 (Wortley) ...	F. C. Armstrong, M.B., B.CH., D.P.H.
23 (Hemsworth) ...	J. S. Walters, M.C., M.B., CH.B., D.P.H.
25 (Barnsley) ...	C. G. Oddy, M.B., CH.B., 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) ...	...	*R. A. McGregor, M.B., B.S., M.R.C.S., L.R.C.P., D.OBST.R.C.O.G., D.P.H. 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) ...	...	*S. H. Brock, M.B., CH.B., D.P.H. Irene M. Hazelton, 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) ...	...	Vacant
12 (Pontefract) ...	...	*J. E. Lee, M.R.C.S., L.R.C.P., D.P.H.
13 (Morley) ...	...	*Barbara Briggs, M.B., CH.B., D.P.H. Irene Hargreaves, M.B., CH.B.
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. Lorna Arblaster, M.B., CH.B.
18 (Calder Valley) ...	...	*Marie P. Milligan, B.SC., M.B., CH.B., D.P.H. G. H. Cooper, M.B., CH.B. W. C. McKerr, M.B., CH.B., B.A.O.
20 (Colne Valley) ...	...	*A. K. Rakshit, M.B., B.S., D.P.H.
22 (Wortley) ...	...	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) ...	...	Anne M. Gill, M.B., B.CH.

Assistant County Medical Officers and School Medical Officers—continued

- 26 (Wath upon Dearne) *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.
Joyce Tompkins, M.B., B.S., M.R.C.S., L.R.C.P.,
D.T.M. and H.
- 29 (Thorne) ... Vacant
- 31 (Rotherham) ... Margaret J. Hallinan, M.R.C.S., L.R.C.P.
- 132 General Medical Practitioners who act as Child Welfare Centre Medical Officers and are employed on a sessional basis. This is the equivalent of 25·12 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.
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

N. N. Agarwell, M.B., B.S., F.R.C.S., D.O.
S. K. Banerjee, M.B., B.S., 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.
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.

ORTHOPAEDIC

J. H. Annan, M.B., CH.B., F.R.C.S.
R. W. L. Calderwood, F.R.C.S., L.R.C.P.
K. S. Davies, M.B., CH.B., F.R.C.S., L.R.C.P.
N. Grewal, O.B.E., F.R.C.S., M.CH.ORTH.
G. F. Hird, M.B., CH.B., F.R.C.S.
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

C. S. Livingstone, M.R.C.P., 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., L.R.C.P.

DERMATOLOGICAL

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

PSYCHIATRIC

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

CHILD GUIDANCE SERVICE

Psychologists ... J. B. Mannix, M.ED.
D. G. Pickles, M.A.
R. I. Pilkington, B.A.
D. J. Rowlands, B.A.
H. B. Valentine, M.A.

10 Psychiatric Social Workers (5 part-time).

SPEECH THERAPY SERVICE

Chief Speech Therapist ... Vacancy.
9 Speech Therapists (7 part-time).

DENTAL SERVICE

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

County Orthodontist ... G. A. Thompson, B.CH.D., L.D.S., Dip.Orth.,
R.C.S.

Dental Specialist ... M. R. Hollings, F.D.S., B.CH.D.

Senior Clinical Dental Officers W. A. Allen, B.D.S.
J. M. Enderby, L.D.S.
H. Taylor, 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.
H. G. Thorp, L.D.S.
H. M. Yuile, L.D.S.

School Dental Officers	...	M. J. Boyles, L.D.S. J. R. Clayton, B.CH.D., L.D.S. D. Datt, O.B.E., M.B., B.CH.D., L.D.S. Joan M. Davison, L.D.S. W. H. Dyke, L.D.S. Mary M. Gibson, L.D.S. R. F. Grainger, B.CH.D., L.D.S. Edith M. M. Hague, L.D.S. M. Hattan, L.D.S. D. A. Hough, B.CH.D., L.D.S. D. H. Hoyle, B.CH.D., L.D.S. F. Kershaw, L.D.S. J. M. Laurent, B.D.S. G. W. Lawrence, L.D.S. R. B. Lawrence, L.D.S. E. Lowery, B.D.S. C. F. Martin, B.CH.D., L.D.S. J. A. E. Morris, B.CH.D., L.D.S. J. Naftalin, L.D.S. K. U. Nasir, B.D.S. R. M. O'Brien, B.CH.D., L.D.S. F. E. Okoisor, L.D.S. M. S. Ormesher, B.D.S. J. O. F. Oshuntola, B.CH.D., L.D.S. D. B. Owen, 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. P. Smith, L.D.S. D. J. Stocks, L.D.S. E. Thornton, L.D.S. P. W. Thornton, L.D.S. A. H. Wigglesworth, B.CH.D., L.D.S. J. G. N. Wills, L.D.S. 3 part-time.
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10 Dental Auxiliaries

Senior Dental Technician	J. O. Ford
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9 Technicians

2 Boy Dental Apprentice

67 Dental Surgery Assistants

NURSING AND MIDWIFERY

County Nursing Officer	...	Marjorie G. Atkinson, S.R.N., S.C.M., H.V. CERT., Q.I.D.N.S.
Deputy County Nursing Officer		Naomi I. Harris, S.R.N., S.C.M., H.V. CERT., Q.I.D.N.S.
Non-Medical Supervisors of Midwives	... ..	Norena M. Everitt, S.R.N., S.C.M., M.T.D. 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.

- 16 Divisional Nursing Officers.
- 384 Health Visitors and School Nurses (61 part-time).
- 4 Orthopædic Nurses and Physiotherapists (2 part-time).
- 6 Tuberculosis Visitors.
- 3 Venereal Diseases Social Workers (Qualified Health Visitors).
- 302 Home Nurses and Home Nurse/Midwives (15 part-time).
- 195 Midwives (3 part-time).
- 5 Matrons and 27 other nursing staff at 5 Day Nurseries.
- 10 Trainee Social Workers.

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, A.A.P.S.W.
 J. G. Jarvis
 Dorothy W. Lynes
 S. Parkinson, A.A.P.S.W.
- 52 Mental Welfare Officers
 - 1 Trainee Mental Welfare Officer
 - Organiser of Training ... Frances E. Woolley, DIP.N.A.M.H.
 - 1 Peripatetic Advisory Instructor
 - 18 Supervisors in Mental Health Training Centres
 - 119 Assistant Supervisors and other assistant staff
 - 4 Cadets
 - 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

3,046 Domestic Helps

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

HEALTH EDUCATION

- Health Education Officer ... Mary Tattersall, S.R.N., S.C.M., H.V. CERT.,
 Q.I.D.N.S.
- 1 Health Education Technician

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

358 Other Clerical Staff (including part-time staff)

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
Census, 1966 ...	...	1,228,510	499,630	1,728,140
Estimated (mid-1966)		1,238,310	510,660	1,748,970

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

Summary for 1966:

The live birth rate was 18·0; the stillbirth rate per 1,000 total births 14·4; the live premature birth rate was 66 and infant mortality 19·8 per 1,000 live births. The death rate from all causes was 12·1; from heart and circulatory diseases 4·48; cancer 2·00; respiratory diseases 1·62; tuberculosis, respiratory 0·046; tuberculosis, other forms 0·003; meningococcal infections 0·001 per 1,000 population: maternal mortality was 0·25 per 1,000 total births.

A comparison of the principal vital statistics since 1890 is afforded in Table 1 of the Appendix.

Live Births:

A total of 31,457 live births was registered which is equivalent to a crude birth rate of 18·0 per 1,000 population. During the period 1955—64, apart from a slight recession in 1959, the rate progressively increased from 15·3 to 18·5. The rate of 18·2 in 1965 and 18·0 in 1966 suggests that the peak in the upsurge of live births has been turned and we may expect the rate to remain around this level for a few years until the children of the post-war bulge era reach maturity. Further reference appears on page 66.

Deaths:

There were 21,137 deaths registered, representing a crude death rate of 12·1 per 1,000 population, the highest rate recorded since 1961. Compared with the previous year the major contributions to this increased mortality were the respiratory diseases: deaths from bronchitis increased from 1,120 to 1,488; pneumonia from 911 to 1,135; influenza from 25 to 174 and other diseases of the respiratory system from 191 to 216. Mortality from vascular lesions of the nervous system increased by 126, heart and circulatory diseases by 86 and violent causes by 50. This increased mortality was partially off-set by a reduction in malignant disease; deaths from stomach cancers were 58 fewer and cancer of the lung and bronchus 44 less.

As the age-sex structure of the population varies from area to area, crude death rates, although related to actual occurrences, do not provide an accurate comparative mortality index. To obtain realistic comparisons of mortality in the areas, weighting or comparability factors which adjust local variations are applied to the crude rates. The death rates from all causes, adjusted by the

appropriate factors were, for the aggregates of Boroughs and Urban Districts 13.3, Rural Districts 12.1, the Administrative County 12.9, which compare with the rate of 11.7 for England and Wales.

Stillbirths and Infant Mortality:

STILLBIRTHS:

The downward trend in the stillbirth rate continued. In all, 458 were registered equivalent to a rate of 14.4 per 1,000 total births: both the number and the rate are the lowest recorded and further reference is made on pages 67 and 69.

PERINATAL MORTALITY:

This term is a measure of 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. The rate continued in the downward trend which it has maintained, except for a slight remission in 1960, for the past decade; the rate of 25.1 is the lowest yet recorded. Both components contributed to the decrease from the rate of 27.3 in 1965 and although the rate now achieved affords some satisfaction, especially when compared with the national rate of 26.3, even lower rates were returned in certain parts of the County which suggests that the irreducible minimum has not yet been reached. Mortality within the group is discussed further on page 69.

INFANT MORTALITY AFTER ONE WEEK:

At ages 1 week up to 1 year there were 280 deaths representing a rate of 8.9 per 1,000 live births. The rate is slightly lower than that of the previous year (9.2) and is the lowest recorded since 1960. The number of deaths in the first four weeks of life, the neonatal period, also decreased from 1965. A total of 397 deaths were registered (438 in 1965) providing a rate of 12.6 per 1,000 live births; both the mortality and the rate are the lowest on record. It is pleasing to report that this rate of mortality too was below that experienced nationally where a rate of 12.9 was returned. The number of infant deaths in the post-neonatal period (ages 4 weeks up to 1 year) was 226 equivalent to a rate of 7.2 per 1,000 live births which was slightly higher than in the preceding year (6.8) but compares favourably with an annual average of 7.5 for the quinquennium 1961—65.

Total infant mortality was 623, representing a rate of 19.8 per 1,000 live births, the lowest yet achieved. Minor fluctuations have been noted in certain years but, as will be seen from Table 36 of the Appendix, since the turn of the century a downward trend has been apparent. Details of the cause of death and the rates at various periods under 1 year appear in Tables 37 to 39 of the Appendix.

Principal Causes of Death:

The number of deaths classified according to cause and age appears in Table 2 of the Appendix. Conforming to the experience of recent years, the most prominent causes or cause groups of death in descending order were, heart and circulatory diseases 7,839 (7,753 in 1965); malignant neoplasms 3,503 (3,583); vascular lesions of the nervous system 3,271 (3,145); diseases of the

respiratory system 3,013 (2,247); accidents, suicide and other violent causes 987 (937). In all, these causes were responsible for 18,613 deaths out of a total mortality of 21,137 (88 per cent.); the relative frequency during the past five years appears in Table 3 of the Appendix.

TUBERCULOSIS:

The number of deaths from all forms of the disease increased from the record low figure of 69 registered in 1965 to 87. The annual average of 92 deaths in the quinquennium 1961—65 however suggests that this set-back, although regrettable, may only be a temporary interruption of the downward trend. The equivalent death rates per 1,000 population were 1966, 0.05; 1965, 0.04; 1961—65, 0.05.

Mortality from respiratory tuberculosis totalled 81, which provided a death rate of 0.05 per 1,000 population, compared with 61 (0.04) in 1965 and a mean of 85 (0.05) for the period 1961—65. The age/sex distribution showed no major change from the previous year; male deaths were in the majority in the ratio of 3.8:1 with mortality heaviest at ages 55 years and over. Indeed, male deaths at these ages accounted for 64 per cent. of the total mortality from the disease. Nationally too, the disease was most frequent in the older population, which was generally exposed to the bacillus in years past. Efforts at eradication must be continued unabated, and such measures as chemotherapy, contact tracing, B.C.G. vaccination, diagnostic radiological services, and the continuing improvements in nutrition and environmental conditions, must be diligently applied.

Deaths from other forms of tuberculosis numbered six, representing a death rate of 0.003 per 1,000 population; in 1965 there were 8 deaths (0.004) and an annual average of 8 (0.005) in the period 1961—65. Mortality has reached such low levels that minor fluctuations from year to year can be expected but are of no real significance.

INFECTIVE AND PARASITIC DISEASES:

The number of deaths assigned to this group totalled 60 compared with 65 in 1965 and an annual average of 72 for the period 1961—65; the corresponding death rates were 0.03, 0.04 and 0.04 respectively.

Compared with the previous year there were reductions in mortality from syphilitic disease which decreased from 33 to 16 and meningococcal infections 3 to 1. Measles was responsible for the same number of deaths, 3, and for the third consecutive year there was no death from diphtheria, whooping cough or poliomyelitis. The number of deaths comprising the group "other infective and parasitic diseases" increased from 26 to 40 but as this is a residual group the classification to individual causes is not available.

The major variation was the reduced mortality from syphilitic disease. In common with the experience of recent years the majority of deaths from the disease related to persons 55 years or over and it is gratifying that there has been no death under 1 year since 1951. The absence of deaths from diphtheria, whooping cough and poliomyelitis too is most satisfactory but this success must not encourage any relaxation of effort to sustain our immunisation programmes at the highest level. Notifications of measles were more numerous than had been forecast but the fatalities, 3, resulted in the low case fatality ratio of 0.02 per cent.

CANCER:

Deaths ascribed to this group, including leukæmia, totalled 3,503, compared with 3,583 in 1965 and an annual average in the quinquennium 1961—65 of 3,394; corresponding death rates per 1,000 population were 2·00, 2·07 and 2·00 respectively.

Although there was a reduction of 80 deaths from the 1965 total, this must not give rise to optimism for the disease, being mainly associated with middle and old age, is likely to take an ever increasing toll of our population and the reduction recorded may be nothing more than a temporary fluctuation of the upward trend.

The number of deaths during the past six years according to sex and principal site is given in the Appendix (Table 4).

The relative contribution to mortality from the separately classified sites remains unchanged; lung and bronchus was the site most frequently concerned followed by, in descending order, stomach, breast and uterus.

The total of 783 deaths from lung cancer was 44 less than in the previous year but this reduction, although welcome, should be viewed with caution for it is the second highest level recorded. The age/sex composition of the previous year continued with male mortality in the majority in the ratio of 6:1, and heaviest at ages 65—74 years.

Cigarette smoking now suffers almost universal medical disapproval and few people can be unaware of the hazard involved. No matter how often or through what media they are warned, some people, however, still continue the habit with a head in the ground attitude of "It couldn't happen to me": their whole bodies might follow earlier than they think! Pollution of the air by coal and other fuels, as well as cigarette smoking increases the hazard of lung cancer. Intensive research is being pursued in various fields but there is no doubt that a reduction in the inhalation of carcinogens either by stopping smoking or by controlling pollution of the air from all sources will reduce the mortality from the disease.

Deaths from cancer of the stomach, 452, reached the lowest annual total recorded since the revised classification of deaths was introduced in 1950. There was a slight increase in mortality from cancer of the breast, while deaths from cancer of the uterus remained at the level of the past few years as did fatalities from leukæmia. Research continues nationally into the hazards associated with radiation and X-rays also into the ætiology of childhood cancers 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 on page 116.

VASCULAR LESIONS OF THE NERVOUS SYSTEM:

Deaths assigned to this group numbered 3,271, once again the highest annual total recorded, equivalent to a death rate of 1·87 per 1,000 population and were responsible for 15·5 per cent. of total mortality. Mortality from the disease pursued an upward trend and it is significant that since 1950 mortality has increased by 29 per cent.

Fatalities increased with age; under 45 years, deaths numbered 45, at ages 45—54 years, 93 (2·8 per cent. of the total deaths from the cause), and ages 55—64 years, 331 (10·1 per cent.), at ages 65—74, 923 (28·2 per cent.) and 75 years or over 1,881 (57·5 per cent.). Below 65 years there was a slight male excess mortality but thereafter female deaths predominated.

HEART AND CIRCULATORY DISEASES:

Numerically, this group represents the commonest cause of death year by year. In 1966 the adverse trend in mortality continued, the number of deaths reaching the highest total yet recorded. In all, 7,839 deaths were classified to this group compared with 7,753 in 1965 and an annual average of 6,703 in the years 1961—65; the resultant death rates per 1,000 population being 4.48, 4.48 and 4.49 respectively. The majority of deaths were of middle aged and elderly people; 22.3 per cent. related to persons aged 45—64 years and 75.3 per cent. 65 years and over. Male excess mortality was in evidence at all ages under 75 years, being pronounced at 45—64 years, indeed, male deaths at these ages accounted for 42 per cent. of total male deaths in this age group; thereafter female deaths were in the majority.

The number of deaths and mortality rates per 1,000 population during the past 6 years are given in Table 5 of the Appendix.

On occasions, mortality from certain diseases in the sub-groups has decreased slightly but coronary disease and angina retains its major role and continues to exact its high and increasing toll of life. It was responsible for 4,519 deaths, 39 greater than in the previous year and 435 more than the annual mean for 1961—65. In short, of the total deaths all causes, one in every five was due to this disease. The age/sex distribution conformed to established trends with appreciably high male mortality up to 74 years. There is as yet no evidence that the disease has become a "fashionable" diagnosis with the risk of overweighting at the expense of other diseases in the group and the increase must be accepted as being a true reflection of mortality.

Mortality assigned to other diseases in the group continued at a relatively high level and although the number of deaths ascribed to hypertension with heart disease and "other heart disease" increased minimally, this is thought to be a minor fluctuation within the slight downward trend.

DISEASES OF THE RESPIRATORY SYSTEM:

Mortality from this group—influenza, pneumonia, bronchitis and "other diseases of the respiratory system"—increased to register the highest annual total since 1940. In all, there were 3,013 deaths—influenza, 174, pneumonia, 1,135, bronchitis, 1,488, and other diseases of the respiratory system, 216—compared with 2,247 in 1965 and an annual average in the quinquennium 1961—65 of 2,501, equivalent to death rates per 1,000 population of 1.72, 1.30 and 1.48 respectively.

The number of deaths classified to the separate causes during the past 6 years is given in Table 6 of the Appendix.

In January and February widespread outbreaks of influenza were reported in many parts of the country. Northern parts of the West Riding were principally affected, the disease being severe among the adult population. It was significant that while mortality occurred in most age groups it was heaviest at ages 65 years and over where 145 of the total 174 deaths (83.3 per cent.) were recorded.

Pneumonia was again prevalent during the first quarter of the year and although continuing as a leading cause of death, was unrelated to notifications

and in many instances was a secondary rather than primary cause. As usual, mortality was heavy in infants under 1 year of age (7.4 per cent. of deaths from this cause), ages 65—74 years (19.0 per cent.) and among persons aged 75 years or over (59.3 per cent.).

Deaths from chronic bronchitis were the most numerous in this group. Mortality, however, indicates only part of the damage occasioned by the disease for it is a frequent and repeated cause of morbidity which represents a serious loss to the country. The number of deaths registered was 1,488 (the highest annual total since 1951) compared with 1,120 in 1965 and an annual average in the period 1961—65 of 1,240. There was an excess of male mortality in the ratio of 2.6:1 being most pronounced at ages 55—74 years; the disease being the third most common cause of death among males over 45 years. The pattern established in recent years was again in evidence, mortality being relatively high in infants under 1 year of age, negligible at ages to 44 years, thereafter progressively increasing. The death rate for England and Wales is among the highest in Europe and has not declined in the past 20 years. Intensive research has produced overwhelming evidence that cigarette smoking and air pollution are the two major factors in the causation of the disease and there is little doubt that effective measures taken against these hazards could prevent much of the ill-health, suffering, and premature mortality which the disease at present inflicts on our population. To this end, Medical Officers of Health and their staffs are persisting with their task of enforcing established and introducing further smoke control areas and, our propaganda efforts to curtail the cigarette smoking habit continue unabated.

MATERNAL MORTALITY:

The number of deaths in this group—pregnancy, childbirth and abortion—increased from 5 to 8 and was equivalent to a death rate of 0.25 per 1,000 live and still births which is in keeping with a rate of 0.26 for England and Wales. A decade ago the number of deaths for the Administrative County averaged 24 per annum representing a rate of 0.86. Now that mortality has reduced to the present low figure slight irregular variations can be expected from year to year and should be viewed as such rather than as pointers to new trends. Further reference to mortality in the group is made on page 70.

VIOLENCE:

Violent death—accidents, suicide and homicide—accounted for approximately 1 in 21 of all deaths. Mortality from the group increased from 937 in 1965 and an annual average of 965 in the period 1961—65 to 987. The number of deaths from the separately classified causes was: motor vehicle accidents 295, other accidents 493, suicide 186 and homicide 13.

Medical Officers of Health have continued to supply details of home accidents and the relative frequency of these deaths and others assigned to the various violent causes during the past 6 years is given in Table 7 of the Appendix.

Motor Vehicle Accidents:

There have always been deaths due to transport accidents: in 1912, for example, there were over 500 deaths on the nation's roads caused by accidents involving horse-drawn vehicles. It is, however, surprising for in spite of the great increase in road useage and in road traffic that the mortality rate today is slightly less than that obtaining in the early 1930's. In 1966 there were 295 fatalities compared with 301 in the previous year. Overall a heavier toll was taken of the male population in the ratio of 2.6:1, with mortality greatest in the 15—34 years age group. It is a sombre thought that at ages 15—24 years of a total of 136 male deaths, 63 (46 per cent.) were caused by motor vehicle accidents. Separate statistics of the vehicles involved are not available for the Administrative County but national records indicate that the highest mortality occurs in users of the motor cycle. Undoubtedly in the hands of the irresponsible driver this is a most dangerous means of mechanical propulsion: whereas 20 years ago only a third of the deaths on two-wheeled transport occurred on motor cycles now the proportion is two-thirds.

Home Accidents:

In comparison with the previous year, accidental deaths other than from motor vehicles increased from 452 to 493 compared with an annual average of 490 for the years 1961—65, and as usual home accidents made the major contribution—293 deaths. Fatalities from home accidents far exceed those from certain diseases which incite public protest and when combined with non-fatal accidents the disability, deprivation and tragedy to the families concerned is immeasurable. The danger periods are well known to be youth and age but in our propaganda activities attention is devoted to all accident-prone groups.

The age/sex distribution of the principal causes of fatal home accidents is indicated in Table 8 of the Appendix.

Fatalities were heaviest in the aged, indeed, 72 per cent. of the accidents related to persons 65 years and over.

The major cause of home accidents was falls which were responsible for 182 deaths or 62 per cent. of all home accidents. By far the majority of accidental falls were females at ages 75 years and over, these deaths accounting for approximately one third of all home accidents. A large proportion of the falls were returned as "unspecified" indicating the high number of these elderly people who lived alone.

Accidental poisoning by gases and vapours was the second highest cause being involved in 42 deaths, an increase of 13 over the previous year. Elderly 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 it is hoped that the introduction of non-poisonous gas into our domestic supply will avert many of these tragedies.

Accidental poisoning from solid and liquid substances continued at a high level. Twenty-three deaths were recorded the majority from barbiturates and their derivatives.

The number of deaths from burns and scalds remained at the same level of 16 deaths, coal fires were involved in 6 cases, gas fires 2, and unspecified burns 7;

the only fatality from scalding was a 5 year old girl who fell into a bath of hot water.

Inhalation of food or vomit (15 deaths) and accidental mechanical suffocation (11 deaths) although lower than the previous year were a depressing feature especially since 14 of the deaths were of infants under one year of age.

Suicide:

Suicides numbered 186 compared with 176 in 1965 and an annual average of 188 for the period 1961—65. The distribution by age/sex and agents employed is given in Table 9 of the Appendix.

As in past years poisoning was the chief method employed accounting for over two-thirds of the deaths. A finer analysis of the substances used reveals that town gas was most frequently incriminated (61 deaths) followed by barbiturates and their derivatives (60); aspirin was responsible for 5 deaths and potassium permanganate and ethyl alcohol 1 each. The remaining 7 deaths, all males, resulted from inhaling exhaust fumes from motor vehicles.

Hanging or strangulation (11 males and 6 females) and drowning (5 males and 6 females) continued at a relatively high level, there was an increased mortality due to cutting instruments (9 males), while deaths from the remaining causes persisted around the average of recent years.

Mortality was heaviest in August when 23 deaths were recorded with secondary peaks in April and May; the usual high incidence associated with the month of October was absent.

It is recognised that social isolation and loneliness may be contributory factors to the incidence of suicide and although precise information is not available as to the number of suicides who were living alone at the time of death, of the 82 females, 11 were spinsters and 21 widows.

Child Mortality:

The number of deaths of children aged 1—4 years inclusive increased to a total of 108 as compared with 89 in 1965 and an annual average of 105 in the quinquennium 1961—65. The equivalent death rates per 1,000 children living in the age group were 0.90, 0.75 and 0.94 respectively. Reference to Table 10 of the Appendix indicates that virtual control over the once traditional childhood diseases has left accidents, cancer, pneumonia and congenital malformations as the causes most numerous.

It will be seen that in the period 1911—49 the number of accidental deaths was more than halved, since when, however, they have averaged 26 deaths per annum. Of the 27 deaths in 1966, 11 resulted from motor vehicle accidents and 11 from home accidents. Of the latter deaths 3 were due to asphyxia, 2 each from falls, carbon monoxide poisoning, and burns, with 1 from barbiturate poisoning and 1 unspecified accident.

Cancer retained its relative importance, 16 deaths, 6 of which were due to leukaemia. Deaths from pneumonia reduced from 16 to 15 but there was an increase in mortality due to congenital malformations from 4 to 14, diarrhoea from 3 to 6, bronchitis from 1 to 4 and measles from 0 to 2.

CO-OPERATION IN THE HEALTH SERVICE

Many well informed people working outside the National Health Service frequently express the desire for co-operation and understanding with and information that goes on between the various branches. The word "co-operation" is an out-of-date expression in an out-of-date world. It is not the only example of a word that has become obsolete. The word "co-operation" is involved in the operation and co-ordination in which the Health Department is involved. The action of the report therefore sets out the ways in which co-operation exists between the various parts of the Department and its constituent bodies.

Co-operation with General Practitioners

STANDING SUB-COMMITTEE ON CO-OPERATION

The main instrument for promoting co-operation and co-ordination between family doctor and the health of the community is the Standing Sub-Committee on Co-operation. This was set up in 1947 as the instrument of co-operation and it is through the good office of the Sub-Committee that much of the success has been achieved in the health service. The following are the main functions of the Sub-Committee:

CO-OPERATION IN THE HEALTH SERVICE

DIVISIONAL ADMINISTRATION

1. W.R.C. (Family Doctor's Council)
2. (a) Board of Health of the County Council
(b) Public Health and Local Authorities
3. Medical Research Council
4. Health Service
5. Notes on the County Council Service
6. Day Service
7. The Year Plan
8. Annual Report of the County Council to the County Council
9. Health Service (County Council) Report
10. Health Service (County Council) Report
11. Health Service (County Council) Report
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97. Health Service (County Council) Report
98. Health Service (County Council) Report
99. Health Service (County Council) Report
100. Health Service (County Council) Report

CO-OPERATION IN THE HEALTH SERVICE

Introduction:

Many well informed people working outside the National Health Service frequently under-estimate the amount of co-operation and interchange of views and information that goes on between the various branches. The West Riding policy of co-operation with general practitioners is an outstanding example of what can be achieved when two arms of the service get together voluntarily. However, within the West Riding area this is not the only example of co-operation and co-ordination in which the Health Department is involved. This section of the report therefore sets out the ways in which co-operation is fostered between the various arms of the service.

Co-operation with General Practitioners:

STANDING SUB-COMMITTEE ON CO-OPERATION:

The major instrument for promoting co-operation and co-ordination between family doctors and the health department is the Standing Sub-Committee on Co-operation. This was set up in 1953 with the intention of promoting liaison and it is through the good offices of this Sub-Committee that much of our success has been achieved in reaching closer working arrangements with general practitioners. The Committee met on four occasions in 1966 and the following are the Agenda on each occasion:

January

1. W.R.C.C. pamphlet—An Outline of the Social Services of Interest to You.
2. (a) Booster doses of poliomyelitis vaccine for miners.
(b) Poliomyelitis and triple vaccination.
3. Medical secretaries' courses.
4. Health Notes.
5. Notes on the County Dental Service.
6. Day nurseries.
7. Ten Year Plan.
8. Annual Report of the County Medical Officer.

April

1. The Public Health (Leprosy) Regulations, 1966.
2. Immunisation:
 - (a) Measles vaccination.
 - (b) Computers and immunisation.
 - (c) Use of health visitors.
3. Communications from the Ministry of Health:
 - (a) Under-doctored areas.
 - (b) Other matters.
4. Equipment of Old Persons' Homes:
 - (a) Oxygen equipment.
 - (b) Radiant heat lamps.
5. Health Centres—definition.
6. Health Notes—distribution.

July

1. Circular 9/66 of the Department of Education and Science on Handicapped Children.
2. Home Help unnecessary visits—can General Practitioner help if patient admitted to hospital.
3. General discussion on Home Help Service in light of possible County Council action.
4. Use of Lactagol. Advice and Prescription from Clinics.
5. Revision of Immunisation Programme.
6. General discussion on Immunisation Recording etc., in light of Review Body reports.

October

1. Immunisation Procedures—Changes.
2. Medical Certification Report.
3. Requests for Medical Certificates by Education Welfare Officers.
4. Ambulance Service—Sudden Illness in the Home.
5. Co-ordination of Education, Health and Welfare Services for Handicapped Children and Young People.
6. Development of Health and Welfare Services—Services for the Elderly.
7. Medical Examination of Children in Care.
8. Health Centres—Present Position.

PREMISES FOR JOINT USE:

The continuing loss of general practitioner manpower from the Administrative Area in earlier years accelerated during the early part of 1966.

The County Council made available old and new clinics to those general practitioners who wished to work in them in association with our nursing and medical staff.

Total general practitioners providing general medical services partly or wholly within the Administrative Area

30th April, 1962	...	...	...	1,490
30th April, 1963	...	...	...	1,479
30th April, 1964	...	...	...	1,472
30th April, 1965	...	...	...	1,458
30th April, 1966	...	...	...	1,428

The list below shows those clinics and health centres in which general practitioners were holding surgeries on 31st December, 1966.

Location	Type of Clinic	No. of General Practitioners in the practices concerned	Type of Surgery
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
Cudworth... ..	C	2	Branch
Dalton	Adapted	2	Branch
Darfield	C	5	Branch
Dodworth	D	2	Main
Elland	Adapted	2	Main
Grimethorpe	C	1	Branch
Hemsworth	Special	3	Branch
Kirkburton	Adapted	2	Main
Kiveton Park	E	3	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	2	Main
South Elmsall	C	3	Branch
Southowram	Mini	5	Branch
Stocksbridge	D	2	Branch

The number of new buildings completed was again disappointing but those built were the forerunners of many in the pipeline. To date, experience has shown that the time between a new health centre project being approved in principle by the County Council to its completion and occupation is about three-and-a-half years; this is in spite of progress in standardisation both in the design and the administrative procedures. The search for sites remained the principal determinant of the speed of progress.

New buildings completed during the year were:—

	Date of Completion
‘ E ’ Type Clinics:	
Kiveton Park	18th October
Ackworth	21st December
Hipperholme	22nd December
Mini Clinics:	
Lofthouse	14th November
Linthwaite	19th December
Adaptation of existing clinics:	
Kirkburton	10th February
Calverley	13th October

Some of the above buildings have since provided main surgery accommodation for practices comprising a total of 13 general practitioners.

During the year the proposed clinics at Holmfirth, Ilkley, Knottingley, Middlestown and Castleford were reclassified as Section 21 Health Centres. In October, a Ministry circular on conditions of service was received and the principle of reimbursement of rent and rates for practice premises removed one of the greatest obstacles to participation of general practitioners in Health Centres. The number of requests from practitioners increased from that date and, at the time of writing, more than 30 Health Centres were being designed. The problem within the department has changed from that of stimulating co-operation with general practitioners to that of satisfying their large response in terms of requests for new Health Centres and staff attachments. A particularly welcome development has been the willingness of more than one practice to work together in central buildings with shared accommodation and record systems.

The Health Centre programme has brought even closer liaison with the officers of the West Riding Executive Council with whom a constant exchange of information is maintained and whose advertisements for practice vacancies now contain added details of the degree of staff attachment and availability of local authority premises to incoming doctors.

STAFF ATTACHMENTS:

The increased numbers of attachments among all three types of nursing staff are shown in the table below.

Attachments of Field Staff to General Practitioners

	No. of Health Visitors attached	No. of Home Nurses attached	No. of Midwives attached
At 31st December, 1964 ...	68	33	27
At 31st December, 1965 ...	128	47	43
At 31st December, 1966 ...	140	70	45

The general practitioners are now using the home nursing service more widely and the earlier decline in visits and patients attended was reversed in 1966 (see page 81) mainly for this reason.

A problem arose during the year concerning health visitor attachments to general practitioners whose practices straddled an administrative boundary between the West Riding and a neighbouring county borough. Analysis showed that the county borough in question would need an increased establishment of health visitors if it were to serve patients living in the West Riding and on the lists of general practitioners having their main list on the county borough side of the boundary. It seems reasonable to suppose that, in most similar areas, there will be more general practitioners having minority lists in the West Riding than in the reverse situation. A knock-for-knock agreement may, therefore, place an undue work load on county borough staff and some compensating financial arrangement across the boundary may be the ultimate solution. The particular county borough concerned decided not to proceed with attached staff working for patients outside their administrative boundary.

GENERAL PRACTITIONERS IN MATERNITY AND CHILD WELFARE WORK:

The tables below show increasing participation in traditional public health activities by general practitioners. In the infant welfare clinics, serious shortages of departmental medical officers have made this inevitable, but the joint participation of general practitioners and local authority midwives in antenatal work, both in clinics and individual surgeries, is entirely attributable to implementation of the co-operation policy. The progress in this field could be one of the factors resulting in the marked reduction in perinatal mortality which took place during the year, bringing the West Riding figure considerably below the national average for the first time.

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

				Total Doctors' Sessions	General Practitioners' Sessions	Percentage of total sessions done by General Practitioners
1963	...	...	...	12,118	5,212	43
1964	...	...	...	12,492	5,496	44
1965	...	...	...	11,761	5,844	49
1966	...	...	...	11,678	6,711	57

Employment of General Practitioners by the County Council in Antenatal/Postnatal 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
1966...	...	...	...	2,693	1,123	295	42

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	5
1966	...	...	...	58	6

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

				Sessions	No. of practices involved
1963	...	...	...	588	15
1964	...	...	...	902	25
1965	...	...	...	1,456	36
1966	...	...	...	1,643	43

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
1966	...	...	3,600	105

HEALTH EDUCATION AND THE GENERAL PRACTITIONER:

On page 85 reference is made to a pilot scheme in the Morley division of the County for encouraging general practitioners to make greater use of the health education facilities of the department. This is principally done by the supply of health education notices to be placed in general practitioners' surgeries and the regular changing of displays and posters by the attached health visiting staff.

COMPUTERS AND IMMUNISATION:

On January 1st, 1967, a pilot scheme for the handling of family doctors' and health department vaccination and immunisation records was started in two divisional areas—Keighley and Wortley. Planning for the introduction of this scheme has taken the greater part of two years and in the Autumn of 1966 discussions were held with the family doctors in both areas. At the beginning of the year some 60 general practitioners had indicated their desire to participate in the scheme. Further reference to this will be given next year.

BULLETIN FOR GENERAL PRACTITIONERS:

The Bulletin now issued to general practitioners consists of two parts, *Health Notes* issued by the County Health Department and the *Divisional Medical Officers' Newsletter* issued in each Division. *Health Notes* was first issued to general practitioners in January, 1965, but the end of 1966 was the end of the first volume.

In considering the design of *Health Notes* we took into account that in establishing such a publication the Health Department, one of the largest in the country, was writing to a body of family doctors who formed an influential proportion of the medical profession in England and Wales. It was therefore essential that *Health Notes* should have a high standard of design, layout and content if it was to be accepted by the profession locally. However, with so large a number of family doctors it had also to be borne in mind that their taste and outlook differ very considerably: many are men of wide culture, others are interested mainly in the technical aspects of medical practice; the majority are betwixt and between these two extremes. The contents of each issue are therefore varied: usually one or more topics are reviewed at some depth; other notes are factual and in the section "Random Sample" an attempt is made to make points obliquely or with humour.

At the beginning of this venture there was a need to publicise the kind of premises that the County Council was providing for joint use by the family doctor

and therefore four supplements were produced to illustrate this aspect of our work; these were:

- (1) The West Riding Mini-Clinic (April, 1965)
- (2) The Cleckheaton Health Centre (July, 1965)
- (3) The E-Type Clinic (October, 1965)
- (4) Adaptations of existing premises (July, 1966)

The local response to the supplements has been extremely good: family doctors were favourably impressed and many have subsequently inquired about the possibility of such premises being provided for them.

The illustrated supplements having been started it was obvious that there were other services of the County Council about which family doctors could be informed in the same way. For example, the orthodontic service run by the Principal School Dental Officer provides a high standard of treatment: this service was illustrated in the fifth supplement. Again the County Ambulance Service is one with which the family doctor has almost daily contact. A sixth supplement was therefore in preparation at the end of 1966 dealing with the control of the service, the types of vehicles being provided, and the training of ambulance personnel.

In order to keep the image of *Health Notes* fresh a decision was taken early in 1966 to redesign the layout, which it is hoped will lead to a more elegant and eye catching document.

Divisional Medical Officers' Newsletter

The Divisional Medical Officers' Newsletters are prepared on duplicating paper with a specially printed heading. The Divisional Medical Officers have produced letters for the issues of *Health Notes*. Their style and their content varies with the outlook of each Divisional Medical Officer and the interests and problems of his area. No attempt has been made by the County Health Staff to influence Divisional Medical Officers in any way as to the content and the mode of presentation of material in their newsletter, except in one particular. All medical officers have been asked to issue regularly through the medium of the newsletter a list of the names, addresses and telephone numbers of the local health department staff together with the information about duty rotas.

A considerable proportion of the newsletters have dealt with the County Council's policy of co-operation and the Divisional Medical Officers have used them as another means to promote local co-ordination of services. However, in addition, sanitary matters have also been mentioned including local slum clearance schemes, smoke control, outbreaks of infectious disease and swimming baths. It is clear that the Divisional Medical Officers are using this newsletter as a means of communication on a wide variety of matters of mutual interest to the family doctors on the one hand and to the Divisional Health Staff on the other.

Co-operation with Hospitals:

MEDICAL OFFICER OF HEALTH LIAISON COMMITTEES—REGIONAL HOSPITAL BOARDS:

In each Regional Hospital Board Area the principal way in which co-operation is maintained between the Regional Hospital Board and the Medical Officers of Health is by the regular meeting of liaison committees. These committees are attended by Medical Officers of Health, by the medical staff of the Regional Hospital Board and by representatives of the Ministry of Health. A wide variety of subjects are discussed.

In the West Riding we are involved in two Regional Hospital Boards, two-thirds of the population living in the area of the Leeds Board and one-third in the area of the Sheffield Board.

OTHER LIAISON COMMITTEES:

In the last two years the Ministry of Health has encouraged the setting up of liaison committees dealing with subnormal patients, the mentally ill and geriatric patients (circulars 24/65 and 18/65). Under the terms of these circulars liaison committees to encourage local co-operation between the three arms of the service have been set up. It is too early as yet to assess the work of these liaison committees but it appears that in some areas they are already having a useful effect in facilitating dealing with day-to-day problems that arise in handling patients.

MATERNITY LIAISON COMMITTEES:

Maternity liaison committees are long established local working parties. Meetings of different committees were held in Barnsley, Dewsbury, Doncaster, Harrogate, Rotherham and York. Matters discussed included General Practitioner Maternity Units—their staffing, and methods of booking; Central Sterile Supply Departments; training of pupil midwives; early discharge of maternity patients; cervical cytology programmes; and taking of blood from expectant mothers for hæmoglobin estimation.

These meetings form valuable occasions for mutual interchange of information and views, from which helpful ways of co-operation can emerge.

SMALLPOX WORKING PARTY:

At the end of 1965 a Smallpox Working Party was set up by the Leeds Regional Hospital Board as recommended in Appendix I of the Memorandum on the Control of Outbreaks of Smallpox published early in that year. The Working Party consisted of Dr. A. Hutchison, Medical Officer of Health for Kingston upon Hull, Dr. A. Telford Burn, Medical Officer of Health for the County Districts of Pudsey, Aireborough, Horsforth, Ilkley, Otley and Wharfedale, Dr. A. A. Driver, Senior Administrative Medical Officer, Leeds Regional Hospital Board, Dr. G. E. Welch, Deputy Medical Officer of Health for Leeds (Secretary of the Working Party), and myself as Chairman.

The Working Party discussed the following main points:—

The co-ordinating of activities between neighbouring authorities affected in an outbreak of smallpox, the formulation of vaccination plans in the event of an outbreak, the co-ordination of ambulance activity, and the final formulation of

a permanent working party to meet in the event of an outbreak. Broad agreement has been reached on all these points.

A similar working party was set up in the area of the Sheffield Regional Hospital Board which is still considering similar arrangements for its own area. A report on this will be given in the Annual Report for 1967.

HEALTH VISITOR ATTACHMENT TO HOSPITALS:

One means of liaison between the services which has not yet been mentioned is the assignment of staff for liaison duties with hospitals.

Fifty-nine members of staff throughout the County had liaison duties involving eighty-two hospitals. In the area covered by Sheffield Regional Hospital Board, twenty-five health visitors visited thirty hospitals, and in Leeds Regional Hospital Board thirty-four staff visited fifty-two hospitals.

In this way continuity of care is maintained for expectant mothers, premature infants, school children, diabetic patients, the elderly, and tuberculosis patients and their families.

In addition, members of staff attached to general practices normally find direct access to hospitals where needed, and access to reports to family doctors from hospitals, much more easily arranged than in the geographical method of working.

DIVISIONAL ADMINISTRATION

The divisional scheme of administration in the County was set up in 1947 and at that time consisted of thirty-one divisional areas. At the beginning of 1966 there were 23 divisions. During the year, however, the amalgamation of divisions 18 and 19 took place reducing the total number to 22. Negotiations were commenced for the amalgamation of divisions 9 and 16 which will ultimately reduce the number to 21.

The following changes have taken place in the senior divisional staff.

Divisional Medical Officers

Division No. 20 (Colne Valley)	Dr. E. Ward retired 16th August Dr. P. M. Sammon commenced 1st November
Division No. 22 (Wortley)	Dr. J. Main Russell retired 29th May Dr. F. C. Armstrong commenced 1st October
Division No. 25 (Barnsley)	Dr. R. Barnes resigned 31st August Dr. C. G. Oddy commenced 1st November

**Deputy Divisional Medical Officers and
Senior Assistant County Medical Officers**

Division No. 4 (Shipley)	Dr. G. Buckle retired 30th June Dr. R. A. McGregor commenced 11th July
Division No. 9 (Wetherby)	Dr. S. H. Brock commenced 16th June
Division No. 20 (Colne Valley)	Dr. A. Kenyon resigned 16th January
Division No. 26 (Wath upon Dearne)	Dr. J. D. Hall resigned 31st July

Divisional Nursing Officers

Division No. 4 (Shipley)	Miss M. Tattersall resigned 30th November
Division No. 13 (Morley)	Miss A. Seelig resigned 31st January Miss A. Hibbard commenced 1st July
Division No. 20 (Colne Valley)	Miss J. L. Law commenced 3rd January
Division No. 25 (Barnsley)	Mrs. C. Dyson died 9th November
Division No. 27 (Doncaster)	Mrs. A. Corless retired 31st January Miss M. E. Young commenced 1st September

A list of senior staff and other details concerning each division is given in the Appendix—Table 11.

The co-ordination of the work of the divisions is undertaken through the work of the Divisional Medical Officers' Conference which meets every month with the exception of August. All major policy and its implementation is discussed at these meetings to ensure that all senior staff may make an appropriate contribution to the consideration of policy and in addition all those problems which arise in divisions are also discussed for clarification and further action.

Senior Assistant Medical Officer and
District Medical Officer

Dr. C. Beckwith (1911-1912)
Dr. R. A. McGehee (1912-1913)
Dr. S. H. Bickel (1913-1914)

Dr. A. K. Kegan (1914-1915)
Dr. A. D. (1915-1916)
Dr. A. D. (1916-1917)

Dr. A. D. (1917-1918)
Dr. A. D. (1918-1919)
Dr. A. D. (1919-1920)

Dr. A. D. (1920-1921)
Dr. A. D. (1921-1922)
Dr. A. D. (1922-1923)

A list of senior staff and other details concerning each division is given in the
Appendix—Table II.

The organization of the staff of the division is indicated through the year
of the medical officer. The medical officer who has been in charge of the
division of the staff and the organization of the staff is indicated in
the Appendix. The staff of the division is indicated in the Appendix.
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PART III

EPIDEMIOLOGY

Notification of Infectious Disease

Vaccination and Immunisation

TUBERCULOSIS

VENEREAL DISEASES

EPIDEMIOLOGY

Incidence and Notification of Infectious Disease:

Table 12 of the Appendix indicates the various Statutes and Regulations under which infectious diseases are notifiable and Tables 13 and 14 summarise the age and sex distribution of each notifiable disease during 1966 and afford a comparison of the notifications during the past six years.

Tetanus Immunisation:

The total number of children who completed a primary course of protection against tetanus during 1966 was 29,614 and of this number 23,428 were born in the years 1965 and 1966. A secondary or reinforcing injection was given to 21,698 children of whom 16,170 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 1966 a total of 5,592 miners completed tetanus immunisation compared with the 1965 figure of 6,943. Juvenile new entrants to the industry commence immunisation almost as a routine and hospitals who have given the first dose of toxoid to a man ensure that the completion of the immunisation is carried out at collieries.

During 1966, little was done in the way of further campaigns amongst miners already in the industry, but it is hoped to start these again when the new organisation in the industry has settled down. With regard to the production of human anti-toxin from miners who are blood donors and have been immunised, progress has been rather slow as blood is only taken from donors about a year after they have been fully immunised (and following a further booster dose) using a stronger form of tetanus toxoid. It is therefore likely to be rather a long time before the success of the experiment is known.

Scarlet Fever:

The number of notifications decreased by 215 from the previous year to 1,353, and represented an attack rate of 0.77 per 1,000 population. Incidence nationally also decreased from 0.56 in 1965 to 0.44. Seasonal incidence conformed to the usual pattern, incidence being highest in the first quarter. As in recent years notifications were most numerous in young children (only 12 per cent. were 10 years or over) with a slight excess among females.

By far the majority of cases were mild and were nursed at home: no deaths were reported.

Whooping Cough:

Following the low incidence of 360 cases in 1965 it is regrettable that notifications increased to 651; this total is, however, the third lowest recorded and compares favourably with an annual average of 772 in the quinquennium 1961-65. Seasonally, notifications increased as the year progressed with 45 per cent. of the cases being notified in the last quarter.

Age-sex distribution followed the established pattern; 8.4 per cent. of the notifications related to infants under 1 year, 52.1 per cent. in the 1-4 years age group and 34.6 per cent. at ages 5-9 years, with a slightly higher incidence among girls persisting throughout.

As will be seen from Table 15 of the Appendix mortality from the disease has declined in recent years but this must not engender apathy or relaxation of effort to secure the highest immunisation state in our child population. The disease appears to be under control but a high risk to infants under 1 year remains. Early immunisation is encouraged and the hazard to the young infant minimised by boosting the protection of older siblings.

IMMUNISATION AGAINST WHOOPING COUGH:

During the year 25,069 children completed a full course of immunisation against whooping cough and since facilities were first introduced in 1952 a total of 247,904 children have been immunised under the County scheme. The number of children protected in the 0—4 years age group is 81,667 representing 72.5 per cent. of the total population in this age group.

Of the 639 notifications of whooping cough in the 0—14 years age group 209 concerned children who had been immunised against this disease.

Poliomyelitis:

For the first year since 1912, when the disease became compulsorily notifiable, no case was reported. Incidence since 1959 has remained low at an average of 10 cases per annum which, when compared with an annual average of 169 cases in the period 1946—55, underlines the success of our vaccination scheme.

Whereas this low incidence may be viewed with satisfaction the need continues to secure and maintain the highest possible immunisation state of all persons up to the age of 40 also those at “ special risk ” if the disease is to be eradicated.

The distribution of cases during the past five years is given in Table 16 of the Appendix.

VACCINATION AGAINST POLIOMYELITIS:

Number of doses of Oral vaccine administered during 1966—126,029. Number of Salk doses administered—112.

At the year end, the total number of persons protected against poliomyelitis in the County taking into account both Salk and Oral vaccine was 773,796 representing 77.6 per cent. of the age group eligible. The percentage distribution within various age groups appears in Table 17 of the Appendix.

Measles:

It was expected that 1966 would be the low year of the biennial measles cycle but notifications totalled 17,567 compared with 18,175 in 1965 and 14,385 in 1964. By early September, 1965, the epidemic of that year was virtually spent and incidence remained low throughout the County until May, 1966. From then on to the end of August increased prevalence was reported in the majority of County Districts with no discernable geographical pattern apparent. This “ out of season ” epidemic subsided during September but during October and onwards the build up to the customary biennial winter epidemic was in evidence, and notifications remained high throughout the first quarter of 1967. This uncharacteristic incidence was also experienced nationally.

Measles is a disease which is acquired by nearly everybody, usually before the age of five or six years: 59 per cent. of the notifications in 1966 were of children under 5 years, and 38 per cent. in the 5—9 years age group. Although prevalence remains high the fatality rate has fallen through the years to the present low level of around two per 10,000 cases. (See Table 18 of the Appendix).

As mentioned in my two previous Reports, the Medical Research Council are conducting trials of measles vaccines. The current trial, in which the Authority is participating, is to assess the value of the vaccines for general use and further reference is made in the research section of the Report.

Diphtheria:

For the second successive year the County was free from the disease. This satisfactory situation must not, however, foster complacency for, while the disease is no longer epidemic in this country, small localised outbreaks continue to occur indicating that there is still a residue of infection still to be eliminated. Society tends to neglect diseases once they are under control and there is still the need for constant vigilance and the continuation of our propaganda efforts to secure and maintain effective protection of our child population.

DIPHTHERIA IMMUNISATION:

The number of children who received immunisation during 1966, together with figures for previous years are shown in Table 19 of the Appendix. Due to a change in the form of return now required by the Ministry of Health, it will be noted that the age groups for the years 1965 and 1966 vary from those reported in previous years.

Also included in Table 19 are details of the immunisation state at the end of the year of the child population 0—14 years inclusive, compared with previous years.

Dysentery:

There was a welcome reduction in incidence reported: notifications totalled 630 compared with 934 in 1965 and a mean of 799 for the period 1961—65.

Contrary to the usual pattern and to national experience, as indicated in the table below, incidence was highest in the third quarter of the year when 38·6 per cent. of the notifications were made.

Season	Male	Female	Total	Percentage of annual total
First quarter ...	78	83	161	25·6
Second quarter ...	76	88	164	26·0
Third quarter ...	116	127	243	38·6
Fourth quarter ...	36	26	62	9·8

As will be seen from Table 20 of the Appendix the age and sex distribution followed the same pattern as in recent years.

There was no outbreak of any significance, the notifications arising in 53 of the 89 County Districts and, as in previous years, of the cases confirmed bacteriologically, Sonne organisms accounted for the majority of notifications.

It is generally accepted that the principal modes of spread are direct or indirect personal contact. The usual conception is of faecal infection being transmitted by the hands of infected persons. Although other measures may help in curtailing or combating the spread of infection, the logical method of prevention is the thorough washing of the hands after every visit to the lavatory.

Meningococcal Infection:

A total of 17 corrected notifications were made compared with 13 in 1965 and an annual average of 22 in the quinquennium 1961—65. Meningococcal infection as distinct from "cerebro-spinal fever" has been notifiable from 1950, since when notifications have fluctuated but have tended to pursue a downward trend. (See Table 21 of the Appendix).

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

The disease continues to be one of the residual problems in the control of infectious disease for, in spite of the availability of effective treatment, one in six patients still dies. As indicated previously, a high proportion of the cases are at early ages when, due to the protean nature of the disease, the making of an early diagnosis is often difficult.

Smallpox:

There was no importation of the disease into the County during the year. The risk of re-invasion from the many endemic foci in the world remains and parents must be reminded continually that in these days of air travel the disease could be introduced at any time.

Table 22 of the Appendix shows the number of vaccinations and re-vaccinations carried out in the period 1964—66.

Acute Encephalitis:

Cases of the disease are classified as "post-infectious" if associated with or following infectious disease or smallpox vaccination; in cases where no such relationship is established the classification of "infective" is made. Only three cases were confirmed, all "infective".

Enteric Fevers:

TYPHOID FEVER:

In 1941, typhoid and paratyphoid fevers became separate entities for notification purposes. Since then the number of notifications of typhoid fever has fluctuated within the range of nil to 27; in 1966 no case was notified.

School parties holidaying in countries bordering on the Mediterranean Sea and certain parts of Europe continue to be advised to receive protective inoculation against typhoid and paratyphoid fevers. It is also impressed on the parties that immunisation does not replace the need for normal standards and measures of hygiene. The arrangements are now accepted practice and no incidents were reported.

PARATYPHOID FEVER:

The disease acquired in Britain is almost always due to paratyphoid B organisms; during the period 1961—65 the mean number of cases was 15, all of this type. In 1966 only one case was confirmed, a woman of 79 years who had been in contact with a known carrier: she was isolated and treated at home.

Recent experience has shown that contaminated food supplies can be a major source of the infection and Medical Officers of Health are particularly alert to the hazards associated with imported food.

Food Poisoning:

The incidence of food poisoning has been assessed from the statutorily notified cases and reports of Medical Officers of Health on outbreaks and the associated investigations.

There was a further reduction in incidence, 68 cases being notified and 18 ascertained, a total of 86 incidents compared with 150 in 1965, 183 in 1964 and an annual average of 322 in the period 1960—64. In the table below the main microbial causes in 1966 are analysed by the type of incident: family outbreaks, general outbreaks—involving more than one family—and single cases.

Presumed Causal Agent	Family Outbreaks		Other Outbreaks		Sporadic Cases	Total Cases
	Number	Cases Involved	Number	Cases Involved		
<i>Salmonella typhimurium</i>	1	4	—	—	6	10
Other <i>Salmonellæ</i>	—	—	1	27	14	41
<i>Cl. welchii</i>	—	—	—	—	—	—
<i>Staph. aureus</i>	1	2	1	5	—	7
Other organisms	—	—	—	—	—	—
Not discovered	4	12	—	—	16	28
All agents	6	18	2	32	36	86

In addition there were 12 cases of salmonella infections not food-borne reported.

The problem of food poisoning in this country continues to be largely that of salmonellosis. Contaminated feeding stuffs, infection among farm animals and contamination in abattoirs may all contribute in introducing the infection into the food factory, the shop or the home and need to be considered concurrently with human infection.

The only outbreak of any significance was due to *S. anatum* associated with an outbreak in Scarborough in July. Twenty-seven members of a party from the Ripon area who had been on their Society's outing to Scarborough were subsequently found to be infected. The source of infection was traced to catering establishments in the latter town and it was thought to have been introduced by carriers. As a precautionary measure the Society's bakery was closed for a period and no secondary cases were reported. Cases connected with the outbreak were reported from elsewhere in the country and of the sporadic cases notified in the Administrative County two gave histories suggesting that their infection was acquired in Scarborough.

Pre-cooking of food, especially meat and meat products, followed by imperfect cooling or storage carries an unnecessary risk of food poisoning: carelessness also is often a contributory factor. Whereas the statutory powers derived from the Food Hygiene Regulations have strengthened the hands of Medical Officers of Health the disease could be virtually abolished by strict adherence to a rigid code of kitchen hygiene and practice supplemented by clean food handling.

Ophthalmia Neonatorum:

The Regulations define the disease as "a purulent discharge from the eyes of an infant commencing within 21 days from the date of its birth". When cases arise it is imperative that treatment should be administered promptly if impaired vision or even total blindness is to be prevented. In post-war years the number of notifications has fallen considerably; in 1966 only three cases were notified, each case responding to treatment with no loss of vision reported.

Puerperal Pyrexia:

In 1951, revised Regulations were introduced which described 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". In the past decade notifications averaged 67 per annum compared with 32 in 1966.

Anthrax:

Notification of the disease in humans commenced in 1960, since when a total of eight cases have been notified; two in 1960, one in 1961 and 1962, two in 1963 and two in 1966. All the cases were sporadic and had no apparent connection.

The first case in 1966 was a 67 years old man who worked in a knacker's yard. He had a gangrenous-looking painless swelling with eschar formation on his right forearm which had been "coming on for a day or two". He did not feel ill when seen by his general practitioner on the 19th February when penicillin and dressings were prescribed. Two days later the area was larger and blacker with marked oedema.

The following day there was some improvement but anthrax-like organisms were cultured from the exudate and after being seen by the Medical Officer of Health the patient was admitted to isolation hospital where the diagnosis was subsequently confirmed. The man made an uneventful recovery.

Thorough investigations made at the knacker's yard failed to reveal the source of the infection.

The second case was a 19 years old girl employed as a carpet yarn twister. Her illness commenced on the 28th March; she was referred by her general practitioner on the 4th April to the casualty department of the local general hospital from where she was referred to the dermatologist the same day and admitted to hospital where the diagnosis was confirmed. The girl had a lesion on the back of her right hand but had no systemic disturbance. Enquiries at the factory and home gave no guide as to how she came to be infected and the factory inspector expressed surprise that a worker handling wool at that stage of its manufacture should contract the disease. Again, the source was untraced but no further cases were reported.

In September, 1965, 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 implementation of such a scheme in January, 1966.

Under the Anthrax Order, 1938, the majority of anthrax infected carcasses in the Administrative County are disposed of by specially trained West Riding Police Officers. It was considered that these personnel should be offered vaccination and by the year-end the disposal teams and their deputies had commenced a course of vaccinations which were undertaken by one of the department's medical officers.

Influenza:

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

Outbreaks of influenza were reported from many parts of England and Wales from mid-January onwards, principally in the north of the country. Illness among schoolchildren was a conspicuous feature, but a substantial number of adults were also involved. In general the illnesses were mild in children, lasting only a few days, but in adults, more prolonged, and among the elderly a number of severe incidents were reported.

In the Administrative County, areas in the northern half were particularly affected from the 14th January onwards. For the most part, histories of the outbreaks conformed to those experienced elsewhere.

Although children were predominantly affected, with some junior schools reporting up to 50 per cent. absentees, most areas reported increased new claims to sickness benefit with influenza frequently the diagnosis. There appeared to be a fairly regular pattern during the outbreak: the younger patients were acutely ill with clinical features of high temperature, cough, sore throat, shivering and in some cases vomiting and diarrhoea over a short period and a quick recovery, the older patients were more severely ill with high temperature, predominantly respiratory symptoms and a more protracted recovery period.

The peak period of infection was the last week in January and by mid-February incidence reverted to its seasonal level, although isolated pockets of infection continued through until March, especially among the adult population.

Of the virus isolations made, it appeared that the younger patients were affected with virus B and the older ones with virus A this being reflected in the mortality statistics.

TUBERCULOSIS

Deaths from Tuberculosis:

There were 87 deaths from tuberculosis (81 respiratory and 6 non-respiratory) representing a death rate of 0.050 (0.046 respiratory and 0.003 non-respiratory), which corresponds with the England and Wales death rate of 0.048 (0.042 respiratory and 0.005 non-respiratory). Details of deaths are given in Table 23 of the Appendix.

Notification of Tuberculosis:

There were 404 primary notifications of tuberculosis arising during the year and 19 supplemental notifications, a total of 423 as compared with 429 (416 primary and 13 supplementary) notifications in 1965. Details of the new cases are summarised in Table 24 of the Appendix.

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 7,218, a decrease of 752 compared with the previous year. Table 25 of the Appendix summarises the revision of the registers in the respective divisional areas.

Care and After-Care of the Tuberculous:

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

Extra nourishment consisting of up to two pints of milk daily, continues to be available for domiciliary patients suffering from active tuberculosis; a total of 483 patients were granted free milk during the year and 334 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 1966, there were no admissions to or discharges from training settlements, leaving 5 patients still in residence at 31st December, 1966—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 Ministry of Social Security, etc., who are able to advise patients in need of help of the facilities available from statutory sources. This "expert" advice

tends to conserve the Committees' funds and ensures that help is given only to those patients and their families who are outside the scope of help provided by the statutory bodies. There are ten such Care Committees active in the West Riding area, three of which serve areas which include a county borough. The Care Committees provide services in thirteen divisional areas and cover approximately half of the County population. Their work is actively encouraged by the County Council who provide grants in aid to supplement the financial resources of the Committees; the grants for this year amounted to £1,005. 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 1,613 contacts were vaccinated, 8 of them being unsuccessful. Full details are shown below.

				AGE GROUPS												All Ages
				Under 1 year Months				Years								
0-	1-	3-	6-	1-	2-	3-	4-	5-	10-	15-	20-					
Vaccinated:																
Male	91	122	72	41	52	36	41	24	157	83	41	35	795
Female	110	123	68	49	38	38	41	25	135	77	47	67	818
TOTAL	201	245	140	90	90	74	82	49	292	160	88	102	1,613
Result of Vaccination:																
Successful:																
Male	61	107	58	26	41	26	31	20	73	48	31	23	545
Female	73	103	49	35	33	27	35	20	58	61	36	49	579
TOTAL	134	210	107	61	74	53	66	40	131	109	67	72	1,124
Unsuccessful	2	2	1	—	—	—	—	—	—	1	—	2	8
Not finally ascertained	65	33	32	29	16	21	16	9	161	50	21	28	481

(b) SCHOOL CHILDREN.—Thirteen thousand, eight hundred and eighty-one 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	24,337
Number found to have been vaccinated previously	724
Number of acceptances	18,263
Percentage of acceptances	77·3

Pre-vaccination tuberculin test:

Number of children tested	...	...	...	...	...	...	16,981
Result of test:							
			<i>Heaf Test</i>		<i>Mantoux Test</i>		
Positive	...	...	...	2,124		223	
Negative	...	...	...	11,764		2,205	
Not ascertained	...	...	...	638		27	Total 16,981
Percentage positive	...	...	...	15.3		9.2	... 14.4

Vaccination:

Number vaccinated—

Following negative Heaf Test	...	...	11,722			
Following negative Mantoux Test	...	...	2,159	Total	...	13,881

Tuberculin test twelve months after vaccination:

Number tuberculin tested after 12 months	...	...	...	1,676
Result of test—				
Positive	...	...	...	1,382
Negative	...	...	...	202
Not ascertained	...	...	...	92
			Total	... 1,676

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

Four students were tested and 3 who were found to be negative were vaccinated.

Mass Radiography:

Sixty-eight thousand six hundred and five persons from the Administrative County were examined by the Mass Radiography Service, 53,899 by units of the Leeds Regional Hospital Board and 14,706 by units of the Sheffield Regional Hospital Board. It will be seen from Table 26 of the Appendix that 57 (0.08 per cent. of the total examined) cases of active tuberculosis and 158 (0.23 per cent.) cases of inactive tuberculosis were discovered; there were also 760 (1.11 per cent.) non tuberculous abnormalities found, 242 (31.8 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 41.02 in the Sheffield Region and only 8.41 in the Leeds Region.

VENEREAL DISEASES

The statistics given in Tables 27 to 35 of the Appendix have been prepared from figures kindly provided to the County Medical Officer by the physicians in charge of the special clinics at which West Riding Administrative County residents attended during 1966. They indicate the trend of new infections but do not represent the true incidence of venereal diseases and sexually transmitted diseases in the Administrative County.

The total number of new patients increased by 30 per cent. compared with 1965. The trend of new cases has followed that of the past five years, namely, a gradual decrease in the total number of patients found to have syphilis, and a slight, but steady, increase in both gonorrhœa and "other conditions". The latter includes sexually transmitted diseases and some conditions which are acquired other than by sexual contact. Patients who have exposed themselves to the risk of infection, but after examination and observation are found to be free from disease, are also included in "other conditions". There has been an increasing number of patients in this last category in the past twenty years—now 40 per cent. of the "other conditions" total. In 1966 there were 2,160 "other conditions"—the highest number ever recorded in the Administrative County. New cases of gonorrhœa increased each year from 1962 to 1966 (244 to 406 respectively). The lowest number of new cases of gonorrhœa was 99 in 1956 and the highest 1,140 in 1946 (Appendix, Table 27).

In 1966 there were 10 new patients found to be suffering from early acquired (infectious) syphilis—two more than the previous year. New patients with late (non-infectious) syphilis numbered 34 compared with 45 in 1965. Since 1950, when the numbers of cases in this group first became available, there has been an almost continuous reduction of new cases of late syphilis. It is anticipated that this reduction will continue unless there is an unexpected rise in early syphilis. There were no cases of congenital syphilis in infants under one year of age and only four over that age (Appendix, Table 28).

New cases from the Administrative County attended at 18 different special clinics during 1966. Three of these centres were in the Administrative County, twelve in West Riding County Boroughs, two in Lancashire and one in the East Riding. Diagnostic sessions were held at Bradford, Doncaster, Leeds, Rotherham and Wakefield. The purpose of these sessions is to enable consultants and general practitioners to refer, for a venereologist's opinion, patients whom they consider unsuitable to be referred direct to a V.D. session. These include babies for pre-adoption examination and blood tests, expectant mothers who require a certificate of freedom from venereal and sexually transmitted diseases prior to admission to a Mother and Baby Home, family members of patients with syphilis and patients with clinical symptoms or signs suggesting venereal infection but no history of exposure to possible disease. The sessions serve a useful function and it is hoped that more will be established especially at the larger hospitals (Appendix, Table 29). Cervical cytology, to help in the early diagnosis of cancer of the cervix in women was undertaken as a routine at many V.D. clinics. Positive and doubtful positive cases were referred to gynaecologists for further investigation. No statistics were given of the number of women tested or the results obtained.

The overall ratio of male to female new cases was 1.6:1; but for gonorrhœa it was 1.9:1. There were no new cases of chancroid, lymphogranuloma venereum or granuloma inguinale. There was a 9 per cent. reduction in the number of

cases of non-gonococcal urethritis in males but the number of patients found to have Reiter's syndrome increased from 7 to 26. Of the males with gonorrhoea 9 per cent. were under 20 years of age. The corresponding figure for females was 26 per cent. (Appendix, Tables 30 and 31).

V.D. Social Work:

During 1966, the staff consisted of three social workers who are all state registered nurses with health visitors 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 encompass 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 duties of the Administrative County V.D. social workers were described in the Annual Report of the County Medical Officer for 1965.

The total number of contacts reported to the County Medical Officer was over twice the corresponding number for the previous year. This may be because venereologists have been taking more interest in this method of contact tracing which was started in the Administrative County eighteen years ago. Within the last few years, several other local authorities have introduced a similar system of contact tracing. Of the Administrative County contacts reported, 80 per cent. were located by the social workers and 70 per cent. were medically examined at special clinics. Of those located and examined 72 per cent. were found to be infected. (Appendix, Table 32).

Thirty-one expectant mothers residing in the Administrative County were found to have positive blood tests for syphilis. Nineteen of them were referred to special clinics for examination and 15 were found to have syphilis. Of the 12 not referred to special clinics, 5 were found to be infected and received treatment from their own general practitioners. (Appendix, Table 33).

Eleven contacts of the antenatal patients found to have syphilis were examined and one contact was found to have the disease. (Appendix, Table 34).

Of 109 patients who defaulted from treatment before being discharged cured, 100 were located by the social workers and 78 returned to special clinics for further examination and, if necessary, treatment. (Appendix, Table 35).

Summary:

There seems to be very little infectious syphilis in the Administrative County. Cases of late syphilis are decreasing in number each year. Gonorrhoea and "other conditions" are increasing each year but 40 per cent. of "other conditions" were patients who attended a special clinic and required no treatment within the centre.

PART IV

LOCAL HEALTH SERVICES

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

Provision of Nursing Equipment

Chiropody

Cervical Cytology

Domestic Help

Mental Health

CARE OF MOTHERS AND YOUNG CHILDREN

Vital Statistics:							Admin- istrative County	England and Wales
Live Births								
Number	...	...	...	...	...	...	31,457	
Rate per 1,000 population	...	...	...	...	...	...	18.0	17.7
Illegitimate Live Births per cent. of total live births							6.0	
Stillbirths								
Number	...	...	...	...	...	...	458	
Rate per 1,000 total live and still births	...	...	...	...	...	...	14.4	15.4
Total Live and Still Births							31,915	
Infant Deaths (deaths under 1 year)							623	
Infant Mortality Rates								
Total infant deaths per 1,000 total live births							19.8	19.0
Legitimate infant deaths per 1,000 legitimate live births							19.5	
Illegitimate infant deaths per 1,000 illegitimate live births							23.9	
Neonatal Mortality Rate (deaths under 4 weeks per 1,000 total live births)								
							12.6	12.9
Early Neonatal Mortality Rate (deaths under 1 week per 1,000 total live births)								
							10.9	11.1
Perinatal Mortality Rate (stillbirths and deaths under 1 week combined per 1,000 total live and still births)								
							25.1	26.3
Maternal Mortality (including abortion)								
Number of deaths							8	
Rate per 1,000 total live and still births							0.25	0.26

Births:

There were 31,457 live births registered compared with 31,463 in 1965 and an annual average of 30,452 in the quinquennium 1961-65; the corresponding crude birth rates per 1,000 population were 18.0, 18.2 and 18.0 respectively. The reduction in the rate from the peak of 18.5 in 1964 suggests that the upward trend in the birth rate which commenced in 1954 has been turned and there is a possibility of the rate remaining around this figure for the next few years.

Comparisons of crude rates for single districts or aggregates are not strictly accurate since no account is taken of the varying sex-age structure of the respective populations. To overcome this difficulty an area comparability factor, which makes due allowance for the proportion of women of child bearing age in each local population, is applied to the crude rates. The live birth rates as adjusted by the appropriate factors for the administrative county, the aggregate of Boroughs and Urban Districts, and the aggregate of Rural Districts were 18.2, 18.2 and 17.9 respectively, as compared with a rate of 17.7 for England and Wales.

In 1966, although the live birth rate fractionally decreased, the proportion registered as illegitimate increased slightly to 6.0 per cent. of total live births. During the inter-war years this proportion was relatively stable around 4 per cent. rising during the last war to a peak of 7.3 per cent. in 1945 thereafter declining to 3.6 per cent. in 1957. Since 1959 the proportion has progressively increased to reach the highest level since 1946. Reference to the cases dealt with under the Authority's scheme appears on page 75.

The number of stillbirths registered was 458 representing a rate of 14.4 per 1,000 total births, the lowest yet recorded. While the rate compares favourably with one of 15.4 for England and Wales, and can be viewed with satisfaction, even lower rates were recorded in certain parts of the county which suggests that further improvement may be possible.

The ratio of illegitimate stillbirths as usual was higher than the corresponding proportion for live births. The number of stillbirths registered as illegitimate represented 7.9 per cent. of the total stillbirths which, although reducing from the ratio of 8.4 per cent. in 1965, compares unfavourably with an average of 6.5 per cent. recorded in the period 1961-65.

Infant Mortality:

A total of 623 infants died before attaining their first birthday which is equivalent to a death rate of 19.8 per 1,000 live births, once again the lowest recorded for the administrative county. This rate was 0.9 less than in the previous year and 2.9 lower than the annual average for the period 1961-65. Satisfaction at the results must, however, be tempered by the continued lower rates recorded nationally (19.0) and in certain other countries which should serve as a spur to even greater effort to reach the irreducible minimum.

The falling rates of infant mortality suggest that the health of infants is better than ever before. Since the turn of the century there was a rapid decline in mortality to 1960, since when the rate of decline has slowed down as is indicated in Table 36 of the Appendix.

An appreciation of the relative contribution to the improvement in mortality by sex and various age groups during the past five years is afforded in Table 37 of the Appendix.

The most striking gain was made in the neonatal period by both sexes and to a lesser extent for females at ages 1—2 months; these reductions, however, were partially offset by increased female mortalities in the 3—5 months age group.

Deaths in the neonatal period numbered 397 or 64 per cent. of the total infant mortality, the resulting neonatal mortality rate was 12.6 per 1,000 live births. Both the number of deaths and rate were the lowest recorded for the administrative county comparing favourably with the rate of 12.9 for England and Wales. The number of deaths and death rates at various ages in the neonatal period for the past seven years are indicated in Table 38 of the Appendix.

The number of infant deaths, assigned to the groups of diseases comprising the International Short List is shown in Table 2 of the Appendix and a detailed analysis of the contributory causes in Table 39.

The number of deaths in the first week of life decreased by 20 to 343 and was equivalent to a rate of 10.9 per 1,000 live births. These deaths represent 86 per cent. of deaths in the neonatal period and 55 per cent. of deaths under one year. Ninety-two per cent. of these deaths were due to conditions present before, or during birth. In descending order the major causes of death at these ages were immaturity 123 (36 per cent. of total deaths under 1 week), postnatal asphyxia and atelectasis 80 (23 per cent.), congenital malformations 49 (14 per cent.) and birth injuries 35 (10 per cent.).

Mortality in the first day of life continued to decline, reductions being achieved from postnatal asphyxia and atelectasis, birth injury, congenital malformations, maternal toxæmia and hæmorrhagic disease of the newborn; these improvements were tempered due to increases from immaturity which increased from 64 to 84. At ages 1—6 days there were 11 fewer deaths as compared with the previous year, deaths from congenital malformations and erythroblastosis being less frequent.

Congenital malformations accounted for most of the mortality in the 1—4 weeks age period; they were responsible for 26 deaths (48 per cent. of total deaths 1—4 weeks), followed by pneumonia and bronchitis 9 (17 per cent.) and gastro-enteritis 4 (7 per cent.).

There was a slight increase in mortality at ages 1 month to 1 year, 226 deaths being recorded compared with 214 in 1965. Contributions to the increase were made by deaths attributed to gastro-enteritis 25 (14 in 1965), other diseases of the respiratory system 13 (7), influenza 3 (nil) with the residual group "ill defined causes" increasing from 16 to 24. These increases were partially offset by reductions in mortality from pneumonia and bronchitis 89 deaths (97 in 1965) and congenital malformations 41 (47). Minor fluctuations are recorded from year to year but the pattern has emerged of pneumonia and bronchitis, congenital malformations, gastro-enteritis, accidental mechanical suffocation and other diseases of the respiratory system making the major contribution to mortality in this age group.

WERDNIG-HOFFMAN'S DISEASE:

Progressive spinal muscular atrophy (Werdnig-Hoffman's Disease) is a progressive muscular paralysis usually manifesting itself within the first six months of life. Children affected almost invariably die within the first year from respiratory illnesses. In England and Wales in the period 1961-65 deaths of infants under 1 year from this disease were probably no more than 10 per annum.

In 1966, however, four babies died from this disease in the West Riding alone. Two were illegitimate children of unmarried women, who were working in hotels in the north of the county: little is known of the putative fathers. The third child from the Doncaster area was the first child of a young married couple; there was no family history. In the fourth case, a paternal uncle had died of respiratory illness in the first year of life.

The disease is recessively inherited. There is no traceable connection between the families involved, but the possibility of the two illegitimate children having the same putative father cannot be ruled out.

Perinatal Mortality:

In the past the infant mortality rate proved to be the most useful measure of the risks during infancy and while it provided an index of the relative well-being of the community there was no satisfactory guide of the standard of maternal care. A measure of the loss of infant life due to conditions associated with pregnancy and events during labour and delivery (perinatal mortality) was therefore introduced and the term describes the combination of stillbirths and deaths in the first week of life expressed per 1,000 total births. Table 40 of the Appendix indicates the perinatal mortality rate also the death rate of infants age 1 week up to 1 year for the past 11 years.

The perinatal mortality rate continued its downward trend to the new record low rate of 25.1 per thousand total births and compares favourably with a national rate of 26.3. As mentioned previously, immaturity, postnatal asphyxia and atelectasis, congenital malformations and birth injuries contribute the major proportion of deaths under 1 week: in total they comprised 84 per cent. of the infant mortality at this age. Many of these infants lived but a few hours and with over two-thirds of the deaths at these ages having a birth weight of 5½ lb. or less the dominance of prematurity is clearly underlined.

Stillbirths contributed 57 per cent. of the perinatal mortality. Under the Population (Statistics) Act, 1960, 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. This information is contributing materially to studies on this and allied subjects. In the table below the number of stillbirths allocated to cause and the rates per 1,000 total births are given.

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)	74	2.32
Absorption of toxic substance from mother ... (Y 33)	—	—
Difficulties in labour... .. (Y 34)	14	0.44
Other causes in mother (Y 35)	1	0.03
Placental and cord conditions (Y 36)	138	4.32
Birth injury (Y 37)	6	0.19
Congenital malformation of foetus (Y 38)	88	2.76
Diseases of foetus and ill-defined causes (Y 39)	135	4.23
All causes (Y 30—Y 39)	458	14.35

Of the major causes of stillbirths identified, placental and cord conditions, congenital malformation of the foetus and diseases and conditions of pregnancy and childbirth were most frequently mentioned and comprised two-thirds of the total stillbirths. As with live born infants in the first week of life, prematurity is a prime factor; indeed, 54 per cent. of the stillbirths weighed $5\frac{1}{2}$ lb. or less.

The mortality rate of infants at ages 1 week and under 1 year decreased slightly to 8.8 per 1,000 total births compared with 9.0 in 1965 and an annual average of 9.7 in the period 1961-65. The level of mortality at these ages is low and slight fluctuations can be expected: it is satisfactory however that since 1961 the rate has progressively declined.

Illustrated graphically are the trends of the rates associated with loss of foetal and infant life during the past 14 years. It will be seen that during this period total wastage of infant life, i.e. stillbirths plus infant deaths expressed as a rate per 1,000 total births has declined from 53.2 to 33.9. With one exception, all the mortality rates associated with infants were the lowest on record for the Administrative County, the exception, infant deaths at ages 1 week to 1 year, being the second lowest recorded.

Maternal Mortality:

The number of deaths from maternal causes has reached such low proportions that slight fluctuations are inevitable. There were 8 deaths registered in 1966—toxæmias 4, maternal sepsis 2, other complications 1 and abortion 1. The resultant death rate per 1,000 total births was 0.25 compared with 5 deaths at the rate of 0.16 for 1965, and the annual average of 9 deaths, 0.30, during the quinquennium 1961-65.

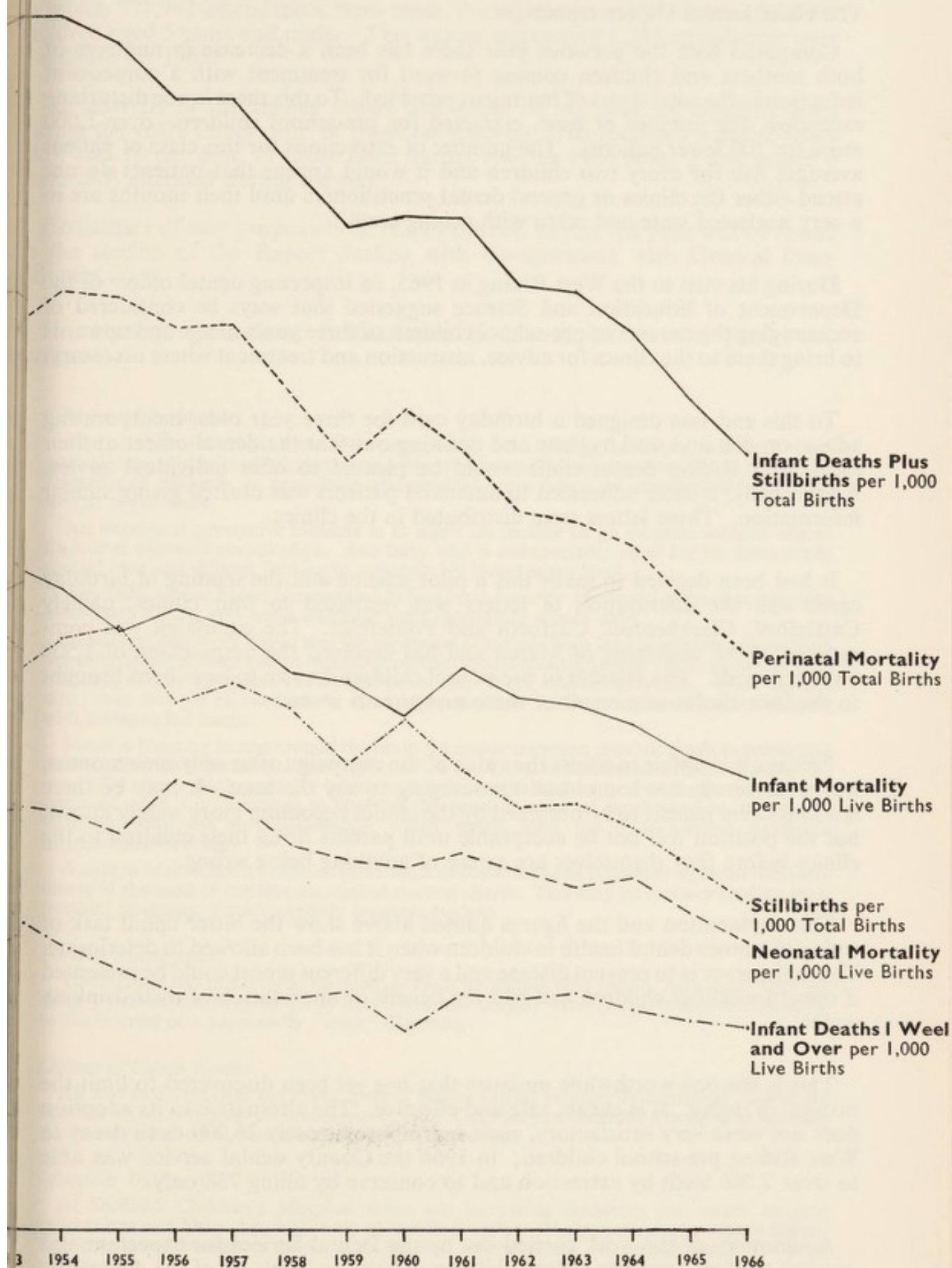
Table 41 of the Appendix affords a comparison of the national and county rates from the various causes during the past 5 years.

Ante and Postnatal Services:

Two thousand six hundred and ninety-three sessions for ante and postnatal examination work were held in the Authority's clinic premises during the year, at which 5,076 women attended for antenatal examination and 709 for postnatal examination, the total attendances made being 28,983 and 852 respectively. The decline in the extent of ante and postnatal work being done directly by the Authority in its own clinics continued.

By the end of 1966, 32 of the Authority's clinics were being used by 43 practices, comprising 104 general practitioners, for antenatal sessions for their own patients. A total of 1,643 sessions were held and, of these, 1,619 were attended by the domiciliary midwives. In addition, 105 midwives attended a total of 3,600 antenatal sessions held by general practitioners in their own surgeries.

The domiciliary midwives have continued to hold antenatal mothercraft and relaxation classes for both hospital and domiciliary booked cases, and details are given in Table 42 of the Appendix.



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

The Chief Dental Officer reports:—

Compared with the previous year there has been a decrease in numbers of both mothers and children coming forward for treatment with a consequent reduction in the total items of treatment provided. To this there is one disturbing exception, the number of teeth extracted for pre-school children—over 1,000 more for 100 fewer patients. The number of extractions for this class of patient averages five for every two children and it would appear that patients do not attend either the clinics or general dental practitioners until their mouths are in a very neglected state and often with aching teeth.

During his visit to the West Riding in 1965, an inspecting dental officer of the Department of Education and Science suggested that ways be considered of encouraging the parents of pre-school children of three years of age and upwards to bring them to the clinics for advice, instruction and treatment where necessary.

To this end was designed a birthday card for three year olds, incorporating advice on diet and oral hygiene and pointing out that the dental officer at their local West Riding dental clinic would be pleased to offer individual advice. Additionally, a letter addressed to antenatal patients was drafted giving similar information. These letters were distributed in the clinics.

It had been decided to make this a pilot scheme and the sending of birthday cards and the distribution of letters was restricted to four clinics, namely Castleford, Cleckheaton, Garforth and Pontefract. The campaign was commenced at the beginning of March and has involved the despatching of 1,500 birthday cards. The number of pre-school children known to have been brought to the four clinics as a result of these measures is seven.

Perhaps it is unfair to assess the value of the campaign after only nine months, but these results are somewhat discouraging to say the least. It may be there is a long-term benefit to be obtained by the clinics becoming more widely known but the position will not be acceptable until parents bring their children to the clinics before they themselves are aware of anything being wrong.

This explanation and the figures quoted above show the bitter uphill task of trying to restore dental health in children when it has been allowed to deteriorate. The real answer is to prevent disease and a very different report could be presented if these pre-school children had had the benefit of fluoridation of their drinking water.

This is the one worthwhile measure that has yet been discovered to limit the ravages of decay. It is cheap, safe and effective. The alternative to its adoption does not seem very satisfactory, each year approximately 26,000 teeth decay in West Riding pre-school children; in 1966 the County dental service was able to treat 2,566 teeth by extraction and to conserve by filling 738 only.

A summary of the work carried out by the Dental Service for expectant and nursing mothers, and pre-school children is given in Table 43 of the Appendix.

Infant Welfare:

At the end of the year, there were 237 static and 3 mobile clinics in operation, at which 571,943 attendances were made during the year by a total of 68,402 children aged 5 years and under. This was an increase of 1,233 attendances over the figure for 1965.

An analysis of the figures shows that some 84 per cent. of children born during the year, 75 per cent. of those born during 1965 (between 1 and 2 years old), and 16 per cent. of those born during 1961 to 1964 (over 2 and under 6 years old) attended during the year.

Particulars of new purpose-built clinics opened during the year will be found in the section of the Report dealing with Co-operation with General Practitioners.

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

“ Perinatal Problems

The placenta (afterbirth) has been perceptively described in American as a multi-categorical, inter-disciplinary phenomenon. We are paying it increasing attention in explaining tragedies of stillbirth, or near-death and residual brain deficit, or unexpectedly tiny birth weight at full term.

An important preventive measure is to allow no mother to go overdue without urgent high-level obstetric consultation. Any baby who is unexpectedly small for his dates needs special care and diligent feeding to maintain his blood sugar level.

Any baby whose bowel has emptied before birth must be presumed to have sustained a near-death agony, and needs watching right through to school days.

Important new work shows that the expansion of the newborn lung to establish respiration depends on the presence of an ingenious chemical surface-acting agent which overcomes the tendency of tiny air spaces to collapse down after every attempted breath. This ‘ surfactant ’ may not yet be available in extremely premature babies who thus die of exhaustion with unexpanded lungs.

Massive bleeding in and around the brain is another common cause of death in premature babies, sometimes because of the fragility of the skull, and sometimes as a result of asphyxia, especially after a prolonged dry labour and instrumental delivery. For the parents’ future peace of mind it is important to establish the precise cause of death, and to be able to state that there was no malformation which would load the odds against successful further child-bearing.

A clue to brain hazard in babies surviving a difficult birth can be gained by serial measurements of the head circumference against normal charts. This may be more rewarding than frequent weighing, if microcephaly becomes evident.

Feeding Management

There is still too much thinning down of feeds for babies who vomit. As a result they are doubly starved and become wildly fretful and lose weight. Hardly ever is dilution desirable in the interest of a supposedly ‘ weak ’ digestion.

Lipoma of Cauda Equina

All soft swellings over the lower spine of babies should be expertly appraised. Some are lipomas which compress the spinal nerve roots. One this year included a bony spur splitting the lower spinal cord, which needed radical operation.

Muscular Dystrophy

At Sheffield Children’s Hospital there are increasing resources for serum enzyme estimations and histo-chemical study of muscle biopsies. These can in some cases differentiate carriers of the disease genes, and atypical disorders can be distinguished to clarify prognosis.

Scabies

The recent increase of infestation has raised misgivings about treatment. Expert advice is that benzyl benzoate is a fully effective application, if only every part of the body surface is treated, including soles of the feet, and if all members of the family are treated simultaneously.

Lead Poisoning

Damage to the brain by unrecognised past accidental lead ingestion is being recognised on the basis of persisting high levels of lead in the blood. Mental deterioration is a possible feature of the hazard."

Phenylketonuria:

During 1966, 30,206 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 3 of these cases was the result confirmed. Details of these are as follows:—

- Case 1* Girl, S.E.C-M. born 14-2-66.
Positive "Phenistix" test by health visitor at 3 weeks.
Phenylketonuria confirmed by hospital 31-3-66.
Admitted to hospital 1-4-66.
Discharged 6-5-66.
Dieting commenced 4-4-66.

Follow-up report (May, 1967):
Still dieting but with only slight restriction. Making normal progress. Continues to be under hospital supervision.

- Case 2* Girl, R.D.R. born 21-7-66.
Positive "Phenistix" test by health visitor at 3 weeks.
Phenylketonuria confirmed by hospital 16-8-66.
Admitted to hospital 16-8-66.
Discharged 10-9-66.
Dieting commenced 16-8-66.

Follow-up report (May, 1967):
On diet—at present changing from Minafen to Cynogram food.
Has Liga biscuits, strained vegetables and fruit. Progress normal—very active and sociable child. Continues to be under hospital supervision.

- Case 3* Girl, S.O'L. born 6-11-66.
Positive "Phenistix" test by health visitor at 3 weeks.
Phenylketonuria confirmed by hospital 28-11-66.
Admitted to hospital 29-11-66.
Discharged 27-12-66.
Dieting commenced 11-12-66.

Follow-up report (May, 1967):
On full restricted diet—mixed feeding, Liga rusks and special milk.
Making normal progress—very lively, responsive and alert child.
Continues to be under hospital supervision.

Table 44 of the Appendix gives details of tests undertaken since the scheme commenced in March, 1960, to 31st December, 1966.

Ortolani Testing for Congenital Dislocation of the Hip:

During 1966, 52 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 120 confirmed cases since the Ortolani test was introduced as a routine procedure in December, 1962. A summary of tests carried out is given in Table 45 of the Appendix.

Congenital Abnormalities:

Under the national scheme for the registration of congenital abnormalities discovered at birth and recorded on the notification of birth form, 502 babies with a total of 586 abnormalities were notified.

The number of births notified during the year was 31,627, giving a percentage of 1.6 for babies with one or more congenital abnormalities.

Illegitimate Children:

Of the total of 1,881 live illegitimate births, 1,418 were dealt with as indicated in Table 46 of the Appendix; 1,358 of them were of West Riding domicile, the remaining 60 being non-county cases. Two hundred and twenty-seven county cases were accommodated during the ante or postnatal period in moral welfare homes under the scheme of the Authority and details are given in Table 47 of the Appendix.

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 2,320 premature births, of which 2,071 were live and 249 still. Of the premature live births, 14 per cent. were born at home and 86 per cent. in hospitals. Of those born at home, 84 per cent. weighed more than 4 lb.

Fuller details are shown in Table 48 of the Appendix.

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. Table 49 of the Appendix shows the extent of the distribution of welfare foods over the last five years.

At 31st December, 1966, there were 303 distribution centres in the county for the issue of welfare foods of which 239 were Child Welfare Centres.

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

Throughout the administrative county, there were 100 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 the remaining Divisions, meetings were held less frequently than quarterly.

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, Ministry of Social Security 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 90 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.

A joint Circular on the subject of Homeless Families—Temporary Accommodation, issued on 31st October by the Ministry of Health (20/66), Home Office (178/66) and Ministry of Housing and Local Government (58/66) was still under consideration at the end of the year.

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 Table 50 of the Appendix.

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 13 children in day nurseries administered by the County Boroughs of Bradford, Halifax, Huddersfield, Sheffield and York. At the end of the year, 4 children were in attendance.

MIDWIFERY

Institutional Midwifery:

The proportion of hospital confinements rose from 76 per cent. to 77 per cent. in the Leeds Regional Hospital Board area, and from 60 per cent. to 66 per cent. in the Sheffield Regional Hospital Board area, giving a County rate of 73.4 per cent.

Nearly 50 per cent. of hospital confinements were discharged before the tenth day, half of these being between the fifth and ninth days.

Details of hospital and domiciliary births and early discharges are shown in Table 51 of the Appendix.

Domiciliary Midwifery:

Although the number of home deliveries declined still further in 1966, antenatal work by county midwives increased considerably. This increase arises from better liaison between hospital antenatal clinics and General Practitioner Obstetricians with regard to notifications and care, and from the increased attendance of midwives at family doctors' surgery antenatal clinics. The number of mothers delivered in hospital, but discharged home two to five days after delivery, also increased.

STAFF SITUATION:

The establishment is 280 whole-time midwives. In post at 31st December, 1966:—

Whole-time midwives	...	...	...	...	195
Part-time midwives	...	...	...	...	2
Whole-time home nurse/midwives	...	...	...	...	47
Part-time home nurse/midwives	...	...	...	...	2
					<hr/>
					246
					<hr/>

The equivalent in whole-time midwifery is 220. There were 27 appointments, 17 resignations, 14 retirements, 4 midwives transferred to other services and 2 died.

RECORDS:

The new record cards came into use on 1st February, and, whilst giving the midwives fewer forms to fill in, they provide for essential facts to be recorded at each stage of antenatal, delivery and postnatal care.

CARE OF PREMATURE BABIES:

The purchase of 26 portable incubators for conveying premature or ill infants from home to hospital, or from hospital to hospital, provides the heated, humid

and, if necessary, oxygenated atmosphere that these babies require. All midwives have been instructed in their use.

IN-SERVICE TRAINING COURSE:

A successful course on "Preparation for Parenthood" was held at Grantley Hall in October. Forty-four midwives from the West Riding, and from adjoining County Boroughs and hospitals attended.

The lecturers were Miss L. P. Burns, Superintendent Physiotherapist, York, Mrs. Greenwood, Senior Teaching Midwife, Bradford, and Mrs. M. Williams, Physiotherapist Tutor to Middlesex County Council, Chairman, Obstetric Association of Chartered Physiotherapists and Vice-Chairman of the National Childbirth Trust.

By lectures and practical demonstrations, the lecturers gave invaluable help toward good preparation of expectant mothers in antenatal classes.

ANALGESIA:

All midwives are 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 no spare was available.

The percentage of mothers who received analgesia was much the same as last year and full details are given in Table 52 of the Appendix.

CARS:

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

EMERGENCY OBSTETRIC UNITS:

There were 49 reported calls on this service, mostly for difficulties connected with the third stage of labour. Units operate from the hospitals shown in Table 53 of the Appendix.

HEALTH VISITING

The health visiting service seeks to watch over the care, development and management of young children; to promote health by teaching, and by immunisation against many diseases; to assist in the early recognition of physical or mental handicaps; to give continuing support to those families who cannot, or do not make the ordinary effort of living without such constant help; to see that the elderly are provided with services according to need; to share in health promotion and education in schools and mothers' clubs, and to co-operate with other workers in statutory and voluntary fields.

Working within the sphere of general medical practice, the shared knowledge and united approach of the family doctor and health visitor are effective, and well liked by families.

At the 31st December, 1966, half the health visitors still worked in the geographical pattern for a variety of reasons. If progress seems very slow, it must be remembered that the full co-operation and goodwill of many people are

involved. Meanwhile, increasing publicity throughout the country adds more and more evidence of the value of the newer way of working.

Figures relating to health visiting are given in Table 54 of the Appendix.

Staff Situation:

Establishment including 16 Field Work Instructors for student health visitor training	407
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In post at 31st December, 1966:—

Qualified Health Visitors	278	
Assistants to Health Visitors	105	
Whole-time School Nurse	...	...	...	...	1	
Whole-time Tuberculosis Visitors	...	...	...	...	6	
					—	390

Changes of staff during the year included:—

Appointments —	Qualified Health Visitors	...	...	33
	Assistants to Health Visitor, S.R.N.			22
Resignations —	Qualified Health Visitors	...	...	17
	Assistants	...	...	10
	Retirements	...	...	12
	Transfers to other services	...	...	3
	Transfers to health visitor training	...	...	12

Mrs. D. Mumford, County Nursing Officer, after nineteen year's service with the County, retired in September. Her energetic service to the County is inestimable, and her wide knowledge of national and international nursing affairs was recognised by many committees who sought her advice.

Miss M. G. Atkinson, formerly Superintendent Nursing Officer to Oxford City Council, was appointed to the post.

Post Certificate Training:

Forty-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" a repeat of the successful course held in the previous year.

The programme was devoted to the emotional development of children with special focus on the normal child; the needs of the handicapped child particularly regarding early diagnosis, treatment and rehabilitation, were also considered.

The course was opened by Miss E. E. Wilkie, B.A., S.R.N., Health Visitor Tutor, Chief Professional Advisor to the Council for the Training of Health Visitors, and the help given by Mrs. Farrow, and other speakers in lectures and discussion groups was invaluable.

Four courses on ascertainment of deafness were held at Wombwell, Rotherham, Harrogate and Doncaster, with the help of Drs. Barnes, Watt, Hepple and Ferguson. Ninety-six members of staff attended with the result that all qualified health visitors on the staff at the end of the year and thirteen assistants to the health visitor had been trained.

Group Lectures:

Group lectures were arranged in five centres in the West Riding during April and May, the subject being "Hearing Defects in Young Children—the importance of Early Detection". Dr. Smith, Senior Administrative Medical Officer, lectured in four centres and Dr. Burn, Divisional Medical Officer, at Otley. Two hundred and fifty-eight members of staff attended.

Group lectures were held on two Saturday mornings in the Council Chamber, County Hall, in May and July.

The subject of the first lecture was "The Future role of the Health Visitor" given by Mrs. Mumford, County Nursing Officer, and Professor S. T. Anning, Senior Lecturer, Dermatological Unit, The General Infirmary, Leeds, spoke on skin diseases at the second group lecture—169 health visitors attended.

Health Visitor Training:

Fourteen students were accepted for training in Leeds; eight students went to Miss D. M. Lane, Tutor at Bradford; two were accepted in the new training course at Sheffield College of Technology. (Miss M. H. Williams is tutor here). One student went to Bolton College of Technology where Miss B. Nicoll is Tutor.

One Student withdrew from Sheffield because of prolonged ill health.

Miss Chambers, Tutor at Leeds, writes in her annual report:—

"The course and examination were to be run entirely under the auspices of the University from this year, and so an ad hoc committee was established by the Faculty of Medicine to advise Senate. . . .

The change in practical work arrangements was satisfactory. Qualified health visitors had been invited to come forward to train as fieldwork instructors in accordance with the Training Council's requirements. They took great pains with selecting, preparing and analysing work for their students, who were very grateful for this expert guidance. Although some justifiable complaints were made about the lengthy journeys to practical work, (due mainly to the siting of fieldwork instructors' districts) the students could not praise their instructors enough. The tutorial staff joined in this. Over the whole country, there had been fears and anxieties about the production of case studies and day books, but it was felt that the students' diligence and the fieldworkers' teaching and encouragement had combined to produce creditable records.

This new approach to teaching on the district relieved, to some extent, the burden on the divisional nursing officers. Planning the practical work was helped because there was one person concerned with each student, though attention must be drawn to the assistance given by other health visitors and staff members. The fieldwork instructors said that they had enjoyed this first year's experience in spite of the extra effort and all this entailed. . . .

All the candidates sponsored by the West Riding County Council were successful, although two other candidates were referred in one paper each. This is a new development which allows the candidate to re-sit up to two written papers instead of the whole examination."

Cars:

Two hundred and forty-six health visitors used cars in connection with their duties, three being provided by the Authority.

HOME NURSING

The number of patients nursed during 1966 rose by 2,446 (32,674 compared with 30,228 the previous year).

Visits increased by 33,022 to a total of 790,387.

Visits to patients aged 65 and over constituted 67 per cent. of the total.

There has been some increase of district nurse attachments to general practice, and undoubtedly the increasing use of local authority premises by family doctors will encourage this more satisfactory method of working. At the 31st December, 1966, 91 home nurses were attached to 71 general practices; 230 family doctors were included in the 71 practices concerned. District nurses who are working in this way are most enthusiastically in favour.

Staff Situation:

The establishment was 290 whole-time nurses. 302 were employed at the end of 1966, 13 less than in 1965, and were made up as follows:—

Home Nurses, S.R.N.	...	...	...	...	244
Senior relief home nurse, S.R.N.	...	...	...	...	1
Home nurse/midwives, S.R.N. (2 part-time)	...	...	...	...	48
Home nurses, S.E.N. (2 part-time)	...	...	...	...	8
Village nurse/midwife, S.E.N.	...	...	...	...	1
					<hr/>
					302
					<hr/>

There were 44 appointments, 38 resignations, 15 retirements and 3 transferred to other services.

Whilst the staffing position has been reasonably satisfactory as a whole, there are areas where it is extremely difficult to recruit suitable staff—notably in more rural areas where only car drivers could cope with the distances involved.

Training:

The training scheme for district nurses continued as in previous years. There were two courses of training in 1966, commencing in May and September.

Twelve students took the course and all were successful. The help given by the senior nurses has been invaluable.

Refresher Courses:

A very successful and enthusiastic course was held at Grantley Hall in September when 38 West Riding students attended. In addition to these were 2 students from adjacent County Boroughs.

The course was similar to the one held last year and once again the theme of the course was "Rehabilitation". As last year the valuable assistance from physiotherapists Miss M. C. Johnson, Miss B. Savage and Miss M. Houghton, was much appreciated.

The lecturers were excellent, providing much interest and stimulation of thought and discussion.

The district nurses found the course both instructive and enjoyable.

Cars:

Two hundred and eighty-two home nurses used cars in connection with their duties, seventy-one being provided by the Authority.

Summary of Work of Home Nurses:

Details will be found in Tables 55 and 56 of the Appendix.

Equipment:

Modern, and in some instances, disposable equipment is now being used by the district nurses following recommendations by the Departmental Working Party mentioned in the 1965 report.

Day and Night Nursing Service:

The object of this scheme, which is provided as an extension of the Home Nursing Service, is to provide a day and 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 are under considerable strain resulting from caring for patients over a long period. Trained nurses, persons with nursing experience and “sitters-in” are employed in the service. Whilst this service is not one which is called upon frequently, it is one which can, nevertheless, be of immense benefit.

During the year, the service was used in all but six Divisions; 248 cases were provided with 11,733 hours of service at a cost of £3,094.

AMBULANCE SERVICES

I am indebted to Mr. V. Whitaker, O.B.E., F.I.A.O., County Ambulance Officer, for the following report and the statistics given in Table 57 of the Appendix.

There has been a further large increase in patient demand, mainly in out-patient work, where the increase is attributable to the continued expansion of the treatment of “day patients”. Most of these are under the care of the psychiatric, geriatric and chronic sick hospital departments to which they are conveyed regularly. They arrive at hospital mid-morning where during the day they are given treatment and care and are then returned home late in the afternoon.

The increase in mileage other than that arising from additional patients can be attributed to the continued use of the Humber estate car/ambulances and the inception of the group control system. The group control system, due to its flexibility, allows vehicles to range over a wider area with more effective inter-station co-ordination which no longer confines vehicles to their own station area.

The new operational system of group control was inaugurated in June, 1966, and by the end of the year, was fully operative in the group comprising Keighley, Menston, Shipley, Pudsey, Birkenshaw, Todmorden, Honley and Brighouse stations, with group control at Headquarters, Birkenshaw. Naturally there have been teething troubles but experience indicates that the aim of increasing service efficiency will be achieved.

The radio-telecommunication scheme was further developed, particularly in the group control area.

July, 1966, was a milestone in the history of the Service, when the Residential Training School for Ambulance Staff was opened in county premises at "Elm Bank," Cleckheaton. A syllabus for a two weeks' course in Ambulance Aid was devised to be undertaken by all staff. The school caters for twenty students per course and by the end of the year, nine courses were held. There is a Chief Instructor and an Assistant Instructor full time, supplemented by selected instructors from the service staff and external lecturers from the County Medical Officer's Department and hospitals.

In drawing up the training syllabus for the school, account has been taken of the fact that basic first aid is not sufficient in itself for professional ambulance work. The necessary wider knowledge needed by ambulance drivers and referred to as Ambulance Aid includes the teaching of techniques involved in extricating casualties from wrecked vehicles and from similar predicaments. Special attention is also given to the handling of all types of medical emergencies—ambulance nursing and patient observation, emergency childbirth, the care of the unconscious patient, and the application of oxygen under emergency conditions. Other aspects include training in the use of equipment carried on ambulances, personal and vehicle hygiene and also driving skills. Considerable use is made of both simulated casualties and incidents to add realism to the training. The principal stress throughout the course is on the handling of patients both physically and psychologically with a view to them arriving at the point of medical aid, wherever possible without any deterioration in condition.

The initial course has been enthusiastically received by the students and without doubt, the instruction and stimulus given should be seen in improved care of the patient.

This series of training courses will be followed by courses in advanced ambulance aid and in specialised technique in radio-telephony. Other possible series of training courses may be run for control room operational staff and officer training courses for senior members of the Service.

Ambulance service instructors have continued to meet the heavy demand for teaching demonstrations of the mouth-to-mouth resuscitation to schools and a wide section of the public.

A National Ambulance Services Competition is organised annually by the National Association of Ambulance Officers. The team representing the West Riding Service (from Bramham Station) won their way through to the final and were successful therein, being placed first, for which they were awarded the National Trophy.

Due to the inadequacy of the present premises, consideration is being given to establishing a new service Headquarters and Control. Negotiations for a site for a new station at Castleford have been protracted but are proceeding, as are plans for new stations at Todmorden and in the Birkenshaw/Morley area.

PREVENTION OF ILLNESS, CARE AND AFTER-CARE

Health Education:

During 1966 the Health Education Section of the department has mainly been concerned with consolidating the work undertaken in previous years. In June, Miss Edwards who had been health education officer from 1960 left the depart-

ment to return to her former work as a health visitor tutor. She was succeeded in November by Miss Tattersall who was the former Divisional Nursing Officer for Division 4 (Shipley).

Considerable health education activity is undertaken by medical and nursing staffs of all divisions. However, the task now remains of building on this foundation and of expanding the work in particular directions.

In my report for 1964 reference was made to the work of the Advisory Panel on Health Education. This met on four occasions during the year and concerned itself with planning for 1967 of the programme of in-service training, the co-ordination of publicity campaigns throughout the County, the design and subjects of exhibition material, the planning of programmes for the making of films and filmstrips with the equipment recently purchased and with many other matters which arose from time to time. This team is composed of members of each section of the headquarters staff together with a divisional medical officer and a divisional nursing officer.

There has been a tendency during the last two or three years for the number of sessions devoted by health visitors to health education work to diminish. However, in spite of this there has been an expansion of the work of health visitors in schools. Several divisions are now running courses on health matters in secondary modern schools and in certain divisions help is also given to grammar and high schools. This is a most valuable part of our work which will require expansion in the future. In many other divisions help and advice is given to teaching staffs with material and subjects for lessons relating to health matters, and assistance with visits by senior school children to view the work of the department or related medical services in their areas.

Mothers' clubs now exist in thirteen divisions. Some divisions have more than one club which meet on many occasions during the year. The majority of clubs are organised by mothers themselves with the help and advice of the divisional nursing officer or the health visitor based on the clinic. The clubs deal with a wide variety of subjects about half of which have a direct bearing on the health of children, but others in relation to home making and personal care are also included together with a modicum of social activities. They form a useful place for discussion and exchange of views and where young mothers in the area can give each other material support and help in case of difficulty. This is potentially a very useful field of work and at the end of the year a small Working Party under the new County Nursing Officer, Miss Atkinson, was set up to investigate the work of these clubs and to make recommendations regarding their future. It is hoped that this Working Party will report during 1967.

EXHIBITIONS:

The health education section holds a wide variety of material to assist divisions with local exhibitions and many of these were prepared and set up by the section during the year. Our only two permanent exhibitions relate to home and farm safety and both of these were in great demand particularly during the summer season for use at shows and galas throughout the County. This is a very useful field of work. Plans were in hand at the end of 1966 to extend the work of the section in this direction.

IN-SERVICE TRAINING:

During 1966 the section organised two non-residential study days and two residential courses at Grantley Hall. The first Grantley Hall course was on the Aims of Health Education and was run on behalf of the department by the Warden, Dr. Strick and his deputy, Mr. Gains: 18 members of the staff attended.

The second course was on the subject of Health Education and the Mental Health Problems of Old Age and was run under the chairmanship of the Deputy County Medical Officer, Dr. Francis, with the assistance of Miss Tattersall, and Mrs. Farrow, Psychiatric Social Worker Tutor. This was attended by twenty members of staff in all.

Both of these courses were most useful and suggestions came forward from both of them for the expansion of the work of the section.

In line with the general work of the department in promoting co-operation with general practitioners, in one division the divisional medical officer has arranged for display boards to be available for general practitioners' surgeries and for posters and other display material to be placed on the boards by health visitors working with the practices.

This has been very much appreciated by the general public and by the family doctors themselves. This is obviously a most useful outlet for propaganda. This pilot scheme is being watched very carefully and the possibility of it being more widely useful must be borne in mind.

Social Workers:

Towards implementing the County Council's decision to build up gradually a staff of qualified social workers to the approved establishment of 25, a further 4 trainees were appointed in September. The pattern of in-service training in conjunction with the Leeds College of Commerce, was continued.

The first 6 trainees, appointed in 1965, proved satisfactory after their probationary period and commenced the two-year course for the Certificate in Social Work at the Leeds College of Commerce in September.

Recuperative Home Treatment:

Two hundred and fifty-seven applications for recuperative home treatment were received as compared with three hundred and twenty-three in the previous year. One hundred and forty-three, twenty-nine men and a hundred and fourteen women, (three with children), were admitted to one or other of the under-mentioned homes, the remaining hundred and fourteen applications (44.3 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 Home 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; W.R.V.S. Home, Hanford House, Ilkley.

Provision of Nursing Equipment in the Home:

Fifteen thousand, eight hundred and ninety items of nursing equipment were issued to patients being nursed in their own homes.

Table 58 of the Appendix shows the wide range of equipment which is now made available.

Chiropody Treatment:

There was a further reduction during the year, from 93 to 87, in the number of voluntary associations providing a service on an agency basis. By the end of the year, a direct service was available at 121 clinics or the premises of voluntary associations, at the premises of 27 chiropodists and in 6 residential private homes.

The service continued to expand but not so rapidly as in previous years. Forty-six thousand, three hundred and fifty-nine patients were treated compared with 45,156 in 1965, and the total number of treatments given was 222,326 compared with 214,490 in 1965.

Of the 46,359 patients, 45,316 were in the aged category which is estimated to be some 18 per cent. of the estimated population of men over 65 years of age and women over 60. The pattern remains widely varied over the County as a whole; in the Skipton, Keighley and Brighouse Divisions, the percentages were as high as 34.4, 28.5 and 25.6 compared with the percentages of less than 12 in the Horsforth, Harrogate, Goole, Pontefract and Morley Divisions. In 9 Divisions, the percentage was between 15 and 20, and in 6 Divisions between 20 and 25.

The extent to which domiciliary treatment was provided during the year continued to cause some concern in some areas. In 12 Divisions, more than 30 per cent. of the aged receiving treatment were doing so on a domiciliary basis, in one Division the percentage being as high as 41.4. The average for the County as a whole was 27.8.

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 will be found in Table 59 of the Appendix.

Cervical Cytology:

During the year, the campaign for prevention of cancer was advanced by the introduction of tests to discover early signs of cellular change in the wombs of women most at risk of cervical malignancy.

The introduction of the cytology service has been piecemeal throughout the County and in some areas disappointingly slow. The essential delaying factor has been the shortage of both money and trained staff in the hospitals at which smears are examined microscopically. Energetic measures have been taken to remedy matters but, since public demand for the service in County areas could not be fully met, facilities were limited as much as possible to parous women over 35 years in the socio-economic groups IV and V. Repeat examinations in those with normal results will be undertaken at five-yearly intervals. Some of the confusion caused by the service being available simultaneously to women in hospital out-patient departments, general practitioners' surgeries, local authority clinics, and family planning clinics, is to be resolved in future by liaison committees representing each interested organisation. At present, all activity by the local authority is reported to the Local Medical Committee.

West Riding clinics are usually staffed by a doctor, midwife and clerk. In view of their other extensive commitments, the health visitors have been mainly excluded from the administration of the scheme. Each woman attending has a smear taken, has her breasts examined for tumours, and is given instructions on self-palpation of the breasts. General practitioners wishing to use the authority's clinics personally to test their own patients may do so free of charge if there is sufficient unused accommodation.

In 1966, 45 local authority clinics held 478 sessions at which 8,279 patients attended for the first time. The number of patients with positive smears was 50, and 76 women were referred to their general practitioners with suspected tumours of the breast.

As further laboratory facilities become available, a publicity campaign to stimulate interest will also expand.

DOMESTIC HELP

With effect from the 1st April the establishment of equivalent whole-time domestic helps was increased from 1,235 to 1,355, this increase having been approved by the County Council in 1965.

A complete review of the service was undertaken in the latter part of 1965 and early 1966, resulting from a request by the Domestic Help Sub-Committee who had questioned whether the amount of assistance being given to the elderly was sufficient.

Figures supplied by the Divisional Medical Officers in January, 1966, indicated that—of a total of 10,846 elderly cases receiving assistance—1,054 were receiving less than three hours per week and 6,880 were receiving between three and five hours. The majority of the Divisional Medical Officers were of the opinion that the average minimum number of hours required per case was about six per week. There was a general acceptance of this by the Committee and the need to continue with a general expansion of the service was appreciated.

Consideration was also given by the Committee to the level of charges made to the elderly for the service and, while not accepting that the service should be provided free of charge and without assessment, approval was given to adjustments in the assessment scales which would have the result that few patients would be required to make any payment.

DOMESTIC HELP ORGANISERS:

As part of the review of the service, the Committee also considered the need for the appointment of domestic help organisers, the Authority being one of the few (if any) who had not previously used such staff. The recruitment of domestic helps, the assessment of need, and general supervision of the service had for many years been undertaken by the health visiting staff but, as the duties of the health visitors increased, it had become imperative that they should be relieved of such duties as could be undertaken by less-qualified staff. It is pleasing to report that the Committee accepted the situation and agreement in principle was given to the appointment of organisers. It is hoped that detailed proposals will be accepted to enable appointments to be made in the latter part of 1967.

In 1966, 1,202·7 equivalent whole-time domestic helps were employed compared with 1,102·3 for 1965 and 1,101·2 for 1964. Eighteen thousand, two hundred and forty-nine cases received 2,501,460 hours help through the service, an increase of 694 cases when compared with 17,555 cases in 1965. The help provided for the aged represented 82·6 per cent. (1965—81·1 per cent.) and 87·4 per cent. of the total hours (1965—87·1 per cent.).

MENTAL HEALTH

Introduction:

Once again the outstanding feature of the services for the subnormals is the continued enthusiasm shown by both trainees and staff for the industrial work undertaken in the training centres. Each succeeding quarter has shown a slight increase both in quantity and value of the goods produced. The continued growth of this work has not brought any diminution to the keenness with which the trainees approach their industrial work contracts and it is now apparent that the advent of industrial work has done much to stimulate and, in some cases discover, talents which formerly were latent in the mentally subnormal person. It is pleasing to note that the trainees received increased rates of incentive payment during the year, the former minimum of 5/- per week being lifted to 7/6 whilst the maximum payment was increased from 15/- to 30/- per week. The income from production (less cost of raw materials) was absorbed in payments made to patients. All goods produced are sold at standard market prices. There is no question of cheap labour work.

The valuable help of voluntary bodies, particularly the Parent/Teacher Associations, is again acknowledged. Of particular interest is the generous offer of the Goole and Selby Round Tables to provide a learner swimming pool at the Rawcliffe Training Centre. The development of this project will be watched with great interest.

Further provision of residential accommodation will have to be made in future planning. Allied to this is the interesting development at Morley where two houses are being adapted for residential use by subnormal and post-psychotic patients. The efforts of a voluntary group in establishing the Outlook Housing Association at Harrogate is particularly praiseworthy and merits special mention.

Mental Health Week held 5—11 June was the first of a series of three such weeks. These are initiated jointly by the National Association for Mental Health and the National Society for Mentally Handicapped Children. During this week there were special 'Open Days' in the training centres. Display panels, posters and literature were available at the Centres and much public interest was displayed. Plans are now in hand for the Mental Health Weeks which will be held in 1967 and 1968.

The capital building programme has been curtailed by financial restrictions but it is gratifying to know that two new special care units are nearing completion and that the new training centre at Brighouse will commence building shortly, also that the new hostel for subnormal children at Skipton will be under way during 1967. A site has also been purchased for a new training centre at Wetherby.

With the completion of a new kitchen and dining room at Heckmondwike, all the comprehensive training centres, except Rawcliffe, are now equipped with cooking facilities on the premises. A scheme for improvements at Rawcliffe is already at the drawing board stage.

Visitors during the year included Mr. Castelow, the Ministry's Adviser on Mental Health Services, and Miss Nagel, Regional Welfare Officer of the Ministry of Health. Mr. Castelow and Miss Nagel visited the West Riding for five days during October and concentrated on services for the mentally ill. They visited Psychiatric Clubs, Day Centres, attended Seminars etc. This was followed

by a visit from Miss Haskins, Advisory Mental Welfare Officer to the Ministry who made a ten day visit from the 11—21 October. Miss Haskins was particularly interested in services for the subnormals and she visited every training centre and hostel during the course of her stay. Encouraging reports were received following each of these visits.

The Command Paper, "Health and Welfare—The Development of Community Care" issued in June indicates the need for constant revision of forward planning and this is a matter which is receiving close attention.

It is fully realised that the Royal Commission on Mental Health recommended that there should be a re-orientation of the mental health services towards community care and away from hospital care except where the special facilities of the hospital services are needed. It may, however, be some years before a local health authority is able to undertake full community care for all who strictly fall within this category.

Training Centres:

ACCOMMODATION AND STAFF:

A full list of training centres for the mentally subnormal, together with details of the places available is given in Table 61 of the Appendix to this report.

An innovation in the staffing structure, is the introduction of a 'Cadet' grade. It was felt that this designation was necessary to cater for girls with the necessary academic qualifications (at least 3 'O' level G.C.E. passes) who professed interest in making a career in mental health. Approval to appoint 4 cadets each year was given by the Committee and the first cadets took up duty in September, 1966. The cadets are supernumerary to the establishment of the centre to which they are appointed, and it is expected that after successful completion of the cadetship (normally 2 years) application would be made for acceptance on the diploma courses. This scheme has advantages both to the cadet and to the Authority—it enables the cadet to have practical experience of working with subnormals before deciding that this is their chosen career, and it gives the Authority opportunity for full assessment of the girls' potentialities before seconding for training.

CENTRE ACTIVITIES:

Parent/Teacher Associations continue to give active and valuable support to many of the training centres. The financial help given by these bodies often enables the purchase of certain 'luxury' items, such as cine cameras and projectors, and large toys etc. which would not be provided in the normal way. Members of the P.T.A. are always willing to help with the special events such as Open Days, Harvest Festivals and Field Days.

A number of entries were sent to the Art Competition run by the National Society for Mentally Handicapped Children, and names from West Riding centres figured prominently in the lists of prize winners.

Despite the emphasis on industrial work, social training continues. This includes shopping expeditions, visits to large towns and places of interest, travelling on public transport, nature walks and visits to farms. Money values, use of the telephone, recognition of essential notices and many other exercises are also taught.

Social clubs continue to operate successfully in a number of centres. These are held in the evenings and the centre staff voluntarily give their time to run these clubs. Valuable help is also given by voluntary workers with youth club experience etc. Transport to and from the social clubs is again provided on a voluntary basis, various organisations sharing in this service.

SWIMMING:

Small parties of selected trainees make regular visits to local swimming baths. Usually a private session is arranged for the trainees who go in small parties accompanied by an adequate number of teachers who are competent swimmers. This is a very popular activity and has resulted in a number of trainees learning to swim.

A learner swimming pool is being built at the Rawcliffe Training Centre. The major contribution to this is coming by the joint efforts of the Goole and Selby Round Tables, who have generously promised to donate the major part of the cost and also to provide voluntary labour for the construction of the pool. This pool will measure 17ft x 9ft wide and will have an even depth of 3ft. The pool will be provided with a roof of plastic sheeting and will be enclosed on three sides by the existing building and on fourth side by a glazed wall. The water will be filtered and heated to a maximum temperature of 80°F.

HOLIDAYS AND OUTINGS:

The main item under this heading was the fortnight's holiday sponsored by the County Council. This took place at Whitby during the period 4—15 June. A mixed party of 50 trainees, drawn from all the training centres in the County, together with eight staff took part in this holiday.

A small party of children from the Horsforth Junior Centre and a party of ten adults from the Kirkburton Centre also enjoyed holidays by the sea. These additional holidays were sponsored by the Parent/Teacher Associations.

All the centres had their annual summer outings at the seaside and trips have been made to various inland places of interest.

INDUSTRIAL WORK:

This has continued, and indeed increased, during the year under review. Some measure of the volume of the work involved can be gained from the financial return for the year ending 31st March, 1966, which shows that the sale of finished products realised a total £15,700 whilst the value of services rendered by patients, e.g. care of grounds, laundry, cleaning of premises etc. came to £3,200 making a total income of £18,900. The cost of raw materials amounted to £9,500 and payments to patients £9,200.

Approximately 75 per cent. of the work undertaken is on behalf of the County Supplies Department. The remaining 25 per cent. of the output is the result of contracts with private firms.

The introduction of powered machinery has continued and the centres are gradually being brought up to a high standard of mechanisation. Contrary to the general expectation, a number of selected trainees have become competent operators of powered machinery. In one particular centre skittles of varying

sizes are produced from rough timber by a trainee who operates a wood-turning lathe with the minimum amount of supervision. Morticing machines, sanding machines, circular saws, and a variety of bench tools are in constant use. Special attention is paid to safety precautions. The local Factory Inspector is asked to advise regarding the siting and guarding of the powered machines. Control switches are located so that a machine, once stopped, can only be re-started by the 're-set' button which is sited or guarded so that only the Instructor has access. The problem of air-borne sawdust has been largely controlled by the introduction of mobile 'Dwarfe' dust collection units. Several major jobs, such as the enclosure of 'wood-splitting' areas, the laying of flagged paths, the construction of new gateways have been undertaken by the trainees under the supervision of their instructors. Work done in this way is assessed by a member of the County Architect's Department and the value of the work is then credited to the trading account of the centre.

The training centre grounds are maintained by the boys, who cut the grassed areas with power-driven rotary mowers. At a number of centres there is also a kitchen garden where vegetables are produced for use in the kitchen. A number of greenhouses have been erected from funds provided by Parent/Teacher Associations.

SOCIAL TRAINING:

This aspect of the training centre programme is not being neglected and the recommended division of time is 17½ hours industrial work to 12½ hours of social training. The latter involves many aspects including organised visits to large shopping centres, visits of observation, travel by public transport, etc. Social visits to other centres, cricket and football matches are also arranged. Dancing and organised indoor games are enjoyed by both adult and junior trainees alike.

PAYMENTS TO TRAINEES:

The scheme for incentive payments to trainees was introduced in April, 1964. Originally the scheme provided for payments ranging from 5/- to 15/- per week, this was, however, varied to allow a minimum payment of 7/6 per week and a maximum payment of 30/- per week as from 1st April, 1966.

The incentive payments scheme has done much to lift the morale of parents, who have been encouraged by seeing their sons and daughters, whom they never expected to earn anything, bring home a weekly wage packet, however small.

Payment is not related solely to productivity, but effort and enthusiasm are taken into account. The trainees receive their pay in transparent envelopes and are encouraged to acknowledge receipt by either signing the wages sheet or making their mark against the amount.

SPECIAL CARE UNITS:

In view of the increasing demand for placement of severely handicapped children, plans are now in hand for increasing the accommodation in the special care units. Two units, each designed to accommodate twelve children, are under construction at Hemsworth and Wombwell. When these are completed the provision for special care will be increased from 73 to 97 places. Another new unit is planned to follow those now being erected, and increased provision is also planned for three of the existing units.

The special care unit is designed for those patients who are too severely handicapped to fit into the normal routine of the training centre. Provision is made in the special care unit not only for the immobile severely physically handicapped child but also for the hyper-active child whose presence can be such a disturbing influence in class and whose activities seriously interfere with the training programme and classroom routine.

The provision of special care has been an undeniable boon to those harassed parents who have struggled, in some cases for years, to bear at home the burden of a severely handicapped child.

The special care units are open for 48 weeks in the year. For appropriate cases special transport is provided, the vehicles being fitted with safety harness and dunlopillo mattresses.

Mental Welfare Officers:

Details of the staffing position are given in the list of staff on page 27.

TRAINING COURSES:

Mr. Hope, Senior Mental Welfare Officer in the Naburn, Bootham and de la Pole Mental Health Area, was awarded the Certificate in Psychiatric Social Work at the University of Leeds and Mr. Willis and Mr. Blackburn, Mental Welfare Officers, were awarded the Council for Training in Social Work's Certificate in Social Work. Three Mental Welfare Officers commenced the course in September.

The Northern Branch of the National Association for Mental Health again had two Induction courses for newly appointed Mental Welfare Officers and nine of our officers attended the courses.

In-Service Training:

MENTAL WELFARE OFFICERS:

Four three-day courses for Mental Welfare Officers were held at Grantley Hall, the County Council's resident college for adult education. The first of these, 29th to 31st March, was entitled "Mental Health and the Elderly". This was a repeat of two courses towards the end of 1965 and was arranged so that every Mental Welfare Officer had the opportunity of hearing papers on this very topical subject.

Similarly three identical courses were arranged in October and November, entitled "Patterns of Rehabilitation". These courses commenced with a visit of observation to the Industrial Unit at Middlewood Hospital, Sheffield, and were attended by a total of 46 Mental Welfare Officers.

Having regard to the many young and relatively inexperienced officers entering the field of Mental Health, it is felt that these in-service training courses are a vital and necessary part of the County Council's training programme. They also keep the older officers up-to-date on modern trends and development.

Further in-service training is maintained through the regular seminars organised by Mrs. Farrow and by attendance of Mental Welfare Officers at case conferences held in the Psychiatric Hospitals.

The Senior Mental Welfare Officers met at monthly intervals throughout the year. All the meetings, apart from the one held in June, were at County Hall, Wakefield. The June meeting was held at the Rawcliffe Training Centre and the afternoon session took the form of a visit to the nearby Day Centre for the Mentally Ill at Snaith.

These meetings are much appreciated and provide a valuable link between the administrative and field services and serve to keep all concerned in touch with events throughout the County area.

TRAINING CENTRE STAFF:

Perhaps there is an even greater need for the teachers and instructors in the training centre to be kept up-to-date with the rapidly moving events in their own sphere of service. Consequently four courses each of four days duration were held at Grantley Hall during the year. These courses included visits of observation to Special Schools, Educational Equipment Contractors, Training Centres and other establishments. The subjects covered were "Special Care Units", "Youth Clubs", "Industrial Work", "Music & Movement", "Drama" and "Social Training".

A total of 64 members of the training centre staff attended these courses, including Supervisors, Instructors, Assistant Supervisors, Trainees and Cadets.

There are a number of new entrants to the service each year and the value of these short courses is being constantly emphasised.

Hostels:

MEADOW BANK HOSTEL, HARROGATE (for subnormal children)

The hostel which accommodates 8 subnormal children has been used almost to capacity during the year. The permanent residents (the children who are at the hostel from Monday to Friday each week during the Training Centre Terms) have been in residence a total of 1,394 days out of a possible 1,511; during the Training Centre holidays 8 children have been admitted to short stay care for a total of 91 days, there were 3 discharges during the year and 4 admissions. The four boys aged 13, 12, 10 and 7 years had all been in residence for more than 2 months and the four girls aged 14, 8, 5 and 5 years comprise the admissions during the year. Of the three children discharged two continue to attend the training centre from their homes and one child has removed to another area.

In April the hostel was adopted by boys from the Ashville School and girls from the Harrogate Convent School, and each Thursday afternoon during the term some of the girls come down to the hostel to play with the children and help with tea. On Thursday evenings four of the older children attend the club run by the local society for Mentally Handicapped Children.

It has been a most rewarding year and one which has confirmed the success of a hostel of this type.

BEALEY CROFT HOSTEL, WESTERTON ROAD, WEST ARDSLEY (for subnormal adults)

Dr. Ireland, the Divisional Medical Officer, and his staff have compiled a

paper following the first full year's working of this hostel, and the following extracts are taken from this paper:—

" This purpose built hostel, the first of its type erected by the West Riding County Council, was completed in July, 1965, and has accommodation for 30 mentally subnormal adults. It is situated in a residential area and structurally it consists of three wings, two of which are at right angles to each other containing the bedrooms and are two storeys high. One is for male residents consisting of two four-bedded rooms, three two-bedded rooms, the sick room and the warden's flat; the other is for female residents consisting of four two-bedded rooms, seven single rooms and two bed-sitting rooms for assistant wardens. These two wings are joined by a common approach to a third wing which is single storied and contains the kitchen, dining room, lounges, games room, office and reception area.

The original aim of the hostel was to function as a substitute home for subnormal adults, catering in the main for the following two groups.

1. Subnormal adults living in the community who lose their parents or guardian, temporarily or permanently by death or illness, or where poor social conditions exist in the home.
2. Subnormal adults living in hospitals but not considered to be in need of treatment.

It was anticipated that the residents would fall into two groups, those in employment and those attending the training centre and places were made available for hostel residents in the training centre which adjoins the hostel. No mid-day meals are provided at the hostel as those in employment eat at work and those attending the training centre eat in that establishment.

The hostel is situated in West Ardsley, Morley, and is within easy reach of Leeds, Bradford, Wakefield and Dewsbury, which as regards employment allows easy access to industry.

Admissions and Discharges

During the period between the 14th September, 1965 and the 30th September, 1966, 42 admissions and 15 discharges occurred as follows:—

Age and Sex of Residents admitted to and discharged from Healey Croft between 14th September, 1965, and 30th September, 1966.

Age	Male		Female		Total		Residents at 30-9-66
	Admitted	Discharged	Admitted	Discharged	Admitted	Discharged	
15—	6	4	3	1	9	5	4
20—	2	2	5*	2*	7	4	3
25—	3	—	1	1	4	1	3
30—	1	—	2	—	3	—	3
35—	3	1	1	—	4	1	3
40—	3	—	3	—	6	—	6
45—	—	—	1	—	1	—	1
50—	4*	3*	2	—	6	3	3
55—	1	—	—	—	1	—	1
60—64	1	1	—	—	1	1	—
TOTAL	24	11	18	4	42	15	27

*Admitted and discharged twice

Nine residents were already in employment on admission to the hostel but four of these had to be found new jobs because of redundancy. Nine other residents were found employment after admission, four graduating from the training centre. Healey Croft is fortunate in having available a number of brickworks in the immediate locality as the type of labour required suits the capabilities of the male residents and the majority of these are employed in varying capacities in this industry. To enable a resident to successfully settle into employment and maintain a good work record it is necessary (a) to make a good assessment of his or her potential and personality, (b) to make contact and continue a working relationship with employers and (c) to have a good relationship with the resident concerned.

that therapeutic help can be given at times of stress and difficulty. In some cases it can be demonstrated that the resident works to please the warden though it is hoped that in time a successful work habit pattern can be formed. It is of course important that the resident recommended for employment be capable of doing the work involved as many employers are not tolerant of repeated failures; and in living with the residents the warden and his resident staff are able to make an accurate assessment of the personality in this respect. Further the Supervisor of the Training Centre advises as regards ability and reactions in a more controlled work situation.

There have been difficulties though not as one might have expected from the mixed sex population at the hostel. This is perhaps because adequate control and supervision have been provided. More evident, however, have been the difficulties associated with the mixed level of ability. All the residents eventually associate themselves with their peers, and two groups, those working and those attending the training centre, materialised early in the life of Healey Croft; the former seeking greater privileges than the latter which does result in a little discontentment at times. This situation has never reached a size to produce a major problem, mainly because of its being almost a straight sex difference in that the female residents attend the training centre whilst the male residents go out to work.

Experience during this first year has shown the value both to residents and resident staff of well defined periods of off-duty and during the early months when the hostel was not fully staffed, holidays and sick leave necessitated long periods of duty. The constant availability of the same member of staff led to a gradual deterioration in general behaviour which was particularly marked in the case of one or two residents. With improvements in the staff situation it was found that the more serene the atmosphere in the hostel the less the difficulty experienced with the settling in of new residents and in this respect the hostel environment seemed to exert a therapeutic action, particularly when one realises the varying backgrounds, training, habits and degree of dependence of one new resident compared with another.

The warden and his wife have two children aged ten and twelve years who follow their own activities within the hostel where they have integrated their daily routine and associations without direction or restriction, and apart from occasional meals taken in staff quarters all meals are taken together in the main dining room. It is thought that the combination of a mixed hostel and the close proximity of resident staff, families and pets, (three dogs and two guinea pigs) has led the residents to identifying the hostel as a home. Fortunately at the present time there is a settled day staff who are also identified with the hostel and are involved by the residents irrespective of whether they are cook, cleaner or domestic assistant. Nevertheless the residents understand the necessity for reasonable behaviour and the modicum of discipline which must be present in any normal home. It is felt these factors have helped to create an environment which consists of a fine balance between discipline and permissiveness which is both tolerable and pleasant for residents and staff alike.

Staff

The resident staff establishment originally consisted of a warden and two assistant wardens. There was a non-resident cook, five part-time domestic assistants working 21 hours each week and a part-time caretaker working approximately 10 hours per week who shared his duties with the adjoining comprehensive training centre. This establishment, however, was modified in the light of experience for two reasons. Firstly, the warden and one of the assistant wardens were in fact man and wife and difficulty arose when both were on annual leave as this meant only one assistant warden was in the hostel during the whole of this period. Accordingly a fourth member of the staff was appointed as an attendant to work full-time. This ensures that at all times when the residents are in the hostel two members of staff are available for duty. Secondly, because some of the male adults are employed in local brickyards it is necessary for breakfasts to be prepared at 5-30 a.m. for them and again at 7-30 a.m. for those attending the training centre. As no mid-day meals are provided at the hostel and in order to provide an evening meal between 6-0 and 7-0 p.m., two cooks are now employed each working on a part-time basis. It took a year to fill all the posts in the establishment though this would appear to be a problem experienced by other local authorities."

BOARD AND LODGING HOUSES:

During the year two houses owned by the authority became vacant and they were considered suitable for use as lodgings for those people who had spent some time in the hostel and were recommended for lodgings. These houses will be brought into operation during 1967 and details of administration will be given in the next Report.

PATIENTS IN HOSTELS RUN BY OTHER AUTHORITIES AND VOLUNTARY BODIES:

The authority has continued to accept financial responsibility for patients admitted to the hostels of other authorities, particularly within the Riding, and homes run by voluntary organisations, and at 31.12.1966, 22 mentally ill patients were being maintained in County Borough hostels and 17 mentally subnormal patients were being maintained in voluntary homes.

It is already evident that the increasing demand for hostel placement for both the mentally subnormal and post-psychotic type of patient, together with the needs of the aged mentally confused, will mean a drastic revision of the authority's proposals in regard to hostel building. This matter is at present receiving attention and the Ten Year Plan will be amended accordingly at the appropriate time.

The "Outlook Housing Association", Harrogate, was formed by a group of local people to provide accommodation for mentally disturbed patients who are homeless or living in unsuitable lodgings. The house is designed to accommodate six persons in bed/sitting rooms and received its first residents in September, 1966. This is a most worthwhile venture and the outcome will be watched with great interest.

Day Centres:

HARROGATE THERAPEUTIC CLUB:

This club has now been established for three years and for some time it has been apparent that the rented premises in Station Parade have been totally inadequate. Arrangements have been made to rent a house at 13, Dragon Parade, Harrogate and it is expected that the necessary repairs will have been carried out and the furniture and equipment provided to enable the club to be transferred there in April, 1967.

The aims of the club have been:

- (1) to maintain in the community a large number of patients who, in spite of the existing services, frequently return to hospital for treatment which can only be described as maintenance, i.e. patients who ought not to be occupying hospital beds.
- (2) to rehabilitate those who, though far from well on discharge, have had all the treatment the hospital can give, and who stand a chance of adjusting to life in the community, given the necessary assistance.
- (3) to attempt to do something about the psychopath in the community.
- (4) to place the Mental Health Service in a position to consider group therapy for juvenile psychotics under the guidance of a psychiatrist.

The first aim has been amply achieved and the hope is that with the new premises greater success will be achieved with the second group. There has been no progress along the lines of the fourth group but undoubtedly the outstanding success of the centre has been the rather surprising progress that has been made towards the treatment of psychopathy. This development has changed the character of the centre. The psychopath often functions quite well in the community until an emotional crisis arises and then he needs help at once. At the club a permissive attitude results in erratic attendances but provides the atmosphere for preventive work with this type of patient.

SNAITH DAY CENTRE:

Dr. Appleton, Divisional Medical Officer for the Goole area, reports:—

“ During the year two patients returned to full-time employment and two to part-time work but one of the latter had a relapse. Two more have registered for light employment. This has tended to encourage others and has resulted in a partial change of direction in running the centre. From occupations which aim at relaxing tensions and restoring confidence there is a growing demand for craft instruction which patients believe will be useful to them when they return to community life.

Instruction in joinery, wood carving and turning is given regularly to a small group and patients are showing an interest in First Aid. One patient, an ex-miner, has progressed so well that he has been accepted for training as a cabinet maker at a Ministry of Labour Training School. It is still important to study each patient individually and preserve his identity as an individual, which is not always possible in hospital. This is well illustrated in the case of Mr. H. who came to the centre after eight years in a mental hospital. He was encouraged to do a little hedge and grass cutting in the vicinity and gradually he found a demand for his services. He has added car valeting to his accomplishments. His self-respect has been greatly strengthened by the feeling that he has made the grade by his own efforts. Behind this and other successes is the steady support and unobtrusive guidance of dedicated therapists working closely with the visiting psychiatrist.

An unexpected development is the active interest of relatives who, when stress prevents the attendance of a patient, telephone the therapist to discuss the problem and how best to maintain contact with the centre by some continuing home work.

In this centre, industrial rehabilitation is only half the problem: social rehabilitation is equally important. Therefore, music, games, discussions and particularly contact with selected normal people, play an important part in the daily schedule. The adjacent secondary school is becoming interested in the centre and one or two pupils make occasional visits. A school group entertained at and joined in the Christmas Party.

1965 was almost entirely an experimental year; 1966, although still experimental, showed the emergence of a purpose planned schedule. Whilst preserving individual occupational therapy, small group therapy is the likely trend for 1967.”

Psychiatric Social Clubs:

A full list of the Psychiatric Social Clubs operating in the County is given in Table 62 of the Appendix.

The *Maltby Social Club* re-opened in October. There was a good attendance at the inaugural and subsequent meetings, 20 out-patients and 14 selected in-patients of Middlewood Hospital being present. It is hoped to widen and improve the scope of the club's activities and to hold meetings at monthly intervals. In July an experimental afternoon club was started in *Wetherby* and was held each Thursday afternoon until the end of September, when it closed due to lack of interest. However, there still remains a need for this type of group activity and further thought is being given to this.

The *White Rose Club* was transferred from Skipton to The Butts Clinic, *Barnoldswick* in August and was held weekly until the end of the year but unfortunately it then had to be suspended. It is hoped to restart activities next year when the establishment of Mental Welfare Officers is again filled.

The *Contact Club* at *Cleckheaton* has continued to meet throughout the year on Tuesday evenings, the weekly attendance is about 30 patients, with considerably more on special occasions. During the three years the club has been operating the membership has undergone a complete change from those who came along in the early days. It has been a pleasant and successful year and much hard work has been called for by all concerned but the results have fully justified the effort made.

The *Castleford Club* membership is now 20 with an average attendance of 12. The premises used are compact and comfortable with the result that a friendly and encouraging atmosphere is prevalent. Mental Welfare Officers are in attendance and have a room set aside for interviews and discussions. Activities are varied as much as possible and a number of club members have become keen supporters of a local Dramatic Society.

The *Handshake Club* at *Tadcaster* provides a useful double service as a means of follow up for discharged patients and for providing club activities in an informal atmosphere for those persons unable to face normal social contacts. There have been interchange visits to the York and Harrogate Clubs and outside activities have included a visit to the cinema and an outing to the Lake District. Generous assistance with the transport arrangement has been given by members of the Round Table and Lions Association, and this help is much appreciated. The 30 members have made 434 attendances during the year.

The *Springhead Club* is held in the afternoon, there are 10 members and the usual attendance is 6—8. The club is still mainly occupational and this year painting has been added to the list of activities. All the members enjoy and look forward each week to the meetings.

The aim of the *Rock Club* at *Wath upon Dearne* is to meet as many as possible of the needs of the mentally disordered who, living within reasonable travelling distance, are able to reach the club on their own initiative and where the services of the club are considered socially to be of therapeutic value. The club membership is 70—and average attendance of 45 during the year demonstrates how many of these needs are being met by group activities in an acceptable setting and where social needs of rehabilitation are given priority. A good staff-to-patient ratio is found necessary and valuable assistance is given by members of the Townswomen's Guild, Youth Club members of the Trinity Methodist Church and other voluntary helpers.

The Rockingham Institute of Further Education arranged a scheme of afternoon sessions at Wath for some of the patients, where various crafts are taught, e.g. millinery, dressmaking, art and embroidery. Three teachers with a fund of kindness and tolerance were specially chosen. The classes commenced with 18 patients and since June an average of 24 patients have attended these weekly sessions regularly.

The *Rothwell Club* has met regularly and the social evenings are much appreciated by the members. The average weekly attendance is 18 but the club serves a much larger number of people, and there is quite a turnover of members.

The *Glen Social Club*, *Shipley*, continues to meet weekly. The club meetings have been varied with guest speakers on a variety of subjects, and film shows. Last year group discussions were started and these have continued and they have shown that many of the new members have been able to achieve a greater measure of socialisation and integration by participation in these discussions.

The *Harrogate Social Club* met on 52 occasions during 1966, attendances totalled 1,167. Ten people have left the club during the year and a similar number of regular attenders have joined the club. Club activities still follow the same pattern, whist, dominoes, 'beetle' and bingo for the older age groups and table tennis and gramophone records for the younger people. Dancing remains a popular pastime and it brings the members together for the last hour

of the club session. The seaside holiday is becoming an annual event and 21 people enjoyed a holiday at Whitby. A weekend stay in a Lakeland Youth Hostel was successful. Help has been given to the club by the Harrogate Citizens' Guild of Help, the Happy Wanderers' Ambulance Organisation and the Harrogate Lions Club.

The *Ilkley* and *Morley* Clubs have continued to meet regularly. West Riding patients continue to attend the clubs held in *Halifax* and *Huddersfield*.

Hospital Admissions and Community Care:

Statistical data relating to hospital admissions is given in Table 63 of the Appendix. From these it will be seen that the number of admissions arranged by mental welfare officers has risen by 102 and the number of compulsory admissions has fallen from 903 to 891. The use of Section 29 increased from 571 to 597.

The compulsory admission procedure provided under Section 29 of the Mental Health Act, is designed for emergency use in exceptional cases. Normally compulsory admissions should be made under Section 25 of the Act upon the medical recommendation of two doctors. Section 29 should, in theory, only be used when the obtaining of a second medical recommendation would involve undesirable delay.

It would appear that one of the reasons for the relatively wide use of Section 29 is difficulty in obtaining the second medical recommendation and the Ministry of Health have expressed concern that such a high proportion of compulsory admissions are effected under the short-term powers of this Section of the Act. In October, 1966, Sir George Godber drew this matter to the attention of Medical Superintendents and Chairmen of the Medical Committees of Mental Illness Hospitals. Since then there does appear to have been a small but definite decrease in the use of this section.

Dr. Watt, Division 31 (Rotherham) has provided an analysis of the 227 cases referred to his mental welfare officers during the year. In 129 cases the accompanying report recommended admission to hospital for in-patient treatment but investigation established that so far as 49 of these cases were concerned, the necessary help and support could be provided by arranging out-patient or day hospital attendance, or by introducing suitable domiciliary services. The mental welfare officers assisted in the admission of 80 people to psychiatric hospitals. Of the 36 men, 15 were in the age group of 45 to 64, 10 in the age group 25—44, and 5 were over the age of 65. Sixteen of these men had previously received treatment in hospital. Of the 44 women, 25 were in the age group 45—64, 11 in the age group 25—44, and 6 were over the age of 65. Twenty-two had previously received treatment in hospital. Of the 80 cases 44 were informal admission, 16 were Section 25 cases and 20 were Section 29 cases. Forty-eight of the patients were discharged within 4 weeks of admission, 13 within 2 months of admission and 4 within 3 months. Eleven patients were still in hospital at the end of the year and of those discharged 35 were referred for after-care. Two hundred and twenty seven referrals is slightly higher than the County average but the stay in hospital of patients reflects a trend in the County which has been apparent for some years.

The problem of elderly patients is still acute. In the Rotherham Division there were 32 referrals during the year. Hospital admission was necessary and arranged in 11 cases and the remainder were able to remain in the community

by the provision of suitable help in the home. Mr. Emmerson, Senior Mental Welfare Officer in the Stanley Royd Mental Health area points out that though a great deal of development has taken place in the area since 1959, the case of the elderly mentally ill has received little attention. The percentage of these patients in hospital is very high and many may have to remain there because of the lack of suitable alternative accommodation. Although the need for hostels for this type of patient is acute, it is doubtful whether even an accelerated building programme could cope adequately with the increasing numbers, and it seems likely that specific accommodation will have to be supplemented by other means. The Stanley Royd area provides the following encouraging example. With the co-operation of the housing authority two ladies who have been in hospital for 24 and 30 years respectively have been provided with a bungalow, and with the support of the hospital and the mental welfare officer they are now enjoying a full and active life in the community after a surprisingly short transitional period.

Psychiatric Services:

The Leeds and Sheffield Regional Hospital Boards have agreed to the appointment of a Consultant Psychiatrist to take over the responsibility for the Psychiatric Service to Barnsley and certain areas of the West Riding. The Consultant will have beds at Storthes Hall Hospital for this purpose. A further development in the area of the Sheffield Regional Hospital Board was the completion of the 81 bedded psychiatric unit at the Doncaster Royal Infirmary. A day hospital with 35 places included in the department will be completed towards the end of March, 1967. These developments have resulted in the following variations in catchment areas as from the 2nd January, 1967:—

Storthes Hall Hospital	To cover Health Division 25
Psychiatric Department, Doncaster Royal Infirmary, (with supplementary assistance from Middlewood Hospital)	To cover Health Divisions 27 and 29
Middlewood Hospital	To cover Health Divisions 22, 26 and 31

Future Planning:

In June, Command Paper entitled "Health and Welfare—The Development of Community Care, Revision to 1975—76 of plans for the Health and Welfare Services of the Local Authorities in England and Wales" had been published. It indicated that the authority's provision of hostels for the mentally subnormal and training centres would fall short of the national average for 1976. So far as hostel accommodation for the subnormal is concerned it was considered undesirable to commit the authority to a forward programme of capital building until there was experience in this field from the operation of experimental units and adequate evidence of the need for, and distribution of, further units. The basic programme of experimentation is not yet complete, although sufficient is known to suggest that the tentative forward planning is inadequate. It is therefore proposed to make an up-to-date assessment of need and to seek the Committee's approval to an amended programme for inclusion in the next

review of the Ten-Year programme. With regard to training centres the present concern has been the completion of the programme already authorised. It is, however, gratifying to know that the proposed Brighthouse Training Centre will now be commenced during the 1967/8 financial year. It is apparent that continued expansion, beyond that already planned, will be necessary but primarily attention has been directed to ensuring as wide a spread of facilities as possible. Again it may be necessary to make a new survey of probable future needs in training centres but it is evident from what has been achieved already that the authority is well equipped to deal with an expanding programme.

PART V

ENVIRONMENTAL HYGIENE

Pest and Drugs

Sanitary Conditions

Amalgamated Public Health

PART V

ENVIRONMENTAL HYGIENE

Food and Drugs

Sanitary Circumstances

Atmospheric Pollution

ENVIRONMENTAL HYGIENE

The Public Health Inspectors Section has once again been able to continue with a full establishment of staff which is a far more fortunate state of affairs than that existing in some of the County Districts.

Our new interests during the year have been the taking of soil samples for the Public Health Laboratory Service Tetanus Survey and joining a working party at County level to consider the problems raised by gypsies and to make recommendations regarding caravan sites.

The only duty not mentioned in the body of the report is the inspection of nursing homes. These have been carried out in conjunction with the medical and nursing staff.

The present number of staff is just adequate for the present duties, but the work continues to increase. The work involved in the supervision and sampling of water at swimming baths has increased greatly and more time could be well spent on this, particularly during the summer months. This of course is the same time as more effort is needed in the supervision of milk supplies for during the year there has been a disquieting number of keeping quality failures. Additionally, to make life even more fully occupied, the Ministry of Health suggested in a circular relating to Brucellosis that monthly sampling should be undertaken. At that time we were sampling quarterly but we are now endeavouring to obtain them every two months, with existing staff, as a compromise.

Food and Drugs Act, 1955:

THE MILK (SPECIAL DESIGNATION) REGULATIONS, 1963:

THE MILK (SPECIAL DESIGNATION) (AMENDMENT) REGULATIONS, 1965:

Licensed Dealers:

The supervision and sampling of dealers has now developed into a regular pattern and would almost appear a not very important routine job. That is unless one stops to think of the poor standards of storage and distribution which were inherited with the duty of licensing in 1961 and the progress made since then. Even now some newcomers to the trade often have little knowledge of the dairy industry and less understanding of the product they are handling. Were it not for the high standards of most of the processing plants in and around the County area there would be many more keeping quality failures.

At the present time there are too many methylene blue failures. The highest percentage is in untreated milk and vigorous efforts are made to ascertain the cause of failure. If the sample is obtained directly from a producer/retailer then notification is sent to the Ministry of Agriculture, Fisheries and Food as they are the licensing authority. When the sample is obtained from a producer/retailer via a second dealer the storage and distribution methods of this person are investigated first of all. Obviously it would be wrong to send notification to the Ministry without ensuring that the dealer licensed by this authority was in order.

A few dealers on the west side of the county have started to sell the new Ultra Heat Treated designation of milk but as yet this is still on a small scale. Samples obtained have been satisfactory. None of the processing plants in the County area has started this method to date.

Table 66 of the Appendix gives details of dealers licensed at the end of the year (excluding licenced pasteurisers and sterilisers and bottling premises, details of which are given separately), and Table 67 of the Appendix shows the number of samples obtained by the department from dealers in the County area, with results of statutory tests.

Processing Plants:

Given in Table 68 of the Appendix are details of licenced establishments for the pasteurising and sterilising of milk.

There has been a disappointing number of failures both of the methylene blue test and the phosphatase test. Five of the phosphatase failures were from the two new processing plants and another plant going through a trial period. One plant which had three failures was puzzling for a time. Eventually it was found that in an endeavour to take advantage of off-peak electricity charges additional milk was being added to a pasteurising vat after the commencement of the holding period. This did not show on the recording chart.

The phosphatase failures at established plants were due to lack of care by inexperienced workers. Strong representations were made to the management concerned.

The majority of plants have carried out their duties well and only minor matters such as decorating and protective clothing have had to be brought to the attention of management.

Advice was sought from the department by one company which had been prosecuted a number of times for dirty bottles by a neighbouring authority.

Details of samples obtained from the processing plants are given in Table 69 of the Appendix.

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. Regular visits were made to the twelve premises concerned and one hundred and fifty four samples obtained. Eighteen of these failed the methylene blue test and were fully investigated. Three samples gave positive cream cultures for brucellosis and the necessary action was taken to stop the sale from these supplies.

SUPPLY OF MILK TO SCHOOLS:

A supply of pasteurised milk is obtained for schools wherever possible but there are still twenty schools which have untreated milk. Eighty eight samples were obtained at the schools and thirteen of these failed the methylene blue test. Investigations were made and repeat samples were satisfactory.

All untreated milk samples are examined for tuberculosis, brucellosis and antibiotics in addition to the keeping quality test. One sample was found to contain antibiotics and one gave a positive cream culture for brucellosis. Immediate action was taken to obtain an alternative source of supply.

SAMPLING OF MILK AT HOSPITAL FARMS:

Sampling, which is carried out at the request of the Ministry of Health, continued at two farms. At Stanley Royd Hospital Farm, Wakefield, where the

production of untreated milk only takes place, twenty six samples were obtained. All passed the methylene blue test and all were free from antibiotics. At Stansfield View Hospital Farm, Todmorden, where a pasteurising plant is installed, thirty samples were obtained. All passed the methylene blue test but there were two phosphatase test failures.

ANTIBIOTICS IN MILK:

1,768 samples were submitted to the Wakefield Public Health Laboratory for examination for the presence of antibiotics. 21 samples or just over 1 per cent. were found to contain antibiotics which is an improvement on last year. Follow-up action has been taken again in co-operation with the Milk Marketing Board and it has not proved necessary to take any formal action. The examination carried out has been the modified T.T.C. provisional method for the detection of antibiotic and other inhibitory substances in milk.

BRUCELLOSIS:

An active year has been spent in this field and the number of samples obtained went up to 1,921. All samples were examined by ring test and cream culture and a limited number by guinea pig inoculation. The number of positive cream cultures was encouraging, only 85 were found. This percentage of 4.4 compared with 7.6 last year shows a marked decline in incidence of infection. Circular 17/66 was issued by the Ministry of Health in October. This document aimed at giving guidance to authorities in interpreting the provisions of the Milk and Dairies Regulations with regard to infection of milk. In the main it followed the policy already in force by this authority but with the major exception of frequency of sampling. Monthly sampling was suggested but with the very large number of producer/retailers in the county this would be impossible to achieve without a substantial increase in staff. By a rearrangement of emphasis in sampling it is hoped to achieve bi-monthly sampling in place of the present quarterly sampling.

There seems to be a far keener interest being shown by farmers in this disease at the present time. A way in which this appears to have been stimulated is by this department's recently applied policy of notifying the farmer immediately we obtain a positive ring test result from the laboratory. If the farmer is sufficiently interested it does give him an opportunity to check his herd before we obtain a positive cream culture result and put the procedure in motion for stopping the sale of his milk.

The policy of notifying Divisional Medical Officers of all results of milk samples taken by the department has continued. Additionally we have endeavoured to work in co-operation with County District Officers and avoid any duplication of sampling. We are grateful for their help and assistance.

The information supplied to us by the Directors of the Public Health Laboratories in and around the County has been most helpful and we are grateful to them.

Our largest bouquet must, of course, go to Dr. L. A. Little, Director of the Wakefield Public Health Laboratory, and his staff, to whom we seem to have provided more work than ever and from whom we have received only help and kindness.

REPORT OF ANALYST:

All County Inspectors of Weights and Measures and Consumer Protection 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, 2,840 samples were submitted by your Inspectors under the Food and Drugs Act, 1955 as set out below:—

	Total Samples	Adulterated or Below Standard	Percentage Adulterated or Below Standard
Milk	1,227	32	2.6
Milk 'Appeal to Cow' ...	11	—	—
Milk, Channel Islands ...	249	3	1.2
Milk Bottle	1	1	100.0
Food and Drugs	1,352	69	5.1
All samples	2,840	105	3.7

Notes on adulterated or otherwise irregular samples

The percentage of combined categories of irregular samples is the same as last year; there are fewer adulterated milks but more unsatisfactory foods of other types.

Milk. 23 samples were deficient in fat in amounts varying from 1.0 to 27.0 per cent. of the standard. 9 samples were adulterated with water, the most serious case contained 5.5 per cent. added water.

In following up these irregularities, 11 'Appeal to Cow' samples were taken. 7 of these were below standard as regards non-fatty-solids, but the freezing point proved that they were genuine milk naturally of poor quality.

Channel Islands Milk must contain at least 4 per cent. of fat. Only 3 samples out of 249 failed to reach this standard. The worst example contained 3.57 per cent.

Meat Products. At the time of writing, there are no legal standards for the meat content of Potted Meat, Brawn, Sausages, Sausage Meat, Sausage Rolls, Meat Pies, Meat and Potato Pies, Steak in Gravy, Chicken in Jelly etc. There are codes of practice relating to some of these items, and some manufacturers are now declaring the meat content on the labels. These are steps in the right direction, but manufacturers and Public Analysts will be glad when firm standards are legalised. The Ministry of Agriculture, Fisheries and Food have issued proposals for many of the above mentioned meat products, but they are still only tentative.

Until such standards are established, Public Analysts must set a reasonable standard based on experience and custom.

Beef Sausages. We continue to demand at least 50 per cent. of meat. 51 samples were all satisfactory in this respect, the meat varying from 50 to 80.1 per cent., average 63.1 per cent.

Pork Sausages. 46 samples were analysed, their meat contents ranged from 58.7 to 87.4 per cent., average 69.7 per cent.

Sausage Meat. Out of 8 samples, only 1, a Pork Sausage Meat, was substandard with 55.1 per cent. meat.

Meat and Potato Pies. These vary widely in composition; many of them should be described as 'Potato and Meat Pies', judging by the ratio of meat to potato. A survey was made of 26 samples, the meat content varying from 5.1 to 21.4 per cent. The Ministry of Agriculture, Fisheries and Food proposed a standard of 12.5 per cent. meat; on that basis 15 of these samples were declared substandard.

Raspberry Jam. The Food Standards (Preserves) Order stipulates a minimum soluble solids content of 65 per cent. Below this limit the jam has poor keeping qualities. One sample contained only 64.7 per cent. soluble solids.

Misdescription

Nut Chocolate. One sample had evidently been supplied with the wrong label, since it contained both raisins and nuts.

Lemonade. One bottle contained simply carbonated water—no sugar, colour or flavouring.

Vinegar. 27 samples were analysed; 2 were found on analysis to be Non-brewed Condiment.

Irregular Labels

Peppermint Cordial Concentrated. A product was being distributed by a door-to-door salesman, and represented as being of special value to aged persons. Being sold in small medicine-type bottles, it was much more expensive than the cordial sold in big bottles in shops. Moreover the product was far below the standard required by the Soft Drinks Order; in addition to this, it contained an artificial sweetener without declaring its presence on the label.

Health Beverage and Nerve Food. This included minute traces of phosphates, iron, iodine etc. in a slippery elm base. The label declared their presence in the form of homeopathic potencies instead of the standard form prescribed by the Labelling of Food Order.

Instant Mashed Potato Flakes. The list of ingredients included 'toluene' (which is a solvent used in chemical industry and as the basis for T.N.T.). This item should have read 'butylated hydroxytoluene'—which is an antioxidant permitted in lard and cooking fats.

Claims for the presence of Vitamins. The labelling of Food Order does not allow general claims that foods contain vitamins. The Vitamin A content must be in terms of International Units, and Vitamin C as milligrams per ounce.

Two samples of Blackcurrant Sweets with Vitamin C and one of Tomato Juice were irregular in that they made simply the general claim for the presence of Vitamin C.

Lists of ingredients

The Labelling of Food Order, 1953 requires that in the case of a food made of two or more ingredients, the ingredients shall be specified in the order of the proportion in which they were used, the ingredient used in the greatest proportion (by weight) being specified first.

A sample of French Mustard, one of Pickled Onions, and one of Mint Sauce bore labels in which the list of ingredients did not comply with this requirement.

Nerve Tonic. 2 samples of Herbal medicine were supplied with crude hand-written labels. They should have been labelled in accordance with the Pharmacy and Medicines Act, 1941.

Ferrous Gluconate B.P.C. The label on this preparation was quite obsolete. It should have had the suffix 'B.P.' (for British Pharmacopoeia) and the strength should have been stated in metric units instead of grains per tablet.

Foreign Bodies in Food

14 samples were submitted for identification of extraneous matter or suspicious discolorations.

2 Loaves were stained with dirty lubricant.

1 Loaf contained a steel bolt; in another there was a piece of paper, while in a third there was a piece of 'plastic'.

In one biscuit there was a length of twine; in another, a moth was embedded.

There was a rubber band in a bun.

A finger bandage was discovered in a tin of tomatoes; a truly revolting sight!

In a packet of dried sliced beans there was a piece of plastic sleeving.

Flies were found in a slice of bread and jam, and also in a coffee cake.

In one sausage there was a piece of bone; in another there was a piece of stained meat—this was due to iron, probably from a rusty hook on which the original meat hung."

QUALITATIVE MILK SAMPLING:

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 the 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 153 of which 4 were found to be below standard. One was deficient in fat and a caution was issued to the vendor; three contained extraneous water and no action was taken in respect of two of the samples and a caution issued to the vendor in respect of the third.

EXTRANEOUS MATTER IN FOOD:

Forty 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—4 cases. One prosecution—fined £50.

Dirty milk bottle—11 cases. Two prosecutions—fines of £30 and costs in both cases.

Foil baking case in a bottle of milk. Prosecuted—fined £5 and costs.

Milk bottle top in a bottle of milk—2 cases.

Dirt in a bottle of milk—5 cases. One prosecution—fined £10 and costs.

Mouldy cornish pasty. Prosecuted—fined £20.

Mouldy fruit pie. Prosecuted—fined £5 and costs.

Mouldy cake.

Glass in cake. Prosecuted—fined £20 and costs.

Insect in a loaf of bread.

Fly in a biscuit.

Slug in frozen peas.

Piece of metal in a tin of corned beef.

Discoloured loaf of bread.

Discoloured potato chips.

Mould in canned pears.

Piece of a beast's lip and hair in a steak and kidney pie.

Sink plug in a tin of apricots.

Piece of wire in fish fingers.

Metal clip in a meat pie.

Foreign vegetable matter in a tin of peas.

Capsules covered with extraneous powder.

It will be seen from the above that the majority of cases involve the dairy industry. There is no doubt that the public could help by simply rinsing and turning milk bottles and ensuring that they are not used for any other purpose than holding milk. In the dairy, failures are caused by checkers being human and letting their attention wander. A bottle always seems to go through at the moment the operator's attention is distracted. Good progress is being made in the development of automatic electronic equipment to do bottle inspection and its installation will be welcomed.

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 thirty samples were examined and in each case the result of the examination was notified to the Medical Officer of Health and other appropriate officers 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 plumbosolvency of such water should be neutralised.

Six samples contained lead in excess of 0.1 parts per million. Appropriate action was taken with the authorities concerned and all supplies were satisfactory at the end of the year.

PRIVATE SUPPLIES OF WATER TO COUNTY PREMISES:

Supervision of private supplies has continued. Details of the samples obtained are given in Table 70 of the Appendix. Full water treatment plant is installed at Grantley Hall, Ingleborough Hall and Upper Wharfedale Secondary School. Aldfield C.E. School has a filter candle and the other supplies are not treated. Upper Wharfedale Secondary School went over to mains supply during the year. The unsatisfactory samples from Grantley Hall were due to faults in the chlorinating equipment. These were soon remedied. Samples from Ingleborough Hall are obtained by the Chief Public Health Inspector, Settle Rural District Council, to whom thanks are due for his co-operation.

FLUORIDATION OF WATER SUPPLIES:

The Ministry of Health has again requested that a report be made on the action taken by the Council under Circulars 28/62, 12/63 and 15/65 on the fluoridation of the public water supplies.

My Report for 1965 gave a comprehensive review, since when the general position has remained unchanged.

In June, the Health Committee considered a circular addressed to Local Health Authorities and Water Authorities by the National Pure Water Association protesting against the fluoridation of water supplies: the Committee reaffirmed their decision approving arrangements with Statutory Water Undertakers for fluoride to be added to public water supplies. Subsequently the Clerk of the County Council communicated with the Water Undertakers reiterating the Authority's decision and its wish to implement the terms of the Circulars as

soon as practicable. At the year-end of the 26 Water Undertakers serving the Administrative County only four had decided categorically not to fluoridate their supplies compared with 13 who were in favour, the remaining undertakers had the matter still under consideration or for a variety of reasons wished to take no action at the present time.

Although no scheme had reached fruition some progress had been made: five of the Undertakers were well advanced with the compilation of technical data and costings in readiness for the submission of schemes to the Ministry of Housing and Local Government. It is hoped that the introduction of fluoride to water supplies to the optimum level will be effected in certain parts of the Area in the not too distant future.

Rural Water Supplies and Sewerage Acts, 1944—61:

Details of applications for grants made during the year are given in Table 71 of the Appendix.

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:

Brief details of the location, capacity and equipment of the pools are given in Table 72 of the Appendix.

Inspection and sampling continued during the year with particular emphasis again on outdoor pools during their summer season.

Laboratory reports on the 150 samples of water taken showed that generally the pool operators are achieving satisfactory standards.

In one case an adverse report was received and enquiries revealed that a defect had arisen in the chlorinating equipment. The Divisional Heating Engineer was informed and a report made to the Divisional Medical Officer. The pool was closed temporarily whilst repairs were made.

At another school investigations have been made over a prolonged period into the unsatisfactory performance of a diatomaceous earth filter that had been installed in 1964 at the school's expense. The filter required constant attention as it only operated for short periods before becoming choked. The manufacturers sent service engineers and eventually a water treatment chemist to solve the problem. All this was to no avail however and the Education Department was advised by us to install a sand filter of a type known to give good results in other schools. The new filter was installed and gives satisfactory service whilst the original type is no longer approved for installation in schools.

Very good co-operation exists between the Education Department and ourselves and all schemes are forwarded for our observations. Only treatment plant approved by this department is installed.

Swimming pools were installed in four more schools, one of which installed two pools. This authority took over the constructed pool at Scissett which previously belonged to the Miners' Welfare Club. The Architect's Department are carrying out extensive works of alteration and renovation.

Construction began on six other pools previously approved and planning and money raising operations began on two more. At the end of the year 41 pools were either installed or planned.

During the year meetings and discussions took place over the possibility of installing a swimming pool at a Mental Health Training Centre. The local Round Table members offered an exceedingly generous donation towards the cost of the project. It is hoped to report on this scheme more fully next year.

It was observed during the year that a wide range of chlorinating agents was being asked for by pool operators and likewise there was a wide range of prices.

Tests were made of a number of products and the most economical one found. This product, which is thoroughly reliable, is now on general issue from the County Supplies Department and should result in savings to the authority.

Certain equipment has been found to need specific material but this is only issued on authority from this department.

West Riding County Council (General Powers) Act, 1964:

PROVISION OF PUBLIC CONVENIENCES:

Discussions have continued with the Department of the County Engineer and Surveyor regarding the provision of sanitary conveniences for motorists on trunk roads.

Authority was given last year for the investigation and preparation of a scheme to provide conveniences on three chosen roads within the County. Each of these three roads has now been surveyed by the County Engineer and Surveyor's Department and consultations held with all interested parties.

It is obvious that there will be difficulties, particularly in rural areas, in counteracting vandalism and providing a satisfactory standard of maintenance. Additionally the three roads chosen are all different in character and differing solutions will have to be found to the problems posed.

Gypsies:

During June the Ministry of Housing and Local Government issued Circular 26/66. This gave details of the results of the census of gypsies and other travellers in England and Wales taken in March, 1965 and the conditions under which they were living.

The Minister's view was that the situation revealed should not be allowed to continue and that help must be given. He asked all authorities to consider the need in their areas and suggested that each county council should take the initiative in assessing the need in its area and in deciding, in consultation with the district councils, how the need can best be met.

Consequently the Clerk of the County Council invited the County Planning Department, the Education Department, and this department to form a small working party to consider the provision of two or three caravan sites, the standards and facilities which are desirable and preliminary costings.

Discussions have been held and visits made to a number of sites. A report to the appropriate committee will be made shortly.

Tetanus Survey:

A long-term survey of the antibiotic resistance of strains of *Clostridium tetani* was commenced during the year by the Public Health Laboratory Service.

This department agreed to assist in the survey and twice a year soil samples are obtained from different parts of the County. The samples are taken from farms with more than 10 cows and from a manured field or a field in which cows are grazing.

Pharmacy and Poisons Act, 1933:

Four hundred and eighty two visits of inspection were made to premises listed for the sale of Part II poisons. The usual contraventions regarding labelling were met and verbal or written warnings were given. There is a surprising lack of knowledge amongst shopkeepers of the requirements of the Act and often amazement shown at the necessity to be a listed seller for such simple items as ammonia and some disinfectants.

Housing (Rural Workers) Acts, 1926—42:

The final inspections were made during the year of those cottages for which grants were given under the above Acts.

Whilst of later years the number of visits had declined considerably this duty has always been interesting and enjoyed as one of the few ways in which the department had a direct interest in housing.

The Riding Establishments Act, 1964:

Premises licensed by the County Council were visited once each during the year. The general public health aspects of each premise were examined and a report submitted to the Clerk of the County Council. This report is considered along with a report of a veterinary surgeon and one from the County Fire Officer before a licence is issued.

Atmospheric Pollution:

The Authority's scheme for the measurement of atmospheric pollution operated in conjunction with 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 38 District Councils were participating involving 50 combined daily smoke filter and sulphur dioxide instruments, and four daily smoke filters only. The results obtained with the instruments operating appear in Table 73 of the Appendix.

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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:

Previous Reports have reviewed the Authority's contribution to the national survey conducted by Dr. Alice Stewart of the Department of Social Medicine at Oxford University designed to discover the causes of childhood cancers.

During the course of the survey certain new facts have been discovered while others have acquired a new significance. It is intended that the survey should be continued until all deaths from childhood cancers in the period 1953—1967 have been investigated.

Although the work involved by the medical staff is most time consuming, on average at least one day being necessary to successfully investigate each case and its paired control, preliminary results indicate that this is a really worthwhile survey, and various leads suggest fields for further research.

Currently, the deaths of children who died during the years 1961/65 are being followed up and at the year end, of the 184 cases debited to the Administrative County, investigations into 124 case/controls had been completed satisfactorily.

Measles Vaccines Trial:

In 1964 the Authority agreed to participate in a large scale trial, held under the auspices of the Medical Research Council's Measles Vaccines Committee, to investigate the degree and duration of protection afforded by measles vaccines of British manufacture.

During October/November, 1964 and September/October, 1965 some 3,510 children aged 10 months to 2 years resident in the Administrative County whose parents had volunteered them to take part in the trial received a dose of killed vaccine followed four weeks later by a dose of live vaccine, the vaccinations being undertaken by the Authority's medical officers.

These children were subsequently followed up to record the frequency of reactions after vaccination and the degree of protection afforded.

Early in 1966 the Committee's report on the preliminary results after 6 months of the trial were published from which it appeared that the vaccines achieved a protection rate of about 85 per cent. The Committee considered that these results justified making the vaccines available to doctors wishing to use them for the protection of individual children but they did not advise general application for the whole community.

It is essential that the surveillance of the children should be continued to determine the quality and duration of immunity if a scheme for general use in the future is to be formulated. As yet, no one can say if, or how often, booster doses may be required and a scheme which merely postponed attacks of measles would have no real advantage: indeed postponement to teenage or adult life may have serious repercussions.

Our participation in the trial is continuing and a careful check is kept on all vaccinated children. It is hoped that our findings will materially assist the Medical Research Council to reach firm conclusions for the future.

THE WELFARE OF THE EPILEPTIC AND SPASTIC

Table 74 of the Appendix gives particulars of known epileptics and spastics.

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, Cleckheaton and Goole. 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 1,313 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 epileptics and 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

Particulars of new registrations during 1966 of blind and partially sighted persons (other than handicapped school children) are given in Table 75 of the Appendix.

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 establishments shown in Table 76 of the Appendix.

REGISTRATION AND INSPECTION OF DISABLED AND OLD PERSONS' HOMES

(National Assistance Act, 1948)

Table 77 of the Appendix lists the premises, which are inspected in conjunction with officers of the Welfare Department, registered as Disabled and Old Persons' Homes.

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 February, 1967, 423 schemes have been approved by the County Council, affecting 81 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 February, 1967, 282 schemes have been approved by the County Council, affecting 47 District Councils.

Under Section 119 of the Housing Act, 1957, eight Housing Associations supervising eleven schemes receive annual contributions in respect of accommodation for aged persons.

I am indebted to Mr. J. H. Bargh, County Welfare Officer, for supplying most of the information on this and the preceding page also Tables 74 to 77 of the Appendix.

REMOVAL TO SUITABLE PREMISES OF PERSONS IN NEED OF CARE AND ATTENTION

When persons are found to be suffering from grave chronic disease or, being aged, infirm, or physically incapacitated are living in insanitary conditions and are unable to devote to themselves and are not receiving from other persons proper care and attention, Medical Officers of Health are empowered, under Section 47 of the National Assistance Act, 1948, to initiate proceedings for their compulsory removal to hospital or Part III accommodation.

Under the original Act, it is necessary for applications to be submitted to a Magistrate's Court for removal of such persons, but under the National Assistance (Amendment) Act, 1951, an accelerated procedure was introduced whereby application can be made to a Justice of the Peace in urgent cases.

Medical Officers of Health indicate their reluctance to enforce these powers; the proceedings are, however, unavoidable in certain instances and it was necessary to remove two men and three women to hospital and one man and two women to Part III accommodation.

REGISTRATION OF NURSING HOMES

(Public Health Act, 1936, as amended by the
Nursing Homes Act, 1963).

There were 7 amended registrations during the year and Table 78 of the Appendix gives brief details of the 26 nursing homes registered on the 31st December.

NOTIFICATION OF BIRTHS

(*Public Health Act, 1936, Section 203*)

Notifications were received relating to 19,601 live and still births occurring in the Administrative County Area, and of 15,112 births occurring elsewhere to mothers who were normally resident in the County. The former figure included 3,086 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 31,627. When this figure is compared with the Registrar General's return of 31,915 births (31,457 live and 458 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 31,085 first visits to children born in 1966 were made by health visitors.

NURSERIES AND CHILD-MINDERS REGULATION ACT, 1948

At the end of the year, there were 8 nurseries registered for the care of 214 children and 70 child-minders registered for the care of 498 children. Two hundred and twenty-four 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

During the year 2,163 health questionnaires were received from applicants for admission to the superannuation scheme. Of this number, 1,557 were admitted to the scheme on the basis of the information obtained from the

questionnaires. 606 applicants were referred for medical examination by reason of:

	<i>Number referred</i>	<i>Approved</i>	<i>Not Approved</i>	<i>Deferred</i>
Age	147	138	5	4
History	256	196	28	32
Category (of employment, e.g. driver)	105	101	1	3
Age and History	53	37	8	8
Age and Category	11	9	—	2
History and Category	31	26	4	1
Age, History and Category	3	3	—	—
	—	—	—	—
	606	510	46	50
	—	—	—	—

Of these examinations, 589 were carried out by the County Council's medical officers and 17 were carried out by medical officers of other local authorities.

66 special medical examinations were carried out by the authority's medical staff at the request of the employing departments.

10 specialist reports were obtained.

41 requests for medical examinations were received from other local authorities.

ROAD TRAFFIC ACT, 1960. SECTION 100(6)

The Clerk of the County Council referred 33 cases 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 for the guidance of the Local Taxation Officer.

In some of these cases, although it is recommended at the time of the enquiry that the person concerned is medically fit to be in charge of a motor vehicle, it is thought advisable that the case should be kept under review and the position re-examined at a later date. Five such cases have been reviewed during the year.

WEST RIDING DISTRESS FUND

Grants from the West Riding Distress Fund were made in 5 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 provision of bedding for a mentally-ill man.

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 59th Annual Report of the Principal School Medical Officer)

Introduction:

The year 1966 has been one of careful planning for the future. An appraisal has been made of the need to change the pattern of medical examinations in school with more emphasis on the early diagnosis of emotional problems. The association of physical as well as environmental factors in the causation of emotional difficulties in childhood has also received attention and is referred to in the report.

Difficulties in staff recruitment still continue especially in regard to speech therapists. Further part-time therapists have joined the staff but one whole-time member left to take up a specialized post elsewhere. The shortage of speech therapists is a national problem.

In the Child Guidance sphere another whole-time psychiatrist, Dr. Blackburn, commenced duties in October, 1966, being employed by the West Riding County Council as a senior medical officer. Dr. Hopkirk, a Consultant Psychiatrist employed by the Sheffield Regional Hospital Board, also took up duties and has six sessions a week devoted to West Riding clinics. Consequently Dr. Brennan relinquished his locum session at the Maltby clinic. A further psychologist took up part-time duties in November, 1966. As a result it has been possible to open four new Child Guidance Clinics at Hemsworth, Horsforth, Selby and Tadcaster. The most serious shortage is in the number of psychiatric social workers. Mr. Skinner left the staff for a senior post elsewhere and was replaced at Harrogate by Miss Phillips but other responses to advertisements have been disappointing.

Regular conferences of the medical staff are still held three times a year. The issue of *Clinical Notes* has continued and the Yorkshire Child Health Group met throughout the year with an active membership. Occasional conferences of the speech therapists have been held and the Child Guidance Clinic staffs meet each term primarily to discuss the boys at Nortonthorpe Hall Hostel. Mr. R. Hughes, the new Warden, was welcomed at the November meeting.

Dr. Smith has spent a considerable amount of time lecturing to various groups of teachers and training college students on aspects of the School Health Service. He has also met the Principals of the Training Colleges in the West Riding to discuss possible future developments in the student health services. Dr. Smith's continued membership of the School Medical Officers' Group Council, the Technical Advisory Panel on Child Health of the Leeds Regional Hospital Board, and the Medical Sub-Committee of the North Regional Association for the Blind is of considerable help in maintaining close contact with consultants and medical officers of the Department of Education and Science.

In March, 1966, the Ministry of Health and Department of Education and Science issued a joint circular on the need for the co-ordination of Education, Health, and Welfare Services for Handicapped Children and Young People. As a result of this a joint panel has now been set up of senior officers from the Education, County Careers, Welfare, Children and Medical Departments. This panel meets periodically to discuss problems as they arise.

A further co-ordinating panel has also been brought into being so that the medical aspects of educational and social problems of the school child can be discussed between the two departments and an agreed scheme of action be taken including any necessary special educational treatment. This link should prove to be extremely valuable and prevent departments working in isolation. Topics which have already been discussed have included the need for helping hearing-impaired children in ordinary schools; the future of remedial centres; and the social aspects of emotional problems.

Once again I would record my appreciation of the full co-operation given by all concerned in the sphere of child health.

Medical Inspections in Schools:

The report for 1965 detailed surveys which had been carried out on the varying percentages of children shown to have defects in certain Divisions and by different doctors. The surveys formed a topic of discussion at the Assistant County Medical Officers' study day held at Wetherby on the 7th March, 1966, and it was generally agreed that more attention needs to be paid to the early diagnosis of emotional problems in childhood rather than on the search for trivial physical differences within the range of normal variations.

Mention was made in the 1965 report of the need to re-deploy the duties of doctors and nurses in the schools and it is hoped to bring many of the ideas into general operation during 1967.

There has been an increasing use of "selective" rather than "routine" examinations in various Divisions and during the year a revised form of the questionnaire to parents has been introduced after general discussion. (See Appendix C).

Experiments have been carried out on a "selective" procedure for the "leavers" inspection in some areas based on the child's previous medical records and school reports and appear to be working well. Children with relevant defects are reported to the County Careers Officers but the number of fit children examined has been reduced.

In another Division, after consultation with the general practitioners and nursing staff, children are being examined as "routines" at the Infant Welfare Centres shortly before entry into school and the child's immunisation state is brought up to date at the same time. Schools situated in very remote areas at a distance from the clinics are being visited each term so that the infants will be seen shortly after entry. After the initial routine examination children are being seen on a "selective" basis at seven, ten and thirteen years and, in addition to the questionnaire to parents, a brief questionnaire is also being issued to head teachers asking for particular types of problems to be referred. (See Appendix D). The schools will be visited each term so that the teachers will have an opportunity of discussing other problems as they arise. Nurses will carry out routine vision testing on children every two years or annually on cases where the child needs more frequent observation. Hearing will be tested by the nurses at six, ten and thirteen years of age. This type of procedure should lead to a closer contact between teachers, medical, and nursing staff and should result in an earlier detection of defects.

Care of the Handicapped Pupil:

The importance of the early diagnosis of defects has been stressed elsewhere. Although it will be some years before the major assessment centres referred to in the 1965 report can come to fruition, in view of the cost involved, much work is proceeding in other directions. It is hoped from 1967 onwards that all infants will have their hearing screened at the age of six—nine months by nurses trained in the techniques necessary and those who do not pass the tests will be followed up regularly. This should also bring forward other problems of non-communication at an earlier age e.g. the retarded child; the child with delayed speech development; and infants showing emotional problems such as withdrawal.

Post-graduate training of medical and nursing staff is essential if knowledge of modern techniques of assessment is to be maintained and it is hoped to increase the facilities available during 1967.

Although facilities for the special educational treatment of marked physical defects are fairly adequate in the surrounding areas more attention is now being directed to the special needs of children with minor degrees of physical impairment. Mention was made in the last report of the "clumsy" child and the need for research into special educational treatment. Recent studies suggest that educational failure as a result of poor hand control and other factors may lead to emotional frustration and consequent maladjustment in the child of potentially normal intelligence. Early recognition of the child's handicap is essential followed by the necessary physical and psychological investigations. It is hoped that it may be possible to re-organize the present remedial centres existing in the West Riding to accommodate more of these children who need special individual help so that emotional problems may be prevented. Further remedial centres in other areas may also be needed in future developments.

DYSLEXIA:

The problem of dyslexia ("word blindness") is closely associated with physical and emotional factors. Many children are referred as potential dyslexics when they have other conditions. In 1960, Dr. J. N. Horne, of the Ministry of Education, carried out an investigation into 19 children in the West Riding referred by the medical staff as possible cases and only found two probable cases. In April, 1966, the Department of Psychology, University of Leeds, asked for co-operation in a survey of children in the seven—thirteen year age group whose verbal I.Q. was four years behind the non-verbal.

An enquiry was addressed to all Divisions and thirty-four cases were referred: thirty-one boys and three girls. Many of these did not satisfy the criteria laid down. Nine boys had a low reading age but no full assessment of the intelligence was available so that they may have been within the educationally subnormal category. Six boys and one girl had I.Q.s. of under 90 and showed little discrepancy between the verbal and non-verbal I.Q.s. Of those with I.Q.s of 90 or over, coming within the range of average intelligence, ten boys showed no significant difference between the verbal and non-verbal results although their reading age was four years retarded or more. One showed "crossed laterality", one boy came from a culturally poor home; one had severely defective vision, and one had a family history of reading difficulty.

In the remaining eight children the following results were recorded:—

Sex	Age	Verbal I.Q.	Non-Verbal I.Q.	Full I.Q.	Reading Age	Remarks
F	11.10	87	99	92	Under 5	Epileptic
F	11.1	94	114	104	7.0	—
M	12.2	92	131	112	6.0	—
M	14.0	76	101	87	8.0	—
M	13.11	89	113	100	5.9	—
M	13.6	79	94	85	9.9	?Dysgraphia
M	13.0	76	108	91	5.1	Familial reading difficulty
M	10.0	99	107	103	5.1	Familial reading difficulty

The condition of "word blindness" has been recognized since 1877. More recently the term "dyslexia" has been used and there has been a tendency to regard it as a specific condition for which little can be done. It may, in fact, be associated with a multiplicity of factors e.g. family background; minor physical abnormalities; partial hearing loss etc. It is remediable, if recognized at an early enough stage, but it requires individual help with emphasis on auditory repetition and oral instruction instead of writing. Parents need to be instructed to communicate freely with the child. The world of conventional education is largely a reading world and many of these children, of potentially average or over average intelligence, become miserable and in despair in their failure to read often leading to an emotional blockage to all forms of learning and to general maladjustment.

THE PHYSICALLY HANDICAPPED CHILD:

Figures for children suffering from cerebral palsy will be found in Table 82 of the Appendix.

The number of children surviving with spina bifida continues to increase as a result of improved operative techniques. These children are often left with severe paresis of the lower limbs and associated double incontinence. They are particularly prone to bladder and renal infections and need careful nursing and medical observation. This imposes a problem in the usual type of school for the physically handicapped and special schools catering for this type of defect are to be set up. Over half the children surviving are of normal intelligence and approximately one-third are educationally subnormal.

THE DELICATE CHILD:

The work of the West Riding's schools at Ingleborough and Netherside Halls continued during the year and little change in the type of admissions was recorded. Over the years the Head Teachers have noted that the proportion of dull children has increased—the brighter asthmatics appear to be able to cope more adequately with the normal school regime.

As a result of various negotiations during the year it is hoped that there will be a freer interchange of pupils between the Wharfedale Children's Hospital School and Ingleborough and Netherside Hall Schools. Many of the children in the hospital school are ambulant and the facilities for out-of-school activities are not so adequate in the hospital environment.

THE DEAF AND PARTIALLY HEARING CHILD:

The problem of the child with hearing impairment in the ordinary school has been referred to in previous reports. Following discussions with Sir Alec Clegg it has now been agreed that a peripatetic teacher of the deaf should be appointed during 1967 to carry out duties in one area of the West Riding. It was considered that this would be preferable to trying to cover the whole of the County with a limited number of personnel as suitably qualified teachers available are few in number.

It is intended that the first area to be covered should be in the Otley, Harrogate and Horsforth districts with possible extension to surrounding areas. The teacher appointed will have an attachment to the Bridge House School for Boys and to the Otley Audiology Clinic. If the pilot scheme is successful extension will take place later with further appointments.

Duties will include the follow up of children seen at the Audiology Clinic in the schools and homes; the supervision of all children wearing hearing aids in schools to ensure that they are being properly used; parent guidance and training; auditory and speech training for individual children; and special remedial teaching and advice to teachers in the schools. The psychologists will assist in the special assessment of intelligence quotients where the child's potential ability, apart from the hearing loss, needs full appraisal.

During 1966, surveys have continued in the Divisions of all children having an average bilateral hearing loss of 30 decibels or over—a level at which the child will hear a normally spoken word as a whisper. By December, 1966, 681 cases had been recorded (538 in December, 1965) and 194 children are known to be wearing hearing aids in school.

The Chief Education Officer, through the Divisional Officers, circulated all schools asking teachers to refer all children considered to have possible hearing loss and not already on the lists received from the medical officers. As a result 864 children were referred. Many of these had only trivial losses or unilateral defects which cause little handicap but in 112 cases a significant hearing loss has been confirmed; in 544 cases no significant loss was found, and 208 cases are still being investigated.

As the early diagnosis of congenital deafness is of vital importance it is hoped to introduce the routine screening of all infants between the age of six—nine months during 1967. This will be carried out by nurses trained by Sir Alexander Ewing in the necessary techniques. Medical officers are being seconded to short courses at the Manchester University organized by Professor Ian Taylor so that they will have the necessary knowledge to investigate children referred by the nurses. The screening will also bring forward other problems of non-communication at an early age including delayed development.

It is also intended to carry out screening tests of hearing at three age groups during school life to pick out children whose deafness has been acquired after

infancy. Most Divisions are now carrying out the procedure as a routine in infants' schools though there are difficulties in some areas due to shortage of nursing staff.

Dr. Ferguson reports as follows on the Doncaster Clinic:—

“When possible, there have been three sessions per month held during the school terms. Unfortunately the summer break is fairly long and results in a break of two months in the clinics for August and September.

The figures are very comparable to the previous two years. Once again I would make a plea for urgent consideration for a peripatetic teacher for the deaf. In a scattered area like South Yorkshire such an appointment would be invaluable for the community and would enhance the work of the Audiology clinic.

Four small transistor speech trainers were made available to the Yorkshire Residential School for the Deaf by the Variety Club of Great Britain and these, in turn, have been given to the clinic for the use of small children. When used intelligently, these machines have proved of great value and the co-operation of the Speech Therapist is necessary for the proper use.

Arrangements were continued, with the co-operation of the Headmaster, whereby several mothers with children under school age with a significant deafness, were able to spend a day with the children in the nursery department of the School for the Deaf. It might be possible some time to arrange for mothers with children hard of hearing to spend 2—3 days in the nursery department whilst awaiting admission to the School.

The Doncaster Hospital now has a post-graduate medical education centre and on one of their post-graduate days I had the pleasure of reading a paper on the work of the Audiology clinic.”

A statistical summary of the work carried out at the above clinic and the Horsforth Audiology Clinic is given in Table 83 of the Appendix.

THE EDUCATIONALLY SUBNORMAL CHILD:

Causation:

Reference was made in the 1965 report to the initial findings of a survey of information received from the completed Forms 2 H.P. when children are examined by the medical officers. This work has continued during 1966 and by 23rd August, 1966, 1,000 consecutive Forms 2 H.P. had been received from 12th October, 1965. The information contained has been reviewed by the Senior Administrative Medical Officer and various points of interest emerge.

The 1,000 cases were divided up as follows:

Primary examinations as possibly E.S.N.	...	...	380
Review examinations: pupils at ordinary schools	...	...	177
Review examinations at special schools	...	...	107
“Care and Guidance” examinations	...	...	237
“Unsuitable for education”	...	...	99

In this series the children were divided into three groups:—

1. Those unsuitable for education.
2. Children regarded as educationally subnormal with I.Q.s up to 79.
3. Children examined for retardation and found to have I.Q.s of 80 or over.

Causative factors (by percentages) were found as follows:—

Causative Factors	Unsuitable for Education			I.Q.s up to 79			I.Q.s of 80 or over		
	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total
Personal Conditions	62.5	58.1	60.6	17.5	21.0	19.0	24.8	27.7	25.5
Familial Conditions	21.4	16.3	19.1	52.5	46.4	50.0	32.2	49.0	36.2
Combination of Personal and Familial Conditions	3.6	9.3	6.1	8.3	8.9	8.5	2.7	2.1	2.6
No cause determined	12.5	14.0	13.1	20.7	21.7	21.1	37.6	19.1	33.1
No information available	—	2.3	1.1	1.0	2.0	1.4	2.7	2.1	2.6

“ Personal conditions ” include prematurity, toxæmia in the mother, neonatal jaundice, Rhesus incompatibility, anoxia at birth, post-maturity, difficult labour, neonatal trauma or infection, associated congenital defects, and acquired conditions after birth.

“ Familial conditions ” include a history of dullness in parents or siblings, or evidence of psychosis. The evidence available was insufficient to group into social classes.

This series supports the previous view that personal factors in the medical history account for much of the causation of the severely subnormal whilst the educationally subnormal child tends to come from similar stock. In the I.Q. range of 80 and over, 25.5 per cent. showed some individual history to account for retardation and included in this group are the children referred to elsewhere as having somatic neural impairment.

In the various groups if one combined personal and familial factors 75.8 per cent. of children found to be unsuitable for education; 77.5 per cent. of children in the I.Q. range up to 79 and 64.3 per cent. of children with I.Q.s over 80 referred as backward, were “ at risk ” from an early age. Very few children became retarded as a result of acquired conditions e.g. meningitis or encephalitis. It should be possible from the personal history and family background of the child to detect potential retardation in a high proportion of children from an early age.

The Influence of the Birth Date:

In 1965, H. G. Armstrong, the Educational Psychologist to the West Riding Education Committee, published a report on the quarterly distribution of births in relation to the children recommended for special education within the ordinary schools—with I.Q.s in the lower 80s. He found that many more children born in June, July and August; and in March, April and May came within the group than those born in the Autumn and Winter months. R. Freyman, of Middlesbrough, also published the results of a wider survey based on a four-monthly distribution of birth dates. He found that educationally subnormal children showed little difference in incidence on the month of birth whilst children in the lower streams of schools showed a similar pattern to Armstrong's.

In the 1,000 cases reviewed the findings were as follows and are compared with Mr. Armstrong's 1965 survey.

Month of Birth	Armstrong's series	Present Survey	
		I.Q.s up to 79	I.Q.s 80 and over
Total:—	258	803	197
June—August	Per cent. 31.4	Per cent. 25.5	Per cent. 34.0
March—May	32.2	27.3	27.4
December—February	19.4	25.2	18.8
September—November	17.0	22.0	19.8

The findings generally support both Armstrong's and Freyman's work. In the I.Q. range of 80 and over there is a significant difference. In the range up to 79 there is little difference in the proportions on the time of birth suggesting that educational subnormality is a specific condition rather than a delayed mental development evident in many children born late in the academic year.

Sex Incidence

	Total	Boys	Girls
Armstrong's series ...	258	183	75
Present series:—			
I.Q.s up to 79 ...	803	457	346
I.Q.s 80 and over ...	197	146	51

Armstrong suggests that the higher incidence of boys is due to a later maturation. The predominance of boys in the I.Q. range up to 79 is in keeping with the general picture of many defects—that more boys show defects than the so-called weaker sex.

Age of Reference for Examination:

The majority of children referred for assessment as possibly educationally subnormal are brought forward by the teaching staff. In the 380 primary examinations 46.6 per cent. were referred under the age of eight years and 87.6 per cent. of the total before the age of eleven years. This shows an increasing trend towards earlier recognition of possible retardation and gives a far better chance for the children to receive special educational treatment where necessary. 27.9 per cent. of the primary examinations showed I.Q.s of 80 and over although regarded as educationally subnormal. These children need help in the ordinary school.

Regression in Intelligence Quotients on Re-test:

This was referred to in the report for 1965 and was subsequently the subject of a paper by Dr. Smith in *Public Health* (May, 1966). In the present series of children who were re-assessed it was found that over 38 per cent. of boys and girls with I.Q.s under 80 showed a significant lowering of the I.Q. on re-test but under 8.5 per cent. where the I.Q. was 80 or over. Research work is at present proceeding on the development of new types of intelligence tests as it is felt that the verbal "weighting" of the Stanford-Binet Scales in the older age group may be a significant factor in the apparent regression. Mr. Pickles, one of the psychologists on the staff, is associated with this work.

Reference for "Care and Guidance" on leaving School:

Of the 1,000 cases in the review 237 children — 140 boys and 97 girls, were considered for care and guidance. Of these, 55 per cent. were referred as needing some supervision after leaving school; 76.2 per cent. of these being in children with I.Q.s under 70. Only one case with an I.Q. of over 80 was referred and the need was doubtful. As a result the number of children being re-assessed has been reduced on the lines indicated in the 1965 report.

During 1966, 156 cases were referred for informal supervision.

References as "Unsuitable for Education" at School:

During the year 74 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. 109 children were attending Training Centres after voluntary admission at the end of 1966.

CHILDREN WITH SPEECH DEFECTS:

The problem of recruitment of staff has already been mentioned. Many areas are without the services of speech therapists and, where available, their time has to be devoted to the more urgent cases. In an endeavour to give some advice to parents the following two leaflets were prepared in consultation with the therapists and circulated to parents.

"Hints to Parents of Children with Speech Defects"

Children vary in the age when they start to talk and in the rapidity with which they become fluent.

If you feel that your child's speech should be better than it is, contact your own doctor or local clinic medical officer who will advise you if speech therapy appears to be required.

Unfortunately there is a national shortage of speech therapists in practice at the present time and there may be a delay before your child can be seen by a therapist if the doctor considers it to be necessary.

The parent can help the child in the home by always speaking clearly and encouraging him. Never make the child a "figure of fun" or comment on his speech development.

When the child sees the therapist it will be decided if active treatment at the clinic is necessary. The therapist can only devote a limited time to each child and it is essential that any exercises advised should be carried out daily in the home. Practice must be a happy time for the child when the parent can give undivided attention. A calm secure atmosphere in the home and the co-operation of the family are vital in helping the child to develop normal speech."

"Advice to Parents whose Child Stammers

During the development of speech, many young children around the age of 2 to 4 years tend to repeat words and syllables. This occurs at the stage when the child's understanding of the spoken word is more advanced than his ability to express himself with the result that he hesitates in attempting to express a lot of ideas with a limited vocabulary.

This phase should soon pass if dealt with sensibly by not regarding it as a stammer, being patient with the child when he attempts to express himself and not rushing him. Speak slowly and clearly when addressing him and help to increase his vocabulary by talking to him and naming new things clearly.

Unwise handling may cause a true stammer with tension and anxiety in the child who becomes conscious of his disability. There may also be a history of a family tendency to stammering.

Stammering appears in many ways. The child may have difficulty in starting his words; he may repeat the first sound or he might even repeat a number of words. Some children stammer a great deal and many move their head, eyes, arms and legs; they may also get very stiff and out of breath.

A calm, secure home life and a great feeling of security is necessary. The stammer should never be discussed in front of the child. Plenty of rest and sleep are required and discipline should be maintained in a firm, but gentle manner—the child should never be slapped for his stammering. Do not over-protect him, but encourage him to become independent and play with other children.

The speech therapist can help considerably if you will follow the instructions given during daily life in the home."

THE MALADJUSTED CHILD:

Causative Factors:

In the report for 1965 an outline was given of the environmental background of boys admitted to the Nortonthorpe Hall Hostel for maladjusted boys. In all the cases there was a history of difficult home conditions.

D. H. Stott, the psychologist, in his book *Troublesome Children* (1966) refers to a series of 33 cases studied closely. In five only did children come from stable families. 28 of the children showed associated "somatic neural impairment"—a term used by Stott to include clumsiness; cerebral dysfunction etc. Six of the 28 showed evidence of epilepsy. Stott suggests that behaviour disorders may have their origin in some type of congenital or neural impairment aggravated by a stressful situation.

At a post-graduate course held at Pontefract General Infirmary in November, 1966, a local consultant neurologist discussed his own series of 32 cases referred by a school psychiatrist as educational failures. Of these six were unrecognized epileptics and a large proportion of the children showed Stott's somatic neural impairment characteristics.

The physical aspects of emotional difficulties have been somewhat overlooked in the past in this country, unlike Scandinavia, and the recognition of defects of this kind with remedial education, where appropriate, may help to prevent later emotional problems. Stott is devising a general test of motor impairment for children which it is hoped to bring into use. Some psychiatrists are becoming more aware of this physical factor and Dr. Maxwell is engaged on research in this sphere with her husband, who is a consultant psychiatrist.

It is of interest that of the 24 boys at the Nortonthorpe Hall Hostel in December, 1966, five boys show abnormalities on electroencephalograph investigation including two with an epileptic pattern. All the boys have not received this investigation but others show evidence of "neural impairment" following prematurity or encephalitis.

It is important to realise that all children showing an abnormal E.E.G. suggestive of epilepsy do not suffer from frank fits although their behaviour may show typical mood changes, periods of lack of attention or automatism without loss of consciousness. Drug therapy has been found to be effective in controlling the aberrant behaviour in a proportion of these children and work is continuing in this sphere.

Of the list of 46 boys awaiting admissions to special schools or hostels for maladjusted pupils surveyed in December, 1966, 16 show an epileptic pattern on the electroencephalogram; three demonstrate some abnormality; and there is a history of possible "brain damage" in four cases. In other cases the physical aspects have not been investigated so fully.

The environmental background of the maladjusted child is of great importance. If deviations from normal behaviour can be detected in the earlier stages remedial work can be carried out by the Child Guidance teams without removing the child from the home environment when the parents are prepared to co-operate and capable of insight into the problems.

The background of many of the children admitted to schools or hostels is frequently so disturbed that the child's only hope of adjustment is removal from that environment. Whilst many factors may operate an attempt has been made to analyse the main one in each case of boys at Nortonthorpe Hall Hostel, the William Henry Smith School for the Maladjusted at Elland, and the children on the active waiting list for admission to schools or hostels.

Total:—	Nortonthorpe Hall Hostel 24 boys	William Henry Smith School 15 boys (West Riding pupils)	Waiting list: 48 (46 boys: 2 girls)
"Broken homes" (Separation of parents etc.)	9	3	16
<i>In Care:—</i>			
From infancy (illegitimate)	1		2
Broken home		1	3
Mother ill			1
Mother over indulgent		1	
<i>Adopted</i>			
Good home		3	
Rejected by adoptive parents	1	1	
Psychopathic adoptive parents		1	
Parental rejection	4	1	
Parental illness (physical)	2		4
Parental illness: (emotional disturbance)		3	6
Poor home conditions	3		8
Problem family	1		
Violent father	1		
Over indulgent parents	2	1	
Father away in forces			2
No adverse reports on home background			6

Some children had been placed in the care of the Children Department because of failure to attend school e.g. the child with the over-indulgent mother.

In this series of 87 cases the home background was apparently satisfactory in only nine instances: three being in adopted children. In the three adopted cases the birth history was unknown: one child commenced epileptic fits at 18 months of age and the other two showed very aggressive behaviour. Of the six children from apparently satisfactory homes a frank epileptic pattern was shown on E.E.G. investigation in three cases; two showed severe aggression and further reports are awaited in one case.

These surveys support the view that physical and environmental factors are both of significance in the causation of maladjustment.

Presenting Signs:

Children were referred for investigation for many reasons and in several a multiplicity of complaints was evident e.g. aggressive children may also be enuretic or indulge in petty theft; children who fail to attend school also often become involved in larceny etc. In the 87 children reviewed the main presenting factors were as follows:—

Aggressive behaviour	...	...	...	...	34
Stealing, breaking and entering	...	...	...	...	28
Non-attendance at school (Including Truancy)	...	...	...	...	15
Fire raising	...	...	...	...	4
Chronic depression	...	...	...	...	3
Enuresis	...	...	...	...	2
Indecent exposure	...	...	...	...	1

On occasion it is purely fortuitous whether the child who is found to be stealing is referred for psychiatric investigation or committed by the courts to Approved Schools.

The Problem of Placement:

This is a national one. As more Child Guidance facilities become available an increasing number of children will be referred for special educational treatment in schools or hostels. The waiting list in the West Riding in December, 1966, of 46 boys and two girls is not a realistic estimate of the total size of the problem. Psychiatrists generally only refer the most urgent cases as they are aware of the shortage of provision. The new school—Hill Top, Ackworth—for maladjusted boys to be opened in 1967 will not solve the problem locally and many children will fail to get admission to special schools.

A survey has been commenced, with the co-operation of the psychiatrists, in an attempt to estimate the total number of children coming to their notice who really require special help.

More may be achieved on the preventive side by earlier recognition of deviations from the normal in the schools; fuller investigation of physical factors; and the wider provision of remedial education before educational failure results in emotional problems. Some children would benefit from the removal from adverse homes to a stable residential environment before frank maladjustment is manifest. Much thought is being given to these problems both from the medical and educational aspects.

Harrogate Clinic—Dr. Gore reports:—

“ 104 new cases were seen. 75 boys and 29 girls. 71 of these were referred from Division 7 as follows:—

Divisional Medical Officer ...	...	27
General Practitioners ...	...	15
Head-teachers ...	...	14
Parents ...	...	3
Children's Officer ...	...	2
Children's Homes ...	...	4
Probation Officer ...	...	2
Youth Employment Officer ...	...	1
Others ...	...	3
		<hr/> 71 <hr/>

Now that the clinic is functioning at Tadcaster we are not seeing cases from the Wetherby area. However, our waiting list remains long, but we have endeavoured to see urgent cases quickly, and the psychiatric social workers have at times interviewed the parents at short notice, when there has been a crisis.

We all regret the retirement in March, 1967, of Miss Blackburn, and I would like to say how valuable her contribution has been, and that I feel the Remedial Department has meant that we have been able to keep a number of children at home, who would have had to go to maladjusted schools.

We continue to find it most helpful to have such close contact with the Health Visitors in the clinic, and also with other social agencies in the area. Also we continue to have discussions of the problems presented by children attending the clinic, with Probation Officers, Child Care Officers, General Practitioners, Youth Employment Officer, Mental Welfare Officer, Head-teachers etc.”

Mirfield, Pontefract, Ossett, Morley and Rothwell Clinics—Dr. Maxwell reports:—

“ I continued to work in the same clinics as the previous year until 7th October, when Dr. Muriel Blackburn succeeded me at the Rothwell Clinic.

The opening of the new Child Guidance Clinics at Hemsworth and Goole will allow the Pontefract waiting list to be reduced. At Mirfield the waiting list is no longer of much duration. The Ossett Clinic is functioning fully, but without delays. On the other hand the clinic at Morley now carries a rather greater volume of work than can be dispatched conveniently in the time available.

A certain amount of teaching is being carried out at all the clinics and during the year several talks were given to local groups on subjects relevant to the clinic work.

The figures for children examined at these clinics were as follows:—

	Mirfield	Pontefract (to 7.10.66)	Ossett	Morley	Rothwell (to 7.10.66)	Total
Number of sessions held ...	192	101	48	48	70	459
Number of new cases ...	104	41	20	31	28	224
Number of cases referred from previous years ...	86	71	8	15	24	204
Number of cases discharged or admitted for residential treat- ment ...	100	70	9	10	28	217
Number of cases carried forward	90	42	19	36	24	211

Swinton, Ecclesfield, Barnsley and Woodlands Clinics—Dr. Orme reports:—

“ There has been intense activity at all the clinics and this is particularly reflected in the figures for the Ecclesfield and Barnsley areas, with an increase of nearly 50 per cent. in the new cases seen. This has been greatly helped by a temporary increase in social workers, but by the end of the year there were no social workers at Ecclesfield so it is expected that less can be done there now.

The assistance of Doctors Bolsover and Gill at Swinton and Barnsley has opened up a new aspect of the work and it is hoped that the training of School Medical Officers in the rudiments of Child Guidance techniques will be a further factor in improving the clinic service.

Intensive seminars with Probation and Child Care Officers have been held at Swinton (two courses) and at Woodlands. These have opened up new experiences of co-operation between the various disciplines. It certainly appears that greater understanding of personal dynamics and family interaction is highly desirable in all people working with children.”

THE WORK OF THE PSYCHOLOGISTS:

Staff:

There was a welcome increase in staff which made it possible for psychologists to participate as members of the teams at newly opened child guidance clinics. Mrs. Pilkington took up her duties in January and Mrs. Rowlands joined the service on a part-time basis in November. By the end of the year, there were thus five psychologists working in the child guidance service.

It has still been necessary for work to be confined principally to the priorities of clinical assessment of maladjusted and handicapped children, school visiting being possible for discussion of only a proportion of the children seen in the clinics. The ratio of psychologists to school children, which in the Riding was approximately one to 65,000 over the complete year, compared unfavourably with the national average for England and Wales which, during 1965, stood at one to 23,000. We cannot therefore undertake the range of work which has become the pattern for psychological services in many other areas of the country.

Maladjusted children:

The great majority of children referred to the child guidance clinics were seen for psychological examination. More varied techniques of cognitive, attainment and personality assessment are being used. Means are also being devised of preserving and collating selected information on children examined.

Age distribution:

	below 5	5—7+	8—10+	over 11	Totals
Boys	14	60	116	156	346
Girls	8	30	26	80	144
TOTALS	22	90	142	236	490
Percentage	5	18	29	48	100

Compared with previous years, there is a slight increase in the proportion of pre-school and infant school children, this being the desirable and expected tendency as the child guidance service develops. The peak age for referral of boys was around 10 years, and for girls around 13 to 14 years.

Intelligence distribution:

Figures were available on intelligence testing of 463 maladjusted children, giving the following distribution.

I.Q.	below 70	70—89	90—109	110—129	above 130	Totals	Mean I.Q.
Boys ...	12	88	152	61	9	322	97.48
Girls ...	15	37	61	23	5	141	94.48
TOTALS...	27	125	213	84	14	463	96.57

The difference in mean I.Q. between the boys and girls occurred in the children of secondary school age and was largely accounted for by a proportion of troublesome adolescent girls who were also of dull intelligence.

Symptoms on referral:

Some analysis has been made of the type of symptoms causing children to be referred to the clinics. Behaviour problems predominated at all ages, except among the girls in the 8 to 10+ age group, in whom behaviour and nervous conditions were about equally balanced; but relatively few girls were referred in this age range. Seventy five per cent. of the symptoms found in the boys were classifiable as behaviour problems, compared with 63 per cent. in the girls. Nervous conditions predominated in 28 per cent. of the girls and 18 per cent. of the boys. Habit disturbances were found in 7 per cent. of the boys and 9 per cent. of the girls. Behaviour problems in the girls were mainly concentrated in the early adolescent years.

Reading attainment:

Not all maladjusted children of school age were tested in reading. Often there was no clinical reason to test brighter children who could obviously read well. For this reason, the mean I.Q. of the "reading sample" is rather lower than that of the whole sample of maladjusted children. A comparison of reading and intelligence quotients gives the following figures:

	No.	Mean I.Q.	Mean R.Q.	Difference
Boys ...	231	96	86	10
Girls ...	93	92	90	2

Retarded readers, defined as those whose reading quotients were 15 points or more below their intelligence quotients, consisted of 77 boys and 15 girls, or 28 per cent. of those tested. Good readers, defined as those whose reading quotients were 5 points or more above their intelligence quotients, consisted of 37 boys and 27 girls, or 20 per cent. of those tested. Good readers were found

much more frequently among both boys and girls with nervous or habit conditions than among those with behaviour problems.

The relationship of reading attainment to the two principal diagnostic groups is shown below.

	BOYS			GIRLS		
	Mean I.Q.	Mean R.Q.	Difference	Mean I.Q.	Mean R.Q.	Difference
Behaviour Problems ...	94	85	9	92	90	2
Nervous Conditions ...	98	89	9	90	90	0

The tendency for boys to be more handicapped than girls in reading thus cuts across diagnostic groups. In children showing habit disturbances there seemed to be a tendency for reading retardation in girls to be almost as great as that of boys, but the numbers were too small for any firm conclusions to be drawn.

School visits:

Visits to ordinary schools to discuss maladjusted children seen in the clinics totalled 251. There were thus many children whose schools could not be visited.

Handicapped Children:

Help with the assessment and educational guidance of handicapped children has continued to take up a large proportion of our time. The total number of handicapped children examined during the year was 386, with the following age and sex distribution.

	below 5	5 to 7+	8 to 10+	over 11	TOTALS
Boys	28	74	90	71	263
Girls	15	37	37	34	123
TOTALS	43	111	127	105	386
PERCENTAGE ...	11	29	33	27	100

As is to be expected, handicapped children are referred at an earlier age than maladjusted children, particularly those who are generally backward in their development. A large number of boys was referred for examination of learning difficulties between the ages of 8 and 10 years, the principal problem being retardation in reading. It was in this category that the difference between boys and girls was most marked.

Details of the various conditions of handicap are given below: several children had dual or multiple handicaps.

Type of Handicap	Boys	Girls	TOTAL
Hearing	53	28	81
Vision	3	0	3
Speech	13	9	22
Motor	18	9	27
Learning	83	22	105
General backwardness ...	103	60	163
Others (e.g. Epilepsy) ...	3	8	11

Reading Disability :

We were concerned about a proportion of children, in both the maladjusted group referred for child guidance treatment, and the group referred only for psychological assessment of learning difficulties, who exhibited serious retardation in reading to the extent that this could be considered a disability requiring special educational help.

There were 119 children (103 boys, 16 girls) who were considered to have such a disability in reading. Their average age was 10 years, average I.Q. 95, and average reading quotient 70. About 50 per cent. of these children (45 boys, 11 girls), with an average age of 9 years, average I.Q. 92, were either quite unable to read or had just a rudimentary recognition of a few words.

Symptoms associated with reading disability in this group of 119 children included 53 with behaviour problems, such as stealing, truancy, disobedience, aggressiveness; 30 with various nervous and habit disturbances, including school phobia; and 17 with some evidence of neurological dysfunction; although the information on related conditions is not complete.

While children are sometimes referred with the apparently isolated problem of difficulty in learning to read, examination of the child and investigation through the parents show that serious reading disability seldom occurs as an isolated symptom. Effective help for these children requires full consideration of related physical, emotional, intellectual, social and educational influences.

Facilities were not always available for giving these children the help they needed, as some of the areas served by the clinics had no remedial centres and provision for special help in the ordinary schools was inadequate. In some urgent cases, the psychologists were able to offer remedial help; but there is little time available for this work.

The Severely Subnormal:

We saw quite a number of children for early diagnostic assessment who were so handicapped intellectually as to require training centre placement, and a few

visits were made to training centres for review and assessment of children who were making good progress. The extension of the child guidance service and increasing demands for psychological assistance in diagnostic work with the handicapped have fully absorbed the increase in psychological staff; so that it has not been possible as yet to undertake any regular work in training centres and hostels for the subnormal.

Future developments:

Although working independently and scattered geographically, we have established regular means of communication for the exchange of information and ideas, and we consider that such co-ordinated activity should prove beneficial to the service as a whole. There are areas of work which we consider need further development. The principal need is to establish closer links between the child guidance clinics and the schools, since, with the exception of a few areas, school contacts are generally patchy. This could be an important avenue for work of a more preventive nature, as the child guidance clinics are still providing mainly a casualty service. Our work in special schools, which is well established, proves difficult to maintain, as commitments in the clinics take precedence. We look forward to the possibility of eventually sharing more in remedial education, and in the work of the training centres.

The following figures summarise the main aspects of work undertaken by the psychologists during the year.

Total number of children seen for psychological assessment:...	...	876
Total number of maladjusted children: ...	...	490
Total number of handicapped children: ...	...	386

Visits:

Schools	...	251
Special Schools	...	59
Homes	...	28
Audiology Clinics	...	28
Training Centres	...	11
Others	...	6

We are indebted to Mr. Godfrey Harrison of the Department of Psychology, The University, Sheffield, for generous help with computer programming of some of the data on which this report is based.

THE PSYCHOTIC CHILD:

Considerable emphasis has been given to the need to refer all children who appear to be withdrawing within themselves for further investigation. The survey of non-communicating children in Division 22 has continued, although somewhat hampered by the retirement of Dr. F. J. S. Esher, the Consultant Psychiatrist seconded for the survey by the Sheffield Regional Board and by shortage of medical staff. So far no new cases of "autism" have come to light in the Division but the studies are proceeding.

Generally in the whole of the West Riding few new cases of psychosis in childhood have been diagnosed during the year and a number of previously suspected cases have been re-assessed with a change in diagnosis.

The situation at the end of 1966 is as follows:—

<i>Children showing evidence of "autism"</i>							<i>Boys</i>	<i>Girls</i>
<i>Pre-school age:</i>								
(At home)...	...	...	...	...	...	...	—	1
<i>School age:</i>								
At home: refused training centre	...	...	...	...	...	...	2	—
At home: withdrawn from training centres for behaviour problems	...	...	...	...	...	...	2	1
At home: withdrawn from Rudolf Steiner School for behaviour	...	...	...	...	...	...	—	1
Attending Training Centres:	...	...	...	...	...	...	4	3
At day schools for the educationally subnormal	...	...	...	...	...	...	3	1
At residential school for the educationally subnormal	...	...	...	...	...	...	1	—
On home tuition	...	...	...	...	...	...	1	—
Attending school for the maladjusted	...	...	...	...	...	...	1	—
Attending Rudolf Steiner Schools	...	...	...	...	...	...	4	1
Permanent hospital placement	...	...	...	...	...	...	2	1
Total							20	9

Children showing evidence of psychosis other than "autism"

Attending training centres	...	...	...	...	...	...	1	2
Attending schools for the maladjusted	...	...	...	...	...	...	2	—
Permanent hospital placement	...	...	...	...	...	...	1	—
In hostel for adolescents	...	...	...	...	...	...	—	1
Total							4	3

Final diagnosis not made: probably not "autistic"

Attending training centres	...	...	...	...	...	...	3	—
At ordinary school awaiting school for maladjusted...	...	...	...	...	...	...	1	—
At day school for educationally subnormal pupils	...	...	...	...	...	...	1	—
Total							5	Nil

This gives a total of 29 boys and 12 girls under the age of 16 years who may be psychotic: a lower figure than in 1965. A number of confirmed cases left the West Riding area during the year.

Causation:

"Autism" was initially regarded by many psychiatrists as a manifestation of psychical trauma as a result of early separation from the parents or early emotional deprivation. This factor does apply in some instances but it has become more recognized that other factors are equally important e.g. the family background and specific conditions in the child.

In the 41 children outlined above the following possible causative factors were found:

						Boys	Girls
Separation from mother in infancy	...	...	...	...	...	2	—
<i>Specific conditions:—</i>							
Encephalitis in infancy	...	...	...	...	...	3	1
Meningitis	...	...	...	...	...	1	—
History of fits	...	...	...	...	...	3	—
Possible "brain damage at birth"	...	...	...	...	...	3	3
<i>Familial Factors:—</i>							
Father showed mental abnormality	...	...	...	...	...	2	1
Mother showed mental abnormality	...	...	...	...	...	3	1
Both parents abnormal	...	...	...	...	...	1	—
Father very dull	...	...	...	...	...	1	—
Father rejects, mother dead	...	...	...	...	...	1	—
Mother rejects	...	...	...	...	...	1	—
"Perfectionist parents"—cold emotionally	...	...	...	...	...	—	1
No apparent cause determined	...	...	...	...	...	8	5

It is therefore becoming more evident that physical and environmental factors are important—as in the educationally subnormal and maladjusted child.

It is sometimes difficult for parents to realise that a child who showed normal milestones in early infancy fails to make further progress as a result of the psychosis. The level of remaining intelligence has a close link with the age at which illness took place. It is a tragedy to see apparently normal children living entirely in a world of their own, completely withdrawn from reality. Parents often hope for a miraculous "break through" and a return to normality.

Education is a great problem and the child needs almost an individual teacher to himself. Even then little progress is frequently made although at schools such as the Rudolf Steiner group social adjustment may be made.

The National Society for Mentally Handicapped Children hopes to set up a special school for autistic children in Yorkshire at some future date when funds are available.

Buzzers for Bedwetters:

In the British Medical Journal of 16th July, 1966, attention was drawn to cases of ulceration of the skin following the use of the alarm apparatus of a particular type. An enquiry was made of all Divisional Medical Officers to ascertain if any similar cases had been heard of in the West Riding. Apart from one case which occurred in the Todmorden area in 1962, following the use of an early model, no instances of ulceration have been reported. The firm concerned has now altered the apparatus.

The service is still widely used, the apparatus being loaned from the Divisional Medical Officer on medical recommendation and no parent needs to be involved in the expense of purchasing expensive equipment often advertised in the press.

Foot Infections:

Following the report in 1965, after numerous discussions agreement was reached with the Chief Education Officer on the instructions to be issued to all schools on the care of the feet and the cleanliness of floors in schools. These instructions were issued to caretakers and physical education staff in August, 1966, and read as follows:—

From time to time doubts are raised about the desirability of barefoot work in physical education and possible dangers of infection, whether from barefoot activities or from the use of changing rooms and showers.

Halls and Gymnasias

There is no medical evidence that barefoot work increases the risk of infection, provided always that the floors used are properly maintained. Firstly the floor itself must be in good condition. Cracked or uneven surfaces may harbour infected material which the caretaker cannot possibly clear away adequately.

Secondly, assuming that the floor is in good order, it must be kept scrupulously clean, and here the caretaker's work is vital. Obviously also the Head should control carefully the use made of the hall and gymnasium by pupils for purposes other than physical education.

Changing Rooms and Showers

The danger of infection is greatly increased where floor surfaces may be wet. Here again cleanliness is all-important.

- (a) **Showers:** The best way of cleaning and disinfecting the floors in showers is to scrub them with a solution of hot water and liquid bleach (hypochlorite), and rinse them. Diluted bleach is, in itself, a disinfectant and can, with advantage, also be applied to the floors after they have been thoroughly cleaned. Most schools will already have a supply of liquid bleach in stock.
- (b) **Changing Rooms:**
 - (i) Quarry-tile floors in changing rooms should be maintained in the same way as the floors in showers.
 - (ii) Other types of flooring (such as sealed wood, thermoplastic, linoleum and rubber) would quickly deteriorate if disinfectant were left on the surface. They should, therefore, be washed, squeegeed, left to dry thoroughly and, wherever possible, maintained in accordance with the recommended procedures set out in Appendix II of the Committee's Handbook.

P.E. Staff

Certain conditions of the feet are highly infectious and the Education Officer and the County Medical Officer would value the help of teachers of physical education in dealing with them. In particular, it would be of great assistance if teachers would:—

- (a) ensure that pupils are made aware of the possibilities of contracting or spreading foot infections.
- (b) see that pupils in no circumstances wear plimsolls which have been used by someone else,
- (c) periodically (say once every two or three weeks) examine the feet of children in their classes. Any unusual condition of the skin should be regarded as possible infection and the pupil referred to the clinic or his own doctor. Meanwhile, such pupils should not do P.E. without plimsolls.

If any Head has any doubts about the wisdom of pupils working in bare feet, he should have a word with the P.E. Adviser or the Supervisor of Caretakers."

FOOT CONDITIONS IN SCHOOL CHILDREN:

A survey was carried out in the Spenborough Division by the chiropodist working in the School Health Service and his report is reproduced as Appendix E.

The School Ophthalmic Service:

Following the retirement of Mr. P. M. Wood temporary difficulties were experienced in maintaining the ophthalmic clinics in the Brighouse Division.

Dr. Cooper, an Assistant County Medical Officer, was seconded for a course on refraction etc. under the consultants Messrs. G. Brockbank and J. Foster at Leeds with the full agreement of the Leeds Regional Hospital

Board and is now recognized to undertake special duties in this sphere and to prescribe spectacles. Similar facilities would be made available if any other medical officer expressed an interest in ophthalmology.

Details of the examinations during 1966 and a comparison with previous years appear in Table 84 of the Appendix.

Medical Treatment at Clinics:

A list of clinics in operation at the 31st December, 1966 is given in Table 85 of the Appendix.

Owing to Dr. Pickup's contraction of areas the Pædiatric Clinic at Rothwell had to be closed down during the year as no replacement could be offered by the Leeds Regional Hospital Board. Dr. Pickup's close liaison with the School Health Service has always been much appreciated and it is fortunate that the link still remains in other areas.

A physiotherapist was appointed for two sessions per week at Todmorden as partial replacement for a previous whole-time member of staff who retired.

Minor Ailment Clinics:

The number of children treated for minor ailments continues to decline. In 1966, 4,889 children were seen; in 1965, 6,147.

Consultant Services:

A summary of the Consultant Services appears in Table 86 of the Appendix.

SCHOOL HEALTH SERVICE ASPECTS—Dr. Harvey, Consultant Pædiatrician, reports:—

Hazards of Tonsil-Adenoid Operations

Under the best possible conditions nearly one in five children bleed more than 10 per cent. of the total blood volume during operation, and in some cases transfusion is necessary (1965. *Brit. med. J.* ii. 1321, leading article).

Several careful doctors during the year have been carrying out needless repeated hæmoglobin checks, and giving children long courses of iron, through not realizing that 75 per cent. to 80 per cent. is a normal level for many young children.

Some children, like some adults, who suffer from chronic nose-block due to allergic swelling of nasal turbinates, stand to benefit greatly by cauterization of the mucous membrane, rather than by antrum washouts. The diagnostic snag is that the swelling may shrink with fright, while waiting to be examined by the specialist, who may thus be in doubt as to what needs doing.

Only one new case of rheumatic heart valve scarring came to light during the year, a 12 year old girl who had been treated at home 8 months earlier for multiple joint pains and swellings. Intensive high drug dosage in hospital is the only adequate treatment for juvenile rheumatism, followed by daily penicillin throughout adolescence.

Rheumatoid arthritis is now more common than cardiac rheumatism in school children.

Several children who have been referred on suspicion of epilepsy have diagnosed themselves by the help of a quiet detailed eye-witness account of recurring attacks. Hunger faints, probably due to low blood sugar before breakfast, are one of the commoner findings.

Peanut Inhalation

Parents failed to disclose to the school medical officer that a 6 year old boy's prolonged harsh cough had started months earlier, at a precise moment during a birthday party, while choking on a mouthful of salted roast peanuts. Eventually he coughed out, 4 months later, a large intact half nut, over $\frac{1}{2}$ inch long. He was lucky not to have died of a lung abscess. Peanuts should be the first suspicion for any harsh cough in a child over 1 year old.

And two rarities

A 7 year old girl was referred to a neuro-surgeon who ruled out suspicion of a brain tumour. But she developed a progressive sub-dural blood clot, and was then found to have malignant hypertension. She recovered after removal of one scarred kidney.

A nine year old athetoid child died suddenly of sagittal sinus thrombosis 4 days after hospital dental extractions. The clotting in the great vein might have befallen any patient, but the extensive tooth decay was an integral feature of her cerebral palsy."

Consultant Cardiac Clinic:

Dr. Hepple reports as follows on the Cardiac Clinic at Harrogate:—

"During 1966, 19 new cases were seen at the cardiac clinic. These included 2 cases from Wetherby Division, 1 case from Horsforth Division and 2 cases from the North Riding of Yorkshire.

A total of 34 clinic sessions were held during the year, 170 children made 219 attendances. No special sessions were held for Mr. Wooler during the year, as children in need of further investigation etc. were referred direct to him at Leeds Infirmary.

Twelve children attended Leeds Infirmary for investigation, including cardiac catheterisation, or were awaiting operations during the year.

Five children underwent surgery in Leeds; two for closure of atrial septal defects; three for ligation of patent ductus arteriosus. Five other children attended Leeds for follow-up after previous operations."

Incidence of Scabies:

Reports in the medical press in December, 1966, suggested that there might be an increase in scabies in the country.

Divisional Medical Officers were asked if there had been an increase of cases in their areas and there have been outbreaks in some districts though the majority of the reports showed little or no increase.

An outbreak occurred at the Baliol School for educationally subnormal boys during the Summer of 1966 and has continued to smoulder since. The situation has been complicated by the atypical distribution of lesions in some cases. Despite energetic treatment with benzyl benzoate emulsion some of the cases failed to clear up and a trial of one per cent. lorexane cream has been made, based on the advice of a dermatologist at a refresher course held during 1966.

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 is referred to in the Section of the Report dealing with Epidemiology, also particulars of the scheme for the vaccination of school children against poliomyelitis.

Cleanliness:

The figures showing the number of children found to be suffering from head infestation during the year compared with previous years appear in Table 87 of the Appendix.

Nutrition:

In 1956 the Minister of Education introduced a change in the classification of the general condition of school children. Table 88 of the Appendix is, therefore, in two parts.

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, 1966 was 189,277 compared with 177,512 in September, 1965. This represents 73.21 per cent. of children in attendance.

Medical Examination of Entrants to Training Colleges:

In connection with their applications for entry to Training Colleges, 1,844 students were medically examined during the year by the School Medical Officers, compared with 1,622 for the year 1965 and 1,372 for the year 1964.

Children and Young Persons Act, 1933, Employment of Children:

Under the Authority's bye-laws relating to the employment of children, 1,244 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. One child was found to be 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.

Protection of School Children Against Tuberculosis:

TUBERCULIN TESTING OF ENTRANTS:

In two Divisions of the West Riding tuberculin testing of younger children has been carried out on an experimental basis. A total of 1,078 children (1,030 entrants and 48 in the 7—8 years age group) were tested, of whom 17 gave initial positive reactions—8 of these had had previous B.C.G. vaccination. Further investigations were carried out by referral of cases and contacts to Chest Clinics and X-ray.

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)	659	645	14	8	— 6	Referred to Chest Physician.
Spenborough (Jelly Test) (Entrants)	371	368	3	—	2 1	One child and nine contacts referred for X-ray. No new cases of tuberculosis discovered.
(7—8 years age group)	48	48	—	—	— —	
	1,078	1,061	17	8	2 7	

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 1953—1957 inclusive, was again carried out in this division of the West Riding in 1966, as requested by the Department of Education and Science.

The results are set out in the following tables:—

	Year of birth				
	1953	1954	1955	1956	1957
Number of children eligible ...	605	380	206	677	699
B.C.G. vaccination previously ...	22	11	13	28	31
Known natural positives ...	79	37	7	22	—
Acceptances ...	386	307	174	592	648
Number tested ...	349	242	146	517	573

Results

Negative ...	285	225	144	510	554
Positive + ...	39	17	2	7	11
++ ...	3	—	—	—	4
+++ ...	1	—	—	—	4
++++ ...	—	—	—	—	—
Total naturally positive ...	122	54	9	29	19
Percentage positive ...	29.9	19.3	5.9	5.6	3.3

1966 results compared with 1963, 1964 and 1965:—

Year of Birth	Percentage positive in			
	1963	1964	1965	1966
1950	17.0	—	—	—
1951	13.0	16.1	—	—
1952	10.9	11.1	20.2	—
1953	15.2	15.8	20.0	29.9
1954	11.1	11.7	13.9	19.3
1955	—	4.5	6.4	5.9
1956	—	—	3.6	5.6
1957	—	—	—	3.3

This table shows once again that there has been a considerable drop in the percentage of reactions to the Heaf test in children born after 1954. The 1953 age group has had high rate of reactions throughout the survey.

The five children found to have a +++ reaction were investigated at the Chest Clinic but no evidence of active disease was found either in the children or in their family contacts.

THE SCHOOL DENTAL SERVICE

The following is the report of the Principal School Dental Officer, Dr. Davies.

Staff:

At the end of the year there was an increase in dental staff which restored the position to its level of two years ago.

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
County Orthodontist	1	1
Dental Specialist	1	1
Senior Clinical Dental Officers ...	3	5
Area Dental Officers... ..	12	18
Dental Officers	35	43
Dental Auxiliaries	10	10

In addition, there were three part-time dental officers, being the equivalent in sessions worked of 1.3 full-time dental officers. These figures represent an increase of two full-time and a decrease of five part-time dental officers and an increase of four dental auxiliaries compared with the position twelve months previously.

Recruitment of dental officers to the service was excellent in the first three months of the year, since when the position has been one of gradual loss and a complete inability to replace. One dental auxiliary left early in the year in order to marry, but five newly-qualified auxiliaries were appointed during September and October, bringing the number up to establishment level.

Of the eleven dental officers appointed during the year, nine were below 35 years of age and two were about 60 years of age. Seven of the young ones were newly-qualified and two had had a few years experience in general practice. Of the older recruits, one had retired from an Army career and the other from general practice.

Nine dental officers left the service, of whom two were retiring, three left to take up careers overseas, two went into general practice, one entered the hospital service and one left for family reasons.

A small change in the establishment was made whereby two posts of dental specialist were created, one of them replacing that of Orthodontic Consultant and now re-named the County Orthodontist. By doing this, it was possible to bring the Orthodontist's salary into line with what is being offered in other comparable local authorities.

A number of dental officers attended post-graduate courses and five dental officers attended the annual conference of the British Dental Association at Scarborough, where a demonstration of the work of the West Riding dental service was staged.

The Chief Dental Officer continued to hold the post of Part-time Lecturer in Public Dentistry at Leeds University and a party of senior students was again conducted around Cleckheaton Health Centre as part of the course.

Clinics:

No new dental clinics came into operation during 1966. During the year 59 clinics were available containing 99 surgeries, of which 98 were actually in use. All five mobile clinics were utilised during the year, working a total of 1,359 sessions, an increase of 291 over the previous year.

Inspections:

In the early part of the year, the influenza epidemic affected both the dental staff and their patients and numbers were much reduced compared with the same months in 1965. However, the increase in staff after Easter produced an improvement and at the end of the year about a thousand more pupils had been inspected. It may be noted from the statistical table that approximately 1,500 fewer children were inspected in school and 2,500 more at the clinic. These latter are not accounted for by emergencies, which were less than in 1965, and this number, therefore, appears to indicate an increased interest among patients and their parents in regular dental inspections. A total of 180,584 children were inspected, of these 110,766 were found to require treatment and 97,907 were offered treatment. The number of children treated during the year was 65,043, an increase of 500 on 1965. In addition, 18,868 children received a re-inspection and 10,787 of these were found to require treatment.

Treatment:

Although changes in the number of staff were not great, nevertheless corresponding changes in the treatment provided followed predictable lines. With more staff, the number of fillings goes up and the number of extractions goes down and with it the number of general anaesthetics. The number of emergencies decreased and the number of more time-consuming items such as root fillings, inlays, crowns, together with the number of courses of treatment increased. The numbers were as follows:—

	1966	1965
Children treated ...	65,043	64,533
Fillings	163,905 (This is the highest figure yet achieved)	160,374
Extractions	78,158	81,260
General anaesthetics ...	24,703	25,745
Emergencies	3,919	4,387

It is particularly gratifying that the number of inlays and crowns has recovered from its drop in 1965. This type of work is very time consuming and while of great benefit to the individual patients concerned, can hardly be undertaken if the treatment of patients requiring routine work might go by default.

The induction of general anaesthesia by intravenous methods was continued and expanded during the year and a start was made in the technique of providing extensive conservative treatment under intravenous sedation. The first of our

patients to receive this treatment was a boy of 14 with a neglected mouth who now regretted his previous refusal of treatment and wished his mouth to be put in order. During a session of two hours 20 minutes overall, 16 cavities were prepared and filled, four front teeth were extracted and an immediate denture was fitted. The actual operating time was one hour 40 minutes. This technique has limited application but is extremely useful in these few cases which otherwise would be almost impossible to treat.

Work of the Laboratory:

During the year the staff of the laboratory was one dental technician below the approved total establishment of thirteen. Recruitment of this class of worker continues to be difficult. Items of work carried out during the year, together with comparable figures for 1965, were as follows:—

1965

Committee	Full Dentures	Part Dentures	Repairs	Inlays, Crowns, etc.	Appliances	Total	Study Models
Education	22	803	285	464	3,727	5,938	5,124
Health	348	179	98	12	0		

1966

Education	14	795	350	569	3,339	5,537	5,422
Health	274	133	51	12	0		

Health Education:

During 1966 three major campaigns were held, each of approximately three weeks' duration, at Batley and Heckmondwike, Todmorden and Sowerby Bridge, and Normanton. In each of these districts all the schools were visited by a health education team consisting of dental officers, dental auxiliaries and dental surgery assistants, and exhibitions and talks were given. In all, more than 18,000 children were addressed. In almost every case the talks were well received and at one school questions were asked by the pupils for more than an hour after the talk had ended.

In addition to the above, a dental health exhibition was set up for one week in the general waiting room of the Cleckheaton Health Centre. A large number of exhibits were shown including a continuous roll film daylight projector. Talks were given to children and adults as they arrived to attend the various clinics at the centre and the film viewer was found to be of particular value in attracting attention in the first place. This exhibition seemed to have a particular value by creating parental interest.

At the end of the year, a few days before the Normanton campaign concluded, Mr. Metcalfe, the Area Dental Officer in charge of dental health education, became ill and it is anticipated that he will be absent from duty for some months.

Under Mr. Metcalfe's supervision this part of the dental service has developed rapidly during the last few years and its progress is bound to suffer a set-back in 1967.

Supplementing the major efforts described, routine low-intensity health education was maintained by the dental auxiliaries and this work must be sustained if lasting benefits are to accrue.

Epidemiological Survey:

A number of dental officers repeated the survey initiated last year in which a number of children aged 5 and 14 were given a detailed dental examination at school inspection. These officers worked in different parts of the County and the results obtained provide a reasonable cross-section of these age groups.

A total of 850 children in each age group were examined and the results are shown in the following table.

	D	M	F	T	Average 1966	Average 1965
Age 5	3,581	692	248	4,521	5.3	4.7
Age 14	4,361	1,202	3,911	9,474	10.9	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 noted that the large number of teeth affected by decay at the age of 14 is almost the same as that of 1965, but that it appears there has been a deterioration in the condition of the children aged 5 to the extent of one additional decayed tooth to every two children. The value of this survey will increase with each year's findings and significant trends will become apparent.

Dental Auxiliaries:

During 1966, the experimental scheme to test the value to the community of dental auxiliaries was concluded and a final report was issued by the General Dental Council. This report stated that the experimental scheme has shown that dental auxiliaries can be successfully trained and employed under proper supervision to do, within the limited field prescribed, work of great value, particularly among young children. The Privy Council accepted this report which was then laid before Parliament and the General Dental Council was subsequently required to draft regulations which will establish dental auxiliaries on a permanent basis.

Experience in the West Riding, where a total of 15 dental auxiliaries have been employed at various times, confirms the finding in the final report as to the usefulness of auxiliaries in both the clinical and health education fields, but disappointment is felt that it should still be thought necessary for a dental officer not only to exercise strict supervision over the clinical side of their work, but to be actually present while the work is being done. Dental auxiliaries are not permitted to carry out dental treatment unless a registered dentist is within call in person and not by telephone. This requirement severely limits the usefulness of auxiliaries and means that they cannot be employed where they are most required, in clinics where there is no full-time dental officer.

If this restriction had not been continued, about 30 auxiliaries could have been initially employed in the Riding, working under the direction of a dental officer and to his prescription. Dental surgeries at present used for part of each week would be fully used and a very substantial contribution to the work needed by school children would be made. Under existing regulations no increase can be recommended in the present establishment of ten which has been shown to extend administrative arrangements to the limit.

It is felt that an opportunity has been lost, at least for the time being, and one is reminded of the position after the 1921 Dentists Act when a half-hearted attempt to make use of similar ancillary workers, then called dental dressers, failed because their usefulness was reduced by later regulations.

Orthodontics:

A large number of orthodontic cases was carried over from 1965, 3,818 compared with 3,152 of the previous year. Because of this fewer new cases could be commenced; 1,494 compared with 2,053, and the number of appliances fitted was reduced. Nevertheless, 2,833 removable appliances were supplied and 224 fixed appliances were fitted. The latter figure shows an increase of 50 over 1965, a considerable increase in this very specialised work. The total number of orthodontic cases treated during the year showed an increase of 107 and 141 more cases were completed than in the previous year.

The orthodontic service suffered a severe loss on the retirement of Miss R. Sclare at the end of the year. Miss Sclare had served the West Riding for 35 years and was first appointed as Orthodontic Specialist in 1952. Together with Mr. B. R. Townend, formerly Chief Dental Officer, Miss Sclare had developed the orthodontic service from its very beginnings to one with a national reputation and her orthodontic skill and quiet, unassuming encouragement will be greatly missed by all dental officers.

The post of Orthodontic Consultant, now re-named County Orthodontist, has been taken by Mr. Thompson, Senior Clinical Dental Officer, who has specialised in orthodontics for a number of years, and in September of this year obtained the post-graduate qualification of Diploma in Orthodontics of the Royal College of Surgeons. It is expected that under Mr. Thompson's supervision the orthodontic service will continue to develop.

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 in addition for the first year was developed for school leavers. This involved the replacement of examination by interview following the distribution of questionnaires to the parents and a scrutiny of the medical records. Following the interview pupils who were thought to require a full medical examination were followed up and examined at a later date. As was expected this number was, in fact, very small.

The work of the Child Guidance Clinic during the year continued to hold our attention and interest. The increase in the amount and kind of work coming to notice is marked and is in general agreement with the expected trend we are finding today.

Organised health education in the school continues to increase although it is not developing as rapidly as we would like.

Early in 1966 the Keighley Borough Council, following a notice of motion, reversed its decision to fluoridate the public water supplies. This was a close decision and it is felt a retrograde one in view of the strong scientific evidence in favour of this preventive measure.

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:—

	1966	1965
Nursery	40	40
Primary	5,152	5,070
Secondary Modern	2,125	2,171
Secondary Grammar	1,174	1,242
Secondary Technical	432	466
Special Schools	94	97

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 classification 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.				
1962 and later	80	80	—	—	—	22	22
1961	598	598	—	—	3	152	153
1960	244	244	—	—	1	65	66
1959	2	2	—	—	—	1	1
1958	272	272	—	260	40	78	105
1957	124	124	—	84	10	24	33
1956	—	—	—	—	—	—	—
1955	—	—	—	—	—	—	—
1954	—	—	—	—	—	—	—
1953	—	—	—	—	—	—	—
1952	—	—	—	—	—	—	—
1951 and earlier	485	485	—	473	43	43	80
TOTAL	1805	1805	—	823	97	385	460

SELECTIVE SCHEME:

The selective scheme of medical examination of pupils in the intermediate age group has been continued as described in previous reports. During the year 746 questionnaires were distributed of which 702 were returned. Following examination of the completed questionnaires 115 children were invited to attend for a medical examination. Parents were invited to be present and in 79 cases either one or other parent did, in fact, attend.

Additionally 281 eight-year old pupils were examined by School Medical Officers in the year and set out overleaf are details of the defects found. It is pointed out that the character of the defects has not varied to any considerable extent in recent years.

A copy of the questionnaire will be found at Appendix i to this report.

During the year the selective scheme of medical examination of pupils, which has been developed during the past six years, was taken a stage further. The school leaving examination was replaced by interview. Questionnaires were distributed to the parents for completion and return. These were scrutinised together with all the available medical records. At the interviews, which were held in the schools, pupils were selected for a full medical examination to be carried out at the school clinic by appointment.

This scheme was introduced in November, 1966 and the figures included in the preceding table should be interpreted as follows:

School leaving examination of pupils during their last year of compulsory school attendance.

482 pupils were examined routinely under old system of routine medical inspection.

478 pupils were interviewed under new system of selective scheme of medical examination, 5 pupils were selected for medical examination of whom only 3 kept the appointments which had been made for them.

473 pupils seen at the interview were found not to require a medical examination.

Total number of school leavers examined or interviewed—960.

A copy of the questionnaire for the school leaver will be found at Appendix i to this report.

Routine tests of visual acuity were carried out by the Assistant Health Visitors/School Nurses in the age groups as follows: 6—7 years, 10—11 years, 12—13 years, 14—15 years. As previously a test of colour vision was also carried out in the age group 12—13 years. The practice of pupils suffering from defects of vision being interviewed by the School Medical Officers has been discontinued. Pupils were referred direct to the Local Authority Ophthalmic Clinic by the Assistant Health Visitors/School Nurses, subject to parental consent and unless the parents chose to arrange for an examination via their general practitioner.

The procedure of referral to the Ophthalmic Clinic by the Assistant Health Visitors/School Nurses, coupled with the selective scheme of medical examination has released the School Medical Officers to devote their time to the examination and investigation of pupils in need of more specialised help.

Defects Found

Defect Code No.	Defect or Disease	T	O
4	Skin... ..	6	3
5	Eyes (a) Vision	50	10
	(b) Squint	8	—
	(c) Other	1	—
6	Ears (a) Hearing	17	10
	(b) Otitis Media	1	—
	(c) Other	11	1
7	Nose and Throat	12	14
8	Speech	9	11
9	Lymphatic Glands	—	—
10	Heart	1	4
11	Lungs	11	8
12	Developmental (a) Hernia	—	1
	(b) Other	3	1
13	Orthopaedic (a) Posture	1	1
	(b) Feet	2	1
	(c) Other	6	1
14	Nervous System (a) Epilepsy	3	2
	(b) Other	1	1
15	Psychological (a) Development	3	9
	(b) Stability	1	4
16	Abdomen	1	—
17	Other	19	11

T = Pupils already under treatment or newly referred for treatment.

O = Pupils requiring observation only.

B. Other Inspections

Number of Special Inspections ...	1,918
Number of Re-Inspections ...	834
Total ...	<u>2,752</u>

Comparative Table of Inspections carried out from 1962—1966.

Year	Routine	Specials	Re-Inspections
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
1966	1,805	1,918	834

TABLE II

INFESTATION WITH VERMIN

(i) Total number of individual examinations of pupils in schools by the school nurses or other authorised persons	22,141
(ii) Total number of individual pupils found to be infested	528
(iii) Number of individual pupils in respect of whom cleansing notices were issued (Section 54(2), Education Act, 1944)	1
(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, 1966

NOTE.

All defects, including defects of pupils at Nursery and Special Schools, noted at periodic and special 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.	Defect or Disease	PERIODIC INSPECTIONS								SPECIAL INSPECTIONS	
		ENTRANTS		LEAVERS		OTHERS		TOTAL			
		(T)	(O)	(T)	(O)	(T)	(O)	(T)	(O)	(T)	(O)
4	Skin	13	3	16	4	6	3	35	10	164	17
5	Eyes— <i>a.</i> Vision ...	4	—	43	4	50	10	97	14	80	34
	<i>b.</i> Squint ...	45	2	1	—	8	—	54	2	29	5
	<i>c.</i> Other ...	5	—	—	1	1	—	6	1	20	7
6	Ears— <i>a.</i> Hearing ...	21	8	1	1	17	10	39	19	65	41
	<i>b.</i> Otitis Media ...	13	7	1	1	1	—	15	8	27	18
	<i>c.</i> Other ...	23	—	1	—	11	1	35	1	16	4
7	Nose and Throat ...	46	26	2	3	12	14	60	43	67	61
8	Speech	20	11	—	—	9	11	29	22	79	44
9	Lymphatic Glands ...	4	5	—	—	—	—	4	5	3	8
10	Heart... ..	1	6	3	1	1	4	5	11	11	35
11	Lungs	18	13	4	4	11	8	33	25	69	54
12	Developmental—										
	<i>a.</i> Hernia ...	1	—	—	—	—	1	1	1	2	1
	<i>b.</i> Other ...	6	10	—	—	3	1	9	11	7	9
13	Orthopaedic—										
	<i>a.</i> Posture ...	—	1	—	—	1	1	1	2	6	4
	<i>b.</i> Feet ...	34	3	3	1	2	1	39	5	57	14
	<i>c.</i> Other ...	6	7	2	1	6	1	14	9	47	11
14	Nervous System—										
	<i>a.</i> Epilepsy ...	1	1	1	—	3	2	5	3	16	7
	<i>b.</i> Other ...	1	1	1	—	1	1	3	2	6	12
15	Psychological—										
	<i>a.</i> Development ...	6	5	—	1	3	9	9	15	128	91
	<i>b.</i> Stability ...	5	2	3	1	1	4	9	7	111	82
16	Abdomen	4	1	—	—	1	—	5	1	6	8
17	Other... ..	22	18	5	15	19	11	46	44	75	93

T = Pupils requiring treatment

O = Pupils requiring observation only

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 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	
	1966	1965
External and other, excluding errors of refraction and squint ...	48	37
Errors of refraction (including squint)	355	230
Total	403	267
Number of pupils for whom spectacles were prescribed	226	132

During the year 48 cases suffering from conditions of the eye such as Blepharitis and Conjunctivitis were treated at the Minor Ailments Clinic. 328 cases of Defective Vision and 27 cases of Squint were examined by the Consultant Ophthalmologist.

Following examination it was found that in 21 cases existing spectacles were considered to be satisfactory, in 124 cases spectacles were not thought to be necessary and 19 cases were referred to the Bradford Eye and Ear Hospital.

For the greater part of the year the Consultant Ophthalmologist attended 2 sessions per week in place of the previous 1. This is reflected in the increased number of cases examined and for whom spectacles were prescribed.

The number of repairs to and replacements of spectacles amounted to 213.

B. Diseases and Defects of Ear, Nose and Throat

	Number of cases known to have been dealt with	
	1966	1965
Received operative treatment:		
(a) for diseases of the ear	—	—
(b) for adenoids and chronic tonsillitis	109	152
(c) for other nose and throat conditions	3	8
Received other forms of treatment	59	78
Total	171	238
Total number of pupils still on the register of schools at 31st December, 1966 known to have been provided with hearing aids:—		
(a) during the calendar year 1966	—	—
(b) in previous years	12	—

Audiometric Survey:

The audiometric survey of seven year old school children was continued during the year, together with the examination of children in the "at risk" categories. As previously indicated 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 examinations. However, it is still thought that both continue to have a place in the scheme, at least for the present. 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	Referral for appreciable hearing loss	investi- gation	Already attending Otologist
<i>"At risk" categories</i>					
(i) deafness in the family ...	6	4	1	1	
(ii) prenatal causes:—					
maternal rubella ...	—	—	—	—	
other conditions ...	—	—	—	—	
(iii) perinatal causes, e.g. toxæmia, anoxia, kernicterus, rhesus incompatability, prematur- ity, etc.	—	—	—	—	
(iv) postnatal:—					
congenital defects ...	—	—	—	—	
cerebral palsy ...	—	—	—	—	
middle ear disease ...	24	16	7	1	
meningitis or encephalitis	—	—	—	—	
speech retardation or defect	4	3	—	1	
educational retardation ...	26	21	5	—	
Routine test on children in 6/7 year age group ...	588	572	12	4	
Referred for possible hearing loss...	49	32	13	4	
	697	648	38	11	

Of the 38 children referred to the Otologist for investigation 22 received operative treatment, consisting of 11 cases of tonsillectomy, 6 cases of adenoidectomy and 5 cases of other forms of operative treatment. In 4 cases no form of treatment was advised and for 12 cases no report has so far been received.

C. Orthopædic and Postural Defects

	Number of cases known to have been treated	
	1966	1965
(a) Pupils treated at clinics or out-patient departments	154	171
(b) Pupils treated at school for postural defects ...	—	—
Total	154	171

Mr. Skinner, Physiotherapist reports:—

"The Physiotherapy Department has had a fairly constant demand made upon it throughout the year. The waiting list of last year, is, at the time of writing non-existent, thus leaving us in the happy position to be able to offer immediate treatment in the majority of cases.

The Orthopædic Consultant Clinics have continued, as in previous years, to work to everyone's mutual benefit.

During the year, we have co-operated with the Child Guidance Clinic and have absorbed some of their children into our classes, often with rewarding results.

We have again had the use of the Swimming Baths and they have provided the means to assist our handicapped children. The majority of those attending learn to swim, occasionally to Bronze Medal standard.

As in previous years, we have co-operated with Hospital Departments in ensuring fairly prompt treatment, in cases recommended by them."

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	...	...	...	...	...	...	22	332
Athetoid	...	...	...	...	...	...	1	36
Benign Hypotonia	...	...	...	...	...	...	1	32
Breathing	...	...	...	...	...	...	38	440
Bronchitis	...	...	...	...	...	...	2	20
Curly toes	...	...	...	...	...	...	11	244
Flat feet	...	...	...	...	...	...	35	465
Manipulations	...	...	...	...	...	...	8	82
Postural drainage	...	...	...	...	...	...	2	7
Posture	...	...	...	...	...	...	22	101
Remedial exercises	...	...	...	...	...	...	4	43
Spastics	...	...	...	...	...	...	8	232
<i>Pre-school Children</i>								
Curly Toes	...	...	...	...	...	...	1	13
Spastics	...	...	...	...	...	...	1	2

Consultant Orthopaedic Clinic :

Number of sessions held 11

*Pre-school School
Children Children*

Number of individual patients seen by consultant, including those continuing attendance from previous year ... 10 81

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 — —

(ii) domiciliary — —

Number of children who obtained operative treatment during the year — —

Total number of attendances at consultant clinic 10 119

Treatment Centres:

Number of sessions held 400

Total number of patients treated (including cases continuing treatment from previous year) 2 154

Total number of attendances 15 2,034

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	
								1966	1965
Ringworm—(a)	Scalp	...	...	...	...	...	...	—	—
(b)	Body	...	...	...	...	...	...	—	—
Scabies ...	...	...	...	...	...	...	...	67	4
Impetigo ...	...	...	...	...	...	...	...	45	20
Other skin diseases	...	...	...	...	...	...	...	79	143
Total								191	167

It will be seen from the figures that there has been a considerable increase in the incidence of Scabies during 1966. The affected children have been treated at the School Clinic, child contacts have also received treatment at the Clinic and their homes visited by the Health Visitor/School Nurse. Adult contacts have been advised and provided with a supply of Benzyl Benzoate for their own treatment. School inspections have been carried out but there has been little evidence of any spread of infection within the schools. Infection has occurred mostly in the homes and between relatives and neighbours.

E. Child Guidance Treatment:

	<i>Number of cases known to have been treated</i>	
	1966	1965
Pupils treated at Child Guidance Clinics ...	174	152

Location of clinic:

School Clinic,
147, Skipton Road,
Keighley.

Number of sessions held during the year 176

	<i>Boys</i>	<i>Girls</i>	<i>Total</i>
Number of new cases seen... ..	61	35	96
Number of cases referred from previous year	58	20	78
Total number of cases discharged or admitted for residential treatment	65	28	93
Number of cases carried forward... ..	54	27	81

The staff of the Child Guidance Clinic remains the same as in 1965, i.e., a Physician in Charge, an Educational Psychologist, a Mental Welfare Officer, and a Psychiatric Social Worker who was appointed in March, 1966. 174 cases have attended the Clinic during the year presenting symptoms of nervous disorder, organic disorder, disorders of habit or behaviour, or requiring guidance with educational and vocational difficulties.

Referrals have come from many sources, e.g., family doctors, health visitors/school nurses, paediatricians, teachers, probation officers and child care officers as well as from School Medical Officers, and from parents. As in previous years we are grateful for the help and co-operation which has been given by the agencies and specialists who have referred children to the clinic and who have assisted in their treatment and management.

Several of the children attending the clinic presented educational difficulties. Children whose intelligence was in the average range were found to have retarded scholastic attainment and in need of special educational help. The causes of their educational retardation were many e.g., minor degrees of sensory impairment, minor ill health, irregular school attendance, impoverished social environment, broken homes, emotional disturbances, minimal cerebral dysfunction, specific disabilities. Each child may be found to be handicapped by more than one factor.

During the past six years the School Medical Officers have been concerned about the number of pupils who have been referred to them for ascertainment for retarded attainment and who on examination have been found to have an intelligence quotient within the average range but who fail to make educational progress in keeping with their intelligence. A recommendation for special education in the ordinary school has been made on their behalf. Some of these cases have been referred to the Child Guidance Clinic for further investigation

and these together with those seen by the School Medical Officers have been reviewed.

From a wider group of children who were found to be failing to fulfil their potentialities of intelligence and capability an investigation was carried out of those with an Intelligence Quotient of above 75 and a Reading Quotient of below 85. Although the lower limit of I.Q. was fixed at 75 most of the children in the group had an I.Q. higher than 80 and a few higher than 100.

25 children in this group are now in attendance at Secondary Schools, and 44 are in attendance at Primary Schools.

The following examples indicate the degrees of retardation which have been considered.

A child aged 9 years	I.Q.	112	Terman Merrill Scale Form L—M
	R.Q.	83	
A child aged 8 years	I.Q.	91	Wechsler Intelligence Scale for Children.
	R.Q.	57	
A child aged 9 years	I.Q.	100	Terman Merrill Scale Form L—M
	R.Q.	69	
A child aged 7 years	I.Q.	99	Wechsler Intelligence Scale for Children.
	R.Q.	72	
A child aged 7 years	I.Q.	108	Terman Merrill Scale Form L—M
	R.Q.	83	
A child aged 10 years	I.Q.	117	Terman Merrill Scale Form L—M
	R.Q.	67	
A child aged 7 years	I.Q.	86	Terman Merrill Scale Form L—M
	R.Q.	68	
A child aged 12 years	I.Q.	91	Wechsler Intelligence Scale for Children.
	R.Q.	58	

As already indicated multiple factors were found to be contributing to the child's failure to make progress in school. Not infrequently there were physical factors and/or sensory handicaps e.g., unhealthy tonsils and adenoids with associated impairment of hearing. Emotional factors varied from primary emotional disturbance centering on family relationships which prevented the child from learning, to secondary emotional disturbance resulting from a failure to make progress at school, other factors included emotional deprivation and rejection, over-indulgence and over-protection. Cultural environments ranged from the under-demanding to the over-demanding.

A few of these children have attended the Child Guidance Clinic for treatment. A comprehensive programme has been followed including medical treatment for physical conditions, psychotherapy, counselling of parents and remedial teaching.

The results of our investigations indicate the need for the provision of special educational facilities for children of average intelligence and retarded attainment. It is in the interest of the mental health and development of these children that the opportunity should be given to them to develop their potentialities to the full, with the reasonable expectation of contributing towards the prevention of neuroses and inadequacies of personality in adult life.

F. Speech Therapy:

	Number of cases known to have been treated	
	1966	1965
	—	—
Pupils treated by speech therapists	—	—

G. Other Treatment Given:

	Number of cases known to have been dealt with	
	1966	1965
(a) Pupils with minor ailments	415	718
(b) Pupils who received convalescent treatment under School Health Service arrangements	1	6
(c) Pupils who received B.C.G. vaccination	355	415
(d) Other than (a), (b) and (c) above—Ultra Violet Light ...	25	17
Total	796	1,156

25 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 4 pre-school children also received ultra violet light treatment and all of these had been discharged at the end of the year. Altogether 85 sessions were held at which 469 attendances were made.

Special Educational Treatment in the Ordinary School:

During the year twenty new cases and two old cases, making a total of 74 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	—	—	—	—	1	—	—
Partially Sighted	—	—	—	3	1	—	—
Deaf	—	—	1	—	3	—	—
Partially Deaf	—	—	—	5	1	—	—
Educationally Subnormal	6	1	25	95	2	—	—
Epileptic	—	—	—	1	—	—	—
Maladjusted	1	—	1	—	6	—	—
Physically Handicapped	—	—	—	2	8	—	—
Suffering from Speech Defect	—	—	—	—	—	—	—
Delicate	—	—	—	—	1	—	—
Total	7	1	27	106	23	—	—

BRAITHWAITE DAY SPECIAL SCHOOL:

At the end of the year 95 children were attending the Braithwaite Day Special School. Of these 65 were Keighley children and the remainder were admitted from areas situated outside the Borough.

Keighley children are now being admitted at an earlier age than formerly and only occasionally are children admitted who are more than seven years of age.

MENTALLY SUBNORMAL CHILDREN:

No child was reported during the year as being "unsuitable for education in school" under the provision of Section 57(4) of the Education Act, 1944 as amended, however, 8 children were reported as requiring "care and guidance". 3 children were admitted to a Day Training Centre on a voluntary basis.

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:—

			1966	1965
Maltoline—8oz. tins	...	...	4	4
Vitamin B Tablets	...	...	50	50
Vitapan—4oz. bottles	...	...	120	53

Nocturnal Enuresis:

During the year 8 children suffering from nocturnal enuresis were issued with an Eastleigh Warning Device on loan and of these 2 were continuing under treatment at the end of the year.

Protection of School Children against Tuberculosis:

TUBERCULIN TESTING OF SCHOOL ENTRANTS:

The 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:—

Number invited	...	...	...	...	...	927
Refused	...	...	...	...	...	66
Absent	...	...	...	...	...	179
Previously examined	...	...	...	...	...	22
Negative	...	...	...	...	...	645
Positive	...	...	...	...	...	14
Not given because of skin condition	...	...	...	...	...	1

Of the 14 cases found to be positive 8 had previously been 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 was 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 575

Number found to have been vaccinated previously 12

Number of acceptances 429

Percentage of acceptances 76.19

Pre-vaccination Tuberculin Test—

Number of children tested... .. 423

Result of Heaf Test:

(i) Positive 68, (ii) Negative 355 423

Percentage positive 16.07

Vaccination—

Number vaccinated... .. 355

Included in the above figures are 48 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 3 children attending Keighley schools were notified as suffering from Pulmonary Tuberculosis, two boys and one girl, aged 5, 14 and 7 years respectively. The usual follow-up of contacts of each case was carried out but no further cases were brought to light.

Details of the work undertaken in this connection are set out below.

Acceptances—

Number of children offered tuberculin testing and vaccination if necessary 236

Number found to have been vaccinated previously 41

Number of acceptances 166

Percentage of acceptances 85.12

Pre-vaccination Tuberculin Test—

Number of children tested... .. 165

Result of Heaf Test:

(i) Positive 8, (ii) Negative 157 165

Percentage positive 5.08

Vaccination—

Number vaccinated... .. 155

Health Education:

We have continued with the routine programmes in schools and although the staff are under pressure of work from all directions they make every effort to maintain their health education commitments. It is found that teachers are increasingly interested in this subject and much more useful discussion takes place in relation to the content of the syllabus, new subjects being introduced either at their request or when the need arises. We have continued to give instruction in the usual subjects, particularly smoking and health; here we try to concentrate on the 10 to 11 year old so that children have some knowledge of the adverse effects of smoking on health before they enter secondary schools.

The home safety essay competition was again organised; 17 schools and 884 children entered. This yearly effort is very undramatic but it involves the staff in an enormous amount of work in that the majority of these children are given some instruction prior to the essay writing.

Medical Examination of Entrants to Training Colleges:

68 students were medically examined during the year in connection with their applications for entry to Training Colleges which was the same number as was examined in the previous year.

Children and Young Persons Act, 1933, Employment of Children:

91 children were examined by School Medical Officers during the year to determine their fitness for employment under the Authority's bye-laws relating to the employment of children as compared with 40 in 1965. The above figures include those children taking part in entertainments. No child was found to be unfit.

Dental Inspection and Treatment:

The following is the report of the Area Dental Officer, Mr. Midgley.

"The arrangement as regards the dental inspection of pupils is that during 1966 all schools, except one, have been inspected and afforded treatment.

Two factors have combined to bring this possibility about, namely the continued assistance of a Dental Officer from the county area and the local increase in the number of younger dentists working in the General Dental Service, who are prepared to accept children for dental treatment. This is in marked contrast to the period 1960—64.

It is now the rule to see large numbers of children who have had multiple fillings, and extractions completed, the exceptions are those who require large amounts of treatment. Until fluoridation is accepted the number of teeth requiring attention will remain twice as great as it need be.

In addition to the annual school inspection, an increasing number of children are inspected at six monthly intervals by a system of postal recall. It is hoped that during the coming year this will be extended.

The following table relates to dental treatment carried out during 1966. With reference to pupils referred to Hospital Consultant this is accounted for by referring patients to the W.R.C.C. Consultant in place of the Hospital Consultant. Cases requiring dental surgery are referred to the Dental Hospital in Leeds."

TABLE VI

Attendances and Treatment

	Ages 5 to 9	Ages 10 to 14	Ages 15 and over	Total
First visit	745	821	201	1,767
Subsequent visits	916	1,902	473	3,291
Total visits	1,661	2,723	674	5,058
Additional courses of treatment commenced	44	116	31	191
Fillings in permanent teeth... ..	1,149	2,395	572	4,116
Fillings in deciduous teeth	252	23	—	275
Permanent teeth filled	1,034	2,311	568	3,913
Deciduous teeth filled	229	19	—	248
Permanent teeth extracted	123	486	117	726
Deciduous teeth extracted	1,437	312	—	1,749
General anæsthetics... ..	470	294	35	799
Emergencies	67	36	9	112
Number of Pupils X-rayed				130
Prophylaxis				70
Teeth otherwise conserved				3
Number of teeth root filled				4
Inlays				6
Crowns				10
Courses of treatment completed... ..				1,900

Orthodontics

Cases remaining from previous year ...	73
New cases commenced during year ...	58
Cases completed during year	49
Cases discontinued during year	8
Number of removable appliances fitted...	100
Number of fixed appliances fitted ...	5
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)...	—	—	—	—
Pupils supplied with other dentures (first time)...	2	17	11	30
Number of dentures supplied	2	30	18	50

<i>Anæsthetics</i> General Anæsthetics administered by Dental Officers...	18
---	----

Inspections

(a) First inspection at school. Number of Pupils	6,941
(b) First inspection at clinics. Number of Pupils	535
Number of (a) + (b) found to require treatment	2,984
Number of (a) + (b) offered treatment	2,984
(c) Pupils re-inspected at school or clinic	390
Number of (c) found to require treatment	252

Sessions

Sessions devoted to treatment	541
Sessions devoted to inspection	47
Sessions devoted to Dental Health Education ...	—

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.....

HEALTH SUMMARY

Pupil's full name

Date of Birth.....

Address.....

School attended.....

Any information given below will be regarded as strictly **CONFIDENTIAL** and will be seen only by the School Medical Officer and his staff.

1. Has (s)he ever suffered from either of the following diseases ? (if " yes " please underline):—

Poliomyelitis

Rheumatic Fever.

2. Has (s)he had any illnesses (or accidents) which have required hospital treatment.

*Nature of Illness or Injury**Age**Duration of Treatment*

3. Is (s)he at present under treatment for any condition ?.....

If " yes " please state its nature.....

4. Have you any special worries about your child

.....

.....

.....

(In special circumstances an interview may be arranged with you and your child at the School Clinic).

Name of Family Doctor.....

Signed.....

Parent or Guardian

Date

SUMMARY

Medical Inspections in Schools:

During 1966, further consideration has been given to a re-orientation of the School Health Service and it is hoped that the introduction of more selective procedures will soon be brought into operation.

Handicapped Children in the Ordinary Schools:

It has now been agreed that a peripatetic service by Teachers of the Deaf to assist hearing-impaired children in the ordinary schools should be introduced although it may be some years before a full service throughout the West Riding is possible owing to shortage of suitably trained teachers. Attention has also been given to the emotional needs of children in the ordinary schools particularly those with associated physical and environmental problems.

Child Guidance Service:

Following the recruitment of a further Senior Medical Officer and the re-appointment of a part-time Consultant it has been possible to extend the service with four new Child Guidance Clinics during the year.

Speech Therapy Clinics:

The position remains the same as in the previous year due to the severe shortage of Speech Therapists which appears to be a national problem.

Training of Medical Staff:

The policy of in-service training continues and further extensions are anticipated shortly.

Medical Inspections in Schools:

During 1966, further consideration has been given to a re-orientation of the School Health Service and it is hoped that the introduction of more selective procedures will soon be brought into operation.

Medical Inspections

It has now been agreed that a permanent service of teachers of the kind to

visit hearing-impaired children in the ordinary schools should be introduced. It may be some years before a full service throughout the West of Scotland is possible owing to shortage of suitably trained teachers. Attention must also be given to the essential needs of children in the ordinary schools particularly those with associated physical and environmental problems.

Further progress will follow in the near future and will be reported in the next report.

Child Guidance Service:

Following the recruitment of a further Senior Medical Officer and the appointment of a part-time Consultant it has been possible to extend the service and four new Child Guidance Clinics during the year.

7 children are now receiving treatment in the year.

Further progress will be reported in the next report.

Speech Therapy Clinic:

The position remains the same as in the previous year due to the severe shortage of Speech Therapists which appears to be a national problem.

Medical Staff:

The policy of a service to give continuity and further extension was agreed.

Further progress will be reported in the next report.

Further progress will be reported in the next report.

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*Extract from the West Riding County Council Evidence
to the Royal Commission on Local Government. October,
1966*

Royal Commission on Local Government

The Local Health Authority

1. The factors governing decisions as to the desirable size of a local health authority are many and complex; some indeed appear to be contradictory. Nevertheless, a solution is suggested which is sufficiently flexible to contain and satisfy these differing requirements.
2. The County Medical Officer is Principal School Medical Officer responsible for the school health service in which joint use is made, with the health service, of clinic premises and of medical, dental, health visiting and certain other staff. The most efficient area for this purpose is one which coincides with that of the education authority.
3. The major activities of the health department arise from the services provided under the National Health Service Act, 1946, which elaborated a tripartite structure for the national health service; that structure consisting of the Local Health Authority, the Executive Council, and the Regional Hospital Board. Problems of health do not fit exclusively into these neat divisions and close co-operation and co-ordination becomes necessary. This is obviously simpler and more effective when the three organisations relate to the same area. For practical purposes this identity of area exists as between the Local Health Authority and the Executive Councils. The hospital service needed the large-scale organisation which determined the Regional Hospital Boards, conforming to no other boundaries, no doubt because of the inadequacy of the existing local authority boundaries. Although they bear some relationship to the Medical Schools there is nothing sacrosanct or traditional in that relationship and an identity of area with the two other partners in the National Health Service could not be other than beneficial to the consumer, the individual in the community—and it is for that person that the service is designed. Hence the need for large-scale organisation comparable to the Regional Hospital Board.
4. Outside the hospital the community health is largely the responsibility of a close partnership between the general practitioner, working through the Executive Council, and the Local Health Authority. Increasingly are the two services becoming integrated making use of the same premises and with the Local Health Authority field staff—the health visitor, the midwife, the district nurse etc.—working with the general practitioner as leader of the team. This process will continue and should not be subjected to the changes which would arise if the Local Health Authority areas varied from those of the Executive Councils. In continuance of this theme it is obviously to the advantage of the general practitioner to be within the jurisdiction of a single Executive Council or, where that is not possible, of as few as possible. At the present time approximately half of the 1,500 general practitioners on the lists of the West Riding Executive Council are also on the lists of others. Whereas marginal problems will always arise in the absence of

boundary barriers sound administration calls for the removal of all unnecessary ones. This again suggests the removal of boundaries which exist within the county and an end, where practicable, to the distinction between the county and the contained county boroughs.

5. Disease knows no frontiers or boundaries and the control of infectious diseases, especially in the event of epidemic or other sporadic outbreaks, requires a single-minded strategy with large-scale resources. This is at present achieved by mutual aid and co-operation between the different authorities, achieved at times not without considerable anxiety and this again calls for the large authority and for the elimination of unnecessary boundaries.
6. The computer is entering into the work of the health department. It is an ideal instrument not only for undertaking routine clerical duties but for the collection of statistics and information which together form the basic intelligence of a medical officer of health. The Executive Council are also examining the possible benefits of a computer and the possibility of joint action in this field leads to exciting possibilities of further developments. If these benefits are to be gained it is again necessary to have recourse to a large population group.
7. The supply of doctors is at present woefully inadequate in all fields—in general practice, in the hospitals and in public health. This is a matter of national concern which under the most favourable circumstances is unlikely to be resolved within the next decade. It is essential therefore that doctors are not employed unnecessarily. Furthermore as the number of leaders in any profession is limited so it is in medicine and the public health section is no exception to this overall picture. The future organisation pattern should recognise this feature and limit the number of independent units to the available supply of chief officers of quality rather than to settle first the unit and then hope to recruit the appropriate chief officers; the latter pattern leads at the best to mediocrity. This is not to say that there are not small authorities with excellent chief officers but it is probable that such officers could be better used in the service of a larger unit.

The same considerations apply to deputy chief officers who, if of quality, are unlikely to remain with the smaller authority for any appreciable length of time.

Mention must also be made of the senior administrative staff—senior medical officers upwards—who are in charge of sections of the department and act as specialist advisers to the County Medical Officer. The Whitley Council for the Health Service is unable to recognise the need for such officers by authorities with populations of less than 250,000. Yet such is the complexity of medicine today that they are an essential feature of any progressive health department.

Other specialist medical officers are being required in connection with the child guidance service, in the translation of medicine to computer, in aid for the deaf, in assessment centres, possibly in specialist geriatric clinics, in charge of special screening clinics etc. In all these specialties there is a real but limited need and it is essential that the knowledge gained by these varying specialists should be dispersed as widely as possible and not wasted by under-employment by small authorities.

All these considerations make it abundantly clear that the wise and effective employment of doctors in the public health service requires the large authority.

8. As with doctors so do similar considerations apply to the specialist workers in the health service. In the dental service a single orthodontic consultant may be required for a population of 2 million or more but they would be the poorer without him. So also for a consultant in advanced conservation. The dental laboratory facilities involve the training of technicians and the use of the most advanced technique and media, which can operate successfully for a population of the order indicated but would be difficult to staff, train, equip and maintain for the small authority. Psychologists, psychiatric social workers and speech therapists are other examples of specialist officers for whose effective employment the large authority is required.
9. Initially there is the need to train health department staff such as health visitors, district nurses, mental health workers etc. but the daily scientific discoveries, the introduction of new techniques and the continually rising standards of service demanded by the community require a continuing training programme for all grades of staff—medical, dental, nursing, auxiliary, technical, administrative and lay. Whilst specific knowledge and advantage may be gained by refresher courses organised elsewhere it is undoubtedly true that in the general application of that knowledge to the particular community the authority's own refresher courses can be of the greatest benefit. This has been demonstrated by the extensive use made of the Authority's Adult College at Grantley Hall. Even more facilities are required and indeed there may well be a demonstrable need for the Health Committee alone to run a training college for the benefit of its staff. Such a project again is beyond the resources of the small authority.
10. The large authority provides by far the most economic medium in which to launch experimental and pilot schemes, designed to indicate the way to further developments. They also permit the introduction of services the need for which is so small that in any but the large authorities they are either neglected or provided under joint user arrangement. Instances of these are in the provision of assessment centres for the handicapped child, in hostels for the varying categories of mental illness, industrial workshops and the like. Further ventures might be in geriatric clinics and other experimental ascertainment centres. Should any experimental project of this kind be a failure the large authority can more readily absorb and indeed use for other purposes the buildings, equipment and staff; failure might well prove disastrous to the smaller authority.
1. There must be complete understanding by the community of the service it receives—and for which it pays. The standard of service, methods of administration and even the existence of the service vary between authorities. It is a constant source of irritation to patients who at a time of need are denied the service, the standard of service, or other aspects of the service which they know to operate in the neighbourhood because of the existence of a local government boundary. Boundary problems will always exist but should be reduced to a minimum.
2. There is an overwhelming case for the large authority, self contained and with a wide variety of both urban and rural content. Against this concept runs the popular, political and emotional belief that the personal services

should be administered on a basis which is responsive to local opinions in the most parochial sense. Insofar as the public is concerned it is necessary to provide a structure which removes the criticism of remoteness and gives an assurance of awareness of need. Furthermore the day-to-day deployment of services and of the staff involved requires the closer proximity than can be envisaged in the large authority. This can be achieved by a system of delegation to divisions similar in fact to the present pattern of divisionalisation, but would not envisage the irresponsible intervention of the "delegated authority". The purpose would be to ensure that finance, policy, staff training and the more esoteric services were determined by the large authority and that the day-to-day administration was delegated to the divisions.

13. The divisional medical officers at present serve two masters, the county council and the district councils, the latter as medical officers of health responsible for environmental health matters. Whether this divided loyalty will continue will depend largely upon the future and functions of the district councils. It is a method of unifying the health services under a common officer which succeeds despite the division but it is possible to imagine a future pattern whereby the divisional medical officer as a full time officer of the county council could be recognised as the medical adviser to the district council or councils in his division.
14. The foregoing considerations all point to a two-tier pattern of administration and to a first tier being an authority large enough to provide the services required and to train and re-train the staff for these services, to take advantage of the modern aids to large-scale management, to provide an acceptable standard of service over a vast area and to ensure that available resources both of finance and staff are deployed to meet the needs of the area. There are today fields in which the West Riding County administrative area is barely large enough to discharge all these functions. In such a situation can any but the largest authorities survive? Leeds and Sheffield, the latter to encompass Rotherham, must remain as regional centres but can any other county borough in the West Riding fully provide the sophisticated service now required? If it is agreed that they are unable to do so is there not an equal inability on the part of the North and East Ridings and is there not now the need to revive the concept of a single authority for the major services and to surrender the identity of the Ridings to that of the greater Yorkshire?
15. The second tier would be an administrative unit designed for the day-to-day administration of the services. Experience in the West Riding Divisional Scheme has shown that the unit of 50,000 population first introduced was too small and the original 31 divisions, by a process of amalgamation has been reduced to the present 22 with divisional populations rising to and in two cases exceeding, 120,000, which is recognised as being not too large; it is a process which will be continued as the opportunity arises. Furthermore, the areas of those county boroughs which it is suggested will be eliminated are eminently suitable for day-to-day administrative purposes. Under the overall control of the first-tier authority it then becomes possible to look at the present county boroughs as the centres from which the services will extend to the furthestmost rural corner. At the present time the Todmorden and Brighouse divisions are being amalgamated. It is patent that were Halifax C.B. to be included there would be an ideal unit

with headquarters in the county borough. This however is not now convenient since all the activities of the division are outside the county borough boundary.

Conclusion

16. It may appear that the pattern advocated is that of a continuous county with delegations to county boroughs but this is not so. Whereas it recognises the existence of the county boroughs as each being a focal point of a large section of the county it distinguishes itself from a collection of county boroughs and safeguards the interests of the rural and other less densely populated districts by making the continuous county the health authority, delegating day-to-day administration to divisions of some 250,000 or more population.
17. The adoption of the proposals outlined will preserve the tradition of local government in a modern concept. Unless there is a widespread acceptance of radical changes of this order the imposition of central control through regional organs becomes a more imminent possibility.

EVIDENCE FOR THE COMMITTEE OF THE GENERAL MEDICAL COUNCIL ON THE DIPLOMA IN PUBLIC HEALTH

The following was a proof of evidence submitted in October, 1966, by the County Medical Officer and the Deputy County Medical Officer in their personal capacities. It was based on documents which were being discussed at that time; these documents have subsequently been accepted as County policy.

Introduction

POSSIBLE RELEVANCE OF THE WEST RIDING EVIDENCE:

In July, 1962, the West Riding County Council adopted a policy of co-operation with general practitioners. This policy has three main facets:

- (1) The provision of buildings for joint use by general practitioners and the Health Department staff. This provision is being made both by the building of Health Centres and by the adaptation of existing clinics: at the present time practices comprising 68 doctors are accommodated in the Department's premises and some 200 will have the use of our buildings by the end of 1968.
- (2) The attachment of health visiting and nursing staff to general practices within the Riding. Some 128 staff are attached to 163 practices which consist of 355 doctors.
- (3) The improvement of communication between the central and divisional offices of the Health Department and the family doctor. This has been done principally by the production of a quarterly bulletin entitled *Health Notes*.

The elements of this policy have been pioneered elsewhere but, as far as is known, no other local health authority has yet been able to progress so rapidly with all aspects of such a policy. The aim is to improve the services to the citizens of the West Riding and their families by an increased functional co-operation between two of the arms of the National Health Service. It does not preclude co-operation between the department and the hospital service, but the intention is to strengthen first by mutual aid the preventive and supportive medical services in the community. It will be clear that the attachment of staff to general practices and the provision of premises for joint use cannot be divorced from such matters as the administration of infant welfare clinics and the organisation of the school health service. It was, therefore, necessary for us to consider early the consequences of this policy for the medical staff.

Apart from the policy of co-operation with the general practitioners, a review of the clinical work undertaken by the doctors in the Department is long overdue. There are many reasons for this: on the medical side, there is a changed pattern of disease in children and technical advances in screening procedures such as the early diagnosis of deafness are now available. There is also an increased medical need in the middle aged and more particularly in the elderly.

Administratively also, there was a need to review the service. Few aspects of the local government health service will be unaffected by the Royal Commission on Local Government, the Seebohm Committee on Social and Allied Services and by such past recommendations as those of the Porritt Committee.

ARRANGEMENT OF THIS REPORT:

The clinical work of the medical staff has now been reviewed and the subsequent report here gives the gist of our conclusions and the evidence on which they are based. In this document we review first the current clinical work of the medical staff; second, the continuing needs and emerging possibilities, followed by the implications of these for administrative work; we then consider the D.P.H. and its place in administrative training, and finally in the concluding section the question is asked, do all candidates need the D.P.H. ?

Current Clinical Work of the Medical Staff

ANTENATAL CARE:

The birth rate in the West Riding has followed the national trend by increasing over the last decade, though with less regularity locally than nationally. In spite of this, the proportion of new cases seen in West Riding antenatal clinics and the absolute numbers seen tended to fall over the last twelve years. In 1954, we saw 41.1 per cent. (10,191) of all expectant mothers but only 18.7 per cent. (5,966) in 1965 (Table I). Nationally, a similar trend has been apparent but the proportion cared for by the local health authorities as a whole has been greater (Table II). The statistics show the work undertaken by the midwives, as well as by the doctors. Were the work of the doctors considered alone, the proportionate fall in numbers seen would probably be greater.

INFANT WELFARE CLINICS:

A paradox of the last few years has been that, in spite of the well acknowledged improvement in the health of young children, the numbers of children seen at infant welfare clinics has risen consistently except in 1965 when there was a fall for the first time for many years. The numbers attending over the last twelve years has risen by approximately one third (Table III). Nationally too the trend has been similar (Table IV). The cause of this increase is difficult to ascertain. One may suspect that it may be due to the increasing emphasis on immunisation in the last decade, to the sale of the welfare foods and to the increasing pressure on the young mother today to give good care to each child.

THE SCHOOL HEALTH SERVICE:

The work of the School Health Service can be divided into two important parts: the medical inspection of school children and the ascertainment of the handicapped child, but since this second function is shared with other sections of the Department, it is considered separately below.

Medical Inspections:

In the West Riding a relative and absolute decline in the numbers of children seen has occurred over the last twelve years. In 1954, 44.5 per cent. (113,509) were seen; in 1964 this had fallen to 35.7 per cent. (99,470). A similar trend is

noted in the national figures (Table V), though a higher percentage of children are seen nationally in each year, mainly because more special inspections and re-inspections are undertaken than is the practice locally (Table VI). In the West Riding, the adoption of selective medical inspection is not so general as to have affected the figures significantly.

Miscellaneous School Health Work:

A considerable proportion of time is taken up by the medical examination of school children for employment. Only a tiny minority are regarded as unfit for employment and clearly a great deal of unnecessary work is done (Table VII). Similarly in Table VIII, it can be seen that minor ailments clinics and other minor treatments have been reduced remarkably in the last twelve years: while these are undertaken by the school nurse, they reflect a change in the doctor's work.

ASCERTAINMENT OF HANDICAP:

The ascertainment of handicap has traditionally been part of the work both of the Infant Welfare Clinics and the School Health Service. No accurate figures are available for the County as a whole except those which relate to those children whose handicap has had to be assessed for various administrative reasons connected with education. The statistics are given in Table IX and it will be seen that the number ascertained has tended to rise slightly over the last ten years. However, these figures are known to be an underestimate of handicapped children in the West Riding, and this is a point for further advice that will be dealt with in the succeeding section of this evidence.

SUPERANNUATION:

The medical examination of adults is summarised in Table X. As far as the work of examining school teachers and entrants to training colleges is concerned criteria are laid down by the Department of Education and Science and no alteration in the work is possible. However, in the County Council Superannuation Scheme we have been able to diminish the number of unnecessary examinations by the use of questionnaires and subsequent selective medical examination. A small but growing feature of the work has been advising on the fitness of persons to hold driving licences.

Continuing Needs and Emergent Possibilities

CHILD HEALTH:

Miller and his colleagues¹ in Newcastle upon Tyne emphasised the continuing need for infant welfare work to be undertaken. Obviously because of the West Riding (and national) experience of the continuing public demand for these facilities there can be no general dismantling of the service at present. This does not mean, however, that it should continue to be staffed by doctors employed whole-time by the local health authority. The care of young children clearly ought to be one of the foundations of the good family practice and it is therefore the intention of the Department, as far as possible, to encourage general practitioners, particularly those working in local authority premises, to undertake their own infant welfare clinics, with the assistance of the Department's health visiting and nursing staff. A second pattern that may emerge is that health visitors who are attached to general practices might well undertake their own

infant welfare clinics as they are trained to do, referring to the family doctors with whom they work only such children as appear to require a full medical examination. In the foreseeable future there will certainly be a mixed pattern of infant welfare clinics, some run by family doctors, some by health visitors on their behalf and others by doctors employed by the local health authority. The participation of the whole-time staff in this work will, because of other demands, tend to diminish.

The continuing need for the school health service is pointed out by the Porritt Committee.² However, if the full needs of the educational system are to be met, then the service at the present time, in spite of its diminishing number of children being examined, is probably under-staffed. One striking fact is this, that there are approximately 28,000 family doctors and approximately 40,000 maintained schools or school departments in England and Wales. It would, therefore, seem possible for general practitioners to play a greater part by as many as possible undertaking responsibility for the routine work in one or two school departments and acting as the school physicians. At the present time, far too many doctors visit schools far too infrequently to really influence them significantly. Co-ordination between the general practitioners and the staffs of schools would undoubtedly be of benefit to children with medical defects, especially those with minor emotional handicaps, whose education continues in ordinary schools.

This pattern of handing over infant welfare clinics and the routine care of school children to the family doctor would release the ordinary medical officer in the health department for the work of the early ascertainment and supervision of the handicapped child—a specialised task. Too few of these cases occur in the average family practice for the doctor to develop sufficient specialised knowledge to undertake this work with confidence and too many for the hospital consultant to co-ordinate this work.

PREVENTION OF MENTAL ILL HEALTH:

An important potential development lies in the field of the prevention of mental illness and Caplan³ emphasised that the antenatal period is one where much work can be done for the prevention of mental illness. Similarly, the late Professor Hargreaves,⁴ in his Heath Clark Lectures, pointed out that the infant welfare service is also one which is well placed to undertake preventive intervention in the mental health of the growing child. The same may also be said of the School Health Service.

MULTIPHASIC SCREENING:

The mass screening of the population with a view to the early diagnosis of disease has come steadily to the fore over the last few years. The earliest to develop generally in this country has been cervical cytology and there have been extensive experiments by Donaldson⁵ at Rotherham. The diseases for which pre-symptomatic screening may be possible are: coronary heart disease and hypertension, carcinoma of the cervix uteri, carcinoma of the lung, carcinoma of the breast, diabetes mellitus, anaemia, respiratory tuberculosis⁶ and to these may be added a number of others as research proceeds, in particular glaucoma. This work is time consuming and certainly in the initial phases, experimental schemes undertaken by public health departments would seem to be indicated. However, the volume of work entailed is enormous and the selection of high risk groups is a basic necessity for the ultimate success of this work. There are many other things

to be considered. First, the treatment facilities available for the diseases thus diagnosed must be adequate and second, that the diseases diagnosed must be treatable at the stage at which they are diagnosed, otherwise needless anxiety is raised in the patient.

After the initial phase, it would seem not unreasonable to expect the screening to pass either into the hands of the general practitioner, particularly one working in a well organised group practice, or to be undertaken by a local authority doctor working in close association with a group practice.

GERIATRIC ADVISORY CLINICS:

The number of elderly people in England and Wales will rise from the 1961 census figure of 5½ million to 6½ million by 1971. Many of the researches into illness and disability in old age reveal a great deal of previously undiagnosed ill health. For example, Williamson in Edinburgh,⁷ discovered that many persons had three, four, five, or more conditions of varying severity and producing variable degrees of disability. Much of this illness is preventable. There have been a number of trials of what have been called "geriatric advisory clinics", most of these being undertaken by medical officers of the local health authority. It would seem, therefore, reasonable for further pilot schemes of this sort to be undertaken by the local health authority in the immediate future.

ASCERTAINMENT OF HANDICAP:

The early ascertainment of handicap as has been said already could very easily be undertaken by the health visitors and medical staff of the local health authority; this is already being done but needs to be extended in quantity and quality. With the aid of computers, which most large local authorities now have, recording and following-up can be undertaken quite consistently. Since most handicaps affect only a small minority of children, then their initial diagnosis and care will require medical officers to specialise to some degree in this work. One particular problem which must be considered for all handicaps is the assessment of the child's educational needs—whether it be decided that he can be educated in the ordinary school or in a special school. The setting up of specialist assessment centres where the doctors employed by the local health authority and hospital consultants can get together with other people, such as educational psychologists and speech therapists, would seem to be highly desirable. It has been stressed repeatedly, for example by the Pædiatric Society of the South East Metropolitan Region,⁸ that assessment can now be undertaken only by several people working as a team, who have sufficient knowledge of the individual children to form profiles of their personalities, attitudes, social status and physical states. Assessments must also be frequently reviewed to ensure that all the needs of the children are adequately met. The West Riding plans to provide a small number of such centres in the near future.

HEALTH EDUCATION AND IN-SERVICE TRAINING:

With the reduction of many infectious diseases health departments are left with the problems of chronic illness and disability. To a large extent preventative measures will depend on the responsibility of each individual. Health education is the only means of influencing individuals to behave in a manner which would ensure their continuing good health. Health education falls into two parts, first, health education in schools will be dealt with mainly by the teaching staff advised by the doctor and, secondly, the health education of older age groups. The second portion can be organised only by a doctor with res-

possibility for the community service and who has access to the organisations to which the average citizen and his family belong. It is undoubtedly a field where activity must increase over the years, since with many adult groups the standing and authority of the doctor may be needed to influence their activities.

Allied to health education is in-service training. Any department of moderate size with a professional staff must ensure that its staff remains abreast of current thinking and research. The organisation of in-service training must be a feature of the work of the senior community doctors.

Implications for Administration

DEPLOYMENT OF STAFF:

This memorandum of evidence opened with our stating our policy of co-operation with the general practitioners undertaken so far by the West Riding. In so far as this memorandum has subsequently indicated possibilities of fresh clinical work being undertaken by the medical staff in the local authority, it should not be regarded as stepping back from this first proposition. In relation to the screening of the population, it is interesting to note that much research on the elderly has been based on random samples selected from the practice records of co-operating family doctors.⁹ This is perhaps the only easy way in which one might select administratively the high risk groups in the population by their age and sex characteristics, and it also has the possible advantage of improving selection if the general practitioner's knowledge of his own patients and their family backgrounds can be used.

The attachment of health visiting and nursing staff and the joint use of premises means that the medical staff also of the Department will have to work in very close association with the family doctor. They will, in any case, meet the family doctors working in shared premises and the health visiting and nursing staff with whom they work will form a direct link between them and the family doctor. In this way rivalries that previously existed may be ended and the giving of conflicting advice to the patients may be avoided. With the progressive handing over of antenatal, postnatal, infant welfare and the routine work of the school health service to the general practitioners and with our doctors working closely with the family doctors the co-ordination of direct preventive activity will be considerable.

THE ADMINISTRATION OF PREVENTIVE WORK:

If multiphasic screening and geriatric advisory clinics for the elderly are to become common preventive practice in this country, then as has been pointed out the Medical Officer of Health may well have a place in its administration.¹⁰ Increasingly, local authorities are employing computers in their day to day work. A notable example of the application of a computer to the administration and management of simple preventive procedures has been made by Dr. T. McL. Galloway, the County Medical Officer of West Sussex, who has placed on the West Sussex computer the immunisation and vaccination records, both for his own department and for co-operating family doctors. The administrative complexity of any scheme of screening and its adequate follow up makes it a natural project for consideration for adaptation to computer methods and is no more difficult than what has been done already.

STUDIES IN PREVENTABILITY:

The main method of preventive medicine employed hitherto in this country has been the direct intervention of the Medical Officer of Health and his staff in clinical work for the patients of other doctors. As has been pointed out previously, in many of the fields in which we now work, we are seeing less people and a lower proportion of the population than before. In some of these fields the work should pass to the general practitioner and the hospital doctor. Antenatal care is an example of this. However, this raises certain problems in that prevention depends not only on doctors dealing with individuals, but also on the trends in disease and in medical care being kept under review.

In the last twelve years, the Ministry of Health has given a lead in the study of what may best be called the "preventability" of disease; this has been in its studies of the preventability of maternal mortality.¹¹ The possible need for the extension of this to other fields is shown by the Perinatal Mortality Survey of 1958. This study revealed that the quality of antenatal care as measured both by certain arbitrary standards, such as the frequency of blood pressure readings and blood group determinations and also the results of care i.e. the perinatal mortality differed by differing sources of care. The same study indicated considerable differences in mortality from area to area, probably reflecting economic, environmental and demographic factors which differ from region to region as does also the standard of medical care.¹² This concept of preventability can be adapted for other diseases and other age groups and it would seem to be one way to ensure that the best use is made of the medical resources available in each area.

EVALUATION AND OPERATIONAL RESEARCH:

In the above section it has been noted that certain medical services in any area need to be kept under surveillance. All preventive routines may become mere rituals and it is, therefore, necessary to ensure that these are reviewed repeatedly. With the attachment of staff to general practitioners there comes, inevitably, a diminishing of direct direction that can be given to the field staff of the Department; the quality of their work will depend to a large extent on the quality of the day to day interchange with the family doctors. The work, therefore, of these staffs in particular, must be watched and evaluation must be undertaken from time to time.

The collection of morbidity data is an essential part of a continuing surveillance of health and preventive measures in any community. With good co-operation and good will existing between the Health Department and the family doctors the collection and handling of such material should not prove difficult.

THE MANAGEMENT OF COMPLEX TEAMS:

The setting up of assessment centres means that the Medical Officer of Health is involved in the management of complex professional teams. In any case, there has been, over a few years, a rise in the number of professionally trained people employed by health departments and the school health service. At the turn of the century, the only professional staff employed by a local authority was the doctor and the inspector of nuisances (now called, of course, the public health inspector). At the present time, the Medical Officer of Health may be responsible in a large authority for the work of doctors, who may themselves have additional training in such things as audiology and child psychiatry; health

visitors; district nurses; home helps; speech therapists; audiologists; physiotherapists; educational psychologists; lay psychotherapists; psychiatric social workers and other social workers, together with his clerical staff. The management of professional teams of this complexity is in itself a highly skilled task, since it involves leadership rather than direction.

The D.P.H. and its place in Administrative Training

The justification for the continuance of the D.P.H. course rests in the continuing need for a doctor to work in a community with the specific responsibility for the organisation of services for preventive medicine and social support. Neither the re-organisation of local government nor the unification of the health services would remove the need for a doctor trained in the techniques of surveillance of the health of local communities and the organisation of preventive measures. From the preceding pages we conclude that the training of such doctors must contain the following:—

- (i) The basic knowledge of the epidemiology of disease, and, increasingly as the years go on, the epidemiology of the non-infectious diseases.
- (ii) The methods of preventing disease, including health education.
- (iii) The techniques of evaluation and research.
- (iv) The management of departments and, in particular, the techniques of managing complex professional teams.

However, in addition to the above other subjects might be included such as the organisation of the social and medical services, and the history of their development. We would favour less emphasis being placed on bacteriology and on public health and related law, and more on the humane sciences such as psychology and sociology the understanding of which must underlie much work in health education, dealing with the diagnosis of handicap and other matters.

Preventive medicine is a research discipline: the doctors practicing it must keep abreast of relevant scientific and medical advances and their potential preventive application; they must be able to ascertain health needs in their areas, if need be by survey; they must see how far the level and deployment of medical resources are adequate to meet the needs. The doctors who undertake such work must in the future be much more flexible in their approach both to their work and to their own staffs. There would seem therefore to be a need to train health administrators, if not to do research, then certainly to have a strong research outlook and we would therefore plead that curricula for the Diploma in Public Health should be considered in the light of this.

Already in the D.P.H. dissertation there could be the beginning of a training in research. However, within the confines of a D.P.H. course it is not possible for any candidate to undertake a major enquiry on his own. We would therefore suggest that the D.P.H. course should give initial training in research methods and that the dissertation should be replaced by a pilot study or by the preparation of a working paper for a research project to be undertaken in the years immediately following the D.P.H. course. We would regard it as a necessity for the candidate who has successfully completed the D.P.H. to continue to undertake a research project, under supervision, for a period of two or three years. Ideally,

this should be for a higher qualification such as an M.D., Ph.D., or M.Sc., but if it is impossible for the candidate to comply with the regulations of the university where he obtained his first degree for any higher qualification, then the research should be for publication only. The research should be relevant to the needs of the community services.

Your Committee may be interested to know that it is our intention to lay before our Committee proposals which would, in any case, bring such a scheme into operation in the West Riding in the not too distant future. A summary of these proposals is given in Appendix II.

It seems to us also that the training as we have suggested here would not be inappropriate for hospital medical administrators and medical administrators in departments of central government. Basically, the need to understand the epidemiology of disease, to be able to initiate or evaluate schemes of research and to deal with or manage complex teams, apply equally to all parts of the service in which medical administrators are now employed. We would therefore favour the evolution of a course of training for medical administrators, which would be suitable for the needs of all the branches where they are employed.

General Comments

It is however worth asking whether all doctors employed by the local health authority require the D.P.H. It would seem to us from the above work that the doctors employed by the local health authority can be divided into two broad but overlapping categories:—

1. Those whose work will continue to be clinical but at some level of specialisation.
2. Those whose work will be mainly administrative.

The West Riding Health Department has run for more than ten years a scheme for training suitable doctors on its staff for the Diploma in Public Health. So far some forty doctors have been so trained and an additional four are at present on D.P.H. courses. From these doctors only about one third are in posts where it is a statutory requirement or its possession is highly desirable e.g. deputies or senior medical officers of large health departments. A further third are still in public health work mainly concerned with clinical duties and the others have left the service. It is interesting to note in passing that between 1961 and 1965, 589 D.P.H.'s were registered with the J.M.C.,¹³ which is more than sufficient to fill all the posts in England and Wales for which the D.P.H. is a statutory requirement—these number 555.¹⁴ Many people who obtain the D.P.H. must therefore either leave the public health service or are employed on duties where it is not required, as our own experience in the West Riding would indicate. It would seem appropriate, therefore, to divide the post-graduate training in public health work into two:—

- (a) Those who are proceeding to administrative careers and, therefore, require the D.P.H. or analogous qualification, and
- (b) Those who will continue to undertake clinical work in preventive medicine and whose needs should not be considered when determining the structure of D.P.H. training.

While the remarks above conclude our evidence on the D.P.H. itself, there are related aspects to which we would like to draw attention:

First: there is a need for candidates for medical administration to have had an adequate clinical background. The post-graduate clinical experience of doctors taking up this work should not be less than that suggested by the College of General Practitioners for family doctors.

Second: related to this first point is the question of selection of candidates. In this Authority we have found a diminishing number of applicants for medical posts from which they might take the D.P.H. course. Between 1954 and 1960, 123 were interviewed and 70 appointed, between 1961 and so far in 1966, 83 have been interviewed and 62 appointed. While few candidates can be regarded as of poor quality, insufficient are of really high calibre. It is important that medical administration should offer a career attractive to potential new entrants.

Third: the majority of new recruits to the service did not regard preventive medicine as the career of their first choice. This may be inevitable; but it may reflect inadequate attention being paid to preventive and social medicine at the under-graduate stage.

Fourth: in any progressive department obtaining a D.P.H. can be regarded as the first step only in professional training, whether it contains an element of supervised research or not. Advances in medicine and its allied sciences are rapid and all professional staff require to keep abreast of new knowledge both by in-service training courses and by individual study. The opportunities available for continued post-graduate training should be kept under review.

Allied to this are the needs of the doctors who wish to continue in clinical work in the public health field. It seems to us that the possibilities we have outlined in this paper suggest that the possible activities of such doctors could have sufficient scope and a sufficient degree of specialisation to justify courses in "clinical preventive medicine", perhaps leading to a diploma. Such courses might include in their curricula, the assessment of handicap, some child psychiatry, screening methods in adult and geriatric populations. We would not however suggest, if such courses are run, that the diplomas awarded should be registrable.

We have included these final remarks, even though they refer to matters outside the Committee's terms of reference because we wished to place our views on the D.P.H. courses in the context of our views on post-graduate training in the whole of this field. We trust some account may be taken of them, since we would regard an improved and unified course for medical administrators as being only one factor amongst many required for an improved service to the community.

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Appendix I

Statistical Tables

TABLE I
ANTENATAL WORK IN WEST RIDING CLINICS 1954-65

Year	Total births (a)	New cases (b)	Percentage (b) as % of (a)	Attendance at M.Os. sessions
1954	24,806	10,191	41.1	50,123
1955	25,267	9,600	38.0	46,010
1956	27,093	9,523	35.1	44,969
1957	27,578	9,690	35.1	46,675
1958	27,934	8,807	31.5	43,596
1959	27,606	8,213	29.8	38,995
1960	28,576	9,078	31.8	38,760
1961	29,143	9,028	31.0	36,495
1962	30,353	8,927	29.4	35,003
1963	31,389	7,090	22.6	not recorded
1964	32,215	6,394	19.8	not recorded
1965	31,974	5,966	18.7	not recorded

TABLE II
ANTENATAL WORK BY LOCAL AUTHORITY CLINICS
ENGLAND AND WALES 1954-65

Year	Live births	Total number of women attending	Percentage
1954	673,651	330,869	49.1
1955	667,811	312,678	46.8
1956	700,335	324,187	46.3
1957	723,381	335,310	46.4
1958	740,715	335,574	45.3
1959	748,501	328,299	43.9
1960	785,005	337,144	42.9
1961	811,281	345,827	42.6
1962	838,736	335,399	40.0
1963	854,055	311,373	36.5
1964	874,178	290,647	33.2
1965	862,725	275,104	32.0

TABLE III
INFANT WELFARE CLINICS: WEST RIDING
1954-65

Year	No. of sessions	No. of Children under one year attending	Total No. of children attending
1954	11,508	19,338	Not recorded
1955	11,604	19,609	46,322
1956	12,096	21,165	46,111
1957	11,916	22,201	48,178
1958	11,940	23,303	49,582
1959	12,780	23,827	51,404
1960	12,420	25,652	52,073
1961	12,348	24,878	56,432
1962	13,368	26,750	58,508
		No. of children attending during the year of birth	Total under 5 years attending
1963	14,810	25,636	57,964
1964	14,528	26,307	69,112
1965	14,691	25,412	65,003

TABLE IV
INFANT WELFARE CLINICS: ENGLAND AND WALES
1954-65

Year	No. of sessions	No. of Children under one year attending	Total No. of children attending
1954	275,964	Not recorded	1,304,262
1955	281,556	Not recorded	1,296,293
1956	286,104	Not recorded	1,325,338
1957	289,704	Not recorded	1,372,004
1958	292,920	Not recorded	1,392,392
1959	300,024	Not recorded	1,433,002
1960	291,012	Not recorded	1,499,471
1961	307,548	568,565	1,618,080
1962	313,548	594,033	1,648,331
		No. of children attending during the year of birth	Total under 5 years attending
1963	329,435	622,352	1,710,417
1964	332,974	653,521	1,857,121
1965	342,557	659,978	1,945,378

TABLE V
SCHOOL MEDICAL INSPECTIONS: WEST RIDING
1954-65

Year	School population	No. of routine medical inspections	% seen	No. of other inspections	% seen	Total	% seen
1954	254,934	79,583	31.2	33,956	13.3	113,509	44.5
1955	261,055	87,520	33.5	35,296	13.5	122,816	47.0
1956	265,300	89,564	33.8	34,021	12.8	123,585	46.6
1957	266,585	83,250	31.2	29,241	11.0	112,491	42.2
1958	266,257	84,346	31.7	28,636	10.7	112,982	42.4
1959	275,370	88,398	32.1	25,999	9.4	114,397	41.5
1960	265,655	83,630	31.5	28,129	10.6	111,759	42.1
1961	264,992	82,938	31.3	25,381	9.6	108,319	40.9
1962	260,959	82,395	31.6	27,194	10.4	109,589	42.0
1963	269,415	76,706	28.5	29,643	11.0	106,349	39.5
1964	273,317	70,895	25.9	27,538	10.1	98,433	36.0
1965	278,456	75,134	27.0	24,336	8.7	99,470	35.7

TABLE VI
SCHOOL MEDICAL INSPECTIONS: ENGLAND AND WALES
1954-63

Year	School population	Number of periodic inspections	% seen	Special and re-inspections	% seen	Total	% seen
1954	6,375,815	2,140,293	33.6	2,354,156	36.9	4,494,449	70.5
1955	6,515,676	2,132,098	32.7	2,215,189	34.0	4,347,287	66.7
1956	6,649,086	2,149,975	32.3	2,130,254	32.0	4,280,229	64.4
1957	6,776,549	2,112,623	31.2	2,033,547	30.0	4,146,170	61.2
1958	6,974,079	2,079,803	29.8	1,852,785	26.6	3,932,588	56.4
1959	6,998,910	2,138,616	30.6	1,745,323	24.9	3,883,939	55.5
1960	7,014,809	2,112,353	30.1	1,761,805	25.1	3,874,158	55.2
1961	7,042,873	2,056,221	29.2	1,660,112	23.6	3,716,333	52.8
1962	7,004,150	2,110,143	30.1	1,621,083	23.1	3,731,226	53.3
1963	7,095,106	2,010,215	28.3	1,590,928	22.4	3,601,143	50.8

TABLE VII

MEDICAL EXAMINATION OF SCHOOLCHILDREN FOR EMPLOYMENT

Year	Number examined	Number unfit
1959	1,386	1
1960	1,321	2
1961	1,671	11
1962	1,561	5
1963	1,315	4
1964	1,306	2
1965	1,152	18

TABLE VIII

MINOR TREATMENTS IN WEST RIDING CLINICS

Year	No. of minor ailments treated *	Ultra-violet light treatment†
1954	40,474	3,838
1955	33,059	3,292
1956	29,086	2,422
1957	27,572	2,236
1958	23,867	1,563
1959	21,557	1,417
1960	15,308	1,190
1961	16,678	937
1962	14,426	771
1963	10,861	507
1964	9,249	322
1965	6,147	199

* Many of these are treated by nurses only

† Treated by school nurses on recommendation of school medical officer

TABLE IX
ASCERTAINMENT OF HANDICAPPED CHILDREN
IN THE WEST RIDING
1956-65

	1956	1957	1958	1959	1960	1961	1962	1963	1964	1965
E.S.N. ...	431	568	418	538	593	462	554	502	625	611
Physically Handicapped	100	84	77	74	92	77	94	76	93	108
Delicate ...	91	81	76	76	64	69	58	42	41	57
Deaf ...	21	15	18	20	26	19	15	13	22	27
Partial Hearing	9	2	5	3	14	8	10	11	24	14
Epileptic ...	11	14	—	13	7	7	9	7	18	8
Speech ...	—	1	—	—	—	—	—	1	1	—
Maladjusted ...	16	36	28	17	29	34	21	32	40	50
Blind ...	4	2	3	5	4	5	2	9	6	8
Partially Sighted	11	11	10	6	3	7	15	13	9	6
Double Defect	8	4	14	10	10	5	6	7	2	2
TOTALS...	702	818	649	762	842	693	784	713	881	891

TABLE X
MEDICAL EXAMINATION OF ADULTS: WEST RIDING
ASSISTANT COUNTY MEDICAL OFFICERS

Year	Entrants to Training Colleges	Superannuation	Road Traffic Acts
1959	1,116	1,312	
1960	1,206	1,509	
1961	1,215	1,491	
1962	1,320	441	
1963	1,265	571	33*
1964	1,372	615	23*
1965	1,622	603	33*

* Undertaken by D.C.M.O. and other senior medical staff

Appendix II

Proposals for Training of West Riding Staff

The new approach to the work of the junior medical staff requires a new training programme. It has to be accepted that for the time being both undergraduate instruction in social medicine and the postgraduate training in public health will be relatively inadequate for our needs. It is therefore essential that we devise our own scheme of training. We should be at least as concerned as the general practitioners to maintain by good education the quality of our staff.

The assistant medical officers can be divided into two broad groups, which overlap to some extent. There are the doctors who are going to make a career in administrative public health and there are those who prefer to continue in clinical work. These differences in approach and ambition should be recognised by our training schemes. While, however, we must have due regard to the needs of the clinical doctor we must also bear in mind that we will need at all times in the foreseeable future 21 to 28 administrative medical officers in the central office and the divisions. Some priority will have to be given to the training needs of the administrative medical staff. It is suggested that we adopt a policy of "retain and train: train and retain": by this is meant, that by a good training programme based on adequate salaries we should be able to retain staff who otherwise we would lose by promotion in other authorities.

ADMINISTRATIVE TRAINING:

Along with this it is suggested that we aim at two basic schemes of training, a major and a minor training programme.

Major Programme:

A major programme would be based on the policy of "retain and train". This should consist of two main parts:

- (a) Secondment for a full-time D.P.H. under contract with the County Council, and,
- (b) After D.P.H. he should be given assistance for research on a topic acceptable at his own University for a higher qualification, such as the M.D., Ph.D., or M.Sc. This of course pre-supposes that the doctor would be able to meet the requirements of the University for research while being on the staff of our own department.

In addition to this it is suggested that we run administrative seminars and some continued supervision. In view of the work involved in a major programme we should examine very carefully the kind of additional duties that the doctor may have to carry if he is acting as deputy divisional medical officer in a busy division.

Minor Programme:

Minor programmes might be of several types.

- (a) Secondment for a part-time D.P.H. followed by the administrative seminars mentioned above for the man whose personality or qualifications, while adequate, would not make him acceptable for a major programme.

- (b) Training in any other specialty (i.e. secondment for the D.P.M. or for the Diploma in Audiology of the University of Manchester) for use in connection with the specialised services for the handicapped. (This would of course apply to clinical training—see below).
- (c) Assistance with a research project for a higher qualification for the candidate who has either completed his D.P.H. before joining the staff or who may wish to undertake research which is useful to the department.

CLINICAL TRAINING:

Clinical training must apply not only to our own staff but also to *part-time staff such as general practitioners*. For full-time staff it is obvious that we must all use the appropriate facilities that are available locally and nationally such as postgraduate courses for the whole or part of the academic year and also through "ad hoc" courses run by various bodies such as N.A.M.H. In addition to this we could consider secondment of suitable candidates to hospital appointments when this is the only way of them getting the appropriate experience. There is already a precedent for this in the arrangements for the D.P.M. This would apply for example to experience in geriatrics. In addition to this it might be necessary for us to run "ad hoc" in-service training courses of the kind we are accustomed to running for other grades of professional staff at Grantley Hall. We might consider similar courses or seminars on an informal basis in certain local areas to ensure that the local needs of the services are met. The adoption of the main proposals of this report would imply the need to review all our means of in-service training.

CONDITIONS FOR RESEARCH:

To be allowed by a public authority to undertake research as part of a professional training would be a considerable privilege; a privilege that must be guarded from abuse. Obviously such research would have to be relevant to the needs of the local health authority itself. This would probably involve the County Health Department laying down certain broad topics in which work may be undertaken, which would be valuable to the Authority. It will also be necessary for the Authority to assure itself that the subject of research is acceptable to the candidate's University and that the candidate has not only the ability but the means at his disposal to undertake it. Experience may well show that in the interests of all parties the County Health Department may have to negotiate on behalf of some candidates with some Universities and will have to exercise some degree of day-to-day supervision.

SUPERVISION OF TRAINING:

It would be in the interests of our own staff and the interests of recruitment if this could be placed on a much more formal basis: two things are therefore suggested:

1. Our records of the medical staff are reviewed to ensure that we can keep ourselves fully informed of their progress and needs.
2. That a small tutorial Committee or working party should be established to keep the post-graduate training of the medical staff under review and to follow the amount of administrative experience that the trained administrative medical officers are receiving.

Only in this way can we get the best value from our training.

CONFIDENTIAL

Form N.P. (Revised)

HEALTH SUMMARY

Child's full name.....

Date of Birth..... Name of Family Doctor.....

School attended.....

Any information given below will be regarded as strictly confidential and will be seen only by the
School Doctor and his staff

1. Is your child well at the moment ? Yes/No.
2. If your child is at present receiving treatment for any condition please give details:

.....

3. If during the past twelve months your child has had any of the following complaints, please underline:

Frequent sore throats	Difficulty with hearing	Difficulty with school lessons
Discharging ears	Difficulty with speech	Frequent skin infections
Bed-wetting	Difficulty with vision	Difficulty with breathing
Nightmares or habit spasms	Squint	Nervous conditions

Please give details of the above:.....

4. If your child **has ever had** any of the following complaints please underline:

Asthma	Heart defects	Nephritis (kidney conditions)
Bronchitis	Epilepsy or Fits	Poliomyelitis
Chorea (St. Vitus Dance)	Tuberculosis	Other deformities
Rheumatic Fever	Diabetes	

Whooping Cough. Measles. Jaundice. Mumps. Chickenpox. German Measles. Scarlet Fever.

Please give details of the above:.....

5. If your child has ever had to be admitted to hospital please give the following details:

Reason for admission	When admitted	Name of Hospital
----------------------	---------------	------------------

6. Have you any special worries about your child ?.....

Signed:..... Parent or Guardian

Address :.....

Date.....

To the Head Teacher.....school

Dear Sir/Madam,

Medical Examination for School Children

As you are aware the routine medical examination of all school children is being replaced by a "selective" procedure at certain ages. Questionnaires are distributed to the parents and based on the replies and previous medical records, it is decided which children need to be seen. In order to ensure that problems occurring within the school are not missed I should be grateful, if you and your staff could let me have on the attached list the names of any children giving cause for concern.

The particular defects in mind are as follows:—

- Children showing limited or no progress.
- Children with suspected hearing loss.
- Children whose visual acuity may be in doubt.
- Children showing emotional disturbances,
e.g. Hyperactive and aggressive.
Timid and withdrawn.
- Children who try to avoid games and P.E.
- "Wetters" in school.
- Children from adverse homes.

The replies can then be checked against children already known and arrangements made for new cases to be investigated.

Yours faithfully,

Divisional Medical Officer

SURVEY OF FOOT CONDITIONS IN SCHOOLCHILDREN IN DIVISION No. 17 (SPENBOROUGH)

Report by the Chiropodist working in the School Health Service.

The survey was carried out in the period 16th June to 22nd July, 1966.

Three schools were selected (a) Liversedge Secondary Modern School, (b) R. M. Grylls Junior School and (c) Millbridge County Infants School. The total number of children examined was 677 with ages ranging from 4—15 years, and the Tables submitted give the collated findings of these inspections.

I would comment on these as follows:—

TABLES I A and I B

The fashion for 'casual' shoes is clearly shown among the older children as is the preference for bar shoes among the girls. On the whole the type of footwear is more satisfactory than one might have suspected.

TABLES II A and II B

These tables show the overwhelming predominance of the use of nylon for inner footwear.

TABLES III A and III B

Again one might have suspected a higher proportion of too-short socks. Presumably the resistance of nylon to shrinkage accounts for this low incidence.

TABLES IV A and IV B

I suppose it was reasonable to expect a large proportion of shoes regarded as being one size too small. The feet are still growing at a faster rate than the shoes are replaced. The ill effects of shoes too short by more than one size are perhaps mitigated by the soft texture of casual shoes which allow protrusion of the heel behind the sole, but it is a point to which health education should be directed.

TABLES V A and V B

Unsatisfactory cleanliness was only recorded where it was evident that the feet had not been washed for a considerable number of days as indicated by the presence of black nails and inter-digital spaces. In this respect the boys compare very unfavourably with the girls.

TABLES VI A and VI B

These record the incidence of various defects found, the number of girls involved and the type of treatment required. Where treatment by a physiotherapist is indicated this is in the main for foot exercises, and they are in fact the chiropodist's assessment and not that of an orthopaedic surgeon. It will be seen that the commonest defects are valgus ankle and hallux valgus. The incidence of valgus ankle appears to be lower at the upper end of the age range and there would appear, therefore, to be a self-correcting factor with increasing maturity. However, it does seem to stress the need for instruction in foot exercises. The treatment of a proportion of cases of valgus ankle is notoriously unsuccessful, but fortunately many people with this condition go through life without incurring discomfort or disability. In the case of hallux valgus there would not appear to be this same correcting factor, and the incidence of this is presumably largely due to unsatisfactory footwear over a prolonged period. The superficial defects which would be subject to chiropody treatment appear to justify the employment of chiropodists in the School Health Service both for an inspectorial and treatment function.

TABLES VII A and VII B

Similar remarks apply to these tables. The incidence of foot defects of all types appear to be substantially less in the boys than in the girls, which is again presumably related to exercise and footwear.

TYPE OF OUTER FOOTWEAR—BOYS

Table I A

AGE IN YEARS

	4	5	6	7	8	9	10	11	12	13	14	15	Total
Laced Shoes... ..	2	8	15	9	20	20	12	20	18	13	20	3	160
Pointed Laced Shoes	—	—	—	—	—	—	—	5	5	2	2	—	14
Bar Shoes	—	—	—	—	—	—	—	—	1	—	—	—	1
Pointed Bar Shoes ...	—	—	—	—	—	—	—	—	2	1	—	—	3
Leather Sandals ...	—	20	9	10	8	8	12	1	2	1	—	—	71
Plastic Sandals ...	—	2	4	6	6	3	—	—	—	—	—	—	21
Open-Heeled Shoes...	—	—	—	—	—	—	—	—	—	—	—	—	—
Casuals	—	—	—	2	1	8	6	4	14	13	10	3	61
Pointed Casuals ...	—	—	—	—	—	—	—	—	2	—	5	4	11
Boots... ..	—	—	—	—	—	1	—	—	3	4	—	—	8
Pointed Boots ...	—	—	—	—	—	—	—	—	—	1	4	1	6
Plimsolls	—	—	—	—	—	—	—	1	—	—	—	—	1
TOTAL	2	30	28	27	35	40	30	31	47	35	41	11	357

TYPE OF OUTER FOOTWEAR—GIRLS

Table I B

AGE IN YEARS

	4	5	6	7	8	9	10	11	12	13	14	15	Total
Laced Shoes... ..	—	2	2	2	3	6	12	10	5	13	13	5	73
Pointed Laced Shoes	—	1	—	—	—	—	—	—	1	1	—	—	3
Bar Shoes	—	2	5	3	14	14	12	6	6	3	5	5	75
Pointed Bar Shoes ...	—	—	—	—	—	1	2	2	7	—	—	—	12
Leather Sandals ...	1	9	4	6	16	15	11	5	3	2	5	1	78
Plastic Sandals ...	—	—	1	1	—	—	—	—	—	—	—	—	2
Open-Heeled Shoes...	—	—	—	—	—	—	—	—	1	1	—	—	2
Casuals	—	—	—	1	—	3	2	7	12	16	14	7	62
Pointed Casuals ...	—	—	—	1	—	—	1	1	6	3	—	1	13
Boots... ..	—	—	—	—	—	—	—	—	—	—	—	—	—
Pointed Boots ...	—	—	—	—	—	—	—	—	—	—	—	—	—
Plimsolls	—	—	—	—	—	—	—	—	—	—	—	—	—
TOTAL	1	14	12	14	33	39	40	31	41	39	37	19	320

TYPE OF INNER FOOTWEAR—BOYS

Table II A

AGE IN YEARS

	4	5	6	7	8	9	10	11	12	13	14	15	Total
Wool Socks ...	—	—	—	—	—	—	—	1	3	1	—	—	5
Nylon Socks...	2	30	28	27	35	40	30	30	44	34	41	11	352
Nylon Stockings	—	—	—	—	—	—	—	—	—	—	—	—	—
None Worn ...	—	—	—	—	—	—	—	—	—	—	—	—	—
TOTAL ...	2	30	28	27	35	40	30	31	47	35	41	11	357

TYPE OF INNER FOOTWEAR—GIRLS

Table II B

AGE IN YEARS

	4	5	6	7	8	9	10	11	12	13	14	15	Total
Wool Socks ...	—	—	—	—	—	—	—	—	—	—	—	—	—
Nylon Socks...	1	14	12	14	33	39	40	31	40	38	33	19	314
Nylon Stockings	—	—	—	—	—	—	—	—	—	1	4	—	5
None Worn ...	—	—	—	—	—	—	—	—	1	—	—	—	1
TOTAL ...	1	14	12	14	33	39	40	31	41	39	37	19	320

SIZE OF INNER FOOTWEAR—BOYS

Table III A

AGE IN YEARS

	4	5	6	7	8	9	10	11	12	13	14	15	Total
Socks too Long	—	1	—	—	—	—	—	—	—	—	—	—	1
Socks too Short	—	—	—	—	—	1	—	2	9	4	2	—	18
TOTAL ...	—	1	—	—	—	1	—	2	9	4	2	—	19

SIZE OF INNER FOOTWEAR—GIRLS

Table III B

AGE IN YEARS

	4	5	6	7	8	9	10	11	12	13	14	15	Total
Socks too Long	—	—	—	—	1	—	—	—	—	—	—	—	1
Socks too Short	—	—	—	—	—	—	—	1	10	5	—	—	16
TOTAL ...	—	—	—	—	1	—	—	1	10	5	—	—	17

SHOE SIZES—BOYS

Table IV A

AGE IN YEARS

		4	5	6	7	8	9	10	11	12	13	14	15	Total
Satisfactory ...	...	2	21	20	20	26	31	18	14	16	14	24	7	213
Too Short X 1	...	—	9	8	6	6	6	9	16	20	17	14	3	114
Too Short X 2	...	—	—	—	—	—	1	2	1	10	3	2	—	19
Too Short X 3	...	—	—	—	—	—	—	—	—	1	—	—	—	1
Too Long X 1	...	—	—	—	1	3	2	1	—	—	1	1	1	10
Too Long X 2	...	—	—	—	—	—	—	—	—	—	—	—	—	—
Too Long X 3	...	—	—	—	—	—	—	—	—	—	—	—	—	—
TOTAL ...	...	2	30	28	27	35	40	30	31	47	35	41	11	357

SHOE SIZES—GIRLS

Table IV B

AGE IN YEARS

		4	5	6	7	8	9	10	11	12	13	14	15	Total
Satisfactory ...	...	1	6	4	7	24	21	20	15	14	26	21	15	174
Too Short X 1	...	—	5	7	7	7	15	17	15	23	13	14	3	126
Too Short X 2	...	—	3	1	—	1	3	3	1	3	—	—	—	15
Too Short X 3	...	—	—	—	—	—	—	—	—	1	—	—	—	1
Too Long X 1	...	—	—	—	—	1	—	—	—	—	—	2	1	4
Too Long X 2	...	—	—	—	—	—	—	—	—	—	—	—	—	—
Too Long X 3	...	—	—	—	—	—	—	—	—	—	—	—	—	—
TOTAL ...	...	1	14	12	14	33	39	40	31	41	39	37	19	320

CLEANLINESS—BOYS

Table V A

AGE IN YEARS

		4	5	6	7	8	9	10	11	12	13	14	15	Total
Satisfactory ...	...	2	23	23	22	24	32	22	27	46	32	29	7	289
Unsatisfactory	...	—	7	5	5	11	8	8	4	1	3	12	4	68
TOTAL ...	...	2	30	28	27	35	40	30	31	47	35	41	11	357

CLEANLINESS—GIRLS

Table V B

AGE IN YEARS

		4	5	6	7	8	9	10	11	12	13	14	15	Total
Satisfactory ...	...	1	10	10	12	30	33	35	31	41	37	34	19	293
Unsatisfactory	...	—	4	2	2	3	6	5	—	—	2	3	—	27
TOTAL ...	...	1	14	12	14	33	39	40	31	41	39	37	19	320

DEFECTS—GIRLS

Table VI A

AGE IN YEARS

		4	5	6	7	8	9	10	11	12	13	14	15	Total
<i>Superficial Defects</i>														
Corns ...	...	—	—	—	1	4	1	3	3	9	7	6	3	37
Callosities ...	...	—	—	—	—	—	—	—	—	—	1	3	1	5
Warts ...	...	—	—	—	1	—	1	—	2	3	2	2	—	11
Abnormal Nails ...	...	—	—	—	—	—	—	—	2	—	—	—	—	2
Skin Lesions...	...	—	—	—	—	—	1	1	—	—	1	1	—	4
Hyperidrosis ...	...	—	—	—	—	—	—	—	—	—	—	1	—	1
<i>Deformities and Mechanical Disturbances General</i>														
Bow Legs ...	...	—	—	—	—	—	—	—	—	—	—	1	—	1
Knock Knees ...	...	—	—	—	—	—	—	—	—	—	—	2	—	2
Toes In ...	...	—	—	—	—	—	—	—	—	—	—	—	—	—
Toes Out ...	...	—	—	—	—	—	—	—	—	—	—	—	—	—
<i>Feet</i>														
Valgus Ankle Supple	R	—	6	5	1	4	6	9	18	12	12	7	7	87
	L	—	5	4	1	3	6	6	13	15	14	9	9	85
Valgus Ankle-Rigid	R	—	—	—	—	—	—	—	—	—	—	—	—	—
	L	—	—	—	—	—	—	—	—	—	—	—	—	—
Pes Cavus ...	R	—	—	—	—	—	—	—	2	2	—	—	—	4
	L	—	—	—	—	1	—	—	2	2	—	—	—	5
<i>Toes</i>														
Hallux Valgus	R	—	—	4	1	1	4	1	11	11	9	15	8	65
	L	—	1	2	1	2	5	2	11	13	16	19	11	83
Hallux Rigidus	R	—	—	—	—	—	—	—	—	—	—	—	—	—
	L	—	—	—	—	—	—	—	—	—	—	—	—	—
Clawed Toes	R	—	—	—	—	1	—	—	—	2	—	—	—	3
	L	—	—	—	—	1	—	—	—	1	—	—	—	2
Hammer Toes	R	—	—	—	—	—	1	—	—	—	—	—	—	1
	L	—	—	—	—	—	1	—	—	—	—	—	—	1
Deformed Fifth Toe	R	—	—	—	—	2	—	—	—	—	—	1	—	3
	L	—	—	—	—	2	—	—	—	—	—	—	—	2
Over-Riding Toes	R	—	—	1	2	—	3	1	3	3	2	1	2	18
	L	—	—	1	2	—	3	1	3	3	2	—	2	17
Underlying Toes	R	—	1	—	—	1	—	1	1	—	—	—	—	4
	L	—	1	—	—	1	—	1	1	—	—	—	—	4
Syndactylism	R	—	—	—	—	—	—	—	—	—	—	—	—	—
	L	—	—	—	—	—	—	—	—	—	—	—	—	—
TOTAL ...	...	—	14	17	10	23	32	26	72	76	66	68	43	447

TREATMENT REQUIRED—GIRLS

Individual Children

Table VI B

AGE IN YEARS

		4	5	6	7	8	9	10	11	12	13	14	15	Total
By Physiotherapist	—	7	6	2	5	9	12	22	26	22	19	13	143
By Chiropodist	—	1	1	3	6	4	3	6	12	10	9	5	60
Other...	—	—	—	—	—	1	—	1	—	—	—	—	2
TOTAL	—	8	7	5	11	14	15	29	38	32	28	18	205

DEFECTS—BOYS

Table VII A

AGE IN YEARS

		4	5	6	7	8	9	10	11	12	13	14	15	Total
<i>Superficial Defects</i>														
Corns ...		—	—	—	1	2	3	—	1	7	2	2	—	18
Callosities ...		—	—	—	—	—	—	—	—	3	—	—	—	3
Warts ...		—	1	—	1	1	1	—	2	3	1	—	1	11
Abnormal Nails ...		—	—	—	1	—	—	1	—	—	—	—	—	2
Skin Lesions...		—	—	—	—	1	1	—	1	1	—	—	—	4
Hyperidrosis...		—	—	—	—	—	—	—	1	1	—	2	1	5
<i>Deformities and Mechanical Disturbances General</i>														
Bow Legs ...		—	—	—	—	—	1	—	1	—	—	—	1	3
Knock Knees ...		—	4	1	1	2	2	—	—	—	1	1	—	12
Toes In ...		—	—	1	—	2	1	2	1	—	—	—	—	7
Toes Out ...		—	—	—	—	—	—	—	—	—	—	—	—	—
<i>Feet</i>														
Valgus Ankle-Supple	R	—	6	6	4	7	11	1	5	8	7	9	—	64
	L	—	8	3	6	8	15	3	4	10	7	11	2	77
Valgus Ankle-Rigid	R	—	—	—	—	—	—	—	—	—	—	—	—	—
	L	—	—	—	—	—	—	—	—	—	—	—	—	—
Pes Cavus	R	—	—	—	—	—	2	—	2	3	1	—	—	8
	L	—	—	—	—	—	2	—	2	3	1	—	—	8
<i>Toes</i>														
Hallux Valgus	R	—	—	3	3	1	6	2	2	7	7	4	—	35
	L	—	—	3	3	1	8	1	3	5	9	6	2	41
Hallux Rigidus	R	—	—	—	—	—	—	—	1	—	—	—	—	1
	L	—	—	—	—	—	—	—	—	—	—	—	—	—
Clawed Toes	R	—	—	—	—	—	—	—	—	—	—	1	—	1
	L	—	—	—	—	—	—	—	—	—	—	1	—	1
Hammer Toes	R	—	—	—	—	—	—	—	—	—	—	1	—	1
	L	—	—	—	—	—	—	—	—	—	—	1	—	1
Deformed Fifth Toe	R	—	—	—	—	—	—	—	—	1	—	1	—	2
	L	—	—	—	—	—	—	—	—	—	—	—	—	—
Over-Riding Toes	R	1	1	1	2	2	3	1	1	2	1	2	—	17
	L	1	2	1	1	2	3	1	1	1	1	1	—	15
Underlying Toes	R	—	1	—	—	—	—	1	1	—	1	—	1	5
	L	—	1	—	—	—	—	1	1	—	1	—	—	4
Syndactylism	R	—	—	—	—	—	—	—	—	—	—	1	—	1
	L	—	—	—	—	—	—	—	—	—	—	1	—	1
TOTAL ...		2	24	19	23	29	59	14	30	55	40	45	8	348

TREATMENT REQUIRED—BOYS

(Individual Children)

Table VII B

AGE IN YEARS

	4	5	6	7	8	9	10	11	12	13	14	15	Total
By Physiotherapist ...	—	8	9	8	9	20	5	9	16	13	12	4	113
By Chiropodist ...	1	3	1	3	5	7	4	5	11	4	7	2	53
Other... ..	—	—	—	—	1	2	—	—	—	—	—	—	3
TOTAL ...	1	11	10	11	15	29	9	14	27	17	19	6	169

Year	1901	1902	1903	1904	1905	1906	1907	1908	1909	1910	1911	Total
Population	100	100	100	100	100	100	100	100	100	100	100	100
Area	100	100	100	100	100	100	100	100	100	100	100	100
Water Supply	100	100	100	100	100	100	100	100	100	100	100	100
Water Demand	100	100	100	100	100	100	100	100	100	100	100	100
Water Deficit	100	100	100	100	100	100	100	100	100	100	100	100
Water Surplus	100	100	100	100	100	100	100	100	100	100	100	100
Water Conservation	100	100	100	100	100	100	100	100	100	100	100	100
Water Pollution	100	100	100	100	100	100	100	100	100	100	100	100
Water Quality	100	100	100	100	100	100	100	100	100	100	100	100
Water Quantity	100	100	100	100	100	100	100	100	100	100	100	100
Water Cost	100	100	100	100	100	100	100	100	100	100	100	100
Water Revenue	100	100	100	100	100	100	100	100	100	100	100	100
Water Investment	100	100	100	100	100	100	100	100	100	100	100	100
Water Profit	100	100	100	100	100	100	100	100	100	100	100	100
Water Loss	100	100	100	100	100	100	100	100	100	100	100	100
Water Gain	100	100	100	100	100	100	100	100	100	100	100	100
Water Balance	100	100	100	100	100	100	100	100	100	100	100	100
Water Total	100	100	100	100	100	100	100	100	100	100	100	100

WATER SUPPLY

Water Supply

Water Supply

Year	1901	1902	1903	1904	1905	1906	1907	1908	1909	1910	1911	Total
Population	100	100	100	100	100	100	100	100	100	100	100	100
Area	100	100	100	100	100	100	100	100	100	100	100	100
Water Supply	100	100	100	100	100	100	100	100	100	100	100	100
Water Demand	100	100	100	100	100	100	100	100	100	100	100	100
Water Deficit	100	100	100	100	100	100	100	100	100	100	100	100
Water Surplus	100	100	100	100	100	100	100	100	100	100	100	100
Water Conservation	100	100	100	100	100	100	100	100	100	100	100	100
Water Pollution	100	100	100	100	100	100	100	100	100	100	100	100
Water Quality	100	100	100	100	100	100	100	100	100	100	100	100
Water Quantity	100	100	100	100	100	100	100	100	100	100	100	100
Water Cost	100	100	100	100	100	100	100	100	100	100	100	100
Water Revenue	100	100	100	100	100	100	100	100	100	100	100	100
Water Investment	100	100	100	100	100	100	100	100	100	100	100	100
Water Profit	100	100	100	100	100	100	100	100	100	100	100	100
Water Loss	100	100	100	100	100	100	100	100	100	100	100	100
Water Gain	100	100	100	100	100	100	100	100	100	100	100	100
Water Balance	100	100	100	100	100	100	100	100	100	100	100	100
Water Total	100	100	100	100	100	100	100	100	100	100	100	100

Table 1 Summary of Principal Vital Statistics, 1890—1966

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
1955–1959	15.3	26	11.7	0.07	0.11	0.01	1.17	1.90	0.67	26
1960–1964	16.4	23	11.8	0.07	0.11	0.02	1.22	1.89	0.52	27
1965–1966	16.6	24	11.7	0.07	0.08	0.01	1.22	1.87	0.51	26
	16.7	23	11.9	0.05	0.09	0.01	1.29	1.97	0.43	24
	16.5	20	11.6	0.04	0.07	0.01	1.26	1.99	0.36	24
	16.9	22	11.5	0.06	0.06	0.01	1.15	1.98	0.73	22
	17.2	20	12.1	0.05	0.06	0.00	1.44	1.98	0.27	25
	17.8	18	12.0	0.04	0.05	0.01	1.47	2.00	0.20	23
	18.2	19	12.0	0.04	0.06	0.01	1.52	1.94	0.45	23
	18.5	18	11.5	0.04	0.05	0.00	1.35	2.02	0.40	22
	18.2	16	11.6	0.04	0.04	0.00	1.28	2.07	0.16	21
	18.0	14	12.1	0.03	0.05	0.00	1.62	2.00	0.25	20

* 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.

Table 2 Principal Causes of Death, 1966

Cause of Death	Age at Death										
	Under 4 weeks	4 weeks and under 1 year	1 and under 5	5 and under 15	15 and under 25	25 and under 35	35 and under 45	45 and under 55	55 and under 65	65 and under 75	75 and over
1. Tuberculosis, respiratory ...	—	—	—	—	—	—	1	6	12	25	16
2. Tuberculosis, other ...	—	—	—	1	—	—	—	—	—	3	1
3. Syphilitic disease ...	—	—	—	—	—	—	—	—	—	3	5
4. Diphtheria ...	—	—	—	—	—	—	—	—	—	—	—
5. Whooping cough ...	—	—	—	—	—	—	—	—	—	—	—
6. Meningococcal infections ...	—	—	—	—	—	—	—	—	—	—	—
7. Acute poliomyelitis ...	—	—	—	—	—	—	—	—	—	—	—
8. Measles ...	—	1	2	—	—	—	—	—	—	—	—
9. Other infective and parasitic diseases ...	—	3	3	4	1	3	3	6	6	7	4
Total—Infective & Parasitic Diseases excl. Tub.	—	4	5	4	1	3	3	9	11	10	9
10. Malignant neoplasm, stomach ...	—	—	—	—	—	2	17	44	111	154	124
11. Malignant neoplasm, lung, bronchus ...	—	—	—	—	—	1	27	103	270	261	121
12. Malignant neoplasm, breast ...	—	—	—	—	—	2	25	63	91	81	61
13. Malignant neoplasm, uterus ...	—	—	—	—	—	—	14	29	33	50	37
14. Other malignant and lymphatic neoplasms ...	—	1	10	14	21	17	64	154	370	550	490
15. Leukemia, leukemia ...	—	1	6	5	8	7	7	9	19	18	12
Total—All forms of Cancer	—	1	16	19	29	29	154	402	894	1,114	845
16. Diabetes ...	—	—	—	—	1	1	1	12	33	60	66
17. Vascular lesions of nervous system ...	—	3	—	—	5	11	24	93	331	923	1,881
18. Coronary disease, angina ...	—	—	—	—	1	9	99	355	991	1,547	1,517
19. Hypertension with heart disease ...	—	—	—	—	—	—	1	9	40	99	157
20. Other heart disease ...	—	—	1	3	1	14	34	70	181	433	1,332
21. Other circulatory disease ...	—	—	—	—	2	8	9	17	89	230	590
Total—Heart and Circulatory Diseases	—	—	1	3	4	31	143	451	1,301	2,309	3,596
22. Influenza ...	—	3	1	2	—	4	—	5	14	36	109
23. Pneumonia ...	19	65	15	2	4	10	11	20	100	216	673
24. Bronchitis ...	1	24	4	1	1	3	15	75	268	537	559
25. Other diseases of respiratory system ...	—	13	1	1	3	1	4	18	47	59	69
Total—Diseases of the Respiratory System incl. Influenza and excluding Tuberculosis	20	105	21	6	8	18	30	118	429	848	1,410
26. Ulcer of stomach and duodenum ...	—	—	—	—	—	1	7	12	18	38	61
27. Gastritis, enteritis and diarrhoea ...	5	25	6	2	—	1	2	6	12	18	25
28. Nephritis and nephrosis ...	—	—	—	1	2	12	7	12	14	32	38
29. Hyperplasia of prostate ...	—	—	—	—	—	—	—	1	6	15	44
30. Pregnancy, childbirth, abortion ...	—	—	—	—	4	3	1	—	—	—	—
31. Congenital malformations ...	75	41	14	5	5	3	1	10	7	2	1
32. Other defined and ill-defined diseases ...	295	28	18	16	23	21	50	100	163	311	583
33. Motor vehicle accidents ...	—	1	11	22	77	35	32	27	30	34	26
34. All other accidents ...	2	18	16	13	21	24	21	36	56	78	208
35. Suicide ...	—	—	—	—	8	26	28	39	47	25	13
Total	—	—	—	—	—	—	—	—	—	—	—

Table 3 Percentage contribution of the five principal cause groups of death to all causes, 1962—66

Cause Group	1962	1963	1964	1965	1966
Heart and circulatory diseases	38.1	37.8	37.9	38.5	37.1
Malignant neoplasms	16.7	16.2	17.5	17.8	16.6
Vascular lesions of nervous system ..	15.4	15.4	15.1	15.6	15.5
Diseases of respiratory system ..	12.7	13.1	11.9	11.2	14.3
Accidents, suicide and violence ..	4.6	5.0	5.3	4.7	4.7
TOTAL	87.5	87.5	87.6	87.7	88.1

Table 4 Cancer Mortality, 1961—66

Year	Stomach	Lung, Bronchus	Breast	Uterus	Other Mal- ignant and Lymphatic Neoplasms	Leukæmia, Aleukæmia	Total All Sites
1961 M.	300	564	6	—	804	44	1,718
1961 F.	213	103	309	146	761	33	1,565
1961 T.	513	667	315	146	1,565	77	3,283
1962 M.	274	584	1	—	871	54	1,784
1962 F.	248	95	304	126	728	68	1,569
1962 T.	522	679	305	126	1,599	122	3,353
1963 M.	275	611	2	—	869	48	1,805
1963 F.	227	93	279	155	686	46	1,486
1963 T.	502	704	281	155	1,555	94	3,291
1964 M.	259	589	2	—	893	64	1,807
1964 F.	205	96	321	163	816	53	1,654
1964 T.	464	685	323	163	1,709	117	3,461
1965 M.	298	723	1	—	877	56	1,955
1965 F.	212	104	301	165	800	46	1,628
1965 T.	510	827	302	165	1,677	102	3,583
1966 M.	236	667	3	—	896	46	1,848
1966 F.	216	116	320	163	795	45	1,655
1966 T.	452	783	323	163	1,691	91	3,503

Table 5 Mortality from Heart and Circulatory Diseases, 1961—66

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
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
1966	4,519	2.58	306	0.17	2,069	1.18	945	0.54	7,839	4.48

Table 6 Mortality from Respiratory Diseases, 1961—66

Year	Influenza	Pneumonia	Bronchitis	Other diseases of the Respiratory System	Total
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
1966	174	1,135	1,488	216	3,013

Table 7 Mortality from Violent Causes, 1961—66

Year	Motor Vehicle Accidents	Accidents in the Home	All other Accidents	Suicide	Homicide and Operations of War	Total Accidents Suicide, Homicide
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
1966	295	293	200	186	13	987

Table 8 Mortality from Home Accidents

Cause of Death	Age at Death—Years							
	Under 1	1-4	5-44	45-54	55-64	65-74	75 and over	All Ages
Accidental poisoning by solid and liquid substances ... { M. — 1 1 3 1 1 1 8 F. — — 1 3 7 3 1 15								
Accidental poisoning by gases and vapours ... { M. — 2 6 1 1 1 8 19 F. — — 1 — 3 9 10 23								
Accidental falls ... { M. — — 2 1 5 14 35 57 F. — 2 1 — 4 24 94 125								
Accidents caused by burns and scalds ... { M. — 1 1 — — 1 3 6 F. — 1 3 — 2 1 3 10								
Inhalation of food or vomit ... { M. 6 — — — 2 — — 8 F. 4 2 — — 1 — — 7								
Accidental mechanical suffocation ... { M. 3 1 3 — — — — 7 F. 1 — 2 1 — — — 4								
Other and unspecified accidents { M. — 1 — — — — — 1 F. 1 — — — 1 1 — 3								
Total ... { M. 9 6 13 5 9 17 47 106 F. 6 5 8 4 18 38 108 187								

Table 9 Suicides

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. — 1 7 5 4 9 1 5 32 F. — 1 4 3 7 5 7 2 29									
Other poisoning ... { M. — 2 5 6 9 6 6 1 35 F. — 2 3 5 10 10 8 1 39									
Hanging or strangulation ... { M. — — 1 3 3 2 1 1 11 F. — — — 1 2 2 1 — 6									
Drowning ... { M. — — — — — 3 1 1 5 F. — — 1 1 — 3 — 1 6									
Firearms ... { M. — — 1 — 2 1 — — 4 F. — — — — — — — — —									
Cutting instruments ... { M. — — 1 2 1 5 — — 9 F. — — — — — — — — —									
Jumping before or lying in path of moving vehicles ... { M. — 1 2 1 — 1 — — 5 F. — — — — 1 — — — 1									
Jumping from high places ... { M. — — — 1 — — — 1 2 F. — — 1 — — — — — 1									
Other agents ... { M. — 1 — — — — — — 1 F. — — — — — — — — —									
Total—All Agents ... { M. — 5 17 18 19 27 9 9 104 F. — 3 9 10 20 20 16 4 82									

Table 10 Child Mortality, 1911-66

Cause of Death	Annual Averages for Quinquennia								1960	1961	1962	1963	1964	1965	1966
	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	—	—	2
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	3	3
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	16	16
Heart and circulatory diseases	4	3	2	1	1	—	1	1	1	1	2	—	1	1	1
Influenza	6	43	10	11	4	2	2	—	2	—	1	—	—	—	1
Pneumonia	457	321	121	85	42	19	14	9	14	17	22	9	16	15	15
Bronchitis	150	42	10	17	9	6	6	5	10	1	9	7	1	4	4
Other diseases of respiratory system	49	15	6	5	3	2	2	2	—	3	—	2	2	1	1
Diarrhoea and other digestive diseases	248	45	38	23	17	4	4	2	3	11	1	7	3	6	6
Congenital debility, malformations	12	9	7	10	12	13	12	12	10	12	12	11	4	14	14
Accidents	82	54	50	47	38	27	23	29	25	26	30	27	21	27	27
Other causes	323	119	52	45	30	23	12	23	21	14	32	22	20	18	18
All causes	2,352	1,017	467	376	227	136	97	97	105	102	131	98	89	108	108
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	0.90	0.90

Table 11 Divisional Administration

Div. No.	County Districts	Population (Estimated Mid. 1966)	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 5,030 5,420 13,050 4,810 3,740 13,790 24,230	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
		80,070	451,754		
3	Keighley B.	55,940	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.	13,420 24,350 2,660 29,790	2,831 11,418 2,536 2,184	Dr. J. Battersby Mr. F. G. Falkingham Miss H. J. Watts (Comm. 23-1-67)	P.O. Box 24, Town Hall, Shipley Tel. Shipley 51363
		70,220	18,969		
5	Pudsey B. Aireborough U. Horsforth U. Ilkley U. Otley U. Wharfedale R.	37,470 29,040 16,610 19,190 11,960 7,240	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
		121,510	65,807		
7	Harrogate B. Ripon City Knaresborough U. Nidderdale R. Ripon and Pateley Bridge R.	60,090 11,110 10,250 16,990 13,670	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
		112,110	212,495		
9	Tadcaster R. Wetherby R.	31,220 27,760	72,987 64,424	Dr. A. L. Taylor (acting) Mr. F. H. Atack Miss M. P. Bramley	Hallfield Lane, Wetherby Tel. Wetherby 2738
		58,980	137,411		
10	Goole B. Selby U. Goole R. Selby R.	18,590 10,760 8,980 7,510	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
		45,840	74,800		
11	Castleford B. Normanton U.	39,750 18,570	4,394 3,067	Dr. J. M. Paterson Mr. C. R. Pickering Mrs. M. Craig	"Castledene," Pontefract Road, Castleford Tel. Castleford 4201
		58,320	7,461		

Div. No. County Districts	Population (Estimated Mid. 1966)	Acreage	Divisional Medical Officer, Senior Clerk and Divisional Nursing Officer	Address of Divisional Health Office
12 Pontefract B. Featherstone U. Knottingley U. Osgoldcross R.	29,260 15,100 14,250 9,230	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
	67,840	46,078		
13 Morley B. Ossett B. Horbury U. Wakefield R.	43,480 16,120 8,940 22,520	9,494 3,333 1,280 21,344	Dr. G. Ireland Mr. A. Wright Miss A. Hibbard	Windsor House, Morley Tel. Morley 4281/2
	91,060	35,451		
15 Batley B. Heckmondwike U.	40,780 8,950	4,457 696	Dr. J. F. Caithness Miss K. Lister Miss D. Day	Market Place, Batley Tel. Batley 3141
	49,730	5,153		
16 Garforth U. Rothwell U. Stanley U.	18,870 26,950 18,770	4,020 10,698 4,866	Dr. A. L. Taylor Mr. S. Hobson Miss M. P. Bramley	Oulton Lane, Rothwell Tel. Rothwell 2326/7
	64,590	19,584		
17 Spennorth B. Mirfield U.	38,370 14,510	8,251 3,394	Dr. W. M. Douglas Mr. P. Marshall Miss D. Day	Health Centre, Greenside, Cleckheaton Tel. Cleck- heaton 3501/4
	52,880	11,645		
18 Brighouse B. Todmorden B. Elland U. Hebden Royd U. Queensbury and Shelf U. Ripponden U. Sowerby Bridge U. Hepton R.	32,340 16,340 18,520 8,990 9,660 4,940 16,690 3,600	7,873 12,789 5,946 7,084 2,795 13,289 5,763 21,758	Dr. N. E. Gordon Mr. H. Marshall Miss C. J. Barker	Police Street, Brighouse Tel. Brighouse 2515 AND Abraham Ormerod Medical Centre, Todmorden Tel. Todmorden 2495
	111,080	77,297		
20 Colne Valley U. Denby Dale U. Holmfirth U. Kirkburton U. Meltham U. Saddleworth U.	20,870 9,850 18,840 18,780 5,800 18,410	16,054 10,165 17,648 13,847 5,906 18,485	Dr. P. M. Sammon Mr. G. A. Beatson Miss J. L. Law	6/8, St. Peter's Street, Huddersfield Tel. Hudders- field 29526/8
	92,550	82,105		
22 Hoyland Nether U. Penistone U. Stocksbridge U. Penistone R. Wortley R.	15,830 7,440 12,180 7,360 51,660	1,998 5,593 4,630 29,002 48,698	Dr. F. C. Armstrong Mr. P. Fullwood Mrs. M. Orr	Mortomley Hall, High Green, nr. Sheffield Tel. High Green 292
	94,470	89,921		

Div. No.	County Districts	Population (Estimated Mid. 1966)	Acreage	Divisional Medical Officer, Senior Clerk and Divisional Nursing Officer	Address of Divisional Health Office
23	Hemsworth U. Hemsworth R.	15,840 53,060	4,163 29,019	Dr. J. S. Walters Mr. G. Ellis Miss J. Crossfield	Adiscombe House, Barnsley Road, Hemsworth Tel. Hemsworth 377/8
		68,900	33,182		
25	Cudworth U. Darfield U. Darton U. Dodworth U. Royston U. Wombwell U. Worsbrough U.	9,120 6,930 15,060 4,270 8,560 19,200 16,390	1,746 2,018 4,717 1,857 1,423 3,838 3,420	Dr. C. G. Oddy Mr. L. S. Wrigg Miss M. E. Pilling (Comm. 20.2.67)	33 Queen's Road, Barnsley Tel. Barnsley 2247/8
		79,530	19,019		
26	Conisbrough U. Dearne U. Mexborough U. Rawmarsh U. Swinton U. Wath upon Dearne U.	17,780 26,740 16,580 19,590 14,270 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
		110,290	13,928		
27	Adwick le Street U. Bentley with Arksey U. Tickhill U. Doncaster R.	18,610 23,510 2,900 77,200	3,605 4,950 5,580 75,093	Dr. J. Ferguson Mr. C. W. Vallance Miss M. E. Young	Station Road, Doncaster Tel. Doncaster 61571
		122,220	89,228		
29	Thorne R.	38,310	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.	14,750 23,580 64,200	4,788 20,070 28,739	Dr. J. M. Watt Mr. A. Hill Mrs. A. Brooks	"Edenthorpe," Grove Road, Rotherham Tel. Rotherham 3131/2
		102,530	53,597		

Table 12 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). Revised Regulations relating to notification of leprosy—The Public Health (Leprosy) Regulations, 1966—became operative on 1st March, 1966. The contagious diseases of syphilis, gonorrhoea and soft chancre (classed under the term venereal diseases) and scabies are not compulsorily notifiable.

Table 13 Notification of Infectious Disease, 1961—66

Disease	Number of corrected notifications					
	1961	1962	1963	1964	1965	1966
Scarlet Fever	911	652	757	1,201	1,568	1,353
Whooping Cough	838	241	925	1,494	360	651
Acute Poliomyelitis (paralytic) ...	34	7	1	3	4	—
Acute Poliomyelitis (non-paralytic) ...	6	3	—	—	1	—
Measles	29,225	11,485	19,882	14,385	18,175	17,567
Diphtheria	—	1	6	9	—	—
Dysentery	1,166	920	545	432	934	630
Meningococcal Infection	32	20	27	17	13	17
Acute Pneumonia (primary or influenzal)	801	578	667	365	327	390
Smallpox	—	2	—	—	—	—
Acute Encephalitis (infective)	1	2	3	2	1	3
Acute Encephalitis (post-infectious) ...	6	4	4	2	1	—
Typhoid Fever (excluding Paratyphoid)	2	2	5	1	1	—
Paratyphoid Fever	11	11	28	6	18	1
Erysipelas	78	57	78	72	86	59
Food Poisoning	58	56	93	114	82	68
Ophthalmia Neonatorum	6	3	5	5	1	3
Puerperal Pyrexia	68	51	69	44	47	32
Tuberculosis:						
Respiratory	550	469	467	423	357	355
Other Forms	89	64	75	73	72	68
*Malaria	1	1	—	1	—	—
Anthrax	1	1	2	—	—	2
Leprosy	†	†	†	†	†	2

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

†Figures not available.

Table 14 Notification of Infectious Disease—1966

	M		F		M		F		M		F		M		F		M		F	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Numbers originally notified ...	688	666	—	1	—	—	—	—	—	—	—	—	373	395	11	8	—	—	—	—
(All ages)	1,354	651	1	—	—	—	17,579	—	—	—	—	768	—	—	19	—	—	—	—	—
Final numbers after correction																				
Under 1 year ...	6	6	—	—	—	—	360	370	—	—	—	13	12	—	—	—	—	—	—	—
1-2 years ...	11	14	—	—	—	—	1,033	1,018	—	—	—	27	21	—	—	—	—	—	—	—
2-3 " ...	59	45	—	—	—	—	1,264	1,203	—	—	—	20	26	—	—	—	—	—	—	—
3-4 " ...	65	59	—	—	—	—	1,308	1,261	—	—	—	25	25	—	—	—	—	—	—	—
4-5 " ...	98	101	—	—	—	—	1,377	1,220	—	—	—	20	17	—	—	—	—	—	—	—
5-9 " ...	372	357	—	—	—	—	3,404	3,299	—	—	—	92	90	—	—	—	—	—	—	—
10-14 " ...	50	60	—	—	—	—	145	129	—	—	—	21	20	—	—	—	—	—	—	—
15-24 " ...	22	15	—	—	—	—	36	36	—	—	—	19	19	—	—	—	—	—	—	—
25 and over ...	3	4	—	—	—	—	15	20	—	—	—	66	89	—	—	—	—	—	—	—
Age unknown ...	2	4	—	—	—	—	37	32	—	—	—	3	5	—	—	—	—	—	—	—
Total (all ages)	688	665	—	—	—	—	8,979	8,588	—	—	—	306	324	—	—	—	—	—	—	—
	1,353	651	—	—	—	—	17,567	—	—	—	—	630	—	—	17	—	—	—	—	—
Age Group																				
Numbers originally notified ...	181	214	2	1	—	—	—	—	—	—	—	—	31	28	46	57	—	—	—	—
(All ages)	395	—	3	—	—	—	—	—	—	—	—	59	—	103	—	—	—	—	—	—
Final numbers after correction																				
Under 5 years ...	29	38	—	—	—	—	—	—	—	—	—	—	1	3	—	—	—	—	—	—
5-14 " ...	12	16	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	—	—	—
15-44 " ...	36	36	2	—	—	—	—	—	—	—	—	—	4	5	10	15	—	—	—	—
45-64 " ...	53	61	—	—	—	—	—	—	—	—	—	—	18	15	7	2	—	—	—	—
65 and over ...	47	59	—	—	—	—	—	—	—	—	—	—	6	4	1	2	—	—	—	—
Age unknown ...	2	1	—	—	—	—	—	—	—	—	—	—	2	—	3	3	—	—	—	—
Total (all ages)	179	211	2	1	—	—	—	—	—	—	—	—	31	28	31	37	—	—	—	—
	390	—	3	—	—	—	—	—	—	—	—	59	—	68	—	—	—	—	—	—

Table 15 Whooping Cough—Incidence and Mortality, 1954—66

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	—	—
1966	55	—	—	339	—	—	257	—	—	651	—	—

Table 16 Poliomyelitis—Incidence, 1962—66

Year	Paralytic Non-Paralytic	0—14 years	15 years and over	Total
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
1966	P.	—	—	—
	N.P.	—	—	—
Totals 1962/66	P. N.P.	11 3	4 1	15 4

Table 17 Vaccination against Poliomyelitis

<i>Age Group</i>	<i>Total Protected</i>	<i>Percentage of Age Group Protected</i>
6—12 months	7,148	46·0
1— 2 years	22,286	73·1
2— 3 years	24,456	82·9
3— 4 years	23,921	81·1
4—24 years	502,801	96·5
24—33 years	114,606	67·7
*Others 33—41 years	78,578	38·9
Total all groups	773,796	77·6

*Includes also those at "special risk"

Table 18 Measles—Incidence and Mortality, 1953—66

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)
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
1959	24,480	6	0·02	1966	17,567	3	0·02

Table 19 Diphtheria Immunisation, 1948—66

NUMBER OF CHILDREN IMMUNISED

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
1966	24,729	1,669	741	27,139	22,789

NUMBER IMMUNISED
(0—14 years age group)

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
1966	103,863	68.6	221,577	85.4	324,440	78.9

Table 20 Dysentery—Incidence, 1960—66

	Males				Females				Persons			
	All ages	0—	5—	10+	All ages	0—	5—	10+	All ages	0—	5—	10+
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
1966	306	105	92	109	324	101	90	133	630	206	182	242

Table 21 Meningococcal Infection—Incidence and Mortality, 1950—66

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
1966	17	1	5.9

Table 22 Vaccination against Smallpox

VACCINATIONS AND RE-VACCINATIONS, 1964—66

Year	Vaccinations							
	0-3 mths.	3-6 mths.	6-9 mths.	9-12 mths.	1	2-4	5-14	Total
1964	311	373	337	430	5,456	1,667	325	8,899
1965	176	188	277	471	7,193	3,232	414*	11,951
1966	108	218	276	434	8,217	3,719	1,262*	14,234

Year	Re-Vaccinations							
	0-3 mths.	3-6 mths.	6-9 mths.	9-12 mths.	1	2-4	5-14	Total
1964	—	—	—	1	16	76	208	301
1965	—	—	—	—	2	77	363*	442
1966	—	—	—	1	16	106	996*	1,119

*5-15 years of age

The increase in the figures for 1966 is due to some extent to requirements of international travel, including school parties travelling abroad. No reports of cases suffering from complications due to vaccination were received.

Table 23 Deaths from Tuberculosis

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	-	4	2	7	5	23	2	16	5	13	3	64	17	81
Non-respiratory	-	-	-	-	1	-	-	-	-	-	-	-	1	-	-	-	2	1	-	1	4	2	6
Totals ...	-	-	-	-	1	-	-	-	1	-	4	2	8	5	23	2	18	6	13	4	68	19	87

Table 24 Notification of Tuberculosis

			AGE PERIODS													Total all Ages
			0-	1-	2-	5-	10-	15-	20-	25-	35-	45-	55-	65-	75-	
FORMAL NOTIFICATIONS:																
Respiratory, Males	...		1	1	5	7	9	18	11	30	26	55	53	26	10	252
Respiratory, Females	...		-	1	3	10	-	9	7	13	20	9	5	5	4	86
Non-Respiratory, Males	...		-	-	-	1	3	3	3	6	4	3	2	2	-	27
Non-respiratory, Females	...		-	1	-	1	1	4	3	14	8	3	2	1	1	39
																404
SUPPLEMENTAL NOTIFICATIONS:																
Respiratory, Males	...		-	-	-	-	-	-	-	1	-	1	1	3	5	11
Respiratory, Females	...		-	-	-	-	-	-	-	-	-	2	1	3	1	7
Non-respiratory, Males	...		-	-	-	-	-	-	-	-	-	-	-	-	-	-
Non-respiratory, Females			-	-	-	-	-	-	-	-	-	-	-	-	1	1
																19

The sources of information of the supplemental notifications were Local Registrars (8 respiratory and 1 non-respiratory), transferable deaths from the Registrar General (2 respiratory) and posthumous notifications (7 respiratory and 1 non-respiratory).

Table 25 Tuberculosis—Number of Cases on Register

Div. No.	Number of cases on register 1st January, 1966				Number of cases added to register				Number of cases removed from register				Number of cases remaining on register 31st December, 1966				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	167	96	18	32	10	1	2	3	24	15	2	3	153	82	18	32	285	3.6
3	170	91	13	14	20	3	3	2	30	24	4	—	160	70	12	16	258	4.6
4	193	89	7	11	11	1	—	4	29	14	1	3	175	76	6	12	269	3.8
5	261	166	30	28	23	13	1	3	56	44	12	10	228	135	19	21	403	3.3
7	249	160	25	40	28	12	—	1	106	71	14	21	171	101	11	20	303	2.7
9	63	45	11	13	3	6	—	—	4	3	—	1	62	48	11	12	133	2.3
10	122	93	16	21	5	6	1	1	30	27	6	8	97	72	11	14	194	4.2
11	197	132	16	15	21	4	1	3	28	12	—	2	190	124	17	16	347	5.9
12	216	154	37	50	17	8	2	3	21	13	1	2	212	149	38	51	450	6.6
13	94	48	8	23	12	6	1	1	31	8	1	5	75	46	8	19	148	1.6
15	60	54	36	14	16	6	6	3	13	5	4	5	63	55	38	12	168	3.4
16	75	57	15	7	13	4	—	1	8	6	—	—	80	55	15	8	158	2.4
17	37	15	5	8	6	3	2	—	12	6	1	1	31	12	6	7	56	1.1
18	187	114	16	10	14	5	—	—	34	14	1	2	167	105	15	8	295	4.9
19	146	83	14	8	8	5	1	—	34	23	2	3	120	65	13	5	203	4.0
20	131	83	22	25	10	7	—	4	22	20	2	2	119	70	20	27	236	2.5
23	219	152	24	34	12	6	—	—	24	16	1	1	207	142	23	33	405	5.9
Leeds R.H.B.	2,587	1,632	313	353	229	96	20	29	506	321	52	69	2,310	1,407	281	313	4,311	3.6
22	312	164	75	62	19	5	3	2	30	20	2	2	301	149	76	62	588	6.2
25	232	140	35	23	27	7	—	3	15	11	17	12	244	136	18	14	412	5.2
26	390	229	45	61	19	7	3	2	21	11	1	1	388	225	47	62	722	6.5
27	311	251	88	62	23	12	3	7	72	72	5	3	262	191	86	66	605	5.0
29	90	56	30	22	17	7	—	—	23	17	11	17	84	46	19	5	154	4.0
31	208	122	39	37	19	8	—	2	4	5	—	—	223	125	39	39	426	4.2
Sheff. R.H.B.	1,543	962	312	267	124	46	9	16	165	136	36	35	1,502	872	285	248	2,907	5.3
West Riding	4,130	2,594	625	620	353	142	29	45	671	457	88	104	3,812	2,280	567	561	7,218	4.1

Table 26 Tuberculosis—Mass Radiography Surveys

A.—LEEDS UNITS

Survey undertaken in Division No.	Number Examined	Abnormalities Discovered			
		Tuberculosis		* Other	Total
		Active	Inactive		
1 (Skipton)...	5,661	4	11	17	32
4 (Shipley)...	5,210	7	7	28	42
5 (Horsforth)...	5,586	4	2	15	21
7 (Harrogate and Ripon)	6,181	2	1	8	11
9 (Wetherby)...	1,459	1	2	4	7
10 (Goole)...	3,196	2	5	33	40
11 (Castleford)...	2,399	7	2	17	26
12 (Pontefract)...	1,721	—	8	2	10
13 (Morley)...	2,906	—	—	4	4
15 (Batley)...	3,431	1	1	3	5
16 (Rothwell)...	4,381	8	3	25	36
19 (Todmorden)...	5,133	4	9	38	51
20 (Colne Valley)...	4,226	3	8	16	27
23 (Hemsworth)...	2,409	1	2	4	7
TOTALS	53,899	44	61	214	319

B.—SHEFFIELD UNITS

Survey undertaken in Division No.	Number Examined	Abnormalities Discovered			
		Tuberculosis		* Other	Total
		Active	Inactive		
22 (Wortley)...	1,108	—	1	8	9
25 (Barnsley)...	3,054	1	13	100	114
26 (Wath)...	6,064	6	43	205	254
27 (Doncaster)...	4,141	6	37	214	257
31 (Rotherham)...	339	—	3	19	22
TOTALS	14,706	13	97	546	656

Totals for the County Area ... 68,605 57 158 760* 975

*Details of the 760 " Other " abnormalities are as follows:—

	<i>Leeds Region</i>	<i>Sheffield Region</i>
1. Anatomical abnormalities—congenital	—	40
2. Anatomical abnormalities—acquired	7	5
3. Tumours of the bony thorax; primary and secondary	2	—
4. Congenital pulmonary malformations	1	—
5. Bacterial or virus pulmonary infections	34	13
6. Other infections of lungs: fungus and parasitic ...	—	—
7. Bronchiectasis	17	23
8. Honeycomb lung	—	—
9. Emphysema	4	15
10. Pulmonary fibrosis—non-tuberculous	12	70
11. Pneumoconiosis	18	224
12. Spontaneous pneumothorax	3	—
13. Benign neoplasms of lungs and mediastinum ...	10	3
14. Primary malignant neoplasms	3	8
15. Secondary malignant neoplasms	1	—
16. Hilar and bronchial adenitis	—	—
17. Sarcoidosis	6	5
18. Pleural thickening	11	35
19. Abnormalities of diaphragm and œsophagus ...	14	13
20. Cardiovascular lesions: congenital	11	3
21. Cardiovascular lesions: acquired	20	85
22. Miscellaneous	38	1
23. Pneumoconiosis and tuberculosis... ..	—	3
24. Awaiting classification	2	—
	<hr/> 214	<hr/> 546

Table 27 Venereal Diseases—New Patients, 1938—66

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
1966	48	406	2,160	2,614

Table 28 Syphilis—Type and stage of disease 1950-66

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
1966	10	34	—	4

Table 29 Venereal Diseases—Distribution of New Cases by Treatment Centre

Special Treatment Centre	Syphilis	Gonorrhœa	Other Conditions	Total
Barnsley Clinic, Queen's Road	2	20	101	123
Bradford St. Luke's Hospital	4	36	178	218
Burnley Victoria Hospital	1	—	7	8
Dewsbury General Hospital	2	49	158	209
Doncaster Royal Infirmary	9	65	307	381
Goole Bartholomew Hospital	2	1	11	14
Halifax Royal Infirmary	3	26	94	123
Harrogate General Hospital	—	21	125	146
Huddersfield Royal Infirmary	1	18	102	121
Hull, Mill Street Clinic	—	9	25	34
Keighley Victoria Hospital	4	23	97	124
Leeds General Infirmary	8	53	337	398
Oldham & District General Hospital	—	—	4	4
Rotherham Moorgate General Hospital	6	15	138	159
Sheffield Royal Hospital	—	5	30	35
Sheffield Royal Infirmary	—	1	23	24
Wakefield Clayton Hospital	6	58	385	449
York County Hospital	—	6	38	44
	48	406	2,160	2,614

Table 30 Venereal Diseases—New Cases—Sex Distribution

	Males	Females	Total
Syphilis	26	22	48
Gonorrhœa	265	141	406
Chancroid	—	—	—
Lymphogranuloma Venereum	—	—	—
Granuloma Inguinale	—	—	—
Non-gonococcal Urethritis	445	—	445
Non-gonococcal Urethritis with Arthritis	26	—	26
Late or Latent Treponematoses—non-syphilitic	—	2	2
Other Conditions requiring treatment	362	442	804
Not requiring treatment	522	358	880
Undiagnosed at 31st December, 1966	1	2	3
	1,647	967	2,614

Table 31 Gonorrhœa—New Cases—Age Distribution

Sex	Under 20		20 to 24		25 and over	
Males	25	9%	64	24%	176	67%
Females	37	26%	27	20%	77	54%

Table 32 Venereal Diseases—Case finding

Total number of contacts reported	...	76				
Located and examined	...		53			
Not infected	...			15		
Infected	...			38		
Already under treatment	...				—	
Brought under treatment	...				38	
Syphilis	...					5
Gonorrhœa	...					22
Other conditions	...					11
Located	...		8			
Not examined	...			5		
Transferred to other authority	...			3		
Not located	...		15			
Insufficient information	...			7		
Unable to locate	...			8		

Table 33 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	
37	6	31	12	19	4	11	4

Table 34 Contacts of antenatal patients found to have syphilis

Number Examined	Found to have Syphilis	Found not to be infected
11	1	10

Table 35 Venereal Diseases—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
109	78	18	9	4	222	172

Table 36 Infant Mortality, 1901-66—Rates per 1,000 live births

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	1966	19	20
1951-1955	27	29			
1956-1960	23	25			

Table 37 Infant Mortality, 1962-66

	Number of Deaths					Deaths per 1,000 Live Births				
	1962	1963	1964	1965	1966	1962	1963	1964	1965	1966
<i>Male Infants—</i>										
Under 4 weeks ...	297	269	281	255	226	19.2	17.0	17.4	15.6	14.2
4 weeks—3 months ...	42	43	52	56	57	2.7	2.7	3.2	3.4	3.6
3—6 months ...	50	42	37	39	36	3.2	2.7	2.3	2.4	2.3
6—12 months ...	40	43	34	35	38	2.6	2.7	2.1	2.1	2.4
Total under 1 year ...	429	397	404	385	357	27.8	25.1	25.0	23.6	22.4
<i>Female Infants—</i>										
Under 4 weeks ...	170	192	206	183	171	11.8	12.8	13.3	12.1	11.0
4 weeks—3 months ...	26	45	32	34	25	1.8	3.0	2.1	2.2	1.6
3—6 months ...	35	49	35	23	46	2.4	3.3	2.3	1.5	3.0
6—12 months ...	35	24	27	27	24	2.4	1.6	1.7	1.8	1.5
Total under 1 year ...	266	310	300	267	266	18.5	20.7	19.4	17.6	17.1
<i>All Infants—</i>										
Under 4 weeks ...	467	461	487	438	397	15.7	15.0	15.4	13.9	12.6
4 weeks—3 months ...	68	88	84	90	82	2.3	2.9	2.7	2.9	2.6
3—6 months ...	85	91	72	62	82	2.9	3.0	2.3	2.0	2.6
6—12 months ...	75	67	61	62	62	2.5	2.2	1.9	2.0	2.0
Total under 1 year ...	695	707	704	652	623	23.3	23.0	22.2	20.7	19.8

Table 38 Neonatal Mortality, 1960-66

	Number of Deaths							Deaths per 1,000 Live Births						
	1960	1961	1962	1963	1964	1965	1966	1960	1961	1962	1963	1964	1965	1966
Under 1 day ...	227	238	235	231	203	200	191	8.1	8.3	7.9	7.5	6.4	6.4	6.1
1—5 days ...	157	170	160	159	196	163	152	5.6	6.0	5.4	5.2	6.2	5.2	4.8
1—4 weeks ...	58	62	72	71	88	75	54	2.1	2.2	2.4	2.3	2.8	2.4	1.7
Total under 4 weeks	442	470	467	461	487	438	397	15.8	16.5	15.7	15.0	15.4	13.9	12.6

Table 39 Causes of Infant Mortality

Aetiological 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 ...	191	152	54	82	82	62	623
Prenatal and Natal Group (including congenital malformations)	Congenital malformations (750-759) ...	24	25	26	17	16	8	116
	Total causes mainly of prenatal and natal origin ...	162	106	9	4	1	—	282
	Intracranial and spinal injury at birth (760) ...	15	18	1	2	1	—	37
	Other birth injury (761) ...	2	—	—	—	—	—	2
	Postnatal asphyxia and atelectasis (762) ...	43	37	1	—	—	—	81
	Attributed to maternal toxemia (769) ...	4	—	—	—	—	—	5
	Erythroblastosis (770) ...	6	—	—	—	—	—	6
	Haemorrhagic disease of newborn (771) ...	1	3	2	—	—	—	6
	Ill defined diseases of early infancy (773) ...	7	9	1	1	—	—	18
	Immaturity alone, or primary to diseases other than of early infancy (774, 776) ...	84	39	3	1	—	—	127
Postnatal Group	Total causes mainly of postnatal origin ...	1	15	16	56	54	46	188
	Causes classified as infective (001-138): others mainly infective in origin (340, 391-393, 480-483, 690-698, 765-768) ...	—	2	3	3	2	5	15
	Measles (085) ...	—	—	—	—	—	1	1
	Causes classified as infective not mentioned above (remainder 001-138) ...	—	—	—	2	—	1	3
	Meningitis (340) ...	—	—	2	—	1	—	3
	Otitis media and mastoiditis (391-393) ...	—	—	—	—	1	2	3
	Influenza (480-483) ...	—	—	—	—	—	—	—
	Skin and subcutaneous skin infections and sepsis of newborn (690-698, 765-768) ...	—	2	1	1	—	—	4
	Pneumonia and bronchitis (490-493, 763, 500-502) ...	—	11	9	30	37	22	109
	Other diseases of respiratory system (470-475, 510-527) ...	—	—	—	5	5	3	13
Unclassified	Gastro-enteritis (including diarrhoea of newborn) (571, 764) ...	—	1	4	12	3	10	30
	Accidental mechanical suffocation from vomit, food, foreign body, or in cot (E921-E925) ...	—	—	—	3	6	5	14
	Lack of care, neglect (including foundlings), infanticide (E926, E980-E985) ...	1	1	—	1	—	—	3
	Other violent causes (remainder E800-E999) ...	—	—	—	2	1	1	4
	Other remaining causes ...	4	6	3	5	11	8	37

Table 40 Perinatal Mortality, 1956-66

	1956	1957	1958	1959	1960	1961	1962	1963	1964	1965	1966
Perinatal mortality (per 1,000 total births)	39.5	39.7	36.7	33.7	35.9	34.2	31.5	31.1	30.0	27.3	25.1
Infant deaths at 1 week and over (per 1,000 total births)	10.1	9.9	9.9	10.2	8.5	10.1	9.9	10.1	9.5	9.0	8.8

Table 41 Maternal Mortality, 1962-66—Rates per 1,000 total births

Cause of Death	1962		1963		1964		1965		1966	
	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) ...	0.10	0.05	0.16	0.03	0.09	0.04	—	0.03	0.06	0.20
Toxæmias of pregnancy and puerperium (not associated with abortion) ...	0.03	0.06	0.10	0.05	—	0.04	0.03	0.05	0.13	
Other complications of pregnancy, childbirth and the puerperium	0.03	0.17	0.16	0.14	0.16	0.12	0.13	0.11	0.03	
Abortion (with or without mention of sepsis or toxæmia)	0.03	0.07	0.03	0.06	0.16	0.06	—	0.06	0.03	
Total Maternal Mortality...	0.20	0.35	0.45	0.28	0.40	0.25	0.16	0.25	0.25	0.26

Table 42 Antenatal Relaxation Classes

No. of sessions:							
(a) separate ... ..	...	...	...	...	...	...	4,555
(b) combined with antenatal clinics ... ..	...	...	...	...	...	...	39
TOTAL ...							4,594
No. of women attending:							
(a) hospital booked ... ..	...	...	...	...	...	...	4,002
(b) domiciliary booked ... ..	...	...	...	...	...	...	1,400
TOTAL ...							5,402
Total number of attendances:							
(a) hospital booked ... ..	...	...	...	...	...	...	20,900
(b) domiciliary booked ... ..	...	...	...	...	...	...	7,376
TOTAL ...							28,276

Table 43 Dental Services for Expectant and Nursing Mothers and children under 5 years

Attendances and Treatment

	Children 0—4 (incl.)	Expectant and Nursing Mothers
First Visit	1,187	450
Subsequent Visits	616	1,677
Additional Courses of Treatment commenced ...	56	23
Number of Fillings... ..	823	1,077
Teeth Filled	738	994
Teeth Extracted	2,566	1,779
General Anæsthetics	897	249
Emergencies	384	80
Patients X-Rayed	18	52
Prophylaxis	71	209
Teeth otherwise conserved... ..	172	—
Teeth Root Filled	—	7
Inlays	—	10
Crowns	—	2
Courses of Treatment Completed... ..	778	319

Prosthetics

Patients supplied with F.U. or F.L. (First Time)	274
Patients supplied with Other Dentures	133
Number of Dentures supplied	407

Anæsthetics

General Anæsthetics administered by Dental Officers	533
---	-----

Inspections

	Children 0—4 (incl.)	Expectant and Nursing Mothers
Number of First Inspections	A. 1,417	D. 492
Number in A. and D. requiring treatment ...	B. 1,287	E. 465
Number in B. and E. offered treatment ...	C. 1,242	F. 464

Sessions

Number of sessions devoted to M. & C.W. patients

For Treatment	583
For Health Education	—

Table 44 Phenylketonuria—Details of Tests undertaken, March, 1960–December, 1966

Total number tested	...	...	...	...	...	...	195,481
Number of confirmed cases	...	...	...	...	...	...	12
Ratio of true cases of phenylketonuria to children tested	...						1 : 16,290

Table 45 Ortolani Testing for Congenital Dislocation of the Hip—Summary tests carried out, 1963-66

	1963	1964	1965	1966
(a) Cases referred to specialist, confirmed as congenital dislocation of the hip and splinted	22	29	17	52
No. included in (a) referred by staff employed by the Authority	20	14	9	27
(b) Cases referred to specialist and said not to be congenital dislocation of the hip	45	29	31	62
(c) Cases referred to specialist, not splinted but given further review appointments	21	15	13	24

able 46 Illegitimate Children—Analysis of Cases

						<i>West Riding Cases</i>	<i>Non- County Cases</i>	<i>Total</i>
Number of cases dealt with during the year:								
Referred by Moral Welfare Organisations						235	46	281
Ascertained by staff of the Health Department... ..						782	4	786
Referred by other services... ..						341	10	351
Totals ...						1,358	60	1,418
Analysis of cases:								
Married	{	with previous illegitimate children ...				87	—	87
		without previous illegitimate children ...				162	2	164
Unmarried	{	with previous illegitimate children ...				181	4	185
		without previous illegitimate children ..				870	54	924
Widowed or Divorced	{	with previous illegitimate children ...				23	—	23
		without previous illegitimate children ...				35	—	35
Totals ...						1,358	60	1,418
Ages:								
Under 15 years of age						10	2	12
15—19 years of age						559	32	591
20—24 years of age						400	18	418
25—29 years of age						202	7	209
30—39 years of age						160	1	161
40 years of age and over						27	—	27
Totals ...						1,358	60	1,418
Disposal:								
Cases settled —Marriage						69	—	69
Baby died... ..						46	—	46
Grandparents taking baby						55	1	56
Baby adopted						248	32	280
Baby fostered						53	6	59
Mother keeping baby						860	20	880
Cases referred elsewhere						10	1	11
Cases not finally settled						17	—	17
Totals ...						1,358	60	1,418

Table 47 Illegitimate Children—Accommodation in Moral Welfare Homes

Moral Welfare Home	Ante and Post natal	Ante natal only	Post natal only	Governing Body
Bradford—Oakwell House	20	2	—	Bradford Corporation
Bradford—St. Monica's Home	7	1	—	Church of England
Bristol—Mount Hope	—	1	—	Salvation Army
Darlington—St. Agnes' Home	1	—	—	Church of England
Halifax—St. Margaret's House	18	1	—	Church of England
Harrogate—St. Monica's Home	17	—	—	Church of England
Huddersfield—Byranwood	20	—	—	Methodist Church
Huddersfield—St. Katharine's Hostel	15	—	—	Church of England
Kendal—Sacred Heart Maternity Home Brettargh Holt	1	—	—	Roman Catholic Church
Leeds—Browning House	17	1	1	Voluntary Committee
Leeds—Mount Cross, Bramley... ..	9	1	1	Salvation Army
Leeds—St. Margaret's Home	18	1	5	Roman Catholic Church
Lincoln—The Quarry Maternity Home	3	—	—	Church of England
Liverpool—Elmswood	1	—	—	Salvation Army
Manchester—Manchester and Salford Methodist Mission Home	2	—	—	Method st Church
Moseley—Beechcroft House	—	—	1	Church of England
Newcastle—Hopedene Mother and Baby Home	1	—	—	Salvation Army
Plymouth—The Mayflower Mother and Baby Home	1	—	—	Salvation Army
Pontefract—"The Haven"	24	3	2	Church of England
Salford—St. Teresa's Mother and Baby Home	1	—	—	Roman Catholic Church
Sheffield—St. Agatha's Hostel	19	1	—	Church of England
Streatham—The Limes Mother and Baby Home	1	—	—	The Church Army
Sutton-on Hull—Sutton House	1	—	—	Church of England
Wiltshire—The Grange	1	—	—	Church of England
York—Heworth Moor House	6	1	—	Church of England
	204	13	10	

TABLE 70 THE RATE OF PREMATURE DEATHS IN THE YEAR 1900 TO MOTHERS NORMALLY RESIDENT IN THE WEST KENYA ADMINISTRATION
County Area wherever the Birth took place

Total adjusted live births—31,457 Number of live premature births—2,071 Percentage of premature live births to total live births—6.6

Weight Group	Number of Premature Births				Number Dying														Number Surviving over 28 days					Percentage Survival 1966	Percentage Survival in previous years																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																															
	Born Alive				Born Dead		First Week								Second Week						A	B1	B2		C	Total	Percentage Survival 1966	1965	1964	1963	1962	1961																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																								
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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.

Table 49 Distribution of Welfare Foods

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
1966	94,779	30,993	27,073	417,351

Table 50 Day Nurseries

<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	38
7	Harrogate	40	29
15	Heckmondwike	40	31
18	Brighouse	40	21

Table 51 Midwifery—Hospital and Domiciliary Confinements

Division No.	Area	Population (estimated mid-1966)	Total noti- fied births (Live and Still)	Place of Birth					
				Hospital				Domici- liary	
				No.	No. of Early Discharges			No.	%
					At 48 hours	After 48 hours up to and includ- ing 5th day	After 5th but before 10th day		
1	Skipton ...	80,070	1,198	1,088	20	94	303	110	9
3	Keighley ...	55,940	994	920	40	315	286	74	7
4	Shipley ...	70,220	1,254	1,081	115	69	675	173	14
5	Horsforth ...	121,510	2,070	1,844	89	96	807	226	11
7	Harrogate ...	112,110	1,647	1,442	170	216	347	205	12
9	Wetherby ...	58,980	1,029	712	98	84	60	317	31
10	Goole ...	45,840	877	507	25	30	23	370	42
11	Castleford ...	58,320	993	724	118	125	174	269	27
12	Pontefract ...	67,840	1,379	931	99	203	366	448	32
13	Morley ...	91,060	1,720	1,167	131	128	178	553	32
15	Batley ...	49,730	996	909	86	13	264	87	9
16	Rothwell ...	64,590	1,353	768	132	202	161	585	43
17	Spenborough ...	52,880	995	910	34	102	73	85	9
18	Brighouse ...	60,520	1,058	731	25	43	33	327	31
19	Todmorden ...	50,560	778	527	29	40	60	251	32
20	Colne Valley ...	92,550	1,476	1,178	36	79	168	298	20
22	Wortley ...	94,470	1,530	1,154	97	119	289	376	25
23	Hemsworth ...	68,900	1,262	806	55	126	400	456	36
25	Barnsley ...	79,530	1,427	948	23	62	208	479	34
26	Wath ...	110,290	2,077	1,377	147	172	252	700	34
27	Doncaster ...	122,220	2,477	1,619	175	489	148	857	35
29	Thorne ...	38,310	818	464	57	159	60	354	43
31	Rotherham ...	102,530	2,219	1,401	181	469	207	818	37
Leeds Hospital Board									
	Region ...	1,201,620	21,079	16,245	1,302	1,965	4,378	4,834	23
Sheffield Hospital Board									
	Region ...	547,350	10,548	6,964	680	1,476	1,164	3,584	34
West Riding Administra- tive County ...		1,748,970	31,627	23,209	1,982	3,435	5,542	8,418	27

Table 52 Midwifery—Analgesia

Div. No.	Area	Percentage receiving Analgesia					Total
		Pethi-dine alone	Gas and air alone	Gas and air with Pethi-dine	Tri-lene alone	Tri-lene with Pethi-dine	
1	Skipton	3	—	—	34	54	91
3	Keighley	9	—	—	17	71	97
4	Shipley	8	—	—	18	63	89
5	Horsforth	3	—	—	37	43	83
7	Harrogate	8	—	—	27	45	80
9	Wetherby	3	1	3	33	48	88
10	Goole	16	—	—	38	28	82
11	Castleford	5	—	—	46	39	90
12	Pontefract	14	—	—	18	52	84
13	Morley	5	—	—	26	47	78
15	Batley	4	—	—	28	63	95
16	Rothwell	26	—	—	23	36	85
17	Spenborough	5	—	—	35	43	83
18	Brighouse	7	—	—	46	38	91
19	Todmorden	7	—	—	16	68	91
20	Colne Valley	7	1	2	28	51	89
22	Wortley	37	—	—	17	14	68
23	Hemsworth	13	—	—	28	35	76
25	Barnsley	15	—	—	21	44	80
26	Wath	29	—	—	24	35	78
27	Doncaster	10	—	—	22	58	90
29	Thorne	30	—	—	13	45	88
31	Rotherham	22	—	—	23	24	69
Leeds Hospital Board Region		11	—	—	29	45	85
Sheffield Hospital Board Region		20	—	—	21	38	79
West Riding Administrative County		14	—	—	26	42	82

Table 53 Emergency Obstetric Units

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

Table 54 Health Visiting

<i>Analysis of Visits</i>							<i>No. of visits</i>
Expectant mothers ...	...	...	...	...	...	...	7,851
Children born in 1966 ...	...	...	...	...	...	...	123,276
Children born in 1965 ...	...	...	...	...	...	...	90,015
Children born in 1961-64 ...	...	...	...	...	...	...	139,865
Children born 1961-1966							353,156
Tuberculous households ...	...	...	...	...	...	...	4,897
Tuberculous households by tuberculosis visitors ...	...	...	...	...	...	...	7,702
Other infectious disease households...	...	...	...	...	...	...	3,351
Persons over the age of 65 years ...	...	...	...	...	...	...	56,122
Number of cases ...	...	...	...	...	...	...	23,443
Number visited at request of g.p. or hospital ...	...	...	...	...	...	...	8,255
Mentally disordered persons ...	...	...	...	...	...	...	2,127
Number of cases ...	...	...	...	...	...	...	605
Number visited at request of g.p. or hospital ...	...	...	...	...	...	...	239
Persons, excluding maternity cases, discharged from hospital (other than mental hospitals) ...	...	...	...	...	...	...	3,983
Number of cases ...	...	...	...	...	...	...	2,258
Number visited at request of g.p. or hospital ...	...	...	...	...	...	...	1,345
School health ...	...	...	...	...	...	...	15,774
Home Help Service ...	...	...	...	...	...	...	123,056
Ineffective visits ...	...	...	...	...	...	...	60,507
<i>Clinics and School Sessions</i>							<i>No. of sessions</i>
Maternity and child welfare ...	...	...	...	...	...	...	31,523
Ultra violet light ...	...	...	...	...	...	...	853
<i>Health Education—</i>							
a. Clubs ...	...	...	...	...	...	...	179
b. Parent/teachers ...	...	...	...	...	...	...	8
c. Schools ...	...	...	...	...	...	...	1,390
d. Antenatal relaxation classes ...	...	...	...	...	...	...	1,647
Other health education activities ...	...	...	...	...	...	...	92
							3,316
Specialist—Chest ...	...	...	...	...	...	...	1,287
Other ...	...	...	...	...	...	...	2,931
School health ...	...	...	...	...	...	...	22,873
Total ...							62,783

There was no outstandingly significant change of visiting pattern

Table 55 Home Nursing—Total Cases Visited

<i>Types of cases attended</i>						<i>No. of cases attended</i>	<i>No. of visits by Home Nurses</i>
Medical	...	...	...	...	...	23,784	622,037
Surgical	...	...	...	...	...	7,281	140,702
Infectious diseases	...	...	...	...	...	317	3,436
Tuberculosis	...	...	...	...	...	263	14,732
Maternal complications	...	...	...	...	...	708	6,087
Others	...	...	...	...	...	321	3,393
Total						32,674	790,387
<i>Age Groups</i>							
0—4	...	...	...	...	...	1,446	10,721
5—64	...	...	...	...	...	12,670	249,801
65 years or over	...	...	...	...	...	18,558	529,865
Total						32,674	790,387
Patients included in the above who have had more than 24 visits during the year						<u>8,207</u>	<u>563,940</u>

Table 56 Home Nursing—Completed Cases

Classification of Cases by Disease:

<i>Disease</i>	<i>No. of Cases</i>
Tuberculosis	233
Other infectious diseases	324
Parasitic diseases	54
Malignant and lymphatic neoplasms	1,679
Asthma	137
Diabetes mellitus	468
Anæmias	1,938
Vascular lesions affecting central nervous system	1,655
Other mental and nervous diseases	473
Diseases of the eye	75
Diseases of the ear	500
Diseases of heart and arteries	1,767
Diseases of veins	641
Upper respiratory diseases	658
Other respiratory diseases	2,269
Constipation	984
Other diseases of digestive system	1,777
Diseases of urinary system and male genital organs	928
Diseases of breast and female genital organs	540
Complications of pregnancy and puerperium	693
Diseases of skin and subcutaneous tissues	1,025
Diseases of bones, joints and muscles	695
Injuries	1,827
Senility	1,147
Other defined and ill-defined diseases or disabilities	1,200
Diseases not specified... ..	715
Total ...	24,402

Nursing Treatment:

<i>Type</i>	<i>No. of Cases</i>
Injections	7,350
General nursing	6,939
Enemas	1,204
Dressings	5,985
Bed baths	797
Wash-outs, douches, etc.	276
Changing of pessaries... ..	121
Preparation for diagnostic investigation	518
Others	1,212
Total ...	24,402

The total number of cases receiving injections was 7,905 but, in a small proportion of cases, the injections were given during the course of a general nursing visit.

<i>Injections:</i>				<i>Type</i>				
Insulin	319
Drugs for anæmia, debility, etc.	2,740
Antibiotics	3,450
Drugs for cardio-renal diseases	668
Others	728
Total								7,905
<i>Referral of Cases:</i>				<i>Source</i>				
General practitioners	19,704
Hospitals	3,398
Health Department staff	726
Others	574
Total								24,402
<i>Disposal of Cases:</i>								
Convalescent	13,376
Transferred to hospital	4,145
Died	3,796
Others	3,085
Total								24,402

Table 57 Ambulance Services

	Year ended 31st December		Variation on 1965	1965 compared with 1964
	1965	1966	Increase	Increase
Admissions	53,313	54,717	1,404	606
Discharges	29,669	29,385	284 (Decrease)	397 (Decrease)
Transfers	13,159	13,231	72	10
Out-patients	478,080	501,264	23,184	20,498
Accident patients... ..	15,355	15,394	39	286 (Decrease)
Total patients of Directly Provided Service ...	589,576	613,991	24,415	20,431
Total patients of Direct Service plus Agency and Hospital Car Ser- vice	634,371	660,747	26,376	27,007
Mileage of Direct Service	3,813,716	3,962,780	149,064	64,430
Total Mileage (including Agency and Hospital Car Service)	4,309,998	4,515,301	205,303	113,079

Table 58 Provision of Nursing Equipment in the Home

Item	Number on loan	Number available for issue	Total	Number of issues during year
Bath lift	—	1	1	—
Bath seat	21	1	22	27
Bedding: blankets, pillows and cases, sheets, etc.—pieces	667	508	1,175	1,014
Bed blocks	10	105	115	16
Bed cradles	352	105	457	655
Bed pans	1,230	558	1,788	2,823
Bed rests	628	185	813	1,248
Bed tables	14	13	27	24
Bedsteads: hospital, with self-lifting pole, and other	256	25	281	392
Chairs: geriatric, relaxing, high rest, 'Amesbury' play, stairway (carrying) etc.	17	9	26	21
Colostomy sets	2	7	9	3
Commodore: chair and other	772	10	782	1,390
Cushions: air and 'Dunlopillo'	53	9	62	99
Enuresis alarms	313	25	338	1,299
Fracture boards	73	—	73	89
Hemiplegic exercisers	—	4	4	2
Hot water bottles	16	39	55	11
Ileostomy sets	3	4	7	3
Lifting hoists	19	4	23	31
Lifting pole and chain	20	6	26	28
Mattresses: air, biscuit, 'Dunlopillo,' hair, water, 'P.C.P.,' spring-interior	340	20	360	511
Open-air shelters	3	2	5	3
Pressure rings: air and foam rubber	596	443	1,039	1,290
Rubber/plastic sheets	1,047	312	1,359	1,972
Sputum mugs	36	128	164	42
Urinals: male and female	748	579	1,327	1,499
Walking aids: 'Amesbury,' 'Bonaped,' 'Zimmer,' 'Companion,' crutches, tripod, walking sticks	903	164	1,067	1,369
Wheel chairs: bath, folding, junior, self-propelled, spinal, stairway, etc.	626	49	675	1,247
Miscellaneous: feeding cups, steam kettles, breast pumps etc.	114	66	180	206
	8,879	3,381	12,260	17,314

Table 59 Chiropody Treatment

	<i>Voluntary Association Schemes</i>	<i>Direct Service by County Council</i>	<i>Total</i>
Number of sessions held:			
In voluntary association premises ...	3,843	—	3,843
In clinic premises	—	8,545	8,545
	3,843	8,545	12,388
Number of patients treated:			
In chiropodists' surgeries:			
Pensioners	6,390	4,870	11,260
Physically handicapped	76	140	216
Expectant mothers	5	3	8
In voluntary association or clinic premises:			
Pensioners	6,506	15,161	21,667
Physically handicapped	82	204	286
Expectant mothers	3	14	17
Domiciliary treatment:			
Pensioners	3,129	9,260	12,389
Physically handicapped	136	379	515
Expectant mothers	—	1	1
Total number of patients treated ...	16,327	30,032	46,359
Total number of treatments given:			
Pensioners	78,122	140,170	218,292
Physically handicapped	1,302	2,664	3,966
Expectant mothers	23	45	68
	79,447	142,879	222,326
Number of patients treated per session:	7.8	8.3	8.2
Percentage of total patients treated receiving domiciliary treatment	20.0	32.1	27.8
Percentage of aged population receiving treatment (men over 65 years and women over 60 years)	6.5	11.8	18.3

Table 60 Domestic Help

<i>Classification of Cases Assisted</i>	<i>No. of Cases</i>	<i>Hours employed</i>
Over 65 years of age	15,068	2,186,388
Under 65 years of age:		
Chronic sick and tuberculous ...	1,552	203,113
Mentally disordered	35	3,532
Maternity	920	42,475
Other	674	65,952
	18,249	2,501,460

Table 61 Mental Health Training Centres

The following is a list of the training centres in operation at the end of 1966, 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	647	373	373	73	1,466

Table 62 Day Centres and Psychiatric Social Clubs

(a) Day Centres:

<i>Club</i>	<i>No. of members</i>	<i>Premises</i>	<i>Meetings</i>	<i>Opened</i>
Harrogate Therapeutic	52	13, Dragon Parade, Harrogate	Monday Wednesday Thursday Friday afternoons	October, 1963 (transferred to new premises May, 1967)
Snaith Day Centre	20	Pontefract Road, Snaith	Daily	December, 1963

(b) 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, High-town, 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	Monthly Thursday evening	April, 1963
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	The Butts Clinic, Barnoldswick	Monday evening	November, 1962
<i>Non-County clubs attended by West Riding patients</i>				
4 U Club, Halifax				January, 1961
Huddersfield Social Club				November, 1962

Table 63 Mental Health—Hospital Admissions

a) Psychiatric Patients (admitted by Mental Welfare Officers)

					1965	1966
Informal admissions	...	...			1,544	1,658
Court orders	...	...	...		7	8
Section 25	...	...	...	...	264	225
„ 26	...	...	...	...	61	61
„ 29	...	...	...	...	571	597
					2,447	2,549

b) Subnormal Patients

Patients provided with short stay care	...	...	236
„ admitted for permanent care...	...	...	29
„ under guardianship	...	...	4
„ awaiting permanent care—urgent	...	...	27
„ awaiting permanent care—non-urgent	...	...	39

Table 64 Mental Health—Number of persons referred to Local Health Authority during year ended 31st December, 1966

Referred by	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.	M.	F.	M.	F.	M.	F.			
General practitioners	5	1	729	350	1	—	1	1	—	—	—	1	22	8	—	—	—	—	—	—	—	—	—	1258	
Hospitals, on discharge from in-patient treatment	2	1	569	1045	—	1	1	—	—	—	—	1	3	28	5	1	—	—	—	—	2	1	—	1653	
Hospitals, after or during out-patient or day treatment	2	—	311	491	—	—	—	—	—	10	3	28	5	1	—	—	—	—	—	—	—	—	—	852	
Local education authorities	1	—	—	—	—	—	—	—	—	48	26	53	36	31	25	—	—	—	—	—	—	—	—	220	
Police and courts	1	—	100	77	1	—	1	—	—	—	—	8	7	—	—	—	1	2	—	—	—	—	—	198	
Other sources	3	3	388	683	—	—	—	—	—	2	2	3	5	9	45	35	10	10	—	—	—	—	—	1199	
Total	14	5	2097	2646	2	1	5	3	3	95	45	198	104	79	60	13	13	—	—	—	—	—	—	5380	

**Table 65 Mental Health—Number of persons under Local Health Authority
Care at 31st December, 1966**

	Mentally Ill				Elderly mentally infirm		Psychopathic				Subnormal				Severely Subnormal				Grand Total			
	Under age 16		16 and over		M.	F.	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.				
Total number	2	4	1321	1939	145	291	—	—	—	—	10	5	305	237	1023	920	218	167	247	293	7127	
Attending day training centre	—	—	13	5	3	3	—	—	—	—	—	—	—	249	188	245	245	153	120	101	119	1444
Awaiting entry to training centre	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	30
Receiving home training	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	6
Awaiting home training	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	3
Resident in L.A. home/hostel	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	36
Awaiting residence in L.A. home/hostel...	—	—	1	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	14
Resident at L.A. expense in other homes/	—	—	8	14	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	39
hostels	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	5
Resident at L.A. expense by boarding out in	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	302
private household	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Attending day hospitals	—	—	110	164	1	3	—	—	—	2	—	—	—	2	3	7	5	1	2	2	—	—
Receiving home visits and not included above:	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Suitable to attend a training centre	—	—	135	169	—	—	—	—	—	—	—	—	—	6	2	40	47	8	8	28	33	476
Others	2	4	1054	1586	141	285	—	—	—	—	8	5	43	39	716	615	43	30	112	129	4812	

Table 66 Milk (Special Designation) Regulations, 1963 and Milk (Special Designation) (Amendment) Regulations, 1965—Dealers Licensed

Number of Licence Holders	Dealing in pre-packed milk			
	Untreated	Pasteurised	Sterilised	Ultra Heat Treated
3,084	462	1,169	2,378	17

Table 67 Milk (Special Designation) Regulations, 1963 and Milk (Special Designation) (Amendment) Regulations, 1965—Details of Samples obtained from Dealers in the County Area

Untreated			Pasteurised					Sterilised		Ultra-Heat Treated	
Methylene Blue Test			Phosphatase Test		Methylene Blue Test			Turbidity Test		Colony Count	
Satisfactory	Unsatisfactory	Void	Satisfactory	Unsatisfactory	Satisfactory	Unsatisfactory	Void	Satisfactory	Unsatisfactory	Satisfactory	Unsatisfactory
1,644	216	61	2,558	6	2,440	67	57	60	—	20	—

Table 68 Milk (Special Designation) Regulations, 1963—Licensed Establishments for 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.
 Old Corn Mill Farm (Eldwick) Ltd., Harden Grange, Harden, Bingley.
 Platts N. H. & Sons, Home Farm, Bretton, near Wakefield.
 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 plants commenced operations:

Old Corn Mill Farm (Eldwick) Ltd., Harden Grange, Harden, Bingley.
 Platts N. H. & Sons, Home Farm, Bretton, near Wakefield.

Table 69 Milk (Special Designation) Regulations, 1963—Details of Samples obtained from Licensed Processing Plants

Pasteurised					Sterilised	
Phosphatase Test		Methylene Blue Test			Turbidity Test	
Satisfactory	Unsatisfactory	Satisfactory	Unsatisfactory	Void	Satisfactory	Unsatisfactory
581	8	579	4	6	36	—

Table 70 Details of Samples obtained from Private Supplies of Water to County Premises

Premises	Source of Supply	Bacteriological Examination		
		Number of samples obtained	Sat.	Unsat.
Aldfield C.E. School, Aldfield, near Ripon	Untreated trunk main	17	17	—
Clint Burnt Yates Endowed School, Burnt Yates, near Harrogate	Bore	14	14	—
Elslack Primary School, Broughton, near Skipton	Well	7	7	—
Grantley Hall Adult College, near Ripon	Land springs	24	22	2
Ingleborough Hall Special School, Clapham, Settle	Lake water	1	1	—
Upper Wharfedale Secondary School, Grassington	Land spring	5	5	—

Table 71 Details of Applications for Grants under the Rural Water Supply and Sewerage Acts, 1944-61

County District or Other Body	Description of Scheme	Date of Application	Estimated Amount of Scheme
			£
Bowland R.D.	West Bradford—Sewer Extension	13th October	9,300
Calderdale Water Board	Hurst Road, Hebden Bridge Water Supply	5th May	4,346
do	The Hollins, Sowerby Bridge Water Supply	5th July	711
do	Mill Fields Ends, Midgley Water Supply	20th December	418
Claro Water Board	The Raikes, Wilsill Water Supply	11th August	1,380
Colne Valley U.D.	Daisy Green, Linthwaite, Water Supply	1st February	560
Craven Water Board	Thornton in Craven Water Supply	23rd March	5,348
Denby Dale U.D.	Emley, Clayton West, Scissett and Skelmanthorpe Sewerage and Sewage Disposal	11th October	245,800
Doncaster and District Joint Water Board	Water Supplies to isolated properties in Thorne R.D. Scheme 2	7th April	4,950
	„ 3		4,000
	„ 4		1,155
Doncaster R.D.	Clayton with Frickley Sewerage	1st June	41,797
Elland U.D.	Upper Greetland Sewerage	29th August	37,147
Goole R.D.	Northern Area Sewerage, (Isle of Axholme)	13th October	11,910
Hebden Royd U.D.	Cragg Vale Sewer Extension	4th March	3,705
Kirkburton U.D.	Linfit Lane Sewerage	14th December	120,000
Leeds C.B.	Part of the Parish of Arthington—Water Supply	29th April	4,340
do	Part of the Parish of South Milford—Water Supply	29th April	1,380
Osgoldcross R.D.	Heck, Hensall and Kellington Sewerage	8th December	230,000
Ripon and Pateley Bridge R.D.	Wormald Green Sewerage	8th February	19,563
Rombalds Water Board	Weston Village Water Supply	29th March	3,770
Saddleworth U.D.	Bunkers and Tunstead Water Supply	30th November	2,500
Sowerby Bridge U.D.	Cottonstones Sewer Extension	20th April	6,791
Tickhill U.D.	Extension of Tickhill Sewage Works	14th June	7,670
Wharfedale R.D.	Pool and Arthington Sewerage and Sewage Disposal—Part Scheme	1st November	3,800
Wortley R.D.	The Folderings, Wharnccliffe Side, Sewage Disposal	20th May	3,000

Table 72 School Swimming Pools

School	Pool		Filtration	Chlorination	Remarks
	Capacity in gallons	Type			
Aireborough Grammar	30,000	Conventional	Sand	Chlorine Gas	—
Armthorpe Junior	12,400	Conventional	Diatomaceous Earth	Automatic Chlorinator	Pool under construction
Bardsey Primary	870	Sunken	Diatomaceous Earth	Automatic Chlorinator	Chlorination and filtration equipment installed 1966
Bewerley Park Centre for outdoor pursuits	12,000	Purley	Diatomaceous Earth	Automatic Chlorinator	Pool under construction
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	—
Bridge House Special School, Harewood	4,000	Purley	Diatomaceous Earth	Automatic Chlorinator	—
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 under construction
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	—
Harrogate Oatlands Mt. J.M.	8,000	Purley	Diatomaceous Earth	Automatic Chlorinator	Pool in planning stage
Harrogate Woodlands	20,000	Conventional	Diatomaceous Earth	Automatic Chlorinator	Pool in planning stage
Hartwith Summerbridge	6,000	Purley	Diatomaceous Earth	Automatic Chlorinator	—
Hebden Royd Centre, Pitt Street, Hebden Bridge	6,000	Purley	Diatomaceous Earth	Automatic Chlorinator	Pool under construction

School	Pool		Filtration	Chlorination	Remarks
	Capacity in gallons	Type			
Horbury C.E.	6,000	Purley	Diatoma- ceous Earth	Automatic Chlorinator	—
Horbury Bridge C.E.	8,000	Mermaid	Diatoma- ceous Earth	Automatic Chlorinator	Pool opened 1966
Hoyland Common J.M.I.	6,000	Purley	Canvas Bags	Drip Feed	Diatomaceous Earth filtration planned
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 under construction
Meltham C.E.	15,000	Constructed	Diatoma- ceous Earth	Automatic Chlorinator	Pool in planning stage
Mexborough C.E.	9,600	Purley	Diatoma- ceous Earth	Automatic Chlorinator	Pool in planning stage
Mexborough Grammar	18,000	Purley	Diatoma- ceous Earth	Drip Feed	—
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	—
Scissett Miners Welfare Club	70,000	Constructed	Sand	Chlorine Gas	Taken over by W.R.C.C. for alterations
Scholes J.M.I.	8,000	Purley	Diatoma- ceous Earth	Automatic Chlorinator	Pool opened 1966
Shade Primary, Todmorden	30,000	Conventional	Sand	Chlorine Gas	—
Sherburn in Elmet	8,000	Purley	Sand	Drip Feed	Sand filter installed 1966

School	Pool		Filtration	Chlorination	Remarks
	Capacity in gallons	Type			
Thorne Grammar	48,000	Purley	Diatoma- ceous Earth	Automatic Chlorinator	Pool opened 1966
Ulleskelf C.E.	6,000	Purley	Canvas Bags	Drip Feed	—
Upper Poppleton C.P., York	2 pools 2,000 14,000	Purley	Diatoma- ceous Earth	Automatic Chlorinator	Pools opened 1966
Upper Wharfedale Secondary	43,000	Conventional	Diatoma- ceous Earth	Automatic Chlorinator	Pool under construction
North Elmsall J.M.I., Upton	21,000	Purley	Diatoma- ceous Earth	Automatic Chlorinator	—
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	—

Table 73 Atmospheric Pollution

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	96	600	8	111	446	13
Keighley—First floor of Public Health Department in built-up area in centre of town	107	589	10	67	217	17
Keighley—Branshaw View, 20ft. above ground in class-room on south-west side of building, $\frac{1}{4}$ mile south-west of town centre. Surrounding district residential	77 for 11 months	523	3	59 for 11 months	197	0
Bingley—Health Department, Town Hall, $\frac{1}{5}$ th mile outside town centre, surrounding district parkland	69	680	5	147	548	25
Shipley—Health Department, Town Hall, surrounding district residential and commercial	110	778	13	148	818	20
Horsforth—Broadway, in residential area, most properties to the south in Smoke Control Areas	97	686	3	143	676	18
Otley—First floor of Council Offices, in town centre, mainly manufacturing	96	587	5			
Pudsey 2 (Stanningley)—“Southville”, Sunfield House, 20 ft. above ground on east side, surrounding district mainly industrial	98	719	9	152	770	19
Pudsey 3 (Farsley)—Farfield House, Farfield Avenue, 20ft. above ground on north side, surrounding district residential	107	631	7	162	829	35
Pudsey 4 (Calverley)—M. & C. W. Clinic, Chapel Street, 20ft. above ground on west side, surrounding district parkland and residential	104	803	10	158	856	14

*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		
Harrogate — Ground floor of Municipal Offices, surrounding district residential and commercial	66	412	4	93	418	0
Harrogate — Ground floor of Regional Office, Milk Marketing Board, surrounding district residential and manufacturing	108 for 11 months	526	6	56 for 11 months	401	7
Harrogate—Wheatlands School, surrounding district low density housing and open parkland	59	482	3	62	297	0
Knaresborough—Knaresborough House, in parkland surrounded by mixed residential and commercial properties, open country to west.	72 for 5 months	371	7	71 for 5 months	291	6
Goole—Health Department, Municipal Offices, Stanhope Street, surrounding area commercial, residential and shipping	89	584	6	94	481	23
Castleford—First floor of Divisional Health Office, in residential area of industrial town	225	1,147	36	165	254	34
Castleford—The Green, Ferry Fryston—situated 12ft. above ground on E. side of the Pavilion, surrounding district residential with open country to E.	133	809	23	77	214	34
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.	139 for 11 months	849	11	174 for 11 months	699	60
Normanton—Nevile House. Surrounding district commercial, residential and a few small factories	193	1,060	6	162	753	18
Pontefract—Municipal Offices. In laboratory on second floor in mixed commercial and manufacturing area	223 for 3 months	659	48	200 for 3 months	500	63

*For period of full year unless stated otherwise.

Situation of Instrument	Smoke			Volumetric SO ₂		
	Average Daily Suspended Impurity*	Highest Value	Lowest Value	Average Daily Concentration SO ₂ *	Highest Value	Lowest Value
	Microgrammes per cubic metre			Microgrammes per cubic metre		
Pontefract—Moverlay Flatts. In rear storeroom of Council Depot, surrounding district residential	305 for 3 months	747	78	232 for 3 months	570	73
Pontefract—Carleton Park. First floor landing of flats in residential area	164 for 3 months	562	15	162 for 3 months	452	23
Horbury—Ground floor lobby of Town Hall, facing east 12ft. above ground, surrounding district residential and manufacturing	132	1,150	11	173	954	20
Morley—Public Health Inspector's Department, Commercial Street, surrounding district residential, commercial and manufacturing	136	899	7	152	504	Alk.
Morley—Spring Avenue, Gildersome in residential area	96	711	3	88	412	25
Ossett—Croft House—on first floor landing on north-east side of building. Surrounding district residential and commercial	98	937	14	179	951	27
Batley—Public Health Department, Market Place, in centre of mixed residential, commercial and manufacturing district	136	1,063	18			
Spennborough—Health Centre, Greenside, in small park, residential and commercial area.	109	837	11	153	697	32
Elland—Council Offices, 20ft. above ground in manufacturing area	191	1,405	15	225	1,844	25
Hebden Royd (Mytholmroyd)—Redacre Sewage Works, residential and manufacturing area, open country to north	104 for 11 months	1,172	9	98 for 11 months	692	Alk.
Hebden Royd (Hebden Bridge)—On second floor landing of Council Offices, in centre of mixed residential, commercial and manufacturing district	122	1,359	13	145	1,080	Alk.

*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		
Sowerby Bridge—Beech Road. Upper room of Public Health Department in a mainly residential area with some industrial plants 200 yards to East	134 for 5 months	1,445	11	142 for 5 months	670	22
Sowerby Bridge—Wharf Street. Situated on main Yorkshire—Lancashire road carrying heavy traffic, in a mainly commercial area	121 for 5 months	809	27	120 for 5 months	459	7
Todmorden—In first floor room on south side of Medical Centre, surrounding district mixed residential, commercial, manufacturing and open country	122 for 11 months	1,312	11	156 for 11 months	982	32
Colne Valley—Town Hall, Cross Street, Slaithwaite, in mixed residential and textile manufacturing district	129	692	8	155	640	32
Denby Dale—Public Health Inspector's Office, surrounding district mixed residential, manufacturing and open country	138	748	20	130	561	34
Holmfirth—On second floor landing of Council Offices, surrounding district open country, residential, commercial and manufacturing	110	1,690	14	136	547	36
Kirkburton—Council Depot, Highroyd, Lepton, 11 ft. above ground, surrounding district residential. Huddersfield C.B. 4 miles to the east	137	1,225	20	87	376	13
Meltham—Public Health Inspector's Office, Town Hall, surrounding district residential, manufacturing and open country	120	1,415	19	117	1,046	Alk.
Saddleworth—Sewage Works, Shaw Hall Bank, Greenfield, surrounding district residential, manufacturing and commercial	90 for 10 months	441	16	80 for 10 months	320	Alk.

*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		
Wortley (Grenoside)—Health Dept., Council Offices, surrounding area industrial and manufacturing	89	494	6	115	437	15
Wortley (Oughtibridge)—County School, Church Street, surrounding district industrial and manufacturing	57	558	5	82	388	12
Hemsworth—Divisional Health Office, Adiscombe House, in residential area	176	1,244	11	116	504	Alk.
Darton—Council Offices, in semi-residential colliery district. Coke by-product plant 1 mile to the S.E.	166	1,174	20	182	1,037	23
Wombwell—The Gables, semi-residential colliery district	235	1,690	40	106	310	31
Wombwell—The Library, Station Lane, surrounding district residential and commercial	217	1,446	22	165	548	42
Worsbrough—Savile House—8ft. above ground in out-building, rear of Council Offices. Surrounding country open and low density residential	163	1,094	15	103	469	19
Conisbrough—Denaby Clinic, in room facing north. Surrounding district residential—high density	177	858	15	147	402	24
Conisbrough—The Priory, in staff dining room facing west. Surrounding district residential—low density	164 for 10 months	1,091	24	134 for 10 months	380	39
Rawmarsh—Public Health Inspector's Office, in centre of residential and industrial area	253	1,128	13			
Bentley with Arksey—Health Department, Chapel Street, semi-residential colliery district	165	977	14	187	626	42

*For period of full year unless stated otherwise.

Situation of Instrument	Smoke			Volumetric SO ₂		
	Average Daily Suspended Impurity*	Highest Value	Lowest Value	Average Daily Concentration SO ₂ *	Highest Value	Lowest Value
	Microgrammes per cubic metre			Microgrammes per cubic metre		
Doncaster (Barnby Dun)—Barnby Dun School, in residential area 5 miles north-east of Doncaster C.B.	117	679	8	117	346	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	107 for 11 months	801	6	177 for 11 months	843	Alk.
Thorne—Council Offices, in semi-residential colliery district	95	531	2			

*For period of full year unless stated otherwise.

Table 74 Welfare of the Epileptic and Spastic—Particulars of known Epileptics and Spastics

	<i>Number</i>	
	<i>Epileptics</i>	<i>Spastics</i>
<i>Adults</i>		
Provided with accommodation under Part III of the National Assistance Act, 1948:		
(a) in homes for epileptics	63	
(b) in homes for spastics and other handicapped persons		35
(c) in County establishments and establishments where County Council has "right of user"	41	
Registered under the County Council's scheme of Welfare Services for Handicapped Persons (General Classes) and not shown above	154	193
<i>Children</i>		
Number ascertained as handicapped:		
(a) Approximate number attending ordinary schools	not known	34
(b) Attending special schools	27	93
(c) Receiving home tuition	1	2
(d) Attending training centres for the mentally subnormal	71	72
Plus 15 children suffering from both epilepsy and spasticity.		

**Table 75 Certification and Treatment of Blind and Partially Sighted Persons—
New Registrations during 1966 of Blind and Partially Sighted Persons
(other than handicapped school children)**

	Disability (B.—Blind, P.S.—Partially Sighted)									
	Cataract		Glaucoma		Retro-lental Fibroplasia		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	120*	45†	9	2	1	—	122	41	252	88
(b) Treatment (medical, surgical, optical or ophthalmic medical supervision)	165‡	156=	29	21	—	—	76	93	270	270
(ii) Number of cases at (i) (b) above who received treatment ...	108	99	23	21	—	—	65	82	196	202

* Includes 18 cases of cataract with glaucoma.

† Includes 1 " " " " "

‡ Includes 32 " " " " "

= Includes 30 " " " " "

Table 76 Residential Accommodation—(National Assistance Act, 1948)

<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 2113	111
‡11, Stockwell Road, Knaresborough	Mr. T. K. Hayward (Secretary)	Knaresborough 2283	87
Wharfedale Lawn, Westgate, Wetherby	Mrs. A. Lofthouse	Wetherby 2446	21*
The Grove, 80, High Street, Starbeck	Miss W. Smeaton	Harrogate 83980	19 ^b

<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
Woodfield House, Woodfield Square, Harrogate	Mr. and Mrs. E. Drake	Harrogate 68728	34
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. E. G. 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 2... ..	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
Heather Court, Main Street, Menston	Mr. and Mrs. W. Reilly	Menston 4813	34
Hall Croft, Church Street, Windhill, Shipley	Mr. and Mrs. H. Gledhill	Shipley 58071	34
Glenholme, Green Lane, West Vale, Greetland	Mr. and Mrs. J. Ellis	Elland 2985	35
Stoneswood, Oldham Road, Delph	Miss M. C. Murphy	Delph 300	20
Thornhill Grange, Hanson Road, Rastrick	Mr. and Mrs. W. Corbett	Brighouse 4810	44
Heathlands, Meal Hill Lane, Slaithwaite	Mr. and Mrs. P. Morrell	Slaithwaite 2856	34
Longlands, Leeds Road, Lightcliffe, Nr. Halifax	Miss A. Dickinson	Halifax 21254	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

<i>Establishment</i>	<i>Superintendent/Matron</i>	<i>Telephone Number</i>	<i>No. of Residents</i>
Stanley View, Park Lodge Lane, Wakefield	Mr. and Mrs. F. W. Radley	Wakefield 71016	207
Beech Towers, Halifax Road, Staincliffe, Nr. Dewsbury ...	Mr. and Mrs. N. W. Jones	Dewsbury 4051/2	294
Knowl Park House, Crow Lees Road, Mirfield	Mr. and Mrs. D. Dyer	Mirfield 2583	34
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 55242	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	22
Brook Lodge, Brook Street, Selby	Mr. and Mrs. T. Bradley	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. J. A. Bromley	South Elmsall 2510	34
Highfield House, Love Lane, Castleford	Mr. and Mrs. F. Butterfield	Castleford 3767	34
Boothferry House, Airmyn Road, Goole	Mr. and Mrs. M. J. Midgley	Goole 2471	34
Wadworth Hall, Wadworth, Nr. Doncaster	Mrs. S. C. Kenny	Doncaster 53272	23
Haynes House, Haynes Road, Thorne	Mr. and Mrs. C. Whitaker	Thorne 3395	34
Don View, 22, Thellusson Avenue, Scawsby, Nr. Doncaster	Mr. and Mrs. W. R. Howell	Doncaster 2257	38

<i>Establishment</i>	<i>Superintendent/Matron</i>	<i>Telephone Number</i>	<i>No. of Residents</i>
Rose House, Church Street, Armthorpe, Doncaster ...	Mr. and Mrs. G. Bromley	Armthorpe 450	34
Owston View, Lodge Road, Carcroft	Mr. and Mrs. A. Brearley	Adwick le Street 3368	34
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
Rolleston House, High Street, Maltby	Mr. and Mrs. G. T. Nutt	Maltby 2118	41
Highfield, Woodsetts Road, North Anston, Nr. Sheffield	Mr. and Mrs. E. B. Stone	Dinnington 2593	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. A. Wild	Barnsley 5529	41
Netherfields, Sheffield and Halifax Road, Penistone ...	Mr. and Mrs. C. Stoney	Penistone 2144	62
Wombwell Grange, Park Street, Wombwell	Mrs. K. M. Smith	Wombwell 218	17*
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
Carlton House, Carlton Street, Cudworth, Nr. Barnsley ...	Mr. and Mrs. J. Lodge	Cudworth 389	34

* Women only

† Men only

‡ County Council have "right of use"

**Table 77 Registration and Inspection of Disabled and Old Persons' Homes—
(National Assistance Act, 1948)**

<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 ...	28	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
Mr. J. N. and Mrs. A. M. Gill, 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 ...	8	I
Mr. A. K. and Mrs. E. J. Sims, "Burnlee House," Park Head, Holmfirth	17	I
Mrs. Minnie Satariano, "Downside," 15, Otley Road, Harrogate ...	15	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
Mrs. 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
Mr. J. Perry, 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
Pentecostal Eventide Home, Aismunderby Close, Quarry Moor Lane, Ripon ...	18	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. J. D. and Mrs. B. L. 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. A. McConney, "Christony," Beech Grove, Sutton in Craven ...	12	I

<i>Establishment</i>	<i>Number of Residents</i>	<i>Type of Home</i> <i>*(Part I, II or III)</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. G. Pickering, "Fairholme," Hebers Ghyll Drive, Ilkley ...	8	I
Mrs. M. Jowett, Valley View Rest Home, 4, Cross Banks, Otley Road, Shipley ...	7	I
Mrs. Doris Jervis, Glenayr Rest Home, 19, Franklin Mount, Harrogate	5	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
Mr. and Mrs. T. H. Horsfall, The Woodlands, Gelderd Road, Gildersome ...	20	I
Mrs. C. Holmes, Hill Crest, 40, Harlow Moor Drive, Harrogate ...	10	I
Mr. W. A. and Mrs. E. V. Hall, Knapping Rise, 53, King's Road, Harrogate ...	11	I
Mrs. E. White and Mr. J. Shilson, Park Lodge Rest Home, 34, Park Avenue, Harrogate ...	12	I
Mr. and Mrs. J. C. Van Der Velde, Waldernheath Hotel for the Elderly, 60, Cornwall Road, Harrogate ...	22	I
Mrs. K. Gregg, Wyndcliffe, Wilton Road, Ilkley ...	9	I
Mrs. N. Cassells, 9, Whitcliffe Crescent, Ripon ...	6	I
Miss A. Watson, 1, Mayfield Villas, Kirklands Road, Baildon ...	4	I
Mrs. E. McCarthy, Carfield, 147, Knaresborough Road, Harrogate ...	6	I
<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.

Table 78 Registration of Nursing Homes

Name and Address of Nursing Home	Number of beds registered	
	Maternity	Other
Brooklands, Long Preston	—	10
Sunnybank, Braithwaite, Keighley	—	9
Norwood House, High Spring Gardens Lane, Keighley	—	10
Elmhurst, Hall Bank Drive, Bingley	—	3
Thornfield, Micklethwaite, Bingley	—	11
Oakbank, Outwood Lane, Horsforth	—	10
Jesmond, New Street, Farsley	—	7
St. Joseph's Convalescent Home, Outwood Lane, Horsforth	—	45
Ardenlea, Queen's Drive, Ilkley (Marie Curie Memorial Foundation)	—	33
Cavendish, 17, Cavendish Avenue, Harrogate	—	16
Duchy House, 9, Queen's Road, Harrogate	5	30
The Pines, 57, Harlow Moor Drive, Harrogate	—	14
Norman Lodge, 58, Kent Road, Harrogate	—	29
Westfield, Killinghall, Harrogate	—	8
Courtfield, 3, St. James' Drive, Harrogate	—	14
Hereford, 16, Hereford Road, Harrogate	—	21
Strathroy, 115, Franklin Road, Harrogate	—	6
Kingsley, 38, Ripon Road, Harrogate	—	17
Ellangowan, 26, Queen's Road, Harrogate	—	14
Clova, 1, Clotherholme Road, Ripon	—	21
Heatherwood, 17, Duchy Road, Harrogate	—	14
Hampden House, 120, Duchy Road, Harrogate	—	46
Cheshire Home, Spofforth Hall, Spofforth, near Harrogate	—	28
Cheshire Home, Kenmore, Whitcliffe Road, Cleckheaton	—	27
White Windows Cheshire Home, Sowerby Bridge	—	35
Woodend, Atherton Street, Springhead	—	13

Table 79 The Medical Inspection of School Children

NUMBER OF PUPILS ON REGISTERS

	<i>Boys</i>	<i>Girls</i>	<i>Total</i>
Nursery	318	298	611
Primary	91,051	86,475	177,526
Secondary	53,677	50,462	104,139
Special Schools (Boarding)	207	114	321
Special Schools (Day)	363	270	633
Special Schools (Hospital)	87	40	127
	145,698	137,659	283,357

TABLE I

MEDICAL INSPECTION OF PUPILS ATTENDING MAINTAINED PRIMARY AND SECONDARY SCHOOLS (INCLUDING SPECIAL SCHOOLS)

A.—Periodic Medical Inspections

Age groups inspected (by year of birth) and number of pupils examined in each, together with classification of the physical condition of the pupils inspected.

Age groups inspected (Year of Birth)	Number of Pupils 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)
1962 and later ...	1 233	1,224	9	—
1961 ...	14 073	14 028	45	—
1960 ...	11,119	11,066	53	—
1959 ...	3,966	3,953	13	585
1958 ...	8,045	8 030	15	1,342
1957 ...	4 587	4 578	9	529
1956 ...	2 116	2,114	2	144
1955 ...	5 355	5,337	18	819
1954 ...	4 270	4,260	10	765
1953 ...	1,798	1,793	5	208
1952 ...	5,807	5,785	22	1,045
1951 and earlier ...	10,753	10,668	85	473
Total ...	73,122	72 836	286	5,910

Column (3) total as a percentage of Column (2) total ... 99·61

Column (4) total as a percentage of Column (2) total... 0·39

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 ...	14,004
Number of Re-Inspections ...	7,033
Total ...	21,037

The number of children examined during 1966 shows a slight decrease on the 1965 figures:—

	<i>Periodics</i>	<i>Other Inspections</i>	<i>Number of pupils found not to warrant an examination on Selective Procedures</i>
1965	75,134	24,336	9,130
1966	73,122	21,037	5,910

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
1962 and later ...	36	117	147
1961 ...	472	1,311	1,774
1960 ...	419	959	1,393
1959 ...	145	334	436
1958 ...	488	797	1,219
1957 ...	260	399	627
1956 ...	123	132	234
1955 ...	283	489	728
1954 ...	218	346	543
1953 ...	111	106	212
1952 ...	289	380	639
1951 and earlier ...	670	636	1,251
Total ...	3,514	6,006	9,203

TABLE II
INFESTATION WITH VERMIN

(i) Total number of individual examinations of pupils in schools by the school nurses or other authorised persons ...	478,017
(ii) Total number of <i>individual</i> pupils found to be infested ...	7,786
(iii) Number of individual pupils in respect of whom cleansing notices were issued (Section 54(2), Education Act, 1944) ...	146
(iv) Number of individual pupils in respect of whom cleansing orders were issued (Section 54(3), Education Act, 1944) ...	35

The percentage of infested pupils found during 1966 was 1.62 as opposed to a percentage of 1.94 in 1965.

TABLE III

DEFECTS FOUND BY MEDICAL INSPECTION IN THE YEAR ENDED 31ST DECEMBER, 1966

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	285	560	302	256	1 012	1,345	577	224
5	Eyes—	946	881	881	1,433	3,452	5,809	641	1,768
	a. Vision	324	482	32	92	512	1,015	77	236
	b. Squint	54	82	39	129	140	378	47	78
	c. Other	235	710	51	131	475	1,430	174	456
6	Ears—	142	566	47	102	293	1,060	50	119
	a. Hearing	55	114	19	34	133	266	37	49
	b. Otitis Media	529	1,885	81	238	892	3,379	176	642
	c. Other	151	704	11	42	239	1,040	153	331
7	Nose and Throat	27	549	3	47	41	836	12	147
8	Speech	62	442	26	147	133	1,001	31	311
9	Lymphatic Glands	147	710	40	162	291	1,398	116	336
10	Heart								
11	Lungs								
12	Developmental—								
	a. Hernia	42	111	3	16	84	230	13	48
	b. Other	55	499	55	78	251	1,050	44	272
13	Orthopaedic—								
	a. Posture	28	75	20	78	84	329	26	86
	b. Feet	200	612	81	203	474	1,452	134	420
	c. Other	82	401	62	198	240	915	79	253
14	Nervous System—								
	a. Epilepsy	34	68	17	35	90	181	44	64
	b. Other	73	298	10	57	142	614	35	121
15	Psychological—								
	a. Development	40	244	8	32	91	564	204	297
	b. Stability	49	523	11	68	120	1,156	167	381
16	Abdomen	27	109	5	25	58	256	20	47

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.

<i>Group 1. Eye Disease, Defective Vision and Squint</i>	Number of cases known to have been dealt with
External and other, excluding errors of refraction and squint	1,103
Errors of refraction (including squint)	18,893
Total	19,996
Number of pupils for whom spectacles were prescribed ...	8,024
<i>Group 2. Diseases and Defects of Ear, Nose and Throat</i>	
Received operative treatment:—	
(a) for diseases of the ear	78
(b) for adenoids and chronic tonsillitis	971
(c) for other nose and throat conditions	64
Received other forms of treatment	218
Total	1,331
Total number of pupils in schools who are known to have been provided with hearing aids:—	
(a) in 1966	38
(b) in previous years	238
<i>Group 3. Orthopædic and Postural Defects</i>	
(a) Pupils treated at clinics or out-patient departments	773
(b) Pupils treated at school for postural defects ...	74
Total	847
<i>Group 4. Diseases of the Skin (excluding uncleanliness for which see Table II)</i>	
Ringworm—(a) Scalp	10
(b) Body	15
Scabies	206
Impetigo	158
Other skin diseases	1,601
Total	1,990

	Number of cases known to have been treated
<i>Group 5. Child Guidance Treatment</i>	
Number of pupils treated at Child Guidance clinics under arrangement made by the Authority	1,288
<i>Group 6. Speech Therapy</i>	
Number of pupils treated by Speech Therapists under arrangements made by the Authority	932
<i>Group 7. Other Treatment Given</i>	
(a) Number of cases of miscellaneous minor ailments treated by the Authority	4,889
(b) Pupils who received convalescent treatment under School Health Service arrangements...	22
(c) Pupils who received B.C.G. vaccination ...	13,881
(d) Other:—	
1. Ultra Violet Light Treatment	86
2. Remedial Exercises	28
3. Audiology	105
4. Abdominal defects	33
5. Cardiac	6
6. Chest and Heart	21
7. Miscellaneous	122
Total (a)—(d)	19,193

Table 80 Care of the Handicapped Pupil

NEW ASCERTAINMENTS AND RE-EXAMINATIONS

The number of new ascertainments and re-examinations undertaken during 1966 was 1,979 compared with 1,936 the previous year. Details are as follows:—

<i>Category</i>	<i>No. of examinations and re-examinations</i>
Educationally subnormal	1,236
Physically handicapped	364
Delicate	125
Deaf	28
Partially hearing	31
Epileptic	36
Speech (requiring special school)	4
Maladjusted (requiring hostel or special school)	73
Blind	21
Partially sighted... ..	40
Double defect	21
Total ...	1,979

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	1	3	—	61	—	—	3	—
Partially Sighted	14	7	24	33	—	—	5	—
Deaf	14	20	48	127	—	—	5	—
Partially Hearing	8	22	44	39	—	—	6	—
Delicate	60	65	18	83	1	1	12	—
*Physically Handicapped	51	50	74	128	—	12	28	35
Educationally Subnormal	236	234	847	308	—	18	297	2
Maladjusted	50	21	1	32	26	7	42	1
Epileptic	11	11	—	27	—	—	2	1
Speech Defects	2	—	1	—	—	—	1	—
Totals	447	433	1,057	838	27	38	401	39

Excluding children sent to or awaiting places in hospital schools.

Table 81 West Riding Special Schools

	<i>Age range (years)</i>	<i>Accommodation</i>
<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, Sedbergh	11—16	64 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
Anchorage School, Sprotbrough	7—16	100 mixed

Table 82 Educable Children Suffering from Cerebral Palsy

The following table gives the details relating to educable cerebral palsied children in the West Riding including children of pre-school age.

Total No. of educable Spastics	No. accom- modated in Special Schools	No. attending Ordinary Schools		No. receiving Home Tuition	No. receiving no Education
		Satisfactorily	Needing placement in Special Schools		
159	93	34	29	2	1

Table 83 Audiology Clinics

SUMMARY OF WORK CARRIED OUT

Doncaster Clinic

<i>Number of Sessions held</i>	24
<i>Number of Individual Children attending</i>	
(a) Referred for first time in current year...	57
(b) Also attended in previous year	38
Total	95
<i>Total number of attendances made</i>	112
<i>Areas from which referred (i.e. number from each Division)</i>	
Division No. 10	1
Division No. 12	5
Division No. 23	5
Division No. 26	3
Division No. 27	37
Division No. 29	3
Division No. 31	3
Total	57
<i>Ages of children referred</i>	
Under 1	—
1—2 years	3
2—5 years	11
5—8 years	17
8—11 years... ..	19
11+ years	7
<i>Results of Clinical Investigation</i>	
Number of children with significant hearing loss	45
Number of children without significant hearing loss	50
<i>Recommendations</i>	
Hearing aid	6
To sit in front of class	6
Speech Therapy	4
School for Deaf	3
School for Partially Hearing	3
School for Speech Defects	—
Referred to Ear, Nose and Throat clinic	13
Loan of Speech Trainer	3

<i>Number of Sessions held</i>	3
<i>Number of Individual Children attending</i>	
(a) Referred for first time in current year... ..	6
(b) Also attended in previous year	4
Total	10
<i>Areas from which referred (i.e. number from each Division)</i>	
Division No. 1	2
Division No. 5	8
Total	10
<i>Ages of children referred</i>	
Under 1	—
1—2 years	1
2—5 years	5
5—8 years	2
8—11 years... ..	—
11+ years	2
<i>Results of Clinical Investigation</i>	
Number of children with significant hearing loss	3
Number of children without significant hearing loss	7
<i>Recommendations</i>	
Hearing aid	—
To sit in front of class	—
Speech Therapy	2
School for Deaf	1
School for Partially Hearing	—
School for Speech Defects	—
For T's and A's	2

Table 84 School Ophthalmic Service, 1952-66

<i>Year</i>	<i>No. of children examined (including re-examinations)</i>	<i>No. prescribed glasses</i>
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
1966	19,996	8,024

Table 85 Medical Treatment at Clinics

Type of Clinic	Number	
	Provided directly by the Authority	Under arrangements with Regional Hospital Boards
Minor Ailment and other non-specialised	86	—
Dental	64	—
Ophthalmic	—	56
Speech Therapy	22	—
Ultra Violet Light	8	—
Pædiatric	13	—
Chiropody	2	—
Consultant E.N.T.	—	17
Consultant Orthopædic	—	12
Consultant Dermatology	—	1
Consultant Cardiac	—	1
Orthoptic	—	4
Remedial Exercises... ..	13	2
Audiology	2	—

Table 86 Consultant Services**CONSULTANT E.N.T. SERVICE**

No. of sessions held during the year 130

	<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 ...	9	349	358
No. of above referred for operative treatment	5	171	176
No. of children:—			
(a) who obtained operative treatment during year	1	174	175
(b) treated at school clinics	—	49	49
No. of attendances at consultant clinics	15	661	676

CONSULTANT ORTHOPÆDIC SERVICE*Consultant Clinic*

No. of sessions held during the year 137

No. of individual patients seen by consultant, including those continuing attendance from previous year ...	381	631	1,012
No. of above—			
(a) referred for operative treatment as short stay cases only ...	6	17	23
(b) recommended long-stay hospital school	—	1	1
(c) recommended treatment by orthopædic nurse or physiotherapist—			
(i) at treatment centres ...	19	51	70
(ii) domiciliary	25	18	43
No. of children who obtained operative treatment during the year	4	15	19
Total number of attendances at consultant clinics	524	905	1,429

Treatment Centres

No. of sessions held during the year 830

Total No. of patients treated, including cases continuing treatment from previous year	63	338	401
Total number of attendances	728	3,488	4,216

<i>Domiciliary Treatment</i>	<i>Pre-school Children</i>	<i>School Children</i>	<i>Total</i>
Total number treated	4	—	4
Total number of visits to patients' homes	18	—	18
<i>Appliances</i>			
No. of appliances—			
(a) recommended	62	95	157
(b) obtained	62	94	156

PHYSIOTHERAPY SERVICE

At the end of the year the staff aggregated the equivalent of 1.66 whole-time officers.

ULTRA-VIOLET LIGHT CLINICS

Clinics are still held in five of the Divisions, but the figures for 1966 show a decrease in the number of sessions and children treated.

Number of sessions held during the year 359

Number of children treated during the year	81	116	197
Total number of attendances	715	1,460	2,175

CONSULTANT PÆDIATRIC SERVICE

Consultant Clinics

No. of sessions held during the year 155

No. of individual patients seen—			
(a) New cases	123	154	277
(b) Cases attending from previous year(s)	190	352	542
Total number of attendances at clinics	460	612	1,072

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 ...	28	29	57
Migraine	5	21	26
Epilepsy	11	48	59
Von Recklinghausen's Disease ...	1	—	1
Heart and Circulatory System ...	53	91	144
Respiratory System, including E.N.T. Defects	34	80	114
Speech	7	14	21
Orthopædic	7	7	14
Cerebral palsy	—	1	1
Skin	—	2	2
Psychological: General	5	14	19
Enuresis	5	—	5

	<i>Pre-school Children</i>	<i>School Children</i>	<i>Total</i>
Mental Retardation, including Educational Subnormality	27	26	53
Congenital Deformities	20	9	29
Gastro-intestinal System: General ...	5	2	7
Genito-urinary System	4	5	9
Glands	1	4	5
Nutritional	13	24	37
Developmental: General	39	24	63
Genetic Undersize	2	—	2
Incontinence	5	30	35
Muscular Disease	—	4	4
Habit Spasms	1	1	2
Rheumatism	—	2	2
Obesity	—	2	2
Prematurity	2	2	4
Exophthalmos	—	1	1
Debility	—	1	1
Unclassified	41	24	65

Table 87 Cleanliness, 1949-66

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
1966	478,017	7,786	2.7

In some areas a system of "Selective" inspections has been introduced as suggested in *The Health of the School Child* 1962/63.

Table 88 Nutrition, 1949-66

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		
1966	73,122	72,836	99.61	286	0.39		

Table 89 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	30,202	28,410	6,431	65,043
Subsequent visits	33,275	66,723	15,890	115,888
Total visits	63,477	95,133	22,321	180,931
Additional courses of treatment commenced	1,493	2,268	585	4,346
Fillings in permanent teeth ...	35,983	87,062	21,892	144,937
Fillings in deciduous teeth ...	17,676	1,292	—	18,968
Permanent teeth filled	27,500	74,424	20,476	122,400
Deciduous teeth filled	15,638	1,160	—	16,798
Permanent teeth extracted ...	2,677	12,274	2,749	17,700
Deciduous teeth extracted ...	48,859	11,599	—	60,458
General anaesthetics	16,249	7,619	835	24,703
Emergencies	2,387	1,221	311	3,919
Number of Pupils X-rayed				3,401
Prophylaxis				19,775
Teeth otherwise conserved				2,315
Number of teeth root filled				266
Inlays				168
Crowns				415
Courses of treatment completed... ..				54,549

Orthodontics

Cases remaining from previous year ...	3,818
New cases commenced during year ...	1,494
Cases completed during year ...	1,264
Cases discontinued during year ...	182
Number of removable appliances fitted... ..	2,833
Number of fixed appliances fitted	224
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	3	10	14
Pupils supplied with other dentures (first time)	25	263	178	466
Number of dentures supplied	38	419	299	756

<i>Anæsthetics</i> General Anæsthetics administered by Dental Officers ...	24,272
--	--------

Inspections

(a) First inspection at school. Number of Pupils	166,609
(b) First inspection at clinic. Number of Pupils	13,975
Number of (a) + (b) found to require treatment	110,766
Number of (a) + (b) offered treatment	97,907
(c) Pupils re-inspected at school clinic	18,868
Number of (c) found to require treatment	10,787

Sessions

Sessions devoted to treatment	25,394*
Sessions devoted to inspection	1,394
Sessions devoted to Dental Health Education	474

*Includes 1,609 Anæsthetist sessions