[Report 1970] / Medical Officer of Health and School Medical Officer of Health, West Riding of Yorkshire County Council.

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COUNTY COUNCIL OF THE WEST RIDING OF YORKSHIRE

ANNUAL REPORTS

of the

COUNTY MEDICAL OFFICER

and the

PRINCIPAL SCHOOL MEDICAL OFFICER

for the Year

1970

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INTRODUCTION

CURRENT TRENDS IN COMMUNITY MEDICINE ARE USEFUL GUIDES TO THE FUTURE WORK OF THE COMMUNITY PHYSICIAN

In my last Annual Report I attempted to interpret to the Committee my thoughts on current views concerning the health services; this needed much by way of assumption and inspired guesswork. Although more still needs to be done by way of clarification, some positive information has recently been given to us so that we now have a rough indication of the future pattern within which we shall be working. Members, of course, are aware of the discussions currently proceeding on the new Local Government White Paper and on the Consultative Document for the health services and they have also experienced the immediate repercussions of the transfer of some services from the health department to the social services and education departments.

It was against this background of uncertainty and the possible gaps which may be left between services with mutual problems that the concept of the community physician was brought into focus, and I attempted last year to outline the duties of such a person as I saw them. Now that the future is a little clearer, I have tried, in writing this Report, to translate the concept of the community physician into more practical terms, largely by way of illustration and by specific essays written by members of the health department staff and reproduced as special reviews.

It is quite interesting to note how, only a short time ago, the term 'community physician' was a little strange in its use and some were not quite clear as to its precise meaning. The term, however, seems now to have been absorbed naturally into day-to-day writing and conversation.

There is still uncertainty in the minds of some writers as to the relationship between medical administration and the work of the community physician. One hopes it will become clearer in the course of time. For my own part, I look upon medical administration as being a natural corollary to the training to be given in community medicine, using 'community' in its widest sense. That training in this new sphere of activities is essential has been made quite clear in the interim report of the Hunter Working Party which recommends urgent training in these duties for existing staffs. Presumably vocational training, as with other medical disciplines, will be the ultimate aim.

It becomes quite obvious, when one looks at the practical applications of community medicine, that administration and 'clinical' work, as applied to communities, are inseparable. This latter must be distinguished from clinical work as applied to individuals. Perhaps the former could come under the broad umbrella of epidemiology. It is in the acceptance of this distinction that some confusion has arisen.

This Report, therefore, has been designed essentially to illustrate from the current events of one year only what is likely to be the future pattern of the work of the community physician and medical administrator. Others could readily add to the examples given.

Reorganisation of Certain Services

Two of the essays deal at length, first, with the build up of the mental health services over the last 12 years and the position which they had reached on the recent transfer to the social services department and the education department, and, second, with the detailed working party deliberations concerning the junior training centres and their transfer to education.

The importance of getting the working relationships right as between the two departments now responsible for this work and with the health department has been illustrated in the very valuable report from the Scottish Home and Health Department of a Consultative Sub-Committee of Medical Officers of Health. In Scotland, they have had some two years' experience of the separation of social and health services and their experience, as set out in this Report, is most valuable. In general, this Report has been agreed by the Social Work Services Group of the Department.

The Report sets out the interest and value of the work of the medical officer of health in the spheres of maternal health, the health of the pre-school child, the health of the school child, in mental health, in the care of the elderly and rehabilitation. If we can use the time between now and the appointed day of the 1st April, 1974, when the responsibility for local health and social services will be separated, to build up experience in this difficult field, much will have been gained. To this end, it has been decided to set up Standing Co-operation Groups between the West Riding health and the social services departments to consider the mutual problems and recommend solutions. I have no doubt that these Co-operation Groups will be extremely busy in the early stages and will have a continuing influence. On the health side, it is intended that all the principal medical officers will be involved together with some other senior members of the department as required.

Social services, of course, are only one of the new local authority's responsibilities which will need to have an active and productive working relationship with the new health authority. This has been recognised centrally and, in accordance with the Government's Consultative Document, a Steering Committee and Working Parties at national level are due to embark on detailed studies. The outcome of these deliberations is of vital importance to the future community physician.

The two essays referred to illustrate the different role of the community physician as between the education department and the social services department. In the former, he has a statutory role as school medical officer and

consequently a considerable influence in executive matters. It is to be hoped that this strong link will not be weakened in the future.

As far as the social services department is concerned, however, he is more in the role of an adviser and, in consequence, in a more difficult position, although the Scottish Report already referred to and a recent communication from the Department have both emphasised the necessity for building close links.

The Public Health Inspector

Environmental health is likely, according to the Local Government White Paper, to be divided between the new counties and the districts and the respective two tiers of local government in the metropolitan areas. This decision is causing some concern to public health inspectors and they seem to be divided in their attitude towards it with a bias perhaps towards all environmental matters being dealt with at district level. The difficulties likely to arise are accentuated by the intended administrative separation of the successor to the medical officer of health from his traditional association with the public health inspector. Whatever views and emotions may be engendered from the purely professional point of view, one cannot escape the fact that some of these environmental matters, particularly those involved with infectious disease, can only be handled by persons with medical qualifications. There are others where medical advice is required and, of course, there are others where the medical role is minimal.

Nevertheless, changes in administration will not alter the needs of the community nor the necessity to continue promoting good environmental circumstances. Added to this, we have the increasing realisation in recent years that some aspects of environmental pollution can only be tackled as a large scale operation. This has been recognised by the setting up of a permanent Royal Commission on Environmental Pollution and its first Report, recently issued, illustrates the need for a broad outlook.

The Central Steering Committee on Collaboration between Health and Local Authorities have here a very great task to perform if they are to weld together these many aspects of the one problem. I hope that public health inspectors will not look at this too narrowly, as they appear to be doing at the moment. Links between health and local government will be needed at all levels of environmental endeavour if something more than just parochial success is to be achieved.

The West Riding County Council, in pursuance of its policy of training public health inspectors, has just received back into its service the first of its successful students, having obtained a B.Sc. honours degree in Environmental Health at the University of Aston in Birmingham. This measure was adopted as one of help by the County Council to the districts to assist in recruitment. It will be interesting to see how such graduates are accepted into the public health inspectors' service.

Public Health and the 'Pop' Festival

This essay by Dr. Brock is an excellent illustration of the need for a large number of different disciplines and services to work together in order to tackle a single environmental problem. True, this was a small and local matter but it showed the tremendous effort which was necessary to prevent a serious situation. Larger problems of a similar kind, as indicated in the previous paragraph and which may eventually be thrown up by the Royal Commission, will equally need the co-ordination of many people's activities far beyond the resources of the district.

The Nursing Services

I have reproduced an essay by Miss Atkinson on the changing patterns of nursing care. Certainly the public health nurses, in common with their sisters in hospital, are undergoing radical administrative changes. Miss Atkinson shows the effect of the new G.N.C. syllabus and of the Mayston Report and of the Peel Report on nursing staff and gives some comments on the work being undertaken by the Briggs Committee, which will pronounce on training and the deployment of nursing staff in the service as a whole. These matters are of vital importance to public health nurses with their current preoccupation in creating working links with hospitals and general practitioners. On the general practitioner side, this, of course, has largely been achieved with the rapid growth in recent years of attachment schemes, and I am grateful to Dr. McDonagh, Medical Officer of Health of Keighley, which is a delegated authority, for giving me permission to reproduce the article which he wrote recently for the *Yorkshire Faculty Journal of the Royal College of General Practitioners*. This in itself illustrates a considerable degree of co-operation, but the importance of Dr. McDonagh's article is to show how, in the space of 10 years when he first started his scheme of attachment in 1961, the value of what was done then has now been fully accepted, appreciated, and largely acted upon by all concerned.

Latterly, however, there has also been considerable increased liaison activities with the hospitals. We have, of course, for many years had a considerable number of our health visitors acting as liaison between certain hospital departments and the health department, and recently their activities have been expanded into another field—namely that of the care of spina bifida cases. Nearly all our health visitors have now had the benefit of instruction from hospital consultants at in-service training courses at Grantley Hall in the care of the spina bifida child so that they can give full family support in accordance with new developments. Twelve of these health visitors, spread throughout the County, have received much deeper instruction in this field. In this way, the value of the total service to the patient is spread by developing a team effort including the hospital, health visitor and consequently the general practitioner by means of her attachment to him.

This liaison with hospitals has now spread more widely to involve the district nurses and, since they have traditionally had such close liaison with the general practitioner as well, this once again is a help in the sum total of patient care.

Recent developments in this connection have been, first, in the care of paraplegics. Whenever a case is to be discharged into the West Riding Administrative Area from the Paraplegic Unit at Pinderfields Hospital, the district nurse first concerned goes to the hospital and receives the necessary instruction in the care of such patients. This is similarly being developed with domiciliary renal dialysis cases.

Another sphere in which district nurses are becoming involved is the field of domiciliary psychiatry. When the mental health service was part of the health department, some of the mental welfare officers, who were trained mental nurses, were able to assist in giving drug therapy at home. This has now ceased and district nurses are receiving the necessary instruction in order to continue with this work. The alternative of sending nurses out from hospital for this purpose is, in my view, quite wrong as it would completely cut across the general practitioner's interest in his home care of the patient.

In one of our new district general hospitals, district nurses are attending certain sessions so that they may know how to deal with cases of early discharge from the surgical departments.

Midwifery has not escaped the changes. Ironically enough, although delivery has become increasingly a hospital function, the remaining domiciliary problems have become considerable in some areas, and one has to watch carefully the developing problems which may be very local indeed. For instance, in one part of the County, midwifery staff have been reduced in number in recent years, because of the increase in hospital confinements, only to find that—because of movement of population and an influx of young married people—local birth rates have soared rapidly causing embarrassment because of the lack of midwives, both in hospital and in the community. This has led to our having to experiment quickly with the introduction of radio communication between the midwives and headquarters to make sure of efficient and full use of the midwifery staff. This should be a useful exercise for the future as undoubtedly, even under the new health service and if confinement work does become completely hospital controlled, problems in the domiciliary field will still arise and radio communication may be the only answer.

I see these developments as a logical outcome of the concept of total health care with the object of cutting across any boundaries which may be dividing health departments, hospitals, and general practitioners. By these methods, district nurses, health visitors and midwives can be of much greater value to the total general practice team effort.

Developmental Assessment

I consider that developmental assessment, as described in one of the essays, as being of great importance for the future development of preventive medicine and the part to be played by community physicians. The article shows how the subject has a bearing on all three branches of the medical service and also on the social services department, particularly in regard to the medical work needed in connection with adoption.

A Departmental Committee of the Home Office, in a Working Paper, have recommended that the adoption medical examinations be carried out by those who have special experience in developmental assessment. The interest, however, is wider than this and we have developed a scheme, agreed to by the Local Medical Committee, which we hope will eventually create a computer-based record of all handicapped children and which will facilitate their automatic follow-up at intervals and provide, in due course, useful information for the social services department. The scheme has grown out of our disappointment with our original efforts to create an 'at risk' register, because the register became completely choked as so many unnecessary cases were included. Our scheme involves an initial survey by health visitors and at specific intervals thereafter. Suspicious cases are referred to a medical officer for more detailed assessment. The health visitors and medical officers have received, respectively, considerable instruction in this interesting and useful field of activities. Their findings, where positive, are entered on to the computer and the register thus builds up. This is added to from other sources, such as routine testing for hearing and visual acuity, and from other relevant sources.

Such work, initiated by nursing staff, naturally becomes involved with group practice and assists the general practitioner to keep close touch with handicapped children. This is one of the spheres in which medical members of the future community physician's department may become closely associated with, or even attached to, general practice.

Prevention of Disease and Presymptomatic Screening

If the concept of preventive medicine has any validity at all, it surely means that screening is part of its total effort. Indeed, it has always been so since the school health service and the child welfare services were set up, and it has been extended in recent years into the fields of mass miniature radiography, congenital hip dislocation tests, and tests for phenylketonuria, amongst many others. However, when screening was expanded on a large scale in certain parts of the country, it met with quite serious resistance professionally, although the general public did not seem to object. The resistance seemed to be based on cost and effort required to carry out such massive screening programmes as well as the fact that a lot of the work was based on allegedly-unsubstantiated theories and the charge was levelled that empiricism was being indulged in. If we allow for the fact that even the most detailed scientific experimentation sometimes has to rely on empiricism, as was clearly described in J. D. Watson's well-known account of the discovery of the molecular structure of deoxyribonucleic acid for instance, it is obvious that some compromise must be reached.

Dr. Leyshon, in writing of the West Riding experience with our own less-erudite problems with screening, has described some pilot schemes which appear to have had a degree of success, and, although some mention is made of the difficulties in expanding this work because of the shortage of staff, this is not considered a vital issue considering the results obtained.

This is a subject which obviously needs further pilot studies and experience but should eventually, when adequately rationalised, become a profitable field of activities for the community physician to engage in in the new health service.

Mental Health

There has recently been considerable concern as to the future of the care of the mentally ill and mentally handicapped, the problem revolving around the relative values and desirability of community as against hospital care. This has been stimulated by some recent criticism of the hospital service (and of the community service too), culminating in the setting up of the Hospital Advisory Service which has now issued some preliminary reports. Lest the pendulum should swing too far too quickly, it is as well to be sure that community care can offer all that is at the present time expected of it. Quite apart from its inability to accept at once all the hospital service would like to give to it, we must be sure that the right type of case is accommodated in the community and the right type of service is available.

The essay by Dr. Jeremiah and Mr. Battye on community and hospital care of the mentally disordered, reproduced as a special review, is of considerable interest in this direction, and, although admittedly only describing an investigation into cases in a few hospitals, it makes the point that we must be sure that the patient will be better off in the community before he is discharged from hospital.

I would refer also to another essay by the same authors, dealing with a development in community care for the mentally ill which has been successful in one division in the County. This scheme involves a progressive system of care from hospital to hostel and then to lodgings with the support of an industrial centre in the background (see photograph), all provided by the authority.

Similar sorts of arrangements have been carried out in other parts of the County in connection with the mentally subnormal using hospitals, training centre, and lodgings. In both cases, the final objective is complete discharge into the community if this is at all practicable.

It was intended that these successful schemes would be duplicated in due course throughout the County and I hope that this will, in fact, come about under the new system. The subject matter of both of these essays on mental health is, obviously, a sphere in which medical advice is essential.

Family Planning

In this Report is reproduced the West Riding plan for expanding its family planning service. The subject is becoming increasingly recognised as of vital importance to the future happiness of the individual and the nation and for the preservation of good family life. It is, however, not a subject which can be dealt with in isolation by the authority; the hospital and general practitioner as well as our own services must all work together.

I am pleased to be able to say that this has been recognised by the Leeds Regional Hospital Board, who took initiative in setting up a small Working Party representing all interests to look at the problem as a whole, and recommendations are likely to be put forward that the Maternity Liaison Committees be used to further the promotion of family planning, both in hospitals and in the community.

A fairly similar plan has been accepted in the Sheffield Regional Hospital Board area.

Co-operation Amongst Ambulance, Hospital and General Practitioner Services

This is a very big field of activities, described in full by Dr. Leyshon in his essay, and illustrates quite clearly how all three branches of the service are closely involved not only in creating an efficient service but also in assisting in reducing unnecessary demand. Where the measures described by Dr. Leyshon have been put into operation over the years, a decided success has been achieved against the general trend elsewhere in the County of expansion in demand. Obviously, these matters have gone now beyond the experimental stage and must be universally adopted. Hospitals, being the greatest users of the ambulance service, must—and, indeed, do—co-operate. Experiments in liaison with general practitioners, particularly in road accident schemes, are very much in the trial-and-error stage and are still somewhat controversial as to their validity. However, this is a field which needs to be further explored and I shall await the experiments being carried out in the Harrogate area with interest.

Bibliography

In Appendix D to this Report is a list of publications by members of the West Riding health department over a ten-year period. This has been purposely produced for this Report as well as for reference purposes. If this exercise were carried out by other authorities, the participants might well be as surprised, as I was, to see the volume and scope of subjects which are of interest to preventive medicine as a whole. They cover an extremely wide field.

In accordance with the general theme of this Annual Report, the bibliography has been included to illustrate part of the wide field in which the future community physician will work. Surely there can be no doubt in anyone's mind that much would be lost if interest in such a wide range of problems of preventive medicine and medical administration were not undertaken!

Illustrations

Apart from the photograph of the Mirfield Industrial Centre for the mentally ill, the rest of the photographs are meant to illustrate three rapidly-developing areas of interest.

First, we have the illustration of the Brighouse Training Centre. This centre, which was kindly opened on the 6th November, 1970, by the Secretary of State, Sir Keith Joseph, is a culmination of 10 years of development of buildings for

this type of work and is a far cry from the original centres which were being run prior to the Mental Health Act of 1959. The development in this field has been quite phenomenal.

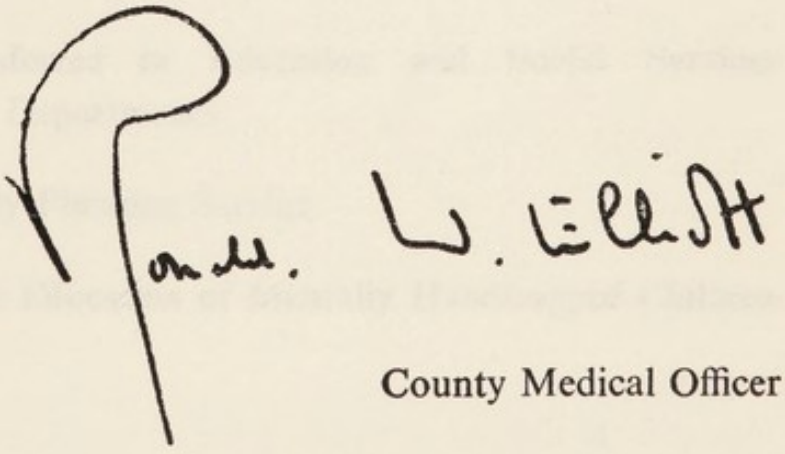
Second, we have the various illustrations and plans of health centres. The Castleford Health Centre represents, at the time of writing, our biggest centre so far and is also the culmination of a considerable amount of development which is still going on. Likewise, the plans of the revised mini clinic and new 'F' type clinic illustrate the fact that our experience of health centres is continuing to accumulate, making it necessary constantly to revise our plans to meet problems as they arise and to relieve the continuing pressure for further accommodation.

The development of health centres has been very rapid indeed and represents an activity which could be the pivot from which future community care will develop.

There have been further developments in the promotion of renal dialysis, which again has expanded recently. It has become necessary, because of the poor home conditions of some of the patients, to evolve portable units and these are illustrated in the photographs.

Conclusion

The developing activities of health departments even as currently constituted, and which I have tried to demonstrate briefly in this Report, should give some indication of the importance of the development of methods for working partnerships in the future. Unless this is done and it is made the responsibility of someone to do it, clinical medicine and the patient will suffer greatly. Such are the challenges facing the community physician.



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County Medical Officer

August, 1971.

SPECIAL REVIEWS

Developmental Assessments

Prevention of Disease and Presymptomatic Screening

Changing Patterns of Nursing Care

Organisation and Management: An Attachment Scheme in a Small Community

Co-operation Amongst Ambulance/Hospital/G.P. Services

Public Health and the 'Pop' Festival

Community and Hospital Care for the Mentally Disordered

Lee Grange Hostel for Post Psychotic Patients, Fountain Street, Morley and Mirfield Day Industrial Centre for the Mentally Ill

Mental Health Services Transferred to Education and Social Services Departments

Family Planning Service

Transfer of Responsibility for the Education of Mentally Handicapped Children

DEVELOPMENTAL ASSESSMENTS

C. Simpson Smith, Denise E. Robertshaw, G. E. Leyshon, Principal Medical Officers

H. W. S. Francis, Deputy County Medical Officer

During the latter half of 1970, a scheme for the screening and assessment of the developmental progress of all children born in the West Riding County Council's area was introduced.

The normal development of a child includes the growth and maturation of the physical, mental, emotional and social factors which contribute to the total make-up of a child.

The rate of growth and maturation varies at different times in a child's life and varies independently for each of the factors named.

Routine examination of a child at regular intervals ensures that it is progressing within the accepted range of normality for each of the factors at any given time. This type of routine examination of all children was a natural progression from the 'at risk' registers which have been used in the past.

A child thought to be 'at risk' is any child who, because of family history, illness of the mother during her pregnancy, birth difficulties including prematurity, dysmaturity (a baby who is born at 40 weeks but is smaller than 5½ lb.) and postmaturity, or because of illness or other factors occurring after its birth, is more prone to retardation of development or physical defect than a normal child.

The concept of an 'at risk' register was first introduced by R. L. Lindow in 1961, but received more publicity following Mary Sheridan's report in 1962.

Sheridan pointed out that some conditions would be obvious at birth, some would have to be sought for, e.g. hearing loss, and some would only become recognisable through careful follow-up of the child's development over months or years. She stressed the problems involved in routinely examining all infants and argued in favour of a register of children 'at risk' and listed various main headings.

In support, she quoted particularly the hearing-impaired child and stated that deafness is found 14 times more frequently in the 'at risk' categories than in the general population. This figure was based on Howarth's report on screening for deafness in Lancashire in 1956/57. The statement was incorrect. It was claimed that six cases of deafness were found in the 'vulnerable group' from 662 children screened from 1st April, 1957, to 12th December, 1957, whilst in the same period two cases were found in 3,065 children amongst the general population: a respective incidence of 9·06 per 1,000 children in the vulnerable

group and 0·65 per 1,000 in the general population. The vulnerable group had been excluded from the general group in this survey. If the combined figures are considered, i.e. the infant population as a whole, the incidence would have been 2·15 per 1,000 not 0·65 per 1,000.

In further studies in Lancashire reported in 1962, from 1st April, 1957, to 31st December, 1962, a figure of 3·8 per 1,000 was found in the general population including the vulnerable group, and 6·2 per 1,000 in the vulnerable group, i.e. less than twice that of the general population. Whetnall and Fry (1964) found that, in 1,103 cases of congenital deafness studied at Gray's Inn Road, only 601 children could have been considered to have been 'at risk' (55 per cent.) supporting the need for routine screening for certain defects such as hearing loss rather than only those 'at risk'.

Sheridan's paper, however, led to various schemes being set up throughout the country. Amongst the pioneers was the County Borough of Reading, and M. G. H. Rogers (1968) wrote an admirable paper quoting many views concerning risk registers before discussing results in Reading. In a previous paper in 1967, Rogers stressed that many cases of handicap occurred in unselected children who had not been considered to be 'at risk' despite the fact that 22 categories had been included up to the end of 1963, leading to 43 per cent. of infants being placed on the register. Only 49 per cent. of children with relevant handicaps from 1959 to 1964 followed-up to school age had been considered to be 'at risk'; these were specified handicaps including hearing and visual defects, cerebral palsy and mental retardation. A comparison of those diagnosed within a year of birth showed that far more came from the children not considered to be 'at risk'.

In the West Riding 'at risk' registers were begun in December, 1962, in one division and extended to four pilot areas by January, 1964. In May, 1964, the situation was evaluated. It was found that up to 40 per cent. of children were being placed on the register and up to 9 per cent. of the total considered to be 'at risk' later showed any defects and only a small proportion showed a handicapping defect. It was, therefore, agreed to stop the 'at risk' register for the following main reasons:

(a) The 'at risk' categories were too wide and non-specific.

(b) The register was never entirely reliable and complete.

(c) The register contained too many names to make full follow-up possible of each child and those not on the register were also being neglected somewhat.

It was agreed that early diagnosis of hearing loss and other handicaps should be based on total screening of infants by health visitors and doctors trained in the techniques of assessment.

At the time when this decision was made, much of the present literature had not been published but has subsequently confirmed the decision taken. Richards and Roberts (1967) expressed their views very forcibly:

> "The widespread adoption of the idea of an 'at risk' register for the detection of handicapping diseases in infancy has led to a situation in which an undefined population is being screened for undefined conditions by people who, for the most part, are untrained to detect the conditions for which they are looking. The 'at risk' concept is an unsound basis for the detection of handicapping disorders; there is no alternative to the clinical examination of all infants in the neonatal period, their screening for metabolic and auditory defects at the appropriate ages, and the careful observation of every infant's developmental progress by doctors supported by health visitors."

Sheridan herself (1967) wrote in the *British Medical Journal* correspondence columns re-appraising the 'at risk' situation and commented, "The need for maintaining risk registers would largely disappear if all doctors working with children, sick or well, were alert to the earliest signs of deviation from normal physical, mental, or personality development."

Following the decision to cease keeping an 'at risk' register in 1964, various methods of observation and examination of handicapped and normal pre-school children were used throughout the County area. All divisions held regular infant welfare clinics where children were seen by the health visitor for advice and weighing, and immunisations and vaccinations were done by a local health authority doctor who also carried out special examinations at the request of the parent or health visitor. Some areas had a system of birthday examinations where all children attending the clinic were examined on each birthday by the local health authority doctor. Some areas held toddler clinics where 2-5 year olds were seen at regular intervals; these were mainly devoted to children who were not progressing normally or who presented problems to their parents.

In some cases, apart from the routine infant welfare clinic, other children were seen by special appointment by the local health authority doctor and, again, these were mainly children who were known to have some form of handicap or who were seen at the request of the parent or health visitor.

In some cases, a form of 'at risk' register was kept and the children on this register were seen at regular intervals.

From 1956, health visitors were being trained to carry out routine screening tests for hearing defect, based on Professor Ewing's tests. In 1966, it was decided that, as far as possible, all children of 7-8 months should have their hearing tested.

With the increasing interest in developmental pædiatrics, several medical officers became dissatisfied with the above schemes for the following reasons:

(1) In many cases, only children visiting the clinic had any regular oversight of their developmental progress.

(2) Even where the mother regularly attended a clinic, attendances ceased at 18 months-2 years unless she was worried about the child. Therefore, in many areas, 2-5 year olds were never seen by a doctor. With the increasing work load of health visitors, the number of home visits to this group was also decreasing. It was felt that many defects were missed until the child had a medical examination on entrance to school, e.g. hearing defect, visual defect.

(3) The ascertainment of subnormal children was very inaccurate if they could not be assessed by Stanford Binet Test and recommendations for placement in training centres were often based on approximate estimations as to level of attainment without any reference to specific tests.

This feeling of dissatisfaction resulted in experimental studies being undertaken in different divisions on ways and means of carrying out developmental assessments. In some cases, full ascertainment was restricted to handicapped children and, in other areas, an attempt was made to include all children.

The members of staff who carried out the assessments varied where normal children were concerned; sometimes the medical officers did the assessment but, in two or three instances, routine screening tests were carried out by health visitors who referred any doubtful cases to the medical officer. All handicapped children were seen by a doctor.

Each office produced its own record form which was based on the work of different authors, e.g. Mary Sheridan, Professor R. S. Illingworth, A. Gesell, etc.

In 1969, Dr. C. Simpson Smith produced a series of charts and tables for the developmental assessment of pre-school children, together with an experimental series of examination sheets for various ages, based on the work of Dr. Mary Sheridan, Sir Alan Moncrieff and Professor R. S. Illingworth. These were used by several members of the medical staff in various parts of the County.

In the autumn of 1969, Dr. R. W. Elliott, County Medical Officer, suggested that it was time to assess the work which had been carried out throughout the County on developmental assessments and to decide the future policy of the department.

A Working Party was set up with the following terms of reference:

"To see how the County Health Department can readily bring pædiatric assessment work into operation in the fields of the departmental medical officers and of health visitors."

The members of the Working Party were:

Dr. D. E. Robertshaw (Chairman), Dr. C. Simpson Smith, Dr. M. Hunter, Dr. W. D. Dolton, Dr. G. Ireland, Dr. R. Stalker and Miss M. G. Atkinson. Mr. D. G. Pickles, Psychologist, was co-opted on to the Working Party for the discussions of the details of the developmental tests to be used.

All members agreed that there was a necessity for routine assessment of developmental progress in children aged 0-5 years. This need would continue in the future, even when assessment centres were present in all district hospitals. It was envisaged that these centres would carry out detailed assessment of handicapped children but that routine screening was necessary to pick up minimal handicaps which could affect the mental, social and educational development of the child at home and in school. Educational assessment centres would also play a part in the future as places where a child could be observed for a varying period of time, until a decision was reached as to the type of education best suited to his needs. The three types of assessment would be—(a) routine screening; (b) hospital-based assessment centres; and (c) educational assessment centres. These would be complementary to each other.

It seemed practical for the routine screening to be carried out by health visitors as, at the time, they covered many of the points of developmental progress of the child during their routine home visits. The need was for a record to be made of these points that was easily understandable by whoever should read it. This record could be completed by the health visitor following screening tests at definite times in the child's life. The place for testing the child would be decided by the health visitor. Any deviation from normal would be referred for a more detailed assessment by the departmental medical officer or by the family doctor if he expressed a wish to do so.

It was decided that the timing of the health visitors' tests should be related to those suggested in *Clinics in Developmental Medicine 30—Developmental Screening 0-5 years*, D. F. Egan, R. S. Illingworth, R. C. McKeith, London: Spastics International Medicine Publications in Association with William Heinemann Medical Books, Ltd., viz. ages (1) 3 months, (2) 6 months, (3) 10 months, (4) 18 months, (5) 3 years , and (6) 4-4½ years.

Where practical, the last test could be replaced by a pre-school medical examination. It was included so that, in areas where pre-school medicals were difficult, a child with any type of handicap would have been discovered and any necessary investigations carried out before he started school.

It was felt that the screening tests carried out by the health visitors should be as simple as possible.

Two record cards were devised:

1. Health visitor screening tests of development;
2. Medical officer's record card—assessment of development 0-5 years.

The health visitor's screening tests consisted of between 5-9 items for each of the pre-arranged age groups. Any child who failed 50 per cent. of the screening tests appropriate for its age should be referred to the Divisional Medical Officer for a detailed assessment.

In view of their importance the screening test for congenital dislocation of the hip carried out by the midwife and health visitor when they see the baby for the first time and the routine tests for hearing defects by the health visitor of children between 7 to 10 months of age would continue to be performed. Failure of either of these tests should result in immediate referral of the child.

An important facet of development was the presence of normal vision and it was decided that the 3-year tests should include vision testing using the 'Stycar' vision test. Routine testing for the presence of a squint was included in the tests at 10 months, 18 months and 3 years.

The medical officer's record card was more extensive than the health visitor's and had tests for the level of development attained at 4 weeks, 3 months, 6 months, 9 months, 12 months, 18 months, 2 years, 3 years, and 4 years, together with space for extra notes or for examinations at other times.

The purpose of this card was to have a standardised basis of assessment throughout the County, whilst leaving it to the medical officer's own discretion as to the extra tests needed for any individual child. In order to maintain a high standard of assessment, the Working Party considered that, wherever possible, developmental assessments should be undertaken by doctors who were qualified for the ascertainment of educationally subnormal children and have had a course of in-service training on developmental assessments.

It was realised that, even with routine screening procedures, some children might not be seen due to illness, lack of co-operation on the part of the parents, etc. In order to try to ensure that every child was progressing normally, it was suggested that, at the age of 18 months, any child who had not been seen by the health visitor at that age or if the health visitor was doubtful of any of the results of her testing, should be brought to the attention of the Divisional Medical Officer. Eighteen months of age was considered to be the most suitable age for a general review as, by this time, a child should show delay in development due to any congenital cause, including cerebral palsy (which might not be apparent before 12 months of age), and it allowed time for more detailed assessments before the necessity of special education was considered, i.e. at the age of 2 years. In addition, it was decided that:

(a) Any child on the handicap/disability register should be reviewed routinely.

(b) Assessment of a child on the observation register would be required at 18 months to decide whether it should be placed on the handicap/disability register.

Following the Working Party's report to the Divisional Medical Officers' Conference in July, 1970, it was agreed that from September, 1970, routine developmental screening would be started as soon as possible in all the divisions of the County following a discussion session with the health visitors on the application of the various tests involved.

For several years past, the health visitors have been trained in the screening of hearing of infants by Sir Alexander and Lady Ewing, the scheme starting in 1956.

Departmental medical officers have been seconded for courses at the Department of Audiology and Education of the Deaf, University of Manchester, in hearing assessment and the problems of the hearing-impaired child—both introductory courses and a more advanced week-end course organised jointly with the Society of Medical Officers of Health.

From October, 1963, onwards a regular study day has been held each term for all clinical medical officers and many aspects of child development have been covered by guest consultant speakers.

Once the decision had been reached in 1964 to embark on a scheme of developmental assessments for all children, consideration had to be given to further training of both medical and nursing staff. No course of this type was available locally and, with a large proportion of medical officers being married women with domestic commitments, it was not considered practicable to second staff to residential courses in London—apart from the expense involved and the need to train as many staff as possible.

It was, therefore, decided to undertake 'in-service' training on a one-day-per-week basis at the conference room of the County Health Department. The first course in 1967-68 was a long course from October to July and was devised to equip selected members of the staff for the role of senior clinical medical officers in various areas.

The subject matter covered a wider area than developmental pædiatrics and handicapped children, but these subjects took up a large proportion of the syllabus. In 1969, a shorter course was arranged for new recruits to the service, part-time staff and interested family doctors in sessional employment. In 1970, a further group of the staff attended a course devoted to developmental assessments. Lecturers included consultant pædiatricians, psychiatrists, psychologists and members of the headquarters staff.

In addition, the nursing staff receive periodic refresher courses on hearing assessment and all are being trained in techniques for the early detection of visual handicaps including the 'cover' test for squints and the 'Stycar' vision tests.

The Role of the Computer in Aiding Developmental Assessments:

It had been envisaged from the outset of the vaccination and immunisation computer scheme that the system would be extended to record on the computer all children with potentially handicapping disabilities.

The first use made of the computer for developmental assessments was with the routine screening of infants at 7-10 months for hearing loss.

Lists of children due for testing and appointment cards for the parents are produced: the result of the test is recorded. Children who have failed to attend, or who have failed the test, are followed up and retested if necessary at 18 months and yearly to 4½ years if desired.

The production of a handicap/disability register posed difficulty because of the recording of diagnosis of the handicap; the International Classification of Disease was inadequate for the recording of handicap as distinct from the recording of death, so that an ad hoc classification had to be devised; even the recent diagnostic index produced by the British Pædiatric Association has not simplified the task of coding handicap on the computer.

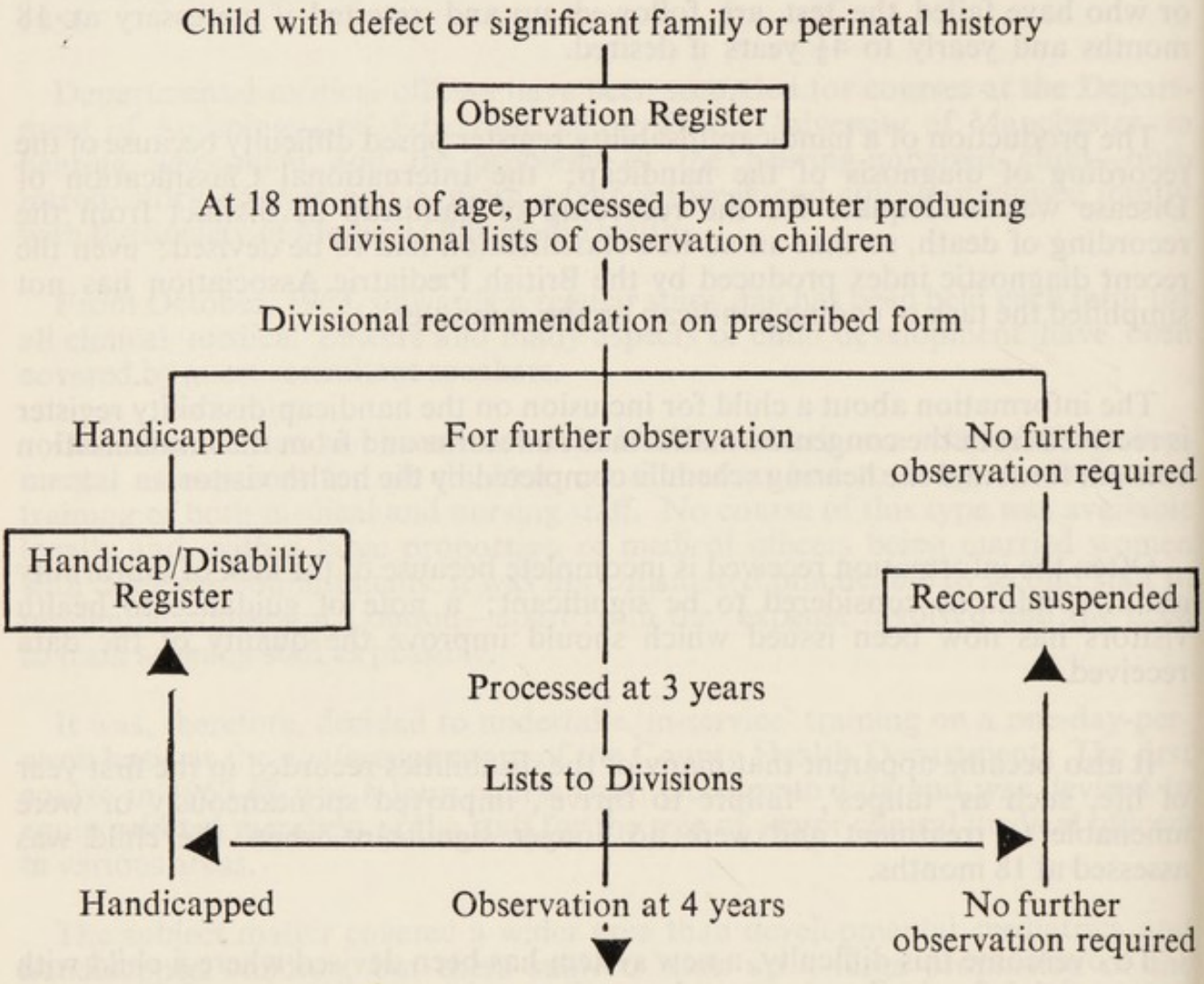
The information about a child for inclusion on the handicap/disability register is received from the congenital malformation returns and from the immunisation consent form and the hearing schedule completed by the health visitor.

Often the information received is incomplete because of the lack of uniformity about conditions considered to be significant; a note of guidance to health visitors has now been issued which should improve the quality of the data received.

It also became apparent that many of the disabilities recorded in the first year of life, such as 'talipes', 'failure to thrive', improved spontaneously or were amenable to treatment and were no longer significant when the child was assessed at 18 months.

To overcome this difficulty, a new system has been devised where a child with a potential defect is placed on an observation register until the age of 18 months. At 18 months, the computer will process this register and issue the relevant details of each child requiring review on a prescribed form which, when completed by the examiner, is returned for updating the computer. This form will carry one of three recommendations; that the child be regarded as handicapped or disabled, in which case a Form 2HP or 4HP will be completed and the child transferred to the handicap/disability register; or the child may no longer suffer from any condition and his name will be removed from the observation register; and finally there will be some children, for whom it may be prudent to defer a decision and these children will remain on the observation register.

This is summarised below:



The children on the handicap/disability register can be followed up at intervals recommended by the examining medical officer.

The purpose of the handicap/disability register will be four-fold:

(a) To ensure that, as far as possible, the ascertainment of handicap is uniform throughout the County;

(b) To aid administration in the co-ordination of services;

(c) To give adequate planning data for the future requirements of the handicapped or disabled in the community;

(d) To facilitate research.

This register, together with the routine developmental screening of all children up to five years, should ensure that, in the future, we are offering every child in the County the opportunity to develop its full potential—physically, mentally, socially and emotionally.

PREVENTION OF DISEASE AND PRESYMPTOMATIC SCREENING

G. E. Leyshon, Principal Medical Officer

A new challenge faces the doctor interested in preventive medicine. If further improvement is to be made in the health of the community the problem of the chronic degenerative diseases must be solved. These diseases are by far the greatest cause of morbidity and mortality in the affluent world.

It is said that the infectious diseases have been conquered. Controlled, perhaps, but conquered is doubtful, for recent experience has shown how versatile and adaptable bacteria and viruses can be.

In general, however, effective measures have evolved to deal with infectious disease, but as yet there is nothing comparable for the control of the chronic degenerative diseases.

Because of the major influence that infections have had on the practice of medicine, the profession has dealt mainly with illnesses of short duration, in which the victim recovered or died within a relatively short time. Preventive measures were relatively easy to apply because the source of infection could be quickly identified and isolated.

Today's diseases have long 'incubation periods'; tumours of the bladder may not appear for 10-20 years after contact with the noxious agent; lung cancer after 20 years or more of smoking cigarettes.

Ischæmic heart disease may develop in late middle-age, though post-mortems on young, fit American soldiers, killed in Korea showed that many had already developed pathological changes in the coronary arteries.

Identification of the cause is now more difficult because of its remoteness in time from the appearance of the symptoms. There is, however, one advantage, namely, that in theory the disease can be detected and treated during this 'incubation period', before symptoms and signs are apparent to the affected individual.

This is why presymptomatic screening is potentially such a valuable preventive measure.

Presymptomatic screening is not a new concept; work carried out in antenatal clinics, child health clinics, and by the school health service are all acceptable examples of this. Screening tests, like mass miniature radiography, applied to the general public have proved beyond all doubt that screening is an effective method of coping with presymptomatic disease.

Yet after the initial enthusiasm for the expansion of presymptomatic screening in the middle of the last decade, opposition to any form of screening has hardened, and has impeded further progress. Though there is natural concern that one should not carry out procedures which are not completely validated, the criteria put forward to justify screening by the Working Group of the Nuffield Provincial Hospital Trust[1] are far more exacting than any that apply to any other medical innovation.

The main reason why stringent criteria are applied is said to be due to the ethical difference that exists between the doctor going to the public, rather than waiting for the public to come to him. If we accept that there is indeed an ethical difference, much of what is now regarded as standard public health practice is unethical.

The extreme caution suggested by the Working Group may be academically correct but their approach might take up to 20 years to provide a scientifically acceptable proof of the efficacy of screening.

Meanwhile recent results support the view that screening can save lives.

Strax *et al.*[2] have shown that periodic screening for breast cancer detects tumours localised to the breast. This is confirmed by Barnes *et al.*[3] who screened patients in general practice and found that the patients with breast cancer were detected with localised tumours and these had a five year survival rate of 96 per cent.

The Veterans' Association[4,5] have shown striking differences in morbidity and mortality between treated and untreated cases of hypertension, many of whom suffered no symptoms attributable to hypertension.

Yet in spite of the obvious benefits of early detection and treatment in these two lethal diseases there is still hesitation in recommending presymptomatic screening.

We are now in the position where the main impediment to extending screening, is finance. If anything it is, perhaps now, unethical not to screen.

Screening is still a crude tool which needs refining in its application; certainly it is much more effective if its use is limited to a vulnerable population, but it is a tool that we should be employing because at the present time it is often the only means at our disposal for combating the chronic degenerative diseases.

Screening Activities in the West Riding:

CERVICAL CYTOLOGY CLINICS:

(Breast palpation is carried out as a routine)

Summary of findings from 1966 to 31st December, 1970

Total smears taken	76,389	Examinations for Breast Abnormalities	76,389
Positive smears	364	Abnormal lumps	457
Rate of 4·8/1,000 examinations		Rate of 6·0/1,000 examinations	

A follow-up by Dr. Hunter, Divisional Medical Officer, (Skipton), of his screening procedure from 1966-1968, produced the following results:

Total smears taken	4,988
Positive smears	50

Rate of 10·0/1,000 examinations

Of the positive cases referred to the gynæcologist 43 had hysterectomies performed.

Examinations for Breast Abnormalities	4,988
Abnormal lumps	101

Rate of 20·2/1,000 examinations.

Of these, the family doctor referred 50 to the surgeon, of whom 25 were treated surgically.

WELL-WOMAN CLINICS:

These clinics are an extension of the cervical cytology clinics. A full medical examination is carried out together with certain other tests: on urine; estimated forced expiratory volume on a Peak Flow Meter; vision; and hearing tests.

Two pilot studies have been carried out in the West Riding.

In the Barnsley Division, 965 women attended during 1969, of whom 11 had a positive cervical cytology test. Other gynæcological abnormalities found were: fibroids (9 cases); cervical erosion (22); polyp (16); prolapse (2); others (21). Other disorders discovered were hypertension (26); obesity (11); glycosuria (1); hernia (1); depression (1); insomnia (1).

During late 1970, a Hæmoglobinometer and a urinary dipslide culture technique were employed at the clinic.

In the Castleford/Pontefract Division, screening in 1968 of 147 women showed that no fewer than 101 (68·7 per cent.) had some defect, the majority of which were again gynæcological, though a hearing loss of >40 db. in both ears was found in 25 women of whom 16 were unaware of hearing loss.

From 1969 to the present time, a further 1,134 have attended the clinic of whom four had a positive cervical smear and eight had abnormal smears requiring further observation. Other defects discovered were: hypertension (13); defective vision (8); deafness (21); anæmia <70 per cent. (2); glycosuria (4); other gynæcological conditions (171).

A total of 190 were referred to the family doctors for further advice and treatment.

These two pilot studies show that in spite of full availability of free medical services, much pathology remains undetected and untreated, unless it is looked for.

PREVENTIVE CLINICS FOR THE ELDERLY:

Two divisions have started pilot schemes, but with slightly different approaches.

In the Rothwell/Wetherby Division the method of enrolling patients was to invite members of clubs run by Old People's Welfare Committees. The examination took place at the clubs, and consequently the standard of facilities varied enormously. The team consisted of a medical officer, a nurse and/or a social worker.

Family doctors were notified of the opening of the clinics and a copy of the examination findings is always forwarded to him, for any action that is considered necessary.

It was intended that the service should be for the fit elderly, but the majority of those who attended were already under medical treatment. During the first eight months, 330 new patients were seen, aged from 60 to over 85 years, the majority being aged between 65 and 74 years.

Although much pathology was discovered, most of this was already known to the family doctors. These clinics will need to be modified so that the younger and fitter elderly population are seen.

In the Skipton Division the elderly are invited through the practice lists of family doctors at one of the health centres. The aim has been to concentrate on the more infirm elderly, and all those invited to attend were over the age of 70 years.

Of the first 74 invitations to attend 50 accepted and were seen at the clinic.

A summary of the findings are given below:

Required no medical treatment or social support	6
Under treatment by the family doctor	4
Under treatment, but alteration in condition requiring further attention by family doctor	3
Requiring, but not obtaining, social support	2
Deafness, but refused hearing aid	3
Advice on treatment given	32

A further clinic has been planned which will concentrate on the disabled elderly, and in which rehabilitation and phsyiotherapy will be carried out.

The provision of divisional transport will be necessary.

CLINICS FOR THE MIDDLE-AGED MAN:

Though these cannot be strictly regarded as carrying out screening procedures, they are most certainly preventive clinics; a health questionnaire was completed by students prior to their attending a course conducted by an Institute of Further Education but supervised by a medical officer. F.E.V., weight, height and skinfold thickness, were all measured periodically throughout the course.

These clinics concentrated on the two major problems which affect this age group—heart and lung disease—and in particular, ischæmic heart disease and lung cancer.

There were nine two-hour sessions; each session being divided into a lecture/discussion period of one hour, followed by a period of graded physical exercises in the gymnasium.

A total of 25 people enrolled of whom 15 attended all nine sessions. Of the 15 regular attenders, three were heavy smokers, one was an ex-smoker, three smoked cigars or pipes and eight were non-smokers. Ages ranged from 37 years to 56 years with an average of 44 years; all the attenders were from skilled and professional occupations.

Overweight was a greater problem than smoking, and a total of 113 lb. was lost in six weeks by the regular attenders, the greatest individual loss being 15 lb. Nine out of the 15 achieved weights within the accepted norm for their height, and all experienced a subjective improvement in well-being.

A further course in another area produced 15 applicants, again with similar backgrounds, similar problems, and similar results.

While these courses were valuable, the enrollers were already conscious of their health, and were in the main non-smokers, so that in future it would seem better to offer two separate clinics, one concentrating on anti-smoking, and the other offering advice and physical exercises for those concerned about heart disease.

Conclusion:

Though screening has progressed no further than pilot schemes in the West Riding, enough has been learned to show that this is a way that preventive medicine can progress in the future.

The main difficulty encountered has been the shortage of skilled staff and time; but many of the clinics could be staffed by trained auxiliaries. This is how progress is likely to be made, especially now that automated techniques are becoming available. The public were extremely appreciative of these clinics.

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CHANGING PATTERNS OF NURSING CARE

Marjorie G. Atkinson, County Nursing Officer

The County Medical Officer of Health's Report for 1969 included an account of the development of the home nursing service since 1962. This paper seeks to discuss present County nursing matters as presented to members of the Briggs Committee on Nursing, to describe briefly three recent reports affecting nursing, health visiting and midwifery, to highlight changes expected in the different nursing disciplines and indicate how the change in overall structure will assist in preparations for reorganisation of the National Health Service.

The reports in question are *The General Nursing Council Syllabus, 1969*, published by the General Nursing Council for England and Wales, the *Report of the Working Party on Management Structure in the Local Authority Nursing Services*, published by the Department of Health and Social Security, the Scottish Home and Health Department, and the Welsh Office, (the Mayston Report) and *Domiciliary Midwifery and Maternity Bed Needs*, published by H.M.S.O., London (the Peel Report).

The 'Briggs' Committee:

The Committee on Nursing set up in Spring, 1970, under the chairmanship of Professor Asa Briggs has as terms of reference:

> "To review the Role of the Nurse and Midwife in hospital and the community, and the education required for that role, so that best use is made of available manpower to meet present needs of an integrated health service."

Whilst there have been Departmental reports on specific nursing and health visiting problems e.g. *Training of District Nurses, 1959*, and the *Report on Recruitment, Training and Field of Work of the Health Visitor* (the Jameson Report) 1956, the Briggs Committee is the first one requested to examine the whole field of nursing function and education.

The Committee is drawn from nursing, medical and educational fields with representation also from the Nurses and Midwives' Whitley Council. It is regrettable that only one Nursing Officer from the field of community care is a member.

Views and comments were freely invited in the nursing press from both interested groups and individuals. The nursing officers from the County drew up comments for the Committee emphasising the educational reforms needed.

In February, 1971, six Committee members and two advisers visited the County. Senior medical, nursing, and administrative officers discussed the following matters with them:

TRAINING:

There is a continuing need for specific in-service training of State Registered Nurses and State Enrolled Nurses in order to nurse most effectively in homes and health centres.

This training will continue to be required even with the community care options envisaged by the General Nursing Council Syllabus of Nurse Training, 1969. Seventy-five per cent. of County home nursing sisters hold the district nursing qualification.

In midwifery, the provision of the wider training programme of community observation and care was discussed. This 12 month course, replacing two separate parts of training is likely to be approved in two training schools with which the County has links.

Discussion on health visitor training showed the probability of some wastage due to competition for available places.

QUALIFICATIONS OF PRESENT STAFF:

Sixty-nine per cent. of the County field staff hold more than one qualification. Thus home nursing sisters include nine Registered Fever Nurses, four Registered Sick Childrens' Nurses, eight with an Orthopædic Nursing Certificate, and 53 with full midwifery qualifications. Midwives and home nurse midwives are mainly State Registered Nurses, four hold the Health Visitors' Certificate. Health visitors and assistants include 197 holding Midwifery Certificates, eight Registered Sick Children's Nurses, and 11 Registered Fever Nurses.

DEPLOYMENT OF STAFF:

The different functions of home nursing sisters with a monthly case load of 40/50 patients, and of health visitors with continuing case loads of approximately 400 families with additional responsibilities in schools, were not understood by the visiting team and were enlarged upon in detail.

The County reluctance to use lay auxiliaries, especially within a professional nursing establishment, was accepted, and the difficulty of continuous supervision of such help was appreciated.

The proposed adjustment of the County nursing management structure along the lines recommended by the Mayston Report was of interest to the Committee and will be discussed later in this article.

Promotion of understanding with hospital colleagues is sought by the County in several ways:

Student nurses from several hospitals spend two days observation in fields of home nursing and health visiting care during training.

Regular liaison visits are paid by 65 health visitors to 50 hospitals involving geriatric, pædiatric, orthopædic, physically handicapped, maternity, diabetic, out-patient sessions and/or ward rounds.

Visits are paid as required by home nursing sisters to meet patients and ward sisters prior to the patients' discharge where special equipment or particular nursing problems are envisaged.

Interchange visits are arranged between hospitals and nursing staff whereby hospital nursing sisters spend a day with home nursing sisters and subsequently act as hostesses to the home nursing sisters in their own wards or departments.

The visits are followed by a session of discussion on improvement of communications. Such programmes are requested from two or three areas each year and contribute to improved care of patients through greater understanding.

The progress of attachment of nursing staff to general practices was commented upon. At the end of 1970, 216 health visitors from 301 qualified staff, 215 home nursing sisters from 298 S.R.N. sisters, and 52 midwives from a staff of 202 were working with general practitioner patients rather than geographical areas. The increasing provision of health centres throughout the County facilitated frequent contact which is one of the main factors in successful working together.

The work of community nursing staff in the school health field was mentioned, with the use of State Registered Nurses in the screening procedures, and qualified health visiting staff in health education programmes.

The latter part of the Committee's visit consisted of group discussions with nursing officers and members of field staff. These were free discussions and administrative staff were not present. The visitors all expressed appreciation of the day's discussions and it was encouraging to learn that discussions with home nursing sisters and health visitors had illuminated the points on their differing functions that had been discussed in the morning.

The G.N.C. Syllabus, 1969:

In 1969 the General Nursing Council—the statutory body responsible for the training and registration of nurses—published a revised syllabus of particular interest to local health services. In addition to the introductory visits of one or two days already paid by students to health services under the 1962 syllabus, the new syllabus suggested a longer period in the community services—from six to twelve weeks—as one of four options by students entering from January, 1971, and as one of two options by students entering from January, 1975.

Following discussions between authorities and hospitals, the majority of programmes—the County programme included—provide for a six week programme for selected student nurses. The County will continue introductory visits for all students and introduce the longer period for students who choose community service experience after 18 months nurse training. This measure will have a far reaching effect on nursing in general. Whilst all nurses working in the community know hospital methods over a period of at least three years, many hospital nurses, sisters and matrons have no experience of problems and priorities of local health services. Future nursing staffs will have increasing knowledge of facilities available for the sick, the frail, the elderly, the mentally ill and the mentally subnormal (with co-operation from the Social Services Department).

The measure will lead to greater co-operation in patient care and increase two way communication and interdependence.

There will also be a younger, vocal and questioning element amongst the qualified and experienced nursing staffs that comprise the home nursing, health visiting and midwifery services, which will keep community staff constantly aware of changing hospital methods. The home nursing sisters can demonstrate

extremely high standards of patient care, sometimes in far from ideal surroundings; the health visitors will demonstrate preventive health care and health education, and midwives, the volume of antenatal care and education that takes place both for home-booked and hospital-booked patients.

The number of students involved is expected to be small until 1975 entrants commence their option periods.

The new six-week programme will mean considerable preparation by Divisional Nursing Officers in preparing necessary background knowledge relating to the provision of health services, and in discussion and tutorial sessions with the students.

It is anticipated that similar experience may eventually be requested for pupil nurses training for the State Roll. Such a request would possibly require extra staff since larger numbers would be involved.

The 'Mayston' Report:

A Working Party on Management Structure in the Local Authority Nursing Services was set up in the autumn of 1968 and comprised representatives of the Health Departments of England, Scotland and Wales, and of local authority associations. The report was published in January, 1970.

The terms of reference were "to consider the extent to which the principles of the Salmon Report on senior nursing staff structure in the hospital service are applicable to local authority nursing services, and what changes in the structure of senior posts, and changes in the definition of posts may be required".

The Report's main recommendations were:

1. Appointment of Chief Nursing Officers where not already in office to co-ordinate health visiting, home nursing and domiciliary midwifery services in the area and to provide a single channel of communication through the Medical Officer of Health to the Health Committee.

2. Reviews by local authorities of existing nursing management structures. Two patterns, geographical and functional are described, but the geographical pattern appeared to the Working Party to be "more consistent with the principles of good management".

3. A management structure comprising top, middle and first line officers, with defined elements of management at each level which would deploy effectively available managerial skills, and provide improved career and promotion prospects.

4. The Working Party recognised that field workers in the local authority nursing services have a wide range of functions and operate independently. Their duties include minor managerial functions in relation to ancillary staff.

5. Each first line manager would co-ordinate the work of a group of field workers in her own discipline. Some of her management responsibilities are expected to be comparable to lower middle management in hospital.

6. Middle managers (Divisional Nursing Officers) exercise programming functions, and should maintain specialist knowledge in one or more fields.

7. Top management includes in larger authorities the Chief Nursing Officer and Principal Nursing Officer(s). These distinct managerial functions include policy forming and co-ordination. Deputising is covered by designating an officer (with functions of her own) to 'act up' during absences of the Chief Nursing Officer.

8. Management training is best given before selection for senior posts. The Working Party suggested the broad content of courses of preparation for each level of management.

9. Statutory supervision of midwives was seen as appropriate to middle management.

10. Staff with teaching responsibilities in the local authority nursing services do not form part of the management structure.

In the County Nursing Service, the basic structure was already well fitted to implement the recommendations in that the County already had a co-ordinating County Nursing Officer, and Divisional Nursing Officers whose duties were of the geographical pattern in covering health visiting, home nursing, and domiciliary midwifery services.

The County Council accepted the recommendation to introduce first line management posts in each discipline; to appoint a Principal Nursing Officer who, with the present Deputy County Nursing Officer, would share co-ordination of divisional services throughout the County; and to link the present post of Health Education Officer with the nursing services as Principal Nursing Officer in the functional role of Health Education. The Non-Medical Supervisors of Midwives would continue to exercise statutory functions and professional supervision. (The diagram opposite shows new structure).

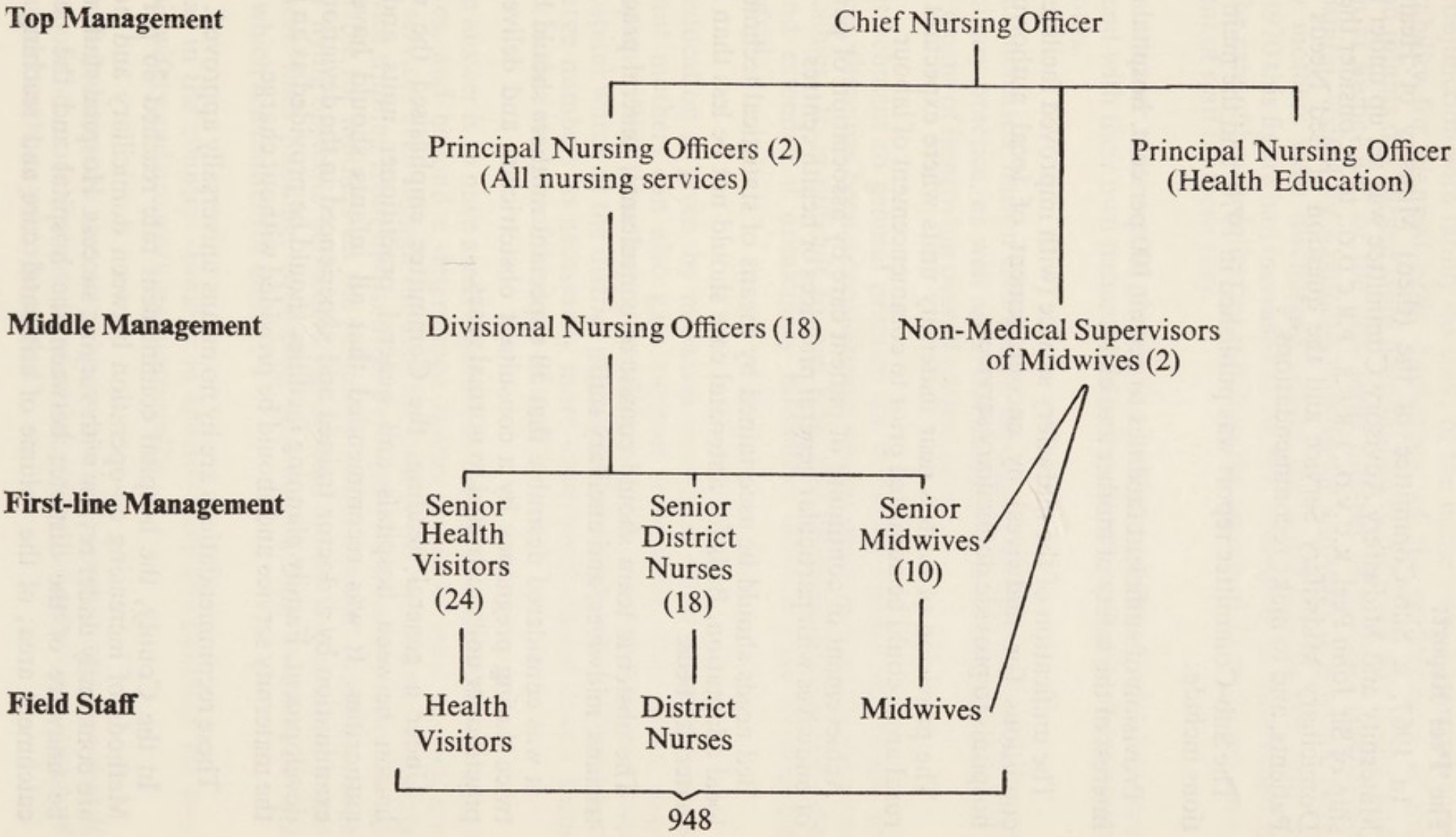
At the time of writing, first line managers are in process of appointment, and negotiations for training in management are proceeding with a College of Technology.

The value of the new structure will, I think, quickly be appreciated in a deeper knowledge of the rapidly changing needs of each area, with improved communication between different levels of management, and also between managers of the different disciplines.

Increased liaison with hospital colleagues is vital to the development of mutual understanding, if the nursing service of the unified National Health Service of the second half of the decade is to be efficient and happy.

Improved career prospects are long overdue and vital with the hospital and community nursing service likely to become one.

NURSING STAFF—STRUCTURAL ORGANISATION



The 'Peel' Report:

In 1967, a Sub-Committee of the (then) Ministry of Health's Standing Maternity and Midwifery Advisory Committee was set up under the chairmanship of Sir John Peel, K.C.V.O., F.R.C.S., P.R.C.O.G., to "Consider the Future of the Domiciliary Midwifery Service and the question of Bed Needs for Maternity Patients, and to make recommendations".

The Sub-Committee report was published in 1970, and the main recommendations include:

Provision of sufficient facilities to permit 100 per cent. hospital delivery in the interest of the safety of mother and child.

The unification of the midwifery service (with improved facilities and working conditions for midwives) by encouragement of local authorities to request hospitals to provide domiciliary services.

The provision of hostels near maternity units where expectant mothers from rural areas could be admitted prior to commencement of labour.

Achievement of continuity of patient care by association of particular groups of midwives with particular general practices or health centres.

Bed needs should be ascertained by means of statistical techniques subject to local adaptation. Beds for antenatal care should not be less than 25 per cent. of maternity beds.

The obstetric team should consist of consultants, general practitioner obstetricians, midwives, and ancillary staff.

It was considered desirable that all expectant mothers should be seen at least twice during pregnancy by a consultant obstetrician, and deliveries in general practitioner units restricted to normal cases.

Under a general heading, the Committee emphasised the need for good liaison between hospitals and general practitioner units and local health authorities. It was recommended that all infants should have a full clinical examination by a doctor trained and experienced in the deviations from normal development. Family planning facilities should be provided as an integral part of the maternity service and should be provided without charge.

These recommendations are by no means universally approved.

In the County, the hospital confinement rate reached 86 per cent. in 1970. Methods of increasing co-operation between domiciliary and hospital services are constantly under review with varying success. Hospital staffs often appear to be unaware of the distance between the hospital and the perimeter of the catchment area; of the volume of antenatal care and teaching undertaken by

midwives in conjunction with family doctors; of the home visits by midwives to ascertain suitability for planned early discharges; of the performance of the Guthrie test on infants discharged from hospital before the sixth day of life, and on those born at home; and of the now large number of mothers discharged early from hospital, visited by a reduced number of midwives in post. In 1962, 5,776 County mothers were discharged before the tenth day to the care of midwives. In 1970 this figure had increased to 16,397. Moreover, in some areas of the County, the rate of home deliveries is still in the region of 21 to 25 per cent. and recruitment of staff far from easy.

General practitioner units are of great value to those midwives who are near enough to attend with their own patients and subsequently to receive them home at about 48 hours.

It is felt that increased liaison efforts and especially involvement of hospital staff in domiciliary practice, as well as of domiciliary staff in hospital practice, offers the best means of improving overall patient care.

Although attachment to general practice for midwives means attachment to several practices, there has been a considerable development in working together in antenatal clinics. It is difficult to see how this working together can be maintained and extended if domiciliary midwifery services pass to hospital orientated control.

Antenatal education is given by midwives usually in small informal classes where expectant mothers can also gain support from each other in an easy relaxed atmosphere. Will these happy conditions apply if there is tremendous pressure in hospital wards at the district general hospital? Or will mothers have to travel in large numbers to necessarily more impersonal classes drawn from many localities in the interests of 'best use of staff'?

Perhaps one answer is to have areas adjacent to the hospital served by hospital based midwives, and beyond a determined radius to retain local domiciliary midwives and services even though the staff are part of one service and receiving regular in-service training from that source. Perhaps, too, obstetric units should be easily available for mothers on the periphery of the hospital catchment area and why not a 'flying obstetric' service for the isolated areas? Would it really cost very much more than building, equipping and maintaining hostels, the full occupancy of which is a matter for doubt?

Certain areas in the country—notably in towns—have co-ordinated the two branches of midwifery and are working successfully.

Radio communications are also more easily used in compact areas, so that it is the question of the more distant parts of hospital catchment areas, and of frankly rural areas that have yet to be settled.

A survey of the County midwifery service is proposed for the early part of 1972. This should be of value in establishing domiciliary requirements under the present circumstances of a high hospital delivery rate.

It must not be forgotten that in the event of infection occurring in maternity units, the domiciliary service has always accepted extra home deliveries and early discharges. Any unified service must therefore include a sufficient number of domiciliary orientated staff to provide adequate home care as and when required.

Undoubtedly the questions surrounding this service need discussion at all levels of responsibility. It is hoped that these will be increasingly encouraged by hospitals, local authorities and professional organisations. It is here that the senior midwifery sisters can give help.

Changes in the Riding:

The changes in the home nursing field described so ably in last year's Report have continued steadily in 1970. It is felt that this service is well equipped to offer valuable nursing observation and training to student nurses who choose community care experience under the 1969 G.N.C. Syllabus described earlier.

In the next few years, earlier discharge from hospital and the use of day surgery will increase the amount of acute nursing done by the home nursing sisters. The use of central sterile supply services of local hospitals would facilitate the nursing of such patients, and will, it is hoped, become available when needed. There is a growing need for more night nursing cover.

More technical and diagnostic procedures are already urged upon nurses in surgery work, and a wider knowledge of treatments and drugs will be maintained in this way. Care will be needed throughout the coming organisational changes to ensure that provision of nursing staff of good calibre keeps pace with increasing duties, or the immensely valuable personal care of patients will be lost through sheer pressure of work.

Present day health visiting is very much concerned with assessment of normal progress and development in babies and young children. An earlier health visiting pattern included routine visits at specified intervals until 'selective visiting' took the stage as different screening procedures and immunisation schemes developed and demanded more health visiting time in clinic sessions. Today's assessment at recommended ages, with standardised recording, takes the best of both systems and should give opportunities for general advice to all mothers at regular times in addition to help as needed at other times.

The recording of these assessment findings will be of value in building up an overall picture of child development, and they should also prove their worth where a detailed background of an individual child is needed.

Health education commitments in primary, junior and senior schools, in youth clubs and in mothers' clubs, formed the majority of the 4,477 sessions devoted to this work in 1970. Programmes vary from the simplest health teaching to primary children, to forthright discussions and questions at mixed youth clubs.

Increase of school health screening procedures, the introduction of pre-school medical examinations, and subsequent selective medical examinations (instead of the former routine of three examinations during school life) is today's programme for the school children.

Care of the elderly, particularly in regard to nutrition and home safety; development of geriatric clinics to maintain optimum available health, assistance in assessment of homes prior to early discharge of patients from hospital, could well develop considerably over the next few years. Certainly, health visitors and their assistants will have much to demonstrate to the student nurses spending six weeks in the community services.

During 1970, one overall nursing establishment was agreed instead of three separate establishments. This will result in more flexibility should service needs fluctuate considerably. At present, both home nursing and health visiting could use considerably increased numbers of staff, and the proposed midwifery survey may well show some increase needed there also.

The new nursing officers of the management structure will help in the fuller development of each part of the service by spending time on ascertainment of new needs, on maintaining high standards of care and by improved communications to and from field staff of their own discipline and to some extent of the other fields of work. Divisional Nursing Officers will become responsible for more training programmes, and for maintaining specialist knowledge in different areas of care. Communications with hospital colleagues will be an important function.

The two organisational Principal Nursing Officers will each develop a wide knowledge of half the County, will assist the Chief Nursing Officer in the formation of nursing policy, and in the setting of nursing standards. More activity in the field of public relations, promotion of community nursing as a career, and mutual preparations for unification with hospital colleagues will come into the programme of the Chief Nursing Officer.

In spite of 'the changes of many-coloured life' which the reorganisation will bring, the County Nursing Service welcomes the prospect of improved patient and family care which is the object of the pending changes.

ORGANISATION AND MANAGEMENT: AN ATTACHMENT SCHEME IN A SMALL COMMUNITY

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A Review of the Problem:

A joint working party of the College of General Practitioners and Royal College of Nursing (1961) gave examples of methods of co-operation in different parts of the country. This report covered all aspects of the historical development of the health visitor and the general practitioner down to the present day. It gave numerous examples of the methods of co-operation which were in operation in different parts of the country and concluded that the health visitor who was already working with general practitioners found her work enriched, the relationship with the doctor's patients easier, and her usefulness increased. It was thought that the general practitioner's standard of practice was raised and the service given to the community improved. Selwyn Clark (1954) described the boon that many doctors found the health visitor to be and showed how she could help patients to obtain the various services available under the National Health and Assistance Acts and from voluntary organisations. The health visitor going to see old people is in a better position than any other domiciliary worker to recognise the early signs of deviation from normal and to seek appropriate help. Selwyn Clark thought that nothing but good had derived from the extension of the health visitors' work and responsibilities since 1949 to the family unit as a whole.

Chalke and Fisher (1957) described the attachment of a health visitor to a group practice which was commenced in 1953. In this trial it was agreed that the health visitor should be responsible for all the patients of the practice wherever they lived. Special attention was given to vaccination and immunisation so much so that 100 per cent. of babies were immunised. Chalke and Fisher concluded that the partnership has been to the mutual advantage of the general practitioner and health visitor and had produced a higher standard of practice which had also enabled more emphasis to be laid on preventive medicine and the promotion of health than would otherwise have been possible in a busy practice.

Pinsent *et al.* (1956) described the attachment of a health visitor to a three doctor partnership of approximately 8,500 living in an industrial area. Much evidence of the kind of service given was collected and it was concluded that the health visitor was of greatest value to patients suffering from diseases in the

following diagnostic groups, (*a*) Nervous system, (*b*) Neurosis, (*c*) Pregnancy, (*d*) Muscular, (*e*) Senility. The frequency of visits by the health visitor was greatest for the following patients:

1. Adults over 15 years of age.
2. Those suffering from diseases in the following groups:

   (*a*) Nervous system, (*b*) Heart, (*c*) Muscular, (*d*) Indefinite, (*e*) Senility.

Repeat visits were more often required by elderly patients of both sexes and it was felt that dealing with their disorders was the clearest indication of co-ordination of the activities of the general practitioner and the district nurse and health visitor. The health visitor's ability to call on social resources to meet a particular social need far exceeded that of the doctor's whose preoccupation was with the medical aspect of the situation.

Egan (1952) referred to the criticism of the health visitor during the Annual Meeting of the British Medical Association following a paper on health visitors by Thomas (1952). Despite the criticism at that time the general feeling was that ways must be found to ensure better co-operation between general practitioners and health visitors. Egan detailed the reasons for friction but maintained that the National Health Service Act had changed the situation and there was now no longer any excuse for this.

The Working Party on Health Visiting (1956) recommended close association between the health visitor and family doctor. Swift and McDougall (1964) described the attachment of nurses, midwives and health visitors by a local authority to work exclusively with family doctors and concluded that the scheme had improved the medical care of the patients. This report is interesting from the administrative angle in that the arrangements cover such widely varying districts, apparently without causing serious administrative difficulties. Akester and MacPhail (1964) have reported on an investigation they carried out in Leeds to anticipate what they thought might be the effect of such a liaison. The authors concluded that the attachment of health visitors to general practitioners was neither desirable nor feasible nor did they find evidence that the doctors desired it. Galloway (1964) described general practice as "a cottage industry supplying the public through the professional equivalent of the corner shop". While many might not agree with these views there is no doubt room for improvement in organisation. Elliott (1964) envisages not only the full time attachment of the health visitor to group practice but also the use of County clinic premises by the doctors concerned for the antenatal and infant welfare sessions and possibly for undertaking routine school medical inspection of the children from the practice attending the local primary school. However, in an authority as large and as varied as the West Riding County Council there will obviously be many variations on the theme. Since 1964 many authorities, large and small have gone forward with the principle of attachment and it is believed that most are satisfied with this new method of deployment and co-operation.

Keighley Scheme:

Attachment of nursing staff to general practitioners requires disciplinary control on the part of both Medical Officers of Health and general practitioners. In the first place the Medical Officer of Health must realise that he is handing over the immediate control of the work of the attached nursing staff and is retaining supervisory and movement control only. The general practitioner must on his side appreciate that with changes of staff, sickness, holidays etc., it will be necessary from time to time for the Medical Officer of Health to redeploy as necessary. Both parties must appreciate their respective roles. It is very easy for one side or the other to become over possessive of his or her health visitor, midwife, etc. This pinpoints what I believe to be the main and almost the only difficulty concerned with attachment. Having said this perhaps we can now consider in detail the various administrative arrangements involved.

ADMINISTRATIVE PROCEDURE:

Naturally the methods must vary considerably depending on the locality in which the scheme is introduced but it must of its nature follow a basic formula. Towards the end of 1961 a scheme of attachment between general practitioners and local authority nursing services was introduced in Keighley, an industrial town with a population of nearly 60,000. Although the new arrangements affected all branches of the nursing services, more will be said of the health visitor co-operation in which the changing pattern was more fundamental than in the case of the midwife and home nurse. The latter have long worked with general practitioners but the health visitor, it has been said, has often worked in opposition. Certainly she worked in isolation on her district. There are 26 general practitioners working in the town, the practices being made up as follows, one group of six, three groups of three, two groups of two and the remaining seven work singly. The main bulk of the doctors are more or less in the centre of the town but eight are responsible for the village communities on the edge of the urban area.

(*a*) *Health Visitors:*

Keighley has an establishment of 15 health visitors. This has never been attained and the difficulty has been met by the use of assistant health visitors who are qualified State Registered Nurses. This has meant that the health visitors must delegate some of their work to these less qualified nurses and consideration had to be given to the kind of work and method of delegation. Very soon after the scheme came into operation it proved to be so popular that most of the doctors in the town were asking for 'their health visitor' and after joint discussions in each case a formulation of broad principles was drawn up. These have largely remained unaltered to the present day although there have been some variations in details. It was agreed that the health visitor should adjust her case load to that of the practice, would ignore ward boundaries within the Borough and that she should have the following responsibilities.

(*a*) Her normal work with the pre-school child in families within the practice.

(*b*) Visiting the elderly, sick and patients discharged from hospital.

(*c*) To give advice and provide help to any family with medical or medico-social problems referred by the doctor.

(*d*) Vaccination and immunisation.

(*e*) Problem families.

(*f*) Care and after-care work, including tuberculosis.

(*g*) School health work in specified schools with supervision of nursing auxiliaries.

In our joint discussions it was emphasised that she would become an important member of the general practitioner/nursing team and should have available to her all confidential and clinical information necessary for the carrying out of her varied tasks. There was in fact little need to stress this as in all instances there has been a full exchange of information. In general the health visitor's work has continued in the ordinary way but she had benefited from the frequent and friendly consultations and discussions with general practitioners and from the two-way flow of referrals.

In Keighley the health visitor conducts the child welfare clinics on her own responsibility without a clinic doctor and refers any sick children found at the clinic to the private practitioner concerned. Attempts have been made to establish similar clinics on general practitioner's premises but for one reason or another these have not been an unqualified success and have in the main changed into immunisation sessions which are normally the responsibility of an assistant health visitor. Cases of unsatisfactory physical or mental development which the health visitor discovers (she is now trained in developmental assessment) are referred to a special clinic where they are examined by experienced doctors on the public health staff, the general practitioner being kept informed of the findings. Because of the shortage of medical manpower new ideas on the re-deployment, not only of doctors, but of senior nursing staff must be considered. As a result of experience gained over the years it also became clear recently that some re-organisation of responsibilities of the health visitor in schools should be considered. We had previously left the health visitor responsible with her assistants for the school medical work, routine eye tests, cleanliness inspections, audiometry inspections etc. It is worth observing at this point that the only routine medical examination carried out in the schools in Keighley today is on five year old children. The intermediate period is covered by questionnaires and only children considered to be in need of a medical examination are seen. At school leaving the final routine medical examination is replaced by an interview by the school doctor and again only those who have defects which require further follow-up are examined following which a suitable recommendation is made to the Youth Employment Officer. This has eliminated a lot of routine school nursing work and enabled more time to be spent on special examination of all children and to give extra attention to 'at risk' groups. We have, therefore, trained three S.R.N's to carry out the school nursing work including follow-up visits to the homes, which may be necessary. This has naturally removed from the health visitor a considerable amount of work which it is hoped they will use in giving teaching courses in health in the schools.

Recently an attempt has been made to ensure that the group of six work as a comprehensive unit with their own nursing staff. With this in view office accommodation was provided for the health visitor and her assistant. Arrangements were also made for the other nursing staff to call at the surgery (health centre) daily and to ensure that the main direction of the nursing services was carried out by the health visitor in charge.

All staff were, therefore, completely occupied with the patients in the practice except for the midwife who must naturally take responsibility for more doctors than were in the group.

The staff attached to the group who have over 13,000 patients consists of one health visitor, one and a half assistant health visitors, one home nursing sister, one full-time S.E.N., one half nursing auxiliary, and one midwife.

Earlier we believed that one health visitor should ideally carry a case load of 4½ to 5 thousand doctor's patients. It will be seen that the staff ratio we are working on is lower than this and if we are able to report in the future that it has worked satisfactorily obviously our earlier estimates must be reviewed.

(*b*) *Home Nursing Sisters:*

In our experience home nursing sisters and midwives have always worked closely and amicably with general practitioners. Nevertheless there were difficulties in changing the organisation. Instead of the home nursing sister having an area she is attached to specific practitioners and looks to them for her work. Clinics are held on the general practitioners' premises and all cases who are fit to travel are seen and treated there, thus saving a considerable amount of visiting and travelling time. Efforts have also been made to make the home nursing sister's work more interesting by removing from them the routine bathing which is carried out by unqualified nursing auxiliaries.

In the group of six the home nursing staff consists of a nursing sister, full-time S.E.N. and half of a nursing auxiliary. The home nursing sister herself carries out much acute work involving removal of sutures from recently discharged hospital patients, follow-up of children after acute illness and infectious diseases, taking of blood specimens etc. As a result of the attachment it is thought that more and more acute work is brought to their notice, and this has meant that while the nurses have more work it is also of a more interesting nature and therefore is carried out with a greater zest.

(*c*) *Midwives:*

Less than 10 per cent. of confinements in the town are domiciliary so that the midwife is spending the main part of her time carrying out antenatal and postnatal care. There are no local authority antenatal clinics; the midwife carried out antenatal examinations with the doctor in his surgery. There have been some administrative difficulties in obtaining an even spread of antenatal

clinic time throughout the town for the different doctors. This has been overcome and it is considered that we have been able to take advantage of the increased importance placed on antenatal care (Cranbrook 1959). The midwives have accepted this and enjoyed the changed emphasis of their work.

(*d*) *Future Project:*

It is hoped that within the next two years a health centre will be built in the central part of Keighley with accommodation for seven doctors. This will include the majority of the doctors who are now working alone and will in all probability increase the liaison between the nursing staff and the general practitioners concerned. It has been somewhat difficult to maintain the close relationship with the individual practitioners as has been maintained with the groups in the town.

Conclusion:

A review of the literature describing various schemes of attachment and a more detailed examination of the scheme operating in Keighley have been presented. It is hoped that this presentation shows that this method of deployment of public health nursing staff in association with the general practitioner is to the advantage of all concerned, the patient, the health visitor and the doctor.

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Note: Dr. McDonagh introduced the attachment of nursing staff to general practice in 1961 and a paper on this work was presented by him to a Royal Society of Health meeting held at Keighley on 29th October, 1964.

CO-OPERATION AMONGST AMBULANCE/HOSPITAL/G.P. SERVICES

G. E. Leyshon, Principal Medical Officer

Ambulance services of local authorities are ideally placed to further co-operation amongst the three branches of the health service.

The West Riding Ambulance Service deals with 41 hospital management committees and over 1,400 family doctors; it is essential therefore for communication to be effective. Difficulties arise because of a lack of understanding by one branch of the nature of the work of the other two services.

The major problem that the ambulance service faces is the increasing demands made upon it. In the 10 year period between 1958 and 1967 there was a 40 per cent. increase in patients carried and a 33 per cent. increase in miles travelled. There have been further increases in both since 1967. With greater emphasis on domiciliary care, expansion in geriatric and psychiatric day hospitals, demand continues to increase. Where liaison between hospitals and the ambulance service was good, as with the Leeds hospitals, there was a decrease of 30 per cent. in demand for ambulances over the same period, despite an increase of 68,000 attendances at out-patient departments. In Batley General Hospital where a liaison committee was formed in 1967, there was a fall of 6,600 patients transported between 1968 and 1969; these patients made their own way to the hospital out-patient department.

If more rational use is made of the ambulance services then these improvements are passed on to the hospital, so that out-patient clinics and day hospitals can be expanded; patients too receive a better service, for waiting times are reduced.

A summary is given below of the progress that has been made in co-operation with the hospital/general practitioners' services.

Liaison with Hospitals:

LIAISON COMMITTEES:

These Committees are composed of ambulance and hospital staff who are directly involved in requisitioning and controlling ambulance transport. At these meetings, problems affecting both the hospital and ambulance services are discussed.

Committees have already been established in the following H.M.C. areas:

Dewsbury, Batley and Mirfield
Airedale
Halifax
Wharfedale
Leeds 'A' (St. James's)
Wakefield
and United Leeds Hospitals (Leeds General Infirmary)

TEN YEAR PLAN:

Future hospital developments affecting the ambulance service are discussed periodically by hospital secretaries and senior ambulance staff; by this means the ambulance service is able to estimate needs in regard to vehicles and staff.

APPOINTMENT OF GROUP TRANSPORT OFFICERS:

As a result of liaison between the hospital and ambulance services, a group transport officer has been appointed in York and a further appointment has been agreed for Wakefield. Leeds and Sheffield have had transport officers for many years. Transport officers may be jointly appointed by the hospital and local authority or they may be local authority appointments only.

PLANNING OF NEW HOSPITAL PREMISES:

Senior ambulance staff are now called in at a very early stage when new hospitals are planned—here again, ambulance problems can be overcome before it is too late. Recent examples were in relation to the proposed district general hospitals at York, Rotherham and Airedale.

TRAINING OF AMBULANCE STAFF BY THE HOSPITALS:

In-Hospital Training:

Pinderfields General Hospital	—	Half day visit to burns unit and neuro-surgical wards.
Ministry of Pensions, Limb Fitting Centre, Leeds	—	Half day visit on care and handling of amputee.
Batley General Hospital	—	Groups of seven students are seconded for a full day, when they are given training in various departments, casualty, theatre, wards etc.
St. James's Hospital, Leeds	—	Half day visit to the renal unit and intensive care unit.

The above visits are part of the six weeks training course for new entrants.

Halifax Royal Infirmary:

One ambulanceman at a time is seconded for in-hospital training for a period of a week. The programme includes:

(i) Half day with the consultant anæsthetist.
(ii) Half day in the fracture clinic.
(iii) Full day in theatre.
(iv) Half day in accident X-ray department.
(v) The remainder of the programme is in the casualty department.

The pilot scheme is in accordance with the Millar Report; it is hoped to implement the in-hospital training of ambulance staff throughout the County.

Training School Lecturers:

Great help has been obtained by the provision of lecturers for certain subjects in our training school syllabus, and also as advisers in the preparation of training notes.

TRAINING OF HOSPITAL STAFF BY THE AMBULANCE SERVICE:

First Line Management Courses for the Hospital Staff:

A session on 'Communications and Liaison' between hospital and ambulance services has been given on the following courses:

	Sessions	*Students Attending*
Keighley Technical College ...	8	242
Huddersfield College of Technology	4	138
Wakefield Technical College ...	8	204

In addition to the above, course members have visited the Control.

Student Nurses:

(i) A group of 28 student nurses from the Halifax School of Nursing visited Control and were given a talk on 'Communication and Liaison' between hospital and ambulance services; this was followed by open discussion.

(ii) A group of 30 student nurses at Storthes Hall received four hours instruction on emergency resuscitation.

Training of Transport Clerks:

Facilities have been provided for newly appointed hospital transport clerks to have a period of training in the central control room at Birkenshaw. This has given the transport clerks the opportunity of seeing and understanding the ambulance service.

RADIO TELEPHONE COMMUNICATION—HOSPITAL/AMBULANCE SERVICE:

Consultations have taken place with both the Barnsley and Rotherham Hospital Management Committees on the subject of establishing a radio link between hospitals and ambulances.

There is at present in existence good telecommunications from ambulance control to hospitals, and while in theory it may seem reasonable for hospitals to speak directly to ambulance crews, in practice this would have limited application.

JUDGING OF COMPETITIONS:

Hospitals are kind enough to afford facilities for doctors on their staffs to act as judges in ambulance service competitions and also on occasions, provide facilities on their premises for such competitions.

Liaison with General Practitioners:

While formal liaison with general practitioners has not progressed to the same extent as with the hospital services, there is good co-operation between station officers and local doctors. There is the possibility however that in future there will be joint projects involving both general practitioners and ambulance service.

ROAD ACCIDENT AFTER-CARE SCHEME:

A group of Harrogate family doctors has initiated a scheme similar to the one in the North Riding. The ambulance service station at Harrogate attempts to call doctors to an accident, whether it be road, home or work. A pilot scheme started in May, 1970, and the results are shown below.

Statistics: 23rd May to 31st December, 1970

Total accidents	146
Total accident patients	198
Telephone calls made to doctors by ambulance service	203
Number of times doctor available	90
Doctor not available	104
No replies	9
Doctor arrived at scene before ambulance	33
Doctor arrived at scene whilst ambulance there	35
Doctor arrived at scene after ambulance had left	18
Abortive calls	4
Times doctor travelled in cab to hospital	6
Number of accidents attended by doctor whilst patients present	68
Number of patients seen by doctor	121

Twelve family doctors are taking part in the scheme, and their enthusiasm remains high.

A major difficulty in a scheme of this nature is how to assess accurately how much part the doctor plays in reducing mortality and morbidity in the casualties.

Until administrative unification of the three branches of the health service occurs there is a danger that the ambulance service will be ineffectively used, but our experience has shown that co-operation is a successful remedy to this.

PUBLIC HEALTH AND THE 'POP' FESTIVAL

S. H. Brock, Divisional Medical Officer

Introduction:

In recent years 'pop' festivals have become increasingly popular, attracting sensational publicity and acquiring, in some cases, considerable notoriety. The origins were partly to be found in jazz or blues festivals and partly in the folk-singing and 'pop' music which was a prominent activity in the 'hippy' communes. By the late 1960's, the commercial potential of these performances had become apparent, there need be no limit to the size of audience or the duration of the performance, and the financial turnover might well be enormous. There followed a spate of these occasions where audiences of up to a quarter of a million thronged together in situations frequently devoid of basic amenities, for periods varying between three days and a week. The 'pop' festival, apart from its entertainment, commercial and sociological interest, has an important bearing on the community in the field of public health. This account of the Krumlin 'Pop' Festival describes the preventive measures taken to control disease, and ensure safety.

Preliminary Planning:

The Krumlin 'Pop' Festival was organised as a week-end event during August, 1970. The site, regarded as ideal by the organisers, was an isolated beautiful valley 10 miles south-west of Halifax and seven miles west of Huddersfield. The auditorium consisted of a 16-acre field, which formed a natural amphitheatre with first-class acoustics; an adjacent field of similar size was set aside as a camping area. However, this isolated site presented immediate difficulties in providing essential services, and several meetings were called at which police, ambulance, public health inspectors, Water Board officials, River Authority officers, St. John Ambulance and the medical officer discussed the problems and briefed the organisers on the need to provide certain essential services ensuring that satisfactory health and safety standards were met. The main points considered were:

1. Estimated Attendance Figure. The organisers could give no valid prediction but eventually agreed to an upper limit of 50,000, with 30,000 being a probable attendance based on advance ticket sales.

2. Traffic Control. Top priority was given to arranging that the narrow approach roads to the site would be kept clear at all times for ambulances and other essential traffic. Adequate sign posts were required and a one-way traffic system devised. The main parking area was to be kept well removed from the site itself.

3. General Security. Crowd control and security were to be the responsibility of the police exclusively, patrols operating within the area and along the perimeter, with a reserve force and drug squad ready in case of need.

4. Casualty Clearance. An ambulance team, with emergency supplies, was required to be stationed on site throughout the festival at the organisers' expense, with three more ambulances on standby at the base. Advance arrangements would be made to remove all but very minor casualties to Huddersfield Hospital, three first-aid tents staffed by St. John's and the Red Cross would provide the necessary field cover. The organisers invited 'Release' to be represented to help cope with any drug problem; mental welfare officers were to operate an attendance rota to supervise any problems arising in their field.

5. Toilet Provision. No mains drainage was available and trench latrines carried a risk of pollution in the local Water Board's catchment area. Chemical toilets seemed the appropriate answer and, drawing upon the experience of those involved in earlier 'pop' festivals, a ratio of one toilet to 50 persons of each sex was eventually agreed. Latrine blocks were to be properly constructed, erected at specified points, clearly marked for each sex, weather and insect proofed and with sanitary disposal units in the female blocks. The organisers agreed to engage the services of a contractor who would operate a continuous emptying service, disinfect and dispose of the material.

6. Water Supplies. Planning the provision of an adequate and wholesome water supply produced difficulties, aggravated by a period of drought. The sources of water were springs, which were too polluted for any type of use, and a 3-inch main capable of delivering, at best, 10,000 gallons per day. To provide an adequate safe water supply in these circumstances was a subject of prolonged and sometimes heated discussion but it was eventually agreed to accept two gallons per head per day for washing, cooking and drinking purposes, provided this was based on the maximum attendance figure. Of this 100,000 gallons per day to be guaranteed, 10,000 would be drawn from the main and the remainder transported by approved tankers running a shuttle service from the Water Board to ten 1,000 gallon-storage tanks on the site distribution system. Elevation and protection of the tanks was required and the reserve system would be chlorinated by the public health inspectors and checked bacteriologically at the outlet points.

7. Food Hygiene. The organisers were required to submit a list of caterers in advance. A pamphlet emphasising the requirements of the Food Hygiene Regulations was sent by letter to the caterers and they were informed that the public health inspectors would be on site on a rota system. A licence to sell beer and ales had been granted but glasses were to be replaced by disposable cartons.

8. Refuse Disposal. Sufficient disposable receptacles were to be placed at approved points. These were to be removed and replaced as necessary and assurances given that the site would be left in a tidy state.

Ultimate Arrangements:

By the time the Festival was due to commence, arrangements for crowd and traffic control, security and communications were well in hand. A mobile police station was set up on site, all activities being co-ordinated from there by field lines to various groups and an outside private line to police headquarters. Casualty clearance arrangements were basically as planned but with the addition of a Landrover ambulance since the promised improvements to access roads did not come up to expectations. Catering arrangements were very satisfactory and the co-operation of the vendors excellent.

However, the ultimate provision of toilets and the water supply did not meet the stated requirements. About half the agreed number of toilets were provided, sign-posting was unsatisfactory, and siting not as planned. Many were relatively inaccessible, which led to other blocks, already depleted in numbers, becoming over-used and disrupting the emptying arrangements. Some toilets became unusable when partitions were damaged, maintenance and repair arrangements being quite inadequate. Two useful points which had been overlooked were the need to provide lighting in the toilets at night and laying a floor of fine rubble or clinker to prevent the muddy unpleasant conditions which developed. In appropriate circumstances urinal troughs draining to soak-aways would effectively reduce the load on male toilets, but had the conditions regarding toilet provision been fulfilled, most of the problems would not have occurred.

The water supply did not meet the requirements, due to delays in the construction of the distribution system, bacteriological checking, even by the most rapid method, was delayed to a critically late stage. It was, nevertheless, cleared by the time the Festival began. The reserve supply of 90,000 gallons was not provided, the organisers reporting, two hours before the opening, that tankers were completely unobtainable. Whilst this was checked, instructions were given that the main water only should be used. Thus, one-tenth of the agreed minimum supply was provided by the organisers and, again, siting and maintenance of the tanks did not meet the demands. The one tank erected in the camping area was quite inadequate to supply the needs, some tanks had not been covered, others were covered by polythene sheets which soon blew off or were removed.

The Festival:

The Festival began a few hours late. During the first evening the numbers increased slowly, which eased the demand on the depleted toilet provision and water supply. The scene was peaceful, controlled and colourful, the weather sufficiently mild to permit sleeping in the open, plastic sacks being widely used as sleeping bags! During this evening one person only was removed by ambulance.

The following day, Saturday, attendance built up rapidly to a figure of about 20,000 according to the police estimate. The water supply, although a matter of concern, was holding out but the inadequacies of the latrine facilities were already apparent. Prompt police intervention forestalled the efforts of drug 'pushers', 10 arrests were made and it was considered that firm control in the

early stages prevented a serious drug problem developing. Similarly, the activities of unauthorised security groups were quickly and effectively terminated. No complaint could be made about the behaviour of the 'fans', generally they were well behaved and intent on peacefully enjoying themselves. However they paid no heed to the provisions for disposing of refuse, mounds of litter accumulated and the freshening wind blew rubbish over the entire arena. The standards of food catering were satisfactory. Three casualties were removed suffering from burns and shock when a gas container exploded.

During the evening an unexpected and marked deterioration in the weather brought increasing wind and heavy rain. The ambulance team removed a suspected case of appendicitis followed by a 17-year-old girl seven months pregnant and with abdominal pain. By this time, weather conditions made it impossible to convey patients by stretcher and the mountain rescue sledge had to be used. Vehicles, including the Landrover, were becoming stuck fast in the mud. 'Fans' crowded into the marquees in increasing numbers since the severity of the storm made sleeping out impossible. Under normal conditions these 'dormitory' marquees, although rough and ready, would have proved adequate; as it was, however, gross overcrowding occurred, many who could not get into the tents seeking protection in the toilet blocks and litter bins!

By 4 a.m., when the first aid tents were inundated with exposure victims, one of the marquees collapsed. All available cover was brought into use and a soup kitchen established; further supplies of emergency equipment, stretchers and blankets had to be obtained to cope with the increasing number of exposure victims. Conditions underfoot were like a quagmire, making any form of rescue work extremely difficult. One person with acute asthma and about 10 of the more serious exposure cases required hospitalisation.

Date	Time	Reason for Removal	Description of Patient
14.8.70	21.25	? Hernia	Male—Sitting
15.8.70	11.59	Burns to arms	Female—Sitting
		Shock	Male—Sitting
		Burns to hands and shock	Female—Sitting
	23.20	? Acute Appendicitis	Female—Stretcher
16.8.70	01.05	7 months pregnant–Acute abdominal pain	Female—Stretcher
	04.35	Asthma	Female—Stretcher
	08.18	Invalid transferred to car park	Male—Sitting
	08.57	Bruised stump and exposure	Male—Stretcher
		Exposure	Female—Sitting
		Exposure	Male—Stretcher
	09.55	Exposure	Male—Stretcher
		Exposure	Male—Stretcher
	11.04	Abdominal pains and exposure	Male—Stretcher
		Asthma and exposure	Male—Stretcher
	13.20	Exposure	Male—Stretcher

Towards morning, when the rain stopped and people began to leave shelter points, the futility of the position became apparent and the Festival was abandoned about 8-30 a.m. As the crowds began to leave, police and ambulance workers continued to search throughout the site to make certain that no casualty was missed. The foregoing table gives details of those persons removed by ambulance but is no measure of the work carried out in the field by ambulance crews, first aid workers, 'Release' team and others to assist the many people who suffered varying degrees of exposure during the night.

General Comments and Conclusions:

1. The Festival proved to be a disaster, financially, for the organisers. At the Bankruptcy hearing it was stated that losses incurred were over £31,000, which included debts to performers, contractors and the local authority. The final cost to the promoters for ambulance cover was £450, and for security carried out by the police £2,800. A deposit of £1,000 had been required but the cheque was dishonoured. The attendance figure had reached its peak by Saturday evening at an estimated level of between 15,000 and 20,000. Receipts from ticket sales, however, corresponded to an attendance of 5,000, the discrepancy being explained by the discovery that a number of tickets had been forged and a number of people had succeeded in breaking in—although it was not possible to estimate precisely how many had entered by this means.

2. Crowd behaviour had given rise to little concern, in contrast to some of the other 'pop' festivals according to reports. Undoubtedly, prompt action to suppress drug taking and rigid prevention of unauthorised 'protection groups' taking over control had made a major contribution in this respect.

3. No attempt was made to clean up the site for several weeks. The area was littered with rubbish, tins, paper and general debris and it was necessary for the District Council to consider legal action against the owners of the fields to secure removal of this public health hazard. Following this threat, the site was eventually cleared.

4. As far as the public health and organisation of services are concerned, it is certain that detailed planning before the event had averted a serious outcome. It is also clear, from the experiences, that there are lessons yet to be learned in the approach to 'pop' festivals.

5. An efficient communications system is essential to ensure that traffic control is adequate and so that contact may be made amongst the various services operating inside and outside the area. Security should be entirely controlled by the police and closed circuit television may provide a quick method of pinpointing trouble spots at a larger function.

6. The approach to the organisation of these festivals would seem to leave much to be desired. Setbacks in planned provision of essential services may reach a critical stage due to delays in organisation. In many instances this is probably

due to financial difficulties—the money involved in the promotion being tied up with ticket sales. If advance ticket sales are slow, it is likely that any available financial resources would be used to increase publicity or book top performers, consequently with delay in the contracting and provision of services.

7. Unless payment is made in advance, financial failure of the festival results not only in the organisers suffering heavy losses but also the various contractors and, possibly, the ratepayer. Present legislation seems too ill-defined to prevent this contingency developing at these festivals. There is thus little incentive to local authority departments and others concerned with the provision of extensive safety and security arrangements when it is possible that if the festival is a financial failure, the ratepayers' purse may have to foot the bill. At present, it would be difficult to argue a case for a legal injunction to stop a festival if the organisers agree to meet the stated requirements, yet having to wait until the event has occurred before being empowered to take legal action is too late—particularly if the festival is a failure.

It would seem, therefore, that the present position whereby the choice of legal action lies between obtaining an injunction before the event or prosecution under the Public Health Act, 1936, after the event is inadequate to meet the case. Legislation is required which will reduce the element of the commercial gamble as well as giving 'teeth' to the authorities so that mere assurances by the organisers that they will fulfil requirements are not sufficient.

One approach to this difficulty might take the form of a declared minimum level of financial backing before plans for the festival were allowed to proceed. Certain sums of money could be set aside as a bond specifically to ensure that health and safety requirements were not only met, but sufficiently ahead of the opening date to enable final inspection and acceptance to be made.

Summary:

An account of the Krumlin 'Pop' Festival is described detailing the steps taken to ensure safety and prevent disease. The importance of these precautionary measures received particular emphasis at this gathering when an unexpected deterioration in the weather to a harsh level, even by Pennine standards, eventually resulted in the Festival being abandoned. Some of the consequences are outlined and attention is drawn to problems which created particular difficulty with suggestions about how these problems might be approached in the future.

Finally, I am indebted to the Public Health Inspectors, Ambulance Officers, Police, Water Board Authorities and many others who were concerned with supervision at the Festival and whose experience at the Festival raised many of the points discussed.

Note: Further reference to this event will be found in the Ambulance and Environmental Services Sections of the Report.

COMMUNITY AND HOSPITAL CARE FOR THE MENTALLY DISORDERED

D. E. Jeremiah, Principal Medical Officer
W. J. Battye, Principal Administrative Officer

Over recent years there has been a considerable increase in the degree of public attention focused upon the needs of the mentally disordered. There have been reports on conditions in some of the large hospitals for the mentally handicapped and a declared policy of running down these large hospitals with increasing pressure on local authorities to provide alternative accommodation for a large number of hospital patients to be discharged to 'community care.'

The emphasis of the 1959 Mental Health Act was the desirability of keeping the mentally handicapped within the community wherever possible, but what does the term 'community care' really mean? Contrary to the popular interpretation that this indicates the transfer of large sections of the hospital population to local authority hostels, the true interpretation of 'community care' is surely 'care within the family'. In order that the mentally handicapped person can be retained within the family unit for as long as possible, instead of admitting these patients to hospital, it was necessary that supportive services on a large scale should be available. To this end the West Riding County Council began, in the early 1960's, an extensive development of the Mental Health Services. Mental welfare officers, whose role was to give support to families with a mentally disturbed member, were appointed. The provision of purpose-built training centres and special care units was speeded-up so that the services necessary for the retention of mentally disordered persons in the community became available.

By the end of 1970 the West Riding County Council were providing some 1,500 training centre places, for children and adults and over 150 places in special care units for severely handicapped persons who suffer from both mental and physical handicaps. This provision, undoubtedly, enabled many mentally subnormal children and adults to remain at home rather than be admitted to hospital. The rapid development of these facilities in the West Riding can be emphasised by the fact that in the short period of three years (1961-64) the number of training centre places was more than doubled rising from a figure of 729 at the end of 1961 to 1,466 by 1964.

Meanwhile there had also been a gradual but considerable decrease in the population of some of the larger hospitals. The changes brought in by the 1959 Mental Health Act meant that many patients who had formerly been in hospital under statutory provision, became voluntary patients and there followed a number of discharges to family care and to local authority hostels. For example, when the County Council's hostel at West Ardsley opened in 1965, 11 patients from Hospital 'B' were amongst the first admissions. The number of beds in this particular hospital was reduced by 20 per cent. (400-320) between 1965 and 1970, thus the hospital population remaining to be dealt with represents a hard core of cases for whom there was no easy route of discharge.

Having regard to the circumstances outlined above, and increasing pressure for the discharge of certain patients who had been in hospital for considerable periods, a detailed study into West Riding patients in three Yorkshire hospitals for the mentally handicapped was carried out. This produced some interesting facts and background information. For ease of reference the hospitals are coded 'A' 'B' and 'C' on the tables given below.

Hospital 'A'. (52 West Riding Patients)

Age Range								Length of stay in Hospital					
Under 15 yrs	15/25 years	25/35 years	35/45 years	45/55 years	55/65 years	65+ years	Total	Under 5 years	5/10 years	10/20 years	20/30 years	Over 30 yrs	Total
15	13	9	5	8	2	–	52	15	17	10	10	–	52

The West Riding catchment area for the above hospital had a population of approximately 218,000 and it was ascertained that 482 mentally handicapped and severely mentally handicapped persons were living at home in the area as follows:

Attending training centre	278
Working and self supporting	67
Part-time self employed and part self supporting ...	3
Employed at home, etc.	114
Unsuitable for work or training centre	20
	482
Number of above awaiting hospital admission	12

In addition to the 52 patients in Hospital 'A' a further 72 were in other hospitals within the Region and 83 in hospitals situated outside the area, giving a total of 207 patients in hospital as compared with 482 living in the community. This indeed shows a considerable improvement in the proportions of mentally handicapped persons living in the community as compared with the situation which previously existed.

Hospital 'B'. (154 West Riding Patients)

In May, 1969, the consultant psychiatrist at this hospital submitted a list of 154 patients whom he considered could be discharged to community care. Every case on this list was investigated by the County Council's mental welfare officers and full details were recorded. The age group and hospitalisation was summarised as follows:

Age Range									Length of Stay in Hospital						
0-5 years	5-9 years	10-19 years	20-29 years	30-39 years	40-49 years	50-59 years	60+ years	Total	0-5 years	5-9 years	10-19 years	20-29 years	30-39 years	40-49 years	Total
–	2	18	22	30	39	26	17	154	21	26	32	44	20	11	154

It will be seen from the above that 82 (53 per cent.) of the patients were over 40 years old and that 75 (48 per cent.) of them had been in hospital for periods exceeding 20 years.

The home conditions were summarised as follows:

Poor conditions with limited accommodation/supervision	7
Aged or inadequate parents	28
Unwilling relatives...	23
Willing relatives but in poor health	11
No immediate relatives	35
Relatives not traced in spite of extensive enquiries ...	34
	138

Cases considered suitable for gradual discharge:

Possible home discharge	2	
Possible week-end leave	12	16
Inter hospital transfer	2	
		154

Brief details of the circumstances of the 16 cases listed as suitable for gradual discharge are as follows:

Possible home discharge — 2

Case No. 74 Parents divorced Mother remarried. Had not visited because her husband had sustained injury through colliery accident. She promised to resume visits and to discuss with the consultant psychiatrist the possibility of home discharge.

Case No. 99 Father a widower. Patient's sister keeps house. Patient already having week-end leave at home. Father and sister considered permanent discharge possible and agreed to discuss this with consultant psychiatrist.

Possible week-end leave — 12

Case No. 18 Patient is a spastic diabetic who is prone to injury. Father retiring from the teaching profession and both parents agreed to have their son home on gradually extended leave preparatory to final discharge.

Case No. 57 This was a child patient admitted to hospital to ease the strain on his parents. His condition was slightly improved and the parents agreed to give a trial to home leave at week-ends.

Case No. 85 Father disabled by colliery accident. Four other children living at home. Parents willing to have patient home for week-ends but could not manage permanent care.

Case No. 107 Parents, brother and two sisters live in a small three bedroomed house. Willing to have patient home for week-ends but because of his behaviour and habits they would not be able to undertake permanent care.

Case No. 109 Mother a widow on old age pension. Brother aged 34 lives at home. Mother willing to have patient home for week-end but is not well enough to give him permanent care.

Case No. 110 Mother, father, two brothers and one sister (all adult) live in three bedroomed house. Parents willing to consider trial period of home leave.

Case No. 120 Arrangements made by mental welfare officer for the patient to take regular week-end leave with the parents.

Case No. 122 Family consists of father, mother and patient's brother. Arrangements made for patient to spend two days per month at home.

Case No. 124 Nearest relative is patient's sister who lives in a three bedroomed house with her two sons. Sister agreed to patient spending one day per week at her home.

Case No. 138 Mother aged 82, lives with subnormal son aged 50, and daughter (52) recently discharged from mental hospital. Mother willing to have patient for short holiday periods.

Case No. 143 Mother willing to have patient for holidays but unable to accept permanent care.

Case No. 152 Nearest relative patient's brother who agrees to accept patient for regular home leave.

Inter hospital transfers — 2

Case No. 42 Parents reside some 30 miles away and requested transfer to a hospital nearer home to facilitate visiting.

Case No. 80 Only interested relative is a brother-in-law who found travelling to this particular hospital very difficult. He requested transfer to another hospital which was easier to reach by public transport.

In November, 1969, a meeting was convened by the Group Secretary of the local Hospital Management Committee to consider the summary. Arising from this meeting it was agreed that a case conference system be set up and that these should commence with a complete review of all the cases in a small annex to the larger hospital (the annex is coded Hospital 'C' in this report).

Hospital 'C'. (46 West Riding Patients)

A series of eight meetings were held over a period of 14 months. The panel at these meetings consisted of the Consultant Psychiatrist, Psychiatric Registrar, Hospital Social Worker, Chief Nursing Officer and members of the Nursing staff from the hospital side; the Principal Medical Officer for Mental Health, the Senior Mental Welfare Officer and District Mental Welfare Officers according to the home area of the cases due for consideration, and an Administrative Officer from the County Health Department.

A summary of the patients seen by the panel is as follows:

Age Range							Length of Stay in Hospital						
10-19 years	20-29 years	30-39 years	40-49 years	50-59 years	60+ years	Total	0-5 years	5-9 years	10-19 years	20-29 years	30-39 years	40-49 years	Total
3	10	11	15	6	1	46	5	10	10	13	6	2	46

From the above it will be seen that of the 46 patients reviewed 22 (48 per cent.) were aged 40 years and over, and 21 (46 per cent.) had spent more than 20 years in hospital.

During the period of the liaison meetings the 46 patients were individually considered with full background reports and each patient interviewed by the panel.

Action taken on the recommendations of the review panel can be summarised as follows:

Discharged home	1
Training facilities provided at sheltered workshop	1
Relatives traced	3
Visiting by relatives reinstated	3
Voluntary visiting arranged for patients who receive no visitors	4
Relatives contacted outside West Riding area	1
Re-assessment by psychologist...	5
Home leave (e.g. week-ends or longer periods)	3
Treatment arranged (e.g. hearing tests, dental, EEG etc.)	3
Prospective employers contacted	3
Interviews arranged at Agricultural Training College ...	2
Inter hospital transfer	1
Additional bedding provided to enable widowed mother to take son for a week-end leave	1

In the case of the remaining 15 patients, these were already receiving regular family support and visiting.

Summary:

From this investigation it is apparent that despite the pressure for the discharge of large sections of the hospital population only a very small proportion could be discharged to satisfactory living conditions in the community. It is also possible that a mere transference of hospital patients to local authority hostels

may not be the ultimate answer to this problem as this could, in many cases, only create another type of institutional life with a limited number progressing beyond the hostel stage, e.g. transference to group homes accepting two or three mentally disordered patients as lodgers in ordinary homes but sponsored by the Local Authority. It must also be recorded that many of the patients interviewed by the review panel (Hospital 'C') regarded the hospital as their home and it would be necessary to uproot these patients from their familiar surroundings. It may be that new hostels built in hospital grounds could meet their needs.

The need for more hostel provision to prevent hospitalisation is, however, very clear and Local Authorities must press on with their building programmes, complementary to which should be a continued search for houses suitable for conversion to group homes to ensure a second stage in the rehabilitation programme.

LEE GRANGE HOSTEL FOR POST PSYCHOTIC PATIENTS; FOUNTAIN STREET, MORLEY; AND MIRFIELD DAY INDUSTRIAL CENTRE FOR THE MENTALLY ILL

D. E. Jeremiah, Principal Medical Officer
W. J. Battye, Principal Administrative Officer

Lee Grange Hostel:

Lee Grange is a purpose built hostel which provides accommodation for 20 post psychotic patients. The bedrooms are in two separate blocks with 10 single rooms for male patients in one block and 10 single rooms for female patients in the other. There is a communal block comprising kitchen, dining room, T.V. room and general lounge, together with the Warden's Office and interviewing room. Staff accommodation comprises a three bedroomed house for the Warden and his family and a flat for the Assistant Warden.

The first resident was admitted on the 28th July, 1968, and by the end of the year there had been 23 admissions and eight discharges.

Applications were received from the following:

	No. of Applications	*No. Accepted for Admissions*
Stanley Royd Hospital	15	9
Storthes Hall Hospital	4	3
High Royds Hospital	3	2
Naburn Hospital	1	—
Clifton Hospital	3 + 6 psycho-geriatrics	—
Scalebor Park Hospital	1	1
Lancaster Moor Hospital	1	—
Middlewood Hospital...	2	1
Westwood Hospital	1	—
Stansfield View Hospital	1	—
Pinderfields Hospital	1	1
Total	39	17
Ackworth Moor Top School for mal-adjusted pupils	1	—
H.M. Borstal, Middlesex	1	—
Patients living at home	12	6
Grand Total	53	23

The decision for providing hostel accommodation is arrived at after consultation and consideration of all the circumstances of the case as is done at the Healey Croft Hostel for Subnormal Adults.

The original intention, in accord with the policy of the Health Committee, was to admit those patients from psychiatric hospitals who had completed their hospital treatment for short periods of time in order to promote social rehabilitation before their return to the community. The admission of patients direct from the community would also be considered but it was felt that this would be a less likely occurrence. To further this aim, consultant psychiatrists from Wakefield, Huddersfield and Leeds hospitals were invited to visit the hostel for an afternoon when the function of the hostel and the type of care envisaged was fully discussed.

Eleven hospitals subsequently referred cases for consideration, the Stanley Royd Hospital submitting the highest number of applications. Of the 15 applications received from that hospital nine were accepted.

Lee Grange was the first post-psychotic hostel in the West Riding and this provided an entirely new service so far as the County was concerned. Initially some psychiatrists referred cases for long rather than short-stay periods and there is no doubt that the hostel could have been filled immediately with such cases. It was realised, however, that this would be the wrong policy and that as the main purpose of the hostel was therapeutic it should not be looked at in terms of 'filled' beds with a long waiting list.

The policy of admitting patients, who had completed their hospital treatment, for short periods in order to promote social rehabilitation necessarily involved a large turnover of cases and during 1969 there were 30 admissions and 24 discharges. The same trend continued during 1970 when there were 35 admissions and 36 discharges.

In a report to a Visiting Sub-Committee in October 1970, the Divisional Medical Officer, Dr. Ireland, wrote:

> "The question which has frequently been posed is 'how much success have you had with the hostel' or 'what successes have occurred as a result of admission to Lee Grange.' The answer of course is that about 80% of cases admitted are a success. The remainder represent those cases which medically were not really suitable for admission and had to be returned under medical care almost immediately, together with those who were perhaps persuaded to be admitted against their own judgment. But the majority regardless of the final outcome came to live in Lee Grange in a community situation and at that point in time proved whether or not they could exist in this manner and cope with the new pressures exerted upon them. This in itself was a success."

Fountain Street, Morley:

It soon became apparent that certain patients made good progress in Lee Grange and were quite ready to move on but had no permanent home to which they could be discharged. It was felt that the Authority should make some form of permanent accommodation for such cases. When, therefore, a County-owned house at 57, Fountain Street, Morley, became surplus to requirements the Mental Health Sub-Committee approved a recommendation that the house be adapted to provide accommodation for persons discharged from Lee Grange.

The house at Fountain Street was adapted to provide four bed-sitting rooms with a communal lounge and dining room. Gas-fired central heating was installed and supplementary heating made available in each of the bedrooms by means of a coin operated electric fire. The house was fully furnished by the County, though not on a lavish scale.

When the adaptations were completed four of the residents at Lee Grange were considered for transfer to Fountain Street. They were all in employment and capable of preparing their own breakfasts and other light meals. It was felt, however, that the preparation of an evening meal and general oversight of the cleaning and housekeeper duties should be undertaken by a non-resident person (or persons). It was further suggested that food be supplied by the County and that the charge to residents be based on full board/residence, excluding mid-day meals Monday/Friday. These recommendations were approved by the Committee and the charge for full board residence, excluding mid-day meals on normal working days, was fixed at £5 per week.

Four of the Lee Grange male residents moved into Fountain Street early in 1970 and experience to date indicates a satisfactory start on this type of group home.

Mirfield Day Industrial Centre:

Although a fair proportion of the Lee Grange residents were able to obtain employment, there were a number for whom the employment prospects were bleak. The unemployed residents presented something of a problem; the longer they were unemployed the less chance they had of getting work and the more likelihood they had of relapsing.

This situation, coupled with a knowledge of a wider need for the rehabilitation of the mentally ill generally, led to discussions on the possibility of establishing a sheltered workshop or day training centre for persons who were recovering from mental illness.

About this time information was received from the West Riding Territorial and Auxiliary Association relating to a number of properties (T.A. Drill Halls) that were to be disposed of. It was thought that some of these properties might be suitable for development as industrial day centres and several were inspected. Of

the properties seen, the most suitable appeared to be the Drill Hall at Mirfield. The building was of sound construction, being built in the 1930's, and was ideally situated on the main Dewsbury/Huddersfield road with good transport facilities.

The purchase of the Drill Hall was approved and the building was brought up to modern standards, the total cost of purchase and adaptations being less than £20,000. The adapted premises provide ideal workshop facilities with ample storage space, loading bays etc. Good office accommodation is provided, also staff and patients dining rooms, rest rooms etc.

The type of industrial work to be undertaken was discussed with the Chief Officer of Supplies and it was decided to concentrate on the production of various forms of stationery, cardboard cartons etc., for which the County Supplies Department had a very large demand. Specialised machinery including power guillotines, stitching machines, counting machines and folding machine were, therefore, installed. (See photograph following page 140).

An admission panel was set up and patients were selected for the initial admissions. These were mainly drawn from the surrounding area but provision was also made for the unemployed residents at Lee Grange Hostel to attend. The first patients were admitted in May, 1970, and production of jotters (unruled scribbling pads), metal edged cartons, folders etc. was soon under way. The speed of production was gradually increased and by the end of 1970 some 400,000 jotters, 100,000 folders and 15,000 metal edged cartons had been produced.

By arrangements with the County Welfare Officer, mid-day meals were drawn from a nearby aged persons' home. The question of incentive payments to the patients was discussed and it was finally agreed that all patients would receive payment at the rate of £2 per week, but that they would be paid on a pro rata basis, e.g. 8s. per day. All patients retain their national allowances, e.g. unemployment or sickness benefits.

Twenty-three patients were on the register at the 31st December. There had, however, been a fairly large turnover during the year with 46 admissions and 23 discharges.

With the opening of the Mirfield Day Industrial Centre it was possible to insist that the Lee Grange residents were either employed or attending Mirfield and thus prevent any sitting around in the hostel during the day, which had become a feature of certain residents.

MENTAL HEALTH SERVICES TRANSFERRED TO EDUCATION AND SOCIAL SERVICES DEPARTMENTS

W. J. Battye, Principal Administrative Officer

Transfer of Responsibility for the Education of Mentally Handicapped Children:

The Education Act of 1944 made the local health authority responsible for children found unsuitable for education in school. These children were then excluded from the education system and were for the most part catered for in training centres. Approximately 800 children were in the 19 training centres, including approximately 130 in the special care units, at the end of 1970.

In November, 1968, a statement was made in the House of Commons by the then Prime Minister, (Mr. Harold Wilson) to the effect that "*after careful consideration of the views expressed by the bodies consulted the Government have decided to accept in principle that responsibility for the education of mentally handicapped children in England and Wales should be transferred from the Health to the Education Service.*"

The Education (Handicapped Children) Act received the Royal Assent on 23rd July, 1970. It made provision to bring within the educational system those children who would previously have been determined as unsuitable for education at school. The operative date for this legislation was fixed by the Secretary of State for Education and Science as the 1st April, 1971.

A Circular (16/70) issued from the Department of Health and Social Security asked for close co-operation between the Health and Education Departments on the appointed day. To this end a small Working Party consisting of members of the Health and Education Departments was set up. Members of this Working Party visited all the centres and their report was subsequently submitted to both Committees.

All staff engaged exclusively on the junior side of the training centres, including general duty attendants and special care staff were transferred to the Education Department on 1st April, 1971. Two training centres which catered entirely for children were similarly transferred and a working arrangement for continued joint user of the former comprehensive centres was agreed.

Of the 64 teaching staff transferred on 1st April, 1971, 39 (65 per cent.) had obtained the Diploma of Teacher of the Mentally Handicapped. This compared very favourably with the position only a few years ago when children were taught by staff who, in the main, did not possess recognised qualifications.

A scheme for the recruitment of cadet teachers was also introduced. Girls with the necessary educational qualification of five G.C.E. 'O' level passes were engaged as cadets. After two years as a cadet these girls then proceeded on the Diploma Course and three cadets who were first recruited in 1966 have now returned as fully qualified teachers. Another three are mid-way through a two-year course and a further three cadets entered training colleges in September, 1970.

The full range of educational aids has been made available to the junior departments and all children received an education suited to their ability and aptitude. Quite a number of children learned to read and all were taught word recognition and money values. Even in the special care units, where children with severe physical disabilties are accommodated, training and education were not neglected. In some cases children were accommodated in the special care unit for part of the day, e.g. for toileting etc., and were able to take part in classroom activities for the remainder of the time.

The progress of children was kept under constant review and re-assessments carried out by medical officers who have received special training in this particular field. Where appropriate, transfers to the special schools for E.S.N. children were arranged.

A high degree of skill has been developed in art and a number of children from West Riding centres have won awards in national art exhibitions. Several of their paintings have been sold and some pictures have been purchased by overseas buyers.

In appropriate cases children were admitted on an 'informal' basis so that they could have a trial period in the centre.

Activities in the junior departments were not confined to classroom work and groups of juniors went out on shopping expeditions and visits to places of interest.

Swimming and physical education were part of the curriculum. Some centres have their own swimming pools and in others children take part in organised parties to the local baths. A number of children have been taught to swim and they all thoroughly enjoyed that part of their programme.

It will be seen, therefore, that a full and varied educational programme has been available to all children in the County Council's training centres, and that an efficient service has been handed over.

Services Transferred to Social Services Department:

In accordance with the requirements of the Local Authority Social Services Act, 1970, the County Council brought into operation on 1st April, 1971, a new

Social Services Department. The functions to be transferred to the new department included the following services previously administered by the Mental Health Sub-Committee of the Health Committee:

(i) Welfare of mentally disordered persons.

(ii) Provision of hostels and training centres for the mentally ill and mentally handicapped.

(iii) Provision of accommodation for children suffering from mental disorder.

The practical effect of this legislation was that the field work staff, i.e. mental welfare officers, who were responsible for the welfare of mentally disordered persons in the community transferred to the new department on 1st April, 1971. At the request of the Director of Social Services, however, the remaining functions (i.e. training centres, industrial centres, hostels and housing accommodation and the day centres at Harrogate and Snaith) remained under the operational control of the Health Department for a further period of three months, i.e. to 1st July, 1971.

It would appear appropriate at this time to recall something of the growth and development of the transferred services and a brief history of these services.

When the 1959 Mental Health Act came into operation many new responsibilities fell upon local health authorities as the main emphasis of this Act was to replace 'custodial care' with 'community care.' There was, therefore, a shift of emphasis away from the hospitals to community care with a consequent need for the development of local authority services to include the provision of residential accommodation for the mentally disordered; of adequate training facilities for children, young persons and adults, and of general social work to help all types of mentally disordered patients and their relatives, including all forms of community care after patients leave hospitals. In order to implement the requirements of the Act the County Council developed the following services:

Welfare of Mentally Disturbed Persons—Community Care by Mental Welfare Officers:

Prior to the Act, the admission of mentally disturbed persons to hospital had been carried out by 24 welfare officers, who were known as 'Duly Authorised Officers' and who undertook this work along with the other general welfare duties. Apart from the admission of patients to hospital they had no other duties in connection with Mental Health and were, therefore, simply 'removal officers.' In addition there were 16 social workers who dealt mainly with the care of the mentally subnormal persons who were living at home.

The immediate need was to recruit a sufficient number of officers to help or advise all mentally disordered persons, whether or not they had been in hospital. To this end an establishment of 53 mental welfare officers was approved, seven of this number to be senior officers appointed to the seven 'mental health areas' into which the County was divided, each mental health area representing the catchment area of one of the larger mental hospitals.

It was originally envisaged that the senior mental welfare officer would provide the liaison between the mental hospital and the mental welfare officers working in the field. The co-operation between the field officer, the general practitioner and the mental hospitals however worked out so well that the mental welfare officers developed a good direct relation with the hospitals without relying on an intermediary. The County Council also began to reap the benefit of the secondment scheme for the training of officers and the number of trained officers steadily increased. Having regard to the way in which the service had developed and with a view to providing better career prospects to retain trained officers in the County service, the Health Committee, in 1970, approved a revised establishment which increased the number of senior appointments from 7 to 17. The establishment of mental welfare officers had been gradually increased and a trainee grade had also been introduced. The approved establishment on 31st December, 1970, was therefore Senior Mental Welfare Officers 17, Mental Welfare Officers 48, Trainees 4, a total of 69 officers which represents an increase of 16 officers over the 1960 establishment.

In addition to the secondment of officers on the two year course leading to the Certificate in Social Work, an intensive in-service training programme has been maintained by means of seminars and residential courses at Grantley Hall.

PROVISION OF HOSTELS AND TRAINING CENTRES FOR THE MENTALLY ILL AND MENTALLY HANDICAPPED:

Hostels:

The County Council's initial programme for purpose-built hostels was for four establishments—two for mentally subnormal children (Harrogate and Skipton), one for mentally subnormal adults (West Ardsley) and one for post psychotic patients (West Ardsley). This initial programme was completed and the four hostels were in operation by early 1969 as follows:

Hostel	*Accommodation*	*Opened*	*Cost*
Meadow Bank, Harrogate	8 subnormal children	1964	£14,000
Healey Croft, West Ardsley	30 subnormal adults	1965	£67,000
Lee Grange ,West Ardsley	20 post psychotic patients	1968	£48,000
The Ghyll, Skipton	16 subnormal children	1969	£40,000

Although provision has been made in the Ten Year Plan to provide 10 hostels with 218 places by 1976, it had never been intended that these numbers would be absolute and it was always in mind that the plans would be subject to revision at the periodic reviews.

By 1967 it was evident that the tentative forward planning was inadequate and the following amended programme was approved by the Mental Health Sub-Committee on 11th September, 1967.

Type	Present Position		Present ten Year Plan forecast by 1976		Provision needed to reach national average by 1976	
	Premises	Places	Premises	Places	Premises	Places
Mentally subnormal children ...	2	24	4	48	6	80
Mentally subnormal adults	1	30	2	60	8	240
Mentally ill adults	1	20	2	50	8	160
Elderly mentally ill	—	—	2	60	3	90
Totals	4	74	10	218	25	570

The national average per 1,000 population envisaged by the overall estimate in the Ten Year Plan, and the provision as outlined above was then as follows:

	Mentally subnormal children	Mentally subnormal adults	Mentally ill	Elderly mentally ill
National average	0·05	0·17	0·09	0·04
West Riding provision	0·05	0·14	0·10	0·05

In 1970, following the declared Government policy to run down the large hospitals for the mentally subnormal, there became apparent a hardening attitude by the hospital authorities and by the consultant psychiatrists to requests for hospital admissions on social grounds. The County Council's hostels for the subnormal were all full and had waiting lists. In this situation it was apparent that the building of hostels for the mentally subnormal needed to be speeded considerably and a report was presented to the Mental Health Sub-Committee on 3rd June, 1970. In accepting the recommendation in this report the Committee approved a revised building programme which gave a greater priority to hostel building and which provided for the commencement of eight hostels for adult subnormals and two hostels for mentally subnormal children during the three year period 1970-1973.

In addition to the hostel provision, an encouraging start has already been made in the way of small group homes in ordinary housing accommodation. Four such establishments are now operating at:

4, Zoar Street, Morley	(3 subnormal adults)
57, Fountain Street, Morley	(4 post psychotic adults)
15, East Park Road, Harrogate	(6 post psychotic adults)
32, Griffiths Road, High Green	(3 subnormal adults)

Full details of the above projects (with the exception of Griffiths Road, High Green which opened in 1971) are given in the main body of the Report.

The Growth and Development of Training Centres:

Training centres of the type now operating in the County have evolved through three distinct stages in the development of the training of mentally subnormal persons. First we had Group Training Classes, secondly Occupation Centres and finally Training Centres. At each stage of development the designation has been indicative of the function.

GROUP TRAINING:

Local Health Authorities had a general duty under the old Mental Deficiency Acts to provide suitable training, occupation and general social care in the community for defectives who had been ascertained as 'Subject to be dealt with' under those Acts, but who did not need to go into a mental deficiency hospital or other institution.

In many places this duty was met by the provision of Group Training Classes or through a service of Home Teachers.

The Group Training was mainly in rented premises and, as the name implied, children of varied ages were grouped together for simple social training and occupational therapy under one teacher. Many of these groups were only part-time, meeting for two or three days per week. Where groups were not practicable a service was given through the employment of Home Teachers who visited the homes of mentally subnormal persons and provided facilities and instruction in simple forms of handicraft, e.g. rug making etc.

OCCUPATION CENTRES:

Under the National Health Service Act of 1946 (Section 28) Local Health Authorities were given a power (but not a duty) to provide other forms of community care and the setting up of 'Occupation Centres' was encouraged for children who had been reported under the Education Act as 'ineducable'. In the early days the functions of these centres was in line with the designation and the general conception was that the mentally subnormal should be 'occupied' rather than 'trained'. Indeed instances have been quoted of a patient being allowed to sand-paper the same block of wood for months because 'it kept him occupied'.

The Royal Commission on the Law relating to Mental Illness and Mental Deficiency (1954-57) produced their Report in May, 1957. The Report reviewed the function of the Occupation Centre and defined the basis as "*habit training, teaching children to keep themselves clean and to dress themselves, sense training to improve alertness, movement and speech.*" The Commission recommended a revision of procedure and terminology so that the approach could be "*more positive and less negative*" and further recommended that the Centres be called "*Training Centres*" rather than "*Occupation Centres.*"

TRAINING CENTRES:

The Mental Health Act of 1959 reiterated the powers of Local Health Authorities under Section 28 of the National Health Service Act and specified that arrangements under this Section should include "*the provision of Centres or other facilities for training or occupation and the equipment and maintenance of such Centres.*"

The implementation of the Mental Health Act gave the necessary impetus to Local Health Authorities and the building of purpose-built centres proceeded rapidly in the 1960's.

The marked increase in the facilities in the West Riding can perhaps be best illustrated by the following comparison between the years 1959-70:

Year	*No. of Centres*	*No. of Places*			*Total*
		Junior	*Adult*	*Special Care*	
1959	12	412	211	—	623
1970	19	664	822	154	1,640

Day Centres:

Two day centres at Harrogate and Snaith, and one industrial centre at Mirfield have been established and were in full operation at the time of transfer. All these centres provided facilities for persons who had been mentally ill although each of the centres had a different approach by reason of the different types of patients they receive. The Harrogate Centre is entirely therapeutic and has no industrial output, the Snaith Centre provides facilities for patients to take occupational therapy and to re-adjust themselves to a return to normal life, the Mirfield Centre is highly industrialised with a large output of valuable contract work and where the patients are given opportunity of adjusting themselves to normal factory conditions with the aim of rehabilitation to industry.

Fuller reports on the working of these centres are included in the Mental Health Section of this Report.

Summary:

Details of all the main Mental Health projects covering the period 1953-71 are given on the following schedule, from which it will be seen that capital expenditure in the region of £1,500,000 has been involved.

MENTAL HEALTH CAPITAL BUILDING PROJECTS 1953-71

Training Centres

Centre and Year of Opening	*Description of Premises*	*Cost* £	£
Keighley			
1953	Junior Centre (purchase of old building)	10,000	
1964	Adult Wing (purpose-built)	47,000	57,000
Hemsworth			
1955	Junior Centre (purpose-built)	14,000	
1963	Adult Wing (purpose-built)	41,000	
1967	Special Care Unit (purpose-built)	19,000	74,000
Brighouse			
1957	Junior Centre (purchase of old building)	1,800	1,800
1970	Comprehensive Centre (purpose-built)	136,000	136,000
Horsforth			
1957	Junior Centre (purchase of old building)	2,500	2,500
1962	Comprehensive Centre (purpose-built)	44,000	
1968	Special Care Unit (purpose-built)	19,730	63,730
Wombwell			
1957	Junior Centre (purchase of property)	2,800	
1963	Adult Wing (purpose-built)	46,000	
1968	Special Care Unit (purpose-built)	19,000	
1971	Extension to Adult Wing	8,500	76,300
Adwick			
1959	Comprehensive Centre (purpose-built)	26,000	
1963	New Kitchen facilities	17,000	43,000
Airedale			
1959	Comprehensive Centre (purpose-built)	24,000	
1963	Adult Wing (purpose-built)	26,000	50,000
Ecclesfield			
1959	Comprehensive Centre (purpose-built)	24,000	
1963	Adult Wing (purpose-built)	24,000	
1963	Special Care Unit (purpose-built)	18,400	66,400
Wath upon Dearne			
1959	Comprehensive Centre (purpose-built)	27,000	
1964	Special Care Unit and kitchen (purpose-built)	31,000	
1971	Extensions to Adult Wing	9,750	67,750

		£	£
Heckmondwike			
1960	Junior Centre (purchase of old building)	10,000	
1966	Kitchen facilities etc.	9,200	
1968	Adult Wing (pre-fabricated building)	10,000	29,200
Maltby			
1960	Comprehensive Centre (purpose-built)	24,000	
1963	Adult Wing (purpose-built)	30,000	
1968	Special Care Unit (purpose-built)	28,000	82,000
Rawcliffe			
1961	Comprehensive Centre (purpose-built)	40,000	
1970	Adult Wing (purpose-built)	88,000	128,000
Harrogate			
1962	Comprehensive Centre (purpose-built)	44,000	
1971	Special Care Unit (purpose-built)	27,400	
1971	Site for Adult Wing	6,000	77,400
Ossett			
1957	Junior Centre (purchase of old building)	2,700	2,700
West Ardsley			
1963	Comprehensive Centre (purpose-built)	50,000	
1969	Special Care Unit (purpose-built)	26,000	
1971	Adult Wing (purpose-built)	105,000	181,000
Kirkburton			
1963	Comprehensive Centre (purpose-built)	73,000	73,000
Rothwell			
1963	Comprehensive Centre (purpose-built)	55,000	55,000
Skipton			
1965	Comprehensive Centre (purpose-built)	57,000	57,000
			1,333,780

HOSTELS

Harrogate			
1964	Meadow Bank Hostel for 8 children (purpose-built)	14,000	14,000
West Ardsley			
1965	Healey Croft Hostel for 30 adults (purpose-built)	67,000	67,000

		£	£
West Ardsley			
1968	Lee Grange Hostel for 20 adults (purpose-built)	48,000	48,000
Skipton			
1969	The Ghyll Hostel for 16 children (purpose-built)	40,000	40,000
	DAY CENTRES		
Snaith			
1969	Additional workshops	2,055	
	Modernisation of old building	4,925	6,980
Mirfield			
1970	Purchase of former Drill Hall	8,750	
	Adaptations	9,000	17,750
			1,527,510

FAMILY PLANNING SERVICE

Report of the County Medical Officer presented to the May, 1970 meeting of the Care of Mothers and Young Children and Nursing Services Sub-Committee.

At their meeting in July, 1968, the County Council resolved as follows:

"That, as from a date to be decided, the grant payable to the Family Planning Association be increased to a figure to be agreed after discussion with representatives of the Association, subject to—

(i) The Association making no charge to West Riding patients attending the Association's clinics situated in the County Administrative Area in respect of advice given, medical examination, and, in medical and problem family cases, in respect of contraceptive substances or appliances supplied.

(ii) Charges being made to non-medical cases in respect of contraceptive substances or appliances supplied.

(iii) No payment being made in respect of the unmarried."

Part (i) of the above resolution has never been implemented because of economies made in succeeding budgets, and it is considered necessary to make an urgent review of the situation.

The National Health Service (Family Planning) Act, 1967, provided for local health authorities to establish their own family planning services and the County Council have authorised the establishment of family planning clinics in those areas where a service is not being provided by the Family Planning Association. In the Circular 15/67 issued by the then Minister of Health in connection with the new Act, local health authorities were prohibited from making any charge to a patient in respect of medical examination and advice given. Thus, in certain areas of the County, family planning clinics are in the process of being established at which the service will be given free except that, in cases other than medical and problem family cases, the patient will meet the cost of the contraceptive substances or appliances.

This situation will inevitably lead to representations from the public in that patients in some areas of the County, and possibly also in neighbouring County Boroughs, can be provided with a free service, whereas patients in other areas of the County, where Family Planning Association clinics only are available, will have to meet the Association's charges.

In June, 1969, the Health Committee, when considering the amount of grant to be paid to the Family Planning Association for the year 1969/70 had before them a memorandum representing the joint views of the County Councils Association, the Association of Municipal Corporations, and the Family Planning Association which stated "that local authorities should move as quickly as possible towards providing under their own auspices a full and unrestricted family planning service entirely free in all cases since charges tend to discourage

women from seeking help. The Association (i.e. the Family Planning Association) themselves are anxious for their work in this respect to be taken over and expanded by local authorities." In view of this statement, the Health Committee approved in principle the complete take over of the family planning service as and when finances permit.

It is considered that the first step towards an eventual comprehensive local authority service should be to support the Family Planning Association in their West Riding clinics more realistically than is at present being done and to provide an equitable service over the County in that no patient will be required to meet charges in respect of medical examination and advice given. For the information of the Committee, the following list shows the clinics available in the County Area, those of the Association being mainly established in County Council clinics and health centres.

Family planning clinics existing or about to be established

Div. No.	*Family Planning Association*	*Direct Service*
1	Skipton	Service for problem families plus clinic service in new health centres when erected
3	Keighley	
4	Shipley	
5	Otley and Ilkley	
7	Harrogate and Ripon	
9		Limited service for problem families and clinic at Garforth
10	Goole and Selby	
11	Castleford and Normanton	
12	Pontefract	
13	Morley	
15	Cleckheaton	Batley
18	Brighouse and Todmorden	
20	Holmfirth	
22		Ecclesfield, Stocksbridge and Penistone
23	South Kirkby	
25	Barnsley	
26	Mexborough	
27	Rotation of clinics in the Division	
29	Stainforth	
31	Brinsworth	

Because of reductions made when the Budget for 1970/71 was under consideration, the eventual financial provision of £15,000 for family planning is more than is required for the establishment of certain direct service clinics and a repetition of the 1969/70 grant of £5,000 to the Family Planning Association in respect of the free treatment of medical and problem family cases, but insufficient to implement the accepted policy of providing free advice and medical

examination for all cases—a course which it is believed is now being followed by many authorities and which is in keeping with central government opinion.

It is recommended, therefore, that the County Council's resolution set out at the beginning of this memorandum now be implemented and that the estimated expenditure of £15,000 in the Budget for 1970/71 be increased to £40,000 at the half-yearly revision to enable discussions to be held with representatives of the Family Planning Association.

The above report was further considered by a Special Sub-Committee who met representatives of the Family Planning Association and the following Resolution of the Special Sub-Committee was subsequently approved by the County Council.

(a) That, as from the 1st October, 1970, scheme 2 of the Family Planning Association be adopted for the provision of a family planning service in the West Riding on the basis of no restriction by residence and with free consultation and free supplies restricted to medical cases, including problem families, and consultation only for non-medical cases on the understanding that the non-married shall be excluded from the scheme, except where a stable co-habitation relationship exists or where persons are about to be married.

(b) That the charges for those services be as follows on the basis that the payment be made by way of an annual lump sum which will be subject to review in the light of actual ascertained costs.

	Financial Year 1970-71	Financial Year 1971-72
	(per case) £ s. d.	(per case) £ s. d.
Medical Cases (including supplies) ...	4 7 0	4 17 0
Non-medical Cases, patient paying for supplies	1 17 0	2 2 0

(c) That in respect of the period from the 1st April to the 30th September, 1970, the usual form of block grant be made to the Association, and that for the period 1st October, 1970, to 31st March, 1971, the charges be based on 50 per cent. of the full annual rate.

(d) That the decision whether a patient be classed as a medical or non-medical case be left to the clinic doctor on the understanding that the County Council may be consulted in deciding on difficult cases.

(e) That the existing policy of the County Council in relation to the use by the Family Planning Association of clinic premises and equipment free of charge be continued.

(f) That the County Medical Officer be authorised to discuss with the Family Planning Association the question of the use of available accommodation in health centre premises for establishing by the Association facilities for vasectomy.

TRANSFER OF RESPONSIBILITY FOR THE EDUCATION OF MENTALLY HANDICAPPED CHILDREN

Report of the Working Party of Officers of the West Riding Health and Education Departments

Education Department Representatives:

Mr. P. A. Newsam
Deputy Education Officer

Mr. A. Lenney
Senior Professional Assistant

Mr. J. G. Millard
Senior Adviser for Special Education

Mr. E. Tilford
Senior Administrative Officer
Special Services

Health Department Representatives:

Dr. C. Simpson Smith
Principal Medical Officer
School Health Service

Dr. D. E. Jeremiah
Principal Medical Officer,
Mental Health Service

Mr. W. J. Battye
Principal Administrative Officer
Mental Health Service

1. Members of the Working Party have now visited all 19 West Riding Training Centres for the mentally handicapped.

The Education representatives have been impressed by the progress which has been made in the provision by the Health Committee of training facilities for both children and adults during the past 10 years, not only by the extent of the provision which has been made but also by the way in which the design of new centres has developed over the years, leading up to the magnificent new centre at Brighouse.

With two minor exceptions* the West Riding centres are all comprehensive in that they provide for adults and children on the same site and in some cases in the same building. The 'comprehensive' centre has had the considerable advantage of making it possible to have local provision in most parts of the West Riding in a comparatively short time and to enable the catchment areas to be kept smaller than might have been the case if separate provision had been made for the children and adults.

It is recommended that the establishment of 17 new day special schools should be proposed in accordance with the schedule attached (Addendum A).

*The small junior centre at Ossett which has two classes for children up to nine or 10 years of age and is accommodated in an old building would be absorbed into the new West Ardsley centre and together they would form

a day special school. The small junior centre at Horsforth would amalgamate with the comprehensive centre at Horsforth (there are two classes at each centre and a special care unit at the comprehensive centre) to form one special school.

2. **Administration:**

Circular 15/70 says that where a junior training centre is part of an all age centre it will be necessary for the Local Authority to make an administrative division between the provision for children and adults so as to allow for the establishment within the premises of a recognisable special school.

The Circular whilst acknowledging that some children of compulsory school age will have to continue to be taught in buildings which provide also for the adult mentally handicapped says that the Secretary of State expects Local Authorities to make separate provision for school age children and for adults "as early as possible."

The training centres in the West Riding are at present administered by the Health Committee and day to day administration is the responsibility of Divisional Medical Officers. With the setting up of the new Social Services Committee, however, responsibility for the training and accommodation of mentally subnormal adults will pass to that Committee. The West Riding centres could be divided into the following categories in accordance with the attached schedule (Addendum B):

(i) Centres where the children are in a separate building which could be administered separately by the Education Committee, with joint facilities as indicated remaining with the Health Committee (or Social Services Committee) and being re-charged on a user basis.

(ii) Centres where the provision for children and adults is in the same building and where it would be extremely difficult to make an administrative division of responsibility so far as the building is concerned. In these cases, it is proposed that administrative control remains with the Health Committee (or Social Services Committee) and be re-charged on a user basis, except for supplies and equipment for the staff and pupils of the special school which would be the responsibility of the Education Committee.

3. **Governing Bodies:**

When the training centres (or those parts of the centres which accommodate children) become special schools it is recommended they be fitted into the existing pattern of day special schools throughout the West Riding. Day special schools serve their surrounding areas and each school is administered by the Divisional Executive for the area in which the school is situated, as with other day schools. (The admission and discharge of pupils continues, however, to be the responsibility of the Education Officer on behalf of the Special Services Sub-Committee. The children admitted are those who have been ascertained to need education at a special school and included in schedules approved by the

Sub-Committee.) The Education (No. 2) Act of 1968 requires that every special school shall have a governing body—one has been constituted for each of the day special schools, consisting of 14 members, six nominated by the County Council, six by the Divisional Executives for the areas from which pupils are drawn, plus the Chairman of the W.R. Education Committee and the Chairman of the Divisional Executive in whose area the school is situated. It is possible for a joint governing body to be constituted for more than one special school but this does not happen at present as no division has more than one day special school.

Ten of the proposed new day special schools would be in divisional areas which at present have a day special school with a governing body and proposals could be submitted for joint governing bodies. The others are in Divisional Executive areas where there is no other day special school at present and governing bodies would need to be proposed. (See Addendum A).

4. **Staffing:**

Some of the comprehensive centres have Supervisors who are qualified and experienced with children and others have Supervisors who are qualified and experienced for the training of adults. Those in the latter category will of course not transfer to Education.

In the Junior Wings there are then—

Teachers* of mentally handicapped (i.e. those holding the Diploma or Certificate of Recognition).	28
Assistant Supervisors (unqualified) taking a class.	19
Assistant Supervisors in Special Care Units.	25
Attendants or General Duty Assistants (one at each centre).	15

*At centres where the Supervisor has been mainly engaged with the adults a senior teacher has been appointed on the children's side—with an addition of £50 to the scale salary.

Members of the Working Party have been considerably handicapped in their visits to the centres by lack of firm information regarding the future pay and status of the present staffs of the centres. It has been indicated that teachers of mentally handicapped children with the Diploma and a certain amount of post-diploma experience would receive qualified teacher status in the education sense and that the interests of other members of the staff would be protected and that they would enjoy terms and conditions of employment not less favourable than those enjoyed immediately before the transfer date.

Circular 15/70 states:

"Prospects for advancement within the service cannot be covered by Statute, but the Secretary of State looks to Authorities, on each occasion when they are making arrangements to fill higher posts, to give full weight not only to the underlying purpose of the Act to integrate the education of mentally handicapped children, and accordingly the staffing pattern, into the general framework of the Education service, but also to the need to ensure that full account is taken of the training and experience of the existing staffs and to their reasonable career expectations."

HEADSHIPS:

In making their recommendations the Working Party have had regard to certain principles which enable the centres (or proposed new day special schools) to be grouped in the following ways:

(a) Centres where the Supervisor is largely engaged in teaching children, has the Diploma and five years post-diploma service, and could be recommended for appointment as Head of the new day special school:

Airedale	Mrs. Stone (44) Diploma 1964	Supervisor since 1964 and Assistant Supervisor from 1960.
Ecclesfield	Mrs. Jeans (51) Diploma 1957/58	Supervisor since December, 1961.
Harrogate	Miss Reynolds (37) Diploma 1959	Supervisor at Harrogate since 1962 and was Supervisor at Oulton Hospital 1959/62.
Hemsworth	Mrs. Ellis (44) Diploma 1962	Supervisor at Hemsworth since 1966. Was Supervisor at Ossett 1963-66 and Assistant Supervisor 1959-63.
Horsforth (Combination of Junior and Comprehensive Centre)	Mrs. Vause (40) Diploma 1961	Supervisor of the Horsforth Junior Centre since 1962 and previously Assistant Supervisor at Horsforth 1957-62 and at Leeds 1956/57.
Rawcliffe	Miss Logan (41) Diploma 1958/59	Supervisor since November, 1961.
Wath	Mrs. Lewis (29) Diploma 1961/62	Supervisor at Wath since June 1967. Mrs. Lewis started at the Ecclesfield Centre as a Nursery Assistant in October, 1959, was promoted Assistant Supervisor in July, 1962, on completion of her Diploma Course and resigned in November 1965 to transfer as Assistant Supervisor at the Spastics Society Day Nursery and Welfare Centre, Barnsley. In January, 1967, she was appointed Supervisor at the Adwick Centre and transferred to her present post in June, 1967. During her three years at Wath Mrs. Lewis has worked with both children and adults—she transferred to the adults when Miss Collins was appointed Senior Teacher but when Miss Collins resigned recently Mrs. Lewis returned to the children's side and a Senior Instructor has been appointed.

West Ardsley	Mrs. Smailes (31) Diploma 1962/63	The Supervisor of the West Ardsley Comprehensive Centre is trained for and mainly engaged with adults and does not wish to transfer. Mrs. Smailes is Supervisor of the Ossett Junior Centre which is to combine with the two classes at West Ardsley to form one special school—the children from the Ossett Centre will move to West Ardsley when the new adult centre is completed (? September, 1971) and the present building becomes available for children only.

(b) To add to these are two centres where the Supervisor has the Declaration of Recognition issued by the Training Council for Teachers of the Mentally Handicapped in 1966/67 to people who were over 45 years of age and had more than 10 years experience:

Skipton	Mrs. Wade (57)	Supervisor at Skipton since 1964. Previous experience, all of which was in working with children: 1943-47—Meanwood Park Hospital School 1954-57—Wakefield Training Centre 1957-62—Supervisor of Horsforth Junior Centre 1962-64—Supervisor of Horsforth Comprehensive Centre.
Wombwell	Mrs. Large (58)	Supervisor of Wombwell Comprehensive Centre since November, 1967. Supervisor of the Wombwell Junior Centre from 1957 to July, 1963, when she was re-designated Senior Assistant Supervisor in the junior wing when Wombwell became a comprehensive centre.

(c) Centres where the Supervisor is qualified/experienced for adults and is not to transfer. It is recommended that the headships of the new day special schools to be established at these centres should be advertised but that a letter should be sent to the senior teacher in each case inviting her to apply. Selected candidates would then need to be interviewed and an appointment made.

Adwick le Street	Kirkburton
Heckmondwike	Maltby
Keighley	Rothwell

(d) Special Category

Brighouse	Where the Supervisor, Mrs. Booth took the Diploma in the Training of Adults in 1962/3 but has considerable experience with children and has made it clear that they are her main interest and she would have preferred to be considered for transfer with the children rather than to remain as Supervisor of the adults. Mrs. Booth has been Supervisor of the new Brighouse Centre since August, 1970, was Supervisor of the Kirkburton Centre from 1963—August, 1970, and had previous experience from 1953/62 —Assistant Supervisor Dewsbury Centre and 1962/63 Ossett Centre. It is recommended that Mrs. Booth should be interviewed.

DEPUTY HEADS AND POSTS OF SPECIAL RESPONSIBILITY:

It is recommended that consideration of this should be deferred until the new day special schools have been established and heads appointed. Senior teachers who are not appointed to headships, will of course be considered for these posts.

UNQUALIFIED STAFFS:

At present Assistant Supervisors (unqualified) taking a class and Assistant Supervisors (Special Care) are paid on the same scale, although those in special care do not enjoy the full school holidays. It is recommended, subject to the further guidance which is to be issued by the Secretary of State that these people should continue to enjoy the same status.

Whilst many of the children in the special care units are very severely handicapped, the possibility of training/teaching is always borne in mind. In some cases considerable progress has been made and some children have moved from the care unit to the classrooms. Others have been able to achieve a degree of communication much in excess of their capabilities on admission. Any progress at all in these extreme cases is achieved only through the constant efforts of a devoted staff, and the smallest achievement is often the result of months of patient work.

5. **Special Care Units:**

Most of the centres have special care units which are included in the proposed new day special schools. They are intended for children who are more severely handicapped (often physically as well as mentally) and who cannot join in the

class or group structure with the other children at the centre. These units vary from small rooms for four children to the newer spacious units with all the amenities needed in the way of toilet and bathing facilities.

It will be noted from the schedule (Addendum A) that there are at present in these units a number of adults over 19 years of age. It is recommended that as a matter of principle these adults should not be in the units which will form part of the proposed new special schools and that the Social Services Department should be asked to arrange alternative provision for them "at the earliest possible date".

These units do not close for the full school holidays as do the junior wings of the centres. Assistant Supervisors in the junior wings have had 60 days holiday a year whilst those in the special care units have had only 26 days, although they are paid on the same salary scale. Whilst this has been made quite clear to special care staff on appointment it has subsequently been a 'bone of contention'.

Supervisors of comprehensive centres have of course also had a shorter holiday because of their responsibility for the adult trainees who do not have 'school holidays'. In practice the centres have remained open for adults and the special care children, for 47 weeks a year, compared to the 40 week year for the children.

As part of the proposed new day special schools, it would have been convenient for the special care units to close for the normal school holidays; nevertheless members of the Working Party recommend that the Education Committee accepts that the Units should continue to be kept open during part of the school holidays, to meet a social need. Many of the children attending these special care units are very severely handicapped and must be a considerable burden on their parents who need the relief which attendance at the special care unit provides.

Arrangements for supervision would have to be made to ensure that the Authority's responsibility for the children in the special care units is being adequately met. It may be necsssary to consider in some cases the recruitment of additional staff so that holidays can be staggered or to recompense the staff for the additional work.

6. **Hostels:**

In the West Riding there are two hostels for mentally handicapped children which have been under the control of the Health Committee.

Skipton: A purpose-built hostel on a separate site perhaps a quarter of a mile from the training centre. There is accommodation for 16 children and at present nine of these are from other areas—the others are mostly children from the remoter parts of the Skipton and Settle areas. A warden is in charge. The children go home for school holidays and for every fourth week-end during term time.

Harrogate: A purpose-built hostel adjoining the training centre, but a completely separate building. There is accommodation for eight children who go home every week-end. A warden is in charge.

Circular 15/70 says that in most cases it would appear appropriate that the administration of hostels should remain with the Local Health Authority—and so pass in due course to the proposed Social Services Department of the Authority but in some cases a hostel may be so closely linked with a junior training centre that the Local Education Authority may wish to propose that it should be taken over and a residential special school established. The Secretary of State would be prepared to consider such proposals on their merits.

It is recommended that the two hostels should remain with the Health Committee/Social Services Committee on the understanding that they will continue to be used for the present purpose as long as they are needed for this purpose. The Education Committee would then have a duty to ensure that places are available for the children living in the hostels to attend the new day special schools to be established at the Skipton and Harrogate Training Centres.

7. **Conveyance:**

At present the children and adults attending training centres are conveyed there together by special buses from the various parts of the catchment area and it is proposed that when responsibility for the children transfers to the Education Committee on 1st April, 1971, this arrangement should continue, at least for the time being, but it is assumed that in the same way as the Secretary of State requires separate provision to be made for the education of mentally handicapped children 'as early as possible' separate arrangements may eventually need to be made for their conveyance. This would involve additional expenditure and the Education Officer is looking at the situation generally to see what separation of conveyance for the children would entail and whether it would be possible to integrate it in some areas with conveyance to the existing day special schools.

Meanwhile it is proposed that the arrangements made by the Health Committee should continue, with a charge to the Education Committee on a user basis.

8. **Swimming Pools:**

Some of the centres have small swimming pools which have been provided mainly by voluntary effort for use both by the adults and the children attending the centre. Naturally the parents are hoping that it will be possible for arrangements to be made for these to continue to be available for joint use, whether they are situated in the adult part of the centre or in that part which is to become the new day special school.

The centres which have these pools at present are:

Rawcliffe— in the part which will become the new special school when the present extensions are completed early in 1971.

Horsforth—in the existing comprehensive centre, which will for the present continue to be shared by the adults and children.

At two centres pools are at present under construction:

West Ardsley—in the part which will become the new day special school when the new adult centre is ready later in 1971.

Kirkburton—this centre will continue for the present under joint user.

Two centres have plans for swimming pools which are at present being considered:

Rothwell

Adwick le Street

The Working Party felt that this matter could be dealt with at local level.

9. **Hospital Schools:**

There are four hospitals in the West Riding administrative area which have mentally handicapped children in residence.

Two have been visited by members of the Working Party.

OULTON HALL, NEAR LEEDS:

There are 37 children on the wards, 30 of whom attend the 'school' which the Hospital Authortities have established on the premises, with three classrooms and the use of a hall. There is a Supervisor, Miss Leonard (26) who has the Diploma and will have five years' post-diploma service by July, 1971. The two Assistant Supervisors are unqualified.

It is recommended that a Hospital Special School should be established at Oulton Hall and that Miss Leonard should be appointed Head Teacher. The Hospital School would then have a visiting Sub-Committee consisting of members of the Special Visiting Sub-Committee as do the Marguerite Hepton and Wharfedale Hospital Schools which have been in existence for several years.

A new hospital for the severely subnormal is being built opposite Pinderfields Hospital, Wakefield, which will be just within the West Riding area. The completion date is January, 1972, and when it is ready (possibly March, 1972) it will have accommodation for 80 children and those who are at present at Oulton Hall will be transferred there, with their school staff.

The new hospital will have provision for four classrooms, two rooms for practical subjects, two special care units and two 'disturbed units' for children.

If the school had remained under the control of the Hospital Board, they had envisaged that the staff required would be a Supervisor and six Assistant Supervisors, plus ancillary staff.

RAWCLIFFE HALL HOSPITAL, NEAR GOOLE:

On the day of the Working Party visit there were 28 child patients at the hospital.

A schoolroom is provided on the premises and 10 of the children (aged from 6 to 10 years) attend. The schoolroom is in charge of Mrs. Mann (56) unqualified Assistant Supervisor and two full-time nursing assistants are employed permanently in the schoolroom, a man and a woman.

The other children have a large room in which they occupy their time and which is very similar to a special care unit of a training centre. They are cared for by the nursing staff.

The possibility was discussed of making a joint arrangement whereby the children at the hospital who were thought to be able to benefit from 'class teaching' might attend each day at the nearby Rawcliffe Training Centre and that the special care children at the centre might attend what is virtually a special care unit at the hospital. This will however require further consideration and consultation and meanwhile it is recommended that a teaching unit (under the provision of Section 56—Education otherwise than at school) should be established at the hospital with the present 'schoolroom' staff.

The other two are:

CASTLEBERGH HOSPITAL, GIGGLESWICK, SETTLE:

This hospital has eight beds for children and has been visited by Mr. Millard, Adviser for Special Education.

There is no 'school' at present at the hospital and the appointment of a full-time teacher is recommended—provision under Section 56—Education otherwise than at school.

STANSFIELD VIEW HOSPITAL, TODMORDEN:

It has not yet been possible to arrange a visit by the Working Party but a visit will be made early in January.

GENERAL COMMENTS:

With the hospitals a similar problem arises as with the special care units of training centres. The 'schoolrooms' at Oulton Hall and Rawcliffe Hall have been kept open throughout the year and the staff holidays have been staggered. The argument has been that once the routine of 'schoolroom' attendance has been established it is better for the children that this should be maintained rather than that there should be breaks for long school holidays during which the children would still be resident at the hospitals.

10. **Children Not Attending Training Centres:**

There are 95 children living at home and not attending training centres, 26 of whom are under five years of age.

The numbers are:

Awaiting training centre places 19 (including 5 under five years of age).

Awaiting special care places 30 (including 9 under five years of age).

Places refused by parents 21 (including 2 under five years of age).

Miscellaneous reasons, such as ill health, deferred until older etc. 25 (including 10 under five years of age).

These children will need to be reviewed to see what special provision for their 'education' needs to be made whilst they are at home.

TRANSFER OF RESPONSIBILITY FOR THE EDUCATION OF MENTALLY HANDICAPPED CHILDREN

Proposed New Day Special Schools

Centre	Number on roll at Centre			Included in Special Care	
	Junior Wing	Special Care	Total	16-19 years of age	20 or over
*Adwick le Street	52	—	52	—	—
Airedale (Castleford) ...	43	9	52	1	—
Brighouse	28	9	37†	—	1
Ecclesfield	30	11	41	—	2
*Harrogate	36	6	42	—	—
*Heckmondwike	41	—	41	—	—
Hemsworth	36	14	50	—	—
*Horsforth (Junior and Comprehensive combined) ...	48	11	59	1	—
*Keighley	52	—	52	—	—
Kirkburton	36	6	42	—	1
*Maltby	56	19	75	3	4
*Rawcliffe	31	4	35	—	—
*Rothwell	38	6	44	—	—
Skipton	32	9	41	—	1
*Wath	60	14	74	1	—
West Ardsley (including Ossett)	46	12	58	—	2
*Wombwell	30	12	42	—	2
Totals	695	142	837	6	13

† The new Centre at Brighouse has only recently opened and is still building up towards the total of 60 children.

* Para 3. Governing Bodies.
The 10 proposed new day special schools indicated by an asterisk are in Divisional Executive areas which have an existing day special school with a Governing Body. Joint Governing Bodies could be proposed in these cases.

TRANSFER OF RESPONSIBILITY FOR THE EDUCATION OF MENTALLY HANDICAPPED CHILDREN

(i) Centres where the children are in a separate wing which could be administered separately by the Education Committee, with joint facilities as indicated remaining with the Health Committee (or Social Services Committee) and being re-charged on a user basis.

Brighouse	Except for kitchen and caretaking. A user charge basis would need to be calculated for heating, lighting etc.
Hemsworth	Except for kitchen and caretaking.
Horsforth	That part of the proposed special school which is at present the junior training centre. (The other accommodation for children in the comprehensive centre will have to be on a shared/user basis).
Keighley	Except for kitchen and caretaking. A new junior wing is approved and building should begin before the end of the present financial year. It will replace the existing old building which is used by the children and will include a special care unit and a kitchen.
Wombwell	Where the children are accommodated in a detached house and there is a separate purpose-built special care unit. Meals are drawn from the kitchen in the adult wing which is in the same grounds. Joint caretaking.

(ii) Centres where the provision for children and adults is in the same building and where it would be extremely difficult to make an administrative division of responsibility so far as the building is concerned. In these cases it is proposed that administrative control would remain with the Health Committee/Social Services Committee and be re-charged on a user basis, except for supplies and equipment for the staff and pupils of the special school which would be the responsibility of the Education Committee.

Adwick le Street	Until such time as the new adult centre is built in the grounds (?1972) when the present building will be available entirely for children. There will still be joint kitchen and possibly caretaking.
Airedale (Castleford)	Until the new adult centre at Pontefract is built, when the Airedale Centre would become available entirely for children (1971/72 building programme).
Ecclesfield	
Harrogate	Until the new adult centre is built in the grounds, when the present building will be available entirely for children.
Heckmondwike	
Kirkburton	
Maltby	
Rawcliffe	Until the new adult centre which is now being built in the same grounds is ready, which may be before 1st April, 1971. Then there will be joint kitchen and caretaking.
Rothwell	Until the new adult centre is built (1973) when the present centre would be available entirely for children.
Skipton	There is a proposal in the Education building programme for a new day special school for the Skipton/Settle areas, to cater for ESN and the present severely subnormal. If this is built the present Skipton Centre could be used for adults only.
Wath	Until the new centre for adults is built at Conisbrough when the Wath Centre will be available for children only. (?1973).

West Ardsley	Until the new centre for adults which is being built on an adjacent site is ready (?September, 1971) when the existing centre will be available entirely for the children and could be administered as a separate building, by the Education Department. (The Ossett Centre for Juniors which is included in the proposed combined West Ardsley new day special school is in a separate building which could be taken over by Education—when the full accommodation at West Ardsley is available for children the two classes from the Ossett Centre will transfer to West Ardsley and the Ossett building will be available for other use—it is an old war-time day nursery of the prefabricated type).

PART I

VITAL STATISTICS

EPIDEMIOLOGY

VENEREAL DISEASE

RESEARCH

See also Tables 1 to 36 of Appendix A

VITAL STATISTICS

Area and Population:

	Municipal Boroughs and Urban Districts	Rural Districts	Administrative County
Area (acres)	380,333	1,226,166	1,606,499
Population:			
Census, 1961 ...	1,187,034	450,884	1,637,918
Estimated (mid-1970)	1,268,760	525,260	1,794,020

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

Summary for 1970:

	Administrative County	England and Wales
Live Births		
Number	31,024	
Rate per 1,000 population	17·3	16·0
Illegitimate Live Births		
Number	2,161	
Per cent. of total live births	7·0	8·3
Stillbirths		
Number	427	
Rate per 1,000 total live and still births	13·6	13·0
Total Live and Still Births...	31,451	
Deaths: All causes	21,017	
Rate per 1,000 population	11·7	11·7
Infant Deaths (deaths under 1 year)	614	
Infant Mortality Rates		
Total infant deaths per 1,000 total live births ...	19·8	18·2
Legitimate infant deaths per 1,000 legitimate live births	19·3	17·5
Illegitimate infant deaths per 1,000 illegitimate live births	25·9	25·9
Neonatal Mortality Rate (deaths under 4 weeks per 1,000 total live births)	13·2	12·3
Early Neonatal Mortality Rate (deaths under 1 week per 1,000 total live births)	10·9	10·6
Perinatal Mortality Rate (stillbirths and deaths under 1 week combined per 1,000 total live and still births) ...	24·4	23·5
Maternal Mortality (including abortion)		
Number of deaths	9	
Rate per 1,000 total live and still births	0·29	0·18

Live Births:

The decline in the birth rate was not maintained; indeed there were 750 more births than in the previous year and resulted in a crude rate of 17·3 per 1,000 population. It is significant that the County rate was appreciably higher than that for England and Wales (16·0), which continued to decline and it may be that the increase is merely a temporary interruption of the downward trend.

The birth rate adjusted for variations in the age-sex structure of the population for the aggregates of Municipal Boroughs and Urban Districts was 17·6, for Rural Districts 17·0, and the Administrative County 17·5.

The ratio of illegitimate live births also increased; there were 2,161 registered as illegitimate representing 7·0 per cent. of live births. (6·6 per cent. in 1969). Although this rate continues to be lower than national (8·3 per cent.) it is the highest level recorded since 1945. Details of the cases dealt with under the Authority's scheme for the care of the unmarried mother and her child are given in Appendix A.

Stillbirths and Infant Mortality:

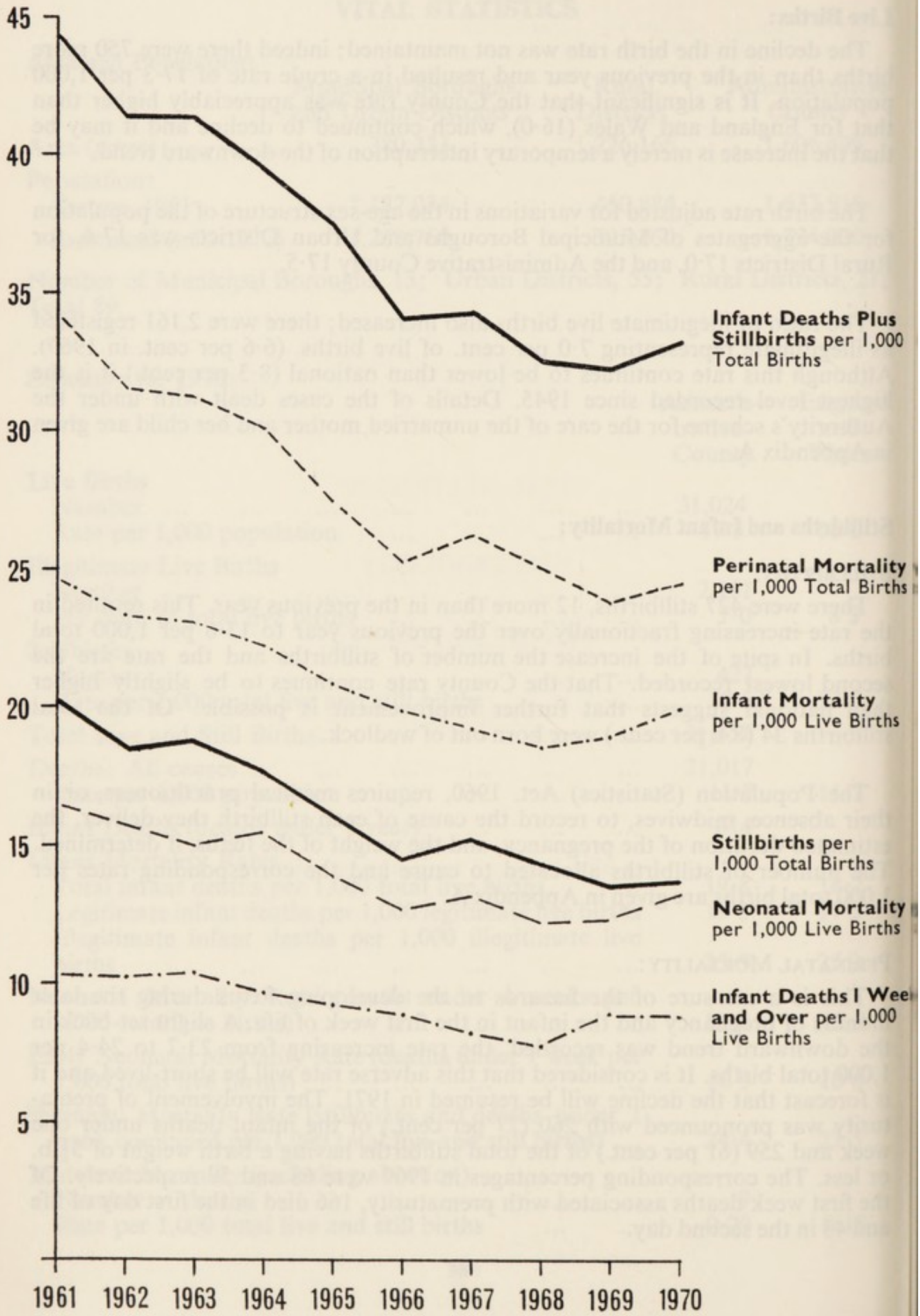
STILLBIRTHS:

There were 427 stillbirths, 12 more than in the previous year. This resulted in the rate increasing fractionally over the previous year to 13·6 per 1,000 total births. In spite of the increase the number of stillbirths and the rate are the second lowest recorded. That the County rate continues to be slightly higher than national suggests that further improvement is possible. Of the total stillbirths 34 (8·0 per cent.) were born out of wedlock.

The Population (Statistics) Act, 1960, requires medical practitioners, or in their absence, midwives, to record the cause of each stillbirth they deliver, the estimated duration of the pregnancy, and the weight of the fœtus, if determined. The number of stillbirths allocated to cause and the corresponding rates per 1,000 total births are given in Appendix A.

PERINATAL MORTALITY:

This is a measure of the hazards to the developing fœtus during the later months of pregnancy and the infant in the first week of life. A slight set-back in the downward trend was recorded, the rate increasing from 23·7 to 24·4 per 1,000 total births. It is considered that this adverse rate will be short-lived and it is forecast that the decline will be resumed in 1971. The involvement of prematurity was pronounced with 260 (77 per cent.) of the infant deaths under one week and 259 (61 per cent.) of the total stillbirths having a birth weight of 5½lb. or less. The corresponding percentages in 1969 were 68 and 59 respectively. Of the first week deaths associated with prematurity, 166 died in the first day of life and 43 in the second day.


45
40
35
30
25
20
15
10
5
1961
1962
1963
1964
1965
1966
1967
1968
1969
1970
Infant Deaths Plus Stillbirths per 1,000 Total Births
Perinatal Mortality per 1,000 Total Births
Infant Mortality per 1,000 Live Births
Stillbirths per 1,000 Total Births
Neonatal Mortality per 1,000 Live Births
Infant Deaths 1 Week and Over per 1,000 Live Births

INFANT MORTALITY:

Since 1947 the rate has halved and, although there have been occasional interruptions from time to time, the rate has pursued a downward trend. It is therefore disappointing to report an increase in the rate for the second successive year. The major increase over the previous year was in the neonatal period; the neonatal mortality rate increasing from 12·3 to 13·2 per 1,000 live births. First day deaths accounted for 32 per cent. of the total infant mortality and deaths in the first week of life for 55 per cent. As referred to previously prematurity was the prime cause and there were only minimal variations in the number of deaths attributed to other diseases.

The County rate continues to be higher than national and certain other countries which clearly indicates that there is ample room for improvement and we are not yet in sight of the irreducible minimum.

Illustrated graphically are the trends associated with loss of fœtal and infant life during the past decade.

Deaths:

The number of deaths and the corresponding crude death rate increased for the second successive year: a rate of 11·7 per 1,000 population was recorded, the same as for England and Wales. The crude death rates adjusted by the comparability factors were, for the aggregates of Municipal Boroughs and Urban Districts 13·0, Rural Districts 11·7, and the Administrative County 12·7.

The major causes of mortality followed established trends: heart and circulatory disease (excluding cerebrovascular disease) accounted for 37·9 per cent. of total deaths (37·7 per cent. in 1969), malignant neoplasms 18·3 per cent. (18·0), cerebrovascular disease 14·9 per cent. (14·6), respiratory diseases 14·4 per cent. (14·6) and violent causes 4·1 per cent. (4·6).

Cancer deaths were slightly more prevalent at ages 45-64 years, otherwise there were only minor variations in the age/sex distribution from previous years. Concern must again be expressed at the continued rise in male deaths from lung cancer; 771 men died from this cause, the highest total recorded and more than twice the level registered 20 years ago.

This increased mortality is not the prerogative of the West Riding, indeed, in all countries from which reliable statistics are available, there has been a marked upward trend in recent decades. The evidence that cigarette smoking greatly increases the incidence of lung cancer, chronic bronchitis, emphysema and ischæmic heart disease is now irrefutable and among Resolutions of the 23rd World Health Assembly was a request for consideration to be given to the desirability of making "The Health Consequences of Smoking" the subject for World Health Day on the earliest possible occasion.

PRE-SCHOOL AGE (1-4 years):

Since the turn of the century the number of deaths at these ages has decreased dramatically; in the period 1911-15 the annual average death rate per 1,000 living in the age group was 17·13, in 1935-39, 5·09 and in 1945-49, 2·23. Since then the rate of improvement has slowed and in 1965-69 the average rate was 0·82. In 1970 there were 88 deaths representing a rate of 0·72 compared with 102 deaths and a rate of 0·83 in 1969.

The elimination of the once traditional childhood diseases has resulted in accidents, congenital malformations, cancers and pneumonia being prominent causes of death: in 1970 they accounted for 57 per cent. of the mortality in the age group.

SCHOOL AGE (5-14 years):

By far the lowest death rates at any age are recorded in this group. The number of deaths from congenital malformations and cancer remained around the same level, but it is significant that almost half the mortality in the age group was due to violent causes, notably motor vehicle accidents, with boys most frequently the victims in the ratio of 3:1.

ADOLESCENCE AND AFTER (15-24 years):

At these ages there has been no major alterations in the causes of mortality during the past decade. Cancer continued to take its toll but violent causes predominated and accounted for 60 per cent. of the mortality in the group. Motor vehicle accidents were the prime cause with male deaths significantly more numerous: of the total male deaths in this age group nearly a half were attributed to this cause.

YOUNG ADULTS (25-34 years):

Mortality in this age group has declined gradually in recent years. Violence, notably motor vehicle accidents and suicide, was most frequently incriminated followed by cancer and ischæmic heart disease. Male deaths continued to be in excess in the ratio of almost 2:1.

ADULT (35-44 years):

Although violence is still a material cause of death at these ages, some of the more common causes of total mortality become manifest. The death rate, however, remains low with slight excess male mortality. In males, ischæmic heart disease, violence and cancer were most frequently involved and in females, cancer, notably of the breast and uterus, and cerebrovascular disease.

MIDDLE LIFE (45-64 years):

At these ages cancer replaced ischæmic heart disease as the major contributor to mortality, then followed cerebrovascular disease and bronchitis.

Among males the predominant cancer was in the lung and bronchus and it is distressing that over 1 in 10 male deaths in the age group were due to this disease. In females, malignancies in the breast and uterus were most numerous. Mortality from ischæmic heart disease continues to increase slightly and of the total male mortality in this age group, over a third was classified to this cause.

OLDER AGES (65 years and over):

The elimination, or effective control, of infectious diseases has been the major factor in enabling increased numbers of the population to survive well into their second half century, so bringing the degenerative diseases into greater prominence.

The pattern of mortality evident in middle life was generally continued at these older ages and two-thirds of the total deaths were in this age group. As age advanced excess male mortality became less pronounced and at ages 75 years and over female deaths were in the majority.

EPIDEMIOLOGY

Incidence and Notification of Infectious Disease:

The tables in Appendix A provide a summary of the age and sex distribution of cases notified during 1970 and where applicable, a comparison is given of the notifications in the five preceding years.

ANTHRAX:

Notification of the disease in humans was introduced in 1960 and up to 1966 eight cases had been confirmed; since then no case has been reported. The vaccination of workers considered to be particularly exposed to the risk of contracting the disease has continued.

DIPHTHERIA:

There has been no case recorded since 1964. The incidence of the disease throughout the country continues at a low level but occasional flare-ups and importations emphasise the importance of achieving and maintaining effective immunisation protection of our child population.

DYSENTERY:

The number of corrected notifications decreased from 691 in 1968 and 476 in 1969 to 287. There was no outbreak of any significance, the majority of cases occurring sporadically with no traceable connection. The disease appears to be endemic and, while the reduced incidence can be viewed with satisfaction, there is no room for complacency.

The character and incidence of the disease has undergone various changes since notification was introduced in 1919; by far the majority of cases in recent years being of the Sh. sonnei strain which has been generally mild with a low fatality rate.

It is now widely accepted that the mode of spread of the disease is by direct and indirect contact with the symptomless excreter also contributing to a lesser degree. Ample evidence has accumulated to support the view that contamination of food, utensils and dust are all secondary to defective personal hygiene.

ENCEPHALITIS:

Three cases were notified, two infective, and one post-infectious. The infective cases were sister (8 years) and brother (9 years) who were admitted to hospital with viral encephalitis on the 25th and 28th January respectively: both made uneventful recoveries. The post-infectious notification was a fatal case, a 15 months old girl who had been admitted to hospital with convulsions, diarrhœa and vomiting. At autopsy the cause of death was ascribed to Encephalitis, presumably viral; virus not isolated.

ENTERIC FEVERS:

Typhoid Fever:

Since 1941 when typhoid and paratyphoid fevers became separately notifiable the annual number of notifications has fluctuated within the range of nil to 27: in 1970 two cases were confirmed. Both were imported but unconnected; the first was a man of 27 years who had visited relatives in Pakistan and it is presumed that the other, a 12 year old boy was infected whilst on a family holiday on the Continent. There were no secondary cases.

West Riding school parties holidaying in countries in the Mediterranean area and certain parts of Europe continue to be advised to be adequately vaccinated against typhoid and paratyphoid fevers. It is also stressed that vaccination does not replace the need for high standards of hygiene. The arrangements are now accepted practice and no incidents were reported.

Paratyphoid Fever:

Incidence has remained low for the past five years. In 1970 no case was confirmed. Indigenous cases usually contribute about half the notifications and medical officers of health and their staff are alert to eliminate all possible sources of infection. As mentioned above, the risk of imported infection is reduced by encouraging individuals and parties who plan to travel overseas to implement the advice given in the 'Notice to Travellers' and receive T.A.B. vaccination.

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 higher recorded prevalence than in the previous year, 145 notified cases and 20 ascertained, compared with 111 incidents in 1969 and an annual average of 153 in the period 1965-69. Summarised below are the major microbial causes analysed by type of incident.

Presumed Causal Agent	Family Outbreaks		Other Outbreaks		Sporadic Cases	Total Cases
	Number	Cases Involved	Number	Cases Involved		
Salmonella typhimurium	1	5	2	25	13	43
Other Salmonellæ	6	15	1	17	26	58
Cl. welchii	—	—	—	—	2	2
Staph. aureus	—	—	—	—	—	—
Not discovered	6	18	1	22	22	62
All agents	13	38	4	64	63	165

In addition there were 12 cases of salmonella infection not food-borne

One of the outbreaks of S.typhimurium involving 11 cases was due to phage-type U20 and was first reported in a maternity unit of a hospital. It spread in the hospital and also in the local isolation hospital to other patients and thereafter to the outside community. All staff were exonerated and although not proven, the source of infection was believed to be a meat product, probably pork. The other outbreak affected 14 cases and was associated with the consumption of raw milk from an infected dairy herd. The cattle affected were treated with antibiotics and the milk was sent for pasteurisation on a voluntary basis. Intensive investigations of all the feeding materials were undertaken but the origin of the infection remained untraced.

Cooked meats sold from a shop in a market hall were the vehicle for S. enteritidis phage type 8 which was the organism responsible for an outbreak of 17 cases. After investigations a member of the staff was found to be a carrier of the organism and was excluded from work until free of the infection; meanwhile the premises had been thoroughly cleansed and unsold meats destroyed voluntarily.

The pre-cooking of food, especially meat and meat products, followed by imperfect cooling and storage creates an unnecessary risk of food poisoning. The disease could be virtually eliminated by strict adherence to a rigid code of kitchen hygiene and practice supplemented by clean food handling.

Infective Jaundice:

A total of 694 notifications were confirmed of which half were children aged 5-14 years. The raised incidence reported in the last quarter of 1969 was continued through to March, 1970, thereafter declining. No outbreak or focus of infection was apparent.

The statutory notification of cases has enabled medical officers of health to obtain more precise information concerning the epidemiology and incidence of infective hepatitis. There are still obscure features of both components of the disease and research is proceeding on various fronts: the production of a virocidal agent is urgent, and it is hoped that the research on the Au-SH antigen will lead to a better understanding of the infection.

Influenza:

The disease is not statutorily notifiable and the most reliable index of morbidity is the weekly notifications of new claims to sickness benefit issued by local offices of the Department of Health and Social Security, supplemented by information of school and industrial absentees.

The epidemic which began in mid-December, 1969, continued through January but subsequently declined; the virus implicated continued to be A2/ Hong Kong/68. The length of illness appeared to be sharply defined: children and teenagers were ill for less than a week but adults not less than two weeks. In

certain areas severe complications were reported which were reflected in the death rates not only of the elderly, but also of middle-aged people; for the year, 285 deaths were recorded, of which 210 were aged 65 years or over and 62 in the 45-64 years age group.

MEASLES:

The regular cycle of increased prevalence of measles from autumn through to spring biennially was interrupted in the summer of 1966 when outbreaks of epidemic proportions occurred throughout the County. There followed a period of low incidence until a further out of regular season outbreak in the spring/summer of 1968. This pattern was repeated in 1970.

Increased prevalence was notified from April onwards with peaks in early June and late July thereafter declining to negligible proportions. Of the 16,351 notifications for the year 11,292 related to the epidemic. There were no 'regular' or 'usual' winter outbreaks. Of the total notifications, 60 per cent. were of children under 5 years and 38 per cent. in the 5-9 years age group; there was a slight male excess in all age groups.

Routine measles vaccination is now generally an accepted procedure in a child's vaccination and immunisation programme. The programme of vaccination which began in 1968 was no doubt responsible for the low incidence in 1969 and the temporary shortage of vaccine due to the suspension of the use of the Beckenham 31 strain contributed to the number susceptible to measles and permitted epidemic spread in 1970. It is important to carry through the vaccination programme effectively to prevent the recurrence of epidemic measles and to avoid a build-up of susceptible older children.

A review of the Authority's participation in the Medical Research Council's trials of measles vaccines which preceded the introduction of the national vaccination scheme is given on page 110.

Measles Vaccination:

The number of persons who received vaccination against measles during the year was as follows:

Born in Year	
1970	15
1969	7,844
1968	10,480
1967	3,167
1963-66	4,906
1954-62	709
Total	27,121

This shows an increase in the region of 87 per cent. over the figure of 14,532 for 1969.

Rubella Vaccination:

By Department of Health and Social Security Circular 11/70 of the 29th July, 1970, Local Health Authorities and Authorities exercising delegated health and welfare functions were asked as a matter of public policy to make arrangements under the provisions of Section 26 of the National Health Service Act, 1946, to offer vaccination against rubella to girls between their eleventh and fourteenth birthdays but that initial priority should be given to those in their fourteenth year. The arrangements were to be brought into operation as soon as possible and general practitioners were to be invited to participate in the scheme and provided with the rubella vaccine they would require.

The Secretary of State recognised that the introduction of vaccination against rubella might cause unexpected additional expenditure by Local Authorities and for this reason he had decided to supply the vaccine required up to the 31st March, 1971, free of charge to enable Authorities to offer vaccination to all girls aged 13 years. Local Authorities would be required to purchase the vaccine required after the 31st March through normal commercial channels. Approval to the operation of the rubella vaccination scheme as from September was given by the West Riding Health Committee on the 7th September. At the 31st December, the number of girls who had received vaccination against rubella was 3,741.

MENINGITIS:

A total of 55 cases was notified compared with 48 in the previous year. Acute meningitis is not a single disease entity and a breakdown of notifications into terms of ætiology was introduced in 1970; meningococcus was incriminated in 22 cases, other specified organisms in 11 and unspecified organisms 22.

Of the total notifications, 29 were under the age of 5 years, 15 in the 5-9 years age group and 11 at older ages. Notifications were more frequent among males in the ratio of 1·7:1.

Although there was slightly increased prevalence in the south of the Riding early in the year there was no focus of infection or apparent connection.

POLIOMYELITIS:

There is cause for satisfaction in the progress in control of the disease: incidence and mortality is still declining nationally and in the Administrative County during the past five years there has been only one confirmed notification, a paralytic case in 1968. The incentive to have children and persons at special risk vaccinated must not be diminished if we are to prevent a recurrence of the disease.

Vaccination against Poliomyelitis:

At the year-end the total number of persons who have received protection against poliomyelitis in the County, taking into account both Salk and Oral vaccine, was 875,079.

SCARLET FEVER:

Following the increase in incidence in 1969, notifications decreased to 661, the lowest total recorded since 1962 and represent an attack rate of 0·37 per 1,000 population. The seasonal distribution conformed to the usual pattern with incidence high in the first and fourth quarters. The majority of cases were mild and were nursed at home; no death was recorded.

SMALLPOX:

The County has been free from the disease since 1962. With the risk of importation of the disease from endemic areas persisting, every effort is made towards protecting the young child by vaccination in the second year of life and re-vaccination at 5 and 15 years.

TETANUS:

Since notification of the disease was introduced on 1st October, 1968, no case has been reported.

Tetanus Immunisation:

The total number of children who completed a primary course of protection against tetanus during 1970 was 26,182. A secondary or reinforcing injection was given to 27,080 children.

WHOOPING COUGH:

There was a substantial increase in notifications compared with the two preceding years. There were 694 notifications, the majority of which (70·7 per cent.) occurred in the fourth quarter. The age-sex distribution differed only slightly from the established pattern: 11·2 per cent. of the notifications were of children under 1 year of age, 41·5 per cent. aged 1-4 years and 43·4 per cent. at ages 5-9 years; the usual female excess was absent.

This can be a disturbing and potentially dangerous disease of early infancy; of the 78 notifications in the first year of life, one was fatal and it is to be hoped that by effective vaccination we can reduce incidence to negligible proportions.

Immunisation against Whooping Cough:

During the year 24,027 children completed a full course of immunisation against whooping cough and since facilities were introduced in 1952 a total of 334,688 have been immunised under the County scheme. The number of children in the 0-4 years age group was 94,212 representing 84·1 per cent. of the total population in this age group. Of the 631 notifications of whooping cough in the 0-14 years age group 276 concerned children who had been immunised.

VENEREAL AND SEXUALLY TRANSMISSIBLE DISEASES

The total number of new cases of venereal and sexually transmissible diseases diagnosed in West Riding Administrative County residents in 1970 attending at 17 special clinics increased by 19 per cent. from 2,262 to 2,698. The 1968 total was 2,083.

The general trend in the apparent incidence of the diseases shown in Table 27 was that of a continuing increase in new cases of gonorrhœa and other sexually transmissible diseases.

Syphilis:

Although there was an increase in cases of syphilis from 30 to 41, only six of these patients were suffering from early infectious syphilis. For the sixth successive year there were no cases of congenital syphilis in infants under one year of age. Cases of syphilis comprised just over one per cent. of the total new cases.

Gonorrhœa:

Cases numbered 588, an increase of 8 per cent. Of 376 cases in males, 14 per cent. were under 20 years of age. Of 212 cases in females almost 29 per cent. were under 20 years of age. It is generally considered that the nearer the ratio of male/female cases of gonorrhœa approaches 1:1 the better the contact tracing. The Administrative County ratio in 1970 was 1·8:1 while that for the whole of England was 3:1. Fifteen per cent. of all new cases were found to have gonorrhœa.

Sexually Transmissible and Other Genito-urinary Cases:

These comprised 54 per cent. of all new cases and totalled 2,069 cases (1,315 males and 754 females), an increase of 18 per cent. compared with the previous year. Of the cases in males 53 per cent. were suffering from non-gonococcal urethritis and of those in females 30 per cent. had trichomoniasis.

Cases Not Requiring Treatment in Special Clinics:

There were 1,125 cases (29 per cent. of all new cases), almost the same number as in 1969. In addition to uninfected persons who had exposed themselves to the possibility of infection, this group included babies for pre-adoption examination and blood tests, and unmarried expectant mothers.

Contact Tracing:

In view of the continued increase in the apparent incidence of venereal and sexually transmissible diseases in the United Kingdom in recent years more emphasis has been directed to the bringing under examination of possible sources of infection by case finding.

The Administrative County has always been in the forefront in this important preventive work and in 1943 was one of the first authorities to appoint a whole time V.D. social worker. In 1947 the establishment of V.D. social workers was increased to four (the present number). Three of the social workers hold joint appointments with the County Boroughs and all attend V.D. clinics in their areas. They have three main tasks:

1. Clinic social work entails helping patients with their various medico-social problems and obtaining information about sources of infection.

2. Case holding. As methods of diagnosis and treatment improve the follow-up of defaulters is becoming less important.

3. Case finding on the other hand is becoming increasingly important. Two main methods are used.

(a) The Contact Slip.

In this method the patient acts as a contact tracer and asks the contact or contacts to attend a special clinic for medical examination. The contact slip method is used at all the clinics attended by West Riding Administrative County patients and achieves a varying success rate of up to 50 per cent. The vast majority of contacts who attend special clinics do so through the use of a contact slip.

(b) The Contact Information Form.

Each completed form gives information in confidence about a contact and is sent to the medical officer of health or to the consultant venereologist of the district in which the contact resides. During 1970 a new simplified contact information form was introduced by the Department of Health and Social Security. This new form has been generally approved by West Riding venereologists and they have agreed to use it in their own areas where the contact slip has failed and in areas where the contact is said to be living in another area. Of course in many cases the information obtainable from the patient about his or her contact (or contacts) may be insufficient. A great deal depends on the expertise of the interviewer—in many special clinics the V.D. social worker. The West Riding Administrative County is fortunate in employing four dedicated and conscientious workers in this sphere.

Of 74 contacts notified in confidence to the County Medical Officer, 65 were located by the social workers and 59 were brought under medical examination at special clinics.

There were 2,698 cases of venereal and sexually transmissible diseases. Assuming 50 per cent. of the contacts of these cases were successfully dealt with by means of the contact slip and in a further 40 per cent. the information was insufficient for tracing, one would still expect many more than 74 contacts to be notified. It is to be hoped that with the new simplified contact information form the number of contacts notified will increase considerably in the future.

RESEARCH PROJECTS

Survey of Childhood Cancers:

In previous Reports reference has been made of the department's participation in the national surveys of childhood cancers conducted by Dr. Alice Stewart of the Department of Social Medicine at Oxford University. The surveys have included the study of cancer ætiology in children who have recently died from malignant diseases also a similar number of healthy controls.

The current survey includes the investigation of deaths in the period 1961-68 and at the year-end, of 273 cases relating to the Administrative County, enquiries into 218 cases and their age/sex paired controls had been completed.

In a progress report on the project Dr. Stewart writes:

"Numerous as they are, the currently available records are still short of the rare 'sib-concordant' cases which are needed to solve some very interesting problems which have been raised by the realization that mutations which conform to certain stringent requirements probably lie at the root of all human cancers, and can certainly be caused by small doses of radiations. For instance, the cancer risk associated with obstetric X-rays has proved to be both dose-dependent and age-dependent and to produce cancers which usually take less than five years to prove fatal.

The survey has also shown that the risk of incurring a 'necessary and sufficient mutation' progressively decreases with age between conception and puberty, and that cancer deaths towards the beginning of this period would be even commoner than they actually are if it were not for the fact that the very early mutations often terminate in abortions. Finally, the survey has shown that the incidence of childhood leukæmias is a poor reflection of the specific mutation risks because there are so many infection deaths during the latent period, and these deaths are so closely related to the accessibility of antibiotics and other drugs.

In short, the data you have helped to collect has made it possible to confirm the mutational origin of cancers and to show that at an early stage of development certain cancers are very likely to have lethal side effects."

Although the investigations undertaken by the medical staff are very time consuming, these interim findings amply justify the work involved.

Measles Vaccine Trial:

The follow-up of children in the Medical Research Council's Measles Vaccines Committee survey has continued.

In 1964 the Authority agreed to take part in a large-scale trial to ascertain the degree and frequency of reactions following vaccination, the extent and duration of protection and to assess the value of the vaccines for general application.

During the autumn of 1964 and 1965, 3,510 children, in the susceptible age group of 10 months to 2 years, resident in certain parts of the Administrative County whose parents had voluntarily agreed to them taking part in the trial were vaccinated with killed vaccine, followed four weeks later with a dose of live vaccine. The children were followed-up by health visitors three weeks after vaccination to assess the reactions to the vaccines and at three, six and nine months to investigate the incidence of measles. Subsequent annual postal follow-ups have been undertaken and visits by health visitors in cases of default.

The Committee's interim reports concluded that the vaccines gave a high degree of protection and when measles occurred in vaccinated children, generally it was milder than the disease in those unvaccinated. Furthermore, the protection rate was higher when a single dose of live vaccine was given. These findings enabled the then Ministry of Health to introduce measles vaccination for all susceptible children up to and including the age of 15 years. However, before vigorous campaigns of vaccination could be mounted in 1969 the supplies of vaccine from one manufacturer were suspended and there was the inevitable shortage which persisted through to mid-1970. These events were clearly reflected in the number of children vaccinated in the general scheme.

The results of the trial recorded to date show that a substantial protection has been maintained; follow-up of the children concerned, however, will be continued to determine the efficacy of the vaccine over longer periods and whether booster vaccinations should be given and, if so, the optimum age for their administration.

Morbidity and Mortality Survey of Chromium Platers:

The Medical Research Council's Committee on Research into Chronic Bronchitis is sponsoring an investigation into past and present workers in the chromium plating industry in the West Riding geographical area. The survey is being conducted by Dr. H. Royle of York. It has already been acknowledged that chromic acid fumes can cause respiratory diseases, including carcinoma of the lung, in workers engaged in the production of chromium, but there is no knowledge as yet as to whether workers in the chromium plating industry are similarly affected. It is well known that upper respiratory symptoms, such as nasal perforation and skin ulceration, can occur in these workers, but there is no evidence of direct damage to the lungs themselves. The purpose of the survey is to ascertain the prevalence of chronic bronchitis and related disorders in individuals who during the past 30 years have worked for more than three months in an atmosphere containing chromic acid compared with a control group of industrial workers in the same district. Interviews of current personnel at their place of work are undertaken by Dr. Royle and for past personnel by health visitors. Additionally, health visitors follow-up chromium platers who are known to have died.

By the end of the year, of the 169 cases allocated to the Administrative County requiring investigation by health visitors, 102 had been completed, 39 refused or were untraceable and 28 were outstanding.

PART II

CO-OPERATION IN THE HEALTH SERVICE

DIVISIONAL ADMINISTRATION

See also Table 37 of Appendix A

CO-OPERATION IN THE HEALTH SERVICE

Co-operation with General Practitioners:

STANDING SUB-COMMITTEE ON CO-OPERATION:

This Committee met on four occasions and given below are the principal agenda items:

February

Nursing Attachment to General Practice. E.C.L. 43/69, Circular 13/69 and Report.
Measles Vaccine.
Health Centres.
Family Planning.
Family Planning Association and Male Sterilization.
Vaccination and Immunisation Scheme.
Medical Examination for Heavy Goods Vehicles Driving Licences.
Chrome Workers Survey.

April

"People with Epilepsy"—E.C.L. 5/70.
Computer Statistics.
Future of Health and Welfare Services. (Social Services Bill and the Green Paper).

July

Safety of Medicine in Homes for the Elderly.
Ambulance Service—Co-operation.
Chronically Sick and Disabled Persons Act, 1970.
Measles Vaccination and General Practitioners.

October

Developmental Assessment Screening—West Riding Policy.
The Mayston Report on Local Health Authority Nursing Services.
Vaccination against Rubella.
Peel Report of Midwifery.
Vasectomy Clinic.
Febrile Illness amongst Immigrants.
Vaccination and Immunisation Computer Schemes—Smallpox.
Vaccination Payments.

PREMISES FOR JOINT USE:

The number of general practitioners providing general medical services wholly or partly within the administrative area at 1st April, 1970, was 1,437 compared with 1,436 in 1969 and 1,433 in 1968. The percentage of general practitioners in group practice continues to increase slightly.

New buildings completed during the year were:

	Date of Completion
'E' Type Health Centre:	
Crosshills	28th January
Health Centres—Special Design:	
Ardsley	29th January
Harrogate (Knaresborough Road) ...	2nd March
Mini Clinics:	
Bishopthorpe	18th August
Copmanthorpe	18th August
Stanley	29th July
Walton	29th July

At the time of writing, 102 practices, comprising 255 general practitioners, are being provided with main or branch surgery accommodation in 73 health centres and clinics. The 'E' type health centre—prefabricated, and a small building providing for a maximum of three general practitioners—was the first of the County Council's health centres. It has been very successful in providing good modern surgery accommodation, but experience over the years with a number of buildings of this type has revealed a number of defects in design and layout of the accommodation. This resulted in the development in 1970 of a redesigned small 'F' type health centre, a plan of which is shown after page 118.

Similarly with the mini clinic. This was originally designed mainly for local health authority services for small units of population up to about 4,000, with occasional use by general practitioners for branch surgeries of short duration. This clinic has been redesigned as the mini Mark II to provide a better layout of the accommodation when used jointly with general practitioners. The revised version is slightly larger and a sketch design is shown after page 118.

General Practitioners in Maternity and Child Welfare Work:

Participation by general practitioners in traditional public health activities is indicated below:

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

	Total Doctors' Sessions	General Practitioners' Sessions	Percentage of sessions done by General Practitioners
1964	12,492	5,496	44
1965	11,761	5,844	49
1966	11,678	6,711	57
1967	11,307	6,679	59
1968	10,762	6,285	58
1969	10,187	5,930	58
1970	10,210	6,641	65

Employment of General Practitioners by the County Council in Ante and Postnatal Clinics

	Total Doctors' Sessions	General Practitioners' Sessions	Percentage of sessions done by General Practitioners
1964	3,011	1,267	42
1965	2,751	1,122	41
1966	2,398	1,123	47
1967	1,920	920	48
1968	1,787	893	50
1969	1,367	776	57
1970	1,078	644	59

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

	Sessions	No. of General Practitioners involved
1964	Nil	—
1965	46	5
1966	58	6
1967	50	2
1968	147	11
1969	294	21
1970	453	36

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

	Sessions	No. of Practices involved
1964	902	25
1965	1,456	36
1966	1,643	43
1967	1,927	51
1968	2,159	53
1969	2,381	57
1970	2,365	59

Midwives attending Antenatal Patients in General Practitioners' surgeries (outside clinics)

	Sessions attended	Midwives involved
1964	1,945	67
1965	1,905	85
1966	3,600	105
1967	3,458	91
1968	4,380	104
1969	4,816	115
1970	4,668	120

STAFF ATTACHMENTS:

Health Visitors

At 31st December	No. attached	No. of Practices	No. of General Practitioners
1964	68	88	185
1965	128	163	355
1966	140	169	377
1967	153	202	416
1968	209	251	514
1969	205	259	550
1970	216	241	549

Home Nurses

At 31st December	No. attached	No. of Practices	No. of General Practitioners
1964	33	51	110
1965	47	71	156
1966	70	99	233
1967	115	165	358
1968	196	249	541
1969	214	263	598
1970	215	266	601

Midwives

At 31st December	No. attached	No. of Practices	No. of General Practitioners
1964	27	38	70
1965	43	47	106
1966	45	51	119
1967	49	54	119
1968	49	63	153
1969	49	64	148
1970	52	72	168

BULLETIN FOR GENERAL PRACTITIONERS:

Health Notes and the complementary *Divisional Medical Officer's Newsletter* continued to be issued quarterly.

Co-operation with Hospitals:

MATERNITY LIAISON COMMITTEES:

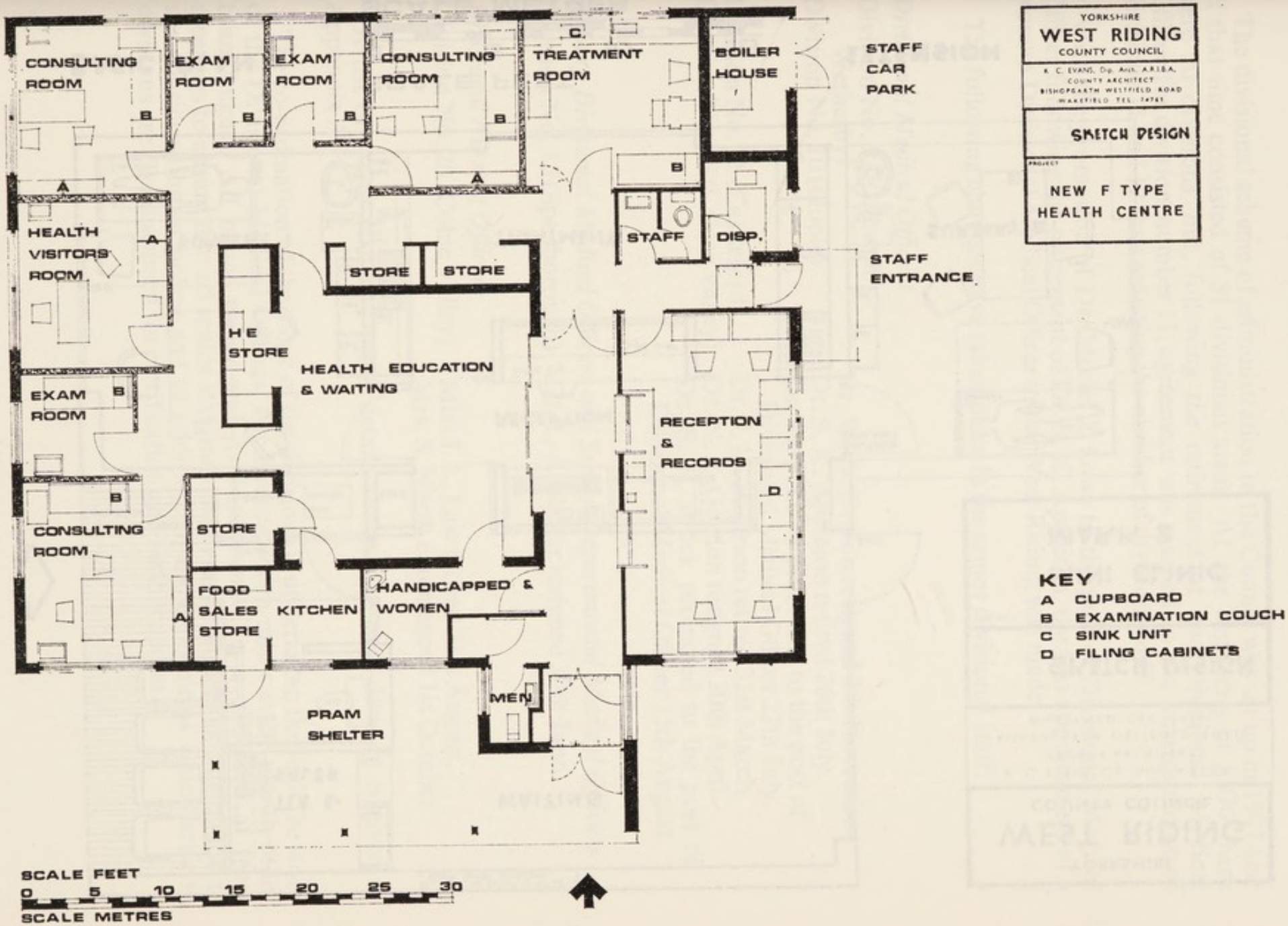
Meetings were held in Barnsley, Bradford, Doncaster, Dewsbury, Harrogate, Ilkley, Rotherham, Wakefield, and York. Subjects discussed included arrangements for family planning services, administrative plans for Guthrie testing of infants, and booking arrangements for general practitioner maternity units.

MENTAL HEALTH LIAISON COMMITTEES:

It was reported in 1969 that committees had been established in conjunction with Doncaster, Storthes Hall and York Hospital Management Committees.

On the 1st October, 1970, a liaison committee was established in connection with the Barnsley Hospital Management Group Committee. The new Barnsley District General Hospital includes the St. Helen Hospital. The psychiatric provision is for 66 psychiatric in-patient beds and 16 day-patient beds.

As a result of discussions at meetings plans are being finalised by the Sheffield Regional Hospital Board for the necessary adaptations to be made at Moorland Court, Gawber Road, Barnsley, for providing additional temporary facilities for the day care of 40 psychiatric patients in late 1971 or early 1972. No doubt this extra provision would ease considerably the difficulties of the area.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K. C. EVANS, Dip. Arch. A.R.I.B.A.
COUNTY ARCHITECT
BISHOPSGARTH WESTFIELD ROAD
WAKEFIELD TEL. 74761
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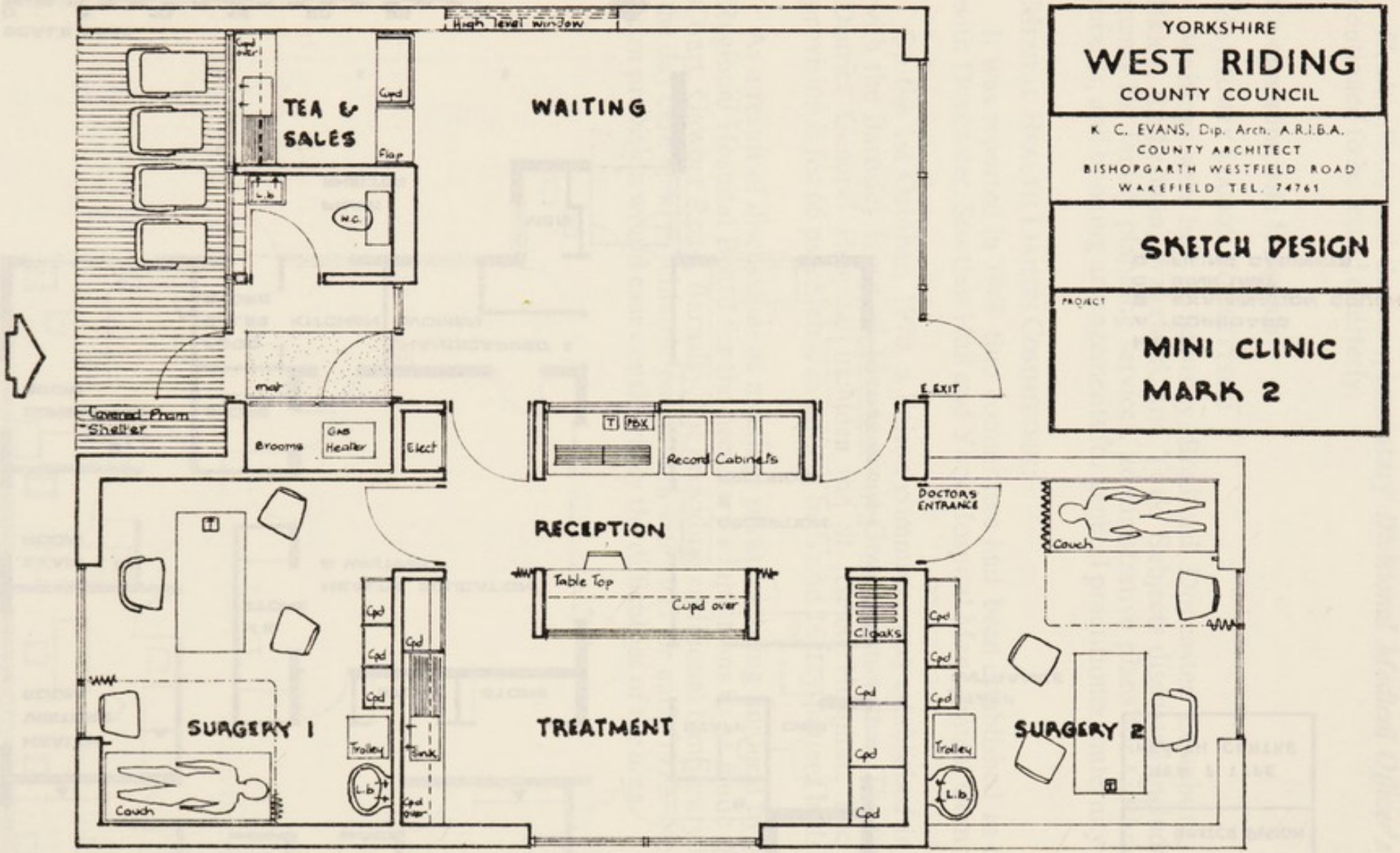

High level window
TEA & SALES
WAITING
Cupd over
Flap
L.b
W.C.
mat
Covered Pram Shelter
Brooms
GAS Heater
Elect
T
PBX
Record Cabinets
E EXIT
DOCTORS ENTRANCE
RECEPTION
Table Top
Cupd over
Couch
Cupd
Cloaks
Trolley
Sink
L.b
SURGERY 1
TREATMENT
SURGERY 2
Couch
YORKSHIRE
WEST RIDING
COUNTY COUNCIL
K. C. EVANS, Dip. Arch. A.R.I.B.A.
COUNTY ARCHITECT
BISHOPGARTH WESTFIELD ROAD
WAKEFIELD TEL. 74761
SKETCH DESIGN
PROJECT
MINI CLINIC
MARK 2
BASIC PLAN
SCALE FEET
0 5 10 15
SCALE METRES
EXTENSION

DIVISIONAL ADMINISTRATION

The divisional scheme of administration in the County was set up in 1947 and at that time consisted of 31 divisional areas. At the beginning of 1970 there were 20 divisions but, following the retirement of the Divisional Medical Officer for division number 11, agreement was reached to the amalgamation of divisions 11 and 12 thus reducing the number of divisions to 19.

With the promotion of Dr. Muriel J. Lowe to the post of Divisional Medical Officer following the retirement of Dr. S. K. Appleton, the first appointment of a woman Divisional Medical Officer in the West Riding was made.

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

Divisional Medical Officers

Division No. 9 (Rothwell/ Wetherby)	Dr. W. D. Dolton resigned 8th November.
Division No. 10 (Goole)	Dr. S. K. Appleton retired 26th July.
	Dr. M. J. Lowe promoted to the post of Divisional Medical Officer 27th July.
Division No. 11 (Castleford)	Dr. J. M. Paterson retired 31st March.
Division No. 18 (Calder Valley)	Dr. N. E. Gordon resigned 30th April.
	Dr. S. H. Brock promoted to the post of Divisional Medical Officer 15th August.

Deputy Divisional Medical Officers and Senior Departmental Medical Officers

Division No. 15 (Spenborough)	Dr. L. Arblaster resigned 30th June.

Divisional Nursing Officers

Division No. 20 (Colne Valley)	Miss J. L. Law retired 31st August.
	Mrs. S. North commenced 1st October.

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

The co-ordination of the work of the divisions is undertaken through the work of the Divisional Medical Officers' Conference which meets every month other than 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.

PART III

LOCAL HEALTH SERVICES

Care of Mothers and Young Children

Midwifery

Health Visiting

Home Nursing

Ambulance

Prevention of Illness, Care and After-Care

Health Education
Recuperative Home Treatment
Renal Dialysis

Mental Health

See also Tables 38 to 61 of Appendix A

Dental Treatment of Expectant and Nursing Mothers and Children under Five:

The Chief Dental Officer reports:

The number of expectant and nursing mothers receiving dental inspection at County clinics rose from last year's figure of 351 to 374, the first increase in numbers since 1961 when free treatment became available to them in the National Health Service. The overall reduction is not of serious concern except in one respect, an opportunity for appraising mothers that the service is available to their pre-school children is lost.

In the Annual Report for 1969 mention was made of the difficulty of access to pre-school children and the success of the co-operation between medical and dental staff of the Garforth Clinic in directing parents with pre-school children to the Dental Officer in the course of Developmental Assessment Clinics. This was in the nature of a pilot scheme and towards the end of the year these clinics were being established in other areas.

Battered Babies:

In February, 1970, a joint circular from the Department of Health and Social Security and the Children's Department of the Home Office was sent to all Medical Officers of Health and Children's Officers, drawing attention to the problem of young children who are injured by their parents, i.e. 'battered babies'.

It was pointed out that preventive action must be taken when such a case came to light as the child may be at risk of further injury and subsequent children in the family may be similarly at risk.

The circular requested that the Medical Officer of Health, the Children's Officer and representatives of Local Medical Committees, Pædiatricians, Consultants responsible for casualty departments, and other social agencies concerned should meet to discuss the present local arrangements for the detection and follow-up of cases of battered babies, and to make suggestions as to further arrangements which should be made to ensure that all necessary protection and assistance could be made available to the child, others at risk in the family, and to the parents and other adults.

Following this circular, joint meetings of the people concerned were arranged, based on the area covered by the local district hospitals. The result of these meetings was the inauguration of Co-ordinating Committees to deal with the problem of battered babies. The Committees laid down a routine procedure of action to be followed where a suspicious case occurred; this referred to the details of the medical examination and to the further investigations which are necessary in such cases.

Future meetings of the Co-ordinating Committees will be held when the need arises.

Phenylketonuria:

In 1970, the Guthrie test was gradually introduced throughout the County to replace the 'Phenistix' test for screening babies for phenylketonuria. By 1st October, 1970, all divisions were using the Guthrie test on babies born at home or discharged from hospital before the sixth day after birth.

The hospital maternity units are responsible for screening infants in hospital on or after the sixth day. In some areas, the medical officer of health is notified by the hospital that the test has been carried out, whilst in other areas the arrangement is that the medical officer of health will be notified of positive test results only. In view of the varying arrangements made, it has to be assumed that all babies born within the County area are screened for phenylketonuria, but figures for the exact number of infants so tested are not available.

During 1970, three new cases of phenylketonuria were diagnosed. One had a positive Guthrie test carried out in a maternity home on the sixth day; the second case had a positive 'Phenistix' test on the 28th day; and the third case had a negative 'Phenistix' test when six weeks old but was later investigated in hospital as she failed to thrive properly and was diagnosed as having phenylketonuria at eight months of age. It is hoped that the introduction of the Guthrie test will eliminate such cases as the one last-mentioned, i.e. where a misleading negative 'Phenistix' result is obtained early in life and a diagnosis of phenylketonuria is only made when the child shows signs of retarded development.

Case 1 — Boy, N. W., born 28.6.70.
Positive Guthrie test on 6th day.
Follow-up report (May, 1971).
Attends hospital regularly but there has been difficulty in maintaining a strictly-controlled diet. Shows signs of retarded development.

Case 2 — Boy, A. J., born 25.2.70.
Positive 'Phenistix' test at 4 weeks.
Admitted to hospital.
Family moved out of County area so a follow-up report is unavailable.

Case 3 — Girl, H. T., born 3.1.70.
Negative 'Phenistix' test at 6 weeks.
Admitted to hospital at 8 months because of failure to thrive and diagnosed as having phenylketonuria.
Follow-up report (June, 1971).
Controlled diet; shows some signs of retarded development.

Ortolani Testing for Congenital Dislocation of the Hip:

During the year, 94 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 411 confirmed cases since the Ortolani test was introduced as a routine procedure in December, 1962.

Congenital Abnormalities:

Under the national scheme for the registration of congenital abnormalities discovered at birth and recorded on the notification of birth form, 474 babies with a total of 576 abnormalities were notified.

The number of births notified during the year was 31,496, giving a percentage of 1·5 for babies with one or more congenital abnormalities.

Welfare Foods:

At 31st December, 1970, there were 296 distribution centres in the County for the issue of welfare foods, of which 226 were health or child welfare centres.

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

There were 90 meetings of the Co-ordinating Committees established, under the chairmanship of the Divisional Medical Officers, to co-ordinate the activities of the many statutory and voluntary organisations concerned in the welfare of children.

Applications for assistance by housing authorities in cases where there was a danger of families being evicted, broken-up and the children taken into care have continued to be considered by the Special Sub-Committee established for this purpose, and, at the end of the year, 205 families remained under review. The action taken by the Committee has helped to prevent the eviction of families and has enabled the work of rehabilitation to continue.

DOMICILIARY MIDWIFERY

Miss M. J. Astin, S.R.N., S.C.M., M.T.D., was appointed Non-Medical Supervisor of Midwives in February, 1970, and Miss A. Sellars, S.R.N., S.C.M., M.T.D., H.V., in September, 1970.

Staff Situation:

The establishment at 31st December, 1970, remained at 280, but with the steady decline of domiciliary deliveries since 1964, there has been a reduced number of midwives employed again this year.

In post at 31st December, 1970:

Whole-time midwives	149
Part-time midwives	10
Whole-time home nurse/midwives	41
Part-time home nurse/midwives	2
	202

The whole-time equivalent is 175. There were 15 appointments, 12 resignations, eight retirements, and one midwife transferred to another service.

New work commenced by midwives during 1969 was the performance of the Guthrie test on babies born at home or discharged home from hospital before the sixth day of life. This test detects phenylketonuria more sensitively than the urine test formerly undertaken routinely by health visitors: 1970 has seen this implemented throughout the whole County.

Four midwives were trained in family planning methods during the year.

Attendance at general practitioner antenatal sessions, nursing of increased numbers of mothers and babies discharged early from hospitals, and antenatal exercise and mothercraft classes, form the remainder of the midwives' work in the County as a whole with domiciliary confinements varying in relation to provision of maternity beds.

Attachment to General Practice:

The increasing number of midwives attached to general practices is shown on page 117.

Emergency Obstetric Units:

There were 39 calls on this service during the year.

In-Service Training:

Thirty-five County midwives, and 10 from adjoining authorities and hospitals attended a course at Grantley Hall. This was the last course to be mainly devoted to preparation to undertake mothercraft and relaxation classes.

Forty-four midwives attended statutory refresher courses.

Liaison with Hospitals:

The attendance by midwives in the Wath on Dearne area at the Montagu Hospital ceased in July, 1970. Discussions on the possibility of County staff attending their own patients in the general practitioner unit at Barnsley District General Hospital were in progress before the unit opened in December, 1970.

Cars:

A hundred and fifty-one midwives use cars for their work, 15 being provided by the Authority.

HEALTH VISITING

Staff Situation:

The establishment at 31st December, 1970, remained at:	407
In post:	
Qualified health visitors (including 25 part-time)	301
Assistants to health visitors (including 55 part-time) ...	108
Whole-time tuberculosis visitors	2
	411
Whole-time equivalent	371
Changes of staff during the year included:	
Appointments—Qualified health visitors	51
Assistants to health visitors	23
Resignations—Qualified health visitors	29
Assistants to health visitors	11
Retirements	19
Transfers to health visitor training	10

Attachment to General Practices:

The number of qualified health visitors attached to general practices is shown on page 117. In addition there are many health visitors with close liaison arrangements with family doctors but who are not wholly attached in the County definition.

In-Service Training:

Thirty-nine health visitors and 18 assistants to health visitors attended a course at Grantley Hall.

Twenty-eight members of field staff and three nursing officers attended courses outside the County.

Training in the detection of hearing loss was given to 72 members of staff at Brighouse, Otley, Morley, and Conisbrough, by courtesy of Drs. Brock, Burn, Ireland, and Cusiter. This training was given by Dr. Burn of Horsforth Division with practical supervision by experienced health visitors in each Division.

Eleven health visitors were trained in family planning methods during the year.

Health Visitor Training:

Thirty-four students qualified in 1969/70. Twenty-two students were accepted for the course commencing October, 1970.

Four fieldwork instructors attended courses of preparation. These members of staff will receive letters of recognition from the Council for Training of Health Visitors.

Cars:

Three hundred and ninety-one health visitors and assistants used cars for their work of which two were provided by the County.

Statistics—Comments on Table 48:

Figures given relate to first visits only as required by the Department of Health and Social Security. Work done in schools and in general practitioners' surgeries is not included.

A survey of health visiting work was undertaken during six weeks in April and May, 1970.

HOME NURSING

Staff Situation:

The establishment is 308 whole-time nurses.

In post 31st December, 1970:

Home Nurses, S.R.N. (26 part time)	276
Senior Relief Home Nurses, S.R.N.	1
Home Nurse/Midwives, S.R.N. (2 part-time) ...	43
Home Nurses, S.E.N. (4 part-time)	13
	333

The equivalent in whole-time home nurses is 296·0.

There were 44 appointments, 24 resignations, 10 retirements, and two transferred to other services.

The number of patients nursed rose by 3,138 to 41,340, compared with 38,202 in the previous year. Visits increased by 32,146 to a total of 881,230. In addition 12,815 hours were spent in doctors' surgeries and clinics treating ambulant patients—an increase of 958 hours on the previous year.

The number of home nurses attached to general practices continues to increase; details are given on page 117.

Training:

Nineteen nurses completed the course and all were successful in gaining the National Certificate in District Nursing.

Refresher Courses:

Forty-nine nurses attended a course at Grantley Hall.

Cars:

Three hundred and seventeen home nurses and home nurse/midwives used cars in connection with their duties, 73 being provided by the Authority.

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 a 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 the 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 12 divisions; 212 cases were provided with 10,175 hours of service at a cost of £3,551.

AMBULANCE SERVICE

County Ambulance Officer's Retirement:

The year was marked by the retirement of Mr. Vernon Whitaker, O.B.E. on 10th August from the post of County Ambulance Officer, which was a unique occasion in that he held the post since the inception of the Service under the National Health Service Act, 1946, when he took up office in January of that year.

Due to his foresight, the County Ambulance Service was the first in the country to introduce radio telecommunications into operational practice, which proved to be of such immense value in increasing vehicle availability and at the same time reducing the expenditure on additional vehicles that it is now adopted as standard practice by all ambulance services.

His work in the national field of ambulance services was extensive and in 1954, he was honoured by the award of the Order of the British Empire for 'Services in connection with the development of Ambulance Services'.

After serving under Mr. Whitaker for many years and as his deputy from 1952, Mr. L. Lord was appointed to succeed him as County Ambulance Officer, with effect from 12th August, 1970.

Special Duty:

An unusual assignment for the service during the past year was the necessity to provide ambulance cover for the open-air Folk, Blues and Jazz Festival held at Krumlin, Barkisland, on the 14th, 15th and 16th August.

The site chosen by the promoters for the festival was a steep hill-side near Upper Firth House Mill and vehicle access was very difficult, in spite of efforts to re-surface some of the lanes. A temporary ambulance station of four ambulances and one stores vehicle was established at Upper Firth House Mill, staffed by one senior officer, one station officer and four to six driver/attendants, with adequate stocks of stretchers, blankets, rescue sledges, medical supplies and oxygen equipment.

By midnight on Saturday, five cases had required transport to hospital but by then, however, the weather had deteriorated to such an extent that it was no longer possible to carry patients by stretcher over the treacherous sloping ground to the ambulance and the rescue sledge had to be utilised. Gale force winds were blowing, accompanied by torrential rain and the area became a quagmire, making even walking very difficult. The 'one lane' access road was fast becoming impassable and the land rover ambulance could only operate with difficulty. The St. John Ambulance post was inundated with exposure cases and the ambulance service supplied blankets and stretchers to alleviate the situation. Marquees and tents were blown down and spectators were wandering aimlessly around seeking shelter. A soup kitchen was set up by the Civil Aid Authorities.

Due to continued heavy rain, the festival was abandoned early on the Sunday morning but the service continued to provide ambulance cover until the evening when the temporary station was closed down.

The number of actual patients conveyed to hospital was 16, plus relatives, but this was no measure of the actual role played by the ambulance service at the festival and under such atrocious conditions. The actions of all staff involved, including those of other organisations, were worthy of the highest commendation.

Industrial Action:

As a result of a national wage dispute by manual workers of Local Authorities, the service experienced its first involvement in major strike action, from 30th September to 7th November.

This, in general, took the form of a ban on the conveyance of non-urgent cases and a refusal to complete official forms or work overtime. The routine maintenance and exterior cleaning of vehicles was also banned, together with all station cleaning. The effect of such action varied from station to station according to the extent of Union membership, but no strike action at all was taken on six of the 23 stations.

Many problems arose during this period but, due to the diligence of staff not on strike and the sense of responsibility of many of the men on strike, a complete breakdown in service was avoided.

The McCarthy Report:

Pressure by the Federation of Ambulance Personnel in 1969 for recognition as a Trade Union with a seat on the National Joint Council, resulted in stoppages of work in London and other parts of the country but the effect on this service was negligible. Dr. W. E. J. McCarthy, Fellow of Nuffield College and the Oxford Centre of Management Studies was called in as an independent investigator to enquire into the problem.

The result of his deliberations was published in May, 1970, in a paper on *Representation and Collective Bargaining in the Ambulance Service*, generally referred to as the 'McCarthy Report'. His recommendations were far-reaching but a forecast of their implementation would be premature at this stage.

Training:

The heavy demand on the Training School at Elm Bank, Cleckheaton, has continued, with the provision of six-weeks basic and one-week refresher courses provided not only for our own service but for 23 other local authorities.

The plan for the establishment of regional schools envisaged by the Department of Health and Social Security and the Local Government Training Board has not yet been finalised but there is every reason to believe that the West Riding County Council may be authorised to establish a purpose-built regional school.

Having to provide basic entry courses for so many authorities necessitates recruits to our own service waiting up to 10 months for a course. As it is impossible to protect the recruits on stations from having to attend accident and emergency work, albeit with trained staff, a crash course in emergency procedures has been given to all recruits awaiting school courses.

The appointment of an additional instructor on the training school staff for the primary purpose of supervising in-service training on stations, has enabled considerable progress to be made in initial tuition prior to attendance at school and also in follow-up of school training. Instruction has been given on all stations in the use of new equipment before being brought into use, e.g. bag and mask, oropharyngeal airways and aspirators.

In line with the recommendation in Part I of the Millar Report that part of an ambulance driver's training should take place in hospital under the direction of medical staff, the following schemes are in operation:

(a) Students on the six-week courses at the training school spend one day at the Batley General Hospital, their time being divided between casualty, fracture clinic, the wards and theatre. In addition, they can also attend, in the evenings, on a voluntary basis.

(b) The six-weeks basic training course includes visits to certain specialised units, e.g.

Renal unit	—	St. James's Hospital, Leeds
Burns unit	—	Pinderfields Hospital, Wakefield
Neuro-Surgical unit	—	Pinderfields Hospital, Wakefield
Limb fitting centre	—	M.O.P., Chapel Allerton

(c) Arrangements have been made with the Halifax Royal Infirmary for a member of Brighouse or Todmorden station staff to attend at the hospital for one week courses. The course includes care of the airway, treatment of fractures, reception and treatment in casualty, and experience in the X-ray department and operating theatre. This experience in hospital is proving invaluable and similar in-hospital training for ambulance service staff is to be extended to other major hospitals in the County.

Outside Service Training:

There has been a further increase in the demand for training from other County Departments and outside organisations. A summary of such work now being carried out by ambulance service instructors is as follows:

FIRE SERVICE:

A session is given on 'Casualty Handling and Co-operation' between Ambulance and Fire Services on all their refresher courses.

POLICE SERVICE:

Cadets:

Cadets who attend at the Wakefield Technical College are given a St. John Qualifying Course in First Aid by our instructors. Apart from preparing them to pass the examination, the aspect of co-operation between the services is also included.

Road Traffic Division:

The Division has recently issued Brook Airways to patrol cars and training of police staff in the use of this item has been carried out.

SCHOOLS:

In addition to sessions given to pupils on 'Emergency Resuscitation' which are long established sessions in many schools, we are now being called upon to give training in 'Essential First Aid'.

Another recent development has been the provision of short courses in 'Essential First Aid' for teaching staff. To date, courses have been run at the Wetherby High School and Don Valley. A further course for 27 teachers at the Rothwell Comprehensive School is to take place in February, 1971.

FURTHER EDUCATION:

A full qualifying course in 'First Aid' is now a permanent feature of craft courses of the Pudsey College of Further Education.

HOSPITAL STAFF:

The Management Courses for Senior Nursing Staff which are being held at Keighley, Huddersfield, and Wakefield Technical Colleges, include a session on 'Liaison and Co-operation between Hospital and Ambulance Services'. These periods are taken by senior officers of our service.

YORKSHIRE PROVINCIAL COUNCIL:

A session on 'Essential First Aid' by us is now included as a permanent feature of their syllabus for Management Courses for L. A. Supervisory Staff.

OTHER ORGANISATIONS:

Requests from Women's organisations such as Women's Institutes, Wives' Groups, Young Mothers etc., have continued to increase.

COUNTY HALL STAFF:

We are continuing to provide full qualifying and re-qualifying courses in 'First Aid' for County Hall Staff, according to the Factories Act requirements.

Exhibitions and Visits to Headquarters:

The service's portable exhibition has been shown to the public in various parts of the County on seven occasions.

Five organisations have visited central control and vehicle workshops.

Central Vehicle Maintenance Section:

The problem of recruiting staff to fill vacancies arising in the vehicle maintenance section has continued throughout the year and much difficulty has been experienced in keeping the fleet on the road.

To meet Government policy in introducing productivity and incentive bonus schemes, the County Council authorised the implementation of Work Study within the workshops, aimed at producing a suitable scheme.

Vehicles:

Replacement ambulances have continued to be on the 25 cwt. Ford Transit chassis with body built to our own specifications. Five standard saloon cars are being obtained as an experiment for use on out-patient work. Completion of the vehicle programme in the current financial year will produce a total fleet establishment of 201 vehicles.

Building Programme:

Deferment of the new training school project resulted in the scheme for the erection of a new ambulance station at Castleford being advanced in the programme. The new station will accommodate 15 vehicles, plus three service bays and space for extension if required.

The erection of the new Ambulance Service Headquarters at Threelands, Birkenshaw, Bradford, was seriously retarded by the bankruptcy of the original contractor but the first phase was eventually completed in September, 1970, thereby enabling the administrative staff to move in. The second phase, which includes central control room, conference room and messing facilities, should be completed in April, 1971.

The station at Gildersome, which was provided to re-house the Old Birkenshaw station, was completed in June.

Preparatory work on four minor projects has been carried out during the year, i.e.

Skipton	—	Three bay extension to garage.
Bramham	—	Two bay extension with additional storage and mess accommodation.
Menston	—	New mess room with locker room and additional storage facilities.
Sherburn	—	Three bay garage.

A search is currently being made for new sites at Thorne, to establish a sub-station to Bentley station; Anston as a sub-station to Maltby station and Harrogate to replace the existing station.

Agency Services:

The year under review has brought problems for several of the agencies who have provided services on behalf of the County Council in the rural areas for many years.

Grassington: Mr. Penny of the Grassington St. John Ambulance Brigade retired at the end of October and, in the absence of volunteers to carry on the work, it was necessary to establish a directly provided service in Grassington, comprising one vehicle and three men.

Ripon and Selby: Due to continually rising costs, these agencies, both run by the local St. John Ambulance Brigades, have found it difficult to provide a service. A closer integration with the County service has now been effected, whereby they have virtually become sub-stations of the nearest County ambulance stations at Harrogate and Goole respectively.

Thorne: Owing to the impending closure of this service, arrangements are being made to establish a direct service sub-station of Bentley station to serve this area.

Clitheroe: Messrs. Tomlinson's taxi firm intimated their desire to terminate this agency and the future provision of cover in this area will be provided under arrangements with the Lancashire County Council Ambulance Service.

Statistics:

In comparison with the previous year the number of patients carried increased by 39,148 and miles covered by 200,696. Practically the whole of the increase in user comprised out-patients, again mainly attributable to increases in hospital services and geriatric day clinics. Close liaison with hospitals continued to be maintained in an attempt to rationalise their demand on the service.

Details of the accident work carried out are given in Appendix A. The figures relate strictly to accidents and do not include other emergency work such as removal of medical cases. It is interesting to note the high proportion of accidents occurring in the home.

PREVENTION OF ILLNESS, CARE AND AFTER-CARE

Health Education:

Progress continues to be made in health education activities in the schools.

The Joint Working Party on Health Education in schools between the health and education departments met on four occasions; a second occasional paper, this time on "First Aid in Schools" was distributed to every teacher in the West Riding. In addition, a further occasional paper on "Drugs and Young People" is to be prepared.

Two study days were organised by the Working Party during the year: one on "Venereal Disease and Sexually Transmitted Diseases" at which 150 people attended, mostly teachers, and "Drugs and Young People" which attracted a similar audience both in size and composition.

It is noticeable that schools are now taking a more active part in health education activities, and the role of the health department staff is changing. In at least four of our divisions, health staff have become incorporated in a team approach. A health education project is planned and the appropriate member of the team is responsible for his or her particular part of the project. Not only are teacher, school doctor and nurse involved, but also guest speakers such as probation officers, social workers, clergymen and bank managers; the range of interest of the speakers illustrates how wide are the influences affecting the health of the community.

During the transitional period from the present day traditional role of school medical officer and nurse to that of advisers to the school on all health aspects pertaining to education a departmental medical officer with special duties in health education has been appointed part-time and has been seconded to two divisions. One part of her task will be to study the future implications that health education in the schools will have on health staff. Her effort has complemented the existing work being done by the health visitors in these two divisions.

In order to fit the health visitor to the more exacting task which will be demanded of her, more in-service training courses have been geared towards the techniques of classroom teaching (see "In-service training").

The programmes of health education at the Teachers' Training Colleges have been expanded with further subjects added to last year's talks.

Group health education continues at child health clinics, women's voluntary organisations, parent/teacher associations and antenatal clinics.

New groups have asked for speakers on health education; there is an increasing demand from pre-retirement associations, a remand home for adolescents runs a course organised by a health visitor, and a hospital has asked for the loan of visual aids in health education courses they have run for their auxiliary staff.

The hospital and general practitioner surgery has, as yet, a community which has virtually escaped the attention of the health educator, but which could provide groups who are otherwise inaccessible.

REVIEW OF ACTIVITIES—HEALTH EDUCATION UNIT:

Visual Aids:

Displays and exhibitions are refurbished and maintained and some new displays made, as part of the routine work of the technician. These have been erected in health centres, schools, shop windows, libraries and at home safety exhibitions. Details are listed below.

Exhibit	*Number of venues*	*Number of days on display*
Puppet Exhibition	16	152
Medicines Display	19	107
Smoking and Lung Cancer Display	18	153
Other Displays, e.g.		
Nursing Stands, Water, Food Hygiene, Rats, Ears, Eyes, Fireworks	111	413

With the erection of new health centres more displays are needed and this demand was met.

Triptych displays and posters were designed and produced by the unit, supplemented by leaflets and other material obtained from national sources; a number of loop cassette films were acquired; new films were previewed and some purchased or acquired on long term loan. Additions of educational aids increase the work of the technician in repair and maintenance. Field staff continue to be trained in the use of projectors.

In-service Training:

The Health Education Officer attended working parties and health staff meetings to promote health education, disseminate new ideas and demonstrate new material and was involved in in-service training courses for field workers and practical help to those actively engaged in health education was given in preparing programmes for health education.

The health education unit arranged the following courses.

1. Grantley Hall Residential Course—"Some Health Problems of Today". The objective of the course was to highlight the current health problems in relation to nutrition and drugs and give the 25 course participants a wider understanding of health education in the teaching of these subjects.

2. Two-day study course—"Teaching Techniques and Class Control". Dr. Dolton, Divisional Medical Officer (Rothwell/Wetherby) and Mr. F. Scott, B.A., Headmaster, Garforth Comprehensive School, co-operated to make a successful course for the 38 health visitors who participated. Teachers demonstrated class control and the health visitors gave classroom demonstrations; 1st and 3rd year pupils were involved.

3. Three-day study course—"Class Control and Teaching Techniques and Questions". This was a requested repeat of a previous year's course but took place with the co-operation of Dr. Sammon, Divisional Medical Officer (Colne Valley) and with Mr. C. W. J. Cox, the Headmaster of Holmfield Secondary Modern School. The course tutor was Mr. M. D. Lynton Porter of the Health Education Council. Twenty-one members of staff including health visitors and doctors attended.

4. Three-session course—"Home Safety". This was held in the West Riding County Library at Wakefield, the course tutor and lecturer being Mr. K. Shaw, M.I.H.E., Home Safety Liaison Officer, North Region, Royal Society for the Prevention of Accidents. Miss Barbara Naish, Head of the Home Safety Division, R.O.S.P.A., was present as observer. Twenty members of staff attended.

REVIEW OF ACTIVITIES IN DIVISIONS:

Education to achieve good health is not new. In the past health education has been mainly directed towards principles of environmental hygiene and the containment of infectious diseases. Today, though these are still of consequence, the primary concern is the individual and how he can be influenced to follow rules of healthy living. This is reflected in the report of Dr. Burn, Divisional Medical Officer (Horsforth):

"During the year regular mothercraft talks have been given by the health visitors and midwives at all the clinics.

The mothers' clubs continue to be well supported and all have a very full programme of subjects of interest to the mother and her family and also help to broaden her knowledge of the community.

There has been a marked increase of work in health education in schools—Infants, Juniors, Secondary Modern and Grammar. Some schools have requested help with sex education programmes, others with community service.

Ilkley College of Education have had the assistance of the health visitors in connection with their programme for students and homes of aged persons and mothers and children have been visited by the students and assistance given with their day-to-day work, etc. At the end of the visits a special meeting of all tutors, students, medical officers, health visitors, welfare officers attended to discuss the findings of the students and in what way assistance had been given.

A new venture on a similar line commenced this year with the students from Trinity and All Saints' College at Horsforth.

Dr. Burn gave talks and showed films on 'Venereal Disease' to Youth Groups and Ilkley College of Education's students."

Dr. Oddy, Divisional Medical Officer (Barnsley) reports:

"The health education programme has progressed steadily throughout the year. The effectiveness of consultations between the health and education departments at top level are shown in that many more teachers are becoming interested and involved in the school health education programmes. There has been an increasing number of calls from the parent teacher associations for advice from the health visiting staff on the subjects causing concern, namely sex, drugs and smoking.

To keep parents informed of the contents of the health education programme, many of the films have been shown to the interested parties and these have produced constructive discussions."

Dr. Walters, Divisional Medical Officer (Hemsworth) comments:

"One high school has a set programme of health education covering fourth form pupils given by the health visitor, plus talks and discussions to sixth formers by the Deputy Divisional Medical Officer. Both other high schools favour team teaching with participation by divisional health staff as required."

Group involvement is also incorporated in the following report from Dr. Hepple, Divisional Medical Officer (Harrogate):

"In some clinics following the reduction in the sale of welfare foods the health visitors gave short talks and small demonstrations whilst voluntary workers cared for the children, etc.

At the Harrogate (Knaresborough Road) Health Centre, the health visitors have given the entire Friday afternoon to health education, using films and giving talks whilst the local Red Cross nurses cared for the children.

This extended use of the infant welfare clinics could be really worthwhile."

Some divisions have specific health problems as seen in the following from Dr. Clow, Divisional Medical Officer (Rotherham):

"Health visitors and midwives have taken part in talks and demonstrations to expectant mothers in preparation for parenthood. This has taken place in all the clinics.

General emphasis was placed on the need for adequate dental care, for it is clear that there is a wide gap between what expectant mothers know about dental health and what they actually do. Much more education is needed here, if we are to encourage mothers to pass on good oral hygiene methods to the next generation.

The visits to primary schools numbered 20 with an audience totalling 1,649. Films were shown to large groups of children on dental care. The dentist followed one month later for examinations; this team work between the health visitor and dentist appears to be working well, and there is evidence of increased awareness of oral care in the parents of the younger children in an area where the problem is particularly acute."

Education for health in an active, practical and informal way is undertaken by all the health staff who visit homes; the health visitor, district nursing sister and midwives realise that health problems are often very personal, they collect information about people's knowledge, attitude and health practices and by their tact, resourcefulness and enthusiasm promote better health and an understanding of health.

Recuperative Home Treatment:

Two hundred and sixty-eight applications for recuperative home treatment were received as compared with 246 in the previous year. One hundred and fifty-eight, 115 women and 43 men, were admitted to a convalescent home; the remaining 110 applications (41·0 per cent.) were cancelled.

Renal Dialysis:

ADAPTATIONS TO PATIENTS' HOMES:

At 31st December, 1970, 32 cases had been referred to the West Riding County Council by the hospital authorities. Twenty patients had been referred by the Leeds Regional Hospital Board (9 males, 11 females), 11 patients by the Sheffield Regional Hospital Board (9 males, 2 females) and 1 patient (male) by the Manchester Regional Hospital Board.

The 32 cases may be categorised as follows:—

Died prior to starting adaptations	3
Transplant prior to starting adaptations	1
Deferred pending further treatment	1
Not suitable for home dialysis	2
Patients undergoing home dialysis	19
(at the time of writing, all adaptations had been completed)	
Transplant after adaptations had been completed	2
Died after adaptations had been completed	4
	32

Of the 19 patients undergoing home dialysis treatment, two patients whose homes were not suitable for adaptations for dialysis purposes were issued with a 'Portakabin'.

MENTAL HEALTH

Training Centres:

ACCOMMODATION AND STAFF:

A list of the Training Centres for the Mentally Subnormal and of the places available is given in Appendix A.

The new Training Centre at Rastrick, Brighouse, was completed and the trainees moved in on 3rd September. The centre was officially opened on 6th November, by the Secretary of State for Social Services, The Rt. Hon. Sir Keith Joseph, M.P. This new centre provides accommodation for 114 trainees made up of 36 places in the Junior Classrooms, 18 in the Special Care Unit and 60 places in the Adult-Workrooms. Prior to the provision of this new Centre, children received their tuition at the Junior Centre at Lightcliffe, whilst the adult trainees had to travel to the County Council's Training Centre at Kirkburton or to

neighbouring County Boroughs. The Junior Centre at Lightcliffe was a prefabricated building which accommodated 27 trainees. This small Centre has now been closed.

A much needed extension to the Special Care Unit at West Ardsley was completed in September and brought into immediate use.

Four members of staff successfully completed the course for the Diploma of Teachers of the Mentally Handicapped and the number holding this qualification now exceeds 50 per cent. of the total teaching staff employed in centres. The in-service training programme has been maintained with three courses at Grantley Hall.

CENTRE ACTIVITIES:

Swimming:

Two Centres, Rawcliffe and Horsforth, now have their own covered and heated learner pools. The Horsforth pool was provided largely through the efforts of the Wharfedale Group of Round Tables who raised approximately £5,000 towards the cost. Representative members of the Round Table attended the official opening of the pool on 7th January, 1970.

Swimming pools are under construction at the Kirkburton and West Ardsley Centres and others are planned to follow.

Parent/Teacher Associations:

Once again the help received from these associations has been most valuable. In addition to maintaining contact between staff and parents the generous practical help given by the associations enables the centres to enjoy a number of amenities, e.g. gymnastic equipment, climbing frames, trampolines, etc. In several instances the P.T.A. have also met the full cost of an entire centre taking a full week of residential training at the seaside.

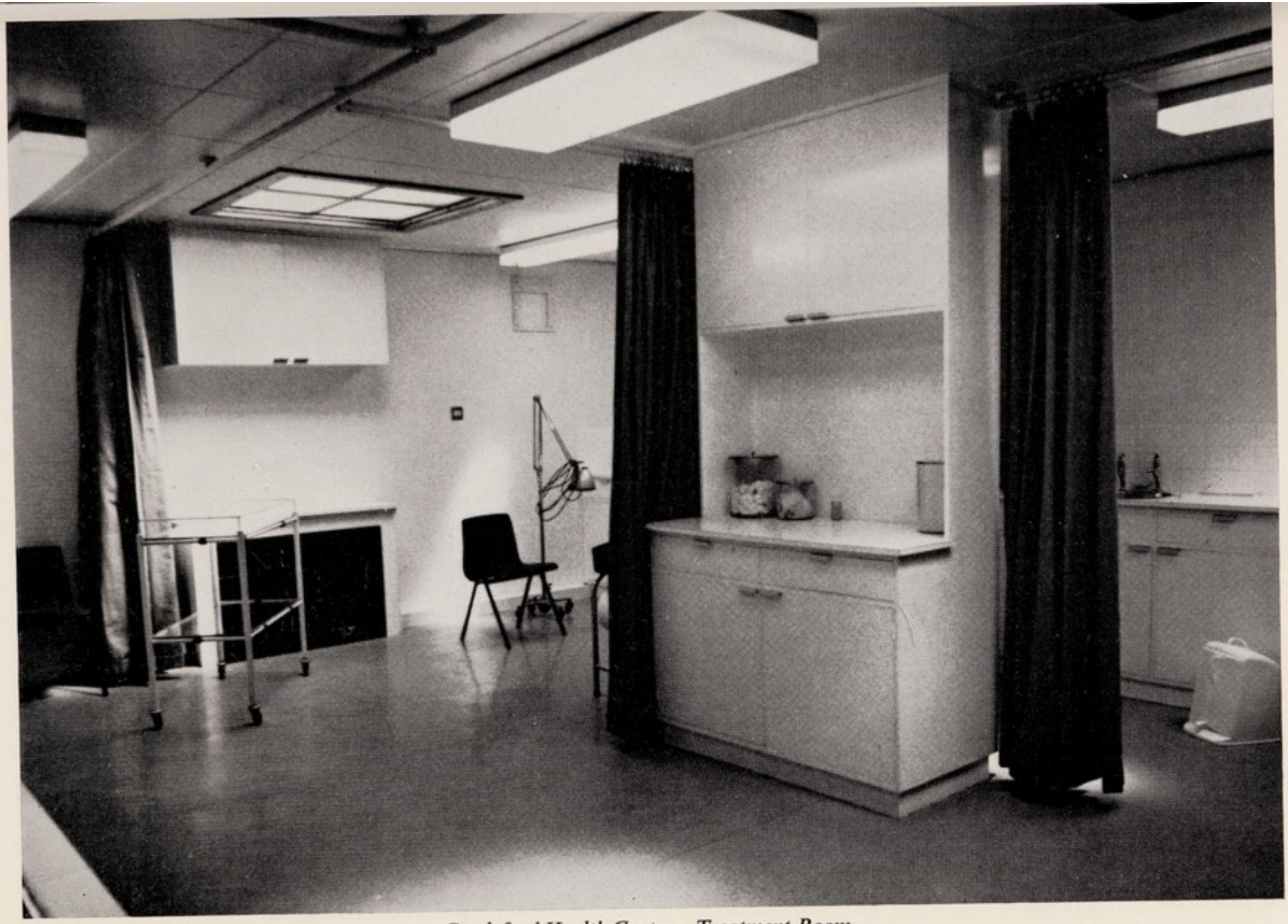
HOLIDAYS AND OUTINGS:

A party of 150 trainees, adults and children, enjoyed a full week's holiday at the Derbyshire Miners' Holiday Centre at Skegness. This holiday was sponsored by the County Council. Necessitous cases were subsidised either in part or fully according to need.

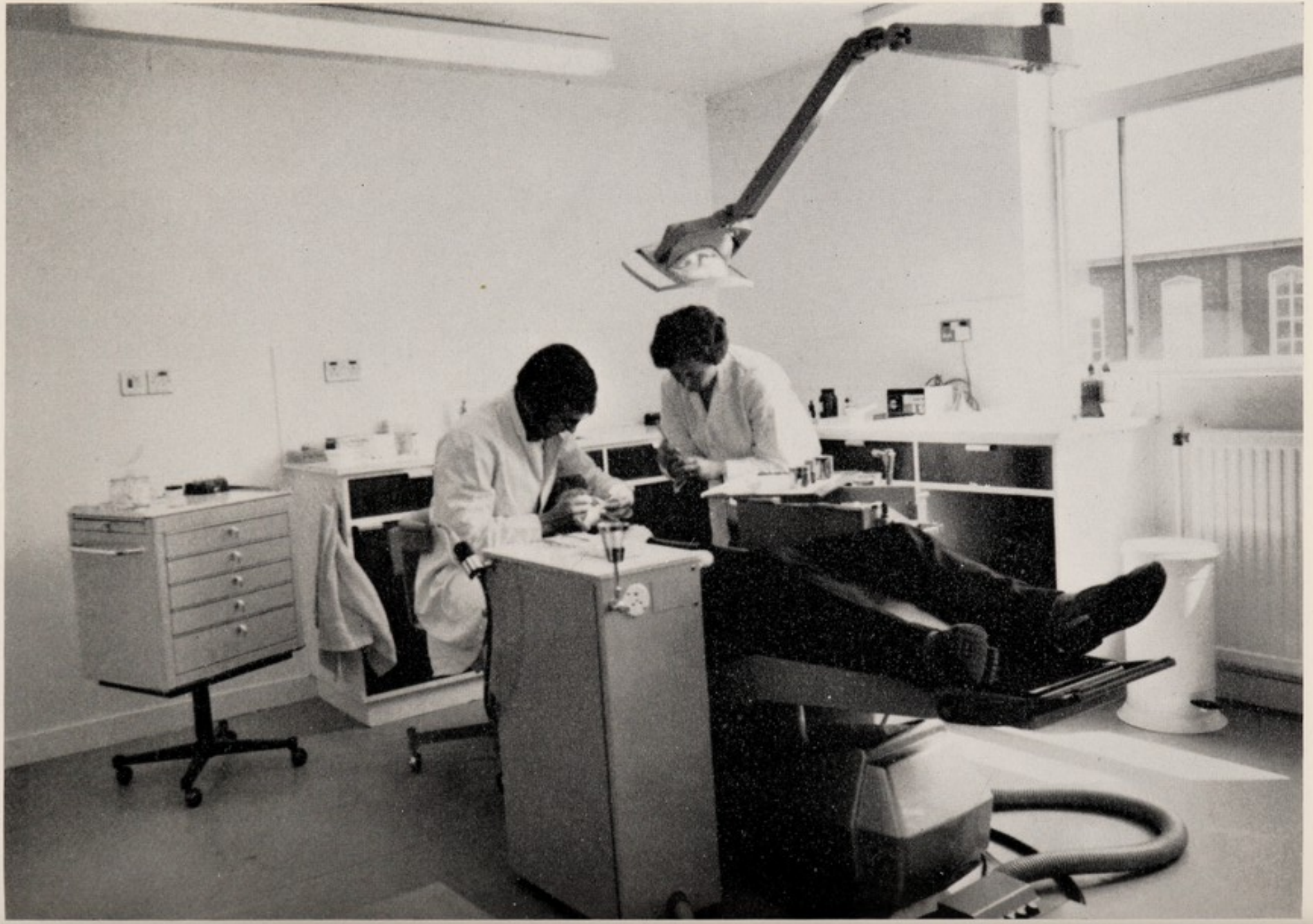
The Rawcliffe Training Centre again shared in a week's holiday organised by members of a local Youth Club. The Wombwell Rotary Club arranged for juniors from the Wombwell Centre to have a week's holiday at Scarborough for the third successive year.

Castleford Health Centre—Reception Area

Castleford Health Centre—Records and Reception



Castleford Health Centre—Treatment Room



Castleford Health Centre—Dental Conservation Surgery

Renal Dialysis—Obviously Portable!

Renal Dialysis—Interior of Portable Unit

Brighouse Training Centre—Adult Workshop

SPECIAL CARE FACILITIES:

Further progress has been made in the scheme for the up-grading of the Special Care Units. New units which are spacious, light and well-ventilated are now operating at Hemsworth, Wombwell, Horsforth, Maltby, Brighouse and West Ardsley. Work at present in progress at Harrogate and Rawcliffe will result in new special care units at these centres. The number of places in these units has now risen to 154, which is more than double the number (73) available five years ago.

Provision is made in the special care unit not only for the immobile severely physically handicapped child but also for the hyperactive child whose presence can be such a disturbing influence in class and whose activities seriously interfere with the training programme and classroom routine.

INDUSTRIAL WORK:

Early in 1963 industrial work was introduced into the adult departments. The first jobs were of a simple nature such as the splitting of firewood for the men and the making of bean bags (for physical education in schools) by the girls. From this modest beginning progress has been very rapid and more than 200 differing contracts are at present being undertaken throughout the County. Much of the work is on behalf of the County Supplies Department but many private contracts are also being undertaken. For the men, the contract work includes the making of art easels, first aid boxes, playhouse screens, sectional timber huts, etc. The women are busily engaged on curtains, aprons, dressing gowns, table cloths, tea towels, Christmas crackers etc.

Powered machinery was gradually introduced and the centres have now reached a high standard of mechanisation. Selected trainees have become competent operators and the men can be seen using routers, morticing machines, lathes etc., whilst a number of the girls are expert in the use of powered sewing machines and laundry equipment. Special attention is paid to safety precautions and the Factory Inspector advises on the siting and guarding of the machines.

A scheme of incentive payments to trainees was introduced in 1964. Originally the scheme provided for payments ranging from 5/- to 15/- per week but this has now been increased to allow a minimum of 50p and a maximum payment of £2·00 per week.

An annual assessment is made of the value of finished products, services rendered by the trainees, e.g. laundry, care of grounds etc. and the pattern over recent years has been that the balance, after deducting cost of materials, has approximated to the amount paid out in incentive payments.

Whilst appreciating the therapeutic value of industrial work, it must be emphasised that the social aspect of the training centre is not being neglected and a balanced programme of work, play and social training is being carried out.

Residential Accommodation—Hostels and Homes:

HEALEY CROFT HOSTEL, WEST ARDSLEY (30 subnormal adults):

Healey Croft Hostel was completed in August, 1965 and has places for 30 subnormal adults, 15 male and 15 female.

There were eight admissions and eight discharges during the year, summarised as follows:

Admissions	Short stay	4
	From hospital	2
	From community on social grounds	2
Discharges	Short stay	4
	To lodgings	3
	To hospital	1

There was a waiting list of 47 potential residents at the end of the year and of the 30 residents at the hostel, nine males and three females were in employment, the remainder attending the West Ardsley Training Centre.

ZOAR STREET, MORLEY—ANNEX TO HEALEY CROFT (3 subnormal adults):

This is a County owned four-bedroomed house, typical of the district, and is let free of rent and rates to a married couple who have undertaken to accept three subnormal adults as lodgers. The house was renovated and opened as an annex to Healey Croft in November, 1968, when three Healey Croft residents were transferred to this accommodation. Two of the original three are still in residence but one of the women lodgers, who attends the Training Centre, became unsettled early in the year and asked if she could return to the Hostel. Apparently she missed some of the comforts and company at Healey Croft. She was transferred back and another hostel resident took her place at Zoar Street.

MEADOW BANK HOSTEL, HARROGATE (8 subnormal children):

Meadow Bank is a small purpose-built hostel situated within the grounds of the Harrogate Training Centre. It accommodates eight children who attend the Training Centre from 9-30 a.m. to 3-30 p.m. Monday to Friday weekly. They all go home for week-ends and holidays.

There were four admissions and four discharges during the year. The hostel remains fully occupied and any vacancy is quickly filled. An 'open evening' was arranged during the summer when over 100 people attended.

THE GHYLL HOSTEL, SKIPTON (16 subnormal children):

This purpose-built hostel is situated to the south of the town in spacious, well laid out grounds, and enjoys a westerly aspect overlooking the Aire Valley.

The hostel accommodates 16 subnormal children and they attend the adjacent Training Centre from Monday to Friday each week. The children living a considerable distance from the hostel are resident on a four weekly basis, and the remainder who live locally go home each week-end.

The hostel is staffed by a Warden, two Assistant Wardens, two full-time and one part-time Domestic Assistants. The Warden's husband is also responsible for certain duties.

During the year the 16 places were fully occupied there being two admissions and two discharges. Eight children were provided with short-stay care.

There were a number of cases of extremely mild scarlet fever in December. Apart from that and a few colds the children's health has been good.

LEE GRANGE HOSTEL, WEST ARDSLEY (20 post psychotic adults):

Opened in July, 1968, Lee Grange is specifically designed for patients who have completed treatment at psychiatric hospitals and require short periods of hostel care in order to promote social rehabilitation before return to the community. Ideally residents should be in employment during this period of rehabilitation but this is not always possible. The opening of the Day Industrial Centre at Mirfield has, however, brought an improvement as residents not in employment now attend the Day Centre. Four residents were admitted to the house in Fountain Street, a new venture referred to below. During the year there were 33 admissions and 37 discharges compared with 30 admisions. and 24 discharges in 1969.

57, FOUNTAIN STREET, MORLEY (4 post psychotic adults):

From experience gained elsewhere it was evident that some of the residents admitted to Lee Grange Hostel would have no homes of their own to return to when their period of rehabilitation at the hostel was completed. Because of this a house at Fountain Street was purchased in order to provide a sheltered environment whereby a small group could live together with a minimum of supervision. The house was rewired, decorated throughout and gas fired central heating installed to provide background heating. Coin operated electric fires were fitted in each of the four bed-sitting rooms, and the house fully furnished.

Two part-time cook housekeepers working a total of 28 hours per week between them were appointed to give a general oversight to the cleaning and housekeeper duties and to provide an evening meal. It was intended that the residents would be capable of preparing their own breakfast and other light meals and that they would be out during the normal working day, either in employment or in attendance at the Mirfield Day Industrial Centre.

Four residents were transferred to Fountain Street from Lee Grange on 9th May, and have been charged at the rate of £5·00 per week for full board residence excluding mid-day meals on normal working days. Of the original four residents admitted, three remained at the end of the year, one having found satisfactory lodgings in Wakefield nearer to his employment.

15, East Park Road, Harrogate (6 post psychotic adults):

Early in 1969 the above mentioned property became available and was taken on lease by the County Council. The accommodation provided six bed-sitting rooms which are let to specially selected patients who are recovering from mental illness and who have no home to accept them after hospital discharge. The residents are charged a nominal rental which was agreed by the County Land Agent. They do their own cooking and buy their own food but the house is under the close supervision of the local mental welfare officers.

No change of tenancy has taken place during the year, and there has been no noticeable change in the mental health of the residents. Five of the six residents have had short periods in Clifton Hospital, and the sixth resident is a burnt out schizophrenic who is likely to remain in the house for life.

There have been no serious problems. A complaint received from a neighbour concerning noise from a radio set was dealt with by the fitting of a fixed volume control.

All the residents are diagnosed 'acute' or 'chronic' and some would doubtless have been lifelong hospital patients prior to the discovery of the new treatments and the possibility of care in the community for this type of patient.

Day Centres:

Snaith Day Centre:

The Snaith Day Centre provides facilities for mentally disturbed patients to attend for full-time therapy on five days per week. A consultant psychiatrist attends the centre weekly. The main aim, besides rehabilitation, is to get as many patients back to work as possible. During the five years the centre has been in operation, 18 have found jobs. Social, occupational and industrial training has continued with over 40 different crafts being offered to the patients. Various school groups, parties of trainee social workers, student nurses, clergy etc. have visited the centre during the year. There are 25 patients on the register with an average daily attendance of 18.

At present the centre is housed in an old Church School and considerable repairs and renovations are being undertaken to bring the building to a reasonable standard. The long-term policy is to replace the existing premises by a purpose-built centre and a site has already been purchased.

HARROGATE THERAPEUTIC CLUB:

This club operates on five full days per week at 13, Dragon Parade, Harrogate. Patients prepare their own mid-day meal on the premises and in the afternoons there are group discussions and many other activities including dressmaking, hairdressing, sewing etc. The local mental welfare officers are responsible for the running of the club and psychiatrists from Clifton Hospital, York follow-up their own patients and keep in close contact by regular attendances at the club.

At the end of the year there were 47 names on the register of patients receiving day care, and 17 on the register of Dr. Galley's Group. Dr. Kerr and Dr. Haslam continue to see an average of eight patients at each of their 'follow-up' sessions (16 patients per week).

The level of mutual support among the members of the club continues to rise. This is very encouraging to all who work in the Therapeutic Club, but a large number of names appear on the register year after year and re-admissions to hospital for short periods are quite common. Very few patients have returned to hospital for long stay. The patients who are referred to the club for short periods of day care are particularly rewarding. They include depressed housewives, subnormal persons temporarily out of work, adolescents who are unable to face a work situation, etc., and the attempts at rehabilitation of long stay hospital patients has met with success. A man who had been in hospital for 17 years recently established himself in a job after having been a club member for just over a year.

Sixteen patients were admitted to the club for day care during the year and the discharges were as follows:

Left the district	3
Unco-operative (left after a day or two)	3
Refused to attend and will be visited	1
Improved (returned to work or home duties)	5
Employment	6
Recovered and returned to home duties	5
Hospital (might sometime return to Club)	7
Died	2

Psychiatric Social Clubs:

These clubs, staffed by mental welfare officers, operate in the evenings and a full list is given in Table 58. They offer a varied programme of activities including whist drives, beetle drives, dominoes, bingo, table tennis, darts etc. Discussion groups play an important role in the therapy undertaken at these clubs. Interchange visits with other clubs are frequently arranged. Some of the clubs arrange holidays, either for week-ends or full weeks. The holiday parties are accompanied by the mental welfare officers who make the arrangements.

Mirfield Day Industrial Centre:

Adaptations to the former T.A. Drill Hall at Mirfield were completed and the first patients were admitted on 11th May.

Specialised machinery for the production of cardboard cartons, exercise books and chain-link netting was installed. The County Supplies Department placed a large order for unruled scribbling pads known as 'Jotters' and also for cardboard cartons of various sizes. Production was soon under way and by the end of the year over half a million jotters and 100,000 cartons had been completed.

Forty-nine patients had been on the register by 31st December, and 27 were in regular attendance on that date. Eight persons took up normal employment and six have been re-admitted to hospital.

The staff consists of a supervisor, one male and one female instructors.

PART IV

ENVIRONMENTAL HYGIENE

Food and Drugs

Sanitary Circumstances

See also Tables 62 to 69 of Appendix A and Appendix B

Food and Drugs Act, 1955:

THE MILK (SPECIAL DESIGNATION) REGULATIONS, 1963:

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

Licensed Dealers:

The only significant change in the number of dealers has been in the increase of those selling ultra heat treated milk. This number is expected to increase rapidly now that the first treatment plant has been installed in the Riding.

The failure rate for the methylene blue test is far from satisfactory and better efforts must be made by dealers to store milk under proper conditions and to ensure that milk is delivered fresh by the avoidance of over-ordering.

Processing Plants:

The list of plants licensed has remained the same but towards the end of the year a plant was being installed in the north of the Riding for the ultra heat treatment of milk. This fully automated plant for the production of ultra heat treated milk has been connected to a Tetra Brik machine which is capable of filling sterile milk into sterile containers under sterile conditions. The machine doing the aseptic filling of this type of pack is the first one to be installed in the country. The resulting pack of milk is able to be stored for much longer than ordinary heat treated milk and does not require refrigeration. Once opened, however, it is as subject to spoilage as normal pasteurised milk.

The pasteurising plant where alterations were mentioned in the last Report has now been completed. Many thousands of pounds have been spent on up to date equipment such as automated cleaning systems for the plant and tanker vehicles and an automatic electronic bottle inspector. Unfortunately this last piece of equipment has proved most unreliable and on inspections of the dairy is frequently to be found not working.

The amount of testing of washed bottles and churns was stepped up and proved that better efforts could be made in this direction. Improved conditions have now been obtained where necessary.

Premises Bottling Untreated Milk:

Regular visits of inspection and supervision were made to the 11 premises where untreated milk is purchased in bulk and then bottled. Of the 123 samples obtained 16 failed the methylene blue test. Follow-up action was taken immediately. On three occasions supplies had to be stopped because of positive cultures of brucellosis being found. One bottler was found to have antibiotics in his milk on one occasion but this situation was quickly remedied.

SUPPLY OF MILK TO SCHOOLS:

Once again it was impossible to supply all schools with pasteurised milk although determined efforts are made to achieve that aim. One hundred and twenty one samples of untreated milk were obtained and submitted to the laboratory for examination for tuberculosis, brucellosis and antibiotics in addition to the methylene blue keeping quality test. Four samples proved positive for brucellosis, two for antibiotics and 12 samples failed the methylene blue test. Follow-up action was taken immediately by the department except for the positive brucellosis results; these were dealt with by the divisional medical officers concerned.

SAMPLING OF MILK AT HOSPITAL FARMS:

Sampling, which is carried out at the request of the Department of Health and Social Security, continued at two farms. At Stanley Royd Hospital Farm, Wakefield, where the production of untreated milk takes place 24 samples were obtained. All passed the methylene blue test. As the milk is not used in its raw state at the hospital but sent for pasteurisation no examination is carried out for tuberculosis or brucellosis. At Stansfield View Hospital Farm, Todmorden, where milk is produced and pasteurised 28 samples were obtained. Two samples failed the phosphatase test and three failed the methylene blue test. The phosphatase test failures were thought to be due to an electricity power cut whilst processing was in operation.

ANTIBIOTICS IN MILK:

Two thousand five hundred and forty samples were examined by the Wakefield Public Health Laboratory using the modified T.T.C. provisional method for the detection of antibiotic and other inhibitory substances in milk. Eleven samples were found to contain antibiotics and action was taken in co-operation with the Milk Marketing Board.

BRUCELLOSIS:

Two thousand five hundred and forty samples were examined for the presence of brucellosis. All samples were submitted to the milk ring test and for cream culture where necessary. At the present time untreated milk is being produced and sold from 813 herds in the Administrative County area. During the year cream culture positive results were obtained from 138 of those herds at least once. A percentage of almost 17 gives no reason for complacency and, at the time of writing, the news of compulsory eradication areas is most welcome.

The Agriculture Act of 1970, making it an offence for any person to offer for sale, otherwise than for slaughter, any animal known to be a reactor to brucella abortus has been of value. We have adopted a policy of drawing the attention of farmers to the Act each time a positive sample result is obtained. In view of the lack of definition of reactor the notice is even given with positive ring test results.

The policy of notifying divisional medical officers of all results of milk samples taken by our staff has continued and grateful recognition is given to them and to the county district public health inspectors for their help and co-operation.

Our thanks go again to the Directors of the Public Health Laboratories in and around the county for the useful information they continue to send to us. A lot of wasteful duplication of work is thereby avoided. Dr. L. A. Little, Director of the Wakefield Public Health Laboratory, and his staff, have once again carried the full load of our endeavours but yet stay our friends and advisers.

QUALITATIVE MILK SAMPLING:

Under the County Council's scheme of qualitative milk sampling, 89 samples were submitted to the County Analyst by county district public health inspectors. Two were deficient in fat, but legal proceedings were not instituted.

FOOD COMPLAINTS:

Forty-two complaints were received and investigated. A summary is given below of the details of each case and the results where legal proceedings were taken. In other cases verbal or written cautions were given.

Dark particles in loaf of bread.
Cap and foil in milk bottle.
Dirty milk bottles—6 cases.
Consignments of sour milk—2 occasions.
Dirt in milk—5 cases. Two prosecutions—one fined £5 and costs and the other fined £20 with £6 6s. 0d. costs.
Fish bone in sliced loaf of bread.
Splinter of wood in slice of bread.
Glass in milk—4 cases.
Loose milk bottle cap.
Piece of cardboard in bottle of milk.
Consignment of school milk in poor condition.
Hairgrip in school one-third pint of milk.
Glass in currant teacake. Prosecuted, fined £10 with £11 14s. 8d. costs.
Piece of wire in cheese and onion croquette.
Blood in milk.
Fly in bottle of school milk—2 cases.
Mould on cheese spread.
Sour sterilised milk.
Foreign matter in bottle of lime and lemon drink.
Bottles of orange drink with peculiar taste and smell.
Mould on meat pie. Prosecuted, fined £10 with £12 2s. 0d. costs.
Piece of wood in Swiss roll.
Toffee paper in bag of nuts and raisins.
Oil-like discoloration on bottom of loaf of bread.
Wasp in sweets.
Soft potato crisps.
Grease in school milk.
Metal foil in loaf of brown bread.

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 30 minutes in a lead service pipe, and the samples were examined for the presence of lead. Two hundred and forty-seven 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.

The W.H.O. International Standards, 1963, give 0·05 mg/l as the maximum allowable concentration of lead and all samples giving a reading above this figure are reported as being unsatisfactory. It is appreciated that the standards have no legal validity but it is hoped that all concerned with the treatment and distribution of water will endeavour to provide it to the highest possible degree of safety.

Private Supplies of Water to County Premises:

As mentioned last year it became apparent that not all supplies were either known or being sampled. Following an extensive survey in conjunction with other departments of the County Council our previous list of five premises has now grown to 17. A total of 193 samples was taken during the year and 41 of these needed follow-up action. Following the necessary investigations, recommendations have been made and improvements are being actively pursued where necessary.

Fluoridation of Water Supplies:

There has been slight progress towards effecting the fluoridation of the water supplies.

The scheme at Reva Reservoir, Hawksworth, reviewed in last year's Report has continued satisfactorily; 64 water samples were taken and examined within the department for fluoride content. All were within acceptable limits except for one which gave the low reading of only 0·1 p.p.m. On investigation it was found that trouble was being experienced with the feeding system and an even flow of fluoride crystals was not being maintained. The equipment was overhauled and a quick return to the optimum level of 1·0 p.p.m. achieved. A further scheme planned by the Rombalds Water Board for the Baildon/Shipley area has not yet come to fruition.

In August, Huddersfield C.B. introduced fluoridated water to part of the Borough, to Golcar and surrounding areas in Colne Valley U.D., and to a lesser extent in parts of Mirfield U.D. Sampling has shown that only slightly fluoridated water is being supplied to the parts of the Administrative County but it is anticipated that the temporary measure of supplying water below the optimum of 1·0 p.p.m. in the Golcar area will be overcome when modernisation of the Borough's Scapegoat Hill plant is completed early in 1971; the fluoride content of the water supplied to Mirfield U.D. will be increased to optimum level at a later date. As modernisation of plant proceeds during the next two years it is hoped that schemes will extend fluoridation throughout the Borough undertaking's limits of supply.

An agreement has been negotiated with Bradford C.B. for the fluoridation of water supplied to the parish of Addingham in Skipton R.D. Manufacturer's modifications to the fluoridation unit, however, has resulted in delays in delivery of equipment but it is expected that the plant will be operative early in 1971.

Rural Water Supplies and Sewerage Acts, 1944-61:

All schemes submitted for grant 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.

Local Government Act, 1958, Section 56:

SEWERAGE SCHEMES—APPLICATIONS FOR GRANTS:

No application was received during the year.

School Swimming Pools:

Details of the 66 swimming pools in operation and under construction are given in Table 68.

One thousand six hundred and thirty-six water samples were obtained and submitted to the Wakefield Public Health Laboratory for bacteriological and chemical testing. In addition to sampling, advice was given to pool operators on water sterilisation and on the operation and maintenance of water treatment plant generally. Recommendations were made to the Children's Department based on the sampling and inspection of their three paddling pools during the previous year. Sampling has continued at these pools and additionally at the swimming pools at the Woodhall Centre, Wetherby and Hilton Grange Children's Home, Bramhope, although these are not County establishments.

The standard of construction and design of school pools has continued to rise during the year and costs have inevitably followed. Parent/Teacher Associations have shown a preference for the covered pool with the total cost being at present around £6,000.

Caravan Sites Act, 1968:

GYPSIES:

The County Council's first site, which will be at Baildon, has now had the necessary plans drawn up and at the time of writing is due to go out to tender.

A suggested second site in the south of the Riding has been the subject of discussions between authorities. As at Baildon a site is needed because a problem exists due to the indiscriminate parking of caravans on land where no sanitary facilities exist. Planning permission to provide the site has been sought and negotiations are in hand to buy the land. It is hoped that an early start will then be made with construction.

Ministry of Housing and Local Government Circular 38/70 drew the attention of local authorities to the fact that Part II of the Caravan Sites Act, 1968, came into effect from 1st April, 1970, and called for a progress report on the provision of sites. It is extremely doubtful whether the two sites suggested will be regarded as a satisfactory solution to the problem and further sites will have to be found.

The County Council Working Party has continued to meet all interested parties and indeed tried to convert some of the disinterested ones. The desired policy of the County Council is to provide sites in a spirit of joint co-operation and willingness with county districts but sometimes it is extremely difficult to understand why the Working Party can see gypsies in an area where others so patently cannot.

Pharmacy and Poisons Act, 1933:

Three hundred and eight visits of inspection were made to premises listed for the sale of Part II poisons.

Tetanus Survey:

The collection of soil samples for a long term survey of the antibiotic resistance of strains of Clostridium tetani has continued. The survey is being undertaken by the Public Health Laboratory Service.

Riding Establishments Act, 1964:

Premises licensed by the County Council were visited at least once each. The general public health aspects of each establishment 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 the Warren Spring Laboratory of the Department of Trade and Industry and Officers of the County Districts, has continued efficiently.

At the year-end 40 District Councils were participating involving 53 combined daily smoke filter and sulphur dioxide instruments, and four daily smoke filters only.

Krumlin 'Pop' Festival:

The first pop festival in the West Riding took place during a weekend in August. Planning for the event commenced almost three months before that date and involved the Public Health Inspectors' Section in a great many meetings and discussions with interested parties. At the actual event four members of that section were involved and particular mention must be made of our two student public health inspectors who lived on the site throughout the weekend.

A detailed account of the festival and the problems involved will be found elsewhere in the text of this Report.

PART V

MISCELLANEOUS

Welfare of the Epileptic and Spastic

'Wardens' Schemes for the Aged

Persons in need of Care and Attention

Registration of Nursing Homes

Notification of Births

Medical Arrangements for County Children's Homes and Residential Nurseries

Medical Examination

Road Traffic Act, 1960

West Riding Distress Fund

See also Tables 70 to 74 of Appendix A

THE WELFARE OF THE EPILEPTIC AND SPASTIC

Details are given in Appendix A of all known epileptics and spastics.

The County Council's scheme under Section 29 of the National Assistance Act, 1948 for the provision of welfare services for physically handicapped persons (general classes) was inaugurated in 1953 and there are now 7,830 registered cases, a number of whom suffer from cerebral palsy or epilepsy.

The County Council administers 40 social and handicraft centres for use by all classes of the handicapped and provides domiciliary visitation by way of district welfare officers, who advise on the many personal and social problems arising from handicap, and by handicraft instructresses, who teach those who are home-bound and cannot attend centres. Additional services provided include the supply of aids on loan and adaptations carried out at the homes of handicapped persons to secure their greater comfort or convenience.

A number of grants were made during the past year to enable severely disabled persons to take a holiday and the County Council has continued its practice of contributing to the funds of voluntary organisations which promote welfare services for those suffering from epilepsy and spasticity.

'WARDENS' SCHEMES FOR THE AGED

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 of July, 1957, to December, 1970, 594 schemes have been approved by the County Council, affecting 83 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 December, 1970, 389 schemes have been approved by the County Council, affecting 52 District Councils.

Under Section 119 of the Housing Act, 1957, 15 Housing Associations supervising 19 schemes receive annual contributions in respect of accommodation for aged persons.

I am indebted to Mr. J. H. Bargh, County Welfare Officer, for supplying the above information also Tables 70 to 73 of Appendix A.

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

Section 47 of the National Assistance Act, 1948, and the National Assistance (Amendment) Act, 1951, which provide for the compulsory removal to appropriate accommodation of persons requiring care and attention had to be instituted in nine cases: one man and four women were admitted to hospital and two men and two women to Part III accommodation.

REGISTRATION OF NURSING HOMES

There were four amended registrations, two cancellations and one new registration during the year under the provisions of the Public Health Act, 1936 as amended by the Nursing Homes Act, 1963.

NOTIFICATION OF BIRTHS

(Public Health Act, 1936, Section 203)

The number of live and still births notified and attributable to the County area was 31,496. When this figure is compared with the Registrar General's return of 31,451 births (31,024 live and 427 still births), the degree of error is small and affords satisfactory evidence of the system of notification. Prompt notification makes it possible to arrange for early visiting of babies by health visitors and it is satisfying to record that 30,929 first visits to children born in 1970 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.

MEDICAL EXAMINATION

During the year 2,226 (2,144) Health Questionnaires were received from applicants for admission to the Superannuation Scheme, either as new appointments or as admissions after two years' service as manual workers. Of this number 1,530 (1,493) persons were admitted to the scheme on the basis of the information contained in the Health Questionnaire and 696 (651) were referred for medical examination. The reasons for referral were:

	Number referred		Approved		Not Approved		Decision Deferred	
Age	150	(176)	140	(164)	10	(1)	9	(11)
History	363	(261)	318	(201)	17	(18)	28	(42)
Category of employment (i.e., driver)	102	(133)	93	(123)	3	(4)	6	(6)
Age and History	53	(69)	38	(42)	5	(13)	10	(14)
Age and Category	11	(3)	9	(3)	2	—	—	—
History and Category	7	(8)	7	(8)	—	—	—	—
Age, History and Category	1	(1)	1	(1)	—	—	—	—
Totals ...	696	(651)	606	(542)	37	(36)	53	(73)

(1969 figures shown in brackets)

These examinations have been carried out by the County Council's medical officers and general practitioners employed on a sessional basis. In addition, 24 (23) examinations have been carried out at the request of other local authorities. Re-examinations have been carried out in 33 cases where the decision was previously deferred. Of these 15 were approved, seven were regarded as unfit for admission to the Superannuation Scheme and 11 were deferred for another examination at a later date. Special medical examinations have been undertaken in respect of 160 (114) employees in the various departments who have had lengthy periods of sickness absence.

ROAD TRAFFIC ACT, 1960—SECTION 100 (6)

The Clerk of the County Council referred 263 (77) cases for advice with regard 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. One hundred and twelve (23) persons, who had been investigated previously, were reviewed.

The increase in applications for driving licences by 186 was due chiefly to the new regulations concerning persons suffering from epilepsy which came into operation on 1st June, 1970. In the four months June to October alone, 154 applications were received, and in 17 of these cases previous applications had been made where epilepsy had not been declared.

Reason for referral	Number of cases	Number who received driving licence
Epilepsy	148 (40)	123 (14)
Diabetes	5 (3)	4 (3)
Cardiovascular disease	10 (10)	9 (6)
Other causes of loss of consciousness ...	30 (4)	24 (1)
Other Physical Disabilities	46 (7)	43 (4)
Vision	2 (3)	— (1)
Mental illness or Subnormality	21 (8)	18 (7)
Miscellaneous (withdrawn)	1 (2)	— —
Total ...	263 (77)	221 (36)

(1969-70 figures shown in brackets)

WEST RIDING DISTRESS FUND

Assistance from the West Riding Distress Fund was made available in six cases as follows:

1. Payment of travelling expenses to enable relatives to visit a patient undergoing hospital treatment.

2. Provision of bedclothes and winter clothing for a mentally disturbed patient who also suffers from severe physical disability.

3. Clothing for a mentally subnormal woman who was admitted to a voluntary home.

4. Provision of bedding to enable a widowed mother to accept her son for week-end leave from a mental hospital.

5. Assistance to enable a mentally disturbed patient to accompany a holiday party organised by a psychiatric social club.

6. Assistance to a mentally subnormal mother to enable her to take a short holiday with her young son (part cost).

PART VI

THE HEALTH OF THE SCHOOL CHILD

The Annual Report of the Principal School Medical Officer

including

The Report of the Principal School Dental Officer

See also Tables 75 to 86 of Appendix A and Appendix C

THE HEALTH OF THE SCHOOL CHILD

(Being the 63rd Annual Report of the Principal School Medical Officer)

Introduction:

The future of the School Health Service continues to be a subject of much discussion both at local and national levels. At the time of writing one still awaits the further pronouncements of the present Government on the second 'Green Paper'. Many educationalists have expressed concern that if the School Health Service becomes integrated with the health services as a whole the close links with the education authorities may be broken. Some have even suggested that if sufficient guarantees are not given regarding future close contacts the education authorities should set up a separate school health service. The praise given to the School Health Service by educationalists has been somewhat flattering as school medical officers have often been the subject of much criticism from teachers in the past. The second Green Paper did give assurances that the links would remain and medically it is felt that it would be wrong to set up a service in isolation as there would be poor prospects of a career structure for the staff and little contact with other spheres of medicine.

In the interests of the child himself integration of the Child Health Services with other medical services has much to commend it and Dr. Simpson Smith wrote a paper on this topic "The Community Pædiatrician" (*Medical Officer*, 1970, Vol. CXXIV, 137-142) which stimulated much comment. In his view the future child health doctor, with special training in developmental pædiatrics, will have much to offer in liaising between the hospital, the family doctor, and the school so that an agreed decision can be made on the education of the child having regard to the individual physical and mental problems.

The close liaison between the Health and Education Departments in the West Riding continues with a multiplicity of joint meetings. In the latter part of 1970 much time was devoted to the impending transfer of training centres for the subnormal children to the Education Committee on 1st April, 1971, and the consultations will, it is hoped, result in a smooth transfer of functions.

From October, 1970, psychiatrists and psychologists have been seconded to work in the assessment centres of the former Children's Department. In view of staff shortages this has sometimes been at the expense of the Child Guidance Service as a whole but it is hoped that further staff recruitment during 1971 will enable the service to expand further and also offer more help to the centres. It has been agreed by the Committee that a further staff psychiatrist and four more psychologists can be appointed in 1971. In-service training of staff continued during 1970 and included a course for medical officers on the assessment of development of the pre-school child. Committee approval has been given to paying travelling expenses for doctors employed on a casual sessional basis to attend the various in-service training courses and several doctors availed themselves of the opportunity to attend the developmental assessment course. Regular study days for all the medical staff continued each term and meetings of psychologists, psychiatric social workers, and speech therapists were also held.

In the general atmosphere prevailing of uncertainty regarding the future of various workers in the service every effort is being made to keep morale at a high level and to continue efforts to increase the efficiency of the service. I wish to express my appreciation of the efforts of the staff in this direction and to applaud once again the continued growth of the team spirit between all the agencies concerned with the health of the child.

Care of Handicapped Children:

The developments envisaged in the Report for 1969 have now come to fruition. Pre-school developmental assessments are an established part of the service and the use of the computer has enabled many gaps to be closed in the follow-up of children with defects.

A third peripatetic teacher for the deaf commenced duties at the end of 1970 in the Castleford and Pontefract areas and the further development of remedial centres is kept under constant review. Meetings have been held in various parts of the County where local teachers have been addressed by the County's Adviser on Special Education and the Principal Medical Officer for the School Health Service in an endeavour to alert teachers to the problems of the 'clumsy' child and children with emotional problems so that joint action can be taken regarding early assessment and appropriate special educational treatment undertaken.

The Maladjusted Child:

There have been continued staff changes in the Child Guidance Service during the year and further developments in any extension of the service have been hampered by shortage of psychiatric social workers. The whole future of the service has not yet been decided and this has caused unrest amongst the personnel. The report on the work of the psychologists which follows gives an indication of the wide scope of their activities. During 1971 it is hoped to appoint four more psychologists so that more time can be spent in the schools and in the assessment units of the Social Services Department.

THE WORK OF THE PSYCHIATRISTS:

Dr. Elizabeth Gore reports as follows on the operation of the Child Guidance Clinic at Harrogate:

"In 1970, 111 new cases were seen—81 boys and 30 girls of whom 101 were referred from Division 7 as follows:

	Boys	Girls	Total
Divisional Medical Officer	38	13	51
General Practitioners	11	4	15
Head Teachers	9	1	10
Parents	9	4	13
Pædiatricians	3	4	7
Others	3	2	5
	73	28	101

The figures show an overall decrease in new cases seen, partly due to a rather smaller number referred by general practitioners. It seems likely that more emotional problems are being referred to the pædiatrician than previously. The slight fall in total number of new cases has enabled us to spend more time studying and treating the families, which has also been possible because we have had three students training in social work this year, two from the Leeds course and one a West Riding trainee.

Mr. Popplewell has been appointed as remedial teacher but we are hoping that Miss Stather, whose work has been so valuable, particularly in the morning group with severely disturbed children with educational problems, and also in helping children with visual perceptual difficulties, will be able to continue on a part-time basis. The work with the morning group has prevented a number of children having to be recommended for maladjusted schools; an important point in view of the extreme shortage of places in such schools.

This annual report tends to look more to the future in view of the changes in legislation and planning. Since the future of child guidance clinics such as the clinic here in Harrogate is in some doubt, we all feel a certain unease in regard to our situation. However, the members of the clinic team here certainly feel that this type of clinic with its close contact with families, community services, schools and general practitioners, and with its team approach, continues to have a value.

The regular assessment, diagnosis, planning of treatment and follow-up of all our cases, and its connection with the medical discipline, also seems to us important. With regard to our contacts outside the clinic, these have if anything increased. We now regularly hold lunch-time meetings on Fridays as well as Thu sdays and usually invite those involved with the cases, such as head teachers, children's officers, etc., to these meetings; sometimes additional students attend."

Dr. Orme, Consultant Psychiatrist at the Swinton, Barnsley and Ecclesfield Clinics, reports as follows:

"1970 has been an exciting year at the Swinton Clinic. The increase in the social worker staff has meant that not only have the number of cases that can be dealt with increased but it has also left time for many outside activities which have been of very considerable value. This has included much better liaison with schools; visits to enable unusual children to be observed in the classroom and playground situation have increased in number both by psychologists and by myself. In the Mexborough area there has been an organisation functioning for some while now under the scheme of educational priority areas and at this unit in Red House there have been interesting experiments which have been of value not only to local teachers but in which the clinic staff have also been involved in understanding relationships within the classroom and the differing abilities of different children and relationships too with their parents. We have also been able to make some visits to homes run by the Children's Department to see some of the difficult children who are being housed and treated there.

This has enabled greater understanding of the problems of staff and we hope have been of some help to the staff at these homes. Finally, there has been the new Remedial Unit at Doncaster Road School, Mexborough, at which it is hoped that children suffering from mild degrees of maladjustment will also be treated. Mrs. Brown, the Psychologist, has been very involved with the assessment of children going into the unit and it is hoped that the co-operation between the clinic and the unit will continue.

In the Barnsley area the clinic has moved from the rather inadequate premises previously provided to the purpose-built clinic of Barnsley Borough. This is not so convenient for some of the area served by the Barnsley clinic but for others from whom we seem to draw a large number of children, namely the Darton and Royston areas, this is in fact more convenient and the facilities in this clinic are widely welcomed. The co-operation from the staff of the Borough Clinic has been very helpful.

In the Wortley Division the survey being carried out by Mrs. Pilkington initially has continued. All the children in the last year of infant school who are now in the first year of junior school have been screened by questionnaire and problems of educational retardation and emotional or behavioural maladjustment are being assessed. From the pilot survey and from the initial result it seems likely that the level of maladjustment in this area is much as it is in other surveys of similar nature, i.e. between 5 and 10 per cent. of children showing some signs of maladjustment. The detailed results of this will be of very great value although it is not expected that the clinic facilities will be able to cope with the numbers that are discovered.

At the Swinton clinic particularly, there has been considerable interest in children who have learning difficulties and as a result are showing disturbances of behaviour or of emotion. The difficulty in helping these children is that in a small clinic like this there are not the facilities available or the modern equipment to be able to overcome the difficulties as they are discovered. So much more is now known about learning under unusual conditions that with modern conditioning techniques and teaching equipment it should be possible to do more for the children who are hampered by their nervousness and sense of inadequacy. Again it would be possible to carry out far more treatment if there was a member of staff who had knowledge of occupational therapy or of art teaching; this would not only enable the inhibited child to be brought out but would be very useful in the treatment of those with minor difficulties of co-ordination or perception. It is hoped that consideration will be given to increasing the staff of this clinic in this way in the future.

Hanging over the entire staff of the clinic there is a sense of anxiety over what will happen in the future. The uncertainties about the place of the clinic in relation to development in the social services and in the hospital services means that there is always some uncertainty whether it will be possible to continue the team approach. One of the things which has been learned very firmly in the past years is that the development of children and the disturbances

which they show cannot be understood or treated effectively by any one discipline but need the close co-operation of social worker, psychologist and psychiatrist. It is only when these individual professions work together to form a unified team that adequate treatment and help for these children is possible. It is to be hoped that these lessons will not be forgotten in any possible re-organisation of the service in the future."

Reporting on the Child Guidance Clinics at Mirfield, Pontefract, Ossett and Morley, Dr. Maxwell states:

"The increase in the numbers of first attendances at these clinics has been halted this year in the cases of the Mirfield and Pontefract clinics. In the latter case this appears to have been due to a larger than usual number of repeatedly failed first appointments, leaving the clinic with a waiting list at the end of the year.

At the Ossett and Morley clinics the number of new cases seen has continued to increase and the Morley clinic is now carrying too heavy a work load for one half day session per week.

I am grateful for the high quality of service provided by social workers at the Mirfield, Ossett and Morley clinics.

As in previous years a number of lectures have been given to interested organisations in the clinic areas and members of the public health medical staff have attended the clinics.

The clinic figures are as follows:

Table 1

	Mirfield	*Ponte-fract*	*Ossett*	*Morley*	*Total*
No. of sessions held... ...	194	95	49	52	390
No. of new cases	154	69	40	47	310
No. of cases continuing attendance from previous years	102	61	24	46	233
No. of cases closed during 1970	140	79	16	40	275
No. of cases carried forward to 1971	116	51	48	53	268

Table 2

	Number of New Cases						
Clinic	*1964*	*1965*	*1966*	*1967*	*1968*	*1969*	*1970*
Mirfield	115	106	104	165	164	161	154
Pontefract	75	67	41	74	74	88	69
Ossett	9	15	20	17	24	28	40
Morley	10	19	31	32	32	40	47
Rothwell	27	37	28 (to 7-10-66)	—	—	—	—
Total	236	244	224	288	294	317	310"

THE WORK OF THE PSYCHOLOGISTS:

It was mentioned in last year's Report that an increase in staff had made it possible to develop a more satisfactory psychological service in the child guidance clinics, in assessment of handicapped children, and particularly in the schools and in connection with remedial aspects of education. We have been fortunate in maintaining an improved service during 1970, with the same level of staffing. There have been new developments, however, four of the psychologists having been seconded from October for assessment work in the Children's Department Observation Centres; and it is apparent that the changing provision for the education of severely subnormal children will require extended contributions from the psychologists. To meet these requirements, additional staff will need to be appointed.

Statistics are given in the Appendix which provide a numerical indication of the range of work undertaken and the problems presented by the children examined. They relate only to children seen individually for psychological examination in clinics or elsewhere during the year, and do not record those seen periodically or included in the group screening or survey procedures which the psychologists conducted.

The total number of children examined individually during the year was 1,758, of whom 716 were children referred to child guidance for investigation of maladjustment and 1,041 being children with other handicaps who were referred for psychological assessment. Six hundred and ninety-three visits were made to ordinary schools, and 124 to special schools. The proportion of time spent in schools is satisfactory but, owing to other commitments, it has not been possible to achieve quite the same standard as the previous year.

Maladjusted Children seen in Child Guidance Clinics:

We have continued to keep records of ages and major symptoms for which children were referred. The proportions, whether by sex, age or symptoms, remain much the same from year to year. Boys are referred much more frequently than girls, the proportion being 527 to 189. Twenty-seven per cent. of the children were under the age of eight years and 39 per cent. over the age of 11 years. The major problems, especially in boys, are of troublesome behaviour, two-thirds of the children having been referred for this reason.

The majority of children were referred by school medical officers or head-teachers, but child guidance is well used by family doctors, other agencies, and by parents themselves.

Children with Handicaps other than Maladjustment:

This area of work continues to grow and to take up more of the psychologists time. It usually involves more detailed diagnostic investigation, often impossible to complete in one session, discussion with teachers and others, and interviewing of parents.

It may be that we are able to cover pretty well the demands for psychological help in the assessment of children with serious physical or sensory handicaps in the County area, as the numbers of such children referred to us have not changed significantly over the past few years. The handicaps we are seeing much more frequently are those of general backwardness, including the severely subnormal, and learning difficulties, usually of a specific kind, in children attending the ordinary schools.

It is known that a proportion of the children attending training centres have not been fully assessed intellectually as they had proved to be 'untestable' on conventional tests at the time of ascertainment. Psychological diagnostic evaluation of many of these children will become necessary with the changing emphasis in their education.

The increasing importance being given to the early investigation of normal children who, for a variety of reasons, are failing to make progress in school is one of the factors which has led to a growth in requests for our assistance. We are aware that the percentage of these children in the school population is such that we could well spend the whole of our time in investigating only the more difficult problems.

Surveys and Screening Procedures:

These have been a useful extension of the psychologists' contribution over the past year or two, in indicating the extent of problems in certain areas, and identifying children in need of special help. They have been carried out in the schools with the collaboration of teachers and heads of remedial centres.

A survey of 1,350 seven-year-old children attending schools in Division 22 was continued and completed by the psychologists working in that Division. Based on a short questionnaire completed by teachers, it selected 110 children (8·14 per cent.) as being in need of further investigation for emotional disturbance, but the proportion of these who might appropriately be referred to the child guidance service is not yet known. A further 109 children (8·07 per cent.) required psychological examination for backwardness in reading, and five per cent. of average intelligence, were considered to need some remedial help; places at the remedial centres could be offered to one per cent. Only two children of the total number screened were found to have I.Q's below 70, and five to have learning difficulties of the 'clumsy child' type.

Internal surveys of reading ability among first year children were undertaken in three Keighley junior schools, and there was a continuation of a follow-up of children with partial loss of hearing in the ordinary schools. A survey of retardation in reading and spelling was also carried out at a senior comprehensive school in Keighley, involving the screening by teachers of a complete year's intake of 14 year olds, and the individual examination of children found to be backward. Nine per cent. of the intake were found to be backward in reading and 19 per cent. backward in spelling. A small group of Asian immigrant children who were very backward in attainment were found, however, to have better scores on the attainment tests than on a test of oral vocabulary, so that their main problem was simply inability to speak and understand English.

The screening of final year infants in the Shipley Division was repeated in modified form and was preceded by a survey of the reading attainment of 864 children of this age in 19 infant schools. The results showed a very satisfactory standard of reading compared with both pre-war and present national standards, with very few non-readers. The screening procedure helped to indicate children needing remedial attention and those whose slowness could be attributed to general immaturity.

Work in Observation Centres:

Four of the psychologists began weekly visits to the three observation centres in October, and 29 visits had been made by the end of the year. As most of the children seen in the centres are in serious distress or trouble, psychological aspects of assessment need to be especially painstaking and thorough. The view can also be taken that psychological assessment should contribute to the research and evaluation which could be an important aspect of the work of the centres. Ideally all children coming through the centres should be assessed psychologically, as has been the practice at Home Office classifying schools. This is far from feasible at present.

Minor Ailment Clinics:

The number of children treated for minor ailments has reduced to 1,241 during the year. The corresponding figure for 1969 was 1,614.

Medical Examination of Entrants to Training Colleges:

In connection with their application for entry to training colleges, 2,221 students were medically examined by the departmental medical officers, compared with 2,138 for the year 1969 and 2,100 for the year 1968.

Children and Young Persons Act, 1933, Employment of Children:

Under the Authority's bye-laws relating to the employment of children, 748 children were examined by the departmental medical officers to determine their fitness for employment. The figures included children taking part in entertainments. Four children were found to be unfit.

Examinations may be selective for those children known from previous medical examinations or from information given by head teachers to have had some previous defect.

The Children (Performances) Regulations, 1968, require a medical examination to be carried out before appearances for films and television to ensure that the child's health will not be affected. The examination cannot be on a selective basis and difficulty is not infrequently experienced in arranging the medical assessment owing to T.V. producers casting the parts with little time available for the

Education Authority to comply with the regulations. The regulations are important and it is regrettable that their significance is not appreciated sufficiently by the entertainment industry.

Consultant Cardiac Clinic:

Dr. Hepple reports as follows on the Cardiac Clinic at Harrogate:

"During 1970 a total of 15 sessions of the cardiac clinic were held at irregular intervals, when 102 children made a total of 117 attendances. Although 15 new cases were referred to the clinic, the number of children attending declined, as the former practice of referring infants with heart conditions from the pædiatric clinic to the special children's cardiac clinic seems to have lapsed and so there is no 'intake' to replace older children who are either transferred to the adult cardiac clinic or returned to the care of their own doctors. Many purely cardiac cases are treated at the pædiatric clinic.

During the period under review four children were transferred to the adult cardiac clinic at Harrogate Hospital, while four others were returned to the care of their general practitioners. Five children were referred to the Cardiac Unit in Leeds for further investigation."

The continued reduction in numbers attending the clinic has been due, in part, to a change in the consultant staff in the area in recent years so that children attending the pædiatric out-patients' department are not being referred for a cardiologist's opinion. The question of whether the clinic should continue is under consideration. One of the values of the clinic has been the opportunity for liaison between consultants and local authority staff.

THE SCHOOL DENTAL SERVICE

On the 31st December the full-time dental staff in post and the authorised establishments were as follows:

	Staff	Authorised Establishment
Chief Dental Officer	1	1
County Orthodontist	1	1
Dental Specialist	1	1
Senior Clinical Dental Officers ...	3	5
Area and Senior Dental Officers ...	18	18
Dental Officers	26	43
Dental Auxiliaries	7	10

Additionally, there were five part-time dental officers contributing the equivalent of 2·2 dental officers.

Following upon the first increase in staff in seven years, reported last year, the position this year has been tedious, recruitment of new staff barely replacing wastage. Once again the gap between the remuneration of the Public Dental Officer and his colleague in general practice has widened, which affects particularly the newly qualified dental surgeons. 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 taken to the dental unit of the Brighouse Health Centre, where demonstrations of the work of the service were given.

Dental Auxiliaries:

The strict supervision required by the General Dental Council for dental auxiliaries, it will be recalled, was relaxed towards the end of 1969. Having now experienced a full year in which advantage has been taken of this, it is pleasing to report its smooth operation. During this time, with discretion, dental auxiliaries have been permitted to work without the full-time attendance of their supervising dental officers, so providing greater flexibility to a dental officer in the planning of his weekly programme.

Dental auxiliaries are still few in number, only a maximum of 60 qualifying each year. The wastage is considerable and it is regrettable that, as yet, no plans have been declared to train larger numbers, either at the present school at New Cross or to establish schools in other parts of the country.

Course in Diploma in Dental Public Health:

The two members of staff authorised in 1969 to attend the course in Dental Public Health at the Leeds University were both successful in gaining the Diploma of the Royal College of Surgeons in this subject. A further two members of the staff are presently attending this course.

Clinics:

The only new clinic to come into operation this year is the one at Stocksbridge, where an existing small clinic has been adapted to provide a very satisfactory two-surgery dental suite with direct access to the new health centre. Treatment for this area was formerly provided from a mobile unit with the attendant difficulties of providing general anæsthetics and treatment of an extended nature.

Equipment:

Thirty-four dental units and chairs installed in clinics throughout the County are between nine and 25 years old and becoming increasingly difficult to maintain.

A new concept in the design of dental equipment has been developed enabling the operator to work comfortably on a more relaxed patient. 'Low-seated dentistry', as this is now called, is being taught in the Dental Schools which are themselves re-equipping. Bearing this in mind and the fact that the service relies to some degree on recruitment of staff from the Dental Schools, approval, in principle, has been obtained for the replacement of this older equipment over a period of three years.

Inspection and Treatment:

In spite of interruption of the service by electricity cuts, a drop in patient-attendance caused by public transport strikes and what appeared to be a greater prevalence of minor ailments, inspection and treatment continued at a satisfactory level. It must be commented upon, however, that extraction of deciduous teeth, over 51,000, continued at a high level. Though some were extracted for orthodontic reasons, the vast majority were lost because available staff was inadequate to provide the necessary conservative treatment without detracting from the care given to the permanent teeth.

The adjustment of the fluoride level of drinking water to 1 part per million is the one certain measure which could substantially reduce this figure and with it take a large stride towards the elimination of the pain and misery of toothache. At the present time the only community in the Authority's area where the fluoride level has been raised to 1 p.p.m. is in the Urban District of Aireborough.

Health Education:

A major campaign was mounted in the Batley area by Mr. Metcalfe, the Area Dental Officer in charge of Dental Health Education. During the spring, every school and play-group was visited when talks and demonstrations on the care of the teeth were given. In the autumn a follow-up campaign was gratifying in revealing how much had been retained by the children of the rules of good dental health.

Additionally, talks were given at schools in Cottingley, Horbury and Wickersley, to numerous play-groups and mothers' clubs and to staff of the Garforth Clinic.

Examination of pre-school and school children in the Aireborough district was continued to observe the effect of fluoridation on the drinking water.

Orthodontic :

Report of Mr. Thompson, County Orthodontist:

The pattern of the County Orthodontic Service continued on similar lines to the preceding three years and a stable situation has now been reached where with the staff available, approximately 2,500 appliances are fitted and 1,000 cases completed in a year. However, several thousands of children remain who would benefit from having their irregular teeth corrected in the orthodontic age group.

There are two solutions to this problem:

(a) The employment of more specialists in orthodontics, each one completing 200 to 250 cases per year. This is the ideal answer but unrealistic as far as the School Dental Service is concerned because the salaries offered are considerably below those earned by specialists in the Hospital Service or by general dental practitioners in the National Health Service.

(b) If all West Riding children received the benefit of fluoridated water with a subsequent reduction of 50 per cent. in dental caries, school dental officers would be able to spend a greater proportion of their time providing orthodontic treatment under supervision. The situation would be improved further by employing larger numbers of dental auxiliaries to do simple fillings.

At the moment, therefore, a position of stalemate has been reached and this may not alter appreciably until fluoridation of water supplies has been a reality for several years, or until the Health Services are integrated and reorganised.

Young dental officers joining the Service show great interest in orthodontics and are anxious to gain experience by treating their own cases. Advice is given by the County Orthodontist and dental officers are visited periodically in their clinics, so that any difficult problems can be discussed, especially where treatment is not progressing satisfactorily.

Problems arise because it is often difficult to ensure continuity of treatment for orthodontic patients because of staff changes, particularly in outlying clinics. Most cases take approximately two years to complete and once appliance therapy is commenced it is essential that the patient be kept under skilled supervision, otherwise treatment may be unsuccessful. The more difficult cases are treated by the County Orthodontist and two more experienced officers in the Wakefield, Harrogate and Brighouse Clinics. Finally, the County Orthodontist was asked to give a demonstration for the fifth successive year at the annual meeting of the Sheffield and District Orthodontic Study Circle.

APPENDIX A

Table 1 Summary of Principal Vital Statistics, 1890—1970

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	16·3	23	11·7	0·06	0·09	0·01	1·23	1·92	0·49	26
1960	16·9	22	11·5	0·06	0·06	0·01	1·15	1·98	0·73	22
1961	17·2	20	12·1	0·05	0·06	0·00	1·44	1·98	0·27	25
1962	17·8	18	12·0	0·04	0·05	0·01	1·47	2·00	0·20	23
1963	18·2	19	12·0	0·04	0·06	0·01	1·52	1·94	0·45	23
1964	18·5	18	11·5	0 04	0·05	0·00	1·35	2·02	0·40	22
1965	18·2	16	11·6	0·04	0·04	0 00	1·28	2·07	0·16	21
1966	18·0	14	12·1	0·03	0·05	0·00	1·62	2·00	0·25	20
1967	18·0	15	11·2	0·03	0·03	0·00	1·29	2·08	0·22	19
1968	17·6	14	11·6	0·04	0·03	0·01	1·60	2·14	0·09	18
1969	16·9	14	11·6	0·05	0·03	0·01	1·60	2·10	0·20	19
1970	17·3	14	11·7	0·04	0·02	0·01	1·53	2·14	0·29	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 Causes of Stillbirth

Cause and I.C.D. number	Number of stillbirths	Rate per 1,000 total births
Congenital anomalies (740-759)	78	2·48
Chronic and acute disease in mother (760, 761)	18	0·57
Maternal toxæmia and infection (762, 763)	30	0·95
Difficult labour (764-768)	21	0·67
Other complications of pregnancy and childbirth (769) ...	58	1·84
Conditions of placenta (770)	88	2·80
Conditions of umbilical cord (771)	38	1·21
Birth injury (772)	4	0·13
Hæmolytic disease of newborn (774, 775)	14	0·45
Anoxic and hypoxic conditions NEC (776)	24	0·76
Immaturity unqualified (777)	9	0·29
Other conditions of fœtus or newborn (778)	—	—
Fœtal death of unknown cause (779)...	45	1·43
All causes (740-779)	427	13·57

Table 3 Perinatal Mortality, 1960-70

	1960	1961	1962	1963	1964	1965	1966	1967	1968	1969	1970
Perinatal mortality (per 1,000 total births)	35·9	34·2	31·5	31·1	30·0	27·3	25·1	26·1	25·0	23·7	24·4
Infant deaths at 1 week and over (per 1,000 total births)	8·5	10·1	9·9	10·1	9·5	9·0	8·8	8·1	7·5	8·5	8·7

Ætiological Group	Cause of Death (and International Classification number)	Age at Death						
		Under 1 day	1 day and under 1 week	1 week and under 1 month	1 month and under 3 months	3 months and under 6 months	6 months and under 1 year	Total under 1 year
ALL CAUSES	All causes	197	142	70	84	79	42	614
Prenatal and Natal Group (including congenital malformations)	Congenital malformations (740-759)	30	20	26	20	14	9	119
	Total causes mainly of prenatal and natal origin other than congenital malformations (760-778)	160	108	12	—	1	—	281
	Chronic and acute disease and infection in mother (760-763) ...	2	—	—	—	—	—	2
	Difficult labour (764-768)	1	—	—	—	—	—	1
	Other complications of pregnancy and childbirth (769-771)	5	1	—	—	—	—	6
	Birth injury (772)	16	9	2	—	—	—	27
	Hæmolytic disease of newborn (774-775)	8	1	1	—	—	—	10
	Anoxic and hypoxic conditions NEC (776)	65	65	1	—	1	—	132
	Immaturity, unqualified (777)	63	28	7	—	—	—	98
	Other conditions of fœtus or newborn (778)	—	4	1	—	—	—	5
Postnatal Group	Total causes mainly of postnatal origin	2	6	23	53	52	31	167
	Enteritis and other diarrhœal diseases (008, 009)	—	—	3	6	5	6	20
	Whooping cough (033)	—	—	—	—	1	—	1
	Meningococcal infection (036)	—	—	—	1	1	—	2
	Measles (055)	—	—	—	—	—	1	1
	Other infective and parasitic diseases (remainder 000-136)	—	1	2	2	1	1	7
	Meningitis (320)	—	1	1	2	1	2	7
	Influenza (470-474)	—	—	—	1	1	—	2
	Pneumonia and bronchitis (480-486, 490-492)	1	3	15	22	17	13	71
	Other diseases of the respiratory system (remainder 460-519) ...	—	1	2	16	21	7	47
	Accidental mechanical suffocation from vomit, food, foreign body, or in cot (E911-E913)	—	—	—	1	2	1	4
	Other violent causes (remainder E800-E999)	1	—	—	2	2	—	5
Unclassified	Other remaining causes	5	8	9	11	12	2	47

Table 5 Infant Mortality, 1901-70—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	1966	19	20
1911-1920	100	109	1967	18	19
1921-1930	72	80	1968	18	18
1931-1940	59	61	1969	18	19
1941-1945	50	50	1970	18	20
1946-1950	36	40			
1951-1955	27	29			
1956-1960	23	25			
1961-1965	21	23			

Table 6 Infant Mortality, 1966-70

	Number of Deaths					Deaths per 1,000 Live Births				
	1966	1967	1968	1969	1970	1966	1967	1968	1969	1970
Male Infants—										
Under 4 weeks	226	237	233	210	228	14·2	14·5	14·5	13·4	14·4
4 weeks—3 months ...	57	44	41	42	53	3·6	2·7	2·5	2·7	3·3
3—6 months	36	42	41	48	44	2·3	2·6	2·5	3·1	2·8
6—12 months	38	23	31	23	21	2·4	1·4	1·9	1·5	1·3
Total under 1 year ...	357	346	346	323	346	22·4	21·2	21·5	20·7	21·8
Female Infants—										
Under 4 weeks	171	176	146	161	181	11·0	11·6	9·6	11·0	12·0
4 weeks—3 months ...	25	40	35	38	31	1·6	2·6	2·3	2·6	2·0
3—6 months	46	24	34	33	35	3·0	1·6	2·2	2·3	2·3
6—12 months	24	21	16	18	21	1·5	1·4	1·1	1·2	1·4
Total under 1 year ...	266	261	231	250	268	17·1	17·2	15·3	17·1	17·7
All Infants—										
Under 4 weeks	397	413	379	371	409	12·6	13·1	12·1	12·3	13·2
4 weeks—3 months ...	82	84	76	80	84	2·6	2·7	2·4	2·6	2·7
3—6 months	82	66	75	81	79	2·6	2·1	2·4	2·7	2·5
6—12 months	62	44	47	41	42	2·0	1·4	1·5	1·4	1·4
Total under 1 year ...	623	607	577	573	614	19·8	19·2	18·5	18·9	19·8

Table 7 Neonatal Mortality, 1964-70

	Number of Deaths							Deaths per 1,000 Live Births						
	1964	1965	1966	1967	1968	1969	1970	1964	1965	1966	1967	1968	1969	1970
Under 1 day ...	203	200	191	188	199	172	197	6·4	6·4	6·1	6·0	6·4	5·7	6·3
1—6 days	196	163	152	161	139	140	142	6·2	5·2	4·8	5·1	4·5	4·6	4·6
1—4 weeks ...	88	75	54	64	41	59	70	2·8	2·4	1·7	2·0	1·3	1·9	2·3
Total under 4 weeks	487	438	397	413	379	371	409	15·4	13·9	12·6	13·1	12·1	12·3	13·2

Table 8 Percentage Contribution of the Five Principal Cause Groups of Death to All Causes, 1966—70

Cause Group	1966	1967	1968	1969	1970
Circulatory diseases except cerebrovascular disease	37·1	37·9	37·3	37·7	37·9
Malignant neoplasms	16·6	18·6	18·4	18·0	18·3
Cerebrovascular disease	15·5	15·4	15·2	14·6	14·9
Diseases of respiratory system ...	14·3	11·6	14·3	14·6	14·4
Accidents, suicide and violence ...	4·7	4·9	4·5	4·6	4·1
Total	88·1	88·4	89·7	89·5	89·7

Table 9 Principal Causes of Death, 1970

	Cause of death	Age at death											
		Under 4 weeks	4 weeks & under 1 year	1 and under 5	5 and under 15	15 and under 25	25 and under 35	35 and under 45	45 and under 55	55 and under 65	65 and under 75	75 and over	Total
B. 1	Cholera	—	—	—	—	—	—	—	—	—	—	—	—
B. 2	Typhoid fever	—	—	—	—	—	—	—	—	—	—	—	—
B. 3	Bacillary dysentery and amœbiasis	—	—	—	—	—	—	—	—	—	—	—	—
B. 4	Enteritis and other diarrhœal diseases	3	17	6	—	—	—	—	1	—	3	3	33
B. 5	Tuberculosis of respiratory system	—	—	—	—	2	—	1	3	11	14	7	38
B. 6	Other tuberculosis including late effects	—	—	1	—	—	1	—	2	6	7	4	21
B. 7	Plague	—	—	—	—	—	—	—	—	—	—	—	—
B. 8	Diphtheria	—	—	—	—	—	—	—	—	—	—	—	—
B. 9	Whooping cough	—	1	—	—	—	—	—	—	—	—	—	1
B. 10	Streptococcal sore throat and scarlet fever	—	—	—	—	—	—	—	—	—	—	—	—
B. 11	Meningococcal infection	—	2	3	—	—	—	—	—	—	—	—	5
B. 12	Acute poliomyelitis	—	—	—	—	—	—	—	—	—	—	—	—
B. 13	Smallpox	—	—	—	—	—	—	—	—	—	—	—	—
B. 14	Measles	—	1	—	2	—	—	—	—	—	—	—	3
B. 15	Typhus and other rickettsioses	—	—	—	—	—	—	—	—	—	—	—	—
B. 16	Malaria	—	—	—	—	—	—	—	—	—	—	—	—
B. 17	Syphilis and its sequelæ	—	—	—	—	—	—	—	2	—	3	3	8
B. 18	All other infective and parasitic diseases	3	4	2	2	1	—	1	3	5	4	3	28
	Total—Infective and Parasitic Diseases excluding Tuberculosis	6	25	11	4	1	—	1	6	5	10	9	78
B. 19(1)	Malignant neoplasm, buccal cavity, etc.	—	—	—	—	—	1	1	9	13	18	27	69
B. 19(2)	Malignant neoplasm, oesophagus	—	—	—	—	—	—	1	8	28	33	33	103
B. 19(3)	Malignant neoplasm, stomach	—	—	—	—	—	1	6	39	108	152	152	458
B. 19(4)	Malignant neoplasm, intestine	—	—	—	—	—	3	9	44	121	192	175	544
B. 19(5)	Malignant neoplasm, larynx	—	—	—	—	—	—	1	5	5	13	6	30
B. 19(6)	Malignant neoplasm, lung, bronchus	—	—	—	—	1	6	21	89	285	368	128	898
B. 19(7)	Malignant neoplasm, breast	—	—	—	—	—	6	28	78	93	78	65	348
B. 19(8)	Malignant neoplasm, uterus	—	—	—	—	—	—	12	37	48	37	32	166
B. 19(9)	Malignant neoplasm, prostate	—	—	—	—	—	—	—	1	19	58	62	140
B. 19(10)	Leukæmia	—	—	4	5	2	6	7	9	25	24	35	117
B. 19(11)	Other malignant neoplasms	1	—	7	7	9	19	35	121	254	296	226	975
	Total—Malignant Neoplasms	1	—	11	12	12	42	121	440	999	1,269	941	3,848
B. 20	Benign neoplasms and neoplasms of unspecified nature	1	1	1	2	1	4	4	5	12	11	8	50
B. 21	Diabetes mellitus	—	—	—	—	4	1	5	5	36	70	80	201
B. 22	Avitaminoses and other nutritional deficiency	—	—	—	—	—	—	—	—	1	1	1	3
B. 46(1)	Other endocrine, nutritional and metabolic disorders	4	5	2	2	1	—	3	7	10	11	22	67
B. 23	Anæmias	—	—	—	1	1	1	—	1	4	20	31	59
B. 46(2)	Other diseases of blood and blood forming organs	—	—	—	—	—	—	1	—	1	5	2	9
B. 46(3)	Mental disorders	—	—	—	—	—	1	—	2	2	11	33	49
B. 24	Meningitis	2	5	3	2	1	1	—	1	1	—	1	17
B. 46(4)	Multiple sclerosis	—	—	—	—	—	1	3	7	9	4	5	29
B. 46(5)	Other diseases of nervous system and sense organs	1	4	4	4	6	5	6	8	25	33	68	164

Table 9 Principal Causes of Death, (*continued*)

	Cause of death	Age at death												
		Under 4 weeks	4 weeks & under 1 year	1 and under 5	5 and under 15	15 and under 25	25 and under 35	35 and under 45	45 and under 55	55 and under 65	65 and under 75	75 and over	Total
B. 25	Active rheumatic fever	—	—	—	—	—	—	—	—	—	—	2	2
B. 26	Chronic rheumatic heart disease ...	—	—	—	—	2	1	18	44	82	83	46	276
B. 27	Hypertensive disease	—	—	—	—	2	2	8	21	44	120	182	379
B. 28	Ischaemic heart disease	—	1	—	—	1	11	99	341	986	1,839	2,121	5,399
B. 29	Other forms of heart disease	—	—	1	—	3	5	5	16	81	227	635	973
B. 30	Cerebrovascular disease	—	1	—	—	1	3	30	90	297	907	1,811	3,140
B. 46(6)	Other diseases of the circulatory system	—	—	1	—	2	3	9	16	90	226	594	941
	Total—Diseases of the Circulatory System	—	2	—	—	11	25	169	528	1,580	3,402	5,391	11,110
B. 31	Influenza	—	2	—	—	1	—	10	21	41	111	99	285
B. 32	Pneumonia	18	46	12	3	3	8	10	30	112	278	676	1,196
B. 33(1)	Bronchitis, emphysema...	1	6	2	2	—	2	10	55	234	458	487	1,257
B. 33(2)	Asthma	—	—	—	2	4	3	1	4	16	15	7	52
B. 46(7)	Other diseases of the respiratory system	3	44	6	1	2	4	3	10	31	62	69	235
	Total—Diseases of the Respiratory System	22	98	20	8	10	17	34	120	434	924	1,338	3,025
B. 34	Peptic ulcer	—	—	—	—	—	1	3	9	21	32	49	115
B. 35	Appendicitis	—	—	2	1	—	—	2	1	1	3	4	14
B. 36	Intestinal obstruction, hernia	11	5	—	1	—	—	1	4	12	28	45	107
B. 37	Cirrhosis of liver	—	—	—	—	—	1	—	6	11	16	8	42
B. 46(8)	Other diseases of digestive system ...	2	2	1	—	—	3	6	14	21	39	76	164
B. 38	Nephritis and nephrosis	—	1	1	—	2	4	5	7	22	11	25	78
B. 39	Hyperplasia of prostate	—	—	—	—	—	—	—	—	3	14	32	49
B. 46(9)	Other diseases of genito urinary system	1	3	1	—	1	1	1	6	21	35	66	136
B. 40	Abortion	—	—	—	—	—	—	—	—	—	—	—	—
B. 41	Other complications of pregnancy, childbirth and puerperium	—	—	—	—	4	3	2	—	—	—	—	9
B. 46(10)	Diseases of skin and subcutaneous tissue	—	—	—	—	1	—	1	3	1	6	5	17
B. 46(11)	Diseases of the musculoskeletal system	—	—	—	—	1	3	4	2	10	29	32	81
B. 42	Congenital anomalies	76	43	7	10	9	4	7	3	3	4	3	169
B. 43	Birth injury, difficult labour, and other anoxic and hypoxic conditions ...	159	1	—	—	—	—	—	—	—	—	—	160
B. 44	Other causes of perinatal mortality ...	121	—	—	—	—	—	—	—	—	—	—	121
B. 45	Symptoms and ill-defined conditions...	1	2	—	1	—	—	—	1	1	8	104	118
BE. 47	Motor vehicle accidents	—	5	8	24	71	36	16	29	29	20	36	269
BE. 48	All other accidents	1	5	12	19	13	13	24	26	32	41	183	369
BE. 49	Suicide and self-inflicted injuries ...	—	—	—	—	10	19	16	25	35	35	16	156
BE. 50	All other external causes ...	—	3	1	2	8	8	13	9	20	5	6	75
	Total—Accidents, Poisonings, Violence (External Causes)	1	8	21	45	102	76	69	89	116	101	241	869
	Total—All causes	409	205	88	93	170	195	449	1,280	3,379	6,118	8,631	21,017

Table 10 Cancer Mortality, 1965—70

Year		Stomach	Lung, Bronchus	Breast	Uterus	Other Malignant and Lymphatic Neoplasms	Leukæmia, Aleukæmia	Total All Sites
1965	M.	298	723	1	—	877	56	1,955
	F.	212	104	301	165	800	46	1,628
	T.	510	827	302	165	1,677	102	3,583
1966	M.	236	667	3	—	896	46	1,848
	F.	216	116	320	163	795	45	1,655
	T.	452	783	323	163	1,691	91	3,503
1967	M.	283	707	8	—	925	49	1,972
	F.	186	109	313	158	868	49	1,683
	T.	469	816	321	158	1,793	98	3,655
1968	M.	254	713	1	—	969	65	2,002
	F.	212	141	348	151	889	58	1,799
	T.	466	854	349	151	1,858	123	3,801
1969	M.	272	742	3	—	922	74	2,013
	F.	185	129	332	143	906	45	1,740
	T.	457	871	335	143	1,828	119	3,753
1970	M.	248	771	1	—	1,014	62	2,096
	F.	210	127	347	166	847	55	1,752
	T.	458	898	348	166	1,861	117	3,848

Table 11 Mortality from Respiratory Diseases, 1965—70

Year	Influenza	Pneumonia	Bronchitis	Other diseases of the Respiratory System	Total
1965	25	911	1,120	191	2,247
1966	174	1,135	1,488	216	3,013
1967	10	930	1,156	185	2,281
1968	110	1,259	1,267	305	2,941
1969	162	1,280	1,323	262	3,027
1970	285	1,196	1,257	287	3,025

Table 12 Maternal Mortality, 1966-70—Rates per 1,000 total births

Cause of Death	1966		1967		1968		1969		1970	
	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) ...	0·06	0·02	0·06	0·02	0·03	0·04	0·03	0·02	0 06	
Toxæmias of pregnancy and puerperium (not associated with abortion) ...	0·13	0·04	0·12	0·05	0·03	0·04	0·07	0·03	0·03	0·14
Other complications of pregnancy, childbirth and the puerperium	0·03	0·13	0·03	0·10	0·03	0 10	0·07	0·10	0·19	
Abortion (with or without mention of sepsis or toxæmia)	0·03	0·06	—	0·04	—	0·06	0·03	0·04	—	0·04
Total Maternal Mortality...	0·25	0·26	0·22	0·20	0·09	0·24	0·20	0·19	0·29	0·18

Table 13 Mortality from Violent Causes, 1964—70

Year	Motor Vehicle Accidents	Accidents in the Home	All other Accidents	Suicide	All other external causes	Total Accidents, Poisoning, Violence
1964	314	299	213	196	15	1,037
1965	301	284	168	176	8	937
1966	295	293	200	186	13	987
1967	315	266	170	189	15	955
1968	277	238	151	177	82	925
1969	272	260	173	182	77	964
1970	269	222	147	156	75	869

Table 14 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	2	—	—	4
	F.	—	—	2	4	4	1	2	13
Accidental poisoning by gases and vapours	M.	—	3	1	1	—	2	1	8
	F.	—	—	2	1	1	2	4	10
Accidental falls	M.	—	2	1	1	—	8	24	36
	F.	—	—	2	2	3	14	98	119
Accidents caused by burns ...	M.	—	—	1	—	—	3	—	4
	F.	1	—	—	1	—	1	5	8
Inhalation of food or vomit ...	M.	1	1	1	—	—	—	—	3
	F.	1	—	—	2	—	1	1	5
Accidental mechanical suffocation	M.	1	2	—	—	—	—	—	3
	F.	1	—	2	—	—	—	—	3
Other and unspecified accidents	M.	—	—	2	—	—	—	1	3
	F.	—	—	—	1	—	1	1	3
Total	M.	2	8	7	3	2	13	26	61
	F.	3	—	8	11	8	20	111	161

Table 15 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.	—	3	1	1	6	5	4	3	23
	F.	—	—	—	1	4	2	3	1	11
Other poisoning	M.	—	4	5	4	1	8	5	1	28
	F.	—	1	6	5	6	6	10	6	40
Hanging or strangulation ..	M.	—	—	2	1	1	3	3	4	14
	F.	—	—	1	1	1	1	1	—	5
Drowning	M.	—	—	1	1	1	3	3	1	10
	F.	—	—	1	—	2	1	2	—	6
Firearms	M.	—	—	1	1	1	4	1	—	8
	F.	—	—	—	—	—	—	—	—	—
Cutting instruments	M.	—	—	—	1	1	1	1	—	4
	F.	—	—	—	—	—	—	—	—	—
Jumping before or lying in path of moving vehicles	M.	—	—	—	—	1	—	—	—	1
	F.	—	1	—	—	—	—	—	—	1
Jumping from high places ...	M.	—	—	1	—	—	—	1	—	2
	F.	—	—	—	—	—	—	—	—	—
Other agents	M.	—	—	—	—	—	—	1	—	1
	F.	—	1	—	—	—	1	—	—	2
Total—All Agents ...	M.	—	7	11	9	12	24	19	9	91
	F.	—	3	8	7	13	11	16	7	65

Cause of Death	Annual Averages for Quinquennia								1970
	1911–15	1927–31	1935–39	1945–49	1950–54	1955-59	1960-64	1965-69	
Measles	439	107	27	10	4	2	2	1	—
Whooping cough	167	67	29	11	5	1	<1	<1	—
Diphtheria	110	47	51	5	1	—	<1	—	—
Other infective and parasitic diseases, excluding tuberculosis	54	45	18	7	9	7	3	3	5
Tuberculosis, respiratory ...	47	13	5	4	1	—	<1	—	—
Tuberculosis, other	201	82	37	30	11	2	<1	—	1
Cancer	3	5	4	4	9	9	11	12	11
Heart and circulatory diseases	4	3	2	1	—	1	1	<1	2
Influenza	6	43	10	4	2	2	<1	<1	—
Pneumonia	457	321	121	42	19	14	14	14	12
Bronchitis	150	42	10	9	6	6	6	1	2
Other diseases of respiratory system	49	15	6	3	2	2	1	5	6
Diarrhœa and other digestive diseases	248	45	38	17	4	4	5	6	6
Congenital debility, malformations	12	9	7	12	13	12	11	10	7
Accidents	82	54	50	38	27	23	27	28	20
Other causes	323	119	52	30	23	12	22	15	16
All causes	2,352	1,017	467	227	136	97	107	96	88
Death rate per 1,000 living in the age group	17·13	10·62	5·09	2·23	1·29	0·99	0·97	0·82	0 72

Table 17 Notification of Infectious Disease, 1965-70

Disease	Number of corrected notifications					
	1965	1966	1967	1968	1969	1970
Measles	18,175	17,567	13,528	15,291	3,392	16,351
Dysentery	934	630	357	691	476	287
Scarlet fever	1,568	1,353	1,145	794	1,053	661
Diphtheria	—	—	—	—	—	—
Acute meningitis:						
Meningococcus	‡	‡	‡	8	48	22
Other specified organisms						11
Unspecified organisms ...						22
Acute poliomyelitis:						
Paralytic	4	—	—	1	—	—
Non-paralytic	1	—	—	—	—	—
Acute encephalitis:						
Infective	1	3	5	3	1	2
Post-infectious	1	—	3	1	—	1
Leptospirosis	‡	‡	‡	—	—	—
Paratyphoid fever	18	1	1	1	2	—
Typhoid fever...	1	—	—	1	—	2
Food poisoning	82	68	56	204	109	145
Tetanus	‡	‡	‡	—	—	—
Infective jaundice	‡	‡	‡	473	756	694
Whooping cough	360	651	1,805	591	181	694
Anthrax	—	2	—	—	—	—
Leprosy	‡	2	—	—	—	—
†Malaria	—	—	1	—	2	4
Ophthalmia neonatorum ...	1	3	5	2	2	7
Smallpox	—	—	—	—	—	—
Yellow fever	‡	‡	‡	—	—	—
Tuberculosis:						
Respiratory	357	355	275	299	268	265
Other forms...	72	68	47	46	36	42

†All the cases were believed to be contracted abroad.

‡Figures not available.

Table 18 Notification of Infectious Disease, 1970

Numbers originally notified	Measles (excluding rubella)		Dysentery		Scarlet fever		Acute Meningitis due to infection with: Meningococcus		Other specified organisms		Un-specified organisms	
	M	F	M	F	M	F	M	F	M	F	M	F
Total (All ages)	8,424	7,946	174	210	335	326	12	10	9	2	14	8
Final numbers after correction												
Under 1 year	430	408	11	9	3	1	5	3	2	1	3	2
1—	1,035	973	15	9	12	6	2	1	—	—	1	—
2—	1,130	1,089	11	11	18	22	1	1	1	—	1	1
3—	1,138	1,148	11	9	31	25	—	1	—	—	—	—
4—	1,221	1,162	7	7	51	41	1	1	—	—	1	—
5— 9 years	3,266	2,952	35	25	157	157	2	1	2	1	6	3
10—14 ,,	107	104	9	6	50	48	—	—	—	—	1	1
15—24 ,,	26	36	7	16	11	20	1	1	2	—	—	1
25 and over	8	14	35	44	2	3	—	1	2	—	1	—
Age unknown	56	50	5	5	1	2	—	—	—	—	—	—
Total (All ages)	8,417	7,934	146	141	336	325	12	10	9	2	14	8

Numbers originally notified	Acute encephalitis: Infective		Acute encephalitis: Post-Infectious		Paratyphoid fever		Typhoid fever		Food poisoning	
	M	F	M	F	M	F	M	F	M	F
Total (All ages)	1	1	—	1	—	—	2	—	449	310
Final numbers after correction										
Under 5 years	—	—	—	1	—	—	—	—	12	10
5—14 years	1	1	—	—	—	—	1	—	40	7
15—44 ,,	—	—	—	—	—	—	1	—	24	21
45—64 ,,	—	—	—	—	—	—	—	—	9	10
65 and over	—	—	—	—	—	—	—	—	1	4
Age unknown	—	—	—	—	—	—	—	—	3	4
Total (All ages)	1	1	—	1	—	—	2	—	89	56

Numbers originally notified	Infective jaundice		Whooping cough	
	M	F	M	F
Total (All ages)	354	343	347	348
Final numbers after correction				
Under 1 year	2	—	33	45
1—	1	1	27	18
2— 4 years	29	25	127	116
5— 9 ,,	115	98	144	157
10—14 ,,	60	76	11	10
15—19 ,,	29	37	—	—
20—24 ,,	26	25	1	—
25—34 ,,	42	38	—	—
35—44 ,,	10	21	—	—
45—54 ,,	19	6	1	—
55—64 ,,	8	3	—	—
65—74 ,,	4	6	—	—
75 and over	3	1	—	—
Age unknown	6	3	2	2
Total (All ages)	354	340	346	348

Table 19 Measles—Incidence and Mortality, 1957—70

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)
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
1960	4,636	—	—	1967	13,528	3	0·02
1961	29,225	8	0·03	1968	15,291	3	0·02
1962	11,485	3	0·03	1969	3,392	—	—
1963	19,882	5	0·03	1970	16,351	3	0·02

Table 20 Vaccination and Immunisation

The following table gives the number of persons under the age of 16 years who were vaccinated or immunised against diphtheria, whooping cough, tetanus and poliomyelitis during the year ended the 31st December, 1970.

	Year of Birth						
Primary Courses	1970	1969	1968	1967	1963-1966	Others under Age 16	Total
Diphtheria	307	17,947	5,487	186	1,099	446	25,472
Whooping Cough	307	17,845	5,400	152	241	82	24,027
Tetanus	307	17,949	5,479	191	1,118	1,138	26,182
Poliomyelitis	304	18,567	5,718	209	1,263	509	26,570
Reinforcing Doses							
Diphtheria	7	356	521	178	21,180	3,345	25,587
Whooping Cough	4	351	474	85	1,426	93	2,433
Tetanus	6	361	564	259	21,513	4,377	27,080
Poliomyelitis	9	373	528	156	21,320	2,176	24,562

Table 21 Vaccination against Smallpox

VACCINATIONS AND RE-VACCINATIONS, 1966—70

Year	Vaccinations							
	0–3 mths	3–6 mths	6–9 mths	9–12 mths	1	2–4	5–15	Total
1966	108	218	276	434	8,217	3,719	1,262	14,234
1967	133	148	229	354	8,941	3,969	768	14,542
1968	39	105	161	198	7,496	3,123	712	11,834
1969	33	72	89	139	10,021	3,556	923	14,833
1970	28	66	91	101	16,868	3,377	941	21,472

Year	Re-Vaccinations							
	0–3 mths	3–6 mths	6–9 mths	9–12 mths	1	2–4	5–15	Total
1966	–	–	–	1	16	106	996	1,119
1967	–	–	–	1	16	77	509	603
1968	–	–	–	3	11	82	426	522
1969	–	–	–	–	21	159	661	841
1970	–	–	–	–	10	198	827	1,035

Table 22 Tuberculosis—Mortality

Classification	Age at Death in Years																				Total		Grand Total
	0—		1—		5—		15—		25—		35—		45—		55—		65—		75—				
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
Respiratory ...	–	–	–	–	–	–	1	1	–	–	–	1	3	–	10	1	13	1	6	1	33	5	38
Non-respiratory	–	–	1	–	–	–	–	–	–	1	–	–	2	–	4	2	5	2	1	3	13	8	21
Totals ...	–	–	1	–	–	–	1	1	–	1	–	1	5	–	14	3	18	3	7	4	46	13	59

Table 23 Tuberculosis—Notifications

	Age Periods												Total all Ages
	0–	1–	2–	5–	10–	15–	20–	25–	35–	45–	55–	65–	75–	
FORMAL NOTIFICATIONS:														
Respiratory, Males	–	–	1	1	2	11	18	14	15	34	37	32	11	176
Respiratory, Females ...	–	–	2	7	6	6	15	13	7	14	8	6	5	89
Non-respiratory, Males ...	–	–	–	2	1	2	2	7	3	4	–	2	–	23
Non-respiratory, Females ...	–	1	2	1	–	–	4	3	3	3	–	1	1	19
														307
SUPPLEMENTAL NOTIFICATIONS:														
Respiratory, Males ...	–	–	–	–	–	–	–	–	–	2	2	5	2	11
Respiratory, Females ...	–	–	–	–	–	1	–	1	–	–	1	2	1	6
Non-respiratory, Males ...	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Non-respiratory, Females	–	–	–	–	–	–	–	–	–	–	–	–	–	–
														17

The sources of information of the supplemental notifications were—death returns from local Registrars (3 respiratory), death returns from Registrar General (4 respiratory) and posthumous notifications (10 respiratory).

Table 24 Tuberculosis—Number of Cases on Register

Div. No.	Number of cases on register 1st January, 1970				Number of cases added to register				Number of cases removed from register				Number of cases remaining on register 31st December, 1970					
	Respiratory		Non-Respiratory		Respiratory		Non-Respiratory		Respiratory		Non-Respiratory		Respiratory		Non-Respiratory		Total	Per 1,000 Population
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F		
1	113	48	19	23	7	2	—	2	16	4	1	4	104	46	18	21	189	2·4
3	141	49	3	5	13	6	3	2	22	7	—	—	132	48	6	7	193	3·5
4	142	62	4	8	4	4	—	—	17	5	—	3	129	61	4	5	199	2·8
5	243	136	18	23	18	10	—	1	8	4	—	—	253	142	18	24	437	3·5
7	108	42	2	4	9	9	—	—	12	9	2	—	105	42	—	4	151	1·3
9	125	94	27	18	7	7	3	2	6	5	1	—	126	96	29	20	271	2·0
10	75	51	6	14	6	1	—	—	16	11	—	2	65	41	6	12	124	2·5
11	383	244	57	67	29	16	1	2	50	24	—	1	362	236	58	68	724	5·5
13	68	54	9	21	8	4	3	—	6	5	—	—	70	53	12	21	156	1·7
15	75	55	43	19	12	7	2	2	21	8	2	5	66	54	43	16	179	1·7
18	199	93	14	11	13	8	2	3	27	19	5	2	185	82	11	12	290	2·6
20	90	54	18	23	13	11	2	—	16	10	3	1	87	55	17	22	181	1·9
23	192	123	23	35	11	4	2	1	14	9	—	—	189	118	25	36	368	5·4
Leeds R.H.B.	1,954	1,105	243	271	150	89	18	15	231	120	14	18	1,873	1,074	247	268	3,462	2·8
22	244	118	72	51	10	3	3	3	13	4	1	2	241	117	74	52	484	5·7
25	191	120	8	13	7	1	—	3	9	2	—	—	189	119	8	16	332	4·2
26	281	147	35	44	9	10	—	—	15	9	—	—	275	148	35	44	502	4·6
27	169	112	69	52	16	6	1	—	25	13	—	2	160	105	70	50	385	3·0
29	57	32	19	5	7	8	—	—	10	6	—	—	54	34	19	5	112	2·8
31	164	73	42	35	9	—	1	1	9	8	2	1	164	65	41	35	305	2·8
Sheff. R.H.B.	1,106	602	245	200	58	28	5	7	81	42	3	5	1,083	588	247	202	2,120	3·9
West Riding	3,060	1,707	488	471	208	117	23	22	312	162	17	23	2,956	1,662	494	470	5,582	3·1

Table 25 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 total of 1,267 contacts were vaccinated as follows:

	Age (years)			
	0–4	5–15	16+	Total
No. vaccinated ...	854	290	123	1,267

(b) SCHOOL CHILDREN.—A total of 17,839 school children 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	20,478
Number found to have been vaccinated previously	544
Number of acceptances	21,636
Percentage of acceptances	85·7

Pre-vaccination tuberculin test:

Number of children tested	20,478

Result of test:

	Heaf Test	*Mantoux Test*		
Positive	... 1,352	123		
Negative	... 14,851	3,124		
Not ascertained ...	... 839	189	Total	20,478
Percentage positive ...	... 8·5	3·8	...	7·6

Vaccination:

Number vaccinated—

Following negative Heaf Test ...	... 14,751		
Following negative Mantoux Test ...	... 3,088	Total ...	17,839

Tuberculin test 12 months after vaccination:

Number tuberculin tested after 12 months			840
Result of test—			
Positive	734		
Negative	53		
Not ascertained	53	Total ...	840

(c) Students attending Universities, Teacher-Training Colleges, Technical Colleges or other Establishments for Further Education.

No students were tuberculin tested during 1970.

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)...	967	—	1	3	4
4 (Shipley)...	2,312	4	3	5	12
5 (Horsforth)	6,526	4	8	24	36
7 (Harrogate)	2,599	3	—	10	13
9 (Rothwell/Wetherby)	2,999	1	3	16	20
10 (Goole)	868	—	1	9	10
11 (Castleford/Pontefract)...	4,624	2	14	23	39
13 (Morley)...	2,027	3	—	7	10
15 (Spenborough)	4,222	10	5	18	33
18 (Calder Valley)	3,291	1	—	9	10
20 (Colne Valley)	3,554	6	4	16	26
Totals	33,989	34	39	140	213

B.—Sheffield Units

Survey undertaken in Division No.	Number Examined	Abnormalities Discovered			
		Tuberculosis		* Other	Total
		Active	Inactive		
25 (Barnsley)	1,601	5	4	61	70
29 (Thorne)...	1,604	3	1	19	23
31 (Rotherham)	1,947	5	4	151	160
Totals	5,152	13	9	231	253

Totals for the County Area ...	39,141	47	48	371	466

*Details of the 371 " Other " abnormalities are as follows:—

	Leeds Region	*Sheffield Region*
1. Abnormalities of the bony thorax and soft tissues—congenital	1	—
2. Abnormalities of the bony thorax and soft tissues—acquired	5	—
3. Tumours of the bony thorax; primary and secondary	1	—
4. Congenital malformations of the lungs	—	—
5. Bacterial and virus infections of the lungs ...	21	14
6. Other infections of the lungs	—	8
7. Bronchiectasis	10	2
8. Honeycomb lung	1	—
9. Emphysema	2	30
10. Pulmonary fibrosis—non-tuberculous	23	—
11. Pneumoconiosis—uncertified at time of attendance	10	56
11. Pneumoconiosis—already certified at time of attendance	—	53
12. Spontaneous pneumothorax	1	—
13. Benign tumours of lungs and mediastinum ...	3	—
14. Carcinoma of the lung and mediastinum ...	7	8
15. Metastases in the lung and mediastinum... ...	1	—
16. Enlarged mediastinal and bronchial glands—non-tuberculous	1	—
17. Sarcoidosis and collagenous disease	10	2
18. Pleural thickening or calcification—non-tuberculous	10	3
19. Abnormalities of diaphragm and œsophagus—congenital and acquired	8	19
20. Congenital abnormalities of heart and vessels ...	6	—
21. Acquired abnormalities of heart and vessels ...	13	24
22. Miscellaneous	—	11
23. Pneumoconiosis with tuberculosis	—	—
24. Awaiting classification	6	1
	140	231

Table 27 Venereal and Sexually Transmissible Diseases—New Cases, 1938-70

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
1967	47	510	2,255	2,812
1968	47	506	2,527	3,080
1969	30	537	2,845	3,412
1970	41	588	3,204	3,833

Table 28 Syphilis—Type and Stage of Disease, 1950-70

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
1967	8	33	—	6
1968	7	35	—	5
1969	9	18	—	3
1970	6	23	—	12

Table 29 Venereal Diseases etc.—Distribution of New Cases by Treatment Centres

Special Treatment Centre	Syphilis	Gonorrhœa	Other Conditions	Total
Barnsley Clinic, Queen's Road	—	18	191	209
Bradford St. Luke's Hospital	—	48	271	319
Burnley Victoria Hospital	—	5	15	20
Dewsbury General Hospital	3	34	212	249
Doncaster Royal Infirmary	9	86	405	500
Halifax Royal Infirmary	2	24	72	98
Harrogate General Hospital	2	34	156	192
Huddersfield Royal Infirmary	1	30	102	133
Hull, Mill Street Clinic	2	9	33	44
Keighley Victoria Hospital (now Airedale General Hospital)	3	30	120	153
Leeds General Infirmary	4	105	573	682
Oldham & District General Hospital ...	—	6	10	16
Rotherham Moorgate General Hospital	4	61	391	456
Sheffield Royal Hospital	3	21	66	90
Sheffield Royal Infirmary	—	8	36	44
Wakefield Clayton Hospital	4	65	503	572
York County Hospital	4	4	48	56
	41	588	3 204	3,833

Table 30 Venereal Diseases etc.—New Cases—Sex Distribution

	Males	Females	Total
Syphilis	29	12	41
Gonorrhœa	376	212	588
Chancroid	1	1	2
Lymphogranuloma Venereum	—	—	—
Granuloma Inguinale	—	—	—
Non-gonococcal Urethritis	695	—	695
Non-gonococcal Urethritis with Arthritis	7	—	7
Trichomoniasis	49	229	278
Late or Latent Treponematoses—non-syphilitic	—	—	—
Other Conditions requiring treatment	563	524	1,087
Not requiring treatment	701	424	1,125
Undiagnosed at 31st December, 1970	5	5	10
	2,426	1,407	3,833

Table 31 Gonorrhœa—New Cases—Age Distribution

Sex	Under 20		20 to 24		25 and over	
Males	52	13·9%	106	28·1%	218	58·0%
Females	61	28·8%	66	31·1%	85	40·1%

Table 32 Venereal Diseases etc.—Contact Tracing

Total number of contacts reported ...	74				
Located and examined		59			
Not infected			9		
Infected			50		
Already under treatment ...				—	
Brought under treatment ...				50	
Syphilis					—
Gonorrhœa					29
Other conditions					21
Located		6			
Not examined			6		
Transferred to other authority ...			—		
Not located		9			
Insufficient information			3		
Unable to locate			6		

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	
18	2	16	1	15	2	8	5

Table 34 Contacts of Antenatal Patients Found to have Syphilis

Number Examined	Found to have Syphilis	Found not to be infected
2	—	2

Table 35 Venereal Diseases etc.—Defaulters

Total number of defaulters	Returned to clinic after visiting	Failed to return	Removed, unable to locate	Trans-ferred	Number of ineffective visits	Number of re-visits
85	55	14	16	—	81	95

Table 36 Gonorrhœa—New Cases—Males/Females Numbers and Ratios

Year	Gonorrhœa		Ratio		
	Males	Females	Males		Females
1961	204	82	2·5	:	1
1962	185	59	3·1	:	1
1963	187	85	2·2	:	1
1964	211	75	2·8	:	1
1965	224	103	2·2	:	1
1966	265	141	1·9	:	1
1967	341	169	2·0	:	1
1968	343	163	2·1	:	1
1969	347	190	1·8	:	1
1970	376	212	1·8	:	1

Table 37 Divisional Administration

Div. No.	County Districts	Population (Estimated Mid. 1970)	Acreage	Divisional Medical Officer, Divisional Administrative Officer and Divisional Nursing Officer	Address of Divisional Health Office
1	Barnoldswick U.	9,870	2,764	Dr. M. Hunter	9, High Street, Skipton Tel. Skipton 2438/9
	Earby U.	4,990	3,519	Mr. K. A. Knowles	
	Silsden U.	5,550	7,101	Miss F. Stevenson	
	Skipton U.	12,770	4,211		
	Bowland R.	4,970	83,325		
	Sedbergh R.	3,750	52,674		
	Settle R.	13,760	152,088		
	Skipton R.	24,430	146,077		
		80,090	451,759		
3	Keighley B.	55,160	23,611	Dr. V. P. McDonagh Mr. A. S. Sanderson (D.N.O. Vacant)	3, Bow Street, Keighley Tel. Keighley 2244/5
4	Baildon U.	14,160	2,834	Dr. J. Battersby	P.O. Box 24, Town Hall, Shipley Tel. Shipley 51363
	Bingley U.	25,530	11,418	Mr. F. G. Falkingham	
	Denholme U.	2,680	2,536		
	Shipley U.	28,710	2,184	Miss H. J. Watts	
		71,080	18,972		
5	Pudsey B.	37,740	5,321	Dr. A. Telford Burn	The Green, Horsforth Tel. Horsforth 5821
	Aireborough U.	29,390	6,856	Mr. A. Hartley	
	Horsforth U.	18,910	2,706	Miss D. Topley	
	Ilkley U.	19,970	8,610		
	Otley U.	13,070	2,934		
	Wharfedale R.	7,260	39,378		
		126,340	65,805		
7	Harrogate B.	62,810	8,320	Dr. N. V. Hepple	Municipal Offices, Harrogate Tel. Harrogate 68954
	Ripon City	11,880	1,812	Mr. L. R. Wilkinson	
	Knaresborough U.	11,330	2,494	Miss M. L. Griffin	
	Nidderdale R.	17,800	75,008		
	Ripon and Pateley Bridge R.	14,330	124,860		
		118,150	212,494		
9	Garforth U.	22,260	4,020	Dr. E. M. Hargreaves	Hallfield Lane, Wetherby Tel. Wetherby 2738 AND Oulton Lane, Rothwell LS26 0ED Tel. Rothwell 2326/7
	Rothwell U.	27,660	10,704	Mr. F. H. Atack	
	Stanley U.	19,990	4,866	Miss M. P. Bramley	
	Tadcaster R.	33,800	72,992		
	Wetherby R.	32,710	64,415		
		136,420	156,997		

Div. No.	County Districts	Population (Estimated Mid. 1970)	Acreage	Divisional Medical Officer, Divisional Administrative Officer and Divisional Nursing Officer	Address of Divisional Health Office
10	Goole B.	18,320	1,274	Dr. M. J. Lowe	6/7, Belgravia, Goole Tel. Goole 4216 and 2923
	Selby U.	11,280	3,847	Mr. R. Towell	
	Goole R.	9,120	36,782	Miss C. J. Badcock	
	Selby R.	10,130	32,910		
		48 850	74,813		
11	Castleford B.	38,990	4,400	Dr. J. F. Fraser	" Castledene," Pontefract Road, Castleford Tel. Castleford 4201 AND Baghill House, Walkergate, Pontefract Tel. Pontefract 3291
	Pontefract B.	31,140	4,865	Mr. W. Carver	
	Featherstone U.	15 320	4,424	M s. M. Craig	
	Knottingley U.	18,250	2,833		
	Normanton U.	18,350	3,067		
	Osgoldcross R.	9,320	33,950		
		131,370	53,539		
13	Morley B.	44,090	9,494	Dr. G. Ireland	Corporation St., Morley Tel. Morley 7021/4
	Ossett B.	17.350	3,331	Mr. A. Wright	
	Horbury U.	9,020	1,280	Miss A. Hibbard	
	Wakefield R.	23,890	21,347		
		94,350	35,452		
15	Batley B.	41,680	4,457	Dr. W. M. Douglas	Health Centre, Greenside, Cleckheaton Tel. Cleckheaton 3501/4 AND Market Place, Batley Tel. Batley 3141
	Spenborough B.	38,980	8,249	Mr. P. Marshall	
	Heckmondwike U.	9,070	696	Mrs. I. Endean	
	Mirfield U.	16,330	3,394		
		106,060	16,796		
18	Brighouse B.	32,990	7,873	Dr. S. H. Brock	Lawson Road, Brighouse Tel. Brighouse 2515 AND Abraham Ormerod Medical Centre, Todmorden Tel. Todmorden 2495
	Todmorden B.	15,130	12,789	Mr. H. Marshall	
	Elland U.	18,500	5,949	Miss C. J. Barker	
	Hebden Royd U.	8,730	7,083		
	Queensbury and Shelf U.	10,420	2,795		
	Ripponden U.	5,000	13,289		
	Sowerby Bridge U.	16,430	5,763		
	Hepton R.	3,470	21,757		
		110,670	77,298		

Div. No.	County Districts	Population (Estimated Mid. 1970)	Acreage	Divisional Medical Officer, Divisional Administrative Officer and Divisional Nursing Officer	Address of Divisional Health Office
20	Colne Valley U.	20,870	16,054	Dr. J. P. Stuart	6/8, St. Peter's Street, Huddersfield HD1 1DH Tel. Huddersfield 29526/8
	Denby Dale U.	10,640	10,166	Mr. G. A. Beatson	
	Holmfirth U.	19,110	17,648	Mrs. S. North	
	Kirkburton U.	19,830	13,851		
	Meltham U.	6,600	5,906		
	Saddleworth U.	19,820	18,485		
		96 870	82,110		
22	Hoyland Nether U.	16,010	2,000	Dr. F. C. Armstrong	Mortomley Hall, High Green, Sheffield S30 4HR Tel. High Green 292
	Penistone U.	7,650	5,588	Mr. P. Fullwood	
	Stocksbridge U.	13 350	4,630	Mrs. M. Orr	
	Penistone R.	7,590	29,007		
	Wortley R.	39,840	48,130		
		84,440	89,355		
23	Hemsworth U.	15,080	4,164	Dr. J. S. Walters	Adiscombe House, Barnsley Road, Hemsworth Tel. Hemsworth 377/8
	Hemsworth R.	53,420	29,021	Mr. G. Ellis	
		68,500	33,185	Miss D. Marsh	
25	Cudworth U.	9,090	1,746	Dr. C. G. Oddy	33 Queen's Road, Barnsley Tel. Barnsley 2247/8
	Darfield U.	7,260	2,018	Mr. L. S. Wrigg	
	Darton U.	15,340	4,716	Miss M. E. Pilling	
	Dodworth U.	4,410	1,859		
	Royston U.	8 510	1,426		
	Wombwell U.	18 870	3,840		
	Worsbrough U.	16,130	3,420		
		79,610	19,025		
26	Conisbrough U.	17,690	1,589	Dr. D. J. Cusiter	Dunford House, Wath upon Dearne Tel. Wath 2251/2
	Dearne U.	26,440	3,888	Mr. P. Goddard	
	Mexborough U.	16,360	1,452	Miss V. Dunford	
	Rawmarsh U.	19,440	2,600		
	Swinton U.	14,450	1,717		
	Wath upon Dearne U.	15,270	2,679		
		109,650	13,925		
27	Adwick le Street U.	18,940	3,605	Dr. R. Stalker	Station Road, Doncaster Tel. Doncaster 61571
	Bentley with Arksey U.	23,590	4,951	Mr. C. W. Vallance	
	Tickhill U.	3,110	5,578	Miss D. M. E. Goldthorpe	
	Doncaster R.	81,580	75,109		
		127,220	89,243		

Div. No.	County Districts	Population (Estimated Mid. 1970)	Acreage	Divisional Medical Officer, Divisional Administrative Officer and Divisional Nursing Officer	Address of Divisional Health Office
29	Thorne R.	40,280	38,408	Dr. G. Higgins Mr. J. T. Howitt Miss C. J. Badcock	Council Offices, P.O. Box 4, Thorne Tel. Thorne 3130
31	Maltby U. Kiveton Park R. Rotherham R.	15,100 26,760 67,050	4,785 20,070 28,856	Dr. J. T. Clow Mr. A. Hill Mrs. A. Brooks	" Edenthorpe," Grove Road, Rotherham Tel. Rotherham 3131/2
		108,910	53,711		

Table 38 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	1,023	366
Subsequent Visits	843	1,047
Additional Courses of Treatment commenced	68	18
Number of Fillings	1,282	895
Teeth Filled	1,157	825
Teeth Extracted	1,705	795
General Anæsthetics	657	141
Emergencies	277	73
Patients X-Rayed	15	26
Prophylaxis	122	190
Teeth otherwise conserved	130	—
Teeth Root Filled	—	4
Inlays	—	3
Crowns	—	9
Courses of Treatment completed	871	265

Prosthetics

Patients supplied with F.U. or F.L. (First Time)	53
Patients supplied with Other Dentures	72
Number of Dentures supplied	192

Anæsthetics

General Anæsthetics administered by Dental Officers	792

Inspections

	Children 0—4 (incl.)	Expectant and Nursing Mothers
Number of First Inspections	A. 1,377	D. 374
Number in A. and D. requiring treatment	B. 1,110	E. 366
Number in B. and E. offered treatment	C. 1,053	F. 366

Sessions

Number of sessions devoted to M. & C.W. patients

For Treatment	460
For Health Education	14

Table 39 Antenatal Relaxation Classes

No. of sessions:	
(a) separate	4,070
(b) combined with antenatal clinics	84
Total	4,154
No. of women attending:	
(a) hospital booked	4,788
(b) domiciliary booked	526
Total	5,314
Total number of attendances:	
(a) hospital booked	24,448
(b) domiciliary booked	2,429
Total	26,877

Table 40 Ortolani Testing for Congenital Dislocation of the Hip—Summary of tests carried out, 1965-70

	1965	1966	1967	1968	1969	1970
(a) Cases referred to specialist, confirmed as congenital dislocation of the hip and splinted	17	52	69	64	62	89
No. included in (a) referred by staff employed by the Authority	9	27	31	27	21	31
(b) Cases referred to specialist and said not to be congenital dislocation of the hip	31	62	43	78	61	108
(c) Cases referred to specialist, not splinted but given further review appointments	13	24	18	35	45	62

Table 41 Illegitimate Children—Analysis of Cases

	West Riding Cases	Non-County Cases	Total
Number of cases dealt with during the year:			
Referred by Moral Welfare Organisations	159	17	176
Ascertained by staff of the Health Department... ...	1,021	6	1,027
Referred by other services...	253	3	256
Totals ...	1,433	26	1,459
Analysis of cases:			
Married { with previous illegitimate children ...	96	—	96
Married { without previous illegitimate children ...	193	2	195
Unmarried { with previous illegitimate children ...	178	1	179
Unmarried { without previous illegitimate children ...	897	22	919
Widowed or Divorced { with previous illegitimate children ...	15	—	15
Widowed or Divorced { without previous illegitimate children ...	54	1	55
Totals ...	1,433	26	1,459
Ages:			
Under 15 years of age	10	—	10
15—19 years of age	586	13	599
20—24 years of age	465	9	474
25—29 years of age	198	3	201
30—39 years of age	156	1	157
40 years of age and over	18	—	18
Totals ...	1,433	26	1,459
Disposal:			
Cases settled —Marriage	90	—	90
Baby died...	27	—	27
Grandparents taking baby	52	—	52
Baby adopted	183	12	195
Baby fostered	35	3	38
Mother keeping baby	1,032	10	1,042
Cases referred elsewhere	5	1	6
Cases not finally settled	9	—	9
Totals ...	1,433	26	1,459

Table 42 Illegitimate Children—Accommodation in Moral Welfare Homes

Name of Home	Ante- and Post natal	Ante natal only	Post natal only	Governing Body
Bradford—Holybrook House ...	4	9	1	Church of England
Bradford—Oakwell House	6	1	2	Bradford Corporation
Bromley, Kent—Ravensbourne House	1	—	—	Church of England
Chepstow—St. Anne's, Crossways Green...	1	—	—	Roman Catholic Church
Clipstone, Mansfield—Gwendoline Grove House	1	—	—	Church of England
Darlington—St. Agnes Home ...	2	1	—	Church of England
Halifax—St. Margaret's House ...	9	1	—	Church of England
Heywood, Lancashire—St. Anne's Home...	1	1	—	Church of England
Huddersfield—Bryanwood with St. Katherine's	16	2	—	Church of England
Leeds—Browning House	11	1	1	Voluntary Committee
Leeds—Mount Cross, Bramley ...	2	—	1	Salvation Army
Leeds—St. Margaret's Home ...	15	—	—	Roman Catholic Church
Manchester—Lorna Lodge, Didsbury	4	—	—	Methodist Church
Pontefract—The Haven	19	5	1	Church of England
Sheffield—St. Agatha's Hostel ...	13	6	—	Church of England
Sheffield—19/21 Hucklow Road, Sheffield, 5	—	1	—	Sheffield Corporation
York—Heworth Moor House ...	8	2	—	Church of England
	113	30	6	

Table 43 Premature Babies

Total adjusted live births—31,024 Number of live premature births—2,017 Number born dead—259 Percentage of premature live births to total live births—6·5

Weight Group	Number of Premature Births						Number Dying														Number Surviving over 28 days					Percentage Survival 1970	Percentage Survival in previous years				
	Born Alive					Born Dead	First Week							Second Week							over 14 up to 28 days										
lb.	A	B1	B2	C	Total		1	2	3	4	5	6	7	8	9	10	11	12	13	14		A	B1	B2	C	Total		1969	1968	1967	1966	1965
5—5½	62	2	258	506	828	21	15	1	4	—	1	—	1	1	—	—	—	—	—	—	1	60	2	253	489	804	97·1	97·8	97·1	96·7	98·0	96·6
4½—5	33	3	156	297	489	24	12	5	5	—	1	1	—	—	1	1	—	—	—	—	—	31	2	149	281	463	94·7	95·5	95·8	94·7	94·7	94·7
4—4½	10	—	89	168	267	36	13	5	4	—	—	—	—	—	—	—	—	—	—	—	1	8	—	76	160	244	91·4	93·4	92·0	89·7	91·2	86·7
3½—4	9	—	56	86	151	41	22	7	5	3	2	—	—	1	—	—	—	—	—	—	—	8	—	39	64	111	73·5	81·9	81·6	84·1	80·8	84·6
3—3½	7	—	26	82	115	23	20	7	3	1	1	—	1	2	1	—	1	—	—	—	2	3	—	18	55	76	66·1	72·3	57·3	72·4	63·5	67·7
2½—3	4	—	19	44	67	40	22	7	2	1	—	2	—	—	—	—	—	—	—	1	1	2	—	10	19	31	46·3	54·2	38·9	57·1	48·5	46·8
2—2½	2	—	10	35	47	33	25	3	3	1	2	1	—	—	—	—	—	—	—	—	1	—	—	2	9	11	23·4	28·8	20·7	24·1	21·7	23·4
1½—2	2	—	6	32	40	26	27	6	1	1	1	—	2	—	—	1	—	—	—	—	1	—	—	—	—	—	—	8·8	3·2	—	6·9	8·1
1½ and under	2	—	5	6	13	15	10	2	—	—	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	5·9	—	—
Total	131	5	625	1256	2017	259	166	43	27	7	9	4	4	4	2	2	1	—	—	1	7	112	4	547	1077	1740	86·3	88·9	86·6	87·8	87·2	86·8

260 10

277

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 44 Distribution of Welfare Foods

Year	National Dried Milk (Packets)	Cod Liver Oil (Bottles)	Vitamin A. & D. Tablets (Packets)	Orange Juice (Bottles)
1966	94,779	30,993	27,073	417,351
1967	81,351	28,835	24,038	442,498
1968	72,262	28,314	22,018	405,803
1969	52,771	26,595	22,727	447,379
1970	43,393	26,049	24,432	494,497

Table 45 Day Nurseries

Division Number	Day Nursery	Number of Places Provided	Average Daily Attendance
3	Keighley	50	37
4	Shipley	50	42
7	Harrogate	40	34
15	Heckmondwike	40	30
18	Brighouse	40	24

Table 46 Midwifery—Hospital and Domiciliary Confinements

Division No.	Area	Population (Estimated Mid-1970)	Total notified births (Live and Still)	Place of Birth					
				Hospital				Domiciliary	
				No.	No. of Early Discharges			No.	%
					At 48 hours	After 48 hours up to and including 5th day	After 5th but before 10th day		
1	Skipton	80,090	1,170	1,115	29	128	664	55	5
3	Keighley	55,160	949	925	15	349	460	24	3
4	Shipley	71,080	1,147	1,052	213	101	634	95	8
5	Horsforth	126,340	1,988	1,902	233	244	801	86	4
7	Harrogate	118,150	1,678	1,615	318	307	448	63	4
9	Rothwell/Wetherby	136,420	2,543	1,953	475	601	272	590	23
10	Goole	48,850	781	614	86	81	104	167	21
11	Castleford/ Pontefract ...	131,370	2,346	1,844	230	364	416	502	21
13	Morley	94,350	1,758	1,386	347	244	200	372	21
15	Spenborough ...	106,060	2,184	2,068	279	241	494	116	5
18	Calder Valley ...	110,670	1,886	1,487	127	91	104	399	21
20	Colne Valley ...	96,870	1,576	1,381	50	141	302	195	12
22	Wortley	84,440	1,602	1,422	221	240	677	180	11
23	Hemsworth ...	68,500	1,222	903	43	240	470	319	26
25	Barnsley	79,610	1,355	982	25	88	520	373	28
26	Wath	109,650	1,988	1,668	65	487	307	320	16
27	Doncaster	127,220	2,279	2,081	186	621	155	198	9
29	Thorne	40,280	828	706	74	237	53	122	15
31	Rotherham ...	108,910	2,216	1,912	564	615	316	304	14
Leeds Hospital Board Region		1,243,910	21,228	18,245	2,445	3,132	5,369	2,983	14
Sheffield Hospital Board Region		550,110	10,268	8,771	1,135	2,288	2,028	1,497	15
West Riding Administrative County		1,794,020	31,496	27,016	3,580	5,420	7,397	4,480	14

Table 47 Midwifery—Analgesia

Div. No.	Area	Percentage receiving Analgesia			
		Pethidine alone	Trilene alone	Trilene with Pethidine	Total
1	Skipton	11	22	47	80
3	Keighley	—	25	58	83
4	Shipley	21	8	50	79
5	Horsforth	13	30	33	76
7	Harrogate	14	19	37	70
9	Rothwell/Wetherby	20	23	29	72
10	Goole	10	50	28	88
11	Castleford/Pontefract	20	28	34	82
13	Morley	14	28	41	83
15	Spenborough	10	16	57	83
18	Calder Valley	15	27	43	85
20	Colne Valley	13	26	39	78
22	Wortley	35	22	12	69
23	Hemsworth	24	29	28	81
25	Barnsley	22	30	24	76
26	Wath	18	22	29	69
27	Doncaster	9	27	49	85
29	Thorne	40	8	45	93
31	Rotherham	23	21	28	72
	Leeds Hospital Board Region	17	27	36	80
	Sheffield Hospital Board Region	23	23	30	76
	West Riding Administrative County	19	25	34	78

Table 48 Health Visiting

Excluding their work in schools and general practitioners' surgeries, health visitors dealt with a total of 187,952 cases. Details are given below of the various case categories; where appropriate, cases have been included under more than one heading.

	Cases	
Expectant mothers	4,011	
Children born in 1970	30,929	
Children born in 1969	28,391	
Children born in 1965-68	59,202	
Persons aged 65 and over (excluding 'domestic help only' visits)	19,323	(includes 8,274 visited at the special request of a general practitioner or hospital)
Mentally disordered persons	624	(includes 333 visited at the special request of a general practitioner or hospital)
Persons, excluding maternity cases, discharged from hospital (other than mental hospitals)	2,433	(includes 1,963 visited at the special request of a general practitioner or hospital)
Other cases (including 'domestic help only' visits)	43,828	
Visits to tuberculous households	1,381	
Visits to households on account of other infectious diseases	2,248	

Health visitors attended 42,324 clinic sessions. Details are given below of the various clinics.

Type of Clinic	*No. of Sessions*
Child health (infant welfare)	27,972
Screening for infant deafness	5,770
Cervical cytology	1,815
Vaccination and immunisation	2,493
Ultra violet light	62
Minor ailments	811
Pædiatric	371
Family planning	66
Ophthalmic	1,632
Orthopædic	87
Ear, nose and throat	94
Dermatological	7
Diabetic	193
Chest	652
Geriatric	251
Others	142
Health Education—	
Mothercraft and relaxation groups	1,914*
Mothers' Clubs	291
Schools	1,722
Parent/Teacher groups	30
Other groups and organisations	520

A total of 35,375 hours was spent in schools and 9,824 home visits were made in connection with school health activities.

* See also Table 39—Antenatal Relaxation Classes

Table 49 Home Nursing—Total Cases Visited

Types of cases attended	No. of cases attended	No. of visits by Home Nurses
Medical	28,834	661,426
Surgical	10,187	191,365
Infectious diseases...	666	3,591
Tuberculosis	216	9,594
Maternal complications	898	7,440
Others	539	7,814
Totals ...	41,340	881,230
Age groups		
0—4...	2,315	10,815
5—64	16,629	284,708
65 years and over	22,396	585,707
Totals ...	41,340	881,230
Patients included in the above who have had more than 24 visits during the year	9,033	611,762

Table 50 Home Nursing—Completed Cases

Classification of Cases by Disease:

Disease	No. of Cases
Tuberculosis	176
Other infectious diseases	661
Parasitic diseases	279
Malignant and lymphatic neoplasms	2,131
Asthma	137
Diabetes mellitus	512
Anæmias	2,353
Vascular lesions affecting central nervous system	1,636
Other mental and nervous diseases	634
Diseases of the eye	129
Diseases of the ear	461
Diseases of heart and arteries	1,752
Diseases of veins	1,016
Upper respiratory diseases	907
Other respiratory diseases	2,903
Constipation	1,185
Other diseases of digestive system	2,519
Diseases of urinary system and male genital organs	924
Diseases of breast and female genital organs	732
Complications of pregnancy and puerperium	876
Diseases of skin and subcutaneous tissues	1,682
Diseases of bones, joints and muscles	1,185
Injuries	2,519
Senility	1,173
Other defined and ill-defined diseases or disabilities	2,416
Diseases not specified	498
Total	31,396

Nursing Treatment:

Type	
Injections	6,237
General Nursing	8,021
Enemas	1,354
Dressings	9,029
Bed baths	1,034
Wash-outs, douches, etc.	295
Changing of pessaries	90
Preparation for diagnostic investigation	938
Others	4,398
Total	31,396

The total number of cases receiving injections was 7,135 but, in some cases, the injections were given during the course of a general nursing visit.

Injections: Type	No. of Cases
Insulin	283
Drugs for anæmia, debility, etc.	2,879
Antibiotics	2,115
Drugs for cardio-renal diseases	440
Others	1,418
Total	7,135

Referral of Cases: Source	
General practitioners	25,888
Hospitals	4,162
Health department staff	915
Others	431
Total	31,396

Disposal of Cases:	
Convalescent	17,102
Transferred to hospital	4,523
Died	3,771
Others	6,000
Total	31,396

Table 51 Ambulance Service

	1970		1969		1970 to 1969	
	Patients	Miles	Patients	Miles	Patients	Miles
Direct Service ...	715,805	4,487,602	676,130	4,296,402	+ 39,675	+191,200
Agencies ...	38,364	344,409	39,022	336,148	— 658	+ 8,261
Hospital Car Service ...	9,784	276,327	9,653	275,092	+ 131	+ 1,235
Total	763,953	5,108,338	724,805	4,907,642	+39,148	+ 200,696

Table 52 Ambulance Service - Accidents Attended

Type of Accident	Number of Accidents	Number of Patients
Road	4,451	6,285
Street	1,591	1,620
Works	1,342	1,360
Home	5,352	5,371
School	520	528
Sport	480	483
Drowning	21	21
Total	13,757	15,668

Table 53 Health Education - Summary of Activities

Subject	Estimated Audience			
	Clinics	Schools	*Other	Total
Antenatal, Childbirth	8,337	2,969	1,073	12,379
Mothercraft and Child Development ...	7,400	3,594	1,606	12,600
Personal Hygiene	2,218	15,837	213	18,268
Personal Relationships, V.D.	250	8,815	2,055	11,120
Accident Prevention	1,376	9,091	4,750	15,217
Vaccination and Immunisation	502	573	40	1,115
Nutrition and General Health	1,015	5,818	837	7,670
Cancer Education	293	4,164	1,284	5,741
Family Planning	52	93	230	375
Local Health Services	69	1,746	1,531	3,346
Care of the Aged	30	324	110	464
First Aid	—	778	231	1,009
Totals ...	21,542	53,802	13,960	89,304

*Includes Mothers' Clubs, Women's Institutes, Guides, Scouts, Youth Clubs, St. John Cadets, Darby and Joan Clubs, etc.

Table 54 Provision of Nursing Equipment in the Home

Item	Total No. available for loan	No. of issues during year
Bath lift	1	—
Bath seats	41	55
Bedding: blankets, pillows and cases, sheets, etc.	1,470	1,317
Bed blocks	124	52
Bed Cradles	671	973
Bed pans	2,143	3,497
Bed rests	1,003	1,759
Bed tables	20	14
Bedsteads: hospital, with self-lifting pole, and other	322	451
Chairs: geriatric, relaxing, high rest, 'Amesbury' play, stairway (carrying), etc.	56	53
Commodes: chair and other	1,163	2,223
Cushions: air and 'Dunlopillo'	289	538
Enuresis alarms	409	1,446
Fracture boards	129	152
Hydraulic hoists	50	77
Lifting pole and chain	47	75
Mattresses: various types	475	707
Rubber/Plastic sheets	1,756	1,981
Tables: 'Amesbury' play	1	1
Walking aids: 'Amesbury', 'Bonaped', 'Zimmer', tripod, 'Companion', 'Fordham', 'Mycroft', 'Welwyn', 'Winchester', etc., crutches and walking sticks	2,048	2,879
Wheelchairs: bath, folding, junior, self-propelled, spinal, stairway, etc.	782	1,720
Miscellaneous	117	140

Table 55 Chiropody Treatment

	Voluntary Association Schemes	Direct Service by County Council	Total
Number of sessions held:			
In voluntary association premises	3,053	—	3.053
In clinic premises	—	12,191	12,191
	3,053	12,191	15,244
Number of patients treated:			
In chiropodists' surgeries:			
Pensioners	2,127	8,692	10,819
Physically handicapped	38	201	239
Expectant mothers	11	7	18
In voluntary association or clinic premises:			
Pensioners	6,121	22,178	28,299
Physically handicapped	115	371	486
Expectant mothers	3	18	21
Domiciliary treatment:			
Pensioners	2,361	13,314	15,675
Physically handicapped	101	563	664
Expectant mothers	—	—	—
Total number of patients treated	10,877	45,344	56,221
Total number of treatments given:			
Pensioners	45,371	206,468	251,839
Physically handicapped	931	4,330	5,261
Expectant mothers	24	55	79
	46,326	210,853	257,179
Number of patients treated per session	8·9	8·4	8·5
Percentage of total patients treated receiving domiciliary treatment	22·6	30·6	29·1
Percentage of aged population receiving treatment (men over 65 years and women over 60 years)	4·1	17·2	21·3

Table 56 Domestic Help

Classification of Cases Assisted	No. of Cases	Hours Employed
Over 65 years of age	18,916	2,502,300
Under 65 years of age:		
Chronic sick and tuberculous	1,611	182,576
Mentally disordered	47	3,708
Maternity	433	15,847
Other	599	51,236
	21,606	2,755,667

Table 57 Mental Health Training Centres

The following is a list of the training centres in operation at the end of 1970, with details of the places provided:

Centre	Junior	Adult Male	Adult Female	Special Care	Total
Adwick le Street	38	25	25	—	88
Airedale (Castleford)	40	30	30	4	104
Brighouse (Rastrick)	36	30	30	18	114
Ecclesfield	42	26	21	6	95
Harrogate	30	25	25	6	86
Heckmondwike	36	24	24	—	84
Hemsworth...	40	20	20	18	98
Horsforth Comprehensive	30	25	25	18	98
Horsforth Junior	27	—	—	—	27
Keighley	50	25	25	—	100
Kirkburton...	30	25	25	6	86
Maltby	48	30	30	18	126
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	18	88
Wombwell	36	25	40	18	119
Totals	664	407	415	154	1,640

Table 58 Day Centres and Psychiatric Social Clubs

DAY CENTRES:

Club	No. of members	Premises	Meetings	Opened
Harrogate Therapeutic	52	13, Dragon Parade, Harrogate	Daily	October, 1963 (transferred to new premises May, 1967)
Mirfield Day Industrial Centre	40	Nettleton Road, off Doctor Lane, Mirfield	Daily	May, 1970
Snaith Day Centre	23	Pontefract Road, Snaith	Daily	December, 1963

PSYCHIATRIC SOCIAL CLUBS:

Club	No. of places	Premises	Meetings	Opened
'Beacon Club' Brighouse	20	Divisional Health Office, Police St., Brighouse	Monday evening	January, 1968
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 Temporarily closed
Morley Social Club	20	Central Clinic, Morley	Thursday evening	January, 1962
Rock Club, Wath upon Dearne	40	Child Welfare Clinic, Church Street, Wath upon Dearne	Fortnightly Thursday evening	August, 1961
Rothwell Club	30	Central Clinic, Oulton Lane, Rothwell	Monday evening	August, 1965
Springhead Club	25	Springhead Clinic, Cooper Street, Saddleworth	Thursday afternoon	December, 1964

Table 59 Mental Health—Hospital Admissions

PSYCHIATRIC PATIENTS (admitted by Mental Welfare Officers)

	1969	1970
Informal admissions	1,787	1,759
Court orders	1	3
Section 25	207	194
,, 26	48	35
,, 29	555	520
	2,598	2,511

SUBNORMAL PATIENTS

Patients provided with short-stay care	274
,, admitted for permanent care	23
,, under guardianship...	3
,, awaiting permanent care—urgent ...	18
,, awaiting permanent care—non-urgent ...	31

Table 60 Mental Health—Number of persons referred to Local Health Authority during year ended 31st December, 1970

Referred by	Mentally Ill				Psychopathic				Subnormal				Severely Subnormal				Total
	Under age 16		16 and over		Under age 16		16 and over		Under age 16		16 and over		Under age 16		16 and over		
	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	
General practitioners	4	4	664	1113	—	—	—	1	12	7	8	8	3	2	2	2	1830
Hospitals, on discharge from in-patient treatment	1	2	454	755	—	—	4	—	2	—	10	7	1	—	2	1	1239
Hospitals, after or during out-patient or day treatment...	—	—	203	276	—	—	1	—	—	—	3	1	2	1	—	—	487
Local education authorities	—	—	—	—	—	—	—	—	18	10	43	35	7	14	2	—	129
Police and courts	—	1	74	73	—	—	1	1	—	—	1	1	—	—	—	—	152
Other sources	2	4	400	653	—	—	2	2	38	26	76	55	40	29	13	20	1360
Total	7	11	1795	2870	—	—	8	4	70	43	141	107	53	46	19	23	5197

Table 61 Mental Health—Number of persons under Local Health Authority Care at 31st December, 1970

Number of Persons under L.H.A. care at 31.12.70	Mentally Ill				Elderly mentally infirm		Psychopathic				Subnormal				Severely Subnormal				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.	
Total number	—	2	1288	1974	67	181	—	—	8	1	260	181	1040	907	319	221	300	302	7051
Attending day training centre ...	—	—	28	14	3	6	—	—	—	—	226	154	307	279	235	180	178	176	1786
Awaiting entry to training centre	—	—	2	—	—	—	—	—	—	—	15	16	10	14	22	14	—	—	93
Receiving home training	—	—	1	4	—	—	—	—	—	—	—	—	—	1	—	—	1	—	7
Awaiting home training	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Resident in L.A. home/hostel ...	—	—	25	10	—	—	—	—	—	—	4	4	26	23	8	8	—	—	108
Awaiting residence in L.A. home/hostel	—	—	—	—	—	—	—	—	—	—	—	—	30	40	—	—	—	—	70
Resident at L.A. expense in other homes/hostels	—	—	—	—	—	—	—	—	—	—	—	—	18	4	6	4	—	3	35
Resident at L.A. expense by boarding out in private household ...	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	1	2	4
Attending day hospitals	—	—	92	83	4	14	—	—	—	—	—	—	1	1	3	1	1	—	200
Receiving home visits and not included above:																			
Suitable to attend a training centre	—	—	131	227	14	21	—	—	—	—	12	1	95	101	8	9	33	38	690
Others	—	2	1015	1640	46	140	—	—	8	1	7	10	563	452	45	13	86	83	4111

Table 62 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
3,243	618	1,505	2,154	75

Table 63 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
2,141	277	122	1,844	12	1,644	71	141	58	—	23	—

Table 64 Milk (Special Designation) Regulations, 1963—Licensed Establishments for Pasteurising and Sterilising Milk

PASTEURISED MILK:

Chappell, R. M., Nether End Farm, Denby Dale.
Co-operative Retail Services Ltd., Doncaster Branch, Dairy Department, York Road, Doncaster.
Co-operative Retail Services Ltd., Goldcross Branch, Horsefair Dairy, Pontefract.
Co-operative Retail Services Ltd., Goole Branch, Centenary Road, Goole.
Crawshaw, J., Blake Lea Dairy, 103, Arksey Lane, Bentley.
Dibb, K., Home Farm, Menston.
Doxey, C., The Dairy, Nutwell Lane, Armthorpe.
Mawer, L. C. & W. O., Glentworth House, Skellow.
Old Corn Mill Farm (Eldwick) Ltd., Harden Grange, Harden, Bingley.
Platts, N. H. & Sons, Home Farm, Bretton.
Rotherham Dairies Ltd., Bramley.
Salmon, P., Ashbrooke, Littlethorpe, Ripon.

The following plant ceased operations:

Whittaker's Dairies Ltd., 77, Tenter Balk Lane, Adwick le Street.

Table 65 Milk (Special Designation) Regulations, 1963—Details of Samples obtained from Licensed Processing Plants

Pasteurised				
Phosphatase Test		Methylene Blue Test		
Satis-factory	Unsatis-factory	Satis-factory	Unsatis-factory	Void
639	1	564	9	67

Table 66 Details of County Premises with Private Supplies of Water

Premises	Source of Supply
Aldfield C.E. School, Aldfield, near Ripon	Untreated trunk main—candle filter
Arncliffe School, Arncliffe, Skipton	Land spring—untreated
Askham Bryan Agricultural College, Askham Bryan, near York	Bore—untreated
Beamsley Boyle and Petyt Primary School, Beamsley, Skipton	Land spring—untreated
Clapham C.E. J.M.I. School, Clapham, Settle ...	Lake supply—chlorinated
Clint Burnt Yates Endowed School, Burnt Yates, near Harrogate	Bore—untreated
Colne Valley Scammonden J.M.I. School, Barkisland, near Halifax	Shallow well—untreated
Colne Valley Wilberlee J.M.I. School, Slaithwaite ...	Land spring—untreated
Cracoe Rylstone District J.M.I. School, Cracoe, Skipton	Land spring—untreated
Grantley Hall Adult College, near Ripon	Land spring—filtered and chlorinated
Ingleborough Hall Special School, Clapham, Settle ...	Lake water—filtered and chlorinated
Laverton Dallowgill J.M.I. School, Kirkby Malzeard, near Ripon	Land spring—untreated
Long Preston Endowed J.M.I. School, Long Preston, Skipton	Land spring—untreated
Martons Both Endowed J.M.I. School, East Marton, Skipton	Land spring—filtered and chlorinated
Rathmell C.E. J.M.I. School, Rathmell, Skipton ...	Land spring to private reservoir—untreated
Ripley Endowed J.M.I. School, Ripley, near Harrogate	Land spring—filtered and chlorinated
Slaidburn Brennand's Endowed J.M.I. School, Slaidburn, near Clitheroe	Land spring—filtered and chlorinated

Table 67 Details of Applications for Grants under the Rural Water Supplies and Sewerage Acts, 1944-61

County District or Other Body	Description of Scheme	Date of Application	Estimated Cost of Scheme £
Brighouse M.B.	Holly Royd, Southowram, Water Supply and Drainage	15th July	1,700
Calderdale Water Board	Towngate, Midgley and Midgley Road Mytholmroyd Water Supply	13th April	13,574
ditto.	Blackshaw Head Water Supply	24th April	23,300
ditto.	Elland Road, Brighouse Water Supply	23rd December	18,046
Colne Valley U.D.	Westwood Edge, Golcar, Sewer	29th July	16,862
ditto.	Bolster Moor, Golcar, Sewer Extension	2nd October	1,400
Doncaster and Tickhill Joint Water Board	Stainforth Road, Barnby Dun Water Supply	8th April	1,410
Hepton R.D.	Blackshaw Head, Sewerage	11th May	44,500
Kirkburton U.D.	Whitestones, Water Supply	2nd January	422
ditto.	Linfit Lane Area, Cock Hat Wood Sewerage Extension	16th September	4,000
Kiveton Park R.D.	Todwick Sewerage and Sewage Disposal	6th May	21,300
Nidderdale R.D.	Beckwithshaw, Sewage Disposal	11th August	19,535
Pontefract, Goole and Selby Water Board	Creykes Sidings, Rawcliffe Bridge, Water Supply	13th July	5,750
Rombalds Water Board	West Chevin Road, Otley, Water Supply	20th April	1,700
Saddleworth U.D.	Bunkers, Greenfield, Sewerage	3rd August	1,762
Skipton R.D.	Coniston with Kilnsey, Sewage Disposal	6th August	22,290
Wharfedale R.D.	Leathley and High Mills (Pool) Sewerage	11th August	86,600
Wortley R.D.	Lane Head, Grenoside, Water Supply	29th May	4,230
ditto.	Glen Howe Park, Wharncliffe Side Water Supply	26th August	1,584

Table 68 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	—
Aston Lodge C.P.	10,500	Learner	Diatomaceous Earth	Automatic Chlorinator	Pool in planning stage
Bardsey Primary	870	Constructed	Diatomaceous Earth	Automatic Chlorinator	—
Bewerley Park Centre for outdoor pursuits	12,000	Constructed	Diatomaceous Earth	Automatic Chlorinator	—
Bingley Grammar	46,400	Conventional	Diatomaceous Earth	Automatic Chlorinator	—
Boroughbridge County Primary	6,000	Learner	Diatomaceous Earth	Drip Feed	—
Bridge House Special School, Harewood	4,000	Learner	Diatomaceous Earth	Automatic Chlorinator	—
Brighouse Woodhouse Junior	8,800	Learner	Diatomaceous Earth	Automatic Chlorinator	—
Collingham C.E.	10,000	Learner	Diatomaceous Earth	Automatic Chlorinator	—
Copmanthorpe J.M.	8,000	Learner	Sand	Automatic Chlorinator	Pool opened 1970
Darton Barugh J.M.I.	6,000	Learner	Diatomaceous Earth	Automatic Chlorinator	—
Darton Kexbrough	6,000	Learner	Diatomaceous Earth	Automatic Chlorinator	—
Dinnington High	90,000	Conventional	Sand	Automatic Chlorinator	Pool in planning stage

School	Pool		Filtration	Chlorination	Remarks
	Capacity in gallons	Type			
Ermysted's Grammar Skipton	29,000	Conventional	Sand	Chlorine Gas	—
Featherstone R.C.	46,000	Conventional	Sand	Chlorine Gas	—
Felkirk Secondary	—	—	—	—	Project cancelled
Goole Riverside E.S.N.	8,000	Learner	Sand	Automatic Chlorinator	Pool in planning stage
Harrogate Granby Park	52,000	Conventional	Sand	Chlorine Gas	—
Harrogate Woodlands	20,000	Conventional	Diatomaceous Earth	Automatic Chlorinator	—
Harthill with Woodhall C.P.	8,000	Learner	Sand	Automatic Chlorinator	Pool in planning stage
Hartwith Summerbridge	6,000	Learner	Diatomaceous Earth	Automatic Chlorinator	—
Hebden Royd Centre, Pitt Street, Hebden Bridge	6,000	Learner	Diatomaceous Earth	Automatic Chlorinator	—
Horbury C.E.	6,000	Learner	Diatomaceous Earth	Automatic Chlorinator	—
Horbury Bridge C.E.	8,000	Learner	Diatomaceous Earth	Automatic Chlorinator	—
Horsforth Featherbank	6,000	Learner	Diatomaceous Earth	Automatic Chlorinator	—
Horsforth Training Centre	5,400	Constructed	Sand	Automatic Chlorinator	Pool opened 1970
Hoyland Common J.M.I.	6,000	Learner	Diatomaceous Earth	Automatic Chlorinator	—

School	Pool		Filtration	Chlorination	Remarks
	Capacity in gallons	Type			
Ilkley Grammar	35,000	Conventional	Sand	Chlorine Gas	—
Ilkley Menston Primary	25,000	Constructed	Sand	Drip Feed	—
Keighley Oakbank Grammar	60,500	Conventional	Diatomaceous Earth	Chlorine Gas	—
Kippax North C.P., Garforth Ninelands C.P., Garforth West C.P.	—	—	—	—	Previous joint proposals now amended to provide a pool at Kippax and at Garforth Ninelands
Kirkburton Training Centre	7,000	Conventional	Sand	Automatic Chlorinator	Pool in planning stage
Kirk Fenton Parochial	8,000	Learner	Sand	Automatic Chlorinator	—
Meltham C.E.	15,000	Constructed	Diatomaceous Earth	Automatic Chlorinator	—
Mexborough C.E.	9,600	Learner	Diatomaceous Earth	Automatic Chlorinator	—
Mexborough Grammar	18,000	Learner	Diatomaceous Earth	Drip Feed	—
Norton J. M.	—	—	—	—	Project cancelled
Ossett Comprehensive	—	—	—	—	Joint proposals with Ossett M.B. under review
Penistone St. John's C. E.	8,000	Learner	Canvas Bags	Drip Feed	Pool not used
Rawcliffe Training Centre	8,000	Learner	Sand	Automatic Chlorinator	—
Ripon Grammar	52,000	Conventional	Sand	Chlorine Gas	—
Rothwell Carlton J.M.I.	8,000	Learner	Sand	Drip Feed	—

School	Pool		Filtration	Chlorination	Remarks
	Capacity in gallons	Type			
Scawthorpe Secondary	50,625	Conventional	Sand	Chlorine Gas	—
Scholes J.M.I.	8,000	Learner	Diatomaceous Earth	Automatic Chlorinator	—
Scissett Miners Welfare Club	70,000	Constructed	Sand	Chlorine Gas	Joint ownership with Denby Dale U.D.C.
Shade C.P. Todmorden	30,000	Conventional	Sand	Chlorine Gas	—
Sherburn in Elmet	8,000	Learner	Sand	Drip Feed	—
Stourton C.P.	8,000	Learner	Sand	Automatic Chlorinator	Pool opened 1970
Swillington J.M.	8,000	Learner	Sand	Automatic Chlorinator	Pool in planning stage
Tadcaster J.M.	8,000	Learner	Sand	Automatic Chlorinator	Pool opened 1970
Thorpe Arch C.E.	13,000	Conventional	Sand	Automatic Chlorinator	—
Thorne Grammar	48,000	Constructed	Diatomaceous Earth	Automatic Chlorinator	—
Thrybergh J.M.	14,000	Learner	Diatomaceous Earth	Automatic Chlorinator	—
Todwick J.M.	8,000	Learner	Sand	Automatic Chlorinator	Pool in planning stage
Ulleskelf C.E.	6,000	Learner	Canvas Bags	Drip Feed	—
Upper Poppleton C.P.	2 pools 2,000 14,000	Learner	Diatomaceous Earth	Automatic Chlorinator	—
Upper Wharfedale Secondary	43,000	Conventional	Diatomaceous Earth	Automatic Chlorinator	—

School	Pool		Filtration	Chlorination	Remarks
	Capacity in gallons	Type			
Upton - North Elmsall J.M.I.	21,000	Learner	Diatomaceous Earth	Automatic Chlorinator	—
Wales C.P.	8,000	Learner	Sand	Automatic Chlorinator	Pool in planning stage
Ward Green J.M.I., Worsbrough	12,000	Learner	Diatomaceous Earth	Automatic Chlorinator	—
West Ardsley Training Centre	9,000	Constructed	Sand	Automatic Chlorinator	Pool in planning stage
Weston Lane C.P., Otley	7,000	Constructed	Sand	Added by hand	—
Whinburn Special School, Keighley	5,000	Learner	Canvas Bags	Drip Feed	—
Whiston C.P.	8,000	Learner	Sand	Automatic Chlorinator	Pool in planning stage
Worsbrough Bank End	8,000	Learner	Sand	Automatic Chlorinator	Pool opened 1970
Worsbrough Birdwell C.P.	13,000	Constructed	Diatomaceous Earth	Automatic Chlorinator	—

Table 69 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
	Micrograms per cubic metre			Micrograms per cubic metre		
Barnoldswick—Health Department, Fernlea, surrounding district residential and commercial with railway nearby	69 for 11 months	508	5	91 for 11 months	378	21
Keighley — First floor of Public Health Department in built-up area in centre of town	74	461	8	93	802	Alk.
Keighley—Branshaw View, 20ft. above ground in classroom on south-west side of building, ¼ mile south-west of town centre. Surrounding district residential	47 for 11 months	384	1	20 for 11 months	86	Alk.
Bingley — Health Department, Town Hall, 1/5th mile outside town centre, surrounding district parkland	38 for 10 months	428	3	91 for 9 months	645	0
Shipley—Health Department, Town Hall, surrounding district residential and commercial	58	663	6	125	1,499	17
Horsforth—Broadway, in residential area, most properties to the south in Smoke Control Areas	45	665	1	89	824	9
Otley–First floor of Council Offices, in town centre, mainly manufacturing	48 for 11 months	302	4			
Harrogate — Ground floor of Municipal Offices, surrounding district residential and commercial	47	395	4	81	414	0

*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 Regional Office, Milk Marketing Board, surrounding district residential and manufacturing	83 for 11 months	522	11	91 for 11 months	319	7
Knaresborough–Knaresborough House, in parkland surrounded by mixed residential and commercial properties, open country to west	46 for 11 months	434	3	50 for 11 months	203	6
Goole—Health Department, Municipal Offices, Stanhope Street, surrounding area commercial, residential and shipping	69	411	12	118	306	37
Selby—Council Depot in residential and commercial area	118 for 2 months	471	24	127 for 2 months	306	44
Castleford—First floor of Divisional Health Office, in residential area of industrial town	111 for 1 month	430	9	141 for 1 month	186	108
Castleford—The Green, Ferry Fryston—situated 12ft. above ground on E. side of the Pavilion, surrounding district residential with open country to E.	108 for 5 months	788	6	88 for 5 months	245	11
Castleford-Slaughterhouse in Superintendent's office, 20ft. above ground, surrounding district, residential and commercial	54 for 5 months	418	6	92 for 5 months	374	13
Normanton—Neville House. Surrounding district commercial, residential and a few small factories	153 for 11 months	855	10	170 for 11 months	570	51

*For period of full year unless stated otherwise.

Situation of Instrument	Smoke			Volumetric SO_2		
	Average Daily Suspended Impurity*	Highest Value	Lowest Value	Average Daily Concentration SO_2*	Highest Value	Lowest Value
	Micrograms per cubic metre			Micrograms per cubic metre		
Pontefract—Municipal Offices. In laboratory on second floor in mixed commercial and manufacturing area	109	753	6	135	804	12
Pontefract—Moverley Flatts. In rear storeroom of Council Depot, surrounding district residential	141	696	5	155	590	Alk.
Pontefract—Carleton Park. First floor landing of flats in residential area	91	558	3	123	501	18
Horbury—Ground floor lobby of Town Hall, facing east 12ft.above ground,surrounding district residential and manufacturing	67	526	7	141	884	27
Morley—Public Health Inspector's Department, Commercial Street, surrounding district residential, commercial and manufacturing	77 for 11 months	428	12	137 for 11 months	543	29
Morley—Spring Avenue, Gildersome in residential area	56	252	6	109	725	23
Ossett—Seemore Arcade. Surrounding district residential and commercial	68	540	6	152 for 11 months	791	19
Batley—Public Health Department, Market Place, in centre of mixed residential, commercial and manufacturing district	114	1,033	6			
Spenborough—Health Centre, Greenside, in small park, residential and commercial area	70	496	8	161	590	15

*For period of full year unless stated otherwise.

Situation of Instrument	Smoke			Volumetric SO_2		
	Average Daily Suspended Impurity*	Highest Value	Lowest Value	Average Daily Concentration SO_2*	Highest Value	Lowest Value
	Micrograms per cubic metre			Micrograms per cubic metre		
Elland–Council Offices, 20ft. above ground in manufacturing area	62	485	2	121	945	5
Hebden Royd (Mytholmroyd)—Redacre Sewage Works, residential and manufacturing area, open country to north	50	346	6	53	448	Alk.
Hebden Royd (Hebden Bridge)—On second floor landing of Council Offices, in centre of mixed residential, commercial and manufacturing district	83	443	2	109	609	6
Sowerby Bridge—Beech Road. Upper room of Public Health Department in a mainly residential area with some industrial plants 200 yards to east	53	464	7	139	787	15
Sowerby Bridge—Wharf Street. Situated on main Yorkshire—Lancashire road carrying heavy traffic, in a mainly commercial area	60	348	10	73	358	Alk.
Todmorden—In first floor room on south side of Medical Centre, surrounding district mixed residential, commercial, manufacturing and open country	56	506	6	117	725	18
Colne Valley—Town Hall, Cross Street, Slaithwaite, in mixed residential and textile manufacturing district	77	437	7	123	479	22
Denby Dale—Public Health Inspector's Office, surrounding district mixed residential, manufacturing and open country	103	556	13	136	481	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
	Micrograms per cubic metre			Micrograms per cubic metre		
Denby Dale—Emley C.P. School. In village in open country	56	297	5	121	530	19
Holmfirth—On second floor landing of Council Offices, surrounding district open country, residential, commercial and manufacturing	77	326	11	126	823	22
Kirkburton—Council Offices, Kirkheaton in residential area	110	480	10	143	523	40
Meltham—Public Health Inspector's Office, Town Hall, surrounding district residential, manufacturing and open country	90 for 11 months	343	7	78 for 11 months	274	Alk.
Saddleworth–Sewage Works, Shaw Hall Bank, Greenfield, surrounding district residential, manufacturing and commercial	60	508	10	85	431	8
Wortley (Grenoside)–Health Dept., Council Offices, surrounding area industrial and manufacturing	40	241	1	92	341	18
Wortley (Oughtibridge)—County School, Church Street, surrounding district industrial and manufacturing	35 for 11 months	205	2	88 for 11 months	290	Alk.
Hemsworth—Divisional Health Office, Adiscombe House, in residential area	96 for 7 months	640	9	87 for 7 months	401	9
Hemsworth—Brierley Hall in residential area	42 for 5 months	203	4	120 for 5 months	377	Alk.
Hemsworth — Grimethorpe, in residential commercial and manufacturing area	103 for 5 months	691	5	141 for 5 months	442	32

*For period of full year unless stated otherwise.

Situation of Instrument	Smoke			Volumetric SO_2		
	Average Daily Suspended Impurity*	Highest Value	Lowest Value	Average Daily Concentration SO_2*	Highest Value	Lowest Value
	Micrograms per cubic metre			Micrograms per cubic metre		
Hemsworth—South Kirkby in residential, commercial and light industrial area	136 for 5 months	865	13	196 for 5 months	608	Alk.
Darton—Council Offices, in semi-residential colliery district. Coke by-product plant 1 mile to S.E.	177 for 10 months	599	36	99 for 10 months	346	26
Wombwell—The Gables, semi-residential colliery district	168 for 11 months	668	18	95 for 11 months	232	22
Wombwell—The Library, Station Lane, surrounding district residential and commercial	155 for 10 months	760	16	128 for 10 months	515	27
Worsbrough—Savile House —8ft. above ground in outbuilding, rear of Council Offices. Surrounding country open and low density residential	115	642	10	101	336	12
Worsbrough—Blacker Hill in open residential area, colliery to N.W., coke ovens to W.	90 for 3 months	274	10	95 for 3 months	254	6
Conisbrough–Denaby Clinic, in room facing north. Surrounding district residential —high density	118	773	10	143	409	43
Conisbrough—The Priory, in staff dining room facing west. Surrounding district residential—low density	114	766	7	122	443	43
Rawmarsh—Public Health Inspector's Office, in centre of residential and industrial area	187 for 10 months	797	13			

* For period of full year unless stated otherwise.

Situation of Instrument	Smoke			Volumetric SO_2		
	Average Daily Suspended Impurity*	Highest Value	Lowest Value	Average Daily Concentration SO_2*	Highest Value	Lowest Value
	Microgrammes per cubic metre			Microgrammes per cubic metre		
Wath upon Dearne—Town Hall, in commercial and residential area with industrial zone 1-2 miles N. to N.E.	87	552	3	124	455	12
Bentley with Arksey—Health Department, Chapel Street, semi-residential colliery district	107	593	11	119	440	31
Doncaster (Barnby Dun)—Barnby Dun School, in residential area 5 miles north-east of Doncaster C.B.	59	396	8	85	327	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	72	387	11	197	1,032	19
Thorne—Council Offices, in semi-residential colliery district	94 for 8 months	516	19			

*For period of full year unless stated otherwise

Table 70 Welfare of the Epileptic and Spastic—Particulars of known Epileptics and Spastics

	Number	
	Epileptics	Spastics
Adults		
Provided with accommodation under Part III of the National Assistance Act, 1948:		
(a) in homes for epileptics	58	
(b) in homes for spastics and other handicapped persons ...		25
(c) in County establishments and establishments where County Council has 'right of user'	51	
Registered under the County Council's scheme of Welfare Services for Handicapped Persons (General Classes) and not shown above	173	257
Children		
Number ascertained as handicapped:		
(a) Approximate number attending ordinary schools	not known	77
(b) Attending special schools	20	95
(c) Receiving home tuition		3
(d) Attending training centres for the mentally subnormal ...	106	76
Plus 26 children suffering from both epilepsy and spasticity		

Table 71 Certification and Treatment of Blind and Partially Sighted Persons

The following table gives particulars of new registrations during 1970 of blind and partially sighted persons (other than handicapped school children.)

	Disability (B.—Blind, P.S.—Partially Sighted)									
	Cataract		Glaucoma		Retrolental Fibroplasia		Others		Total	
(i) Number of cases registered during the year in respect of which Section F recommends:	B.	P.S.	B.	P.S.	B.	P.S.	B.	P.S.	B.	P.S.
(a) No treatment	37*	37†	12	—	—	—	52	38	101	75
(b) Treatment (medical, surgical, optical or ophthalmic medical supervision)	130‡	122=	38	20	—	—	96	97	264	239
(ii) Number of cases at (i) (b) above who received treatment ...	71	71	32	12	—	—	72	79	175	162

* Includes 6 cases of cataract with glaucoma.
† Includes 5 „ „ „ „ „
‡ Includes 42 „ „ „ „ „
= Includes 22 „ „ „ „ „

Table 72 Residential Accommodation—(National Assistance Act, 1948)

Under the scheme for residential accommodation the County Medical Officer is responsible for the general medical oversight of the following:

Establishment	Superintendent/Matron	Telephone Number	No. of Residents
The Shroggs, Skipton Road, Steeton	Mrs. M. Wallis-Bellmann	Steeton 53213	20
Farfield Hall, Bolton Road, Addingham	Mrs. S. A. Edwards	Bolton Abbey 241	35
Neville House, Neville Crescent, Gargrave	Mr. and Mrs. S. Blackburn	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

Establishment	Superintendent/Matron	Telephone Number	No. of Residents
Wharfedale Lawn, Westgate, Wetherby	Miss L. Oliver	Wetherby 2446	20*
The Grove, 80, High Street, Starbeck	Miss W. Smeaton	Harrogate 83980	19*
Springfield Garth, York Road, Boroughbridge	Mr. and Mrs. H. S. Topliss	Boroughbridge 2189	34
Fircroft, Wighill Lane, Tadcaster...	Mrs. L. McLaughlin	Tadcaster 3204	27
Woodfield House, Woodfield Square, Harrogate	Mr. and Mrs. E. Drake	Harrogate 68728	34
Thornton View, Thornton View Road, Pasture Lane, Clayton, Bradford	Mr. and Mrs. F. Innis	Queensbury 2007/8	191
Hillworth Lodge, Oakworth Road, Keighley	Mr. and Mrs. D. Moor	Keighley 4014	123
Woodville, Spring Gardens Lane, Keighley	Mrs. C. Robinson	Keighley 2428	20
Crow Trees, Leeds Road, Rawdon	Mrs. J. Mitchell	Rawdon 2908	20
Burley Hall, Burley in Wharfedale	Mrs. D. Carling	Burley in Wharfedale 2334	27
Park House, 41, Lister Lane, Bolton, Bradford 2... ...	Mr. and Mrs. F. T. Lovelady	Bradford 639913	22†
Moor Court, Fieldway, Ben Rhydding	Mr. and Mrs. C. A. Bennett	Ilkley 4734	34
Littlelands Court, Littlelands, Cottingley	Mr. and Mrs. T. Farrar	Bingley 5330	34
Manorfield House, Manor Road, Horsforth	Mr. and Mrs. G. Bevitt	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. E. Mather	Elland 2985	35
Stoneswood, Oldham Road, Delph	Miss V. Smith	Saddleworth 4300	20

* Women only † Men only

Establishment	Superintendent/Matron	Telephone Number	No. of Residents
Thornhill Grange, Hanson Road, Rastrick	Mr. and Mrs. W. Corbett	Brighouse 4810	44
Heathlands, Meal Hill Lane, Slaithwaite	Mr. and Mrs. J. L. Raine	Slaithwaite 2856	34
Longlands, Leeds Road, Lightcliffe	Mrs. E. G. Iddon	Halifax 21254	20
Scaitcliffe Hall, Burnley Road, Todmorden	Mrs. N. M. Harris	Todmorden 2814	24
Scissett Mount, Busker Lane, Scissett	Mr. and Mrs. J. G. Raby	Skelmanthorpe 3260	34
Belle Vue House, Belle Vue Road, Shelf	Mr. and Mrs. R. Glew	Bradford 679011	34
Fieldhead, Fieldway, Shepley	Mr. and Mrs. K. Dixon	Kirkburton 3369	34
Brig Royd House, Halifax Road, Ripponden	Mr. and Mrs. J. R. D. Clee	Ripponden 3374	34
Greenacres, Huddersfield Road, Meltham	Mr. and Mrs. A. J. Kershaw	Meltham 669	34
Stanley View, Park Lodge Lane, Wakefield	Mrs. S. Radley	Wakefield 71016	177
Beech Towers, Halifax Road, Staincliffe, Dewsbury ...	Mr. and Mrs. N. W. Jones	Dewsbury 5691	213
Knowl Park House, Crow Lees Road, Mirfield	Mr. and Mrs. M. McEwan	Mirfield 2583	34
Knowle Manor, Tennyson Terrace, Morley	Mr. and Mrs. J. Brown	Morley 4740	34
Walton House, Shay Lane, Walton	Miss M. Manterfield	Wakefield 55242	20
Home Lea House, Wood Lane, Rothwell	Mr. and Mrs. H. Roberts	Rothwell 3218	34
Turnsteads, Whitcliffe Road, Cleckheaton...	Miss J. E. L. Thwaites	Cleckheaton 2972	22
Brook Lodge, Brook Street, Selby	Mr. and Mrs. T. Bradley	Selby 2815	99
Northgate Lodge, Skinner Lane, Pontefract	Mr. and Mrs. G. H. French	Pontefract 3351/2	142

Establishment	Superintendent/Matron	Telephone Number	No. of Residents
Parklands, Station Road, Rawcliffe	Mr. and Mrs. N. Swan	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. G. Powell	Castleford 4110	34
Norman House, Attlee Street, Normanton	Mr. and Mrs. A. S. Huxley	Normanton 2366	34
Ferndale, Purston Park, Featherstone	Mr. and Mrs. C. W. Hutchinson	Pontefract 71642	34
Bullenshaw House, Bullenshaw Road, Hemsworth	Mr. and Mrs. R. A. Harris	Hemsworth 611622	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. G. Harrison	Castleford 3767	34
Boothferry House, Airmyn Road, Goole	Mr. and Mrs. M. J. Midgley	Goole 2471	34
Willow Grange, Fitzwilliam Street, Kinsley	Mr. and Mrs. E. Saddington	Hemsworth 610471	34
Grange Court, Church Lane, Garforth	Mr. and Mrs. H. Firth	Garforth 4845	34
Haynes House, Haynes Road, Thorne	Mr. and Mrs. C. Naylor	Thorne 3395	34
Don View, 22, Thellusson Avenue, Scawsby	Mr. and Mrs. W. R. Howells	Doncaster 62257	38
Rose House, Church Street, Armthorpe	Mr. and Mrs. M. Rogers	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

Establishment	Superintendent/Matron	Telephone Number	No. of Residents
Highfield, Woodsetts Road, North Anston	Mr. and Mrs. E. B. Stone	Dinnington 2593	34
Winterwell House, Dryden Road, West Melton ...	Mr. and Mrs. E. Bradley	Wath on Dearne 2096	34
Monkwood House, Whiteleys Avenue, Rawmarsh	Mr. and Mrs. W. Butler	Rawmarsh 2651	34
Howarth 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 2186	17*
Mortomley House, High Green	Mr. and Mrs. G. A. Smith	High Green 323	45
Oakwood, Back Lane, Royston	Mr. and Mrs. J. Wakeling	Royston 2752	34
Carlton House, Carlton Street, Cudworth	Mr. and Mrs. J. Lodge	Cudworth 389	34
Charnwood House, Charnwood Street, Swinton	Mr. and Mrs. J. Carroll	Mexborough 2236	34
Starbeck House, 35 Avenue Close, Starbeck	Mr. and Mrs. E. Hubbick	Harrogate 86940	34
Sowood Grange, Horbury Road, Ossett	Mr. and Mrs. J. Gant	Ossett 3105	34
Eddercliffe Grange, Littletown, Liversedge	Mr. and Mrs. R. C. Cost	Cleckheaton 4803	34
Yew Tree House, Askern Road, Bentley	Mrs. J. Allen	Doncaster 54620	34
Oldfield House, Oldfield Lane, Stainforth	Mr. and Mrs. V. Horne	Stainforth 753	34
Water Royd House, Gilroyd, Dodworth	Mr. and Mrs. A. Heathcock	Barnsley 81389	34
Kershaw Grange, Kershaw Crescent, Luddendenfoot ...	Mr. and Mrs. J. Ellis	Calder Valley 2506	34
Green Park House, High Street, Penistone	Mr. and Mrs. P. Hale	Penistone 2000	34
Havenfield, Highfield Road, Darfield	Mr. and Mrs. G. C. Waite	Wombwell 3111	34

* Women only

Establishment	Superintendent/Matron	Telephone Number	No. of Residents
Pannal Grange, Pannal Green, Pannal	Mrs. S. M. Phillips	Harrogate 89319	40
Ingrow Green, Staveley Road, Keighley	Miss E. Parker	Keighley 2954	34
Spring Gardens, Westbourne Grove, Otley	Miss M. C. Murphy	Otley 4497	40
Richmond House, Richmond Road, Farsley	Mrs. F. Schurmer	Pudsey 71533	40
Hazel Garth, Hazel Road, Knottingley	Mr. and Mrs. E. Hall	Knottingley 3455	40
Monument House, Chequerfield Estate, Pontefract ...	Mr. and Mrs. G. H. French	Pontefract 71427	40
Steadhaven, Skiers View Road, Hoyland	Mrs. S. G. Kenny	Barnsley 742650	40

Table 73 Registration and Inspection of Disabled and Old Persons' Homes—(National Assistance Act, 1948)

Establishment	Number of Residents	Type of Home *(Part I, II or III)
Congregation of Sisters of Charity of our Lady of Good and Perpetual Succour, St. Anne's Convent, Burghwallis, Doncaster	30	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	28	II
Mrs. M. L. Healey, 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
Mr. E. Fowler, Haversham Court, Ben Rhydding Road, Ilkley ...	26	III
Mr. and Mrs. I. B. McKnight, Gratton Home for Aged Ladies, 11, East View Terrace, Otley	16	I
Mrs. A. C. Shepley, Batley Hall, Upper Batley	13	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	108	II
Mr. J. N. and Mrs. A. M. Gill, The Gables, Norland, Sowerby Bridge	11	I
Mrs. E. M. Hall, Lansdown, 30, Westcliffe Grove, Harrogate ...	8	I
Mr. and Mrs. G. North, " 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 ...	9	I
Mr. Douglas Kneen, Thorpe House, Triangle, near Halifax	22	I
Mrs. D. M. Thompson, Brooklands, Harper Lane, Yeadon	6	I
Mrs. R. E. Higgins, Housley Manor, Housley Hall Lane, Chapeltown	18	I
Pentecostal Eventide Housing Association, Brooklands, Bakewell, Pentecostal Eventide Home, Bradford Road, Wrenthorpe	30	I
Mrs. N. E. Wilkinson, Granville House, Exley Road, Keighley ...	9	III
Mrs. A. G. Turner and Miss G. Carradice, Ghyll Court, The Wells Walk, Ilkley	22	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
Keighley and District Institution for the Blind, Home for the Blind, Westfield, Bromley Road, Bingley	16	II
Pentecostal Eventide Home, Aismunderby Close, Quarry Moor Lane, Ripon	20	I
Mrs. Dorothy Pearson, Thornlea Villas, Holme House Road, Cornholme, Todmorden	6	I
Mrs. L. Lawrence, Fearby House, 77, High Street, Starbeck, Harrogate	9	I
Mr. and Mrs. N. Stockle, Bankfield Guest House, Hollins Lane, Sowerby Bridge	13	I
Mrs. B. Townend, Lyndon, 30, Ripon Road, Harrogate	10	I
Pudsey Voluntary Committee for the Welfare of the Blind, Lynwood Centre and Residential Home, 18, Alexandra Road, Pudsey ...	9	II
Mrs. A. McConney, Beech Grove, Sutton in Craven	13	I

Establishment	Number of Residents	Type of Home *(Part I, II or III)
Sue Ryder Home for Concentration Camp Survivors, Hickleton Hall, Nr. Doncaster	35	III
Mrs. H. M. Dobson, Carr Farm, Darley, Nr. Harrogate	5	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	8	I
Mrs. D. Jervis, Straymeade, 38, York Place, Harrogate	15	I
Mr. and Mrs. T. H. Horsfall, The Woodlands, Gelderd Road, Gildersome	20	I
Mr. and Mrs. A. K. Sims, Oaklands, Turnshaw Road, Kirkburton, Huddersfield	26	III
Mrs. C. Holmes, Hill Crest, 40, Harlow Moor Drive, Harrogate	10	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	38	I
Mr. and Mrs. B. Auton, 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
Miss M. R. Murison, 10, Regal Flats, Clarence Drive, Harrogate	3	I
Mrs. P. H. Booth, Fellstow, 5, Clifton Road, Ilkley	17	I
The Management Committee of the West Riding Cheshire Homes, White Windows, Sowerby Bridge	35	III
Mr. A. S. Burch, Meralda Hotel, 13-15, Grove Road, Harrogate	15	I
Mrs. M. A. Lund, The Borrins, Station Road, Baildon	17	I
Mrs. J. M. Barker, Ivy Bank, 162, Highfield Lane, Keighley	5	I
Mr. A. J. and Mrs. A. S. Lee, Springfield, 3 Lowther Avenue, Garforth	15	I
Mrs. D. Wilson, Wilsonia Rest Home, 51, Tewitt Well Road, Harrogate	6	I
Mrs. M. G. Harker, North Villa House, 155, Skipton Road, Keighley	8	I
The Management Committee of the West Riding Cheshire Homes, Champion House, Clara Drive, Calverley, Pudsey	13	III
Mr. D. and Mrs. D. A. Hodgson, Ferndale Residential Home for the Elderly, Britannia Road, Morley	3	III
Clement Birkinshaw Home for the Elderly, Woolley Moor House, Woolley Moor, Near Wakefield	21	I
Mr. W. C. and Mrs. M. Snelling, Kingsley House Gentlefolk's Home, 40, Ripon Road, Harrogate	9	I
Mrs. E. M. and Mrs. J. M. Dutton, Mon Abri, 67 Kent Road, Harrogate	7	I
Harrogate Neighbour's Housing Association, Heath Lodge, 6 Pannal Ash Road, Harrogate	30	I
Mr. L. Stackhouse, Residential Home for the Retired, 62 York Place, Harrogate	10	I
Mrs. J. Pennington, Elmhurst, Hall Bank Drive, Bingley	3	I
Mrs. J. E. Priestley, Ivy House, 111 Moorhead Lane, Shipley	19	I
Mrs. A. Beck, Beckfield, Church Lane, Pudsey	8	I
Incorporated by Royal Charter 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 74 Registration of Nursing Homes

Div. No.	Name and Address of Nursing Home	Number of beds registered	
		Maternity	Other
1	" Christony ", Eshton Hall, Gargrave	—	48
3	Sunnybank, Braithwaite, Keighley	—	9
3	Norwood House, High Spring Gardens Lane, Keighley ...	—	14
5	Oak Bank, Outwood Lane, Horsforth	—	13
5	Jesmond, New Street, Farsley	—	7
5	St. Joseph's Convalescent Home, Outwood Lane, Horsforth...	—	45
5	Ardenlea, Queen's Drive, Ilkley (Marie Curie Memorial Foundation)	—	33
5	Hanford House, 22, Margerison Road, Ben Rhydding, Ilkley	—	7
7	Cavendish, 17, Cavendish Avenue, Harrogate...	—	17
7	Duchy House, 9, Queen's Road, Harrogate	—	35
7	The Pines, 57, Harlow Moor Drive, Harrogate	—	14
7	Norman Lodge, 58, Kent Road, Harrogate	—	29
7	Westfield, Killinghall, Harrogate	—	9
7	Courtfield, 3, St. James's Drive, Harrogate	—	14
7	Hereford, 16, Hereford Road, Harrogate	—	22
7	Strathroy, 115, Franklin Road, Harrogate	—	6
7	Kingsley, 38, Ripon Road, Harrogate	—	26
7	Ellangowan, 26, Queen's Road, Harrogate	—	16
7	Heatherwood, 17, Duchy Road, Harrogate	—	14
7	Clova, 1, Clotherholme Road, Ripon	—	21
7	Hampden House, 120, Duchy Road, Harrogate	—	46
7	Edenfield, 3, Tewit Well Road, Harrogate	—	32
7	Warwick, 10, Warwick Crescent, Harrogate	—	8
9	Cheshire Home, Spofforth Hall, Spofforth, Harrogate ...	—	28
15	Cheshire Home, Kenmore, Whitcliffe Road, Cleckheaton ...	—	27
20	Woodend, Atherton Street, Springhead	—	13

Table 75 The Medical Inspection of School Children

NUMBER OF PUPILS ON REGISTERS

	Boys	Girls	Total
Nursery	372	314	686
Primary	100,204	95,695	195,899
Secondary	60,306	57,483	117,789
Special Schools (Boarding)	252	111	363
Special Schools (Day)	552	483	1,035
Special Schools (Hospital)	33	25	58

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)
		Number Satisfactory	Number Unsatisfactory	
(1)	(2)	(3)	(4)	(5)
1966 and later ...	5,238	5,232	6	—
1965 ...	15,526	15,460	66	—
1964 ...	9,793	9,727	66	56
1963 ...	2,400	2,368	32	1,018
1962 ...	2,567	2,559	8	4,035
1961 ...	2,119	2,115	4	3,023
1960 ...	1,167	1,164	3	2,532
1959 ...	1,534	1,524	10	3,020
1958 ...	833	831	2	3,341
1957 ...	286	283	3	2,565
1956 ...	2,374	2,358	16	3,738
1955 and earlier ...	2,560	2,542	18	5,798
Total ...	46,397	46,163	234	29,126

Column (3) total as a percentage of Column (2) total ... 99·50

Column (4) total as a percentage of Column (2) total... 0·50

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	12,683
Number of Re-Inspections ...	5,287
Total ...	17,970

The number of children examined during 1970 shows a decrease on the 1969 figures:

Year	Periodics	Other Inspections	Number of pupils found not to warrant an examination on Selective Procedures
1969	51,765	21,498	27,915
1970	46,397	17,970	29,126

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
1966 and later	85	286	352
1965	393	1,235	1,534
1964	268	809	1 019
1963	68	181	239
1962	132	428	525
1961	110	269	365
1960	56	104	154
1959	109	181	272
1958	70	107	163
1957	24	34	53
1956	154	288	424
1955 and earlier	191	269	456
Total	1,660	4,191	5,556

Table II

Infestation with Vermin

(i)	Total number of individual examinations of pupils in schools by the school nurses or other authorised persons	446,376
(ii)	Total number of individual pupils found to be infested	10,292
(iii)	Number of individual pupils in respect of whom cleansing notices were issued (Section 54(2), Education Act, 1944)	368
(iv)	Number of individual pupils in respect of whom cleansing orders were issued (Section 54(3), Education Act, 1944)	32

The percentage of infested pupils found during 1970 was 3·20 as opposed to a percentage of 2·30 in 1969.

TABLE III

DEFECTS FOUND BY MEDICAL INSPECTION IN THE YEAR ENDED 31ST DECEMBER, 1970

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	203	647	175	130	520	980	265	254
5	Eyes—a. Vision	794	1,503	345	372	1,620	2,377	366	1,383
	b. Squint	335	590	3	41	408	746	77	283
	c. Other	24	124	6	37	45	212	20	45
6	Ears—a. Hearing	265	824	51	76	482	1,258	265	554
	b. Otitis Media	94	562	25	33	161	710	63	172
	c. Other	51	118	10	6	77	148	54	48
7	Nose and Throat	344	1,498	50	87	539	1,888	143	599
8	Speech	306	810	7	9	402	960	209	263
9	Lymphatic Glands	21	512	1	8	24	561	18	88
10	Heart	80	459	12	38	113	619	21	278
11	Lungs	123	631	20	83	222	920	66	336
12	Developmental—								
	a. Hernia	59	105	1	1	77	130	8	42
	b. Other	64	782	34	25	162	968	51	293
13	Orthopædic—								
	a. Posture	14	94	1	19	23	145	8	65
	b. Feet	145	674	33	43	253	884	84	304
	c. Other	78	342	16	84	132	528	72	230
14	Nervous System—								
	a. Epilepsy	32	99	6	21	68	192	50	83
	b. Other	49	513	15	37	132	700	46	194
15	Psychological—								
	a. Development	37	308	6	17	105	513	378	393
	b. Stability	37	677	7	38	104	1,018	367	560
16	Abdomen	28	143	11	21	67	227	19	68
17	Other	235	901	55	51	429	1,161	116	680

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.

	Number of cases known to have been dealt with
Group 1. Eye Disease, Defective Vision and Squint	
External and other, excluding errors of refraction and squint	285
Errors of refraction (including squint)	18,503
Total	18,788
Number of pupils for whom spectacles were prescribed	6,259
	Number of cases known to have been treated
Group 2. Diseases and Defects of Ear, Nose and Throat	
Received operative treatment:	
(a) for diseases of the ear	174
(b) for adenoids and chronic tonsillitis	1,239
(c) for other nose and throat conditions	263
Received other forms of treatment	254
Total	1,930
Total number of pupils in schools who are known to have been provided with hearing aids:	
(a) in 1970	39
(b) in previous years	280
Group 3. Orthopædic and Postural Defects	
(a) Pupils treated at clinics or out-patient departments	563
(b) Pupils treated at school for postural defects	77
Total	640

	Number of cases known to have been treated
Group 4. Diseases of the skin (excluding uncleanliness for which see Table II)	
Ringworm—(a) Scalp	13
(b) Body	15
Scabies	594
Impetigo	306
Other skin diseases	717
Total	1,645
Group 5. Child Guidance Treatment	
Number of pupils treated at Child Guidance clinics under arrangements made by the Authority	2,237
Group 6. Speech Therapy	
Number of pupils treated by Speech Therapists under arrangements made by the Authority	2,852
Group 7. Other Treatment Given	
(a) Number of cases of miscellaneous minor ailments treated by the Authority	1,241
(b) Pupils who received convalescent treatment under School Health Service arrangements	20
(c) Pupils who received B.C.G. vaccination	17,839
(d) Other:	
1. Ultra Violet Light Treatment	13
2. Audiology	130
3. Abdominal defects	6
4. Chest and Heart	68
5. Miscellaneous	242
Total (a)—(d)	19,559

Table 76 Care of the Handicapped Pupil

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	6	6	—	47	—	—	3	—
Partially Sighted	12	7	30	23	—	—	2	1
Deaf	10	16	55	101	—	—	5	—
Partially Hearing	9	8	39	47	—	—	3	—
Delicate	40	66	64	86	1	—	9	—
*Physically Handicapped ...	60	43	100	121	1	14	29	26
Educationally Subnormal ...	254	327	1,276	244	—	16	285	—
Maladjusted	35	38	2	71	26	7	40	2
Epileptic	4	3	—	19	—	—	2	1
Speech Defects	2	1	—	2	—	—	1	1
Totals	432	515	1,566	761	28	37	379	31

* Excluding children sent to or awaiting places in hospital schools.

Table 77 Audiology Clinics

Summary of Work Carried Out

Otley Clinic

Number of Sessions held	7
Number of Individual Children attending	
(a) Referred for first time in current year...	14
(b) Also attended in previous year	5
Total	19
Total number of attendances made	21
Areas from which referred (i.e. number from each Division)	
Division No. 5	19
Total	19
Ages of children referred	
Under 1	—
1—2 years	—
2—5 years	5
5—8 years	6
8—11 years...	5
11+ years	3
Results of Clinical Investigation	
Number of children with significant hearing loss	7
Number of children without significant hearing loss	12
Recommendations	
Hearing aid...	1
To sit in front of class	2
Speech Therapy	1
School for Deaf	1
School for Partially Hearing	—
School for Speech Defects	—
Myringotomy and T's and A's at Harrogate Hospital ...	6

Number of Sessions held	33
Number of Individual Children attending	
(a) Referred for first time in current year...	80
(b) Also attended in previous year	50
Total	130
Total number of attendances made	143
Areas from which new cases referred (i.e. number from each Division)	
Division No. 11	2
Division No. 12	6
Division No. 23	1
Division No. 25	1
Division No. 26	3
Division No. 27	61
Division No. 29	2
Division No. 31	4
Total	80
Ages of children referred in current year	
Under 1	2
1—2 years	9
2—5 years	13
5—8 years	34
8—11 years...	15
11+ years	7
Results of Clinical Investigation	
Number of children with significant hearing loss	61
Number of children without significant hearing loss	60
Number of children at present undiagnosed	9
Recommendations	
Hearing aid...	10
Front seat in class...	10
Speech therapy	6
School for the Deaf	2
School for the Partially Hearing	1
Referred to E.N.T. Consultant	31
For Supervision for Peripatetic Teacher	23
To be seen by Psychologist	28
To spend half a day in the Nursery Department of the Y.R.S.D.	12

Table 78 The Work of the Psychologists

Children Seen

Maladjusted

Age Range

	Below 5	5—7+	8—10+	Over 11	Totals
Boys ...	16	123	185	203	527
Girls ...	10	48	55	76	189
Totals ...	26	171	240	279	716
% age ...	3·6	23·9	33·5	39·0	

Symptoms on Referral

	Nervous	Behaviour	Habit	Others	Totals
Boys ...	110	358	40	19	527
Girls ...	52	117	14	6	189
Totals ...	162	475	54	25	716
% age ...	22·6	66·3	7·6	3·5	

Children with Handicaps other than Maladjustment referred for Psychological Assessment

Age Range

	Below 5	5—7+	8—10+	Over 11	Totals
Boys ...	78	249	257	133	717
Girls ...	32	128	124	40	324
Totals ...	110	377	381	173	1,041
% age ...	10·5	36·2	36·6	16·7	

Type of Handicap

	Vision	Hearing	Speech	Motor	Learning	General Back-wardness	Others	Totals
Boys ...	14	52	43	30	293	270	15	717
Girls ...	5	25	7	16	99	158	14	324
Totals	19	77	50	46	392	428	29	1,041

VISITS

Schools	Special Schools	T.C.	Homes	Observation Centres	Aud. Clinics	Others
693	124	24	84	29	41	37

Table 79 School Ophthalmic Service, 1956-70

Year	No. of children examined (including re-examinations)	No. prescribed glasses
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
1967	20,167	7,649
1968	20,725	7,747
1969	20,052	7,221
1970	18,788	6,259

Table 80 Medical Treatment at Local Authority Clinics

Type of Clinic	Number
Minor Ailment and other non-specialised	154
Dental	59
Ophthalmic	59
Speech Therapy	56
Ultra Violet Light	2
Pædiatric	10
Chiropody	2
Consultant E.N.T.	—
Consultant Orthopædic	3
Consultant Dermatology	—
Consultant Cardiac	—
Orthoptic	7
Remedial Exercises	2
Audiology	1
Immigrants	13
Enuretic	85
School Medical Officers' Special Examination	

Table 81 Consultant Services

Consultant E.N.T. Service

No. of sessions held: 97

	Pre-school Children	School Children	Total
No. of individual children seen by consultant, including those continuing attendance from previous year	13	274	287
No. of above referred for operative treatment	6	121	127
No. of children:			
(a) who obtained operative treatment ...	5	293	298
(b) treated at school clinics	2	38	40
No. of attendances at consultant clinics ...	26	555	581

Consultant Orthopædic Service

Consultant Clinics

No. of sessions held: 137

No. of individual patients seen by consultant, including those continuing attendance from previous year	457	560	1,017
No. of above:—			
(a) referred for operative treatment as short stay cases only	5	11	16
(b) recommended long-stay hospital school	—	—	—
(c) recommended treatment by orthopædic nurse or physiotherapist:—			
(i) at treatment centres	6	26	32
(ii) domiciliary	15	7	22
No. of children who obtained operative treatment	42	84	126
Total number of attendances at consultant clinics	601	773	1,374

Treatment Centres

No. of sessions held: 608

Total No. of patients treated, including cases continuing treatment from previous year ...	43	219	262
Total number of attendances	451	2,457	2,908

Domiciliary Treatment

	Pre-school Children	School Children	Total
Total number treated	6	—	6
Total number of visits to patients' homes ...	6	—	6

Appliances

No. of appliances—			
(a) recommended	92	22	114
(b) obtained	84	18	102

Physiotherapy Service

At the end of the year the staff aggregated the equivalent of 0·81 whole-time officers.

Ultra-Violet Light Clinics

Clinics are held in only two Divisions.

Number of sessions held: 105

Number of children treated during the year ...	2	25	27
Total number of attendances	81	430	511

Consultant Pædiatric Service

Consultant Clinics

No. of sessions held: 64

No. of individual patients seen—			
(a) New cases	46	45	91
(b) Cases attending from previous year(s) ...	50	129	179
Total number of attendances at clinics ...	112	230	342

The following table gives details of the various types of defect or disease for which children were referred for consultant opinion:

Defect or Disease	Pre-School Children	School Children	Total
Central Nervous System: General	4	8	12
Epilepsy	5	9	14
Migraine	2	—	2
Other defects...	—	—	—
Heart and Circulatory System	13	62	75
Respiratory System, including E.N.T. defects	3	27	30
Speech	1	5	6
Orthopædic	1	4	5
Scaphocephaly	—	1	1
Cerebral Palsy	—	1	1
Skin	—	—	—
Psychological: General	—	4	4
Enuresis	—	10	10
Behaviour	—	1	1
Mental Retardation, including Educational Subnormality	9	5	14
Congenital Deformities	5	9	14
Gastro-intestinal System	2	2	4
Genito-urinary System	1	5	6
Glands	—	—	—
Nutritional	3	4	7
Developmental: General	19	17	36
Incontinence	—	4	4
Genetic undersize	—	—	—
Muscular Disease	—	—	—
Habit Spasms	—	2	2
Rheumatism	—	—	—
Obesity	—	2	2
Degeneration of macula and optic atrophy...	—	—	—
Unclassified	10	3	13

Table 82 Cleanliness, 1952-70

Year	Total number of examinations made by school nurses	Number of individual children found to be infested	Percentage of school population
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
1967	455,124	7,119	2·4
1968	446,713	7,980	2·6
1969	425,329	7,243	2·3
1970	440,376	10,292	3·2

In some areas a system of 'Selective' inspections has been introduced as suggested in *The Health of the School Child*, 1962/63.

Table 83 Nutrition, 1959-70

Year	Total number of pupils inspected	Classification			
		Satisfactory		Unsatisfactory	
		No.	% of Col. 2	No.	% of Col. 2
(1)	(2)	(3)	(4)	(5)	(6)
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
1967	68,382	68,264	99·83	118	0·17
1968	59,315	59,187	99·78	128	0·22
1969	51,765	51,645	99·77	120	0·23
1970	46,397	46,163	99·50	234	0·50

SCHOOL MEALS

The number of meals provided to school children daily according to a check made in September, 1970, was 210,416 compared with 209,484 in September, 1969. This represents 72·46 per cent. of children in attendance.

Table 84 Protection of School Children Against Tuberculosis

TUBERCULIN TESTING OF SCHOOL ENTRANTS

Health Division	No. tested	Negative reactions	Positive reactions	Of column (d)		Further investigation
				Previous B.C.G. Vaccination	Final Skin Test	
(a)	(b)	(c)	(d)		— +	
Keighley (Heaf Test)	740	731	9	6	— 3	Referred to Chest Physician.

Table 85 Speech Therapy

(a) Number of children seen for the first time during the year	1,420	
(b) Number of children attending for treatment from previous year ...	1,491	
	2,911	
Number of children awaiting treatment at end of year	735	
(a) Interviewed and placed on waiting list	438	
(b) Not seen	450	
Number of visits made to schools	527	
Number of home visits	259	
Analysis of children treated	*Boys*	*Girls*
Stammerers (Dysrhythmia)	246	69
Defects of Articulation due to:		
(a) Cleft Palate	41	24
(b) Cerebral Palsy	22	8
(c) Other structural malformations	48	28
(d) Other causes e.g. neurological	96	29
(e) No specific cause found	1,094	458
Disorders of Language due to:		
(a) Retarded language development (non-specific)	276	128
(b) Retardation with associated subnormality	151	65
(c) Retardation associated with deafness	42	36
(d) Dysphasia	18	7
(e) Aphasia	5	1
(f) Other reason	22	11
Dysphonia	16	4
Other Defects	11	6

Table 86 Dental Inspections and Treatment Carried Out

Attendances and Treatment

	Ages 5 to 9	Ages 10 to 14	Ages 15 and over	Total
First visit	28,077	26,330	5,562	59,969
Subsequent visits	33,486	63,112	14,072	110,670
Total visits	61,563	89,442	19,634	170,639
Additional courses of treatment commenced	1,724	2,014	541	4,279
Fillings in permanent teeth ...	35,821	83,252	21,403	140,476
Fillings in deciduous teeth ...	20,553	1,485	—	22,038
Permanent teeth filled	27,312	69,237	19,056	115,605
Deciduous teeth filled	18,987	1,383	—	20,370
Permanent teeth extracted ...	2,528	10,815	2,268	15,611
Deciduous teeth extracted ...	40,398	11,238	—	51,636
General anæsthetics	14,358	7,112	758	22,228
Emergencies	2,600	1,233	249	4,082

Number of Pupils X-rayed	3,542
Prophylaxis	18,452
Teeth otherwise conserved	2,157
Number of teeth root filled	252
Inlays	90
Crowns	477
Courses of treatment completed... ...	50,614

Orthodontics

New cases commenced during year ...	1,275
Cases completed during year	1,052
Cases discontinued during year	129
Number of removable appliances fitted...	2,478
Number of fixed appliances fitted ...	114
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)...	3	6	5	14
Pupils supplied with other dentures (first time)	35	234	108	377
Number of dentures supplied	53	364	189	606

Anæsthetics General Anæsthetics administered by Dental Officers ... 21,433

Inspections

(a)	First inspection at school. Number of Pupils	172,194
(b)	First inspection at clinic. Number of Pupils	18,979
	Number of (a) + (b) found to require treatment	108,186
	Number of (a) + (b) offered treatment	94,960
(c)	Pupils re-inspected at school or clinic	15,874
	Number of (c) found to require treatment	7,921

Sessions

Sessions devoted to treatment	23,669*
Sessions devoted to inspection	1,214
Sessions devoted to Dental Health Education ...	336

*Includes 1,542 Anæsthetic sessions

FOOD AND DRUGS ACT, 1955

Report of County Analyst

During the year, 2,763 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	1,034	28	2·7
Milk 'Appeal to Cow' ...	13	1	7·7
Milk, Channel Islands ...	153	3	1·9
Food and Drugs	1,563	56	3·6
All samples	2,763	88	3·2

NOTES ON ADULTERATED OR OTHERWISE IRREGULAR SAMPLES:

The proportion of adulterated or irregular samples is slightly below that of last year.

Milk. Out of 1,034 samples, 28 were unsatisfactory; nine of these were deficient in fat in amounts varying from 2·0 to 20·6 per cent. Nineteen samples contained extraneous water varying from 1·2 to 62·7 per cent. Another was 20·3 per cent. deficient in fat and also contained 10·2 per cent. extraneous water.

'*Appeal to Cow*' *Milk Samples* being taken under official supervision are normally genuine. Out of 13 samples taken, one was declared to be adulterated by 13·6 per cent. of extraneous water. A second visit to the farm confirmed that a quantity of water had been lodged in the pipework of the milking machine.

Channel Islands Milk must contain not less than 4·0 per cent. of fat. Three samples were below standard, with only 3·38, 3·69, and 3·80 per cent. of fat, the first named sample also contained 3·5 per cent. of extraneous water.

Pork Sausages. Seven samples out of 97 were deficient in meat. Instead of the required 65 per cent. of meat, the meat content of these ranged from 59·4 to 64·0 per cent. One of these, and two other samples were irregular in that they contained preservative without proper declaration of the fact. The average meat content of the 97 samples was 71·8 per cent., the highest 95·3 per cent., and the lowest 59·4 per cent.

Beef Sausages. All 62 samples tested were correct as regards meat content. One sample contained 520 parts per million of sulphur dioxide thus exceeding the limit of 450 parts per million. The average meat content was 64·0 per cent., the highest 86·9 per cent., the lowest 50 per cent.

Curried Casserole Vegetables and Lamb must contain not less than 35 per cent. of meat. We found two samples with only 24 and 31 per cent. respectively.

Soft Drinks, including Shandy and Shandy-type Drinks. Cyclamic acid may not now be used to sweeten soft drinks. Three samples were found to contain this artificial sweetener. Another contained saccharin without the required declaration of its use.

As yet there is no legal standard for the alcohol content of shandy, but the Labelling of Food Regulations, 1970, will require shandies to contain between 1·5 and 2·0 per cent. of proof spirit; this will come into force on January 1st, 1973. Most manufacturers are working to this standard already. Only one sample was below the limit, containing 1·3 per cent. proof spirit. Three other samples contained excessive amounts of alcohol, owing to secondary fermentation of the sugars.

Although some manufacturers maintain that shandy-type drinks such as lime cordial and lager are not shandies, it is my belief that they should be covered by the same standard for alcohol content. We found two samples of lime cordial and lager with only 1·2 and 1·26 per cent. proof spirit; four others contained 1·5 per cent. or more.

Malt Vinegar and Non-Brewed Condiment must contain at least 4·0 per cent. of acetic acid. Two samples of malt vinegar contained only 3·4 per cent. and two samples of non-brewed condiment contained only 3·25 and 3·3 per cent.

Drugs. Over 100 samples of drugs were analysed, and only two were unsatisfactory. A sample of rose hip and vitamin C tablets was badly deficient in vitamin C, and the label was in irregular form. Purified Borax B.P. failed to comply with the required standard and also bore an irregular label.

Preserves. Out of 69 samples of preserves, only two were below standard, both as regards soluble solids. This means that their sugar content was deficient, and would adversely affect their keeping qualities.

Tinned New Potatoes. One sample contained an excessive amount of sulphur dioxide preservative.

Golden Raising Powder. In order to maintain a proper balance of bicarbonate of soda and the acid ingredient, the relevant Food Standards Order stipulates that this commodity shall not have more than 1·5 per cent. residual carbon dioxide. One sample contravened this Order.

Labelling Offences:

Hundreds of labels were examined and only 11 were criticised. There were cheeses sold without proper declaration of type, and tins of fruit, vegetables, etc. with lists of ingredients not in the prescribed form. Pickled onions contained preservative but there was no declaration of the fact. A sample of American rice made a general claim to contain vitamins and minerals; such general claims are forbidden—they must be quite specific, stating the quantities per ounce.

Mouldy Food:

Samples of cheese, confectionery and skinless sausages were amongst samples condemned. A tin of pork shoulder was opened, and the contents were mouldy and evil-smelling. Close examination revealed the cause—there had been corrosion along a ridge in the base of the tin, producing a fine slit in the metal, admitting air, mould spores and bacteria.

A transparent packet of potato crisps was submitted for examination. The packet was intact and yet the contents were soft and mouldy. The cause of the spoilage was a lump of half-cooked potato containing a large proportion of moisture. This had spread its moisture to the contents of the packet, and encouraged the growth of mould.

Foreign Matter in Food:

Some examples of 'foreign matter' are of slight importance, others are more serious and dangerous.

Several samples of white loaves had brown streaks within them—the streaks were only traces of brown bread dough from the mixing and kneading machinery. One contained black specks—simply crumbs of burnt bread which had been left in the loaf tin. In another loaf there were tufts of fibres from some fabric.

Dark stains on processed cheese were caused by corrosion on the inside of the tinplate container.

There was a moth embedded in the pastry of an almond tart, and a fly in a tin of chopped pork.

The purchaser of a bar of chocolate was shocked to find a dead grub inside the packet—it was a larva of the cocoa moth, and it had gnawed and scraped the surface of the chocolate and left debris including webbing and fæcal pellets.

Whilst consuming a faggot, the purchaser found a sharp sliver of aluminium inside it.

KEIGHLEY EXCEPTED DISTRICT

V. P. McDonagh, Borough School Medical Officer

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.

Again we have to report that there is no ophthalmologist available to the pupils at the school clinic although towards the end of the year there were some signs that an appointment of such a consultant may be made. This is an important service and we look forward eagerly to this appointment.

The joint assessment clinic recently started at Airedale General Hospital is a pointer to the way we believe pædiatric work of the future will develop. Now there are joint consultations between all the professional staff who are concerned with a child's health and future. In this way also any possibility of overlap or miscarriage of information is eradicated. The importance of the work of the school physiotherapist should not be forgotten. Cases are being referred to him by the consultant pædiatrician and consultant orthopædic surgeons at Airedale so that treatment can be carried out at a convenient time near to the school and in association with other children.

Child guidance work continues to occupy the major part of the time of one senior departmental medical officer, together with the other members of the team. The investigations of the psychologists referred to in the last report were continued during the year and the summary of their findings makes interesting reading. Once again it is necessary to refer to the large number of children who have been recommended for special education in the ordinary school but for whom there is as yet no remedial centre. It is believed that this kind of provision is vital to the child's full development.

While the area dental officer reports that the dental health of school children is improved he nevertheless goes on to observe that this could be a great deal better if the public water supply were fluoridated. There is no doubt that as the years go on the volume of evidence in support of this important preventive measure against dental decay becomes more and more convincing.

The 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:

	1970	*1969*
Nursery	188	43
Primary	5,710	5,603
Middle Schools ... ... (including Secondary Technical)	1,985	1,910
Voluntary Secondary	552	552
Upper Schools	1,413	1,529
Special Schools	99	96

TABLE I

MEDICAL INSPECTION OF PUPILS ATTENDING MAINTAINED PRIMARY AND SECONDARY SCHOOLS (INCLUDING NURSERY AND SPECIAL SCHOOLS)

A. Periodic Medical Inspections

Age groups inspected (by year of birth), number of pupils who received a full medical examination together with 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 disease 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
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1966 and later	108	108	—	—	1	19	20
1965	636	636	—	—	16	154	159
1964	184	184	—	—	6	49	54
1963	2	2	—	—	—	1	1
1962	256	256	—	438	7	114	117
1961	69	69	—	84	4	19	21
1960	—	—	—	—	—	—	—
1959	—	—	—	—	—	—	—
1958	—	—	—	—	—	—	—
1957	—	—	—	683	—	—	—
1956	—	—	—	101	—	—	—
1955 and earlier	—	—	—	—	—	—	—
TOTAL	1255	1255	—	1306	34	356	372

Column (3) total as a percentage of Column (2) total ... 100·00%
Column (4) total as a percentage of Column (2) total ... 0·00%

B. Other Inspections

Number of Special Inspections	...	1,691
Number of Re-Inspections	...	747
Total	...	2,438

Comparative Table of Inspections carried out:

Year	Routine	Specials	Re-Inspections
1970	1,255	1,691	747
1969	1,293	1,911	930
1968	1,313	1,963	1,074
1967	1,354	1,629	1,033
1966	1,805	1,918	834

SELECTIVE SCHEME:

The selective scheme of medical examination of pupils in the intermediate age group has continued as described in previous reports. During the year 847 questionnaires were distributed of which 819 were returned and 325 of these pupils were invited to attend for a medical examination. Details of the defects found are shown in Table III.

School leaving examination of pupils during their last year of compulsory school attendance:

The selective scheme of examination of school leavers was continued in 1970 following the instigation of this procedure in 1967. Questionnaires were distributed to parents of school leavers for completion and return. These were scrutinised together with all the available medical records. At the medical 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.

Seven hundred and eighty-four pupils were interviewed in accordance with the provisions of this scheme. In no case, however, was it found necessary to invite a pupil to attend the school clinic for a fuller medical examination.

CONSULTING SESSIONS:

Consulting sessions are held twice weekly at the school clinic by a senior departmental medical officer. Appointments are given to parents, following school medical inspections, to bring their children to the school clinic for investigation and consultation if this is requested by the parents or advised by the

senior departmental medical officer who has carried out the medical inspections in school. Pupils are also referred to these clinics by teachers, education welfare officers or are brought by the parents themselves for examination and consultation for a variety of health problems.

The poor school attender is referred frequently for the problem to be assessed and for decisions to be made regarding treatment, the need for special educational placement or for reassurance that a child is fit to attend school regularly.

Parents who are concerned about their child's general health, behaviour difficulties or disorders such as nocturnal enuresis frequently seek the advice of the senior departmental medical officer. If further investigation is considered to be necessary referral is made appropriately either to the family doctor, to a specialist, or to the child guidance clinic. Pupils attend the clinic for advice concerning ear, nose and throat conditions, chest, orthopædic and skin conditions.

This consulting service is also available to pre-school children.

Table II

Infestation with Vermin

(a)	Total number of individual examinations of pupils in schools by the school nurses or other authorised persons	21,152
(b)	Total number of individual pupils found to be infested... ...	790
(c)	Number of individual pupils in respect of whom cleansing notices were issued (Section 54(2), Education Act, 1944)	—
(d)	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

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 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	3	1	—	—	4	—	7	1	185	4
5	Eyes–a. Vision ...	23	3	—	—	11	—	34	3	36	11
	b. Squint ...	37	2	—	—	7	—	44	2	35	2
	c. Other ...	—	2	—	—	—	—	—	2	13	—
6	Ears–a. Hearing ...	28	2	—	—	33	4	61	6	156	49
	b. Otitis Media	2	—	—	—	1	—	3	—	35	2
	c. Other ...	29	—	—	—	6	1	35	1	41	1
7	Nose and Throat ...	34	9	—	—	23	—	57	9	68	13
8	Speech	29	5	—	—	9	—	38	5	113	9
9	Lymphatic Glands ...	—	1	—	—	—	—	—	1	16	2
10	Heart...	6	—	—	—	2	2	8	2	5	25
11	Lungs	9	—	—	—	9	6	18	6	33	7
12	Developmental–										
	a. Hernia ...	4	—	—	—	—	—	4	—	—	—
	b. Other ...	6	—	—	—	—	—	6	—	3	2
13	Orthopædic–										
	a. Posture ...	1	—	—	—	—	—	1	—	1	—
	b. Feet ...	4	—	—	—	3	1	7	1	29	2
	c. Other ...	23	—	—	—	5	—	28	—	52	4
14	Nervous System–										
	a. Epilepsy ...	4	4	—	—	4	1	8	5	35	5
	b. Other ...	2	1	—	—	1	—	3	1	2	1
15	Psychological–										
	a. Development	5	8	—	—	19	9	24	17	308	102
	b. Stability ...	5	8	—	—	21	9	26	17	291	83
16	Abdomen	1	—	—	—	2	1	3	1	8	—
17	Other...	37	1	—	—	35	6	72	7	39	7
18	Totals	292	47	—	—	195	40	487	87	1,504	331

T = Pupils found to require treatment O = Pupils found to require observation

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	
	1970	1969
External and other, excluding errors of refraction and squint ...	13	45
Errors of refraction (including squint)	—	440
Total	13	485
Number of pupils for whom spectacles were prescribed	—	206

Due to circumstances beyond our control the services of a consultant ophthalmologist were not available to pupils at the school clinic. Pupils requiring an ophthalmic examination during the year were referred to their family doctors for the examination to be arranged.

Screening Tests of Vision:

A vision screening test was carried out as part of the school entrant examination and routine tests of visual acuity were repeated in the 6-7, 10-11, 12-13 and 14-15 year age groups. A colour vision test was also undertaken in the 10-11 year age group and repeated if necessary in the older age groups. These tests are carried out by the assistant health visitors/school nurses and have been greatly facilitated by the use of the Keystone vision screening apparatus which has been particularly successful with school entrants.

General:

During the year 13 cases suffering from conditions of the eyes such as blepharitis and conjunctivitis were treated at the minor ailments clinic.

The number of repairs to and replacements of spectacles amounted to 150.

B. Diseases and Defects of Ear, Nose and Throat:

	Number of cases known to have been dealt with	
	1970	1969
Received operative treatment:		
(a) for diseases of the ear	—	—
(b) for adenoids and chronic tonsillitis	—	—
(c) for other nose and throat conditions	—	—
Received other forms of treatment	108	83
Total	108	83
Total number of pupils still on the register of schools at 31st December, 1970 known to have been provided with hearing aids:		
(a) during the calendar year 1970	1	
(b) in previous years	7	

SCREENING TESTS OF HEARING:

The routine audiometric testing of seven year old pupils was carried out by the assistant health visitors/school nurses during the year, together with the examination of pupils in the 'at risk' categories.

Following the audiometric sweep test of pupils in school a weekly clinic is held where pupils who fail the test are seen by appointment for the purpose of obtaining an audiogram and medical history. A further weekly clinic is held when a senior departmental medical officer is available to conduct an aural examination and select cases for referral to the consultant otologist. The family doctors are informed in the usual way or cases are referred to them in the instances where this is desired. There is good communication between the senior departmental medical officers, family doctors and consultant otologist.

Referral to the child guidance clinic is easily effected so that advice re educational requirements or emotional problems associated with hearing loss is readily available.

Fifty pupils in attendance at Keighley schools are suffering from a bilateral hearing loss of 30 decibels or more. Hearing aids have been prescribed for eight of these pupils.

Pupils who are suffering from a bilateral hearing loss of 30 decibels or more and who are in attendance at the ordinary school are examined by the psychologist to assess their educational progress and needs for special educational help. As a result of these examinations it is found that partially hearing pupils are very much in need of the services of a specialist teacher of the deaf.

Pupils Tested by Pure-Tone Audiometry

	Number Tested	No appreciable hearing loss	Referral for investigation	Already attending Otologist
'At risk' categories				
(i) deafness in the family ...	13	6	6	1
(ii) prenatal causes:				
maternal rubella	–	–	–	–
other conditions	–	–	–	–
(iii) perinatal causes *e.g.* toxæmia, anoxia, kernicterus, rhesus incompatability, prematurity, etc.	–	–	–	–
(iv) postnatal:				
congenital defects ...	–	–	–	–
cerebral palsy	–	–	–	–
middle ear disease ...	37	14	20	3
meningitis or encephalitis	–	–	–	–
speech retardation or defect	10	9	–	1
educational retardation ...	44	41	3	–
Routine test on children in 6/7 year age group	1,116	1,091	18	7
Referred for possible hearing loss...	93	60	26	7
	1,313	1,221	73	19

C. Orthopædic and Postural Defects:

	Number of cases known to have been dealt with	
	1970	1969
(a) Pupils treated at clinics or out-patient departments ...	142	119
(b) Pupils treated at school for postural defects	—	—
Total ...	142	119

JOINT ASSESSMENT CLINIC:

Following the opening of Airedale General Hospital a joint assessment clinic has been held bi-monthly at the hospital with the senior departmental medical officers, physiotherapists, speech therapist, Dr. Morgan, consultant pædiatrician and Mr. Cape, consultant orthopædic surgeon. This clinic enables all persons concerned with the care and treatment of physically handicapped children to exchange opinions on the individual cases and should prove advantageous to the patients and professional staff.

PHYSIOTHERAPY:

In addition to the usual remedial work, the school clinic physiotherapist has continued to treat severely physically handicapped children at the clinic. As formerly treatment at the swimming baths has continued for physically and emotionally handicapped children and assistance has been given with the children from Whinburn Special School at their swimming class. The results from both classes have proved most satisfactory during the year and fully justify the time and effort put into them.

The monthly orthopædic clinic continued under the care of Dr. McNae until October, 1970.

The following shows details of the work undertaken by the physiotherapist.

School Children	No. of Cases	Attendances
Asthma	1	1
Breathing	56	867
Cerebral palsy (spastic)	5	23
Cerebral palsy (other)	10	149
Curly toes	7	125
Foot exercises	32	438
Manipulations	6	53
Muscular dystrophy	4	47
Posture	6	31
Remedial exercises	10	85
Round shoulders	1	22
Scoliosis	–	–
Spina bifida	4	33
Pre-school Children		
Cerebral palsy	6	103
Curly toes	2	5
Foot exercises	4	74
Manipulations	1	2
Remedial exercises	1	3

CONSULTANT ORTHOPAEDIC CLINIC:

Number of sessions held ... 9

	Pre-school Children	School Children
Number of individual patients seen by consultant, including those continuing attendance from previous year	17	81
Number of above—		
(a) referred for operative treatment as short-stay cases only	—	—
(b) recommended long-stay hospital school	—	—
(c) recommended treatment by orthopædic nurse or physiotherapist—		
(i) at treatment centres	—	6
(ii) domiciliary	—	—
Number of children who obtained operative treatment during the year	—	—
Total number of attendances at consultant clinic	21	84

Treatment Centres:

Number of sessions held	438	
Total number of patients treated (including cases continuing treatment from previous year)	14	142
Total number of attendances	187	1,874

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 uncleanliness for which see Table II):

	Number of cases known to have have been treated	
	1970	1969
Ringworm—(a) Scalp	—	—
(b) Body	—	—
Scabies	110	227
Impetigo	68	91
Other skin diseases	189	212
Total	367	530

It will be seen from the figures that the incidence of scabies has increased during the year. 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 visitors/school nurses. 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. The incidence of impetigo which has also increased has occurred largely as a secondary complication of other skin diseases.

A weekly clinic is held for the treatment of plantar warts.

E. Child Guidance Treatment:

	Number of cases known to have been treated	
	1970	1969
Pupils treated at Child Guidance Clinics	208	213

Location of clinic:

School Clinic,
147, Skipton Road,
Keighley.

Number of sessions held during the year 180

	Boys	*Girls*	*Total*
Number of new cases seen...	79	22	101
Total number of cases discharged or admitted for residential treatment	52	33	85
Number of cases carried forward...	90	33	123

The staff of the child guidance clinic remained the same in 1970 as in 1969, the team consisting of a physician in charge, who is a senior departmental medical officer, two psychologists, a psychiatric social worker and a mental welfare officer.

As in previous years the children attending the clinic with their parents have included pre-school children, physically and mentally handicapped children and children suffering from behaviour, nervous and habit disorders. Activities have included the counselling of parents in the clinic and in their homes, the treatment of children at the clinic including psychotherapy and play therapy, and the counselling of teachers in the schools.

The psychologists have been able to undertake further work outside the confines of the child guidance clinic and have carried out the psychomatric examination of pupils prior to the full examination by one or other of the senior departmental medical officers for the purposes of ascertaining those pupils who are in need of special education. They have also made frequent visits to schools to discuss the educational problems of children they have examined. The psychiatric social worker and the physician in charge have also visited schools to discuss with teachers other problems concerning the behaviour or personality difficulties which have arisen in other cases. These visits seem to be welcome to the teaching staffs concerned. Discussions have also taken place in certain instances with probation officers and child care officers.

The following tables relate to the number of children seen by the psychologists during the year including those attending the child guidance clinic and those who were examined for the purposes of ascertainment.

Total number of children seen by psychologists

Age	5	5—7+	8—10+	11+	Total
Boys	16	51	46	32	145
Girls	9	23	32	14	78
Total	25	74	78	46	223

Total number of children seen by psychologists, classified according to major handicap.

	Hearing	Vision	Speech	Motor	Learning	General Backward-ness	Malad-justment	Total
Boys	11	1	2	6	19	69	37	145
Girls	10	—	1	3	6	45	13	78
Total	21	1	3	9	25	114	50	223

In addition work continued at the grammar school which was under study in 1969 and is reported as follows:

"Retardation of Older Pupils:

With the assistance of the staff of Greenhead Grammar School a reading and spelling survey was carried out among pupils entering the school in the year 1969/70.

A screening procedure was used in order quickly to eliminate pupils whose reading was normal or better than normal. The results of this screening test suggested that 31 boys and 18 girls were possibly retarded.

These 49 pupils were tested individually in reading and spelling during the spring term of 1970. For many, this was their last term at school.

Reading and spelling quotients were calculated for each pupil and boys and girls who failed to reach a quotient of 85 were considered to be retarded.

Results were:

Retarded in Reading	boys	21
	girls	2
		23
Retarded in Spelling	boys	29
	girls	12
		41

The figures include five Asian boys, whose reading and spelling ability was much below that of the whole retarded group. Their problem appeared to be simply their inability to speak English.

Excluding such pupils with an obvious language difficulty the retarded readers represented about 9 per cent. of the total intake from middle schools. Seventeen per cent. of the boys were retarded readers and 2 per cent. of the girls. With regard to spelling 19 per cent. of the total intake were retarded comprising 25 per cent. of the boys and 13 per cent. of the girls.

As this was the first year of compulsory transfer from middle schools a valid comparison with the results of last year's testing cannot be made. On that occasion the children tested were voluntary transfers from middle schools also the standards of retardation were less closely defined.

Intelligence tests were not used but it seems likely that some of these children were working fairly close to their theoretical level of ability.

There appeared to be a link between retardation and medical and social factors but with this small sample, the association did not reach the accepted level of statistical significance."

FURTHER SCHOOL STUDIES:

With the willing co-operation of teachers, internal surveys of reading ability among first year junior children were carried out in three schools. As well as reading tests, the children were given tests in intelligence and visual-motor material and their social adjustment was assessed by a questionnaire, so that factors associated with reading failure could be identified.

PARTIALLY HEARING PUPILS:

As in 1969 partially hearing pupils were examined by the psychologists in schools to ascertain their intelligence and educational needs. Only those children who were newly registered as partially hearing pupils during the year were seen so that the number was small and no general conclusions can be drawn. The examination is of great value to the particular child concerned and to his teachers and affords an opportunity to discuss problems relating to this particular handicap.

SPECIAL EDUCATION IN THE ORDINARY SCHOOL:

Number of new cases examined by a senior departmental medical officer or psychologist during 1970 and considered as being in need of special education 23

Number of cases examined and considered to be in need of special education in previous years and still in attendance at school 116

Total number of children who have been examined and are considered to be in need of special education in the ordinary school ... 139

In conclusion it will be seen that the foregoing investigations indicate most strongly the needs for special educational provision for the retarded pupil. A junior remedial centre is once again recommended.

F. Speech Therapy:

	Number of cases known to have been treated	
	1970	1969
Pupils treated by speech therapists	213	171

Speech therapy during the year was carried out by the speech therapist employed by the Authority for four sessions a week. The speech therapist employed by the Hospital Management Committee who also gave a part-time service to the Authority in 1969 continued to give two sessions a week until the end of August, 1970, and one session a week until the 30th September, 1970. Therapy has continued to be given to the pupils at Braithwaite Day Special and Whinburn Residential Schools alternate Thursday afternoons and occasional visits have been made to the Day Training Centre.

The following shows details of the work undertaken by the speech therapists.

1. Number of half-day sessions held during the year 180

2. (a) Number of children seen for the first time during the year ... 62
   (b) Number of children attending for treatment from previous year 151
   Total number of children treated 213

3. Number of children awaiting treatment at end of year 18
   (a) Interviewed and placed on waiting list ... ... —
   (b) Not seen 18

4. Children discharged during the year

	Boys	*Girls*
Total	33	22
Analysis		
Speech normal	9	7
Speech improved	8	3
Unsuitable for treatment	—	—
Non-co-operation	10	4
Admitted to special schools	—	—
Left school	3	2
Left district	3	6
Other reasons	—	—

5. Number of visits made to schools 49

6. Number of home visits ... ... — —

Analysis of children treated

	Boys	*Girls*
1. Stammerers (Dysrhythmia)	21	4
2. Defects of articulation due to:		
(a) Cleft palate	3	—
(b) Cerebral palsy	—	—
(c) Other structural malformations	1	1
(d) Other causes e.g. neurological	—	—
(d) No specific cause found	68	34
3. Disorders of language due to:		
(a) Retarded language development (non-specific) ...	22	20
(b) Retardation with associated subnormality ...	17	14
(c) Retardation associated with deafness	—	2
(d) Dysphasia	—	—
(e) Aphasia	—	—
(f) Other reasons	—	—
4. Dysphonia	—	—
5. Other defects	3	3

G. Other Treatment Given:

	Number of cases known to have been treated	
	1970	1969
(a) Pupils with minor ailments	537	553
(b) Pupils who received convalescent treatment under School Health Service arrangements	2	—
(c) Pupils who received B.C.G. vaccination	981	859
(d) Other than (a), (b) and (c) above—Ultra Violet Light ...	13	13
Total	1,533	1,425

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	929
Refused	58
Absent	112
Previously examined	19
Negative	731
Positive	9

Of the nine cases found to be positive, six had previously been vaccinated with B.C.G. and the remainder were referred to the consultant chest physician for further investigation and/or observation.

B.C.G. Vaccination of Older School Children:

The scheme for 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
Number of children offered tuberculin testing and vaccination if necessary, whether the offer was made during the year or previously	1,561
Number found to have been vaccinated previously	132
Number of acceptances	1,046
Percentage of acceptances	73·19
Pre-vaccination Tuberculin Test—	
Number of children tested	1,030
Result of Heaf Test:	
(i) Positive 49, (ii) Negative 981 (iii) Not ascertained	—
Percentage positive	4·76
Vaccination—	
Number vaccinated	981

Included in the above figures are 77 immigrant children who were tuberculin tested as part of a full medical examination which was undertaken prior to their admission to school; two of these had, however, been tested previously.

Ultra Violet Light:

Thirteen pupils received ultra violet light treatment of whom three were continuing at the end of the year. Through the inter-availability of clinics, two pre-school children also received ultra violet light treatment, one of whom was also continuing at the end of the year. Altogether 80 sessions were held at which 252 attendances were made by pupils and 81 by the pre-school children.

Patients are normally referred by their general practitioners.

Care of the Handicapped Child:

Details of the number of handicapped pupils are given in the following table:

TABLE V

	New Ascert-ainments	Re-Ascert-ainments	New placings in Special Schools	Total No. attending Special Schools		Number awaiting placement in Special Schools	Number receiving home tuition
				Day	Boarding		
Blind	—	—	1	—	1	—	—
Partially Sighted	—	—	1	2	—	—	—
Deaf	3	—	3	2	3	—	—
Partially Deaf	1	—	—	3	2	1	—
Educationally Subnormal	17	4	16	96	3	—	—
Epileptic	—	—	—	1	—	—	—
Maladjusted	2	—	—	—	1	2	—
Physically Handicapped	3	1	1	6	1	3	—
Suffering from Speech Defect ...	—	—	—	—	—	—	—
Delicate	2	—	1	—	3	—	1
Total ...	28	5	23	110	14	6	1

BRAITHWAITE DAY SPECIAL SCHOOL:

At the end of the year 101 pupils were attending the Braithwaite Day Special School. Of these 57 were Keighley pupils, the remainder being admitted from areas situated outside the Borough.

Keighley pupils are now admitted at an earlier age than formerly and only occasionally are pupils 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" in accordance with Section 57(4) of the Education Act, 1944 as amended; 11 children were admitted to a day training centre on a voluntary basis and six were reported as requiring care and guidance on leaving school.

Nocturnal Enuresis:

During the year five pupils suffering from nocturnal enuresis were issued with an Eastleigh Warning Device on loan. All of these had, however, completed the course of treatment at the end of the year.

Health Education:

During the year talks were given in many of the schools in the town by the health visitors/school nurses. All the talks were illustrated by the use of films, filmstrips, flannelgraphs and posters. It is thought that these additional aids tend to make the subject more interesting and clear. The usual subjects were covered but special attention was given in the infants and junior schools to personal hygiene and dental care. One or two talks were given in the senior schools on the

water supply and fluoridation. Talks on the misuse of drugs in the community were also given to the older age-groups. While attention is constantly drawn to the hazards of smoking nevertheless it would seem that we are, as yet, making little or no impact on this deplorable habit.

Medical Examination of Entrants to Training Colleges:

Arrangements were made for 78 students to be medically examined during the year in connection with their applications for entry to Training Colleges compared with 92 in the previous year.

Children and Young Persons Act, 1933, Employment of Children:

During the year 22 children were examined by the senior departmental medical officers to determine their fitness for employment under the Authority's bye-laws relating to the employment of children as compared with 45 in 1969. No child was found to be unfit.

Dental Inspection and Treatment:

Mr. Midgley, Area Dental Officer reports:

"An increase in the time between dental inspections in schools has been caused by the loss of one member of staff half way through the year. Additional sessions have been worked to compensate for this loss, but this has not resulted in all the schools being inspected and treated during the year.

The dental health of the school children mentioned in previous reports continues at a high standard and it would appear that parents are aware of the benefits of regular dental inspection and treatment.

The amount of dental decay observed is regrettable in view of the increasing evidence that the fluoridation of the public water supply is an effective and safe method of prevention."

TABLE VI

Attendances and Treatment

	Ages 5 to 9	Ages 10 to 14	Ages 15 and over	Total
First visit	559	785	169	1,513
Subsequent visits	371	1,984	431	2,786
Total visits	930	2,769	600	4,299
Additional courses of treatment commenced	40	71	21	132
Fillings in permanent teeth...	428	2,080	614	3,122
Fillings in deciduous teeth	183	2	—	185
Permanent teeth filled	428	2,079	613	3,120
Deciduous teeth filled	183	2	—	185
Permanent teeth extracted	52	450	120	622
Deciduous teeth extracted	1,268	417	—	1,685
General anæsthetics...	424	326	45	795
Emergencies	253	119	16	388

Number of pupils X-rayed	108
Prophylaxis	46
Teeth otherwise conserved	—
Number of teeth root filled	9
Inlays	2
Crowns	—
Courses of treatment completed... ...	1,495

Orthodontics

New cases commenced during year ...	64
Cases completed during year	42
Cases discontinued during year	3
Number of removable appliances fitted ..	114
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) ...	—	—	1	1
Pupils supplied with other dentures (first time) ...	2	18	7	27
Number of dentures supplied	2	32	15	49

Anæsthetics General Anæsthetics administered by Dental Officers	—

Inspections

(a) First inspection at school. Number of pupils	6,337
(b) First inspection at clinic. Number of pupils	630
Number of (a) + (b) found to require treatment	2,981
Number of (a) + (b) offered treatment	2,767
(c) Pupils re-inspected at school or clinic	474
Number of (c) found to require treatment	300

Sessions

Sessions devoted to treatment	421*
Sessions devoted to inspection	36
Sessions devoted to Dental Health Education ...	—

* Includes – anæsthetic session

APPENDIX D

WEST RIDING COUNTY HEALTH DEPARTMENT STAFF BIBLIOGRAPHY 1960/69

H. W. S. Francis, Deputy County Medical Officer and T. R. Schofield, Principal Administrative Officer

The published work collated here was selected on three criteria:

(a) Work by West Riding staff.

(b) Published either when on the West Riding Health Department staff or the the basic work should relate to the Administrative County, and

(c) Published during the decennium 1960-1969.

These criteria unfortunately excluded several excellent papers such as Dr. McDonagh's on 'The Significance of the Abattoir in Salmonella Infection in Bradford' which was excluded both on the grounds of date and place. Dr. Elliott's essay on 'The Community Physician' was written during 1969, but was not published by the County Councils Association as a pamphlet until March, 1970.

The published work falls naturally into two groups:

(a) Work published by outside journals.

(b) Work published by the West Riding County Health Department.

The material listed in section (b) comes mainly from three sources:

i. *The County Medical Officer's Annual Reports.*

ii. *Health Notes* issued quarterly to family doctors since January, 1965. The bulletin is issued with a Divisional Newsletter, the material from which has not been listed here.

iii. *Well-being*, a bulletin for teachers and others published jointly with the Education Department once each term since the first term in 1968.

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W.R.C.C. Medical Officer's Annual Report, 1967.

Burgess, J. A. — Consultant Venereologist, Leeds Regional Hospital Board and Adviser on Venereal Disease to the West Riding County Council.

"Venereal Disease in the West Riding, 1964."
Health Notes, 1965, *1*, 13.

"Venereal Disease: Contact Tracing."
ibid, 1967, *2*, 7.

"Venereal Disease."
Health Notes Supplement No. 15, July, 1969.

Burn, A. T. — Divisional Medical Officer.

"Deafness and Partial Hearing in Infancy."
Health Notes, 1966, *1*, 23.

"Aspects of Training Centres for the Subnormal: Some Wider Implications."
ibid, 1966, *1*, 30.

"Accidental Vaccinia: A West Riding Case."
ibid, 1969, *3*, 15.

Chambers, Miss R. E. — Formerly Health Visitor Tutor, now Lecturer in Health Visiting Birmingham University.

"The Training of Health Visitors."
Health Notes, 1965, *1*, 16.

Chapman, R. — Formerly Senior Departmental Medical Officer, now Deputy Medical Officer of Health, Sheffield C.B.

"Mental Subnormality: Three Unusual Cases."
Health Notes, 1969, *3*, 3.

Clow, J. T. — Divisional Medical Officer.

"Attachment of Local Health Authority Nursing Staff to General Practitioners." (Co-author).
W.R.C.C. Medical Officer's Annual Report, 1967.

"Health Visitor Attachment: A West Riding Survey."
Health Notes, 1968, *2*, 18.

"Poliomyelitis—Still a Threat."
ibid, 1969, *3*, 7.

Cusiter, D. J. — Divisional Medical Officer.

"Chronic Bronchitis and Pneumoconiosis."
Health Notes, 1966, *1*, 22.

"Hearing Aids and Fluorescent Lighting Tubes."
ibid, 1969, *3*, 7.

Davies, D. — Formerly Chief Dental Officer and Principal School Dental Officer, now Dental Adviser to the Government of Northern Ireland.

"Dental Service for Mothers and Young Children."
Health Notes, 1965, *1*, 10.

"The Orthodontic Service for West Riding Schoolchildren."
ibid, 1965, *1*, 18.

"Orthodontics."
Health Notes Supplement No. 5, October, 1966.

Dolton, W. D. Formerly Divisional Medical Officer, now Deputy County Medical Officer, Cheshire.

"Human Genetics."
Well-being, 1968, *1*, 5.

"Food Poisoning: An Outbreak Caused by Salmonella."
Health Notes, 1968, *2*, 31.

Douglas, W. M. Divisional Medical Officer.

"The Health Centre." (Co-author).
Health Notes Supplement No. 2, July, 1965.

Edwards, Miss M. G. Formerly Health Education Officer ,now Lecturer in Health Visiting, Durham University.

"Health Education: Smoking."
Health Notes, 1965, *1*, 10.

Elliott, R. W. County Medical Officer.

W.R.C.C. Medical Officer's Annual Reports, 1960-69.

Future Developments in the Health Service and Co-operation with General Practitioners.
W.R.C.C. July, 1964.

"Introduction of Health Notes."
Health Notes, 1965, *1*, 1.

"The West Riding Mini-Clinics: The Concept of the Mini-Clinic."
Health Notes Supplement No. 1, April, 1965.

"The Health Centre." (Co-author).
ibid, *No. 2*, July, 1965.

"Health Notes: Introduction of Volume 2."
Health Notes, 1967, *2*, 1.

"Prevention: A New Pattern."
ibid, 1967, *2*, 5.

To the Future. (Co-author).
W.R.C.C. July, 1967.

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W.R.C.C. Medical Officer's Annual Report, 1967.

"Emergency Medical Help in General Practice."
Health Notes, 1968, *2*, 19.

"Child Tattooing: West Riding."
ibid, 1968, *2*, 19.

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Well-being, 1968, *1*, 8.

"History and Medicine: The Illness of George III."
ibid, 1968, *1*, 13.

"Venereal Disease in the New Born."
Health Notes, 1968, *2*, 27.

"General Practitioners' Rentals: Health Centres and Clinics."
ibid, 1968, *2*, 31.

"The Green Paper and the School Health Service." (Co-author).
W.R.C.C. Medical Officer's Annual Report, 1968.

Emmerson, A. Senior Mental Welfare Officer.

"The Mentally Disordered Epileptic and the Community." (Co-author).
Health Notes, 1969, *3*, 10.

Farrow, Mrs. M. Psychiatric Social Worker-Tutor.

"General Social Workers in the County Health Department."
W.R.C.C. Medical Officer's Annual Report, 1968.

Francis, H. W. S. Deputy County Medical Officer.

"Poliomyelitis in the West Riding, 1960-64."
Health Notes, 1965, *1*, 9.

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ibid, 1965, *1*, 14.

"Carcinoma of the Cervix." (Co-author).
ibid, 1965, *1*, 16.

"The Mental Welfare Officer and the General Practitioner."
ibid, 1966, *1*, 20.

"Patterns of Violence."
ibid, 1966, *1*, 25.

"Aspects of Training Centres for the Subnormal." (Co-author).
ibid, 1966, *1*, 29.

"Breast Feeding."
ibid, 1966, *1* 33.

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W.R.C.C. December, 1966.

"The Family Doctor and Cruelty to Children."
Health Notes, 1967, *2*, 6.

To the Future. (Co-author).
W.R.C.C. July, 1967.

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Health Notes, 1967, *2*, 11.

"Werdnig-Hoffman's Disease: West Riding Cases 1966."
ibid, 1967, *2*, 15.

"West Riding Family Doctors and the West Riding Computer."
Health Notes Supplement No. 10, January, 1968.

"Sport and Fitness."
Well-being, 1968, *1*, 6.

"Lifting Injuries in Ambulance Crew."
Health Notes, 1968, *2*, 22.

"Infected Terrapins in School."
Well-being, 1968, *1*, 10.

"Psittacosis in School Pets."
ibid, 1968, *1*, 10.

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ibid, 1968, *1*, 10.

"Mental Illness in University Students and Its Implications for the Schools."
ibid, 1968, *1*, 11.

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Health Notes, 1968, *2*, 31.

"History and Medicine: The Illness of Charles Darwin."
Well-being, 1969, *1*, 32.

"Sport and Fitness."
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"Computer Matters: Doctors in the Vaccination and Immunisation Scheme."
Health Notes, 1969, *3*, 11.

Francis, H. W. S. (cont.)

"The Green Paper and the School Health Service."
W.R.C.C. Medical Officer's Annual Report, 1968.

Gordon, N. E. — Formerly Divisional Medical Officer, now Divisional Medical Officer, Co. Down, Northern Ireland.

"Tuberculin Skin Tests."
Health Notes, 1965, *1*, 14.

Greenwood, D. — Chief County Public Health Inspector.

"Brucellosis."
Health Notes, 1965, *1*, 3.

"Plumbo-solvent Water Supplies."
ibid, 1966, *1*, 28.

"The Construction (Health and Welfare) Regulations, 1966."
ibid, 1967, *2*, 2.

"Hygiene: Food Vending Machines."
ibid, 1968, *2*, 19.

"Brucellosis: New Developments."
ibid, 1968, *2*, 23.

"Radioactivity of Water Supplies."
ibid, 1969, *3*, 11.

"Fluoridation of Water Supplies."
ibid, 1969, *3*, 14.

Harris, Miss N. I. — Deputy County Nursing Officer.

"Pads and Pressure Sores."
Health Notes, 1969, *3*, 6.

Harvey, C. C. — Former Consultant Pædiatrician, Sheffield Regional Hospital Board and Adviser on Pædiatrics to the West Riding County Council.

"Phenylketonuria." (Co-author).
Health Notes, 1965, *1*, 9.

"Two Congenital Conditions."
ibid, 1966, *1*, 27.

"Inhalation of Talc Dust."
ibid, 1967, *2*, 2.

"Fits and Faints in Early Childhood."
ibid, 1967, *2*, 8.

"The Handicapped Pupil: Faints and Fits in Schooldays."
ibid, 1967, *2*, 10.

"Saving Cyanosed Babies."
ibid, 1968, *2*, 23.

"Innocent Heart Murmur of Childhood."
ibid, 1969, *3*, 2 and 6.

"Non-disease of the Heart."
Well-being, 1969, *1*, 31.

Hope, J. H. — Formerly Senior Mental Welfare Officer, now Principal Social Worker, Leeds C.B.

"The Mentally Disordered Epileptic and the Community." (Co-author).
Health Notes, 1969, *3*, 10.

Hunter, M. Divisional Medical Officer.

"Defective Colour Vision."
Well-being, 1968, *1*, 8.

"Co-operation with Family Doctors: Cervical Cytology."
Health Notes, 1968, *2*, 27.

Ireland ,G. Divisional Medical Officer.

"Aspects of Training Centres for the Subnormal: Social Training of the Subnormal."
Health Notes, 1966, *1*, 29.

"Mental Health Service: Healey Croft Hostel and Zoar Street, Morley."
W.R.C.C. Medical Officer's Annual Report, 1968.

Jeremiah, D. E. Principal Medical Officer.

"Social Clubs and Centres for the Mentally Ill."
Health Notes, 1965, *1*, 5.

"Aspects of Training Centres for the Subnormal." (Co-author).
ibid, 1966, *1*, 29.

"Hostels for Mentally Disordered Patients."
ibid, 1968, *2*, 23.

"A Hostel for the Post-psychotic Patient: West Ardsley."
ibid, 1969, *3*, 7.

Kersner, Miss M. Formerly Speech Therapist, now in private practice.

"Speech Difficulties in Children: How Teachers can Help." (Co-author).
Well-being, 1968, *1*, 10.

Leyshon, G. E. Principal Medical Officer.

"Cancer of the Breast."
Health Notes, 1969, *3*, 9.

McDonagh, V. P. Divisional Medical Officer and Medical Officer of Health, Keighley M.B.

"Food Poisoning: An Outbreak caused by Salmonella."
Health Notes, 1968, *2*, 31.

Milne, J. H. Principal Administrative Officer.

"Issue of 'Lactogol' in Clinics."
Health Notes, 1967, *2*, 3.

Mumford, Mrs. D. (neé Walker) Formerly County Nursing Officer.

"Health Visitors and Family Doctors: Making Co-operation Work." (Co-author).
Health Notes, 1965, *1*, 2.

Oddy, C. G. Divisional Medical Officer.

"Obesity and Exercise in Childhood."
Well-being, 1968, *1*, 5.

"Industrial Lead Poisoning—A West Riding Case."
Health Notes, 1968, *2*, 27.

"Liver Fluke: A West Riding Case."
ibid, 1969, *3*, 11.

Pickles, D. G. Senior Psychologist.

"School Phobia."
Health Notes, 1966, *1*, 21.

"Deprivation in Childhood: Cultural Aspects."
Well-being, 1968, *1*, 3.

"Attitudes and Motives in Health Education."
ibid, 1969, *1*, 39.

Richardson, G. Chief Administrative Officer.

"New County Health Department Premises."
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ibid, 1965, *1*, 18.

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"New County Health Department Premises."
Health Notes, 1967, *2*, 11.

"Recently opened Health Centres and Clinics."
ibid, 1969, *3*, 7.

"Mental Health Premises."
ibid, 1969, *3*, 11.

Schofield, T. R. Principal Administrative Officer.

"Carcinoma of the Cervix." (Co-author).
Health Notes, 1965, *1*, 16.

"Child Mortality."
ibid, 1968, *2*, 30.

Scott, Mrs. G. M. Formerly Health Visitor.

"Health Visitors and Family Doctors: Making Co-operation Work." (Co-author).
Health Notes, 1965, *1*, 2.

Shields, Mrs. J. R. (neé Davy) Formerly Speech Therapist, now Lecturer in Speech Therapy, Leeds Polytechnic.

"Speech Difficulties in Children: How Teachers Can Help." (Co-author).
Well-being, 1968, *1*, 10.

Smith, C. Simpson Principal Medical Officer.

"Buzzers for Bedwetters."
Health Notes, 1965, *1*, 4.

"The 'Autistic' Child."
ibid, 1965, *1*, 13.

"The National Child Development Study."
ibid, 1965, *1*, 13.

"Intelligence Quotients."
ibid, 1965, *1*, 18.

"Speech Therapy in the West Riding."
ibid, 1966, *1*, 23.

"Special Education of the Handicapped Pupil."
ibid, 1966, *1*, 26.

Smith, C. Simpson (cont.)
"Deafness in the School Child."
Health Notes, 1966, *1*, 28.
"The Handicapped Pupil: The Delicate Child."
ibid, 1966, *1*, 31.
"The Handicapped Pupil: The Child with Physical Handicaps."
ibid, 1966, *1*, 35.
"Eye Tests."
ibid, 1966, *1*, 35.
"The Handicapped Pupil: The Child Suffering from Deafness or Partial Hearing Loss."
ibid, 1967, *2*, 4.
"The Handicapped Pupil: Blind and Partially-Sighted Children."
ibid, 1967, *2*, 7.
"Co-ordination of Education, Health and Welfare Services for Handicapped Children and Young People."
ibid, 1967, *2*, 8.
"Foot Infections in School Children."
ibid, 1967, *2*, 10.
"Special Educational Treatment for Epileptics."
ibid, 1967, *2*, 10.
"Family Doctors and Local Authority Work."
ibid, 1967, *2*, 11.
"The Handicapped Pupil: The Educationally Subnormal Child."
ibid, 1967, *2*, 14.
"Partially-Sighted Patients."
ibid, 1967, *2*, 15.
"Possible Causative Factors in Retardation in the Child."
W.R.C.C. Medical Officer's Annual Report, 1967.
"The Handicapped Pupil: The Maladjusted Child."
Health Notes, 1968, *2*, 18.
"Deprivation in Childhood: Sensory Deafness."
Well-being, 1968, *1*, 2.
"Foot Infections in School Children."
ibid, 1968, *1*, 4.
"Physically Handicapped Children in Ordinary Schools."
ibid, 1968, *1*, 4.
"The Handicapped Pupil: The 'Clumsy' Child."
Health Notes, 1968, *2*, 22.
"The Handicapped Pupil: Home Tuition."
ibid, 1968, *2*, 26.
"The Handicapped Pupil: Future Needs."
ibid, 1968, *2*, 30.
"Birthdates of Children Referred for Suspected Retardation."
Well-being, 1968, *1*, 20.
"Intelligence in Mongolism: A Survey in the West Riding."
W.R.C.C. Medical Officer's Annual Report, 1968.
"In-Service Training for Medical Officers."
ibid.
"The Handicapped Child in the Ordinary School: Reading Disability in Childhood."
Well-being, 1969, *1*, 27.
"Cerebral Palsy."
ibid, 1969, *1*, 28.

Smith, C. Simpson (cont.)

"Spina Bifida and Hydrocephalus."
Well-being, 1969, *1*, 28.

"The Clumsy Child."
ibid, 1969, *1*, 29.

Spruce, J. Senior Administrative Officer.

"Compulsory Admission to Hospital of Mentally Disordered Patients."
Health Notes, 1967, *2*, 15.

Stalker, R. Divisional Medical Officer.

"Terrapins and Salmonella."
Health Notes, 1968, *2*, 27.

Taylor, H. Chief Dental Officer and Principal School Dental Officer.

"Children's Teeth and Natural Fluoride."
Well-being, 1968, *1*, 10.

Whitaker, V. Formerly County Ambulance Officer.

"Mouth-to-Mouth Resuscitation."
Health Notes, 1966, *1*, 28.

"Ambulance Service: Sudden Illness in the Home."
ibid, 1967, *2*, 3.

"W.R.C.C. Ambulance Service."
Health Notes Supplement No. 6, January, 1967.

"Medical Transport and the Hospital."
W.R.C.C. Medical Officer's Annual Report, 1968.

Woolley, Mrs. F. E. Organiser of Training, Mental Health Training Centres.

"Aspects of Training Centres for the Subnormal: Industrial Therapy in Training Centres." (Co-author).
Health Notes, 1966, *1*, 30.

APPENDIX E

STAFF OF THE HEALTH DEPARTMENT

as at 31st December, 1970

MEDICAL STAFF

County Medical Officer and Principal School Medical Officer	Ronald W. Elliott, M.D., M.SC., D.P.H.
Deputy County Medical Officer	H. W. S. Francis, M.A., M.B., B.CHIR., D.P.H.
Principal Medical Officer:	
Care of Mothers and Young Children and Nursing Services	Denise E. Robertshaw, M.B., CH.B., D.P.H., D.C.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.
Epidemiology	G. E. Leyshon, M.B., CH.B., D.OBST.R.C.O.G., D.P.H.
Additional Medical Officer ...	J. A. Cooney, M.B., CH.B., B.A.O., D.T.M. and H.
Venereologist (part-time) ...	J. A. Burgess, M.D., CH B , D.P.H.
Obstetrician (Joint appointment with Hospital Services)	J. C. MacWilliam, L.R C.P., L R.C.S., L.R.F.P.S., D.OBST.R.C.O.G.
Medical Officer for the Child Guidance Service	Katharine N. Maxwell, M.B., CH.B. R. V. Read, M.R.C.S., L.R.C.P., D.P.M.

Divisional Medical Officers—

Division No. and Name	
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 (Rothwell/Wetherby)	Vacancy
10 (Goole)	Muriel J. Lowe, M.B., B.S., M.R.C.S., L.R.C.P., D.P.H., D.C.H.
11 (Castleford/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 (Spenborough) ...	W. M. Douglas, M.B., CH.B., D.P.H.
18 (Calder Valley) ...	S. H. Brock, 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.

Divisional Medical Officers—continued

27 (Doncaster)	R. Stalker, M.B., CH.B., D.P.H.
29 (Thorne)	G. Higgins, B.SC., M.B., CH.B., D.P.H.
31 (Rotherham) ...	J. T. Clow, M.B., B.S., D.P.H.

Departmental Medical Officers and School Medical Officers—

Division No. and Name	
1 (Skipton)	*G. H. Cooper, M.B., CH.B. *Helen M. Dean, M.B., CH.B., D.P.H. *Shirley Jessop, M.B., CH.B., D.P.H.
3 (Keighley)	*J. I. Bennet, M.B., CH.B. *Doreen E. Gledhill, M.B., CH.B.
4 (Shipley)	*Adaline N. Ambler, M.B., CH.B.
5 (Horsforth)	*Helen M. Mitchell, M.B., CH.B. Agnes A. Crone, M.B., CH.B., D.C.H. Joan M. Murdoch, L.M.S.S.A. Annette M. Whalley, M.B., CH.B.
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 (Rothwell/Wetherby)	*J. Briffa Boothman, M.D., D.P.H. Elizabeth M. Ingles, M.B., CH.B., D.P.H. Teresa Rose, M.B., B.S., M.R.C.S., L.R.C.P.
10 (Goole)	*Eileen M. R. Bell-Syer, M.B., B.S.
11 (Castleford/ Pontefract) ...	Sheila F. Schofield, M.B., CH.B., D.P.H., D.C.H.
13 (Morley)	*Barbara Briggs, M.B., CH.B., D.P.H. Doreen M. M. Anderson, M.B., CH.B. Irene Hargreaves, M.B., CH.B. Ruth L. Skrine, M.B., CH.B.
15 (Spenborough) ...	*Freda M. Cox, M.R.C.S., L.R.C.P., D.P.H. Emma M. H. Holdsworth, M.B., CH.B. Alexandrina McPheat, M.B., CH.B., D.P.H. W. McPheat, L.R.C.P. & S., L.R.F.P. & S.
18 (Calder Valley) ...	*Marie P. Milligan, B.SC., M.B., CH.B., D.P.H. W. C. McKerr, M.B., CH.B., B.A.O.

Departmental Medical Officers and School Medical Officers—continued

20 (Colne Valley) ...	*L. Lloyd-Evans, M.B., CH.B. G. D. Roworth, M.B., CH.B.
22 (Wortley)	Melba R. McGinty, M.B., CH.B.
23 (Hemsworth) ...	*Josephine Hayes, M.B., CH.B. C. H. Merry, M.R.C.S., L.R.C.P.
25 (Barnsley)	C. B. Ball, M.B.E., J.P., L.M.S.S.A.
26 (Wath upon Dearne)	*Margaret E. J. Bolsover, M.B., CH.B. *S. K. Pande, M.B., B.S., D.P.H. Elizabeth M. Harvey, M.R.C.S., L.R.C.P.
27 (Doncaster)	*J. A. Beal, M.R.C.S., L.R.C.P., D.P.H. Elizabeth R. M. Harvey, M.A., M.B., B.CHIR.
29 (Thorne)	Vacancy
31 (Rotherham) ...	Mary J. Daly, M.B., B.CH., B.A.O., DIP.L.M. Patricia J. Elson, M.B., B.S. Margaret J. Hallinan, M.R.C.S., L.R.C.P.

¦61 General Medical Practitioners who act as Child Welfare Centre Medical Officers and are employed on a sessional basis. This is the equivalent of 21·6 whole-time Departmental Medical Officers.

* Senior Departmental Medical Officers.

Chest Physicians—(Joint Appointment with Hospital Services) –

LEEDS REGION

D. 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., M.R.C.P., M.R.C.S.
M. J. Livera, M.D., B.S., M.R.C.P.
B. T. Mann, B.SC., M.D., CH.B., D.P.H.
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.
A. Weleminsky, M.D. (Prague)

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.
J. D. Stevens, M.D., B.SC., M.R.C.S., L.R.C.P.

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

OPHTHALMIC

S. K. Banerjee, M.B., B.S., D.O.
M. A. Davies, M.B., B.S., M.R.C.S., L.R.C.P., D.O.
S. B. Davies, L.R.C.P., L.R.C.S., D.O.
M. K. Godbole, M.B., B.S., D.O.
R. Hawe, M.B., CH.B., B.A.O., D.O.
M. Hussain, M.B., B.S.
M. A. C. Jones, M.B., CH.B., F.R.C.S., D.O.
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. K. Prasher, M.B., B.S., D.O.
T. B. Priestley, M.R.C.S., L.R.C.P., D.O.
S. Robertson, M.B., CH.B., D.O.M.S.
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.

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.
P. A. I. Macleod, B.SC., M.B., CH.B., F.R.F.P.S., F.R.A.C.S.
W. H. Maitland-Smith, M.B., CH.B., F.R.C.S., M.CH.ORTH.
J. K. Oyston, M.B., B.S., F.R.C.S.
Marion 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.
A. J. S. Bell Tawse, M.A., M.B., B.CHIR., F.R.C.S., L.R.C.P.

E.N.T.

P. J. Batchelor, M.B., B.S., F.R.C.S., D.L.O.
P. H. Beales, F.R.C.S.
T. B. Hutton, M.A., M.B., B.CHIR., F.R.C.S., L.R.C.P., 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.

PAEDIATRICS

P. C. N. Clarke, M.R.C.P., D.C.H.
C. S. Livingstone, M.R.C.P., D.C.H.
J. D. Pickup, M.D., CH.B., D.C.H.
R. J. Pugh, M.B., CH.B., M.R.C.P., M.R.C.S., D.C.H.
G. Rajan, M.R.C.P.
A. P. Roberts, M.B., B.S., M.R.C.P., M.R.C.S., D.C.H.

CARDIAC

W. S. Suffern, M.D., CH.B., M.R.C.P., M.R.C.S., L.R.C.P.

PSYCHIATRIC

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

CHILD GUIDANCE SERVICE

Psychologists ... ... P. W. Atkinson, B.A.
Felicity A. Brown, B.A.
Annette B. Castle, B.A.
Susan M. Goulding, B.SC., DIP. ED.
J. B. Mannix, M.ED.
P. J. Monaghan, B.A.
D. G. Pickles, M.A.
Julia C. Scott, B.A.
H. B. Valentine, M.A.

10 Psychiatric Social Workers (5 part-time).

SPEECH THERAPY SERVICE

Chief Speech Therapist ... Vacancy.
17 Speech Therapists (11 part-time).

DENTAL SERVICE

Chief Dental Officer and Principal School Dental Officer ... H. Taylor, L.D.S.

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.
Joyce Neden, B.D.S.
F. H. Sanderson, L.D.S

Area Dental Officers ... ... J. R. Clayton, B.CH.D., L.D.S.
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.
Mary M. Gibson, L.D.S.
Valerie P. Lindsay, L.D.S.
E. Lowery, B.D.S.
A. S. Metcalfe, L.D.S.
E. S. Midgley, L.D.S.

Area Dental Officers (continued)

S. Mitchinson, L.D.S.
J. Naftalin, L.D.S.
M. S. Ormesher, B.D.S.
B. Sleight, B.CH.D.
H. G. Thorpe, L.D.S.
H. M. Yuile, L.D.S.

School Dental Officers ... A. Brooke, L.D.S.
Mary G. Brown, B.CH.D.
Shirley C. Clapham, B.CH.D.
Eileen M. Cooper, B.D.S.
M. Davidson, L.D.S.
Joan M. Davison, L.D.S.
Patricia A. Duffield-Harding, B.D.S.
W. H. Dyke, L.D.S.
Jean G. Elliott, L.D.S.
R. F. Grainger, B.CH.D., L.D.S.
M. Hattan, L.D.S.
F. Kershaw, L.D.S.
J. M. Laurent, B.D.S.
R. B. Lawrence, L.D.S.
M. J. Limb, B.D.S.
B. Niman, L.D.S.
M. J. Prendergast, B.D.S.
Lesley M. M. Rhind, B.D.S.
Jessie Rothera, L.D.S.
R. L. Selby, B.D.S.
D. J. Sinnett, B.D.S.
W. J. Smalley, B.CH.D.
P. Smith, L.D.S.
E. Thornton, L.D.S.
J. G. N. Wills, L.D.S.

7 Dental Auxiliaries

Chief Dental Technician ... K. A. Battersby

8 Technicians

3 Boy Dental Apprentices

61 Dental Surgery Assistants

NURSING AND MIDWIFERY

County Nursing Officer	Marjorie G. Atkinson, D.N., S.R.N., S.C.M., H.V. CERT., D.T. (Queens)
Deputy County Nursing Officer	Naomi I. Harris, S.R.N., S.C.M., H.V. CERT., D.T. (Queens)
Non-Medical Supervisor of Midwives	Margaret J. Astin, S.R.N., S.C.M., M.T.D. Agnes Sellars, S.R.N., S.C.M., H.V.CERT., M.T.D.

15 Divisional Nursing Officers
301 Health Visitors/School Nurses (25 part-time)
108 Assistant Health Visitors (55 part-time)
2 Orthopædic Nurses and Physiotherapists (2 part-time)
2 Tuberculosis Visitors
4 Venereal Diseases Social Workers (Qualified Health Visitors)
333 Home Nurses and Home Nurse/Midwives (32 part-time)
164 Midwives (15 part-time)
5 Matrons and 30 other nursing staff at 5 Day Nurseries
13·5 Social Workers
5 Trainee Social Workers

AMBULANCE SERVICE

County Ambulance Officer	L. Lord, F.I.A.O., M.R.S.H., A.M.B.I.M.
Deputy County Ambulance Officer	J. C. Gledhill, A.I.A.O., D.P.A.

2 Assistant Ambulance Officers
1 Training Officer
Operations Staff:
Headquarters 51
Field 668

MENTAL HEALTH SERVICE

Psychiatric Social Worker-Tutor	Maria Farrow, A.A.P.S.W.
Senior Mental Welfare Officers	R. Aspinall J. D. Blackburn Margaret M. de la Cour A. Emmerson J. G. Jarvis Dorothy W. Lynes P. G. Noden, D.P.A. R. O'Kane S. Parkinson, A.A.P.S.W. Florence H. Redman

54 Mental Welfare Officers
Organiser of Training — Frances E. Woolley, DIP.N.A.M.H.
19 Supervisors in Mental Health Training Centres
156 Teachers of the (Mentally) Subnormal, Instructors and other assistant staff
2 Home Teachers for (Mentally) Subnormal Children (2 part-time)
4 Wardens in Mental Health Hostels
7 Assistant Wardens in Mental Health Hostels

DOMESTIC HELPS

13 Domestic Help Organisers
9 Assistant Domestic Help Organisers
3,523 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 Pupil Public Health Inspectors
2 Milk Sampling Officers

HEALTH EDUCATION

Health Education Officer ... Mary Tattersall, D.N., S.R.N., S.C.M., H.V. CERT., D.T. (Queens)

1 Health Education Technician

ANALYSTS

County Analyst ... ... R. Mallinder, B.SC., F.R.I.C. (part-time)
Deputy County Analyst ... ... N. Harrison, M.CHEM.A., A.R.I.C.

ADMINISTRATIVE AND CLERICAL

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

Principal Administrative Officers ... ... J. H. Milne, D.P.A.
H. Beatson
W. J. Battye
C. J. Kirk, A.M.B.I.M.
R. S. Marshall
T. Myton, D.P.A.
T. R. Schofield, D.P.A.

Senior Administrative Officers	... ...	G. Brabant H. V. Brook E. Brown J. W. Ibbotson D. Marshall, D.P.A. D. Ramsbottom J. Spruce, D.P.A. P. Ward, D.P.A.
22	Divisional Administrative Officers	
381	Other Clerical Staff (including part-time)	