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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
1972

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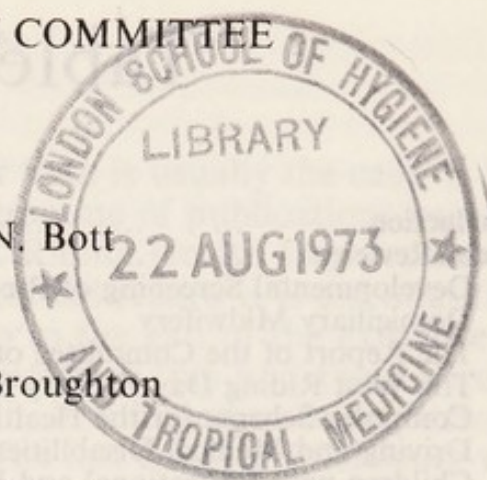


Table of Contents

	Page
Introduction ...	5—9
Special Reviews ...	11—74
Developmental Screening of Pre-School Children ...	12
Domiciliary Midwifery ...	16
The Report of the Committee on Nursing ...	29
The West Riding Day Nursery Service, 1940-1971 ...	34
Computer Scheme for the Health Surveillance of Personnel ...	47
Driving and Medical Disabilities ...	52
Children with Educational and Related Difficulties in Primary Schools ...	68
The History of the Orthodontic Service ...	73
PART I	
Vital Statistics ...	76—82
Epidemiology ...	83—89
Venereal and Sexually Transmissible Diseases ...	90—91
Research ...	92
PART II	
Co-operation in the Health Service ...	94—99
Divisional Administration ...	100
PART III	
Local Health Services ...	101—117
Care of Mothers and Young Children ...	102
Midwifery ...	104
Health Visiting ...	105
Home Nursing ...	106
Ambulance Service ...	108
Prevention of Illness—Care and After-Care ...	113—116
Health Education ...	113
Renal Dialysis ...	115
Family Planning ...	116
PART IV	
Environmental Hygiene ...	119—125
Food and Drugs Act, 1955 ...	120
Sanitary Circumstances ...	123
PART V	
Miscellaneous Services ...	127—129
PART VI	
The Health of the School Child ...	131—142
The School Dental Service—Report of Principal School Dental Officer ...	140—142
Orthodontics ...	142
Appendices	
A Tables ...	143—223
B Report of County Analyst ...	224—226
C Report of School Medical Officer to the Keighley Excepted District ...	227—244
D Staff of the Department ...	245—252

INTRODUCTION

It is hoped that this Report will appear earlier than is usually the case. It has been necessary to make adjustments in our programme of publications because we must prepare for the winding up of the West Riding Health Department by April, 1974. For the sake of continuity and historical record it is essential that the Annual Report should be produced right up to the end of the existence of the West Riding. Because of pressure on the staff of this and their normal work as well, plus the pressure of Reorganisation, it is hoped to bring forward the demise of our publications to some degree. The last issue of *Well-being* will appear in July and that for *Health Notes* in November, 1973; this Report will be published in September. By phasing in this way and the adjustment of record keeping it should be possible to complete our task without interfering with any timetables of Reorganisation and to produce the Annual Report for 1973 before April, 1974. If factual information is to be recorded for future reference it is essential that adjustments of this kind should be made.

All this emphasises the fact that the West Riding Executive Council and the West Riding Health Department have a common problem in that unlike other authorities there is no natural successor either on the health or the local government side which can act as an umbrella until the disintegration can be sorted out. It will be readily seen that from a geographical point of view the hospital service and the Executive Councils, (other than the West Riding) and the County Borough health departments have fewer problems in this respect.

It will be understood I am sure that this situation does have an effect upon staff morale and I am pleased to see that the Staff Advisory Committee have realised that we have such problems, and one hopes that their recognition of this fact will help them in designing the future employment of people who have been extremely loyal to the Health Department. It has surprised me how very few people have left our service in these difficult times.

It is not only the staff who should have special consideration but there are certain services which have been developed and conducted on a County basis, in support of the divisions, whose future is most uncertain because of the lack of a natural successor to organise them. Perhaps I could just mention a few to illustrate the problem.

We have a very well developed central dental service, including a well equipped laboratory and a relatively large number of technicians serving the County area—this is situated in Wakefield. Similarly the dental staff themselves in Wakefield have specialised in certain aspects of dental work and particularly in orthodontics; again on a County basis. It is difficult to split this service into small pieces.

The computer applications of health services have also been organised on a County basis and although we can see a possible part solution to this problem it has been a difficult task to ensure the continuity of this work by the future Health Authorities.

The development of health centres has involved the specialisation of a small number of officers in the health and architect's departments and they are involved with a very big rolling programme. The future of all this is very worrying both to the County Architect and to myself. It will be difficult to hand over responsibility for this to 18 different authorities. It should really be, at least for the time being, a regional problem, but this does not seem to be the intention of the Reorganisation.

Although health education and in-service training have again been organised centrally, and the central health education unit is a service which must now be handed over, it seems likely that the only way to deal with this would be to ask the Wakefield Area Health Authority to accept it *in toto*, but it will be seen that this can only be a temporary expedient.

After many years of successful operation the Standing Sub-Committee on Co-operation between headquarters staff and general practitioner representatives of the Local Medical Committee must, as I see it, now come to an end. This has been the basis of much of the progress of community medicine in the West Riding. One hopes that the new relationship in the health service will fully compensate for this.

There is, of course, also the future of the specialised staff at the health department headquarters, medical, nursing and administrative, who obviously cannot all be absorbed into the relatively small Wakefield area health authority. Other health departments in the region are unlikely to have the same problem.

In spite of these difficulties the department adheres completely to the West Riding policy of continuing their normal activities and in continuing to develop the service right up to the last day, and this we intend to do. The contents of this Report, and particularly the personal essay contributions by members of the staff, indicate clearly that we are achieving this objective.

One wonders at times whether community medicine as a discipline is fully understood by our clinical colleagues and their supporting staffs. I feel certain that in the West Riding we have made excellent strides in our joint efforts with general practitioners, and I am sure the basis on which we have done this will continue to bear fruit. In latter years I have also been pleased to see the greater understanding between ourselves and the hospital service, although this has been a little more difficult to achieve. It is, however, still possible I am sure to achieve greater co-ordination on the hospital side and I hope that the current interest in community hospitals run by general practitioners, and where possible in association with health centres, will further this aim. There are signs that serious thought is being directed to this matter. Certain London teaching hospitals have long since adopted a more positive community role. I am sure there is more scope for this in the future.

In this connection I have been pleased, from my association with the new integration courses being run at the present time in many parts of the country,

to see how very effective they have been in bringing together all the disciplines displayed in hospital and community work. In my own experience I witnessed a similar pattern in each of the courses with which I have been associated; first, a strangeness at meeting people doing different jobs yet associating on common ground for educational purposes, followed very closely by the realisation that each knew less than enough about the other's job, and finally an enthusiasm for working together. A similar pattern I have found develops in a joint liaison committee, whether at area or region, and this, one hopes, will be of assistance in overcoming any isolation which may have developed in the three branches of the service during the last 25 years. I feel sure that to complete this pattern of interchange of ideas it may well be necessary for short seminars for consultants and general practitioners to give them an insight into the administration of the new service and the work of the community physician.

It may be of interest to mention a few of the problems which have confronted the West Riding Health Committee or the County Health Department during the last 12 months and in themselves they will illustrate the wide sphere of responsibilities within which community medicine works. For instance, I have had a good deal of sympathy with the committee in their difficult task of deciding their policy towards family planning in these days when attitudes towards such matters have changed so much. I have admired the way in which committee members have faced their delicate task and have realised how each member has had to try and reconcile all the conflicting elements involved. In coming to a decision to offer a free service the committee have not done this lightly but have considered all the aspects concerned and I am sure each of them must have had a considerable conflict of views and emotions to deal with. Their problem of course is a national one, and there has been the inevitable and difficult task of weighing in the balance towards possible increased permissiveness and the ill-effects of some unwanted pregnancies.

The sale of proprietary foods in clinics has also gone through an interesting phase during the past year. It will be remembered that in June, 1970, the committee sponsored some research which was supported by the Research Group of the Society of Medical Officers of Health and carried out by Dr. Duncan Dolton. This research showed that alternative methods of distribution of proprietary foods by and large improved its up-take and gave the nursing staff more time to expand their work amongst other things in the routine assessment of children. These were beneficial results to staff and parents alike and the method was unofficially adopted by a number of divisional medical officers. Recently, however, the committee have approved the adoption of this system throughout the County. Inevitably there has been a little anxiety on the part of some district councils who feared that there might be a lessening of accessibility to food products. Experience has shown, however, that this fear is unfounded; not only can we benefit by directing staff time to duties for which they are trained, but it would appear that welfare foods, which are still on sale at clinics, have in fact increased in their popularity, which is a side benefit which we did not expect since these foods are equally acceptable, from a nutritional point of view, as proprietary brands and are of course an entitlement to mothers of young children. This

change has not had any deleterious effect on the professional work of the clinics and has no doubt improved their usefulness.

Smallpox inevitably becomes priority news whenever it occurs and it was therefore inevitable that the few cases which occurred recently in the London area should be linked with the recent withdrawal of routine vaccination against smallpox for young children. It was not easy to get across the idea to some members of the general public that the two things were quite unconnected, and many saw a contradiction in our withdrawal of routine vaccination for infants and the tremendous number of people who had to be vaccinated around Easter, 1973, before proceeding on holiday. This country was referred to by many foreign countries as an infected area, although officially speaking the designation applied only to the London area. It has to be realised that apart from imported cases this country has been free from smallpox for many decades and we now know how to contain the imported cases when they do occur. It is also as well to remember that vaccination itself carries some risk. The decision therefore not to vaccinate young children is correct in that we had reached the position in this country whereby more misfortunes were being caused by vaccination than by smallpox. The demand for vaccination by other countries when we happened to have one or two cases of imported smallpox on the other hand is something which we have to accede to if the traveller wishes to proceed abroad.

The reorganisation of the social services in 1971 has still left behind it several problems in connection with mental health and questions and problems are still being directed to this department by psychiatrists and general practitioners who feel that the changes have not been for the best. From a practical point of view there appears to be a move from a number of hospitals and departments to introduce their own staff into the community to carry out tasks which they feel are not being done at the present time. A new method of working will be necessary not only for the social services department but for the health department and its successors if new problems are not to be created by unilateral action. It would be sad if the hospitals in their anxiety to fill the gap, neglect the important assistance which could be given to them by general practitioners and community nursing staff for patients discharged from hospital. It is highly important that this problem should be dealt with urgently.

It does look as though the future of certain ancillary workers in local authority health departments such as speech therapists, chiropodists, physiotherapists, occupational therapists, orthoptists etc. are likely to be transferred to the new health authorities, probably with some safeguards as far as those currently employed are concerned. A similar situation could occur regarding hospital social workers who may be employed in the future by local authorities. There has been much debate on these problems and final decisions are awaited. We are still left, however, in some doubt as to the future administration of child guidance which still seems to be causing a good deal of thought. My own view is that it should continue to be linked with the school health service which is to be transferred to the health authority. It seems to me that this is the best way of ensuring continued access to all the skills needed for child guidance problems.

It is hoped that by the time the 1973 Report is published, the history of the Department which is now in an advanced stage of preparation will be available. It already illustrates clearly the fascinating change of emphasis of the Department's activities towards widely changed problems over the last 80 years or so.

My thanks to staff and Committee alike for their patience and understanding.

Health Department,
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May, 1973

on the

W. L. H. H.

County Medical Officer

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SPECIAL REVIEWS

Developmental Screening of Pre-School Children

Domiciliary Midwifery

The Report of the Committee on Nursing

The West Riding Day Nursery Service, 1940-1971

Computer Scheme for the Health Surveillance of Personnel

Driving and Medical Disabilities

Children with Educational and Related Difficulties in the Primary Schools

The History of the Orthodontic Service

DEVELOPMENTAL SCREENING OF PRE-SCHOOL CHILDREN

Denise E. Robertshaw, Principal Medical Officer

The implementation of the scheme for the screening of the developmental progress of pre-school children by health visitors, followed by a detailed developmental assessment by a member of the medical staff if necessary, was completed throughout the County by August, 1971. The routine screening tests are done when a child is 3 months, 6 months, 10 months, 18 months, 2 years and 4 years of age, and, since 1st August, 1971, all children born in the County have been included in this scheme. In some Divisions, only children entering the scheme at birth are having routine screening, but in others children have been introduced into the screening process as they reach the appropriate age for a specific group of tests. Whether or not attempts are being made to screen all pre-school children, the importance of testing the vision of all 3-year-olds has been emphasised and this is being done routinely, sometimes independent of developmental testing.

At the start of the scheme in each Division, all the health visitors were given a talk on the importance of developmental screening, the details of the tests to be done, and a demonstration of the use of the 'Stycar' vision test for 3-year-olds. A standard card is used by the health visitors to record the results of the screening tests; each health visitor has a copy of briefing notes on the tests used and a copy of the report by Mary D. Sheridan, *The Developmental Progress of Infants and Young Children*. However, by the beginning of 1972, it was apparent that the original in-service training of staff would need to be followed up by further training, both to ensure standardisation of testing techniques throughout the County and to allow the staff to discuss the difficulties which had arisen in practice.

The problem was how to do this for approximately 300 members of staff, when what appeared to be needed was a practical demonstration of the tests used, highlighting the difficulties which might arise, and allowing the staff to ask questions. To be of value, such demonstrations needed to be undertaken for a small audience only, otherwise it would have been impossible to establish rapport with the child being tested. If standardisation of testing throughout the County was to be achieved, then ideally one person would have to undertake the whole of the additional training of the staff. Films and slides were one possible method of presenting standardised procedures to different groups, but a study of those available commercially showed that it was not possible to obtain either a film or set of slides which showed the exact tests at the appropriate ages for the West Riding scheme.

It was decided, therefore, to make an 8 mm. film of the screening tests being undertaken by the health visitors, including both correct techniques and some of the common mistakes. This film could then be used to ensure that all staff knew the standard way in which some tests must be given. It would also be useful for

showing to new members of staff and for future revision of testing techniques. The film was made in the Spring of 1972 at the Ardsley Health Centre with the assistance of Mr. F. Smith, Health Education Technician, and the participants were two members of the health visiting staff and children from the neighbourhood. Finally, loop cassettes were made from the film of each group of tests to allow individual showing of the tests done at specific ages. A set of notes was produced to ensure that the important points are emphasised when the cassettes are used for teaching purposes.

In addition to the film, there was a need for the staff to be able to discuss the specific problems that had arisen and it was felt that the quickest way to do this would be for the nursing officers (health visiting) to meet and discuss the difficulties being experienced. Two meetings were arranged with approximately 10 nursing officers attending each, and a preliminary talk on the reason for standardisation of testing techniques, following which there was a discussion of the problems which arose with each test, a practical demonstration of the tests for each age group and a final summing up.

The most common problems were:

- The difficulty of doing an 'Ortolani' test on a 3-month-old baby.

- Uncertainty as to the exact method of using the light test for detecting a squint (all found the cover test impossible in young infants).

- Very few children are toilet trained at 18 months.

- Some staff had not appreciated that 1 inch cubes, not interlocking bricks, must be used for building.

- Care must be taken to ensure a child copies, not imitates, to complete the 'Copy a Circle' and 'Copy a X' tests successfully, etc.

Other difficulties had also been experienced, e.g. whereas some testing was done in the child's own home, a large amount was undertaken at special clinic sessions and, in some areas where mothers started work whilst the children were still young, attendance at these sessions was poor. However, most of the staff felt that they could manage to see all children at least once during the first 10 months of life at the appropriate age for developmental screening; but that it was not possible to see every child in every age group. One health visitor had paid seven home visits without being able to see one child. It was pointed out that this was over zealousness and that, if it was not possible to see a child at the correct age, it was better to leave that particular group of tests and to try to ensure the child was seen when it was due for the next developmental screening test. The nursing officers felt that the discussions had been very helpful and the responsibility for ensuring that the health visitors in their area received further practical training and help was left in their hands.

The return for 1972 on developmental assessments of pre-school children showed that the health visitors had screened the majority of children born in that year. There were 27,999 live births in the County and 21,262 children born

in 1972 had been screened by a health visitor at least once. The total number of individual children screened by the health visitors in 1972 was 83,199; of these, 2.7 per cent. were referred to the local authority medical staff for a detailed assessment; 0.8 per cent. were kept under observation by the local authority doctors and 0.75 per cent. were referred for further examination and treatment. As a result of developmental assessments, 174 children were placed on the observation register in 1972 (0.21 per cent. of total screened) and 145 on the handicap/disability register (0.17 per cent. of total screened). Although these numbers may appear small, they refer to children who were found to have defects as a result of developmental screening and do not include children who were placed on either register because of defects discovered in other ways—congenital malformations, hospital consultants' letters, screening tests for specific defects, e.g. phenylketonuria. It is of interest that these figures make up 4.7 per cent. of the total number of children placed on the observation register and 6.3 per cent. of those placed on the handicap/disability register in 1972 so that a significant number of children with conditions or handicaps, which would affect their future development and because of which special education might need to be provided, would not have been identified at such an early age if routine developmental screening was not being done.

During 1972, 1,491 children with suspected squint were referred to ophthalmologists. Early specialist supervision of children with squints is important in order that treatment may be given as soon as is necessary to prevent permanent defects of vision. This early detection of possible squints has improved since 1971 when 711 cases were referred to ophthalmologists.

'Stycar' vision testing of pre-school children increased in 1972 when 19,554 individual children were tested; of these, 3.3 per cent. were kept under observation and 1.5 per cent. had a visual loss sufficient to require referral to a specialist. In the past, the majority of these children would not have been discovered until they had a vision test at their school entry medical examination at 5 years of age.

The work done by the health visiting staff in connection with developmental screening involved them in an extra 5,373 clinic sessions in 1972, whilst not appreciably reducing the number of home visits that were made to children under 5 years of age. However, from the figures quoted above, this work has produced positive results apart from other benefits which are immeasurable; for example, an opportunity to give health education advice to the mothers during the tests, and increased contact between health visitors and mothers and children 2-5 years of age.

The introduction of developmental screening of pre-school children, together with an increasing trend for health visitors to undertake routine vaccination and immunisation of children has meant an alteration in the pattern of child health clinics. In many cases, the child health clinic of the past, attended by a doctor and a health visitor and where a miscellany of tasks was carried out by the health visitor, e.g. weighing of babies, health education, general advice on feeding etc., whilst the doctor did the vaccinations and immunisations and examined children

at the request of the mother (often for conditions on which the family doctor should have been consulted), no longer exists. The present child health clinics are often staffed by health visitors and assistants to health visitor and the children attend by appointment for vaccination and immunisation and developmental screening tests. Children requiring to see the local authority doctor because of special defects or because they require further assessment following their developmental screening tests are seen at sessions set aside for this purpose. Although this has meant that the child health clinic, as a social gathering for mothers, has been lost, both the medical and nursing staff feel that there are more rather than less opportunities for the mothers to discuss their problems with the staff. There is, therefore, a more comprehensive health service being offered to all children under 5 years of age.

The birth rate in England and Wales continued to rise until 1964, after which it started to decline and the birth rate in the West Riding County Council area has followed this general trend (Fig. 1). At the same time, there has been a continued fall in the percentage of domiciliary deliveries in the County (Fig. 2). This is related to a growing awareness of factors such as 'older age of mother', 'high parity', 'history of previous difficult or dangerous pregnancy or delivery', 'low occupational or social class', which place the mother and child at risk during pregnancy and delivery and has resulted in emphasis being placed on encouraging these women to go into hospital for their confinement. A growing tendency of women who are delivered in hospital has led to an increasing tendency for women to be discharged home from hospital before the 10th day after delivery (Fig. 3). This has been accompanied by more participation by the general practitioner in the antenatal and postnatal care of women booked for hospital confinement, together with an alteration in the local health authority's midwifery services. In 1964, 7,239 women attended local health authority antenatal and postnatal clinics; by 1971 this number had fallen to 2,328. The number of sessions attended by local health authority medical officers or doctors working on behalf of the authority was 3,008 in 1964 and 989 in 1971. Work undertaken by the general practitioner for his own patients showed a corresponding increase. In 1964, 902 antenatal sessions were held in County health centres and clinics by family doctors for their own patients and domiciliary midwives attended 1,945 antenatal sessions in the doctors' own surgeries; in 1971, the numbers were 2,849 and 4,308 respectively (see pages 96 and 97).

Accompanying these changes in maternity care, the number of domiciliary midwives employed was reduced from 234.7 whole-time equivalent in 1964 to 173.6 whole-time equivalent by 1971.

If a 24-hour cover was to be provided for domiciliary confinement, further reduction in staff and been considered to be impossible. The decrease in the number of births at home could mean that midwives were 'on call' for long periods during the evening and night without having a request to visit a patient. The need to assess how much time was being spent 'on call' unnecessary 'on duty', together with the overall change in the pattern of the domiciliary midwifery

DOMICILIARY MIDWIFERY

Denise E. Robertshaw, Principal Medical Officer

Marjorie G. Atkinson, Director of Nursing Services

In 1970 a sub-committee of the Department of Health and Social Security's Standing Maternity and Midwifery Advisory Committee reported on *Domiciliary Midwifery and Maternity Bed Needs* (Peel Report). Although the recommendations of the Report have not been implemented, in this County it stimulated an interest in reviewing the existing pattern of domiciliary midwifery.

The birth rate in England and Wales continued to rise until 1964, after which it started to decline and the birth rate in the West Riding County Council area has followed this general trend (Fig. 1). At the same time, there has been a continued fall in the percentage of domiciliary deliveries in the County (Fig. 2). This is related to a growing awareness of factors such as 'older age of mother', 'high parity', 'history of previous difficulties during pregnancy or delivery', 'low occupational or social class', which place the mother and child 'at risk' during pregnancy and delivery and has resulted in emphasis being placed on encouraging these women to go into hospital for their confinement.

The greater number of women who are delivered in hospital has led to an increasing tendency for women to be discharged home from hospital before the 10th day after delivery (Fig. 3). This has been accompanied by more participation by the general practitioner in the antenatal and postnatal care of women booked for hospital confinement, together with an alteration in the local health authority's midwifery services. In 1964, 7,239 women attended local health authority antenatal and postnatal clinics; by 1971 this number had fallen to 2,328. The number of sessions attended by local health authority medical officers or doctors working on behalf of the authority was 3,008 in 1964 and 989 in 1971. Work undertaken by the general practitioner for his own patients showed a corresponding increase. In 1964, 902 antenatal sessions were held in County health centres and clinics by family doctors for their own patients and domiciliary midwives attended 1,945 antenatal sessions in the doctors' own surgeries; in 1971, the numbers were 2,849 and 4,308 respectively (see pages 96 and 97).

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The need to assess how much time was being spent on unnecessary 'on call' duty, together with the overall change in the pattern of the domiciliary midwifery

service and the imminent Reorganisation of the National Health Service resulted in a decision to make a detailed survey of the work undertaken by the midwives throughout the County. The survey took place between 20th March and 16th April, 1972, inclusive, and all the domiciliary midwives and home nurse/midwives were involved. The objectives of the survey were:

1. To review the content of the domiciliary midwife's daily work.
2. To estimate which work will continue to be undertaken by the domiciliary midwife in the community setting, regardless of place of confinement.
3. To assess whether some of the work at present being undertaken by the domiciliary midwife could be carried out by other staff.
4. To assess whether it is possible to reorganise the work of the domiciliary midwife to result in better deployment of available staff.
5. To ascertain how much work is undertaken by the domiciliary midwife at the present time on behalf of hospitals (this includes the antenatal care of hospital-booked cases and the care of early discharges from hospital).

Throughout the survey period each member of staff kept a diary of details of her work during the day and when 'on call'. Off duty, sick leave, and annual holiday were also noted, as it is necessary to provide staff to cover these contingencies.

Summarised in the Addendum are the categories of work undertaken by the midwives and the average amount of time per four weeks spent on each.

Comments on Statistical Results:

TO REVIEW THE CONTENT OF THE DOMICILIARY MIDWIFE'S DAILY WORK:

The Work of Full-time Midwives:

A. Visits to Home:

Antenatal: Visiting time (including ineffective calls) amounted to a County average of 7 hrs. 28 mins. per midwife for the four-week period of the survey, the range being from 1 hr. 43 mins. to 15 hrs. 29 mins. Obviously, since the birth rate and the proportion of home confinements vary throughout the County, there must be wide variation in the numbers of expectant mothers requiring to be booked or visited. It is also notable that, where the hours spent on labour calls are relatively higher than the County average (9 hrs. 24 mins.), the antenatal visiting times are also higher.

Labour: The County average was 9 hrs. 24 mins. per midwife over the four weeks of the survey. The range was from no labour calls at all in two Divisions to 17 hrs. 14 mins. per midwife.

It should be noted that the first two weeks of the survey were the last two weeks of a quarter in which the national number of births fell from 204,000 in 1971 to 188,000 in 1972. (Registrar General's statistics for the March quarter.)

Postnatal nursing visits: Over the four-week period, the County figure of 26 hrs. 42 mins. per midwife was exceeded in 12 Divisions and, in four of these, the divisional figures were not associated with a relatively-high figure for labour calls.

The time spent on both antenatal and postnatal care seems to be less than uniformly-high standards would suggest was necessary.

B. Visits to Hospital/Maternity Unit:

This second section was on direct links with hospital and/or laboratory. Only one Division, where links with the general practitioner maternity unit are well developed, showed much activity from all midwives. Liaison work—carried out by one or two members of staff on behalf of colleagues—is still a worthwhile and valuable exercise, but is not accurately reflected in a survey such as this.

C. Clinics:

During the four-week period involved, six Divisions exceeded the County figure of 15 hrs. 22 mins. per midwife, the total range being from 8 hrs. 10 mins. to 29 hrs. 42 mins. General practitioner sessions, mothercraft classes, local health authority antenatal sessions and cervical cytology were the headings in this section. Work in clinics will be discussed more fully later in this report, but it was pleasing to find that there is reasonable educational coverage over the whole County.

D. Consultations:

Consultations with nursing colleagues at divisional health offices and with general practitioners, 'others', and hospital staff (in that order) contributed over the four weeks to a County average of 5 hrs. 2 mins. per midwife, individual Divisions ranging from 2 hrs. 21 mins. to 8 hrs. 21 mins.

E. Miscellaneous:

This section included *travelling time*. With a County average for four weeks of 22 hrs. 59 mins. per midwife, the range was from 17 hrs. 34 mins. to 38 hrs. 36 mins. All those Divisions showing above average figures either include rural areas or are linked with a higher-than-average home visiting figure; sometimes both factors apply. *General written work* during the survey showed an average of 4 hrs. 21 mins., the range being from 2 hrs. 12 mins. to 6 hrs. 28 mins. The *telephoning* average was 1 hr. 12 mins. and—apart from one high figure (7 hrs. 32 mins.)—the range was from 17 mins. to 3 hrs. 34 mins. These figures appear to be what could reasonably be expected. The *written work relating to the survey* was longer—from 3 hrs. 40 mins. to 10 hrs. 20 mins. Other 'miscellaneous' items included preparations for students, for talks, community visits with pupil midwives, special visits, care of equipment, home nursing duties where

appropriate, and uncoded work. The County average for miscellaneous items other than travelling, written work and telephoning was 9 hrs. 58 mins.

Comments:

The total midwifery content amounted to 100 hrs. 20 mins. (excluding uncoded work) as a County average. In terms of hours of total active work per week, the range was from 22 hrs. 51 mins. to 35 hrs. 50 mins. Together with these figures, however, the on-call hours must be considered. The average per midwife for the survey period was 282 hrs. 12 mins. per midwife. The range throughout the County was from 177 hrs. 47 mins. to 349 hrs. 21 mins. In weekly terms, the range is from 44 hrs. 25 mins. to 87 hrs. 20 mins. In total terms of work/on-call commitment, therefore, the weekly range is from 71 hrs. 26 mins. to 114 hrs.

With the declining domiciliary delivery rate, this heavy on-call commitment should be investigated by more realistic night rotas wherever such arrangements are practical. The increasing tendency to routine planned induction of labour is, of course, the ultimate answer except for those women who refuse either hospital confinement or intervention.

The Work of Home Nurse/Midwives and Part-time Midwives:

Four Divisions have dual-purpose nursing staff, comprising 36 *full-time home nurse/midwives*. Looking at the same categories of activity as the full-time midwives, a similar pattern emerges and, remembering that only half their time is devoted to midwifery, their averages reflect a broadly-similar proportion of midwifery as is worked by full-time midwives. It has been assumed that they were spending more time on home nursing duties than on midwifery, but the survey period showed that the work was evenly distributed.

Mention must be made of the work of *part-time midwives* (14 in all), whose main contribution is in postnatal visiting to mothers discharged early from hospital, attendance at general practitioner antenatal clinics, cervical cytology and mothercraft classes. In the employment of part-time midwives, flexibility to meet specific needs makes the standardisation of their contribution in a survey such as this extremely difficult.

TO ESTIMATE WHICH WORK WILL CONTINUE TO BE UNDERTAKEN BY THE DOMICILIARY MIDWIFE IN THE COMMUNITY SETTING, REGARDLESS OF PLACE OF CONFINEMENT:

The tables show that the majority of the domiciliary midwives' work is done in the patients' homes or in the local clinic (either general practitioner or local health authority). If 100 per cent. hospital confinements occurred, this would only account for 7 hrs. 31 mins. per month of the midwives' present domiciliary work (code nos. 7, 10 and 13). It is suggested that, wherever the place of confinement, the greater part of the antenatal and postnatal care should take place in the area of the woman's home.

A survey of the main hospitals used by domiciliary midwives shows that the distances travelled may be from 300 yds. to 30 miles. The distances to be

travelled by patients would be comparable and it is unreasonable to expect a woman (with, perhaps, one or two toddlers) to travel long distances for routine antenatal care which could be given by her family doctor and the domiciliary midwife.

Similarly, the long distances involved point to the advantage of having some midwives based on the district rather than on a hospital, although the organisation of both hospital and domiciliary midwives' work in any one area may be controlled from a central point. In compact areas, some midwives could be based on the hospital but, in the more scattered areas, e.g. Division No. 1 (Skipton) where midwives travel from 1-20 miles, Division No. 7 (Harrogate), $\frac{1}{2}$ -14 miles, and Division No. 9 (Rothwell/Wetherby), 4-15 miles, it would be uneconomical to base the majority of midwives working in the field on the hospital. Also, in these areas, the number of hospitals visited by local health authority midwives is large; several Divisions send patients into 11 different hospitals. Reorganisation may reduce this number but, in rural areas, there will still be occasions when doctors practising in the same area will use different hospitals or one doctor may use several hospitals. If there is to be close co-operation between family doctors and midwives for the benefit of the patient, it is probably better that there is a one-to-one relationship between the doctor and midwife rather than several midwives from different hospitals attending one doctor's patients.

TO ASSESS WHETHER SOME OF THE WORK AT PRESENT BEING UNDERTAKEN BY THE DOMICILIARY MIDWIFE COULD BE CARRIED OUT BY OTHER STAFF:

In addition to the coding sheets, each member of staff completed a form relating to location, staffing, patient attendances, duties and length of antenatal sessions attended during the period in question.

The attendance of midwives at general practitioners' antenatal sessions has increased considerably over the past few years, but it is important that the midwife should be present in a truly professional capacity if patients are to benefit. Hence, it is expected that the midwife will book patients and, whilst she may prepare patients for examination by urine testing and taking of blood pressures, she should also then complete the care by abdominal palpation and general observation. This, in fact, happens in the large majority of sessions. In 10 Divisions, some clinics were midwives' sessions without a doctor present. In many instances, more than one doctor was holding a session at the same time and more than one midwife was then attending.

The majority of general practitioners provided clerical help but few local health authority clinics had such assistance.

Attendances were linked to length of sessions (from 7 patients to 31 and from less than 1 hour to 4 hrs. 18 mins.). The clinic situation would appear to be well organised.

TO ASSESS WHETHER IT IS POSSIBLE TO REORGANISE THE WORK OF THE DOMICILIARY MIDWIFE TO RESULT IN BETTER DEPLOYMENT OF AVAILABLE STAFF:

Because of the results of the survey showing how the domiciliary midwives' time is spent and in view of the impending Reorganisation of the whole Health Service, major redeployment of midwifery staff is not now anticipated. There is increasing liaison between local health authority midwives and hospital midwives and, with 1974 in mind, it might be advantageous to hold joint meetings of midwifery staff in relation to future health areas.

TO ASCERTAIN HOW MUCH WORK IS UNDERTAKEN BY THE DOMICILIARY MIDWIFE AT THE PRESENT TIME ON BEHALF OF HOSPITALS (THIS INCLUDES THE ANTENATAL CARE OF HOSPITAL-BOOKED CASES AND THE CARE OF EARLY DISCHARGES FROM HOSPITAL):

The average amount of time spent by all full-time midwives in the County on work included in this section (code nos. 2, 5, 8, 11, 18, 19, 20, 21, 34 and 52) is equivalent to approximately 20 per cent. of their working time. This average includes wide variations in the time spent by midwives in different Divisions on this work, the range being between 13 hrs. 19 mins. to 37 hrs. 18 mins. In the rural areas, the domiciliary midwife tends to spend more time than average in connection with hospital-booked patients whilst the midwives in the more urban areas spend less. The greater part of the work done by domiciliary midwives in relation to hospital bookings are postnatal visits, mainly to patients four days or more after delivery. It is of interest that follow-up visits to the home of antenatal patients booked for hospital confinement tend to account for more of the midwives' time in the south of the County than in the north. There is no outstanding difference in the time spent in rural and urban areas on such work. Only one Division has any involvement with hospital antenatal/postnatal clinics. This is the Division which shows the largest amount of full-time midwives' time spent on special visits done at the request of the hospital, i.e. 45 mins. (County average—7 mins.). However, the amount of time involved is so small that it is doubtful if any significance can be attached to this.

Conclusions:

The survey findings emphasise the volume of work done in the community on behalf of hospital-booked patients in the antenatal period. Care is very frequently given by general practitioners and midwives until the thirty-second week of pregnancy; antenatal education is given to many mothers booked for hospital confinements. Both these items are helpful in that the mothers' travelling to and from hospital is lessened. After delivery in hospital, many patients return quite quickly to the district midwives, whom they now already know and who are, in fact, expecting them home. From this it would appear that within the community a certain amount of valuable continuity of care is maintained, and expectant and nursing mothers know a local midwife to whom they can and do turn for advice. The sense of working as a member of a team would be heightened if it were possible for more consultant obstetricians to hold clinics around the periphery of the maternity unit catchment area at regular intervals supported by community-based staff.

Involvement of community staff in general practitioner units has, to date, been most successful in the Barnsley area where 14 midwives accompanied 104 patients into the unit for delivery during 1972 and subsequently cared for them until discharge. Attachment of staff to general practitioner units can take two main forms—either each midwife accompanies her patient in labour into the unit, delivers her and subsequently returns for nursing visits until discharge home, or the domiciliary midwives staff the unit on a rota basis, delivering and subsequently nursing each other's patients. The first may be called patient-centred involvement, and the second unit-centred. The first method is the choice where distances are not too great.

The work mentioned above, as undertaken on behalf of hospitals, was also midwifery done with general practitioners in a close teamwork situation. Attachment of midwives to one general practice is not normally numerically feasible, but every endeavour is made for the same midwives to attend the same general practitioner clinics. Ease of working together, and reasonable continuity of care to patients, is at present facilitated by a similar philosophy towards hours of work and acceptance of time spent 'on call'. These close links are very valuable to general practitioners and midwives alike.

It is fitting here to pay tribute to the long-serving domiciliary midwives whose delivery rate for many years was far too high and whose 'on call' commitments were heavy indeed at the end of a long day's work.

As the delivery rate has declined, it has been possible to organise night rotas or unofficial stand-in arrangements by mutual consent. Work is now being undertaken with a view to reducing the 'on call' commitment as far as is practicable and many Divisions now use such rotas. A scrutiny of three Divisions showed that two midwives 'on call' per night will probably be adequate. For the future, shift working could be the right way. The economic necessity of requiring staff on night shift to be actively engaged suggests that attendance at hospital is called for and, if deliveries could be undertaken when not involving district work, expertise in delivery could thereby be maintained. Even this does not quite fit the areas furthest from the hospital when, in severe weather, it would obviously be ludicrous for the midwife on duty to struggle through fog or snow, only perhaps to struggle back again shortly afterwards. Beyond a certain radius, therefore, daytime work to cover the district from 9.00 a.m. to 6.00 p.m., with 'on call' duties on a rota basis (followed by morning relief if called out) would be preferable. Whichever of the two systems applied, a period of two to three weeks hospital in-service training per annum, particularly for deliveries, would be necessary together with attendance at study days.

Once this was the accepted pattern, it may be valuable for hospital midwives willing to undertake relief in the community, or considering a change to community work, to have a two to three week community refresher course. In addition, a hospital-based midwife could helpfully share in the community-based antenatal education.

It is somewhat ironical to find that, as the domiciliary delivery rate declines, requests for domiciliary involvement in midwifery training are more numerous than ever before, requiring more approved midwife teachers, and certainly, in the County view, requiring either adequate numbers of domiciliary deliveries or involvement with general practitioner units, so that the community-based midwife is seen to be expert in all facets of midwifery. The wider single period training syllabus, with observation visits to many other services, is welcomed as appropriate to today's team approach to care.

The final point that the survey findings highlighted has been briefly touched upon—that of distances to be travelled either by mothers to and from hospital or by staff attending hospital or general practitioner units, and hence the continuing need for community-based staff. This is not trying to resist change, or unification, but the result of years of thinking in relation to areas of widely differing population densities. Unification will have simpler aspects such as common supplies, easier communications, and shared in-service training facilities, but will only develop at a deeper level by mutual respect for and understanding of differing traditions of working. If community staff attend for two to three weeks in hospital each year, and consultants find it possible to attend the larger health centres (which could serve 25,000-30,000 population) in turn, the best ways of working for each locality can eventually be worked out by the team as a whole.

Acknowledgements:

Our very warm thanks are due to the midwives who took part in the survey, the divisional medical officers and staffs, Mr. T. R. Schofield and Mr. E. Brown, and their colleagues, who collated the figures.

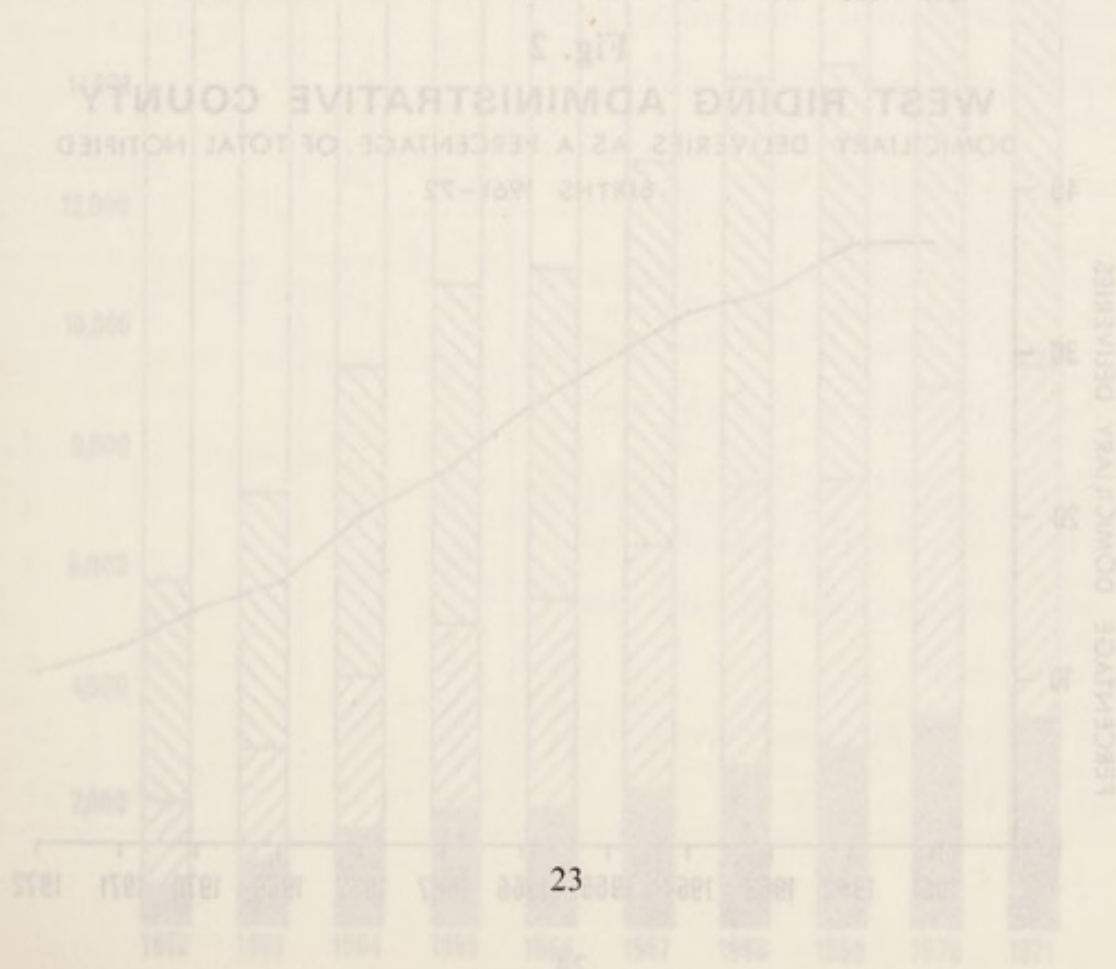


Fig. 1
BIRTH RATES 1961-72

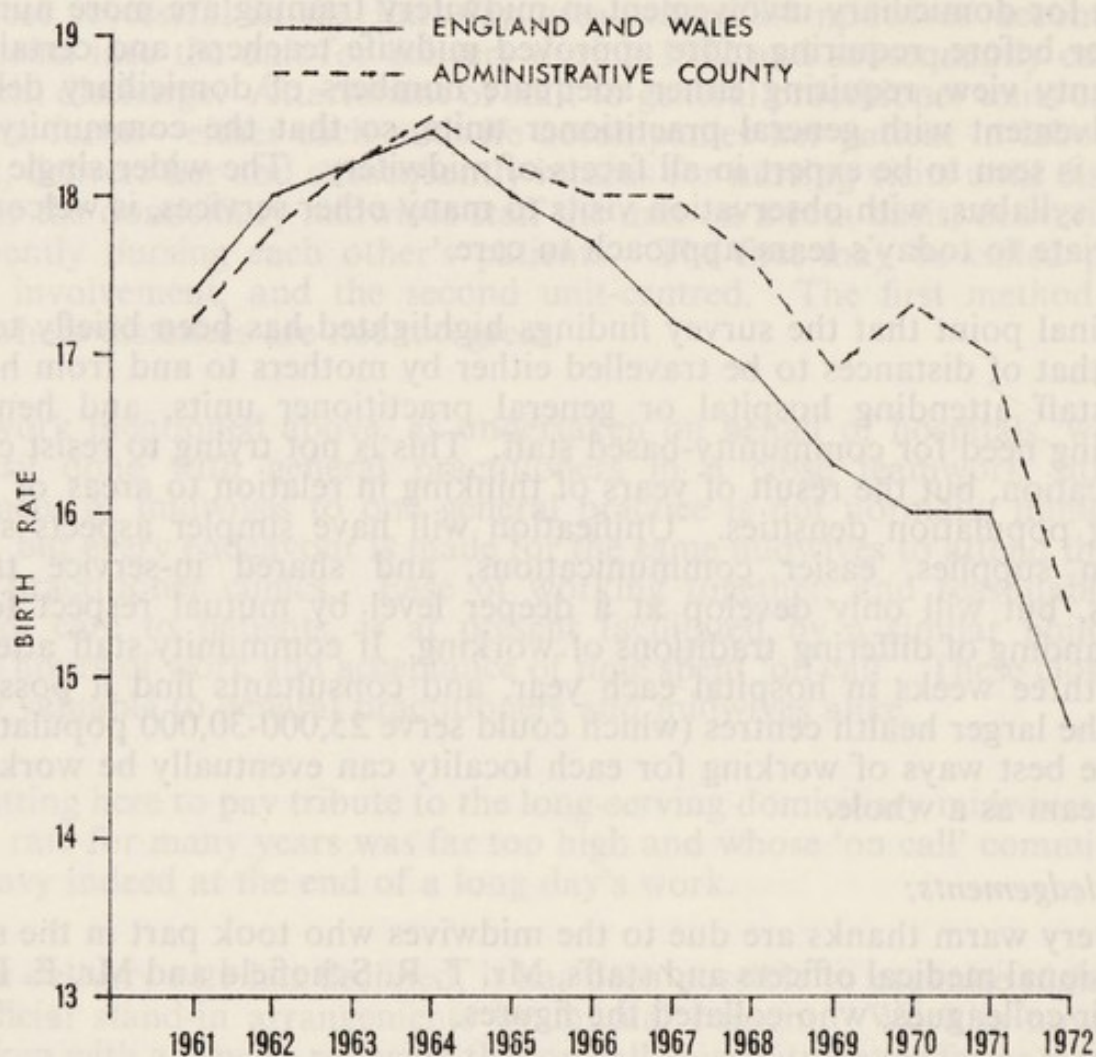


Fig. 2
WEST RIDING ADMINISTRATIVE COUNTY
DOMICILIARY DELIVERIES AS A PERCENTAGE OF TOTAL NOTIFIED
BIRTHS 1961-72

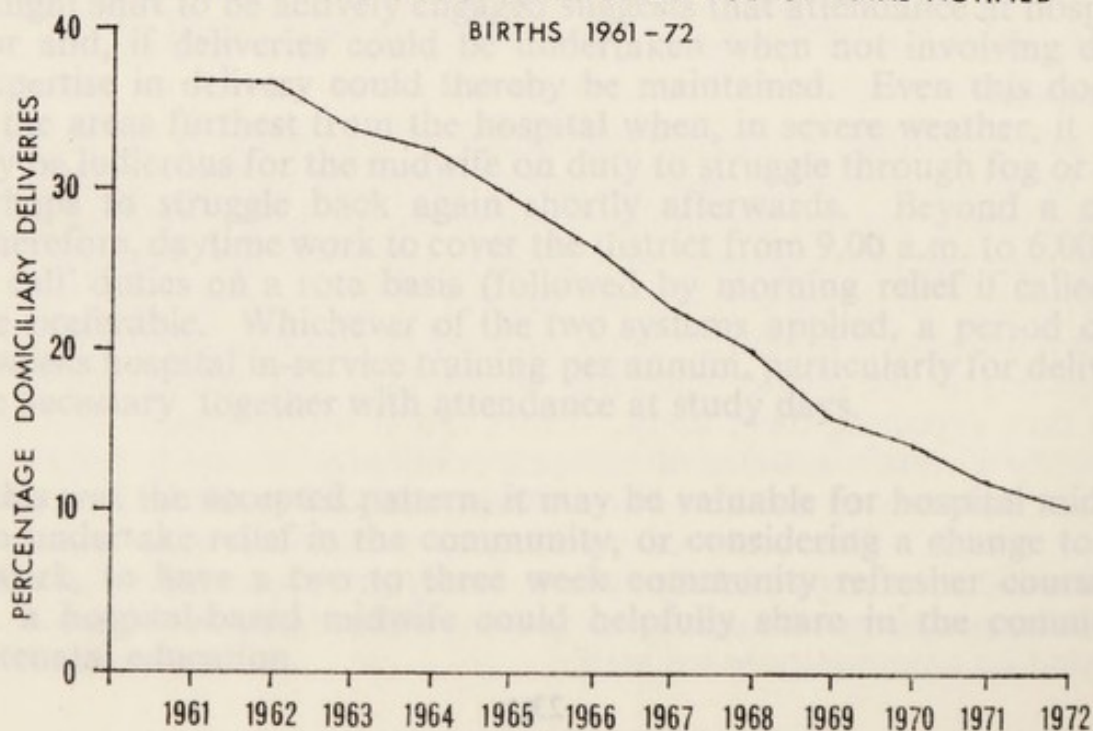
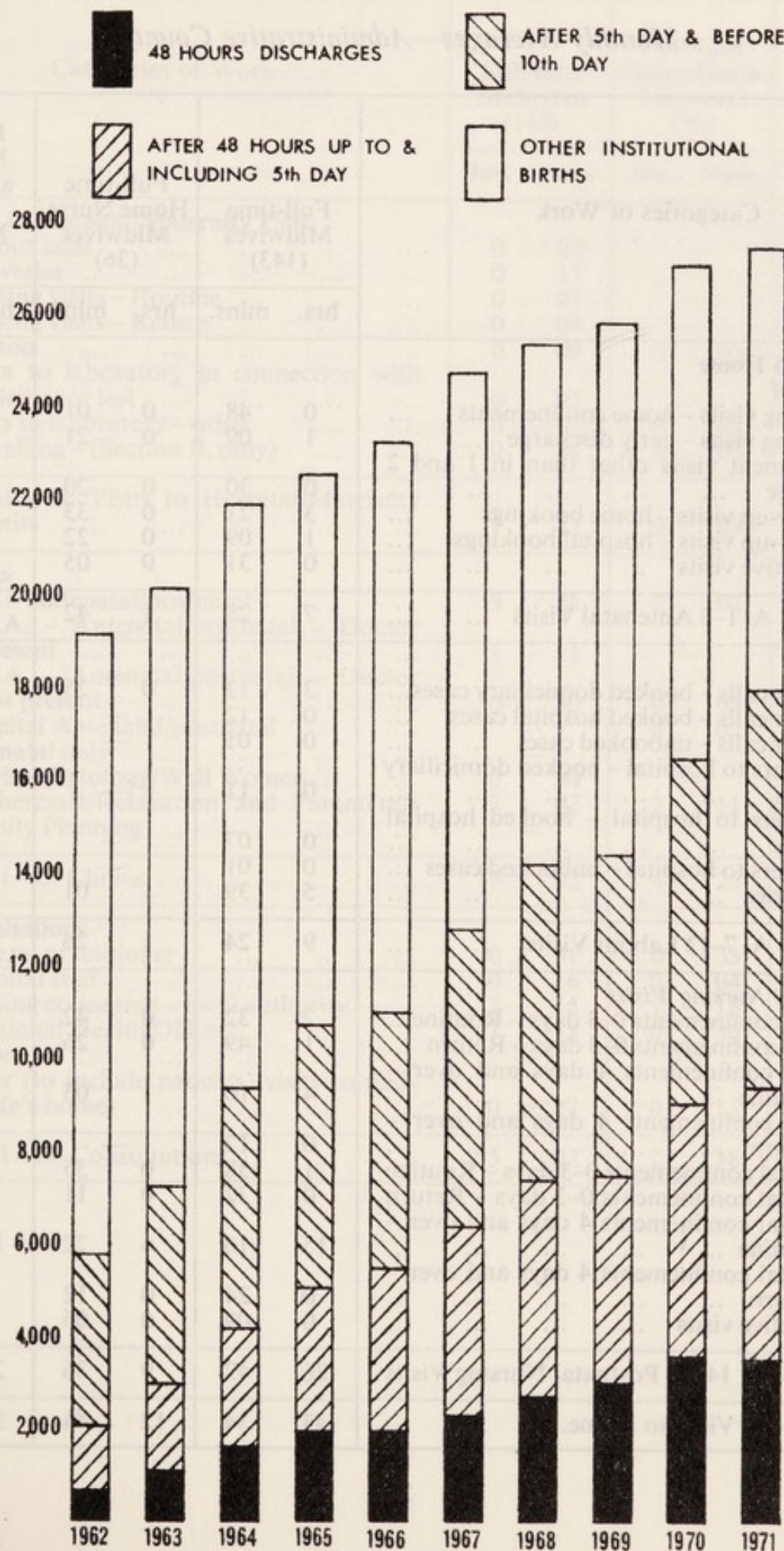


Fig. 3

WEST RIDING ADMINISTRATIVE COUNTY

PATTERN OF TIME OF DISCHARGE FROM INSTITUTIONS 1962-71



Monthly Averages—Administrative County

Categories of Work	Full-time Midwives (143)		Full-time Home Nurse/ Midwives (36)		Full-time Midwives and Home Nurse/ Midwives (179)	
	hrs.	mins.	hrs.	mins.	hrs.	mins.
A. Visits to Home						
<i>Antenatal</i>						
1. Booking visits – home confinements ...	0	48	0	01	0	38
2. Booking visits – early discharge ...	1	09	0	21	0	59
3. Assessment visits other than in 1 and 2 above ...	0	30	0	20	0	28
4. Follow-up visits – home bookings ...	3	21	0	33	2	47
5. Follow-up visits – hospital bookings ...	1	09	0	22	1	00
6. Ineffective visits ...	0	31	0	05	0	26
Total – A. 1–6 Antenatal Visits ...	7	28	1	42	6	18
<i>Labour</i>						
7. Labour calls – booked domiciliary cases...	3	13	0	25	2	39
8. Labour calls – booked hospital cases ...	0	12	—	—	0	10
9. Labour calls – unbooked cases ...	0	01	—	—	0	01
10. Transfers to hospital – booked domiciliary cases ...	0	11	—	—	0	09
11. Transfers to hospital – booked hospital cases ...	0	07	—	—	0	06
12. Transfers to hospital – unbooked cases ...	0	01	—	—	—	—
13. Deliveries ...	5	39	1	01	4	43
Total – A. 7–13 Labour Visits ...	9	24	1	26	7	48
<i>Postnatal Nursing Visits</i>						
14. Home confinements 0–3 days – Routine...	2	32	0	42	2	10
15. Home confinements 0–3 days – Return ...	1	49	0	26	1	32
16. Home confinements 4 days and over – Routine ...	4	10	1	03	3	32
17. Home confinements 4 days and over – Return ...	0	12	—	—	0	10
18. Hospital confinements 0–3 days – Routine	1	38	0	35	1	26
19. Hospital confinements 0–3 days – Return	0	32	0	11	0	28
20. Hospital confinements 4 days and over – Routine ...	15	16	6	22	13	28
21. Hospital confinements 4 days and over – Return ...	0	24	0	12	0	22
22. Ineffective visits ...	0	09	0	05	0	08
Total – A. 14–22 Postnatal Nursing Visits	26	42	9	36	23	16
Total – A. Visits to Home... ..	43	34	12	44	37	22

Monthly Averages—Administrative County — continued

Categories of Work	Full-time Midwives (143)		Full-time Home Nurse/ Midwives (36)		Full-time Midwives and Home Nurse/ Midwives (179)	
	hrs.	mins.	hrs.	mins.	hrs.	mins.
B. Visits to Hospital/Maternity Unit						
23. Labour calls	0	03	—	—	0	02
24. Deliveries	0	17	—	—	0	14
25. Nursing visits — Routine	0	07	—	—	0	06
26. Nursing visits — Return	0	03	—	—	0	03
27. Liaison	0	09	0	05	0	08
28. Visits to laboratory in connection with Kleihauer test	0	02	—	—	0	01
29. Visits to laboratory — other	0	07	0	01	0	05
30. Travelling — (Section B. only)	0	24	0	03	0	20
Total — B. Visits to Hospital/Maternity Units	1	12	0	09	0	59
C. Clinics						
31. G.P. — Antenatal/postnatal	9	25	2	02	7	56
32. L.H.A. — Antenatal/postnatal — Doctor present	1	11	—	—	0	57
33. L.H.A. — Antenatal/postnatal — Doctor not present	0	30	0	05	0	25
34. Hospital Antenatal/postnatal	—	—	0	07	0	01
35. Postnatal only	—	—	—	—	—	—
36. Cervical Cytology/Well Women	0	34	—	—	0	27
37. Mothercraft/Relaxation and Parentcraft	3	42	2	11	3	24
38. Family Planning	—	—	—	—	—	—
Total — C. Clinics	15	22	4	25	13	10
D. Consultations						
39. General practitioner	0	51	0	33	0	48
40. Hospital staff	0	16	0	04	0	14
41. Nursing colleagues — local authority	2	15	1	18	2	03
42. Divisional Health Office	1	13	0	30	1	04
43. Tutors	—	—	—	—	—	—
44. Other (to include patients' visits to mid- wife's home)	0	27	0	13	0	24
Total — D. Consultations	5	02	2	38	4	33

Monthly Averages—Administrative County — continued

Categories of Work	Full-time Midwives (143)		Full-time Home Nurse/ Midwives (36)		Full-time Midwives and Home Nurse/ Midwives (179)	
	hrs.	mins.	hrs.	mins.	hrs.	mins.
E. Miscellaneous						
45. Travelling (other than in B.30)	22	35	23	32	22	47
46. Written work – general	4	21	4	30	4	23
47. Written work relating to survey	4	35	3	26	4	21
48. Telephoning (other than included in D. Consultations)	1	12	1	40	1	17
49. Preparation for pupil midwives and student nurses	0	14	—	—	0	11
50. Preparation for talks and demonstrations	0	18	0	09	0	17
51. Community care programme visits with pupil midwives	0	05	—	—	0	04
52. Special visits at request of hospital ...	0	07	0	05	0	07
53. Care of equipment... ..	1	43	1	26	1	39
54. Home nursing duties (for Home Nurse/ Midwives only)	—	—	57	23	11	33
55. Uncoded work (including refresher courses)	7	21	5	04	6	53
Total – E. Miscellaneous	42	31	97	15	53	32
Total – A, B, C, D, E	107	41	117	11	109	36
56. Off duty	205	32	183	00	201	00
57. Annual holiday	71	25	64	00	69	55
58. Off sick	5	10	8	00	5	44
59. On call	282	12	299	49	285	45
Total – Four Weeks' Period	672	00	672	00	672	00
Hospital Work (Items 2, 5, 8, 11, 18, 19, 20, 21, 34, 52)	20	36	8	13	17	39

THE REPORT OF THE COMMITTEE ON NURSING

Marjorie G. Atkinson, Director of Nursing Services

A Committee under the chairmanship of Professor Asa Briggs was set up on 2nd March, 1970, with its terms of reference:

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

Health in the West Riding, 1970, mentioned the visit of some members of the Committee to the County. The Report of the Committee (The Briggs Report) was published in October, 1972, and, if implemented, far reaching changes in nurse training will be brought about within the next seven to 10 years.

Before enlarging upon the Report, it will be helpful to review the present County involvement in nurse training.

Post Registration Training:

The County requires and provides training in district nursing for the members of its staff. Two courses annually are held with 10 students in each course. Similar training for State Enrolled Nurses is planned to commence in January, 1973.

The County has a sponsorship scheme for health visitor training whereby up to 33 candidates are trained at schools in Leeds, Bradford, Sheffield, Hull, Manchester, and Preston. Practical fieldwork experience is provided by 21 Fieldwork Instructors and, in addition, observation weeks are arranged for up to 30 student health visitors from other schools.

The County participates in the training of midwives chiefly from the York and Doncaster training schools. This involves practical teaching in the community by approved teaching midwives. The Central Midwives Board is in process of replacing a two-part training by a single period of training of slightly less than a year. Whereas many maternity units formerly undertook Part I training only, and this was wholly within the hospital and thereby made no call on community services, the single period training involves 12 weeks in the community at a specific stage in training for all pupil midwives. Hence all midwifery training schools are now dependent on the number of community places available for training when determining the quarterly intake of pupils.

Basic Nurse Training:

At present, the majority of men and women entering nursing do so in one of six ways: As a student for three years in general nursing; in nursing of mental

illness; in nursing of the mentally subnormal; or as a pupil for two years in general nursing; in nursing of mental illness; or in nursing of the mentally subnormal. Students achieve registration, pupils enrolment.

For many years, involvement with basic nurse training was limited to visits of observation by students to the community nursing services and lectures prior to such visits by Nursing Officers, as and when requested.

The General Nursing Council revised its syllabus for general registration training in 1969 and suggested, amongst other changes, a period of 12 weeks in the community for approximately 25 per cent. of students commencing on and after January, 1971, and for 50 per cent. of students commencing on and after January, 1975.

However, 12 weeks was considered too long a period to accommodate students—sometimes at an early stage of training, and from the point of view of some hospitals, the long absence left the wards without the necessary student services, so that a six week programme has come to be widely accepted in different parts of the country. Useful progress has been made in this provision in five County Divisions, but student numbers have remained small, mainly because the larger training schools are situated in County Boroughs. The students have made good use of their time, have written area projects and compiled case histories. They have very much appreciated being full-time students for this brief period.

Practical requirements for this training option require that:

- (a) There shall be reasonable travelling facilities from the student's home or hospital to observation area. In the event of large numbers of students coming into the community, either assistance with transport, or provision of temporary accommodation will be required in order to use staff working further afield.
- (b) There shall be suitable field staff to receive them—not all staff are equally capable of the enthusiastic teaching needed by the young students.
- (c) There shall be sufficient field staff to 'ring the changes' when visiting homes—this recalls a health visitor training school overseas where the surrounding village homes formed a 'training area' and the same families were repeatedly visited by successive student groups, year after year, so that whilst all the 'right' answers were forthcoming from the families, it was impossible for really helpful relationships to develop. In the present state of staffing ratios, no home nursing sister should be asked to take more than three students per year if she is to retain interest throughout the six weeks (the sister would actually have the student with her for the first two and the last week of the course).
- (d) Students must really wish to come out into the community. It is a privilege to visit and work in patients' own homes and, whilst enthusiasm is helpful, the least show of reluctance could be distressing, particularly to the elderly or the confused patient.

(e) Ideally, as numbers grow, there will be need for community tutors. Up to the present, both Nursing Officers and Senior Nursing Officers (Divisional Nursing Officers) have given able tutorial help.

In addition to the six week option, a two-day course introducing the community services is offered to all students.

Subsequent to the introduction of the community option for general registration students, requests were received from training schools for mental illness and mental subnormality nursing to provide a similar six week period in the community. Since the numbers of general registration students were not at that time fully known and since, too, it is estimated that 60 per cent. of psychiatric students proceed later to general training and many would, therefore, then qualify for six weeks community experience, it was considered wiser to wait for the results of the first option before developing the scheme. Psychiatric students and pupils, however, are offered the two-day course introducing the community services.

Such is the present County involvement with nurse training. If it appears complicated, the total training possibilities, basic and post basic, inside and outside hospital, are far more so. In one recent nursing journal there were 29 different courses of study offered. The Joint Board for Clinical Nursing Studies is attempting to regulate post basic courses, but for major reorganisation, the proposals of the Briggs Committee are needed. In preparation of its Report, the Committee undertook its own research, commissioned other research from appropriate bodies, received considerable amounts of oral and written evidence, and made personal visits to 88 institutions and local authorities.

The Committee sees the role of the nurse and midwife in hospital and community as the provision of comprehensive and continuous oversight of care in the interests of the comfort, recovery and integrity of the person being cared for (para. 41). From this, four corollaries are developed. First, comprehensive care involves co-ordination of hospital and community nursing resources to meet the patient's needs, wherever he is. Secondly, this provision cannot only be done by any one profession, so that health teams, including differing professions, are envisaged. Thirdly, even within nursing, a wide range of abilities will be required and, fourthly, nurses and midwives themselves require support in the provision of skilled care.

The recommendations are summarised under six headings:

1. *The Statutory Framework.* It is proposed that a single central body shall be responsible for professional standards, education and discipline—the Central Nursing and Midwifery Council.

England, Scotland and Wales would each have an Education Board, below which Area Committees (co-terminous with one or two large or several small Health Areas) would provide education.

Midwifery interests would be represented by a Statutory Standing Midwifery Committee of the Council.

2. *Education.* It is recommended that the age of entry should be lowered from 18 years to 17 years by 1975.

One basic course lasting 18 months would lead to a Statutory Certificate of Nursing Practice for all nurses and midwives.

A second 18 months course open to nurses holding the above Certificate would lead to Registration.

Further (Higher) Certificates in special branches could be gained.

All courses would be planned on a modular basis, i.e. 12 week units of experience and related teaching. Whilst the main areas of nursing would be covered by all students for the Certificate, additional units of clinical experience would provide a balance between acute and longer term nursing, and the nursing of different age groups.

Training would take place in Colleges of Nursing and Midwifery.

Education of special groups is also discussed—University courses, mature entrants, overseas nurses, re-entry courses following long absence from professional practice, and in-service training of nursing aides.

3. *Manpower.* Proposals to improve recruitment and to reduce wastage by personnel counselling are made. The need for minimum staffing ratios for short term use and detailed manpower and personnel policies for the future are advised.

4. *Conditions of Work.* The Committee viewed the long (12 hour) day with disfavour and proposed permanent night shift in preference to rotation, revision of 'on call' systems, definition of the working week for community staffs, the provision of an occupational health service, and assistance with travel, accommodation and day nursery facilities.

5. *Organisation of Nursing and Midwifery Work.* Good liaison between hospital and community; 'patient-orientated' organisation of wards; maximum delegation of responsibility; and more staff posts are advocated here. The Committee advises the continuation of the distinct roles of home nurses and health visitors.

It is also envisaged that a new caring profession for the mentally handicapped will emerge gradually, but meanwhile more emphasis is needed on social care.

6. *Assimilation* of nurses and midwives trained under present arrangements into the new structure is outlined.

The Report has, on the whole, been favourably received, with one or two exceptions. Many nurses feel that midwives receive undue consideration by the provision of a separate Committee which offsets the simplicity of one central body. Health visiting will suffer considerably if the present year-long training is reduced to six months.

Community modules of 12 weeks for all nurses in their first 18 months, in selected courses leading to Registration, and in Higher Certificate Courses are far beyond the bounds of practical possibility with present levels of community staffing.

However, with due discussion and modification as needed, the implementation of the Report over a period of five to seven years could well cater for the forthcoming needs of the new National Health Nursing Service.

THE WEST RIDING DAY NURSERY SERVICE, 1940-1971

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The West Riding day nursery service is of particular interest for two reasons. Firstly, the inauguration of the service was virtually the only positive achievement to emerge from the sterility of the War years and, secondly, the service is unique in the annals of the health service for the rapidity of its expansion and subsequent contraction. Thus some 30 day nurseries were provided during the 21 months between June, 1942, and February, 1944, yet some 11 years later the number of day nurseries had been reduced to seven and the service went through a long period of stagnation. Basically, four main phases can be discerned in the history of this service—the development of a government-financed war-time nursery service in response to the problems presented by evacuated children and, more important, by the need to provide care for children whose mothers were occupied in industrial work; the establishment of a County day nursery service as part of the general scheme for child welfare carried out under Section 22 of the *National Health Service Act* and its expansion to meet the needs of the post-war export drive; the decline of the service in the 1950s and the slight revival of interest in pre-school care which characterised the late 1960s.

Action in relation to day nurseries was first stimulated by Ministry of Health Circular 1936, dated 9th January, 1940, which proposed the establishment of nurseries and crèches in any available premises or in private houses. It was envisaged that these centres would provide care for evacuated children and that they would be staffed by voluntary workers under the control of a trained supervisor. The County Council set up a special sub-committee to consider the issues raised by the Circular but no action was taken and, in fact, the only nursery group which ever operated in the West Riding in accordance with the suggestions incorporated in the Circular was a baby-minding centre started by Pontefract Borough Council.

In May, 1941, the Ministry of Health issued a further Circular which considerably altered the concept of day nursery provision, for it had become an urgent necessity to provide day nursery accommodation for the children of women war workers. To facilitate this, the Ministry of Health proposed to make prefabricated hutments available to local authorities. The County Council's Special Sub-Committee was re-formed and after consultation with representatives of the Ministries of Health and Labour and with the Board of Education it was agreed that, initially, 25 day nurseries would be provided in temporary hutments. Each day nursery would have accommodation for 40 children and it was estimated that the annual cost of the service would be £44,250 with a non-recurring capital expenditure of £22,500. The whole of this expenditure would be reimbursed by the Ministry of Health.

Fairly rapid progress was made in implementing these plans—indeed further day nurseries were later authorised—and the full extent of the County Council's provision during this phase is detailed in the Addendum to this paper.

Superficially, the war-time day nursery service represents a considerable achievement but in practice the nurseries were "never utilised . . . on the scales anticipated by the Ministry of Labour".¹ As a result of poor attendances—the day nurseries in question had an average attendance of only 11.1—six nurseries were closed in 1944 and seven in 1945. Several explanations were put forward for the lack of response to the new service. Firstly, it often took mothers several months before they became accustomed to sending their children to a day nursery and the Government tended to order the closure of a nursery before it had been given time to gain popularity—one nursery at Yeadon was, for example, open for only four months. A second point was that sites of day nurseries were sometimes agreed by the Ministries of Health and Labour with little or no consultation with the County Council regarding local conditions.

The end of the war naturally brought a re-appraisal of the role of the day nursery and the Ministries of Health and Education issued a joint Circular on the future of the service. This Circular envisaged that day nurseries as such would gradually become unnecessary because the expansion of nursery classes planned under the provisions of the *Education Act, 1944*, would cater for children over the age of two. It was felt that local health authorities should positively discourage mothers of children under two from going out to work and that the development of child-minding schemes would adequately cater for any special cases in this age group. It was recognised that day nurseries would be necessary for a transitional period but the Ministry of Health was not prepared to continue the special grants for day nurseries after 31st March, 1946. The then Deputy County Medical Officer reported on Circular 221/45 to the Maternity and Child Welfare Sub-Committee in February, 1946. At that time the County Council still had 15 day nurseries and it was decided that with the exception of the day nurseries at Baildon, Guiseley, Horsforth and Sowerby Bridge, which all had fairly high attendances, these should be closed. The storm of protest with which the district councils greeted this decision was such that the Committee had to re-consider the situation and it was agreed that the day nurseries at Hebden Bridge, Otley and Yeadon should also continue. The 26 properties which had been or were to be discontinued as day nurseries were allocated to other uses as follows: six were to be taken over by the Health Department for use as child welfare centres, 11 were to be taken over by the Education Department, six were to be taken over jointly by the Education and Health Departments and their future use decided at a later date, two were to be returned to the Ministry of Health for disposal and one requisitioned property returned to its owner.

The change in the status of the day nursery service from a service designed specifically to meet war-time needs to one operating in a peace-time setting occasioned a lengthy report by the Deputy Council Medical Officer to the Maternity and Child Welfare Sub-Committee. The report urged the continuance of the service and, indeed, its extension to include short-stay residential nurseries. It is notable, however, that stress was placed on the value of day nurseries as a means of safeguarding the health of children rather than as a means of permitting women to work although it was recognised that there would be a continuing need to accommodate the young infants of women working in

essential industries. It is a reflection of this trend that the categories of children considered eligible for admission to day nurseries were extended to include health grounds as well as industrial grounds:

"There will continue for some time the need to accommodate the young infants of the many women who are working in essential industries. In addition, there will be the many others to be admitted on health grounds. These should include the young child whose mother is ill or having a baby, the illegitimate child whose mother is seeking work to enable her to retain her infant, the illegitimate baby awaiting adoption, the babies and young children of mothers and fathers who cannot find suitable homes, who are living in overcrowded and/or insanitary dwellings, the child whose father is awaiting admission to a sanatorium and whose presence at home carries grave risks of infection, the young child of the widow who must educate and support her family unassisted by father, young child of the large family whose mother and father go out to work to earn sufficient."²

Day nurseries were also regarded as a valuable course of education for they provided mothers with instruction in "the practical principles of child care which are so often lacking in modern homes"² and also facilities for the training of nursery nurses—a training which often provided a valuable preliminary to general nurse training. As a result of the Deputy County Medical Officer's report, the Sub-Committee passed the following resolutions:

- "1. That the provision of short-stay day and residential nurseries for the care of young children from 0 to 5 years be continued under the supervision of the County Medical Officer.
2. That, in the first place, two residential nurseries be established to accommodate 40 children, and that one of these be established at Skellow Hall, near Doncaster.
3. That payment for the admission of children in residential nurseries be made on a welfare basis according to means.
4. That admission to the existing day nurseries be extended to meet health reasons.
5. That a charge of 1s. 0d. (5p) per day as at present be made for the admission of children to day nurseries, subject to reduction in special cases of hardship.
6. That day nurseries be established in other parts of the County as from time to time appears expedient.
7. That the residential nurseries for long-stay care of children 0-5 years of age at present administered by the Deputy County Welfare Officer be used in conjunction with short-stay residential nurseries for the training of nursery nurses.
8. That a Supervisor of Nurseries, being a qualified nurse, and if possible, holding a Sister Tutor's certificate be appointed to supervise the day and

residential nurseries and to act as tutor for the students in the nursing aspects of training, at a salary range of £300 by £25 to £375, plus war bonus, the salary and expenses of such appointment to be shared jointly between the Public Health and Welfare, and Education Committees.

9. That two student nurses' hostels, each accommodating 40 students, be provided.
10. That nursery students working in day or residential nurseries be provided with full hostel accommodation and uniform and be paid 10s. 0d. (50p) per week.
11. That autonomous Welfare Authorities be requested to continue their day nurseries for peace-time purposes and to permit the training of nursery students under the supervision of the County Supervisor, the cost of such training being defrayed by the County Council." ³

The duty of providing day nurseries was further endorsed by the *National Health Service Act, 1946*, which gave local authorities a general duty "to make arrangements for the care, including in particular dental care, of expectant and nursing mothers and of children who have not attained the age of five years and are not attending primary schools maintained by a local education authority". The County Council's proposals under this Act were that the seven day nurseries administered by the County Council should be continued as should the day nurseries operated by the autonomous authorities. These were 17 in number and were situated in the following areas—Brighouse (2 nurseries), Harrogate (2), Keighley (2), Morley (2), Pudsey, Shipley (3), Ilkley (2), Rothwell, Spensborough, Heckmondwike. A total of 24 nurseries would thus be provided giving some 932 places. The proposal to provide two 30-place residential nurseries was also reiterated at this stage.

Before the *National Health Service Act* came into operation, however, the next stage in the development of day nurseries had been initiated and in May, 1948, the County Medical Officer reported to Committee on a request by the Minister of Health that, to aid the export drive, urgent consideration should be given to the establishment of day nurseries. As first priority it was suggested that Holme House, Lightcliffe, should be re-opened by Brighouse Corporation. This day nursery had been established in a Ministry of Health hutment in November, 1942, but it was never very well patronised and was, therefore, closed in 1945. It was felt, however, that in 1948 a day nursery at Lightcliffe would be a more viable proposition not only because of the economic position but because two new housing estates had been built near the site of the nursery. In view of this the County Council, who would of course become financially responsible for the nursery after the appointed day, raised no objection to the re-opening of the nursery.

The anxiety of the Minister of Health with regard to the provision of additional day nurseries was stressed again in a letter from the Regional Officer of the Ministry of Health dated 28th May, 1948:

"The importance to the Textile Export Drive of married women labour is I am sure appreciated and in this connection it is understood that in certain areas many married women workers would respond to the appeal were nursery facilities available for their children. The Government therefore consider it to be very necessary that additional nursery provision should be made as quickly as possible in your authority's area to meet this demand."⁴

The letter went on to indicate that the areas where it was considered to be particularly vital to provide day nurseries were Brighouse, Keighley, Pudsey, Todmorden, Bingley, Shipley, Barnoldswick, Elland, Holmfirth, Mirfield, Otley, Saddleworth, Silsden, Slaithwaite, Skelmanthorpe, Sowerby Bridge and Spen Valley. In July, 1948, the Health Committee approved an estimate of £159,000 for the provision of an additional 16 day nurseries. Progress in bringing these plans to fruition was however very slow largely because of the difficulty of securing sites and the only visible signs of activity were the re-opening of Holme House Nursery and the establishment of a new nursery at Todmorden, a scheme started by Todmorden Corporation before the appointed day. In view of these difficulties, and of the increasing need for national economy, the County Council's proposed day nursery provision was reduced to five 50-places nurseries to be built at Baildon, Barnoldswick, Bingley, Keighley and Shipley.

In November, 1950, the Care of Mothers and Young Children and Nursing Services Sub-Committee requested "a comprehensive report on the question of day nursery provision",⁵ a request provoked partly by the economic situation but also by the agitation of several district councils anxious to obtain day nurseries in their areas. Another factor was the proposal of the Government to end requisitioning powers in 1951. The County Medical Officer's report emphasised the social and medical aspects of day nursery care as is illustrated by the following extract:

"Nurseries make an important contribution to the success of social medicine, this is altogether apart from the help given to industry by releasing mothers for essential employment. The nursery helps mothers to care for their children, and sets a high standard of child hygiene; it takes in children from over-crowded and insanitary dwellings where mothers are gravely handicapped, if not wholly obstructed, in their greatest work—progressive development of their children; it attends to health by regular supervision and monthly medical examinations."⁶

As a result the committee decided to regulate further the admission of children to day nurseries and it was decided that no child should be admitted to a day nursery if the vacancy could be filled by a child in one of the undermentioned categories:

1. The young child whose mother is ill or having a baby.
2. The illegitimate child whose mother is seeking work.
3. Children of parents who cannot find suitable homes or are living in overcrowded and/or insanitary dwellings.

4. The young child of the widow who must educate and support her family unassisted, and also the young child of the mother whose husband is ill.

It was also recommended that the number of children attending day nurseries on industrial grounds should be reduced to allow the admission of health cases on the waiting lists. It was agreed, however, that the five additional day nurseries on which work had begun should be continued, and all were eventually completed although when the new nursery at Keighley was opened in 1952 the old one at Victoria Park was closed so that the property could be derequisitioned.

The opening of five day nurseries to help the Government's export drive represents the peak of the County Council's achievement in this field for the ideas as to the true role of the day nursery which began to be aired after the end of the war gradually gained credence. This process was helped by the fact that the post-war boom in textiles gradually lost impetus and applications for day nursery places on industrial grounds decreased. By 1953, therefore, the picture was one of falling attendances and a growing belief that health needs should be paramount. This trend had national implications as the following extract from the County Councils' Association Official Gazette shows:

"The Minister of Health approved amending proposals of the Surrey County Council under the *National Health Service Act, 1946*, concerning the day nursery service. Admissions were restricted to certain priority classes: where the mother is the sole wage-earner; where there is sickness in the family or where there are home conditions which are likely to prejudice seriously the health of the child; and in exceptional circumstances where it appears that admission is necessary in the interests of the child. Eleven day nurseries were subsequently closed."

As a natural corollary to the closure of day nurseries by local authorities there was an expansion in the day care facilities provided by private enterprise. The fact that many mothers wished to work to augment the family income created a demand for child-minding and day nursery facilities and private individuals were willing to meet this. Unlike local authorities they could do so without considering whether or not they were having regard to the best interests of the child, and recognition had in fact been given to this problem in 1948 when a Private Member's Bill to provide for the registration of certain day nurseries and child-minders passed through Parliament. The *Nurseries and Child-Minders Regulation Act, 1948*, required local authorities to maintain a register of premises where children were looked after all day, or for a substantial part of a day, and also a register of child-minders who looked after children in their own homes for a day or a substantial part of a day. Before a local authority agreed to register a nursery or a child-minder certain requirements had to be met and local authorities therefore had a certain amount of control over the standard of care which children were receiving in the private sector.

The West Riding Health Committee set up a Special Sub-Committee to consider the future of the day nursery service in October, 1953. This was partly the result of the Government again pressing for the return of all requisitioned

property and partly the result of a suggestion from the West Riding Treasurer that in view of the economic situation the charges for the day nursery service should be increased. In his report the County Medical Officer indicated that only 53% of the day nursery accommodation was occupied by health cases. The County Medical Officer put forward the view that the West Riding day nursery service was at that time serving the needs of industry rather than the socio-medical needs of the community, a point illustrated by the fact that there were no day nurseries at all in the South of the County where the employment of female labour had never been a feature of the industrial scene. The Special Sub-Committee reported in November, 1953, and the main recommendations of the Committee are embodied in the following resolution:

"The Sub-Committee consider that the time has now arrived when the Day Nursery Service should be planned primarily from the point of view of the health service and only in so far as accommodation is available after the health need has been satisfied should any other categories of cases be admitted. It is clear from a close study of the information before them that very few of the existing thirty Nurseries measure up to this test and in the circumstances the Committee are of the opinion that the Nursery Service should be concentrated to provide for health cases and the surplus Nurseries closed on the understanding that so far as health cases are concerned and where reasonably practicable, health cases from surrounding areas shall be transported to those Nurseries which are to remain open. It is recommended that the following Nurseries shall be closed:

Woodbine, Keighley
Manor Lane, Shipley
Windhill, Shipley
29 Victoria Park, Shipley
Guiseley
Yeadon
Burley in Wharfedale
Station Avenue, Harrogate
Gildersome
Stourton
Cleckheaton
Ogden Lane, Brighouse
Holme House, Lightcliffe, Brighouse
Hebden Bridge."⁸

The recommendations of the Special Sub-Committee were in due course endorsed by the Health Committee and the County Council but several of the district councils involved were vehemently opposed to the new policy. Members of the Sub-Committee met representatives of the district councils to explain the reasons behind the changes and also conducted a review of all cases in day nurseries. As a result of this a further recommendation was made involving a change in the hours of opening of day nurseries and it was agreed that nurseries should only open from 8.30 a.m. to 4.30 p.m. As the County Council's new

policy involved changes to the Authority's proposals under the *National Health Service Act* permission had to be obtained from the Ministry of Health. This permission was not immediately forthcoming, for although the Minister of Health was fairly easily convinced that health cases could be accommodated in the day nurseries which were to remain open, he was perturbed that shorter hours of opening would prevent the County Council from providing help for those categories which needed it, that is the unsupported mother. At the request of the Minister, the Health Department undertook a survey to assess the effect of the new hours on the 190 health cases accommodated in the day nurseries. From this it emerged that 79 cases (42%) were unaffected by the change whilst the mothers of the other 111 children were able to make adequate arrangements for the care of their children during the hours when they were working and the nursery was not open. On 20th July, 1954, representatives of the County Council attended a meeting at the Ministry of Health in London and succeeded in convincing the representatives of the Minister that the County Council's proposals were feasible. The County Council did, however, agree to conduct regular surveys to check that the children's health was not suffering from their reduced attendance at the nursery. When these surveys were subsequently held it was ascertained that "the general picture as indicated by weight and inspection was that of no deterioration of the health of children whose mothers were working longer hours than those of the nursery, as compared with those children whose mothers worked shorter hours than nursery opening hours."⁹

When the County Council originally planned the cut-back in day nurseries it was envisaged that approximately half the nurseries would be closed. In practice, however, all but seven day nurseries were closed by the end of 1955 for it became increasingly obvious that when all industrial cases were excluded very few day nurseries could be justified. The seven day nurseries which continued in existence were situated at Keighley, Shipley, Harrogate, Heckmondwike, Brighouse, Sowerby Bridge, and Todmorden and provided a total of 310 places. The position of these day nurseries was kept under review and periodic reports on attendances were made to a Special Sub-Committee. In May, 1956, it was reported that attendances at Sowerby Bridge Day Nursery had fallen to an average of 19 and it was, therefore, decided that the nursery should be closed with effect from 1st August. In 1960 a similar decision was made in respect of Todmorden Day Nursery, where attendances had fallen to 12, and the nursery was closed on 31st March, 1961.

The rapid contraction of the County Day Nursery Service in the mid-1950s and the failure to build new nurseries in the South of the County was partly the result of the periodic financial crises which made it impossible for local authorities to obtain loan sanction for new day nursery projects. A more important factor, however, was the social climate of the era for this was dominated by the belief that the place of the mother was at home with her child. This theory owed much to the work of Dr. John Bowlby who in his Report for the World Health Organisation—*Maternal Care and Mental Health*¹⁰—in 1951 had emphasised the need for a child to be able to form a bond with its mother and had suggested that a child was unable to maintain such a bond if the mother was frequently

absent. Bowlby had stressed the short-term and long-term consequences of a failure to create such a bond or of the disruption of the bond once created and his conclusion that "mother love in infancy and childhood is as important for mental health as are vitamins and proteins for physical health" had a profound influence on the care of the pre-school child and was one of the factors which caused the stagnation of the day nursery service. By the mid-1960s, however, there were signs that this attitude was changing and the work of Dr. Michael Rutter and the late Dr. Simon Yudkin gave credence to the idea that the attachment of the child and its mother was not perhaps all-important and that attachments to other members of the family could be equally vital. It was considered that the intensity of a mother's contact with her child rather than the duration of the contact was instrumental in establishing a bond between them and that this bond was more easily maintained than had sometimes been suggested.¹¹

Certain factors combined with these research trends to make day care socially acceptable. There was a growing awareness of the value of social contact for young children, especially for those who were isolated from children of their own age. A growing traffic problem and the development of 'high-rise' flats also brought about a need for safe play facilities. Lastly the idea that formal education could and should begin before the age of five was gaining credence especially amongst the articulate middle classes. These developments were reflected in an increasing number of applicants for registration as child-minders under the *Nurseries and Child-Minders Regulation Act, 1948*, and in the growth of the pre-school playgroup movement.

The pre-school playgroup movement was essentially unofficial for playgroups were not required to register with the local health authority as were child-minders and day nurseries. The movement did, however, receive tacit acceptance from many educationalists and some local health authorities, including the West Riding, undertook unofficial supervision of play groups. At national level, the Report of the Plowden Committee¹² drew attention to the lack of provision for the under-fives and an unofficial report by Yudkin suggested that adequate child care could be provided by substitute mothers providing that continuity and stability were ensured. It was also suggested that a working mother was often a sign that the family had a high standard of responsibility and care. These developments—both unofficial and official—bore fruit in 1968 when the *Health Services and Public Health Act, 1968*, became law. Section 60 of this Act tightened the regulations regarding day care and brought the playgroups movement within the law by enforcing registration. The playgroup movement thus received official recognition and at the same time an attempt was made to ensure that reasonably high standards were maintained.

The Minister of Health followed up the new legislation by issuing Circular 37/68 in October, 1968. The general effect of this circular was to urge local authorities to expand their day care facilities, even if this had to be done at the expense of other services:

"Other authorities may feel it right, in the light of the relative needs for facilities of different kinds in their areas, to divert some resources from other

services in order to extend day care facilities without increasing their total expenditure. The extent to which day care facilities can be expanded in this way must be for authorities themselves to decide; and they are asked to consider what may be possible in the short term, and also whether any extension of facilities is needed over a longer period.”¹³

At the same time, however, the Minister of Health stressed that the local health authorities should only arrange day care “for children who, from a health point of view or because of deprived or inadequate backgrounds, have special needs that cannot otherwise be met”¹³ and that the provision of day care should still have regard for the principle that “early and prolonged separation from the mother is detrimental to the child.”¹³

The Minister of Health nevertheless did give a fairly extensive list of children for whom some form of day care should be desirable. This included children with only one parent; children who need day care because of their mother’s illness; children whose mothers are unable to give them adequate care; children for whom day care might prevent the break-up of the family or the break down of the mother; children whose home conditions constitute a hazard to their health and welfare and children whose health and welfare are threatened by a lack of opportunity of playing with others. The Minister of Health concluded by asking local authorities to assess the need for day care within their areas and provide information on this by 30th June, 1969.

In the West Riding a small working party was set up to bring into operation Section 60 of the *Health Services and Public Health Act, 1968*, and to draw up suitable standards for child-minders and playgroups. The working party completed its task early in 1969 and registration under the new Act began. This proved to be a long and arduous process for there were about 150 playgroups operating unofficially and all had to be placed on a formal footing. In addition the playgroup movement was expanding and new groups were constantly applying for registration. In order that the implications of Circular 37/68 could be adequately assessed a Special Sub-Committee consisting of representatives of the Health and Education Committees was appointed. In their report to the Sub-Committee the County Medical Officer and the Chief Education Officer commented on a survey undertaken by the Divisional Medical Officers which revealed that approximately one child in 30 was in need of some form of day care. In 1969 the facilities available for these children could be summarised as follows—five day nurseries providing 220 places, approximately 3,000 places in nursery schools and classes, 25 private day nurseries providing 127 full-time and 440 part-time places and 134 registered child-minders providing 841 full-time places and 40 part-time places. When the Special Sub-Committee met on 16th June, 1969, the Education Department had already made proposals for extending the provision of nursery classes under the Urban Aid Programme but the Committee made other far-reaching recommendations. Firstly, the categories of children considered eligible for day care were revised in accordance with the recommendations in Circular 37/68. The following resolutions were then agreed:

"That approval, in principle, be given to the provision of additional day nurseries in areas where the West Riding Health Committee deem this necessary to provide adequate facilities for children in the above priority groups.

That children in the priority groups be placed with selected child-minders or in private day nurseries at agreed terms.

That approval, in principle, be given to the granting of financial aid in selected areas where it is considered necessary to encourage the establishment of private day nurseries to meet the needs of children in the priority groups."¹⁴

The recommendations of the Special Sub-Committee were subsequently endorsed by the parent committee and one result was that a more detailed survey was undertaken into the number of children eligible for day care. This confirmed that the greatest need was in the south of the County and in January, 1970, the Care of Mothers and Young Children and Nursing Services Sub-Committee passed the following resolution:

"That approval in principle be given to the erection of two nurseries in the south of the County and that authority be given for suitable sites for these buildings to be sought"¹⁵

It was at this interesting juncture, when the day nursery service was showing signs of revitalisation, that the responsibility for the service passed to the new Social Services Department, and the Health Department was not able to take up the challenge with which it had been presented. A study of the historical background to the service provides an explanation and a justification for the main features of the County Day Nursery Service for it grew up where there was a demand for female labour and where the satisfaction of that demand was in the national interest. Once the national emergency was passed insurmountable difficulties were placed in the way of the development of the day nursery service for there were complications with requisitioned property, periodic financial crises and, especially in the West Riding, the difficulty of siting a day nursery so that it was fully utilised without mothers having to travel long distances with their children. Lastly, there was public opinion, for perhaps more than any other service, the day nursery service was subject to fluctuations in social thinking and, for most of the period under consideration, the prevailing belief was that day care was not generally in the interests of the child and that it should only be provided when it was essential for the child's mother to work. The West Riding followed this belief through to its logical conclusion by providing a free day nursery service (the small charge which was made was in respect of the child's meal) but once the climate of opinion became more conducive to the development of day nurseries, the West Riding showed itself ready for change.

References:

1. Report of the Deputy County Medical Officer to the Maternity and Child Welfare Sub-Committee, 13th February, 1946.
2. Report of the Deputy County Medical Officer to the Maternity and Child Welfare Sub-Committee, 10th July, 1946.
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Day Nursery Provision in the West Riding, 1942—1944

Nursery	Date Opened	Comments
Crigglestone	8.6.42	Hutment on site owned by local authority
Stainforth	8.6.42	„
Kirk Sandall	12.6.42	Hutment on leased site
Maltby (2)	22.6.42	Hutments on requisitioned site
Skipton	1.8.42	„
Thorne	5.10.42	Adapted requisitioned premises
Horsforth	12.10.42	Hutment on leased site
Otley (2)	12.10.42	Hutment on site owned by local authority
Silsden	12.10.42	Adapted requisitioned premises
Hebden Bridge	16.11.42	Hutment on requisitioned site
Swinton	30.11.42	Hutment on site owned by local authority
Horbury	22.12.42	Hutment on requisitioned site
Earby	16.2.43	„
Guiselley	3.3.43	Hutment on site owned by local authority
Baildon	23.8.43	Adapted requisitioned premises
Boston Spa... ..	23.8.43	Hutment on requisitioned site
Yeadon	23.8.43	„
Woodlands... ..	31.8.43	Adapted requisitioned premises
Featherstone	13.9.43	Hutment on site owned by local authority
Normanton	13.9.43	„
Elland	20.9.43	„
Normanton (Benson Lane)	13.12.43	Hutment on requisitioned site
Sowerby Bridge	20.12.43	Hutment on site owned by local authority
Yeadon (South View) ...	20.12.43	Hutment on requisitioned site
Mexborough	17.1.44	„
Sprotbrough	17.1.44	Hutment on site owned by local authority
Knaresborough	31.1.44	„
Dalton	21.2.44	Hutment on requisitioned site
Dinnington... ..	28.2.44	„

COMPUTER SCHEME FOR THE HEALTH SURVEILLANCE OF PERSONNEL

G. E. Leyshon, Principal Medical Officer

Doctors, nurses, ambulancemen and others, are liable to contract an infectious disease in carrying out their work. In many cases there are acceptable vaccines available to prevent these diseases, yet too often, immunity has been allowed to lapse, or occasionally, primary immunisation has not been carried out.

It is tragic that even in a disease like smallpox, there may be many staff at risk and it is not unusual for some of the cases that occur in any smallpox outbreak to be health personnel. Indeed in the outbreak in the United Kingdom in 1962, one of the first people who died was a doctor who had not been vaccinated and who dealt with the index case.

In any large organisation like the local authority or National Health Service it is useful to know the immunisation state of the staff who operate the service and though it is, in theory, easy to maintain a manual recording system, in practice, it is likely that only in some authorities will this be efficient.

This became clear in the West Riding when the records were checked prior to adopting a computer scheme for monitoring vaccination status of health staff. Although all the staff are recommended to have certain procedures, only a minority had in fact done so and maintained their immunity.

There are legal implications too in ensuring that efficient records are available, for if an infectious disease is contracted during the course of employment, a claim can be made against the authority—probably the most likely circumstance in which this could occur is with tuberculosis. It was after such a case in the health department that a computer scheme was devised.

In the first instance this was a pilot scheme involving the 700 ambulancemen employed by the health department.¹

Pilot Study:

Agreement was reached with the ambulance officers and union representatives on the desirability of the procedures which were to be offered. This was essential; acceptance of the scheme depended on the principle that participation would be entirely voluntary.

The following procedures were agreed:

Mantoux or Heaf Test—once only; B.C.G. (if Mantoux or Heaf Test was negative)—once only; poliomyelitis—five yearly; tetanus—five yearly; smallpox—annually; chest X-ray—annually (this was changed to three yearly from March, 1972).

The ambulance section is divided into the central administration and 26 ambulance stations, each under the direct control of a station officer, and from which the ambulancemen operate. There are about 700 people in the service distributed among these stations.

To establish the computer record a questionnaire was sent to each station officer requesting information for each man, such as surname and initials, date of birth, date of last protection for the six procedures.

Each of the 26 stations was allocated a code number and there is a unique number identifying the person; new entrants to the service fill in a questionnaire to establish their individual records.

The file is processed by the computer twice yearly in March and September, and a print-out of procedures which are due is produced. These procedures are completed at any time within the next five months, before the print-out is returned for updating the computer record.

Station officers note on the print-out those staff who have resigned from the service, so that their record is terminated.

Print-outs are produced in triplicate. The first copy goes to the county ambulance officer for information; the second copy to the station officer; the third copy to the divisional medical officer in whose area the ambulance station is situated.

Although the divisional medical officer is provided with a print-out and can arrange with the station officer a mutually convenient time to carry out the procedures, each ambulanceman can have these carried out by a medical practitioner of his own choice.

Results:

From the results obtained it was obvious that the computer scheme had improved the immunity of the ambulancemen, (Table 1)—and the next stage was to include all the nursing staff (approximately 1,000 people). Again the results obtained have been so impressive that as from 1st January, 1973, all the 3,000 or more staff of the Wakefield Hospital Management Committee will be included in the scheme.

There has been a marked improvement in the uptake of procedure since the introduction of the computer in April, 1970.

Thus 28.1 per cent. of ambulancemen had received protection against poliomyelitis at the commencement of the scheme, but this had increased to 70.2 per cent. by October, 1972. There have been similar substantial increases with all the others; these numbers represent those having undergone a procedure within the recommended period, thus in October, 1972, 49.1 per cent. had received a smallpox vaccination within the preceding year; many more would have been vaccinated within three years and would therefore still have a good immunity.

Table 1. Vaccination and Immunisation of Ambulancemen

Staff	April, 70 673		April, 71 699		April, 72 715		October, 72 725	
	No.	%	No.	%	No.	%	No.	%
Mantoux (once only)								
Positive	180	26.7	285	40.8	367	51.3	412	56.8
Negative	61	9.1	65	9.3	58	8.1	56	7.7
Refused			50	7.1	61	8.5	203	28.0
B.C.G. (once only)								
Protected	61	100.0	64	98.5	57	98.3	56	100.0
Polio (every 5 years)								
Protected	189	28.1	414	59.2	478	66.8	509	70.2
Refused			52	7.4	59	8.3	171	23.6
Tetanus (every 5 years)								
Protected	61	9.1	315	45.0	450	62.9	472	65.1
Refused			62	8.9	87	12.2	202	27.8
Smallpox (annually)								
Protected	19	2.8	338	48.3	269	37.6	356	49.1
Refused			44	6.3	84	11.8	199	27.4
X-Ray (annually)								
Protected	65	9.7	304	43.5	525	73.4*	544	75.0*
Refused			38	5.4	32	4.5	140	19.3

*This applies to protection within the past 3 years.

against the disease. The falling-off in the number accepting smallpox in April, 1972, coincided with the Department of Health and Social Security's recommendation to abolish routine smallpox vaccination.

The numbers offered appointments but awaiting completion of procedures have been omitted from the table.

Again there has been a substantial improvement in the uptake of the services offered to the nursing staff, comprising district nursing sisters, health visitors and midwives.

It was surprising to find that 159 of the nursing staff had a negative Mantoux or Heaf at the initial test in April, 1972, but 151 of these negative reactors accepted B.C.G. vaccination.²

Smallpox vaccination is carried out every three years in this group.

Table 2. Vaccination and Immunisation of Nursing Staff

Total Nursing Staff							April, 1972 971		October, 1972 968	
							No.	%	No.	%
Mantoux (once only)										
Positive	...	...	...	...	...	...	433	44.6	533	55.1
Negative	...	...	...	...	...	...	159	16.3	149	15.4
Refused	...	...	...	...	...	...	166	17.1	189	19.5
Due	...	...	...	...	...	...	213	22.0	97	10.0
B.C.G. (once only) (only if Mantoux is negative)										
Protected	...	...	...	...	...	...	151	94.9	140	94.0
Due	...	...	...	...	...	...	8	5.1	9	6.0
Polio (every 5 years)										
Protected	...	...	...	...	...	...	127	13.1	554	57.2
Refused	...	...	...	...	...	...	185	19.0	210	21.7
Due	...	...	...	...	...	...	659	67.9	204	21.1
Tetanus (every 5 years)										
Protected	...	...	...	...	...	...	149	15.3	524	54.1
Refused	...	...	...	...	...	...	200	20.6	244	25.2
Due	...	...	...	...	...	...	622	64.1	200	20.7
Smallpox (every 3 years)										
Protected	...	...	...	...	...	...	201	20.7	499	51.6
Refused	...	...	...	...	...	...	212	21.8	249	25.7
Due	...	...	...	...	...	...	558	57.5	220	22.7
X-ray (every 3 years)										
Protected	...	...	...	...	...	...	445	45.8	717	74.1
Refused	...	...	...	...	...	...	110	11.2	121	12.5
Due	...	...	...	...	...	...	416	42.9	130	13.4

Discussion:

It should be emphasized that the scheme is controlled by the 'user' department, that no pressure is put on the staff to participate and that prior agreement with the union representatives was essential. It is simple and cheap to operate.

The cost of data preparation and computer processing is less than £50 per annum and the time to run the programme on the Honeywell 200 Series computer is approximately one hour annually.

Other local authority departments could also benefit from the scheme—for example the constabulary, who often have contact with the less salubrious members of society, and who are also exposed to high risk of physical injury. Some are involved with anthrax control and need regular booster vaccinations. The scheme can also be expanded to include other procedures, such as influenza vaccination.

Perhaps its greatest potential would be within the hospital service where at present there are innumerable staff at risk from preventable diseases.

It will be interesting to see if the same good results will be obtained with this much larger group who have a much more rapid turnover of staff.

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DRIVING AND MEDICAL DISABILITIES

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Summary:

The County Medical Officer of the West Riding has advised the licensing authority since 1962 on the fitness of applicants with medical disabilities to drive motor vehicles. Six hundred and seventy-seven referrals were considered, of which 458 (68%) were granted licences after medical investigation. Most referrals, 363 (54%) were from epileptics but other disabilities—diabetes especially—were responsible for more reported accidents. The effect of The Motor Vehicles (Driving Licences) Regulations, 1970 and 1971, is shown to have increased the number of referrals by epileptics. It is considered that although only a small proportion of road accidents may be caused by medical disabilities, these might be prevented by the adoption of more adequate and uniform medical supervision of applicants with disabilities.

Introduction:

Local authorities, who on behalf of the Secretary of State for the Environment issue driving licences, sometimes request medical guidance before granting them. If an applicant declares on his application form (form DL1), that he suffers from a disease or disability then the licensing authority may refer the application to a medical referee.

Dr. A. Elliott of Kent disclosed in a paper read to the Association of County Medical Officers in June, 1962, that few licensing authorities had a standard procedure. In many cases the decision, to revoke or withhold a licence for medical reasons, was made by a lay committee from information, often conflicting, obtained from many sources—the applicant's relative, the police, the family doctor or a hospital consultant. Much of the evidence was medical.

As the decision of a licensing authority to refuse or revoke a licence can be contested in court, the medical evidence upon which the committee acts should be capable of being sustained under cross-examination. It should be founded on fact and not opinion. It seemed imperative, therefore, that a licensing

authority should seek the advice of a medical officer who could consider the medical evidence available, then give an impartial decision which would occasionally need to be defended in court.

Since 1962, in the West Riding, the county medical officer has acted as medical adviser to the licensing authority. The purpose of this paper is to recount his experience and to show that medical advice is necessary. Because of changes in the legislation over epilepsy, the paper deals with two groups of applications, those considered before June, 1970, and those for a year after the introduction of *The Motor Vehicles (Driving Licences) Regulations, 1970 and 1971*.

Medical Disabilities and Road Accidents:

In 1968 there were 349,208 road accidents in the United Kingdom, with 6,810 fatalities. The exact number caused by disabilities such as ischaemic heart disease, defective vision, epilepsy, hypoglycaemia and certain physical disabilities is not known, but the Medical Commission on Accident Prevention (1968) estimated this to be just under 1%. In the United Kingdom annually some 3,500 road accidents with 68 fatalities could be due to drivers with medical disabilities.

Of 81 cases of sudden deaths at the wheel resulting in 36 accidents, Petersen and Petty (1962) found that three-quarters were due to ischaemic heart disease. Herner *et al.* (1966) in Sweden estimated that three out of every 10,000 traffic accidents reported were caused by epilepsy. Californian drivers with medical disabilities, including alcoholism, were shown by Waller (1965) to average twice as many accidents per million miles as a normal control group, and Crancer and McMurray (1968) showed that drivers with medical disabilities had statistically significant higher accident rates than the normal driving population of Washington. There is justification, therefore, for some medical supervision of drivers of motor vehicles and this already exists with *The Heavy Goods Vehicles (Drivers' Licences) Regulations, 1969*, under which it is obligatory for an applicant for a heavy goods vehicle licence to undergo a medical examination. An applicant for a motor vehicle driving licence merely declares on his application form whether he does or does not suffer (or in the case of epilepsy and disabling giddiness or fainting, has suffered) from the prescribed disabilities.

Statutory Control:

This is effected mainly through the *Road Traffic Act, 1960*, but there have been several modifications to this, such as the *Vehicle and Driving Licences Act, 1969*, and more recently *The Motor Vehicles (Driving Licences) Regulations, 1970 and 1971*.

Under the *Road Traffic Act, 1960*, epilepsy, liability to sudden attacks of disabling giddiness or fainting, and an inability to read at 25 yards with or without glasses an arrangement of six letters and numbers similar to the registration mark of a car, were conditions in which a driving licence should be withheld or revoked. Where a licence is withheld or revoked, the applicant can

appeal at a Magistrate's Court if aggrieved. But if a person in his application or otherwise admits suffering from the condition then he cannot be aggrieved and therefore cannot appeal.

Other conditions in which the authority can withhold or revoke a licence are: mental disorder, for which the individual is liable to be detained or is receiving in-patient treatment under the *Mental Health Act, 1959*: severe subnormality when the person is subject to guardianship or residence in local authority accommodation or in care under Section 28 of the NHS Act: and finally any form of mental disorder resulting in the individual's estate being in the hands of a receiver.

All the applications referred to the county medical officer up to June, 1970, were considered under the *Road Traffic Act, 1960*.

The later amendments are, for the purpose of this article, concerned with a modification of the form (DL1) so that an applicant who suffers or has suffered from epilepsy, or sudden attacks of disabling giddiness or fainting states the name of his doctor and gives his written consent for this doctor to be approached by the medical referee for further information about these disabilities.

Most important, there has been a change in that a history of epilepsy is no longer a complete bar to a driving licence being granted. Under *The Motor Vehicles (Driving Licences) Regulations, 1970*, an epileptic can be granted a licence providing that:

- (a) he shall have been free from any epileptic attack whilst awake for at least three years from the date when the licence is to have effect.
- (b) in the case of an applicant who has had such attacks whilst asleep during that period he shall have been subject to such attacks since before the beginning of that period.
- (c) the driving of a vehicle by him in pursuance of the licence is not likely to be a source of danger to the public.

The Motor Vehicles (Driving Licences) Regulations, 1971, consolidated some amendments in the definitions of the six disabilities prescribed by the *Road Traffic Act of 1960*.

On vision, for example, this is now:

"inability to read in good daylight (with the aid of glasses if worn) a registration mark fixed to a motor vehicle at a distance of 75 feet in the case of a registration mark containing letters and figures $3\frac{1}{2}$ inches high or at a distance of 67 feet in the case of a registration mark containing letters and figures $3\frac{1}{8}$ inches high.

Provided that in the case of an applicant for a licence authorizing the driving of vehicles of a class or description included in group K only, the reading shall be 45 feet in the case of a registration mark containing letters and figures $3\frac{1}{2}$ inches high, and 40 feet in the case of letters and figures $3\frac{1}{8}$ inches high."

Of particular importance was the slight change in the phrasing of the clause dealing with epilepsy whilst asleep, to read:

"in the case of an applicant who has had such attacks whilst asleep during that period he shall have been subject to such attacks whilst asleep but not whilst awake since before the beginning of that period."

The regulations regarding epilepsy made the greatest impact on the work of the medical referee as will be shown from our results.

Procedure in the West Riding:

Elliott's paper to the Association of County Medical Officers stimulated a review of the procedure in the West Riding. The Licensing Authority accepted the county medical officer as a medical referee but agreement had to be reached with local medical practitioners. It would be them who would provide most medical information about applicants.

The procedure under which the work was to be undertaken was considered by the standing sub-committee—a body, whose function it is to promote co-operation between the local authority and the local medical committee. This committee agreed that the sending of medical reports directly to the county medical officer was a much more acceptable procedure than submitting them to a lay committee. The county medical officer would obtain the permission of the applicant to contact the family doctor and any other doctor who had treated the applicant, for information about his fitness to be in charge of a motor vehicle. The applicant would also agree to examination by the county medical officer or a specialist appointed by him.

Great dependence was placed on reports from the family doctor, but this had disadvantages because a patient who was refused or had had a licence revoked equated this with lack of support from the doctor; this could lead to a disturbed patient-doctor relationship. In one case in particular, where an applicant appealed against the decision of the licensing authority for refusing her a licence, the family doctor was subpoenaed to give evidence against her; the appeal was lost.

Mrs. L. collided with a lorry, but stated that she had suffered a blackout. Later this statement was refuted and a certificate was received from an eminent neurologist confirming that Mrs. L. was fit and competent to drive. The family doctor, however, stated that Mrs. L. had been under treatment by him with anticonvulsants for blackouts; the electroencephalogram was negative.

There was doubt in this case about the exact diagnosis but because Mrs. L. had suffered from recurring attacks of partial or complete loss of consciousness, it was decided that she was unfit to be in charge of a motor vehicle.

If through information from the family doctor, there is a likelihood that a licence will not be granted, the applicant is referred for an independent consultant opinion: this applied to half the cases in our series. Should a licence then be refused, the applicant will feel free to return to the family doctor for advice. A copy of the specialist's report together with the decision of the licensing authority is always sent to the family doctor.

Our procedure has needed modification because of *The Motor Vehicles (Driving Licences) Regulations, 1970*, with regard to epilepsy. An applicant who has stated that he suffers or has suffered from epilepsy or disabling giddiness or fainting on form DL1, is now asked by the medical referee to complete form DL 93A which requests further details about frequency and timing of attacks. This form together with form DL 93B is sent to the family doctor for verification and completion by him. A fee agreed with the British Medical Association is payable for this service. This procedure has replaced the more informal approach that we had used, and which, thanks to the co-operation of the family doctors, was successful.

Findings in Relation to Specific Disabilities:

About 270,000 licences are issued each year in the administrative county, of which only a small proportion, averaging 50 per year are referred for medical advice. There was a gradual increase in referrals from five in 1962 to 77 in 1969; these, however, have increased considerably since the introduction of *The Motor Vehicles (Driving Licences) Regulations of 1970*. Whereas over the 8-year period 1962 to June, 1970, there were 369 new referrals, from June, 1970, to May 31st, 1971, there were no fewer than 308.

Before June, 1970, licences were granted to 199 (54%) applicants with disabilities after investigation by the medical referee. In the year after June, 1970, 259 (84%) were granted licences, a substantial increase. Of the total of 677 referrals, there were 511 men and 166 women.

Disabilities Considered:

DISORDERS OF CONSCIOUSNESS:

Loss of consciousness from any cause can be disastrous if it occurs when the sufferer is driving. Conditions considered in this category include epilepsy, diabetes and cardiovascular disease. Epilepsy and sudden attacks of disabling giddiness or fainting are the only ones specifically mentioned by the various Acts regulating driving; consequently 363 (54%) referrals were for epilepsy (Table Ic).

Diabetics and sufferers from cardiovascular disease need not disclose their ailment on the prescribed form (DL1) except if they have sudden attacks of disabling giddiness or fainting, or are likely to be a source of danger to the public by driving a motor vehicle. Only a small proportion disclose any disability; most diabetics (58%) come to the attention of the licensing authority because of involvement in a road accident (Table II).

TABLE Ia

*Disabilities referred and recommended for a licence by the county medical officer,
1962—June, 1970*

Disability	No. referred	% total referrals	No. approved for a licence	%
Epilepsy	165	45	63	38
Diabetes	24	7	19	79
Cardiovascular	23	6	14	61
Other disorders of consciousness ...	50	14	31	62
Visual defects	17	5	12	70
Other physical disabilities ...	34	9	23	68
Mental illness or subnormality ...	43	12	34	79
Miscellaneous medical conditions ...	13	4	3	23
Total	369	—	199	54

TABLE Ib

*Disabilities referred and recommended for a licence by the county medical officer
June, 1970—May 31st, 1971*

Disability	No. referred	% total referrals	No. approved for a licence	%
Epilepsy	198	64	166	84
Diabetes	7	2	6	86
Cardiovascular	15	5	11	73
Other disorders of consciousness ...	36	12	32	89
Visual defects	4	1	4	100
Other physical disabilities ...	28	9	24	86
Mental illness or subnormality ...	20	7	16	80
Miscellaneous medical conditions ...	—	—	—	—
Total	308	—	259	84

TABLE Ic

Total disabilities referred and recommended for a licence by the county medical officer from 1962—May 31st, 1971

Disability	No. referred	% total referrals	No. approved for a licence	% approved
Epilepsy	363	54	229	63
Diabetes	31	4	25	81
Cardiovascular	38	6	25	66
Other disorders of consciousness ...	86	13	63	73
Visual defects	21	3	16	76
Other physical disabilities	62	9	47	76
Mental illness or subnormality ...	63	9	50	79
Miscellaneous medical conditions ...	13	2	3	23
Total	677	—	458	68

(a) *Epilepsy:*

It is necessary to subdivide the referrals in this category into those considered before and after the Regulations of 1970.

The *Road Traffic Act, 1960*, implied that a person who suffers from epilepsy was not entitled to drive a motor vehicle, although, in practice, the phrase "suffers from epilepsy" was open to wide interpretation.

TABLE II

Disabilities referred to the county medical officer after an accident 1962—June, 1970

Disability	Total no. of referrals	Accident as reason of referral	%
Epilepsy	165	8	5
Diabetes	24	14	58
Cardiovascular	23	8	35
Other disorders of consciousness ...	50	29	58
Visual defects	17	1	6
Other physical disabilities	34	11	32
Mental illness or subnormality ...	43	5	12
Miscellaneous medical conditions ...	13	2	15
Total	369	78	21

Before June, 1970, some licensing authorities decided—often on arbitrary grounds—that an applicant who had not had an epileptic fit for a given period, could no longer be considered as suffering from epilepsy. Our practice has been that most applicants referred as possible epileptics were seen by a consultant for an examination and electroencephalogram. If the applicant was indeed an epileptic but had remained free of fits for three years on medication and for two more years without drugs and providing the consultant considered that liability to further seizures was remote, a licence was granted, subject to an annual review. This was in broad agreement with the view expressed by Hierons (1956) but which was not generally accepted in Britain until the Regulations of June, 1970. Epileptics, since 1970, have a conditional right to a licence.

Table Ia shows that 165 cases of epilepsy were referred up to June, 1970, (45% of all referrals) and 63 (38%) were granted licences after medical investigation. Only eight cases (5%) were referred following an accident (Table II) in which epilepsy had not been disclosed previously, but there were other referrals from the police, of epileptics found unconscious in their cars but not involved in accidents. These people may have received some forewarning of an impending attack in time to stop the car safely.

The increase in numbers of referrals for epilepsy for the year following *The Motor Vehicles (Driving Licences) Regulations, 1970* is clearly shown in Table Ib. This also shows the greater proportion of epileptics (84%) who were successful in obtaining a licence.

(b) Diabetes:

Though fewer diabetics were referred (Table Ia) a higher percentage were involved in road accidents (58%, 14 cases; Table 2); but whereas only a third of epileptics were granted licences before June, 1970, (Table Ia) more than three-quarters of diabetics were successful in obtaining one.

Consultant physicians are reluctant to advise diabetics against driving; diabetics referred to the county medical officer usually obtained medical opinion to say that their condition was well controlled, and that hypoglycaemic attacks only occurred under extreme circumstances.

R. was driving a hydraulic tractor shovel when he developed hypoglycaemia. A fellow employee was crushed to death attempting to rescue him. The case was referred to assess his medical fitness to drive. He refused to agree to examination by a specialist nominated by the CMO, and the licensing authority therefore revoked his licence. In court R. produced medical evidence that this was his first hypoglycaemic attack, which had been precipitated by the unusually bad weather conditions; the diabetes being usually under control.

The appeal was granted but with costs against the plaintiff for refusal to co-operate with the licensing authority.

It is believed that hypoglycaemia, unlike epilepsy, gives warning of an impending attack, but the following case is worth noting.

In June, 1966, B. was driving a 4-ton van with power steering northwards along the A1, crossed the central reserve colliding head-on with other vehicles travelling south. Four people died and others were injured. B. sustained only minor injuries to the legs. A charge of dangerous driving was dropped when it became known that he was a diabetic, and that the accident was said to be due to hypoglycaemia. B. was taking 88 units of Lente and 12 units of Semi-Lente IZS daily, at the time of the accident. He had suffered previously from hypoglycaemic attacks and it was considered that he was an unstable diabetic; his licence was revoked. In September, 1969, B. re-applied for his driving licence. His insulin requirement was now 40 soluble, and 28 PZI daily. However a series of blood sugars on two separate occasions showed this to be from a minimum of 15 mgm to a maximum of 198 mgm %, with seven readings under 70 mgm %. At no time did he complain of symptoms of hypoglycaemia, although it is highly likely that there was some transient cerebral impairment. A licence was not granted.

Other cases, fortunately not ending in fatalities, suggested that it may not be necessary to suffer loss of consciousness to cause an accident: a low blood sugar with cerebral impairment can occur without the diabetic being aware of the fact.

Diabetes, therefore, poses a special problem in that an applicant for a licence need not disclose that he suffers from this condition, except if he has hypoglycaemic attacks when he may volunteer the information that he has attacks of disabling giddiness or fainting. It is only for this that a licence can be withheld or revoked. It is, however, an offence under the *Road Traffic Act, 1934*, to drive whilst under the influence of drugs, and insulin is regarded as a drug.

(c) *Cardiovascular disease:*

Cardiovascular conditions, such as valvular heart disease causing aortic regurgitation and ischaemic heart disease, can cause sudden attacks of loss of consciousness. Cases of hypertension were referred after accidents in which this was put forward as a mitigating factor. There is also the possibility of postural hypotension from drug therapy.

After colliding with a stationary car, a man informed the police that he had suffered a 'blackout' and was on treatment for high blood pressure, which on examination was 210/130; his urine contained albumin. He also complained of sudden loss of consciousness suggestive of postural hypotension. His licence was revoked.

Thirty-eight cases with cardiovascular disease were referred; up to June, 1970, eight referrals were after accidents.

(d) Other disorders of consciousness:

Most cases in this category (58 %, Table II) were referred by the police after an accident in which the driver had stated in his defence that immediately before the accident there had been a loss of consciousness. In many of these cases, physical examination, electroencephalography, electrocardiography and glucose tolerance tests were negative, but in some, there were unusual conditions responsible for the loss of consciousness, as illustrated by the following case:

A driver travelling at 25 m.p.h. began to cough uncontrollably. He saw spots before the eyes, felt faint and dizzy and then lost consciousness. The car travelled a further 60 yards, hit a wall and was extensively damaged; the driver sustained lacerations to his face. This was his first accident in 37 years of driving. The police successfully prosecuted him for dangerous driving, but lost the appeal when it was stated that the man suffered from cough syncope. He was a driving instructor, with his own business and loss of his licence could have been financially disastrous. On examination, he was a stout plethoric man of 15 stone who smoked 40 cigarettes a day. The blood pressure was 180/120; ECG was normal. There was a history of one previous attack. A consultant physician stated that there was little likelihood of further attacks. His licence was not revoked on condition that he agreed to an annual review of his state of health. To date he has remained well.

Another case of cough syncope in 1969 resulted in severe injury to a pedestrian through a driver's coughing attack, and on another occasion a stationary vehicle was damaged. The driver's licence was revoked and this decision was upheld in court when the applicant appealed. Cough syncope was first described in 1876 by Charcot and over 400 cases have been reported (Katz, 1970).

An unusual case was that of a 61-year-old man involved in two accidents within a few minutes.

He first collided with a stationary car then pulled out into a major road, colliding with another vehicle; he had no recollection of either event. A consultant physician to whom he was referred found a blood pressure of 220/120, a left lower quadrantic homonymous hemianopia, a sensory deficit of the left arm and leg and a left extensor plantar response. The man made a complete recovery with the exception of some residual left hemianopia. His licence was not revoked but was conditional on an annual review. There had been no recurrence of the symptoms by February, 1967, but in March he complained of dizziness with a tendency to fall to the left. His blood pressure was now 170/100; discs showed only minimal hypertensive changes. His licence was renewed. In May, 1968, his general health had deteriorated and he had aged considerably but there had been no further attacks of loss of consciousness. A full medical examination by a consultant physician disclosed a mild diabetes controlled by diet, ECG

changes of an old postero-lateral infarct but with normal cardiac function; central nervous system was essentially normal. The licence was again renewed; however, he died in November, 1968.

This case was typical in every respect of what Alvarez (1966) and Hutchinson (1969) call "little strokes"—involving minor blackout, with neurological signs which improve, the recurrence of similar episodes, rapid ageing, and concomitant heart attack.

Yoss (1969) suggested that one cause of automobile accidents was drowsiness whilst driving, but that only certain drivers were especially prone to this problem. He described a pupillographic test to detect such drivers and quoted case histories of such people who had fallen asleep at the wheel.

DISORDERS OF THE MIND:

Mental illness or subnormality, although accounting for only 9% of referrals (Table Ic) were difficult to deal with. Under Section 100 of the *Road Traffic Act, 1960*, and *The Motor Vehicles (Driving Licences) Regulations, 1971*, a licence can be withheld or revoked only as follows:

"mental disorder for which the applicant for the licence, for as the case may be, the holder of the licence is *liable to be detained under the Mental Health Act, 1959(a) or is receiving treatment as an in-patient in a hospital or nursing home* within the meaning of the Act." (our italics).

"mental disorder for which the applicant for the licence or, as the case may be, the holder of the licence is liable to be detained under the *Mental Health (Scotland) Act, 1960(b)* or is receiving treatment as an in-patient in a hospital within the meaning of that Act;"

"severe subnormality as a result of which the applicant for the licence, or as the case may be, the holder of the licence is subject to guardianship under the *Mental Health Act, 1959* or is either resident in accommodation provided, or having effect as if provided, by or by arrangement with a local health authority under Section 12 of the *Health Service and Public Health Act, 1968(c)* or otherwise receiving care from a local health authority under that section;"

"mental deficiency such that the applicant for the licence or, as the case may be, the holder of the licence is incapable of living an independent life or of guarding himself against serious exploitation as a result of which he is subject to guardianship under the *Mental Health (Scotland) Act, 1960* or is either resident in accommodation provided by, or by arrangement with, a local health authority under Section 27 of the *NHS (Scotland) Act, 1947(d)* or otherwise receiving care from a local health authority under that section;"

"any form of mental disorder or mental defect as a result of which the estate of the applicant of the licence or, as the case may be, of the holder of the licence is in the hands of a receiver, curator bonis or judicial factor;"

Since 1960 there has been a marked change in the treatment of mental illness. Most mental patients now attend hospital on an informal basis and are therefore not liable to be detained under the 1959 Mental Health Act. The interpretation of liability is unclear and few psychiatrists will support the revocation of a licence in their patients. Consequently there may be many mentally ill people who do not conform to the definition in the Act and who hold driving licences. The most that can be done is to insist on a driving test of competence and for this a provisional driving licence must be granted. Once the authority is satisfied of a person's competence it is unlikely that an authority would request a further test, unless there has been a marked deterioration in health.

F. began behaving abnormally after the breakdown of his marriage and consequent divorce. Several weeks after the divorce he visited the west country, but acted in such a strange manner that he was taken to the railway station by the police and put on the train to Yorkshire. He arrived instead in London entered a bank and attacked a man, then ran off. After arrest by the police he stated that he had entered the bank in response to voices which had told him to kill Himmler's son who worked there. He was admitted to a mental hospital, but discharged himself after seven days and returned to Yorkshire. He was deluded and paranoid and refused to take treatment. He was asked to surrender his licence and this he did but several weeks later demanded its return. In the meantime he had attended a psychiatric hospital voluntarily and had received ECT with some improvement. The licence was returned.

A most unusual case was the 27-year-old man who, when stopped by the police for a driving offence, stated that he had no recollection of how he came to be in the car, though he was 80 miles from his home. On a further occasion he was found wandering around his home town in the middle of the night. He was examined by a psychiatrist, who stated that he suffered from a fugue state which was a reaction to considerable sexual and domestic problems, but that in his view it was perfectly safe for the man to drive a vehicle. A second psychiatrist was less positive of the man's fitness to be in charge of a motor vehicle but with some reservation, his licence was not revoked on condition that his case be reviewed in six months. At review it was stated that he had suffered no further fugues.

DEFECTS OF SPECIAL SENSES:

Three per cent. of the referrals were for vision; most were referred by the Department of Environment driving examiner, because the applicant was unable to read a car number plate at the required distance. Some cases were referred by the police following accidents. If a person who cannot read a car number plate at 25 yards is tested by the police whilst in charge of a vehicle, he or she may be prosecuted.

Mrs. R. admitted on her application form that she had bilateral cataracts; she also enclosed a letter from a consultant ophthalmologist stating that her vision without glasses was 6/9, and that she had full visual

fields. She had driven for 29 years without an accident. In spite of the above recommendation, it was decided that she be requested to take the statutory eye test, i.e. reading a car number plate at 25 yards. This she failed to do on three attempts. A licence was therefore refused.

OTHER PHYSICAL DISABILITIES:

These include poliomyelitis, rheumatoid arthritis, Parkinsonism, amputation of a limb, and similar disabilities in which there is difficulty in manipulating the controls of a vehicle.

A licence or provisional licence can be granted providing suitably adapted vehicles are driven. The first provisional licence issued after declaration of a disability (or worsening of an existing disability) is unrestricted, but at the subsequent test, the driving examiner states the type of vehicle and its modifications which may be driven. This procedure is followed irrespective of the result of the test.

MISCELLANEOUS MEDICAL CONDITIONS:

This category covers conditions which the licensing authority believe could influence driving ability; for example:—myasthenia gravis, and partial gastrectomy because the sufferer had been told to beware of fainting attacks. Occasionally after an accident a person may state to the police that he was suffering from an acute infection such as influenza or pneumonia, which has a direct bearing on the accident, but is unlikely to have a long term effect on driving ability.

Some cases withdraw their applications rather than submit to medical investigation.

Mode of Referral:

Sixty-one per cent. of the cases were self-referred, that is, had made a declaration of disability on the driving licence application form; the other sources of referrals are shown in Table III. Police referrals accounted for 27% of cases.

Cases referred by the driving examiner were mainly for vision, a few were for a physical disability that the examiner felt affected ability to control a vehicle; in one case the applicant's behaviour pattern was so abnormal as to suggest a mental illness.

TABLE III

*Source of referral of cases to county medical officer
1962—June, 1970*

Method of referral	Number	%
Self	225	61
Police	100	27
Driving examiner ...	11	3
Licensing authority ...	10	3
Public	11	3
Other	12	3
Total	369	100

The licensing authority receives information from other licensing authorities about certain applicants, but this system is far from foolproof. An applicant can state a disability, and if, after medical investigation no licence is granted, may then use an address in the area of another licensing authority, not disclose the disability, and consequently receive a licence. Though we have no evidence that this practice is general, we have one case on record of someone who attempted this deception. Central computerization of records will make this type of evasion more difficult.

'Public referral' includes letters or telephone calls from neighbours who may be genuinely worried that the person named is unfit to drive; it can be malicious gossip. 'Other' occasional sources of referral are doctors and disablement resettlement officers.

Refusal of Licence:

An applicant who is aggrieved at the refusal or revocation of a licence can appeal in a court of law. There were six appeals in all and four of these were in the first 12 months of the scheme. In only one case did the magistrate reverse the decision of the licensing authority. The refusals consisted of two epileptics, two diabetics and a case of cough syncope.

Discussion:

Our experience in the West Riding has confirmed our belief that medical disabilities are responsible for some road accidents, (a fifth of referrals were after accidents, Table II) and that medical supervision of licence holders with certain disabilities is necessary. Epilepsy was the most common disability referred to the county medical officer. Before June, 1970, it was the disability in which a licence was refused most frequently, but this is not surprising because the *Road Traffic Act, 1960*, stated that a person suffering from epilepsy

should not hold a driving licence. Some authorities took the view that the safest course to take was "once an epileptic always an epileptic" (Elliott, 1963) and did not grant licences to any person who had suffered an epileptic attack. The more liberal interpretation of the Road Traffic Act by the West Riding enabled 38 % of epileptic applicants to receive a licence, without (to our knowledge) any dire consequences.

If one of the purposes of *The Motor Vehicles (Driving Licences) Regulations, 1970*, was to promote self-disclosure, it has certainly succeeded, and it has led to a greater proportion of epileptic applicants (84 %) obtaining driving licences. It is disquieting, however, that all these applicants obtained licences without any medical examination. Before June, 1970, each epileptic applicant did have a full medical assessment: now licences are granted on the statement of the applicant that he has suffered no fits for three years. The family doctor endorses this statement in so far as he is able, by confirming that to the best of his knowledge the statements made by the applicant are correct.

In view of the extensive degree of concealment of the diagnosis to obtain a driving licence, (40 %, Maxwell and Leyshon, 1971) the Regulations of 1970, placing as they do an almost total reliance on the veracity of the applicant, are open to abuse.

A surprising finding was that disorders of consciousness other than epilepsy made a greater contribution to road accidents—diabetes in particular, yet this condition need not be disclosed on the driving licence application. Fourteen diabetics compared with only eight epileptics were involved in accidents. It is possible that epileptics involved in an accident could conceal the diagnosis except if revocation of the licence was the lesser penalty. There may well be a case for closer medical supervision of disabilities such as diabetes and heart disease, which could be mentioned specifically on the driving licence application form. At least 17 States in the USA have a system whereby drivers with specified medical disabilities are registered and subjected to periodic medical checks (Waller, 1965).

In the West Riding there were few appeals against the decision of the licensing authority, which may be indicative that it was just. Certainly, the fact that a decision is reached only after consultation with many bodies, improves the possibility that it is so. The medical referee has access to the licensing authority file, police records if relevant, the family doctor's report together with letters from specialists, and the report of an independent consultant to whom the case may be referred. The co-operation of the family doctor has been necessary for the success of this scheme, but he is not placed in the invidious position of having to state that his patient is fit or unfit to drive, so that an applicant may return to him for advice if a licence is refused or revoked. The gradual increase in numbers of applicants referred shows that the licensing authority regard this as a valuable service, but this is still a local arrangement; there is no requirement for a licensing authority to refer for medical advice, except in cases of epilepsy.

Although only a small but unknown proportion of road accidents are due to medical disabilities, these could be prevented. The driving licence application form should mention other specific disabilities together with epilepsy and sufferers from these disabilities should be regarded as a special category requiring closer medical supervision.

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CHILDREN WITH EDUCATIONAL AND RELATED DIFFICULTIES IN THE PRIMARY SCHOOLS

C. Simpson Smith, Principal Medical Officer

Dennis G. Pickles, Senior Psychologist

One of the difficulties arising during school life has been the late identification of children with educational problems. In the past these have sometimes been appreciated only when a child has presented with secondary emotional symptoms such as aggressive behaviour as a result of frustration due to educational failure. Many children may have difficulties although of average intelligence due to inco-ordination of movement and hand control so that they are clumsy, cannot draw or write well, and often feel inferior to their peers. Others have specific learning problems of varied causation affecting reading development. These children may not be readily picked out during brief medical examinations and it is only in recent years that there has been an increasing awareness of their problems. Previously they were often regarded as lazy, inattentive or of limited potential.

Another group of children, those classified as educationally subnormal on investigation, have often been identified far too late—at the end of their primary period of education or even when of secondary age. There have been several reasons for this. Some teachers feel that children should not be 'labelled' if they present no problem other than slowness in the ordinary school. Others feel that it is a reflection on their competence as teachers if they have to admit failure. Another reaction of both teachers and doctors has been that it was pointless to identify these children as there were limited special school placements available. This has been unwise as an authority cannot plan for further places and submit proposals until a factual basis of need is available—it is insufficient to quote national figures as there are wide local variations. Investigation should help a child immediately by an awareness of his problems. Various studies locally and elsewhere have shown that at least 75 per cent. of e.s.n. pupils can be identified by the age of six years. The special schools for e.s.n. pupils can take in children by the age of seven years and units are being developed for the five to seven year group. At this age the secondary emotional problems may not have arisen and the child can be helped more successfully.

The scheme now operating in the West Riding of developmental assessments throughout the pre-school period will help to identify many children with physical and emotional problems at an earlier age but some children will need a period in the school situation before a full assessment of their educational potential will be possible.

Discussion of these and related questions led to the formation of a working party of psychologists to consider the use of a screening procedure which would have the purpose of:

- (a) assisting the schools in the early detection of children needing extra attention;
- (b) helping to establish more uniform procedures of selecting children for remedial help; and
- (c) providing comparative information on the incidence of need in different parts of the County.

The working party formed in June, prepared a report at the end of July, 1972, in which consideration was given to various aspects of screening and suggestions made regarding a screening procedure that, given general agreement, could be brought into operation on a wide scale throughout the County in 1973. The main proposals of the working party can be summarised as follows:

Purpose of Screening:

A screening procedure should have the purpose of identifying children with various problems apart from backwardness in attainment. The importance of educational attainment, especially in reading, was acknowledged, and the recommendations of the D.E.S. (1972) in *Children with Specific Reading Difficulties* were taken into account. It was considered, however, that there should not be over-emphasis on reading to the possible neglect of other problems presented by young children.

A screening procedure on a wide scale could only be practicable if applied to a particular age group; and for various reasons it was suggested that the top infant age group would be the most appropriate one.

To be effective and to provide the necessary basic information, the screening should be applied to a total age group and not to a pre-selected proportion of it. The screening would not necessarily impose standards arbitrarily, as these could emerge in the process of screening itself.

Proposed Procedure:

As many children would be involved, and there would be a need for economy as well as efficiency, it was considered that a screening procedure should be kept as simple as possible and that every effort should be made to avoid placing any undue burden on teachers.

A two stage procedure was suggested, screening of a total age group being followed by the further assessment of children identified by the initial screening.

(1) The first screening stage would require the completion by teachers of a short questionnaire on each child, which would cover behaviour, adjustment and circumstances, as well as educational performance, and consist of seven items. As these items, derived from previous experience in the use of similar questionnaires, would be indicative of definite 'disturbance' or backwardness, it could be anticipated that they would only need to be checked for a minority of children, and the clerical labour for teachers would not be as onerous as might at first appear. Consideration has been given to the production of a suitable form or card for each school, on which information can be checked on a single line for each child, to facilitate ease of recording and collation.

In view of the importance of reading, the recommendations of the D.E.S. pamphlet, and the need to have more information about reading standards in this age group, it was suggested that the opportunity should be taken to incorporate a reading survey in the initial screening. An individual test of reading accuracy rather than a group test was considered preferable for many reasons; and it has been recommended that the rearranged Burt test be used. It would not be the intention to use the test to obtain 'reading ages' or 'reading quotients', and all that would be required would be for teachers to report the 'raw score', i.e. the total number of words read correctly on the test by each child without help, together with the age of the child at the time of testing.

(2) From the information obtained from the initial screening, ways have been suggested for deciding which children should be included in the second or assessment stage of the procedure.

These would fall into two main groups, although there would be some overlap between them. There would be children with emotional behavioural and social difficulties who would be referred for selective school medical examination. The other group would consist of children handicapped in learning.

The latter group would require further assessment in their schools, and this would involve the use of certain tests, to be given by teachers, heads of remedial centres and psychologists, according to local needs and facilities.

Careful consideration was given to the possible use of a variety of tests, the essential requirements being that they should be suitably discriminative, provide a measure of verbal and non-verbal skills, be as short as possible, attractive and not stressful to small children, usable by teachers, and preferably be tests which had previously been used for similar screening purposes with children of this age.

The tests which have been suggested are: the English Picture Vocabulary Test 1 (E.P.V.T.1); a test of copying six simple designs; the drawing of a man; and a retest on the Burt reading test. The drawing tests could be group administered, but the E.P.V.T. and the Burt test require individual administration. The administration of the E.P.V.T. takes about five minutes and the Burt about the same with most children of this age. It would not have been possible to find tests of greater convenience than these.

The proportions of children requiring this assessment will vary from school to school, and it could be expected that schools in 'priority' areas might produce the larger numbers.

Further Action:

The assessment stage would indicate children needing different kinds of help.

Some children who appeared particularly backward or whose scores varied widely would need further and more detailed individual examination by psychologists and school medical officers. Children who might require special schooling would be included in this group.

Some would need to be considered for places in the remedial centres; and in areas not served by remedial centres, lists could be prepared of children suitable for this provision if it were available.

The assessment stage might also indicate some children handicapped in a specific way, such as clumsiness or visual motor difficulties, or with particular verbal disabilities.

It would provide further information on those children who would continue to need extra help in their own schools.

Additionally, the selective medicals could indicate certain children in need of child guidance attention and others who might require help through other social agencies.

Decisions regarding any further action on behalf of a child would be made in consultation with the school.

The above summary can only describe the essentials of the proposals made by the working party. A screening procedure of the type suggested would in a sense be using the convenience of universal schooling to survey the needs of a cross-section of the population at a particular age, and could bring to notice a wide range of problems, evident in school, but often symptomatic of circumstances outside the school. It could be a convenient focus for collaboration between various professions concerned with the well-being of children. It is appreciated that, as an attempt at diagnosis is implicit in screening, there would also be implications for further action to help certain children either through their own schools or through other special services.

As a school-based procedure, it would rely upon information provided by the schools. Throughout their discussions, the members of the working party were conscious of the need to ensure that teachers should not be overburdened, that the procedure should interfere as little as possible with their normal teaching duties; and were hopeful that it might be of some assistance to teachers in their dealings with children who were experiencing difficulties.

Any screening procedure will have limitations and infallibility cannot be expected. The outlined procedure is likely to be more efficient in the detection of educationally backward children. As it would not be possible to include information from parents, the information it would give on 'maladjustment' is likely to be less than complete. But the screening should give a fair indication of the numbers of children causing concern in school through various behavioural and emotional difficulties.

A provisional time schedule, operating during the first half of the Lent term for the initial stage of the screening, and early in the Summer term for the assessment stage, has been suggested; and there should be opportunities for consultation between psychologists, remedial centre heads, and school staff, regarding procedural matters.

The scheme has now been accepted after discussions with the Senior County Advisers on Education and the Chief Education Officer, and is to commence in 1973.

We are indebted to the psychologists and particularly the members of the working party, Mr. Atkinson, Mrs. Goulding, Mr. Mannix, Mrs. Pilkington, Mr. Pickles, and Mr. Valentine, for their detailed studies and the comprehensive report which ensued. Whilst imposing some additional work on the teachers it should obviate the need for the completion of many Forms 3 H.P., which is a time-consuming form filled in as a preliminary to an assessment by a medical officer on Form 2 H.P. Over 40 per cent. of primary examinations in the past have shown that the children were not within the e.s.n. category and the screening procedure should identify them and their problems much more readily. The collation of material from the surveys should assist the educationalists in identifying areas of particular need for remedial classes, centres and further special school provision.

THE HISTORY OF THE ORTHODONTIC SERVICE

H. Taylor, Chief Dental Officer

Little orthodontic treatment was carried out in this country before 1935 and the first reference to its introduction within the County service occurs in the *Annual Report of the School Medical Officer, 1938*, when Mr. B. R. Townend, the first Chief Dental Officer, wrote "A small amount of orthodontic treatment to straighten crooked teeth has been done during the past year and it is hoped that with the establishment of central clinics more of this very important branch of dental surgery will be undertaken." Towards the end of 1939 a dental laboratory was equipped and the first technician, Mr. J. O. Ford, appointed. Often during war-time 'fire-watching' at the Wakefield clinic, these two pioneers experimented with the construction of orthodontic appliances. And so it was in this small experimental manner that the West Riding Orthodontic Service, soon to achieve a national reputation, was born.

The two clinical sessions a week devoted by Mr. Townend to this type of treatment were soon increased and further augmented by Miss Rachel Sclare, a dental officer with a particular interest in orthodontics and who, some years later was to be appointed Orthodontic Specialist. Articles published under their names in professional journals focused interest on the service* and requests for information and for visits to Wakefield from all over the British Isles and even from overseas were received. In 1954, the Royal College of Surgeons conferred upon Mr. Townend an honorary Diploma in Orthodontics and Miss Sclare was similarly honoured in 1956.

Many patients made long, difficult journeys into Wakefield and, as a first step in taking the treatment to them, another centre at Brighouse was equipped in 1948 and a year later a further clinic in Harrogate. As more general dental clinics came into being, so the orthodontic service expanded and in 1952 Miss Sclare was appointed the first full-time Orthodontic Specialist, indeed the first in the country. On Mr. Townend's retirement in 1960, Miss Sclare took over the supervision of the orthodontic service until her own retirement at the end of 1966, when her post, re-designated County Orthodontist, passed to Mr. G. A. Thompson.

Each year the demand for this type of treatment increased and was met by encouraging all dental officers to carry out such work as they felt was within their ability and to refer the more complex cases to the specialists. In 1939, 78 patients were treated with orthodontic appliances, in 1972 the number of appliances produced, in a laboratory with an establishment of 12 technicians, was over 3,000.

Until quite recent times the bulk of orthodontic treatment in the West Riding County area, including referrals from general dental practice, has been carried out by the school service. In the last few years, however, additional hospital orthodontic consultant appointments have been made.

*A bibliography of these papers is being prepared for inclusion in the Report for 1973.

The resignation of the County Orthodontist towards the end of 1972 and the decision not to fill the vacancy in view of the closeness of the reorganisation of the health services, created problems of continuity of the service, which were overcome, befittingly, by Miss Sclare emerging from retirement, in part-time capacity, to see the service through to 1974. As the whole dental service is to be divided among 14 new Area Health Authorities, it will be for these to decide the future.

Ex-members of the staff of the West Riding will be able to look back with pride at the record of the dental service and perhaps particularly the orthodontic service, which introduced to its patients a little-known dental science and which developed until its prowess became nationally known.

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VITAL STATISTICS

PART I

VITAL STATISTICS

EPIDEMIOLOGY

VENEREAL DISEASE

RESEARCH

See also Tables 1 to 35 of Appendix A

VITAL STATISTICS

Area and Population:

	Municipal Boroughs and Urban Districts	Rural Districts	Administrative County
Area (acres)	380,315	1,226,148	1,606,463
Population:			
Census, 1971	1,272,706	520,772	1,793,478
Estimated (mid-1972)	1,283,970	530,860	1,814,830

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

Summary for 1972:

	Adminis- trative County	England and Wales
Live Births		
Number	27,925	
Rate per 1,000 population	15.4	14.8
Illegitimate Live Births		
Number	1,943	
Per cent. of total live births	7.0	8.6
Stillbirths		
Number	346	
Rate per 1,000 total live and still births	12.2	12.0
Total Live and Still Births...	28,271	
Deaths: All causes	21,956	
Rate per 1,000 population	12.1	12.1
Infant Deaths (deaths under 1 year)	492	
Infant Mortality Rates		
Total infant deaths per 1,000 total live births	17.6	17.2
Legitimate infant deaths per 1,000 legitimate live births	17.3	16.9
Illegitimate infant deaths per 1,000 illegitimate live births	21.6	21.1
Neonatal Mortality Rate (deaths under 4 weeks per 1,000 total live births)	11.8	11.5
Early Neonatal Mortality Rate (deaths under 1 week per 1,000 total live births)	10.3	9.8
Perinatal Mortality Rate (stillbirths and deaths under 1 week combined per 1,000 total live and still births)	22.5	21.7
Maternal Mortality (including abortion)		
Number of deaths	1	
Rate per 1,000 total live and still births	0.04	0.15

Live Births:

The downward trend in the crude birth rate continued and reached the lowest level recorded since 1955. There were 27,925 births registered, equivalent to a rate of 15.4 per 1,000 population, compared with a rate of 17.0 in 1971 and an annual average of 17.4 in the years 1967 to 1971. It is expected that the decrease in the rate will persist through 1973 although with the rate of decline less marked. The County rate was again higher than that for England and Wales (14.8).

The birth rate, adjusted for variations in the age and sex structure of the population, for the aggregates of Municipal Boroughs and Urban Districts was 15.5, for Rural Districts 15.6, and the Administrative County 15.5.

For the second successive year there was a reduction in the number of extra-marital births; 1,943 were registered as illegitimate compared with 2,122 in 1971 and an annual average of 2,075 in the quinquennium 1967 to 1971: the total is the lowest recorded since 1966. The ratio per 100 total live births was 7.0 once again appreciably lower than national (8.6).

Stillbirths and Infant Mortality:

STILLBIRTHS:

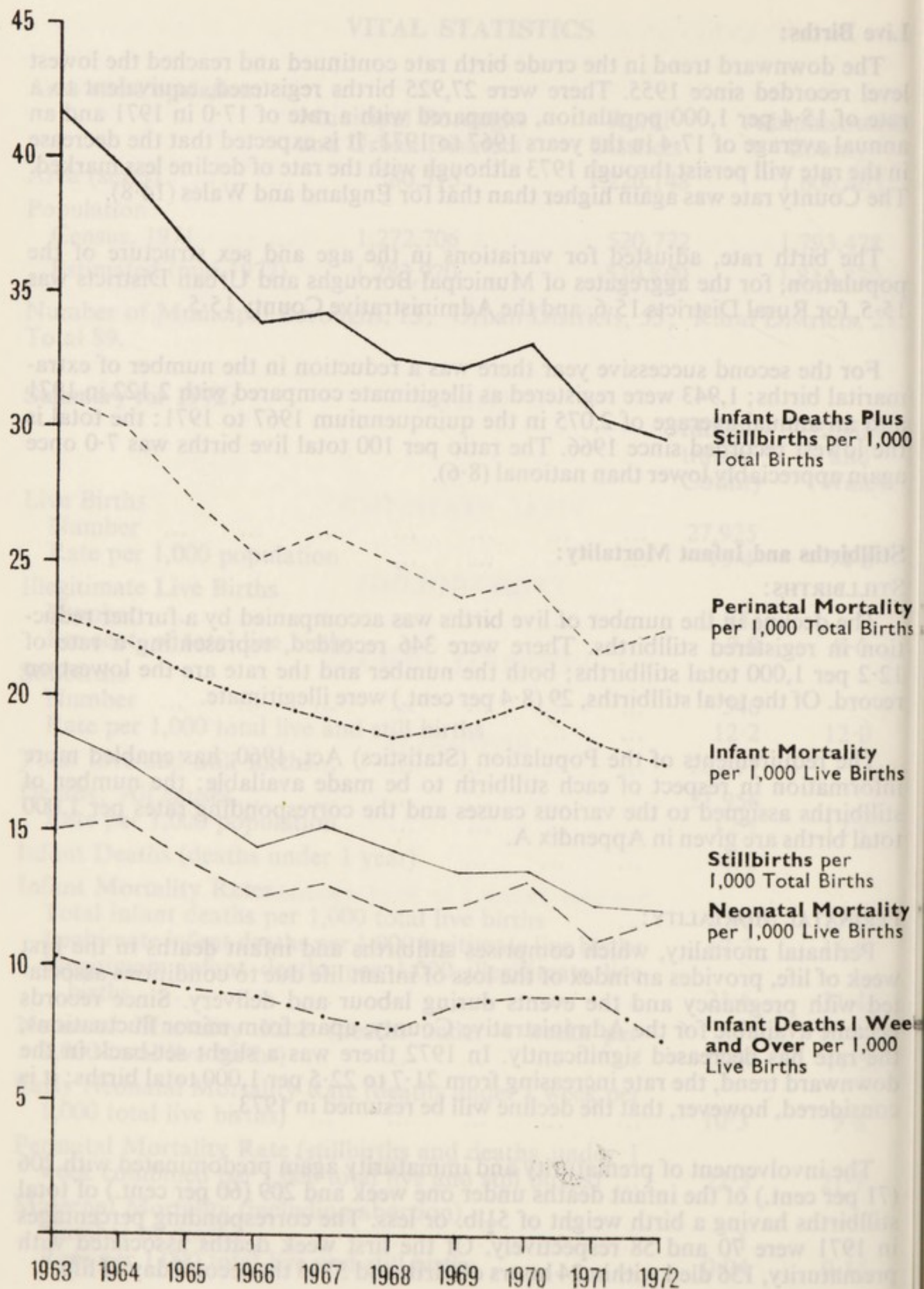
The decline in the number of live births was accompanied by a further reduction in registered stillbirths. There were 346 recorded, representing a rate of 12.2 per 1,000 total stillbirths; both the number and the rate are the lowest on record. Of the total stillbirths, 29 (8.4 per cent.) were illegitimate.

The requirements of the Population (Statistics) Act, 1960, has enabled more information in respect of each stillbirth to be made available; the number of stillbirths assigned to the various causes and the corresponding rates per 1,000 total births are given in Appendix A.

PERINATAL MORTALITY:

Perinatal mortality, which comprises stillbirths and infant deaths in the first week of life, provides an index of the loss of infant life due to conditions associated with pregnancy and the events during labour and delivery. Since records became available for the Administrative County, apart from minor fluctuations, the rate has decreased significantly. In 1972 there was a slight set-back in the downward trend, the rate increasing from 21.7 to 22.5 per 1,000 total births; it is considered, however, that the decline will be resumed in 1973.

The involvement of prematurity and immaturity again predominated with 206 (71 per cent.) of the infant deaths under one week and 209 (60 per cent.) of total stillbirths having a birth weight of 5½lb. or less. The corresponding percentages in 1971 were 70 and 58 respectively. Of the first week deaths associated with prematurity, 136 died within 24 hours of birth and 37 in the second day of life.



INFANT MORTALITY:

Apart from some years the rate has pursued a continuing downward trend. As mentioned above, the number of deaths in the first week of life were more numerous than in the previous year, this increase in mortality, however, was more than off-set by the gains made at older ages which resulted in the rate declining further to a new low record of 17.6 per 1,000 live births.

First day deaths accounted for 33 per cent. of the total infant mortality and deaths in the first week of life for 59 per cent.; the respective mortality rates per 1,000 live births were 5.8 and 10.3. Although there was a fractional improvement in the rate at ages 1 week and under 1 month, 1.4 per 1,000 births (1.5 in 1971) the major savings in infant life were in the 3 to 5 months period with a rate of 2.1 (2.8 in 1971) followed by infants aged 4 weeks and under 3 months, 2.3 (2.8) and 6 to 12 months, 1.4 (1.8).

Prominent causes of death in the first week of life were anoxic and hypoxic conditions 107 (94 in 1971), immaturity with no other contributory cause 65 (78) and congenital malformations 48 (52), while at older ages congenital malformations 56 (61), pneumonia and bronchitis 25 (75) and other diseases of the respiratory system 37 (46) were the major contributors to total infant mortality. There were only minimal variations in the numbers of deaths attributable to other diseases.

In spite of the reduction in the loss of infant life the County rate continues to be higher than that for England and Wales and that for certain other countries; clearly, further gains must be achieved before an irreducible minimum is reached.

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

Deaths:

Deaths of County residents numbered 21,956 compared with 20,585 in 1971; the corresponding crude death rates were 12.1 and 11.4 per thousand population respectively. The crude death rates adjusted by the comparability factors were, for the aggregates of Municipal Boroughs and Urban Districts 13.0, Rural Districts 12.2 and the Administrative County 12.9.

The major causes of the increased mortality were malignant neoplasms which were responsible for 4,051 deaths (3,897 in 1971); diseases of the circulatory system 11,721 (11,096) of which ischaemic heart disease registered an increase of 435 and cerebrovascular disease 103; and diseases of the respiratory system 3,131 (2,566) with deaths from influenza greater by 98, pneumonia 291 and bronchitis 165.

Table 9 of Appendix A shows the distribution of deaths by age and major cause groups. The proportion of deaths ascribed to the principal causes conformed to the general pattern of the past decade; the percentage contributions to total mortality were as follows: heart and circulatory disease (excluding cerebrovascular disease) 38.6, (38.6 in 1971), malignant neoplasms 18.5 (18.9), cerebrovascular disease 14.8 (15.3), respiratory diseases 14.3 (12.5) and violent causes 3.9 (4.1).

The foregoing represents the contribution to total mortality by these causes, but in economic terms the relative frequency of certain diseases assumes greater importance. Over 70 per cent. of the deaths were of persons aged 65 years or over who, on average, would have retired and reached their expected life-span; mortality at ages 15-64 years, however, caused a loss of around 60,000 working years which might otherwise have been available before retirement. Of this premature loss of working life malignant neoplasms accounted for 26 per cent. of the total, ischaemic heart disease 25 per cent. and other circulatory diseases 8 per cent., violent causes (of which motor vehicle accidents predominated) 17 per cent., diseases of the respiratory system 9 per cent. and cerebrovascular diseases 6 per cent.

Once again it is distressing having to report an increase in deaths from malignant diseases which reached a new high level. Cancers of the lung and bronchus continued to take a greater toll, the number of deaths for both sexes being the highest recorded. Mortality from ischaemic heart disease pursued an upward trend with the number of fatalities progressively increasing with age. Deaths from diseases of the respiratory system were more prevalent than in the past decade, all components contributing to the increase.

Few people are now unaware of the positive correlation between cigarette smoking and ill-health. In 1967, Sir George Godber, Chief Medical Officer of the Department of Health and Social Security, wrote of the association between cigarette smoking and lung cancer: "It is clear that abandonment of the cigarette smoking habit will lead to early and progressive improvement in health and in prospect of survival . . . The reduction of cigarette smoking amongst adults might be expected to lead to a great reduction in the number of young people who start smoking. No other public health programme of any kind offers an attainable target of a ten per cent. reduction in mortality and up to twenty per cent. reduction in morbidity. . . ." The past five years have reinforced this message. When the damage of cigarette smoking in causing certain forms of respiratory and heart diseases is fully apprehended by the public, the possibility of averting periods of incapacity and premature death are greater than was then appreciated.

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 average annual death rate was 17.13 per thousand living in the age group, by 1935-39 the average annual rate had reduced to 5.09 and for 1945-49 to 2.23. Subsequently there has been a slowing down in

the rate of improvement and in 1965-69 the average rate was 0.82. In 1972 there was a set-back in the rate's progressive downward trend, 105 deaths being registered representing a rate of 0.86 compared with 65 deaths and a rate of 0.53 in 1971. Deaths from malignant diseases, congenital malformations and accidents were more prevalent than in recent years and these causes, together with respiratory diseases, were responsible for two-thirds 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; further improvements, however, could be achieved if fatalities from accidental causes were eliminated. In the age group there were 101 deaths, of which motor vehicle accidents accounted for 25 and other accidents 22; these totals are higher than in the two preceding years. Mortality from remaining causes were around the same level as in recent years; there were 12 deaths from malignant neoplasms of which leukaemia contributed 3; and congenital malformations 8. The general death rate has remained fairly steady throughout the past decade.

ADOLESCENCE AND AFTER (15-24 years):

There have been only minimal variations in the level of mortality for a number of years, certain cause groups, however, have assumed greater prominence. The number of deaths from diseases of the respiratory system retained their relative position but mortality from malignant neoplasms recorded a slight increase. Violent causes now predominate in this age group and in 1972 accounted for 112 of the 169 deaths. Motor vehicle accidents were involved in 78 of the deaths and caused over a half of the male mortality. A large proportion were associated with riding motor cycles and I welcome the introduction of *The Motor Cycles (Wearing of Helmets) Regulations, 1973* which come into operation on 1st June, 1973, and will require helmets to be worn by riders and their passengers; this will prevent many head injuries.

YOUNG ADULTS (25-34 years):

During the past 20 years mortality at these ages has pursued a gradual downward trend. The sex and cause of death distribution followed the usual pattern with male deaths in excess in the ratio of 1.6:1. Of the 188 deaths, violence (58), notably motor vehicle accidents (29) and suicide (10), was the major cause, followed by diseases of the circulatory system (43) and malignant neoplasms (34).

ADULT (35-44 years):

At these ages, while the general death rate remains at a low level, some of the more frequent causes of total mortality, notably diseases of the circulatory system and malignant neoplasms, gain prominence. Deaths totalled 431, 261 males

and 170 females. Among males, ischæmic heart disease (87), malignant neoplasms (54—15 of lung and bronchus) and violent causes (50) were the principal causes and in females malignant neoplasms (58—18 of the breast), violent causes (20), ischæmic heart disease (12) and cerebrovascular disease (12). The number of deaths ascribed to the groups varies slightly from year to year with no trend apparent.

MIDDLE LIFE (45-64 years):

Of the 4,816 deaths registered in this 20 years life span the most numerous causes, in descending order, were diseases of circulatory system (2,339) malignant neoplasms (1,413), diseases of the respiratory system (500) and violence (183).

Mortality from ischæmic heart disease continued in an upward trend especially in males; more than one-third of male deaths in the age group were from this cause. Of the cancer deaths, the predominant site was lung and bronchus in males (1 in 9 male deaths in this age group) and in females malignancies in the breast and uterus.

OLDER AGES (65 years and over):

As mentioned previously, 70 per cent. of the total mortality was at these higher ages. In all there were 15,654 deaths with the patterns of mortality in middle life being broadly continued with the degenerative diseases predominating. As age advanced the excess male mortality being less evident 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 1972, 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:

No case has been recorded since 1964. Although the incidence nationally remains low, occasional flare-ups and imported cases emphasise the importance of achieving and maintaining the optimum level of protection of our child population by immunisation.

DYSENTERY:

As incidence varies from year to year with no discernible trend it is pleasing being able to report that the number of corrected notifications decreased from 406 in 1971 to 124, the lowest total since 1949.

Seasonally, cases were slightly more prevalent in the winter months. 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 of the disease has undergone various changes since notification was introduced in 1919; in recent years most cases have been of the *Sh. sonnei* strain which has been generally mild with a low fatality rate. It is now accepted that the mode of spread of the infection is by direct and indirect contact with defective personal hygiene the prime cause, and symptomless excretors playing a minor role.

ENCEPHALITIS:

Cases of the disease are classified as 'post-infectious' if associated with or following infectious disease or smallpox vaccination; in cases where no such relationship is established the classification of 'infective' applies. In 1972 one case of the infective form was notified, a girl aged 11 who had viral encephalitis. She was admitted to hospital and was discharged home eight days later having made a satisfactory recovery.

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 1972 three cases were confirmed. All the cases contracted the disease abroad but were unconnected with each other.

A 24 year old man had travelled extensively, chiefly in the Far East, and had spent three months in India. The patient had periods of severe diarrhoeal illness whilst abroad and on return to this country he developed general malaise, weakness and fever. He was investigated in hospital where the diagnosis of *S. typhi* was confirmed: fortunately his recovery was uneventful.

The second case was a woman aged 50 years who was infected whilst on a family holiday in Spain: she made a steady recovery and there were no secondary cases.

Whilst on a family holiday in Morocco an 11 year old boy, along with other members of the family suffered from diarrhoea and vomiting. The boy recovered from his illness and returned to school but subsequently he developed headache, pyrexia, abdominal pain and loose stools. He was admitted to hospital where his appendix was removed. At the time of the operation the surgeon observed that there was excess fluid in the peritoneal cavity with thickening of the mucosa of the lower ileum and mesenteric adenitis. On referral to the Consultant in Infectious Diseases the boy was transferred to the isolation ward and examination of faeces revealed the presence of *S. typhi*, phage type E1. Blood culture was also positive. After several days the symptoms resolved satisfactorily but for many days he refused to speak, developed a blank expression and was thought to be suffering from a toxic psychosis due to *S. typhi*. The boy made slow but steady progress towards recovery. Again, there were no secondary cases.

West Riding school parties holidaying in the Mediterranean area and certain parts of Europe continue to be advised to be adequately vaccinated against typhoid and paratyphoid fevers. It is emphasised 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:

There was only one confirmed case, a 48 year old woman who suffered from cramp-like abdominal pains, severe diarrhoea and vomiting. She was investigated in hospital and while culture of faeces was negative, there was a fairly dramatic rise in the serum Vi titre for *Salm. paratyphoid B*. Follow-up investigations revealed that other members of the family had had milder abdominal symptoms which had cleared up spontaneously and were clinically free of the disease. The source of infection remains untraced.

FOOD POISONING:

Recorded incidence of food poisoning is assessed from the statutorily notified cases and reports of medical officers of health on outbreaks and the associated investigations.

There were 94 incidents reported (90 notified cases and 4 ascertained) compared with 126 in 1971 and an annual average of 164 in the period 1967 to 1971. Summarised in the table in Appendix A are the major microbial causes analysed by type of incident.

There was no outbreak of any significance.

Salmonellosis made the major contribution to total incidence being responsible for 69 cases. The importance of *S. typhimurium* within the total picture of salmonella food poisoning is clearly underlined; there were 42 cases forming 61 per cent. of all cases of salmonellæ (56 per cent. in 1971) and 45 per cent. of total incidence (37 per cent.). Additionally, there were 41 cases of salmonella infections not food-borne one of which, a baby boy died aged 23 days, the causal agent being *S. typhimurium*. The vehicle of infection was untraced and at post-mortem he was found also to have congenital renal hyperplasia.

For the most part our food supply is beyond criticism or suspicion: marked progress has been made in the manufacture, preservation, storage, transportation and distribution and food poisoning could be virtually eliminated by strict adherence to a rigid code of clean food handling supplemented by high standards of preparation techniques and kitchen hygiene.

INFECTIVE JAUNDICE:

Of the total of 608 confirmed notifications 325 related to children aged 5-14 years. There was no outbreak of any significance and, as in previous years, incidence was highest during the winter months.

Statutory notification of cases has enabled medical officers of health to investigate the epidemiology and incidence of the disease. There are still many obscure features of both components and various research projects are being undertaken in endeavours to unravel the epidemiological complexities. In recent years there has been a case fatality rate nationally of about one per cent. which emphasises the urgency of the production of a virocidal agent and/or an effective vaccine.

INFLUENZA:

The winter of 1971/72 was free of epidemic influenza and only sporadic cases were reported during the year until mid-December when there was increased prevalence chiefly in western parts of the County. From then up to mid-January minor outbreaks occurred throughout the County with no focal point in evidence. Generally the disease was clinically mild and was due to variants of virus A/England/42/72 with all age groups being affected.

MEASLES:

Since 1966 a variation in the seasonal incidence of measles has occurred. Previously it was usual for the disease to assume epidemic proportions during autumn through to spring biennially but in the summer of 1966 this pattern was interrupted when large scale outbreaks were reported throughout the County. High prevalence during the summers of 1968, 1970 and again 1972 with winter peaks absent suggests that this has now become the cyclic norm.

In 1972 there were 11,137 notifications of which 6,861 (61.6 per cent.) arose in May to August. Of the total notifications 5,412 (48.6 per cent.) related to children under 5 years of age and 5,343 (48.0 per cent.) in the 5-9 years age group. There was no pronounced male excess.

Routine vaccination against measles is now generally an accepted procedure in a child's vaccination and immunisation programme. In view of the disquieting prevalence of the disease during the summer months there remains the need for vigorous campaigns to achieve a high acceptance rate of vaccination among susceptible children of all ages up to and including 15 years with particular attention being paid to vaccinating unprotected children before they attend nursery or primary school.

A review of the Authority's participation in the Medical Research Council's trials of measles vaccines which preceded the introduction of the national scheme of vaccination appears on page 92.

Measles Vaccination:

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

Born in Year	
1972	2
1971	11,541
1970	8,898
1969	631
1965-68	948
1956-64	52
Total	22,072

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 31st March, 1971, free of charge to enable Authorities to offer vaccination to all girls aged 13 years. Local Authorities would be expected to purchase the vaccine needed after 31st March through normal commercial channels. Approval to the operation of the rubella vaccination scheme as from September, 1970, was given by the West Riding Health Committee. During the year 1972, 9,936 girls received vaccination.

MENINGITIS:

There were 35 cases confirmed compared with 30 in 1971 and 55 in 1970. Acute meningitis is not a single disease entity and an analysis in terms of the infecting micro-organisms revealed that meningococcus was incriminated in 18 cases (17 in 1971), other specified organisms in 7 (8) and unspecified organisms 10 (5).

Of the total notifications 14 were of children under 5 years of age and seven in the 5-9 years age group. There was no focus of infection or traceable connection.

POLIOMYELITIS:

After being free from the disease for the past three years it is disappointing having to report that a case of the non-paralytic form was notified. Commenting on the case, Dr. Brock, Medical Officer of Health for Todmorden M.B. wrote:

"A girl aged 10 years was admitted to hospital on 2nd September, 1972, with a history of pain in her back for four days followed by pyrexia and difficulty in flexing her neck. She had complained of headache for a day and had vomited once.

On examination she looked well but had a temperature of 100.2°F. A few small lymph nodes were palpable in her neck. She had doubtful neck stiffness and no other abnormal signs were found. A lumbar puncture revealed a clear fluid containing 28 cells (mainly lymphocytes)/c.mm. with a protein of 39mg% and a sugar of 67mg%. No growth was obtained on culture. Her hæmoglobin was 98%, the white blood count being 6,100/c.mm. and her urine was normal apart from a trace of albumin. A Mantoux 1:1,000 was negative.

She appeared to have a virus meningitis and specimens were sent for virus studies. Her symptoms gradually subsided and she was discharged home on 9th September.

On the 28th September, the laboratory reported that after C.S.F. inoculation on monkey kidney tissue, a cytopathic agent was isolated—a virus neutralised by polio virus type 2 antiserum.

There were three other children in this family, all older and all have been vaccinated against poliomyelitis. The patient was vaccinated in 1963 and with a booster dose in 1967. The family have not been abroad and have not, to their knowledge, been in contact with any person exhibiting similar symptoms to the case. The little girl recovered fully; the laboratory considers this to be a case of poliomyelitis by a 'wild virus' and not due to 'vaccine virus'."

Satisfactory progress towards elimination of the disease is being maintained with incidence and mortality remaining low nationally. That cases continue to arise clearly underlines the need to vaccinate children and persons at special risk if a recurrence of the disease is to be prevented.

Vaccination against Poliomyelitis:

At the year end the total number of persons who had received protection against poliomyelitis in the County, taking into account both Salk and Oral vaccine, was 931,328.

SCARLET FEVER:

Notifications totalled 683 compared with 740 in 1971 and an annual average of 879 during the quinquennium 1967 to 1971. Over a half of the notifications were of children in the 5-9 years age group. The seasonal distribution of cases conformed to the established pattern with incidence highest in the winter months. By far the majority of cases were mild and were nursed at home; no death was reported.

SMALLPOX:

No case has been notified since 1962. Active eradication programmes in endemic areas are being continued and reported incidence throughout the world has declined. In 1971 this change of prevalence with a diminishing likelihood of the occurrence of outbreaks in this country prompted the Joint Committee on Vaccination and Immunisation to re-assess the balance of risk in the recommended schedule of vaccinations against the benefits derived. The Committee concluded that vaccination against the disease need not now be recommended as a routine procedure in early childhood; all travellers to and from areas of the world where smallpox is endemic or countries where eradication programmes are in progress should be protected by recent vaccination; and health service staff who come into contact with patients should be offered vaccination and re-vaccination. These conclusions were endorsed by the Secretary of State and were implemented by the Authority with consequential amendment of the vaccination and immunisation schedules.

TETANUS:

Notification of the disease was introduced on 1st October, 1968, and up to 1971 no case had been reported. In 1972 one case arose which unfortunately proved to be fatal. Brief notes on the case are given below in which the necessity of carrying out prophylactic immunisation of all people and especially high risk groups such as children and those indulging in physical contact sports is clearly underlined.

A 22 year old married man sustained a cut knee during the course of an amateur football match and was then taken to a casualty department where 10 sutures were inserted into the wound. He was given an injection of tetanus toxoid and one of a long-acting penicillin, but no antitoxin, and was told to return a week later for removal of sutures.

Four days later he attended the morning surgery of his family doctor as he felt unwell, but there was no obvious cause for this. The same day he returned to evening surgery because the wound was oozing thick dark purulent blood; the wound was re-dressed. The following day he walked to the surgery, a distance of one mile, and indicated that he could not speak. He was immediately admitted to the intensive care unit of an infectious diseases hospital. On admission he was given 20,000 units of anti-tetanic serum; he died five days later of tetanus. One injection of tetanus toxoid had been given 10 years previously.

The playing pitch had been used for the past 13 years without any known previous cases having occurred.

Tetanus Immunisation:

The total number of children who completed a primary course of protection against tetanus during 1972 was 28,289. A secondary or reinforcing injection was given to 30,686 children.

WHOOPIING COUGH:

There was a dramatic decrease in notifications from 857 in 1971 and an annual average of 826 in the period 1967 to 1971 to 51, the lowest total recorded. Nearly two thirds of the cases occurred in the winter months with no focus of infection. The age/sex distribution conformed to established patterns with the majority of cases relating to children under five years of age. The reduction in incidence was in accord with national experience and it seems likely that recent modifications in content and potency of the vaccines administered together with a higher vaccination rate have been largely responsible.

This can be a disturbing and potentially dangerous disease in early infancy and it is hoped that by effective vaccination we can reduce incidence to negligible proportions.

Immunisation Against Whooping Cough:

During the year 26,477 children completed a full course of immunisation against whooping cough and since facilities were introduced in 1952 a total of 387,569 have been immunised under the County scheme. The number of children in the 0-4 years age group was 96,822 representing 86.4 per cent. of the total population in this age group. Of the 50 notifications of whooping cough in the 0-14 years age group 25 concerned children who had been immunised.

VENEREAL AND SEXUALLY TRANSMISSIBLE DISEASES

The new quarterly statistical return form allocating cases into one of four groups was again used at special clinics.

Syphilis:

The number of new cases of all types of syphilis increased by six to 44 of which at least four were known to be suffering from the early infectious stage of the disease. There has been a marked decline in the number of cases of early infectious syphilis over the past 10 years. For the eighth successive year there were no cases of congenital syphilis in infants under one year of age. Cases of syphilis comprise a very small proportion, about one per cent. of the total new cases. The number of West Riding antenatal patients found to have positive serological tests for syphilis was 10 and these were all referred to special clinics for assessment.

Gonorrhœa:

The number of new cases was 641, showing a slight decrease in total compared with the previous year. Males accounted for 404 infections and females 237. Approximately 13 per cent. of all new patients had gonorrhœa.

Other Genital Infections:

This group, about 49 per cent. of all new cases, included four common infections, namely, non-specific genital infection, candidiasis, trichomoniasis and genital warts. The conditions uncommonly seen included scabies, pubic lice, genital herpes and Reiter's disease, which is a non-specific genital infection complicated by conjunctivitis and arthritis. Non-specific genital infection is a very common condition in the male and sometimes presents problems in treatment which complicate the course of the disease. Candidiasis and trichomoniasis are commonest in females. The parasites of these conditions are difficult to recover from the male genito-urinary tract.

Other Conditions:

This group included treponemal diseases other than syphilis (one case as in the previous year), other conditions requiring treatment (495) and conditions not requiring treatment (1,241 cases). This latter group included babies for pre-adoption examination and serology and also other persons, uninfected, who had been exposed to possible infection with venereal or sexually transmissible disease.

The total number of West Riding Administrative County residents attending the 16 special clinics was 4,693 compared with 4,448 the previous year. It is not possible to estimate the number of patients who attend and receive treatment from their own practitioners and are thus not seen at a special clinic. There are many reasons for the general increase in clinic attendances and these include, the declining standards of morals and behaviour in Western societies, indiscipline, irresponsibility, the contraceptive pill, early sexual maturity, the permissive society etc. There has been a decrease in the number of prostitutes and an increase in the number of homosexuals attending special clinics.

Contact Tracing:

The effective work of the four V.D. social workers employed by the West Riding County Council has continued. The majority of patients found to have venereal and sexually transmissible diseases at special clinics are given contact slips to give the contact or contacts. In this way the patient acts as a contact tracer, and is thus able to get contacts, primary and secondary, to attend the clinic. The primary contact is considered to be the source of infection, and the secondary contact or contacts are those with whom the patient, after infection, has had sexual intercourse. The social workers have a valuable role to play in finding and persuading primary contacts to attend for examination at special clinics. In many cases these persons are unaware that they have any disease and are thus acting as reservoirs of infection. Of the contacts dealt with and located, 81 per cent. attended for examination.

The writer is most grateful to the consultant venereologists and their staffs in charge of the 16 special clinics for their help and co-operation in providing statistical details of West Riding cases. The help and co-operation from the West Riding V.D. social workers and the staff at the central office, County Hall, is also very much appreciated.

RESEARCH PROJECTS

Survey of Childhood Cancers:

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 and, since 1971, by the Marie Curie Memorial Foundation, has continued. The surveys have included the study of cancer ætiology in children who have died recently from malignant diseases also a control group of children selected from the general population.

Although the work undertaken by the medical staff is very time consuming, the findings to date indicate that the effort involved is amply justified and various leads have suggested fields for further research. The work of analysis continues and current points of interest are the relationship between viral infections in pregnancy and subsequent malignant diseases of the child, and a study of the occurrence of malignancy among siblings.

The present survey entails the investigation of deaths in the period 1961-71 and at the year-end, of the 362 deaths relating to the Administrative County, enquiries into 276 and their age/sex paired controls had been completed.

Measles Vaccine Trial:

The follow-up of children in the Medical Research Council's Measles Vaccines Committee survey is still being undertaken.

In the autumn of 1964 the Authority agreed to take part in a large-scale trial which was designed to assess the value of the vaccines for general use which necessitated a study of the degree and frequency of reactions following vaccination, also the extent and duration of protection afforded.

During October/November, 1964, and September/October, 1965, 3,510 children in the susceptible age group of 10 months to 2 years, resident in certain areas 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 any reactions to the vaccines and at three, six and nine months to ascertain the incidence of measles. Subsequent annual postal follow-ups have been undertaken and visits by health visitors where appropriate.

The Committee's reports have confirmed initial conclusions that there is a high protective efficiency and attacks of measles contracted in vaccinated children were usually milder and required less medical attention than in those who were unprotected. This is very satisfactory, with vaccine efficiency undiminished at better than 90 per cent. after three expected epidemics of measles; the children, however, will continue to be followed-up to determine whether the immunity conferred is life-long or if booster doses should be given and, if so, the optimum age for their administration.

CO-OPERATION IN THE HEALTH SERVICE

PART II

CO-OPERATION IN THE HEALTH SERVICE

DIVISIONAL ADMINISTRATION

See also Table 36 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 during the year and discussed the following items:

January

Screening for routine Cervical Cytology—Arrangements for Recall for Re-examination. D.H.S.S. Circulars L.H.A.L. 33/71, E.C.L. 100/71, E.C.N. 887 and H.M. (71) 79.

Assessment of G.P. Attached Nursing Staff.

Smoking—Chief Medical Officer's Letter M.L. 4/71.

Family Planning.

The Doman-Delacato Method of Treatment of Children Suffering from Brain Damage.

Employment Medical Advisory Bill.

April

Industrial Rehabilitation Service.

Aids to Improved Efficiency in the Local Health Services—Deployment of Nursing Teams. D.H.S.S. Circular 13/72.

Home Nursing Records.

Home Nursing Service—Charcoal Pads for Ileostomy and Colostomy Cases.

Computer Health Applications—Statistics.

Pinderfields Assessment Unit for Handicapped Persons.

Hexachlorophane.

Chronic Sick and Disabled Persons Act, 1971. D.H.S.S. Circular 4/71.

July

Family Planning—West Riding Developments.

Vaccination against Rubella for Women of Childbearing Age. D.H.S.S. Circular 17/72.

Hunter Working Party Report.

Hospital Based Assessment Centres for Multiple Handicapped Children.

Child Psychiatrists.

October

Future of the West Riding Health Computer Systems.

Ambulance Arrangements for Early Discharge of Maternity Cases.

Amendment to the Computer Vaccination and Immunisation Scheme—
D.H.S.S. booklet "Immunisation Against Infectious Disease".

Negative Response—Letter from Joint Secretaries of Medical Defence Union
and Medical Protection Societies.

"Drugs and Young People"—West Riding Joint Working Party on Health
Education Occasional Paper No. 3.

Surgery Accommodation in Health Centres and Clinics. D.H.S.S. Circulars
L.H.A.L. 41/72 and E.C.L. 100/72.

Heating for Elderly People in Winter. D.H.S.S. Circular 33/71.

PREMISES FOR JOINT USE:

At the time of writing, 114 practices comprising 301 general practitioners are
being provided with main or branch surgery accommodation in 82 health centres
and clinics.

New buildings completed during the year were:

'F' type health centres					Date of Completion
Poppleton	...	...	...	...	17th March
Featherstone	...	...	...	...	17th July
Wilsden	...	...	...	...	31st July
Mirfield	...	...	...	...	7th December
Bentham	...	...	...	...	20th December
Health centres—special design					
Swinton	...	...	...	...	27th November
Goole	...	...	...	...	15th December

GENERAL PRACTITIONERS IN MATERNITY AND CHILD WELFARE WORK:

The participation of general practitioners by sessional employment with the
County Council is indicated in the tables below:

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
1971	...	...	...	9,545	6,254	65
1972	...	...	...	8,972	5,506	61

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
1971	...	...	989	559	56
1972	...	...	821	421	51

FACILITIES OFFERED TO GENERAL PRACTITIONERS:

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
1971	...	...	...	573	40
1972	...	...	...	684	49

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
1971	...	...	...	2,849	64
1972	...	...	...	3,446	72

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
1971	...	...	4,308	117
1972	...	...	5,747	129

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
1971	215	248	554
1972	254	281	644

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
1971	247	296	660
1972	250	295	699

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
1971	46	64	151
1972	51	72	184

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, Dewsbury, Doncaster, Halifax, Huddersfield, Rotherham, Sheffield and York. Items discussed included Family Planning, Perinatal Mortality Survey, Integration of Midwifery Services, Ambulance Services for Early Discharge of Maternity Cases, Use of General Practitioner Units, and the admission of Infected Patients to Maternity Units.

SERVICES FOR THE MENTALLY HANDICAPPED:

The meetings with representatives of the Leeds and Sheffield Regional Hospital Boards, commenced in 1971, were continued. The object of these meetings was for joint discussion of Command Paper 4683—*Better Services for the Mentally Handicapped* and the preparation of a joint report on the proposals made by the Hospital and Local Authority Services to implement the recommendations in the Command Paper.

Co-operation with Other Services

CHRONICALLY SICK AND DISABLED PERSONS ACT, 1970:

Section I of the above Act, which came into effect on 1st October, 1971, requires the County Council to ascertain the numbers and needs of handicapped persons living within the administrative area and to ensure that those persons are aware of the services to which they are entitled.

Whilst it is not a requirement that the Authority should achieve 100% registration of handicapped persons great care was necessary to ensure that maximum information on the incidence of physical handicap in the County was obtained. Circular 45/71 from the Department of Health and Social Security suggested that one way of obtaining this information would be by local sample surveys.

Responsibility for obtaining the required information rested primarily with the Social Services Department and the Director requested the assistance of the Health Department in carrying out a sample survey in the following specific areas:

- (i) Castleford Borough and Normanton Urban District.
- (ii) Urban Districts of Adwick, Bentley and Tickhill, together with the Rural District of Doncaster.
- (iii) Urban Districts of Baildon, Bingley, Denholme and Shipley.

These districts were chosen so as to give a selection of rural and urban areas as well as textile and more general industrial regions, the population consisting of about a quarter of a million people living in some 90,000 houses and representing approximately one seventh of the population of the County.

The survey was intended to test the accuracy of the information available to the County Council from all sources and thus to enable a reliable estimate to be made of the need over the whole of the administrative area.

The Health Department's close association with general practitioners, through the attachment of the health visiting and nursing staff, was a big advantage in identifying the needs in sample survey areas. This department was able to give the Director of Social Services details of some 2,600 handicapped persons in these areas.

WORKING PARTIES WITH THE HEALTH, SOCIAL SERVICES AND EDUCATION DEPARTMENTS:

Following the implementation of the *Education (Handicapped Children) Act, 1970* and the *Local Authority Social Services Act, 1970*, on 1st April, 1971, the Health Department's responsibility for mentally handicapped children, including the operation of the Junior Day Training Centres was transferred to the Education Department, and the Social Services Department became responsible for the welfare of mentally disordered persons including the provision of training centres and hostels for the mentally handicapped and mentally ill. Other services transferred to the Social Services Department included Nurseries and Child-Minders, Home Help Service, Care of the Unmarried Mother and Recuperative Home Treatment.

Having regard to the extent and complexity of the transferred services it was obvious that close co-ordination between the three departments was necessary to ensure a smooth continuance of vital services which were well established. To this end there was established a Co-ordinating Group (Adults) and a Co-ordinating Group (Children), each group consisting of three representatives from the Health and Social Services Department with an additional representative from the Education Department on the Co-ordinating Group (Children).

The co-ordinating groups have continued to meet at approximately six-monthly intervals and have dealt with a wide range of subjects.

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 end of 1972 there were only 19 divisions due to a number of amalgamations.

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

Divisional Medical Officers

Division No. 1 (Skipton)

Dr. M. Hunter retired 30th December, 1971.
Dr. R. Singh appointed 17th April, 1972.

Division No. 4 (Shipley)

Dr. J. Battersby died 30th April, 1972.
Dr. V. P. McDonagh, Divisional Medical Officer, Keighley, also acts as Divisional Medical Officer, Shipley, as from 1st May, 1972.

Division No. 31 (Rotherham)

Dr. J. T. Clow resigned 30th April, 1972. This position was advertised but no applications received. Dr. D. J. Cusiter, Divisional Medical Officer, Wath, also acts as Divisional Medical Officer, Rotherham, as from 1st May, 1972.

Divisional Nursing Officers

Division No. 9 (Wetherby/
Rothwell)

Miss M. P. Bramley resigned 31st July, 1972.
Mrs. C. B. Macaulay appointed 7th September 1972.

Division No. 15

(Spenborough)

Mrs. J. Pearson appointed 24th January, 1972.

Division No. 22 (Wortley)

Mrs. M. Orr resigned 31st August, 1972.
Miss S. Thwaites appointed 7th September, 1972.

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

Renal Dialysis

Family Planning

See also Tables 37 to 53 of Appendix A

CARE OF MOTHERS AND YOUNG CHILDREN

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

The Chief Dental Officer reports:

The number of expectant and nursing mothers presenting for dental examination at County Clinics during the year was only 296—a reduction of 60 on the previous year. The need for a priority service for these patients has almost disappeared with the ready availability of treatment for them in general practice under the National Health Service.

It is pleasing to report for the second successive year an increase in the number of pre-school children being inspected at dental clinics. The number 1,828 is however very small when one considers that there are about 40,000 children in each pre-school age group.

Dental staff is still much below strength and the problem of decay in the pre-school child could be largely solved by the fluoridation of drinking water. Further evidence of this is revealed in the results of a dental survey on the incidence of decay in three-year-old children in Aireborough where the level of fluoride in the drinking water was raised to one part per million at the beginning of 1969.

Phenylketonuria:

During 1972, the Guthrie Test gave a positive result in three cases, two of which were confirmed. Details of these cases are as follows:

- Case 1 Girl, M. F., born 22.4.72.
Positive Guthrie test 27.4.72.
Transferred to Sheffield Children's Hospital and placed on special diet.
Follow-up report (March, 1973).
Child was kept under regular supervision until her death from broncho-pneumonia and bronchitis on 1st March, 1973.
- Case 2 Boy, R. B., born 8.6.72.
Positive Guthrie test 15.6.72.
Admitted to hospital and placed on specially prescribed diet.
Follow-up report (March, 1973).
Attends hospital regularly. Has made normal progress and passed three months and six months assessment tests.

Ortolani Testing for Congenital Dislocation of the Hip:

The increased incidence of confirmed cases of congenital dislocation of the hip, first noted in 1971, was maintained in 1972 (see Table 39 of Appendix A). In a total of 127 confirmed cases, seven children were not suspected of having any

abnormality before the age of 10 months. Whilst the majority of cases were suspected in the first few weeks of life, 28 cases in the 120 cases discovered as a result of the Ortolani Test were first noticed by the health visitor between the ages of 12 and 17 weeks. This confirms the impression gained last year that the introduction of a repeat Ortolani Test at three months is worthwhile, as cases not picked up by the initial Ortolani Test are being discovered before the child starts to walk.

Congenital Abnormalities:

Under the national scheme for the registration of congenital abnormalities apparent at birth 507 babies with a total of 605 abnormalities were recorded on the notification of birth form. The number of births notified during the year was 28,333 giving a percentage of 1.79 babies with one or more congenital defects. This figure is higher than in preceding years (1.5% in 1969 and 1970) and analysis of the cases shows that the number of cases of congenital dislocation of the hip, talipes and hypospadias notified is responsible for over 50% of this increase. Doctors and midwives are becoming more aware of the desirability of early treatment of congenital dislocation of the hip and talipes and this has resulted in an increase in the notification of suspicious cases at birth (and later in life as with congenital dislocation of the hip).

Welfare Foods:

At 31st December, 1972, there were 260 distribution centres in the County for the issue of welfare foods, of which 201 were health or child welfare centres.

THE COUNTY NURSING SERVICE

There was one change in the nursing staff at County Hall during 1972—Miss A. Sellars, Non-Medical Supervisor of Midwives, resigned in July in order to return to teaching midwifery.

Two Divisional Nursing Officers left. Mrs. M. Orr retired in August, and Miss M. P. Bramley was appointed to Director of Nursing Services, North Riding County Council, in September.

Mrs. J. Pearson, Miss S. Thwaites, and Mrs. C. B. Macaulay were appointed Divisional Nursing Officers for the Spensborough, Wortley and Rothwell/Wetherby Divisions respectively. All three had had experience as Nursing Officers under the management structure introduced in 1971.

Miss Atkinson, Director of Nursing Services, attended a multi-disciplinary National Health Service Integration Course in October. Miss Harris and Mrs. Endean, Principal Nursing Officers, attended Senior Advanced Management Courses, and eight Divisional Nursing Officers attended Management Courses during the year. Initial management preparation was provided for 20 Nursing Officers.

In addition to the traditional Grantley Hall In-Service Courses for Home Nursing Sisters, Health Visitors, and Midwives, an extra course catered for Divisional Nursing Officers and colleagues from another County Council, six County Boroughs, two teaching hospitals and 10 hospital management committees (19 hospitals). Primarily to share ideas of caring for patients, it was encouraging to find that all 51 course members found the three and a half days' residential course stimulating and enjoyable, and were able to learn much from each other.

DOMICILIARY MIDWIFERY

Staff Allocation:— 194 including a reserve of 3, and 9 nursing officers.

In post 31st December, 1972:

Nursing officers, midwifery	...	...	...	9
Nursing officers, home nursing/midwifery	...	...	...	1
Whole-time midwives	...	...	...	147
Part-time midwives	...	...	...	14
Whole-time home nurse/midwives	...	...	...	31
				<hr/>
				202
				<hr/>
Whole-time equivalent	...	...	...	179

Changes of staff included:

Appointments—Nursing officers	...	...	...	2
Midwives	...	...	...	15
Resignations	...	...	...	7
Retirements	...	...	...	4
Transfers to other services	...	...	...	1
Death	...	...	...	1

In-Service Training:

Thirty-eight midwives attended statutory refresher courses outside the County.

Forty-three County midwives and 10 from hospitals and adjoining County Boroughs attended at Grantley Hall.

Attachment to General Practice:

It will be seen from the tables on page 97 that the majority of midwives continue to share in the antenatal care of patients in general practitioners' surgeries. This is the main aspect of general practitioner co-operation with the midwifery service, and is of value in building and maintaining local links with mothers booked for hospital confinement, as well as those booked for home delivery.

Emergency Obstetric Units:

There were 27 calls on this service during the year.

Cars:

One-hundred and seventy midwives used cars for their work, 17 of which were provided by the Authority.

Midwifery Survey:

All midwives and home nurse/midwives took part in a survey of their work for four weeks during March and April, 1972. A report on the findings is available on pages 16 to 28.

HEALTH VISITING

Staff Allocation:— 444 including a reserve of 4·5, and 24 nursing officers.
In post 31st December, 1972:

Nursing officers	...	...	...	...	20
Qualified health visitors—whole-time	...	...	...	...	266
Qualified health visitors—part-time	...	...	...	...	25
Assistants to health visitor—whole-time	...	...	...	...	76
Assistants to health visitor—part-time	...	...	...	...	72
Tuberculosis visitor—whole-time	...	...	...	...	1
					<hr/>
					460

Whole-time equivalent 411·5

Changes of staff included:

Appointments—Nursing officers	...	...	3
Qualified health visitors	...	...	42
Assistants to health visitor	...	...	66
Resignations—Nursing officers	...	...	4
Qualified health visitors	...	...	21
Assistants to health visitor	...	...	20
Retirements	...	...	12
Transfers to other services	...	...	2
Transfers to health visitor training	...	...	15
Death	...	...	1

Attachment to General Practice:

The position is shown on page 97.

In-Service Training:

Thirty health visitors attended courses outside the County.

Fifty-five health visitors and assistants to health visitor attended a course at Grantley Hall.

Training in the detection of hearing loss was provided for 70 members of staff.

Family planning training was provided for 14 members of staff. In addition to formal training in family planning, arrangements were made to give general knowledge of family planning methods to all members of nursing staff.

Health Visitor Training:

Twenty-six students qualified in 1971/72. Thirty-one students commenced training in October, 1972.

Four health visitors were trained in fieldwork instruction of health visitor students.

Cars:

Four-hundred and thirty-two health visitors and assistants used cars for their work, five of which were provided by the Authority.

Statistics:

As mentioned in previous Reports, the visiting statistics in Table 44 of Appendix A only relate to first visits to any person and, therefore, do not convey the volume of work undertaken. It is, however, evident that the developmental assessment programme for children under five has lessened the total amount of home visiting, particularly to people between 5 years and 64 years. The progress of developmental assessments is described on pages 12 to 15.

HOME NURSING

Staff Allocation:— 341 including a reserve of 4.5, and 19 nursing officers.
In post 31st December, 1972:

Nursing officers	...	...	...	...	17
Home nursing sisters, S.R.N.—whole-time	...	...	...	...	251
Home nursing sisters, S.R.N.—part-time	...	...	...	...	35
Home nurse/midwives—whole-time	...	...	...	...	31
Home nurses, S.E.N.—whole-time	...	...	...	...	20
Home nurses, S.E.N.—part-time	...	...	...	...	16
					<hr/>
					370
					<hr/>
Whole-time equivalent	...	...	...	...	324.5

Changes of staff included:

Appointments—Nursing officers	...	...	1
Home nurses	...	...	70
Resignations—Nursing officers	...	...	2
Home nurses	...	...	38
Retirements	...	...	8
Transfers to other services	...	...	7
Death	...	...	1

Attachment to General Practice:

The position is shown on page 97.

In-Service Training:

Forty-eight County staff and 11 from adjoining authorities and hospitals attended a course at Grantley Hall.

Other members of staff attended local hospitals as need arose for specific help when required.

Training:

Twenty S.R.N. students completed the training course and all gained their National Certificate in District Training.

Cars:

Three-hundred and sixty-five home nursing sisters used cars for their work and 71 of these were provided by the Authority.

Statistics:

These are given in Tables 46 and 47 of Appendix A.

Statistics were recorded rather differently during 1972 at the request of the Department of Health and Social Security, so that emphasis is now placed on the number of individuals nursed or treated at least once during the year, and the place where each was treated. Sixty-one thousand five hundred and eighty-one individual patients were treated during 1972, 40,349 at home and 21,232 elsewhere.

As in health visiting, the total load of work is not now clearly defined in annual figures.

Day and Night Nursing Service:

This service, whilst retaining its objective of providing temporary care day or night in cases of terminal illness, or in emergency for a few nights prior to hospital admission, or for relief of the strain of a long illness on relatives of a patient, has been much more widely used this year, reflecting the trend toward 24 hour nursing cover.

During 1972, 790 patients were provided with 46,494 hours of service at a cost of £21,577.

AMBULANCE SERVICE

County Operational Control:

The publication of the White Paper on the Reorganisation of the National Health Service (Cmnd. 5055) in August clarified many points on the future structure of that Service and on the boundaries of Regional and Area Health Authorities outside London. As a result of this information, it was decided not to proceed with the expansion to full operational County Control of the present Service as envisaged in my last Report. This means that no action has been taken to centralise control of those stations which will be situated in the proposed new South Yorkshire Metropolitan County, i.e. Bentley, Thorne, Maltby, Wath, Hoyland and Penistone: nor to include Harrogate, which falls within the boundary of the new North Yorkshire Area Health Authority.

Progress has, however, been made with the absorption of South Kirkby, Wakefield, Castleford, Sherburn and Bramham into Central Control and when this development is completed early in 1973, all the West Riding County Ambulance Stations which fall within the area of the proposed new West Yorkshire Metropolitan County will be controlled for operational purposes direct from County Control at Birkenshaw Headquarters.

Hospital Surveys:

As part of a continuing policy, officers of the Ambulance Service, together with representatives of the Huddersfield Hospital Management Committee commenced a joint survey of hospital/ambulance arrangements in the Huddersfield area in November.

This joint survey carried out at the suggestion of the County Ambulance Officer, is aimed at isolating problem areas and measuring the extent of the problem with a view to amending procedures to provide a more rationalised demand and thereby a better service to ambulance patients. It involved a physical check on the flow of patients through the hospitals, a re-appraisal of the appointments system, requisitioning procedures, zoning of ambulance patients' appointment times, level of abortive or false calls and the levels of utilisation of ambulance service vehicles.

At this point in time, whilst the physical and statistical part of the survey has been carried out, an examination of the material produced has not yet been completed but it is felt that the effort has been worthwhile and once finalised will produce a better service to the patient.

Incentive Bonus Scheme—Militant Action:

Failure by a firm of consultants to introduce an incentive bonus scheme for ambulance crews caused considerable discontent. Station staff had co-operated with the consultants and were generally of the opinion they would receive some financial reward when a bonus scheme was introduced.

Discussions continued with the trade unions without reaching any satisfactory conclusions and it was decided by both sides to refer the matter to the National Joint Industrial Council.

Unfortunately staff on some stations were not prepared to await the outcome of the N.J.I.C. deliberations and introduced various forms of militant action.

In June, 1972, the N.J.I.C. proposal of £1.10 a week to all ambulance crews was rejected by the staff side and the dispute was then referred to an Arbitration Panel under the Chairmanship of Dr. W. E. J. McCarthy, Fellow of Nuffield College, and the Oxford Centre for Management Studies.

The Arbitrators' Award on the 21st July, 1972, of £2 a week payment to ambulance staff as soon as stations returned to normal working, was instrumental in resolving the dispute. This award was in the nature of an Efficiency Agreement rather than an Incentive Bonus Scheme and was specifically for the West Riding Ambulance Service.

After further discussions with the trade unions, a formula was agreed, comprising—

- (1) A 'lead in' payment (a payment where it is considered that a bonus or efficiency payment is feasible) of £1 a week from the 1st March, 1972, to the 27th June, 1972, in the case of staff who took industrial action and from the 1st March, 1972, to the 24th July, 1972, to those staff (comprising 10 stations) who took no industrial action.
- (2) Followed by a £2 a week payment subject to staff accepting certain conditions, the main one being the return to full normal working conditions.

This was acceptable to some stations immediately, whilst other stations were a little longer in their acceptance.

From midnight on Friday the 11th August, 1972, all form of militant action had ceased and the Service was back to normal working.

Training School:

The Training School again operated at full capacity throughout the year, catering for six weeks basic courses and two weeks refresher courses. Student intake, apart from our Service, came from 17 other Ambulance Services. The following courses were held:

<i>Type of Course</i>	<i>No. of Courses</i>	<i>W. R. Trainees</i>	<i>Other Authorities</i>	<i>Total</i>
6 wks. Basic Training	6	55	89	144
2 wks. Refresher Training	5	42	78	120
	11 (46 wks.)	97	167	264

In-Hospital Training:

Further progress has been made in the development of in-hospital training for ambulancemen and a further three hospitals, Huddersfield Royal Infirmary, Pontefract General Infirmary and Rotherham Hospital have been brought into the scheme during 1972. This now makes a total of seven hospitals which are carrying out this training and 127 men have been so trained during this year, bringing the overall total to 247. Preliminary discussions have taken place with Bradford Royal Infirmary and it is anticipated that they will join the scheme in the near future, when they will provide training for ambulancemen from the Menston, Shipley and Pudsey Stations.

Officer Training:

The policy of sending officers at various levels on management courses has been continued during the year. Details are as follows:

<i>Type of Course</i>	<i>Organised by</i>	<i>Rank of person(s) Attending</i>	<i>Number</i>
Basic Foremen & Supervisor	Yorkshire Provincial Council	Shift Leaders	5
Middle Management Course	ditto	Control Supervisor	1
ditto	ditto	Workshop Superintendent	1
Advanced Foremen & Supervisor	ditto	Shift Leaders	6

A major development in management training was the publication in August of this year by the Local Government Training Board of Recommendation 14 on officer training within the Ambulance Service. Arising from this, a request was received by this Service from the Department of Health that we mount a pilot middle management course based on these recommendations. This course was held in December at Whirlow Grange, Sheffield, and the students were drawn from this Service and six other Ambulance Services. The course was highly successful and the experience gained will form a basis for future national courses.

New Training Centre:

Work will begin early in the new year on the new training centre, the former Nurses' Home in Cartmel Street, Keighley, and it is anticipated that this will be commissioned towards the end of 1973. This centre will provide 52 student places as compared with the 24 available at Cleckheaton. With the increase in student places, it is anticipated that the backlog of places required for both basic and refresher training can be eliminated in the first six months. From that point the training centre will be able to meet the continued need for these types of courses and in addition will be in a position to cater for specialist courses as recommended, e.g. Driving, Officer Training, Control etc.

In-Service Training:

In-service training continued but on a limited scale due to the restricted availability of training staff. Priority was given to short courses for new entrants awaiting attendance at the training centre. With the appointment of six area training officers in October, plans are now going ahead to ensure that there is a continuity of in-service training to include all staff.

Other Training:

For details of training given to other County departments and outside organisations see Table 50 of Appendix A.

Drugs, Overdoses, Poison Cases etc. 1972:

Reports on the cases conveyed as suffering from drug overdoses and poisoning of various other kinds were maintained for 1972 in the same manner as reported for 1971 and the following statistics showed:

Total number of patients carried: 1,100 (1971—833)

Drugs, medicines, tablets etc.	859
Household goods, bleach, disinfectant etc.* ...	73
Gas	22
Alcohol/drug combinations	27
Cause unknown	119
	<hr/>
	1,100
	<hr/>

*Includes six cases of children eating laburnum seeds.

Again, the most common drugs were Mandrax, Mogadon and Tuinol, with Aspirin a close fourth.

Competitions:

The Service's Annual Inter-Station Competition was held in April, resulting in the team and driver from Honley and the attendant from Bramham representing the West Riding at the Regional Round of the National Competition held at Harrogate in June.

Although it was their first entry into the regional round of the competition, the tie in third place gained by the Honley members enabled the West Riding to obtain third place overall.

Building Programme:

The new Ambulance Station in Beancroft Street, Castleford, was completed in June and the former premises in Smawthorne Lane were handed back to the General Purposes Committee for disposal. The new building has been erected on a site adjoining the new County Fire Station, which provides central heating for both premises on a cost-sharing basis.

The garage area is designed to accommodate 16 ambulances with maintenance facilities in the form of vehicle hoist and wash bays and a mechanics' workshop. Allowance has also been made for a future extension of four more ambulance bays. A 1,000 gallon petrol tank and pump has been provided in the forecourt and there is a parking area for 16 cars at the rear of the site. The number of staff catered for initially is 41 but account has been taken of a possible future establishment of 50-55. The operational control of Castleford Station will be direct from Ambulance Central Control at Birkenshaw Headquarters. The administrative portion of the building includes entrance hall, station officer's office, general office, mess room, kitchen, male and female toilets, locker room and storage accommodation.

The official opening of the Station, which was carried out by County Councillor S. Illingsworth, B.E.M., J.P., Vice-Chairman of the Ambulance Sub-Committee, on 7th November.

BARNOLDSWICK AMBULANCE STATION:

The present station in Bank Street is inadequate for service requirements. Four vehicles are garaged in space intended for three, the staff accommodation is sub-standard and parking and fuel storage facilities practically non-existent. In addition, the building is subject to rising dampness on three sides and the internal petrol installation presents a possible fire hazard. For these reasons a site, already owned by the County Council in Brogden View on the northern edge of the town, was appropriate for a modern purpose-built ambulance station. A certain amount of local opposition was encountered to the position of the site but this was eventually resolved in July when the Committee confirmed that, having regard to the area to be covered, the Brogden View plot is the most suitable one available. Plans for the new six-bay station have been prepared by the County Architect and construction is expected to start before the end of the financial year.

BRAMHAM AMBULANCE STATION:

SHERBURN AMBULANCE STATION:

Minor extensions were completed at these two stations during the year. The accommodation at Bramham was increased by a two-bay garage, a store room and an extended mess room. Sherburn was enlarged by three vehicle bays and additional parking space for staff cars.

SOUTH KIRKBY AMBULANCE STATION:

HOYLAND AMBULANCE STATION:

Approval was obtained and work commenced on two major station extensions during 1972. The plans for South Kirkby included seven additional ambulance bays, a separate vehicle wash and washing machine and a large extension to the staff accommodation.

The Hoyland Station will be increased by six bays with forecourt, one of which will include a vehicle washing machine, additional car parking areas and enlarged staff facilities.

Vehicles:

The fleet replacement programme continued with a plan for 40 Ford Transit—Hanlon bodied ambulances but due to industrial action, none have so far been received.

Five Ford Transit crew buses and one B.M.C. A.55 type 10 cwt. van have been brought into service with the medical divisions for general purpose work.

A mobile clinic complete with Landrover to replace existing units commenced service in the northern part of the County.

After experiments with a long wheel base Landrover and in view of the hilly terrain and inaccessibility of the district, a new short wheel base Landrover with special modifications (to permit a stretcher trolley to be accommodated) commenced service at Todmorden.

General:

In collaboration with the Research Development Council, a firm of body builders has produced a new ambulance which features independent suspension, front wheel drive and other desirable arrangements which should improve conditions for the patients. Final tests are expected shortly.

A test journey was carried out on a gas-powered vehicle with impressive results. In addition to savings on fuel (propane gas), claims are made for reduced pollution and experiments are to be introduced on two vehicles in the coming year.

PREVENTION OF ILLNESS, CARE AND AFTER-CARE

Health Education:

Health education is fundamental to the work of preventive medicine. The aim is to encourage and sustain a healthy way of life. All, from birth to old age, can benefit from continuous education and re-appraisal of their attitudes towards health. One of the most important aspects of the health educator's work is to help the individual to develop the capacity to think critically about health needs in relation to himself and a constantly changing environment. Health staff must therefore utilize every learning experience which can contribute to this end whether the opportunity presents in the home, school, work environment, hospital or elsewhere. But in the end it is the person himself who makes the vital decisions about his health.

An analysis of the work undertaken in schools by health department staff showed an increase over the year (see Appendix A). The personnel involved included local health authority doctors, midwives and district nursing sisters, but it will be seen that health visitors carried the heaviest load. Teaching sessions were undertaken in 268 schools and advice to teaching staff given in a further 38 schools. Junior and middle schools totalled 139, whilst secondary schools numbered 116. Teaching sessions were undertaken in 13 special schools for the educationally subnormal. The frequency and amount of health education undertaken in these schools varied and was determined by the needs of the school and the availability of the health department staff, but probably more important, by the enthusiasm of the class teacher and health visitor.

The analysis showed that a high proportion of the work was covered in short courses consisting of one session weekly for a period of six to eight weeks. However specialised subjects were dealt with on a 'single lecture basis', whilst in some areas members of staff had one full day in school covering many classes during the period.

There were many new ventures in the divisions.

Dr. Ireland, Divisional Medical Officer (Morley) began two geriatric screening clinics staffed by health visitors and general practitioners.

Health visitors have also taught in school programmes for various certificates awarded by the National Association for Maternal and Child Welfare.

Several slimming clubs have begun, both for adults and schoolchildren. Dr. Burn, Divisional Medical Officer (Horsforth) reported on a lunch time club held twice weekly for overweight girls at Otley Comprehensive School—'The Apple Club'.

In 1971 a working party of senior midwives and health visitors was set up to study the teaching of parentcraft in the County. This work was completed in 1972 and a *Syllabus and Lesson Guide for Teaching Parentcraft* was published for those midwives and health visitors teaching this subject. This study emphasized that although the need to promote a healthy attitude towards the physical requirement still exists, there is a yet greater need to motivate better interpersonal relationships of family life, in particular the important role of the father and the needs of children.

Health education activities in the health centres and other health authority premises increased by 26.1 per cent. compared with the previous year. The reasons for this are both numerous and complex but are undoubtedly affected by the following factors: (a) improved facilities provided by modern health centres; (b) increasing interest in health education by the specialised groups attending screening clinics; (c) the interest in weight control; (d) the awareness

of the importance of child development; (e) the availability of display materials and the stimulation and interest this provides.

IN-SERVICE TRAINING:

The following courses were arranged during the year to promote interest and increase the skill of the field staff:

1. Grantley Hall residential course—*Group Dynamics*: this dealt specifically with human behaviour and attitudes.
2. Study day—*Health Education in Schools*. This was led by Dr. E. M. Harvey, and was a general discussion on health education in schools for those members of staff engaged in this work. Approximately 60 members of staff attended.
3. Day release course of eight weeks—*Principles and the Art of Teaching*. Held at the Institute of Further Education, Horbury, and based on the Yorkshire Council Course for part-time teachers. Mr. R. W. Birch, Principal, Gaskell and Staincross Institute of Further Education, was responsible for the course. The demand from field staff for this course was such that two further courses were organised.

VISUAL AIDS:

The ever increasing demand for exhibition materials and equipment, films and other visual aids covering a wide range of subjects continues. The unit's exhibitions were displayed at 177 venues for a total of 1,469 days.

A second puppet exhibition on safety and outdoor activities was introduced in May and quickly proved to be as popular as the home safety exhibition. Requests for bookings were well in excess of the availability of the unit.

Renal Dialysis:

ADAPTATIONS TO PATIENTS' HOMES:

At 31st December, 1972, 62 cases had been referred to the West Riding County Council by the hospital authorities since the inception of the scheme. Thirty-four patients had been referred by the St. James's Hospital, Leeds (20 males, 14 females), 25 patients by the Lodge Moor Hospital, Sheffield (19 males, 6 females), 2 patients by the Withington Hospital, Manchester (1 male and 1 female), and 1 patient (female) by the Hull Royal Infirmary.

The 62 cases may be categorised as follows:

Died prior to starting adaptations	5
Transplant prior to starting adaptations	2
Not suitable for home dialysis	1
Patients undergoing home dialysis	36
Adaptations in progress (includes also provision of portable units)	8
Transplant after adaptations had been completed... ..	5
Died after adaptations had been completed	5
	<hr/>
	62
	<hr/>

Of the 36 patients undergoing home dialysis treatment, there are four patients whose homes were not suitable for adaptation for dialysis purposes. Two of these were provided with a 'Portakabin' and two with a demountable portable unit. Of the eight patients due to commence home dialysis, one is to be supplied with a demountable portable unit, the remaining seven having adaptations carried out to their homes.

FAMILY PLANNING SERVICES

The year 1972 showed a continuing expansion of the family planning services provided by the West Riding County Council, with increases in the total number of local health authority clinics and Family Planning Association clinics. At 31st December, 16 local health authority clinics and 36 Family Planning Association clinics were in operation within the County area.

During the early part of 1972, several meetings were held between representatives of the Health Committee and the Family Planning Association to discuss further expansion and improvement of the service. The first result of these meetings was a decision by the County Council that from 1st April, 1972, Scheme 5 of the Family Planning Association's Agency Scheme would replace Scheme 2. The latter provided free consultation and supplies to medical cases (including problem families) and free consultation only for non-medical cases, with the provision that the unmarried should be excluded except where a stable-cohabitation relationship existed or where the people were to be married. The Scheme placed no restriction by residence but was applicable only to those attending Family Planning Association clinics situated within the County Administrative Area.

This Scheme was adopted on the assumption that the neighbouring county boroughs would do the same but, in practice, most local health authorities used Scheme 5 which provides similar services but is restricted to residents of the local health authority who may attend Family Planning Association clinics

within or outside the authority's boundary. This meant that West Riding residents attending Family Planning Association clinics in the adjoining county boroughs were having to pay for all their family planning services, whereas, if they attended a Family Planning Association clinic or a local health authority clinic within the County Area, at least part of these services would be free. To correct this anomaly, it was decided to change to Scheme 5 in line with the other authorities.

Further results of the meetings were that, in October, 1972, the family planning services were extended to include the unmarried over 16 years of age, and the County Council gave approval in principle to the provision of a totally-free service from 1st April, 1973 (Scheme 4 of the Family Planning Association's Agency Scheme). Financial provision has now been made for a free service for West Riding County Council residents attending either local health authority or Family Planning Association clinics as from 1st April, 1973.

Throughout the year, members of the nursing staff have been sent on Family Planning Association training courses and efforts have been made to update all the nursing staff in order that they can discuss family planning in detail with anyone who should question them. At the present time, 71 members of the nursing staff have had a full course of training. The intention is to use these nurses in local health authority family planning clinics and also in the follow-up of defaulters, e.g. women from problem families from either local health authority or Family Planning Association clinics.

Discussion with the Divisional Medical Officers indicated that a domiciliary service, with a doctor and nurse visiting the home, is rarely necessary, and that the best use of staff and resources is for a trained nurse to do the home visiting (handing out contraceptive supplies where required) and, if the nurse thinks a doctor should see the woman, then—wherever possible—arrangements should be made for her to be taken to the clinic. Only occasionally has it been found necessary for the doctor to make a home visit.

The Family Planning Association have been encouraged to notify the local health authority of defaulters from their clinics if it is thought they should be followed up by a home visit.

In addition, talks on family planning have been given to members of the Social Services Department so that they know of the facilities available and can help their clients to make use of them.

PART IV

ENVIRONMENTAL HYGIENE

Food and Drugs

Sanitary Circumstances

See also Tables 54 to 61 of Appendix A and Appendix B

ENVIRONMENTAL HYGIENE

Food and Drugs Act, 1955:

THE MILK (SPECIAL DESIGNATION) REGULATIONS, 1963:

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

Licensed Dealers:

The number of dealers has not altered to any extent in the past year but there has been a 50 per cent. increase in those selling ultra heat treated milk as a choice of designation.

During the year it was found that some dealers were becoming lax in their choice of vehicle for delivery purposes. Little or no protection was being afforded the milk from the vagaries of the weather and a number of warnings had to be issued. The consumer has every right to expect his milk to be delivered in the same first class condition as it leaves the dairy; not covered in rain and dirt or cooked by the sun.

Processing Plants:

Two new pasteurising plants came into operation during the year. Satisfactory conditions and procedures were obtained at one from the word go but at the other education is still being given. Unfortunately it may well require the sharper lesson of a prosecution before satisfactory working standards are obtained.

Seven phosphatase test failures occurred during the year and immediate investigations were carried out. Three were from the plant referred to above and due to insufficient attention to holding times and temperatures, three were due to failures in mechanical plant and one due to plant being operated by unqualified staff because of illness.

The testing of washed bottles and churns has continued. Average results were obtained on bottles but improvements over last year's figures were shown on churns.

The ultra heat treatment plant has operated satisfactorily throughout the year and there has been no sample failure. At the year end extensions to the dairy were being built to house the ever increasing output.

Premises Bottling Untreated Milk:

Regular visits of inspection and supervision were made to the 10 premises where untreated milk is purchased in bulk and then bottled. Of the 98 samples obtained seven failed the methylene blue test. Investigations were instituted and appropriate action taken. No sample proved positive for brucellosis and no sample contained antibiotics.

SUPPLY OF MILK TO SCHOOLS:

Whilst efforts are made to ensure pasteurised milk supplies to schools a number still have to accept untreated milk. Seventy-five 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. Two samples, whilst giving positive brucella ring test results, were both negative when cultured. Two samples failed the methylene blue test and follow-up action was taken regarding them.

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. Although the milk is not used at the hospital in its raw state, 23 of the samples were examined for the presence of brucellosis and antibiotics. None of the samples was positive for either. At Stansfield View Hospital Farm, Todmorden, where milk was produced and pasteurised, 12 samples of pasteurised milk were obtained up to May, 1972, when the farm and stock were sold by the Hospital Authorities. The samples were all satisfactory.

ANTIBIOTICS IN MILK:

Two thousand one hundred and ninety-three 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. Twenty-one samples were found to contain antibiotics and action was taken in co-operation with the Milk Marketing Board.

BRUCELLOSIS:

Two thousand one hundred and ninety-three 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 milk is being produced and sold from 777 herds in the Administrative County area. During the year cream culture positive results were obtained from 61 of these herds at least once; at 7.8 per cent. this continues the satisfying trend toward eradication of the disease. The percentages for 1970 and 1971 at 17.0 and 11.6 respectively show that at last real progress is being made. Three hundred and three of the herds covered by the sampling system of the Department are now entered on the British Register of Brucellosis Accredited Herds and this must be regarded as the major factor in the decrease of the disease.

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.

In co-operation with a divisional medical officer, it became necessary to prosecute a producer retailer for contravening a notice served under Regulation 20 of the Milk and Dairies (General) Regulations, 1959. Evidence of brucellosis was found in milk being sold after an order had been made forbidding the sale of milk from this herd. A fine of £25 was imposed.

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 us. Wasteful duplication is thereby avoided. Our particular gratitude must go to Dr. L. A. Little, Director of the Public Health Laboratory, Wakefield, and his staff, who are on the receiving end of all our sampling work. At the time of writing the Wakefield Laboratory is due to close shortly and the work load removed to Leeds. Fortunately we expect to be dealing with many of the existing Wakefield staff and look forward to the same degree of help and co-operation as we have received in the past.

QUALITATIVE MILK SAMPLING:

Within the County Council's scheme of qualitative milk sampling 47 samples were submitted to the County Analyst by county district public health inspectors. One sample was found to be deficient in fat on informal sampling but the follow-up formal sample was satisfactory.

FOOD COMPLAINTS:

Twenty-two complaints were received and investigated. A summary is given below of the details of each and the results where legal proceedings were taken. In other cases verbal or written cautions were given.

Mould in yoghurt.

Dirty milk bottle.

Metal screw in tin of rhubarb.

Pin in loaf of bread. Prosecution, fine £10 with £8.40 costs.

Clay in bottle of school milk.

Decomposed carrots.

Hair on crust of loaf of bread.

Larvae in cherry brandy bar.

Taint of bleach in school milk.

Cooked chicken infested with maggots.

Sediment in milk—2 cartons.

Mouldy steak and kidney pie.

Glass in milk—2 cases.

Mercury in bar of coconut ice.

Five pence piece in chocolate cake.

Matchstick in piccalilli.

Insects in bag of flour.

Taint in bag of cereals.

Garden slug in bottle of milk. Prosecution, fine £15 with £15.39 costs.

Mouldy chocolate cake.

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 be plumbo-solvent 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 twenty-three 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 Standard for lead in drinking water of 0.10 mg/l was regarded as the maximum allowable concentration. Samples above this level were reported as unsatisfactory and the appropriate authorities asked to take remedial action.

PRIVATE SUPPLIES OF WATER TO COUNTY PREMISES:

Supervision and sampling of these private water supplies has continued. Filtration equipment has been installed at a number of premises but is still awaited at others. In one instance the argument has been advanced that there is little point in improving the school supply when children go home and drink the same water, but if we had waited for a complete solution to our problems in public health before taking any action little progress would ever have been made. A more sensible attitude would be for the local inhabitants to push their county district councils into taking action, in co-operation with the County Council, under the Rural Water Supplies and Sewerage Acts.

Two hundred and twenty-seven samples of water were taken of which 35 required some follow-up action.

FLUORIDATION OF WATER SUPPLIES:

It is disappointing having to report yet again that only slight progress towards achieving fluoridation has been made.

Previous Reports have reviewed the Rombald Water Board's scheme at Reva Reservoir, Hawksworth; this was in operation throughout the year and 49 water samples were taken by members of our staff and examined within the department for fluoride content, all were within acceptable limits.

The modernisation of Huddersfield Corporation's plant at Scapegoat Hill was completed during the year and fluoridation of the water supplied to the Golcar area of Colne Valley U.D., which previously had been receiving only partially fluoridated water, commenced at the optimum level on the 18th May. After a running-in period the plant has operated efficiently and 23 samples obtained and tested by our staff gave satisfactory results. As the proposed modernisation of other plant proceeds during the next two or three years it is hoped that schemes will extend fluoridation throughout the Borough's limits of supply.

The introduction of fluoridation by Bradford Corporation at Addingham commenced on the 1st June, but only operated satisfactorily for two months due to mechanical and electrical faults developing in the fluorosilicic acid dilution equipment, which necessitated the removal of the equipment from the plant and overhaul at the manufacturer's workshops. Fluoridation recommenced on the 10th January, 1973.

In pursuance of the County Council's policy, negotiations have been proceeding with Bradford Corporation for the fluoridation of the water supplied by their undertaking in Silsden U.D. Modernisation of the plant concerned is being completed and fluoridation is expected to commence in the Spring of 1973. A further scheme with Rombalds Water Board is also under consideration. Accommodation for fluoridation equipment was provided by the Board in their new treatment works at Graincliffe which supplies Shipley and Baildon U.D's. At the year-end the erection of the plant was nearing completion and preliminary enquiries made regarding the fluoridation equipment. Although no firm date can be given, it is likely that a scheme will be introduced early in the new year.

Rural Water Supplies and Sewerage Acts, 1944-61:

All schemes submitted for grants 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 71 swimming pools in operation and under construction are given in Table 60.

One thousand one hundred and 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. Sampling was also carried out at the Woodhall Centre, Wetherby, Hawksworth Hall Spastics School, Hawksworth, and Hilton Grange Children's Home, Bramhope, although these are not County establishments.

Caravan Sites Act, 1968:

GYPSIES:

Progress in the provision of sites has been very slow. At the time of writing the site at Baildon is still not completed and the one at North Anston, Kiveton Park, has not yet been started.

Investigation of eight possible sites in the Selby area has been undertaken and after consultation with the authorities concerned two are now the subject of more detailed examination.

A number of other possible sites has been considered adjacent to the A1. trunk road and again this field is being narrowed down to two alternatives.

It must also be said that as news of these possibilities reaches the general public protests and petitions are quickly received by this Authority. Even the people who can see a need for the provision of sites never see the answer in the vicinity of their own homes.

Pharmacy and Poisons Act, 1933:

Seventy-four 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 reports of a veterinary surgeon and 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 39 district councils were participating involving 53 combined daily smoke filter and sulphur dioxide instruments, and four daily smoke filters only.

Investigation of eight possible sites in the Selby area has been undertaken and a consultation with the authorities suggested two are now the subject of detailed examinations. It is anticipated that the results of these examinations will be ready for the next meeting of the Board. A number of other possible sites have been considered adjacent to the A1 trunk road and again this field is being narrowed down to two alternatives.

It must also be said that as news of these possibilities reaches the general public, pressure and petitions are likely to be received by the Authority. Even the possibility of a new site for the provision of a new site for the Authority's own housing is being considered. It is anticipated that the results of these examinations will be ready for the next meeting of the Board. A number of other possible sites have been considered adjacent to the A1 trunk road and again this field is being narrowed down to two alternatives.

Water Supply and Sewerage Act, 1945:
The collection of soil samples for a long term survey of the soil is being undertaken by the County Council's Engineering Service.

Public Health Act, 1947:
Premises licensed by the County Council were visited at least once each. The results of these visits are being reported to the County Council. The results of these visits are being reported to the County Council.

Atmospheric Pollution:
The Authority's scheme for the measurement of atmospheric pollution is being continued in conjunction with the Warren Spring Laboratory of the Department of Scientific and Industrial Research. The results of these measurements are being reported to the County Council.

Public Health Act, 1947:
The results of these visits are being reported to the County Council.

At the time of writing, the results of these visits are being reported to the County Council.

PART V

MISCELLANEOUS

Persons in need of Care and Attention

Registration of Nursing Homes

Notification of Births

Medical Arrangements for County Children's Homes and Residential Nurseries

Road Traffic Act, 1972

Medical Examination

See also Tables 62 to 63 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 two cases, both females who were admitted to hospital.

REGISTRATION OF NURSING HOMES

There were three amended registrations, two new registrations and two cancellations of 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 28,333. When this figure is compared with the Registrar General's return of 28,271 births (27,925 live and 346 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 27,395 first visits to children born in 1972 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.

ROAD TRAFFIC ACT, 1972—SECTION 87

There has been a slight increase in the number of cases referred by the Clerk of the County Council where enquiries and investigations have been carried out and appropriate recommendations made regarding medical fitness to hold driving licences—294(265).

A further 149 cases were reviewed to ascertain continuing medical fitness to hold driving licences and in two cases revocation of the driving licence was recommended.

Forty-three cases were referred for a Consultant's opinion and co-operation has been received from family doctors and specialists when asked for information regarding their patients.

Reason for referral	Number of cases	Number who received driving licence
Epilepsy	176 (172)	146 (126)
Diabetes	8 (5)	2 (3)
Cardiovascular disease	22 (16)	20 (13)
Other disorders of consciousness	60 (43)	52 (36)
Vision defects	2 (2)	1 (—)
Other physical disabilities	10 (14)	8 (13)
Mental illness or subnormality	13 (8)	8 (7)
Other	3 (5)	3 (3)
Totals ...	294 (265)	240 (201)

(1971 figures shown in brackets)

MEDICAL EXAMINATION

During the year 2,433 Health Questionnaires were received from persons being considered for admission to the Superannuation Scheme. In 745 cases a medical examination was considered necessary; 1,688 cases were admitted on the basis of the information contained in the questionnaire. The reasons for referral for medical examination were as follows:

	Number referred		Approved		Not Approved		Decision Deferred	
Age	151	(123)	148	(116)	2	(3)	1	(4)
History	381	(413)	351	(373)	16	(19)	14	(21)
Category of employment (i.e. driver)	110	(117)	107	(114)	—	(2)	3	(1)
Age and History	83	(89)	74	(56)	7	(18)	2	(15)
Age and Category	3	(11)	2	(11)	—	(—)	1	(—)
History and Category	12	(10)	11	(8)	1	(2)	—	(—)
Age, History and Category	5	(3)	4	(2)	1	(—)	—	(1)
Totals ...	745	(766)	697	(680)	27	(44)	21	(42)

(1971 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, 15 (25) examinations have been carried out at the request of other local authorities. Re-examinations have been carried out in 23 cases where the decision was previously deferred. Of these 10 were approved, seven were regarded as unfit for admission to the Superannuation Scheme and six were deferred for another examination at a later date. Special medical examinations have been undertaken in respect of 160 (135) employees in the various departments who have had lengthy periods of sickness absence.

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 64 to 75 of Appendix A and Appendix C

THE HEALTH OF THE SCHOOL CHILD

(Being the 65th Annual Report of the Principal School Medical Officer)

Introduction:

The year 1972 has been full of developments both nationally and locally. The Government paper of August *National Health Service Re-organisation, England* in paragraph 20 indicated clearly that the school health service is to be transferred to the Area Health Authorities in April, 1974, whilst preserving close links with the new Education Authorities. The Report of the Committee appointed by the Secretaries of State for Education and Science, for the Social Services, for Scotland and for Wales *Speech Therapy Services* (Quirk Report) published later in the year recommended many changes in training and attachment also to the Area Health Authorities. So ended a period of uncertainty for many members of the present staff. Much work has to be done to ensure a smooth transfer of functions and there are problems to be faced.

The medical staff will have closer links with other members of the profession e.g. the hospital paediatricians, and a unification of medical care should be of help to the child. Many active steps have already been taken in this direction. Several Assessment Centres have been set up in the West Riding based on hospitals. Here the children can be assessed by a multi-disciplinary team and at each centre there is the attachment of a present local authority medical officer as a member of the team to co-ordinate the findings with the child's future education. Doctors working in this sphere need to have special knowledge of child development. Much training has already been carried out in the West Riding but 1972 saw the beginning of a course based on Leeds University on Developmental Paediatrics to which the Principal Medical Officer has an attachment as honorary course tutor and took an active part in the planning of the syllabus with the Deputy County Medical Officer. Previous experience in the West Riding was of considerable help and four members of the medical staff who had not previously received in-service training are course participants.

In the field of assessment the policy regarding the actual testing of I.Q.'s is now developing in the direction that psychologists will take over this aspect of the work and the previous training courses on I.Q. testing for medical officers will cease nationally in 1973. The doctors will, however, as in the Leeds course, be given instruction on a wide variety of tests used by psychologists so that they can interpret psychological reports in assessing the child as a whole.

Some concern has been expressed regarding the future of the Child Guidance Services following paragraph 22 of the Government's White Paper. The psychologists will be with the education authorities—as is now common practice although in the West Riding they have been attached to the School Health Service. The psychiatric social workers will be transferred to the Social Services Departments—many have fears that their particular expertise may be lost unless there are safeguards. The psychiatric aspect may be in future increasingly based in the hospitals although many psychiatrists themselves feel that clinics in the com-

munity should not be discontinued as the hospital has a particular aura for parents and children. It would be of great advantage however if the child psychiatrists had access to hospital beds for the investigation and possible drug therapy of severely disturbed children—a provision sadly lacking nationally at the present time. Many fear that the proposals will break up the team spirit of the present Child Guidance Service despite the emphasis made in the paper on the need for close co-operation. Based on past experience reservations may be justified when three different employers are involved with the personnel.

The valuable work of the psychologists is highlighted not only in their reports but in the essay elsewhere on screening procedures. This development is likely to prove a major one in identification of educational problems and demonstrates the team spirit between the different disciplines in the West Riding. In this regard Mr. George Dobinson who succeeded J. Geoffrey Millard as County Adviser on Special Education, has proved similarly to be a tower of strength in the joint efforts to help the handicapped child.

The former training centres, now schools for the severely retarded children, have benefitted from the better staffing ratios and the increasing provision of new accommodation under the Education Authority. Efforts are being made to provide physiotherapy and visits by speech therapists as personnel become available. These children are being given increasing help and cannot be regarded in any way as neglected in the West Riding.

Despite uncertainties regarding the future there has been a continued increase in numbers of medical staff, psychologists and psychiatric social workers during the year and many areas now have a full staff of medical officers. Extra recruitment of psychologists and social workers is anticipated in 1973 as an increased complement of staff has been agreed. Speech therapists still come, and go for family reasons and some areas are depleted although the overall position is better than a few years ago.

One cannot conclude without again thanking all our colleagues for their continued efforts in the interests of the children.

Care of the Handicapped Children:

One major development has been the opening of a new school for maladjusted boys: Northways School at Clifford. The school for delicate junior children has been transferred from Ingleborough Hall at Clapham to the former junior school for e.s.n. pupils at Keighley, Whinburn. This makes the children more accessible to parents for visits and has the advantage that hospital facilities are easy of access at the Airedale Hospital where the consultant pædiatrician also visits the school.

The combined policy of developmental assessments in the pre-school period and the use of the computer to maintain registers of children with handicaps and disabilities is leading to earlier recognition and is of value in alerting the Education Authority to future needs for handicapped children. The system of recall

ensures that children are not overlooked through files not being available at the appropriate time. The register also facilitates studies of individual handicaps when research projects are undertaken involving incidence of defects, children requiring special help etc.

The Work of the Psychiatrists:

Dr. Gore reports as follows on the operation of the child guidance clinic at Harrogate.

"In 1972, 150 new cases were seen—116 boys and 34 girls; 142 of these cases were referred from Division 7 as follows:

	Boys	Girls	Total
Divisional Medical Officer	40	11	51
General Practitioners	16	7	23
Head Teachers	13	2	15
Pædiatrician	27	6	33
Parents	7	2	9
Others	6	5	11
	<hr/> 109	<hr/> 33	<hr/> 142

As this is the last Annual Report I shall prepare in respect of the Harrogate Child Guidance Clinic, I am prepared to enjoy the luxury of 'blowing my own trumpet' to the extent of admitting a measure of satisfaction in the work which has developed at the clinic both in spread and in depth.

The clinic which I took over in 1960 from Dr. Jack Khan, although only open one day per week, had already established a close liaison with the community and those caring for the children referred to us. It is, of course, the members of the clinic team as a whole who are responsible for the growth and achievements of the clinic.

1972 proved to be a 'bumper year' in respect of new referrals seen (150 cases, 116 boys and 34 girls) and the scope of the work done. The fact that we have had two psychologists working between them nine sessions per week, and for the most part of the time three social workers in training in addition to a full-time psychiatric social work supervisor, has meant that we have, I think, been able to offer a very good service to the cases referred to us. The members of the team, particularly the psychologists, but in some cases where appropriate, the social workers also, have been utilised in treatment of individual children and the families. In some cases the psychiatric social worker has seen a group of mothers while the same mothers were being seen individually by student social workers. This and other similar arrangements have meant that these families have received speedier and more efficient help.

We have continued to have large numbers of visitors to the clinic particularly from head teachers and other teachers, and I think this has been one of the very useful aspects of the work here, also we have been able to have a closer contact with family doctors and with the pædiatrician. Students from the Institute of Education in Leeds have been able to contribute to our discussions from their own experience.

In spite of accommodation difficulties the work of the remedial teacher has flourished. A greater problem than accommodation has really been the amount of work which could well justify an additional teacher, since the work is so important as it often does away with the necessity of a child going away from home.

I would like to thank my colleagues at the clinic, both past and present, for the high standard of work which they have always maintained and for their constant support and loyalty to me, and the reliable and devoted secretaries, particularly Mrs. Ramsbottom who has also left the clinic this year, and to Miss Griffin, Divisional Nursing Officer, for her help and co-operation. I would also like to bid a regretful farewell to Dr. Hepple and my other good friends at the Divisional Health Office in Harrogate.

I hope that the clinic will continue to flourish. It is most important that the work should be carried on."

Reporting on the Child Guidance Clinics at Mirfield, Pontefract, Ossett and Morley, Dr. Maxwell states:

"During 1972 I continued to work in the Mirfield, Pontefract and Morley Clinics. At the Mirfield Clinic there have been staff changes as Mr. Monaghan, Psychologist, left the area to commence a senior appointment and Miss Fairburn, Social Worker, proceeded to the Leeds University course in Psychiatric Social Work. Mr. Ellis and Mrs. Arora were appointed as Psychologists and Mrs. Williams came to the clinic as Psychiatric Social Worker. We are fortunate to have the continued and valued help of Mr. Pickles for part of the clinic time and are twice blessed in that Mrs. Murgatroyd, our secretary, is with us still. The number of new cases seen and the general work load of this clinic is greater than at any time previously. It is pleasing to note that all the associated services make good and frequent liaison with the Mirfield Clinic.

The Pontefract Clinic has changed little during 1972, the staff remaining as in 1971 and the work volume being similar.

The Morley Clinic continues to have the services of Mr. Mannix, Psychologist and on Miss Fairburn's secondment Mrs. Williams took up the Morley Social Work duties. Already the number of cases treated justifies the 1971 increase from a half to a full day clinic weekly; it is believed that a further increase can be expected from this busy area.

Lectures relating to Child Guidance work continue to be part of the team commitment within the areas served by the clinics.

The clinic figures are as follows:

	<i>Mirfield</i>	<i>Ponte- fract</i>	<i>Morley</i>	<i>Total</i>
No. of sessions held... ..	192	96	96	384
No. of new cases	213	83	62	358
No. of cases continuing attendance from previous years	108	58	60	226
No. of cases closed during 1972	200	84	69	353
No. of cases carried forward to 1973	121	57	53	231

Dr. Orme, consultant psychiatrist at the Swinton, Barnsley and Ecclesfield clinics, reports as follows:

"Work at the Swinton clinic was dominated by the changes in social work staff. Early in the year attempts were made to have social workers from Social Services Departments working for occasional sessions. Although this was helpful in individual cases there were great difficulties because of the conflicting loyalties and it was apparent that such dual arrangements needed careful working out. It was seen that a dual appointment worked well in the Ecclesfield area when there was careful study of differing roles of the various workers and definite decision that the time spent in each department was about equal, i.e. a social worker can work in both clinic and social services departments but this needs to be balanced on a half and half basis with definite limitations of commitment and load by both departments. During the autumn however work has been much more satisfactory with Miss Kelly joining the staff at Swinton full-time and Mrs. Collins, returning from the Psychiatric Social Worker course, part-time in this area with commitments elsewhere.

Anticipation of the move into the new clinic and the various delays have limited the remedial work by Mrs. Riches. It is hoped that the new clinic will be of considerable help, but it must always be emphasised that the most important part of our work is through the building of personal relationships which are independent of the surrounding bricks and mortar.

The psychologists have in all areas been involved with improving relationships with schools. It is noticeable what help it is to disturbed families when liaison is consistent and active as for example in the Worsbrough area. The problems of the screening procedures have also taken up their time.

All over the area pressures for individual assessment and treatment are increasing so that we can only look forward to improving facilities with increasing staff."

Dr. Sanderson reports as follows on the operation of the Hemsworth, Ossett, Rothwell and Tadcaster Child Guidance Clinics:

"During the past year we have been able to undertake a small research project on children who steal. This is an important common problem in boys referred to the clinics, and, to a lesser extent in girls.

In many cases an adverse emotional climate at home appears to be an ætiological factor. In others subcultural influences in the immediate neighbourhood, unfortunate separation experiences and difficulties with school work seem to play a part.

I would like to take this opportunity of thanking all psychologists and social workers who have helped in this work and hope to have details of results for discussion within the next few months.

We were sorry to lose Mrs. Kinch from Rothwell and Tadcaster clinics but pleased to have Mrs. Adams return and to welcome Mrs. Elmhirst, Psychologist, to Tadcaster. We also welcome Mrs. Williams, Social Worker, at Ossett, who has replaced Miss Fairburn while the latter attends the P.S.W. course in Leeds."

The Work of the Psychologists:

Further staff were appointed in 1972 and there were 20 psychologists, the equivalent of 18 full-time, employed in the service at the end of the year. The recent rapid growth of the service has been most encouraging and is enabling important new work to be undertaken. It is likely that the recommendation of the Summerfield Committee that there should be one psychologist for 10,000 school children in the area of each local authority could now be realised at an earlier date than the Committee anticipated, as more psychologists are being trained.

The psychologists are now spending much more time in the schools as well as maintaining their contribution to the team work of the child guidance clinics. An adequate service is also being offered to the Social Services assessment centres. It has been possible over the past few years to start pilot screening procedures for the early detection of children with educational and related difficulties in the primary schools; and, with present establishment, to suggest that a screening procedure could be started throughout the County in 1973. Figures are given in the Appendix regarding the work undertaken by the psychologists in 1972. Some work, such as assistance with screening and the selection of children for remedial help in the secondary schools, has not been recorded. The total number of children seen for individual psychological examination in 1972 was 3,097, compared with 2,289 in 1971. The number of children seen as part of child guidance team investigation was 991, compared with 872 the previous year. The greatest increase has been in children referred

principally for educational psychological assessment and guidance, owing to physical, sensory and intellectual handicaps and to learning difficulties. The number of such children was 2,106, compared with 1,413 in 1971. Nearly 12 per cent. of these were handicapped children of pre-school age.

There has been a real improvement in direct contacts with the schools, 1,769 visits being made to ordinary schools and 441 to special schools, the comparable figures for 1971 having been 1,129 and 206. There is still a demand for further help from the psychologists in the schools, with occasional complaints from teachers that they seldom see a psychologist. In some areas, the psychologists themselves would wish to work more intensively with handicapped children, and to have closer working relationships with their teachers, but other demands on their services must have priority. There is now a close integration of the work of the psychologists with that of the remedial centres.

The objective that all children coming into the three Social Services assessment centres should be examined by a psychologist was virtually achieved, the psychologists making 280 visits to the assessment centres compared with 173 the previous year.

It has been necessary to curtail the information collected about children seen for individual examination, and the classification of children according to the problems for which they were referred has been omitted this year. The proportions of these have remained fairly stable over the years, so far as children referred for child guidance are concerned, there generally being a majority, particularly boys, referred for investigation and treatment of behaviour problems. Information on the ages at which children were seen is given in the statistical tables. The proportion of boys to girls referred for child guidance is about 2.6 to 1, and approaches 4 to 1 in the eight to ten year age group. There are also about twice as many boys as girls among the children referred only for psychological assessment, the difference between the sexes being sharpest among children with learning difficulties, especially in reading.

Reference is made elsewhere in this Report to the proposals made by a working party of psychologists for a screening procedure which could be applied throughout the County in 1973, to identify children in need of extra attention for educational and other problems early in their school careers. The working party met in June and July and presented a report at the beginning of August. It is gratifying that, after further discussions, these proposals have been accepted and the necessary administrative arrangements made so smoothly and speedily to enable the procedure to begin in January, 1973. Meetings were held with headteachers and teachers in December to outline the procedure, these were well attended and the general response very favourable.

The technical aspects of the procedure will be the responsibility of the psychologists and a screening procedure of this magnitude will bring extra work in the further examination and follow-up of children identified by it. The service will be stretched in completing this new work together with a continuance of normal duties in the school health and child guidance services.

A comprehensive and flexible psychological service now exists in the West Riding, operating as an integral part of the school health service, and, with present establishment, offering a wider service to the schools and special schools, the social services for children, as well as the clinics. The framework of the service in the West Riding has been particularly favourable to an easy collaboration of the psychologists with all other professions, in the educational, social work and medical fields, and has given the psychologists opportunities for working with children and young people of all ages and conditions. With approaching local government and health service reorganisation, the future is a little uncertain; but there can be no doubting the wide range of problems, in children and young people, and also in handicapped persons beyond school age, for which local authorities have extended responsibilities, and in which there is a need for the application of psychological principles and procedures.

Consultant Cardiac Clinic:

Dr. Hepple reports as follows on the Cardiac Clinic at Harrogate:

"During 1972, 10 sessions of the Cardiac Clinic were held when 95 children made a total of 100 attendances. There were 12 new cases, eight of whom had been discovered to have heart defects at routine school medical examination while two had been referred by another consultant. Only two babies were referred to the Clinic by their family doctors as Dr. Clarke prefers to see infants with heart defects at his Pædiatric Clinic. It follows inevitably that, as older children are discharged and fewer babies come to the Clinic, the number of patients gets less and Cardiac Clinics can be held only at infrequent intervals.

During the period under review four children were transferred to the Adult Cardiac Clinic at Harrogate Hospital, four left the area and 12 were returned to the care of their own doctors."

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
Dental Specialist	1	1
Senior Clinical Dental Officers ...)	2	5
Area and Senior Dental Officers ...)	20	18
Dental Officers	28	43
Dental Auxiliaries	5	10

There were also six part-time staff contributing the equivalent of 2.4 full-time dental officers.

A total of 24,594 sessions were worked by dental officers during the year, compared with 24,998 in 1971, indicating an overall reduction in staff equivalent to one dental officer.

A number of newly-qualified dental surgeons joined the service but, without exception, had resigned by the end of the year. It is unfortunate that having gained experience and self-confidence, they succumb to the financial advantages of general practice. In addition this year the lack of information regarding the structure and promotion prospects within the future school service has contributed to these exceptionally rapid departures.

By reason of its size, the West Riding Dental Service has, over the years, been able to develop specialities in orthodontics, general anaesthesia, advanced conservation and dental health education. Even at this late date, no clear picture emerges as to how the senior staff involved in these specialities will be absorbed into the reorganised health service and apart from giving rise to a general apprehension, this continuing uncertainty contributed to the loss of the County Orthodontist.

Dental Auxiliaries:

Although the establishment of auxiliaries is 10, throughout the year the number in post was the equivalent of only three. Recruitment of this important class of worker to clinics in the north of the country is still a problem and is likely to remain so, so long as there is no increase in the number being trained each year. These girls, almost without exception, are extremely well trained and adept in treating the very young and apprehensive patient.

Courses:

Of the three members of staff authorised to attend the course in Dental Public Health at Leeds University in 1971/72, two were successful in gaining the Diploma of the Royal College. A further two members of staff are presently attending this course.

Clinics:

A new two-surgery dental suite in the new Health Centre at Goole replaced the old, adapted clinic.

Equipment:

At the end of the year, the second instalment of the three-year plan to renew dental equipment in 34 surgeries was well under way. It will be recalled that this programme is to replace obsolete equipment, becoming increasingly difficult to maintain, with the modern equipment on which dental students are now trained.

Inspection and Treatment:

Statistical details of inspection and treatment are reproduced in Table 75 of Appendix A. These largely speak for themselves but significantly the number of permanent teeth extracted rose by almost 3,000 compared with the previous year and the number of permanent teeth filled fell by almost 9,000. With the equivalent of one dental officer and two auxiliaries less throughout the year, the fall in output of fillings is of about the order to be expected and the increase in extractions is an indication of a continuing inadequacy of staff. However, bearing in mind all the circumstances, the overall picture is one of a very reasonable year's work.

Epidemiology:

A national study of the dental health of school children in England and Wales has been commissioned to supplement the survey of "Adult Dental Health in England and Wales, 1968", and the "Quinquennial Surveys of the Dental Health of School Children", which have been carried out since 1948. The co-operation of this Authority has been sought and Miss Joyce Neden, Dental Specialist, will be carrying out the examination of a sample of 5 to 15 year old children as part of this survey early in 1973.

Additionally, it is intended that a special interviewing staff will visit the mothers of children of certain ages to seek their opinions about dentistry and dental health. It is hoped that the results of this extensive national survey will be published in 1973 and that it will contribute considerably in appraising the dental health and treatment of children as presently being carried out in this country.

Dental Health Education:

The spring of 1972 saw the completion of the survey on the teeth of three-year-old children in Aireborough, where fluoridation of the drinking water was implemented in January, 1969. This survey confirms the already overwhelming evidence that the adjusting of the fluoride level in drinking water to one part per million brings about a reduction in dental decay of at least 50 per cent.

A full scale campaign was mounted in the Wath upon Dearne area, where talks were given at each school and play group in the area.

Invitations as in previous years continue to be received from schools in many areas and requests to talk to young wives' groups and parent/teacher associations were met during the year.

Orthodontics:

It has been customary for this section of the report to be contributed by the County Orthodontist but, as mentioned earlier, Mr. Thompson left the service at the end of October. As in previous years, there was a small increase in the number of patients who received this treatment. This has been the national pattern for many years and there appears to be little indication as yet that the full demand for orthodontic treatment is being met.

In view of the forthcoming reorganisation of the health services, it was decided not to attempt to fill the post of County Orthodontist and the problem of seeing this branch of the service through to 1974 has been met by a former County Orthodontist, Miss R. Sclare, emerging from retirement to help us out in a part-time capacity.

The orthodontic service since its inception has been something rather special and a review of its history appears elsewhere in the Annual Report.

Laboratory:

The staff of the laboratory continues to meet the increasing needs of dental staff with work of a very high standard. The laboratory is well equipped and, under the supervision of the chief technician, produced over 5,000 items of work during the year, together with nearly 5,000 study models.

It must be stated that our laboratory is the largest local authority laboratory in the country. The equipping and staffing has taken many years and every care must be taken to ensure its future.

Table

Page

1	Summary of Principal Vital Statistics, 1890-1972 ...	145
2	Causes of Stillbirth ...	146
3	Perinatal Mortality, 1962-72 ...	146
4	Causes of Infant Mortality ...	147
5	Infant Mortality, 1901-72 ...	148
6	Infant Mortality, 1968-72 ...	148
7	Neonatal Mortality, 1966-72 ...	149
8	Mortality by Age Groups, 1968-72 ...	149
9	Principal Causes of Death ...	150
10	Percentage Contribution of the Five Principal Cause Groups of Death to All Causes, 1968-72 ...	152
11	Cancer Mortality, 1967-72 ...	152
12	Mortality from Respiratory Diseases, 1967-72 ...	153
13	Mortality from Violent Causes, 1966-72 ...	153
14	Mortality from Home Accidents ...	154
15	Suicides ...	154
16	Child Mortality, 1911-72 ...	155
17	Notification of Infectious Disease, 1967-72 ...	156
18	Notification of Infectious Disease, 1972 ...	157
19	Measles—Incidence and Mortality, 1959-72 ...	158
20	Incidence of Food Poisoning ...	158
21	Vaccination and Immunisation ...	159
22	Tuberculosis—Mortality ...	160
23	Tuberculosis—Notifications ...	160
24	Tuberculosis—Number of Cases on Register ...	161
25	B.C.G. Vaccination ...	162
26	Tuberculosis—Mass Radiography Surveys ...	164
27	Venereal and Sexually Transmissible Diseases—New Cases, 1938-72 ...	166
28	Syphilis—Type and Stage of Disease, 1950-72 ...	167
29	Venereal Diseases etc.—Distribution of New Cases by Treatment Centres ...	168
30	Venereal Diseases etc.—New Cases—Sex Distribution ...	168
31	Gonorrhœa—New Cases—Age Distribution ...	169
32	Venereal Diseases etc.—Contact Tracing ...	169
33	Antenatal Patients with Positive Serological Tests for Syphilis ...	169
34	Venereal Diseases etc.—Defaulters... ...	170
35	Gonorrhœa—New Cases—Males/Females Numbers and Ratios, 1961-72 ...	170
36	Divisional Administration ...	171
37	Dental Services for Expectant and Nursing Mothers and Children under 5 years ...	175
38	Antenatal Relaxation Classes ...	176
39	Ortolani Testing for Congenital Dislocation of Hip, 1965-72 ...	176
40	Premature Babies ...	177
41	Distribution of Welfare Foods ...	178
42	Midwifery—Hospital and Domiciliary Confinements ...	179
43	Midwifery—Analgesia ...	180
44	Health Visiting ...	181
45	Health Visiting—Clinic and Health Education Sessions ...	182
46	Home Nursing—Total Cases Visited ...	182
47	Home Nursing—Completed Cases ...	183
48	Ambulance Service ...	185
49	Ambulance Service—Accidents Attended ...	185
50	Ambulance Service—Training given to County Departments and Other Organisations, 1972 ...	185
51	Health Education ...	186
52	Provision of Nursing Equipment in the Home ...	187
53	Chiropody Treatment ...	188

54	Milk (Special Designation) Regulations, 1963 and Milk (Special Designation) (Amendment) Regulations, 1965—Dealers Licensed ...	189
55	Milk (Special Designation) Regulations, 1963 and Milk (Special Designation) (Amendment) Regulations, 1965—Details of Samples obtained from Dealers	189
56	Milk (Special Designation) Regulations, 1963 as amended—Licensed Establishments for Pasteurising and Sterilising Milk ...	189
57	Milk (Special Designation) Regulations, 1963 as amended—Details of Samples obtained from Licensed Processing Plants ...	190
58	County Premises with Private Supplies of Water ...	190
59	Applications for Grants under the Rural Water Supplies and Sewerage Acts, 1944-61 ...	191
60	School Swimming Pools ...	192
61	Atmospheric Pollution ...	197
62	Certification and Treatment of Blind and Partially Sighted Persons—New Registrations ...	204
63	Registration of Nursing Homes ...	205
64	Medical Inspection of School Children ...	206
65	Care of the Handicapped Pupil ...	211
66	Audiology Clinics ...	212
67	The Work of the Psychologists ...	214
68	School Ophthalmic Service, 1957-72 ...	215
69	Medical Treatment at Clinics ...	215
70	Consultant Services ...	216
71	Cleanliness, 1953-72 ...	219
72	Nutrition, 1960-72 ...	220
73	Protection of School Children Against Tuberculosis ...	220
74	Speech Therapy ...	221
75	Dental Inspections and Treatment ...	222

Table 1 Summary of Principal Vital Statistics, 1890—1972

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
1960-1961	16.9	22	11.5	0.06	0.06	0.01	1.15	1.98	0.73	22
1962-1963	17.2	20	12.1	0.05	0.06	0.00	1.44	1.98	0.27	25
1964-1965	17.8	18	12.0	0.04	0.05	0.01	1.47	2.00	0.20	23
1966-1967	18.2	19	12.0	0.04	0.06	0.01	1.52	1.94	0.45	23
1968-1969	18.5	18	11.5	0.04	0.05	0.00	1.35	2.02	0.40	22
1970-1971	18.2	16	11.6	0.04	0.04	0.00	1.28	2.07	0.16	21
1972	18.0	14	12.1	0.03	0.05	0.00	1.62	2.00	0.25	20
	18.0	15	11.2	0.03	0.03	0.00	1.29	2.08	0.22	19
	17.6	14	11.6	0.04	0.03	0.01	1.60	2.14	0.09	18
	16.9	14	11.6	0.05	0.03	0.01	1.60	2.10	0.20	19
	17.3	14	11.7	0.04	0.02	0.01	1.53	2.14	0.29	20
	17.0	12	11.4	0.04	0.02	0.01	1.41	2.16	0.10	18
	15.4	12	12.1	0.03	0.02	0.01	1.66	2.23	0.04	18

* 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)	67	2.37
Chronic and acute disease in mother (760, 761)	8	0.28
Maternal toxæmia and infection (762, 763)	33	1.17
Difficult labour (764-768)	10	0.35
Other complications of pregnancy and childbirth (769) ...	20	0.71
Conditions of placenta (770)	93	3.29
Conditions of umbilical cord (771)	43	1.52
Birth injury (772)	4	0.14
Hæmolytic disease of newborn (774, 775)	7	0.25
Anoxic and hypoxic conditions NEC (776)	23	0.81
Immaturity unqualified (777)	3	0.11
Other conditions of foetus or newborn (778)	1	0.04
Foetal death of unknown cause (779)... ..	34	1.20
All causes (740-779)	346	12.24

Table 3 Perinatal Mortality, 1962-72

	1962	1963	1964	1965	1966	1967	1968	1969	1970	1971	1972
Perinatal mortality (per 1,000 total births)	31.5	31.1	30.0	27.3	25.1	26.1	25.0	23.7	24.4	21.7	22.5
Infant deaths at 1 week and over (per 1,000 total births)	9.9	10.1	9.5	9.0	8.8	8.1	7.5	8.5	8.7	8.8	7.2

Table 4 Causes of Infant Mortality

Aetiological Group	Cause of Death (and International Classification number)	Age at Death						
		Under 1 day	1 day and under 1 week	1 week and under 1 month	1 month and under 3 months	3 months and under 6 months	6 months and under 1 year	Total under 1 year
ALL CAUSES	All causes	163	126	40	65	58	40	492
Prenatal and Natal Group (including congenital malformations)	Congenital malformations (740-759)	25	23	19	19	12	6	104
	Total causes mainly of prenatal and natal origin other than congenital malformations (760-778)	134	85	8	5	1	—	233
	Chronic and acute disease and infection in mother (760-763)	3	—	—	—	—	—	3
	Difficult labour (764-768)	—	—	—	—	—	—	—
	Other complications of pregnancy and childbirth (769-771)	9	1	—	—	—	—	10
	Birth injury (772)	12	14	—	1	—	—	28
Postnatal Group	Haemolytic disease of newborn (774-775)	—	2	—	—	—	—	2
	Anoxic and hypoxic conditions NEC (776)	59	48	4	3	—	—	114
	Immaturity, unqualified (777)	49	16	3	—	—	—	68
	Other conditions of fetus or newborn (778)	2	4	1	1	—	—	8
	Total causes mainly of postnatal origin	1	12	6	24	34	25	102
	Enteritis and other diarrhoeal diseases (008, 009)	—	1	—	4	5	2	12
Unclassified	Measles (055)	—	—	—	—	1	1	2
	Other infective and parasitic diseases (remainder 000-136)	—	—	2	—	—	—	2
	Meningitis (320)	—	—	1	—	—	—	3
	Pneumonia and bronchitis (480-486, 490-492)	—	10	3	6	10	6	35
	Other diseases of the respiratory system (remainder 460-519)	—	—	—	11	16	10	37
	Accidental mechanical suffocation from vomit, food, foreign body, or in cot (E911-E913)	—	—	—	1	1	3	5
Unclassified	Other violent causes (remainder E800-E999)	1	1	—	2	1	1	6
	Other remaining causes	3	6	7	17	11	9	53

Table 5 Infant Mortality, 1901-72—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	1971	18	18
1951-1955	27	29	1972	17	18
1956-1960	23	25			
1961-1965	21	23			

Table 6 Infant Mortality, 1968-72

	Number of Deaths					Deaths per 1,000 Live Births				
	1968	1969	1970	1971	1972	1968	1969	1970	1971	1972
<i>Male Infants—</i>										
Under 4 weeks ...	233	210	228	195	180	14.5	13.4	14.4	12.4	12.5
4 weeks—3 months ...	41	42	53	55	38	2.5	2.7	3.3	3.5	2.6
3—6 months ...	41	48	44	45	34	2.5	3.1	2.8	2.9	2.4
6—12 months ...	31	23	21	34	22	1.9	1.5	1.3	2.2	1.5
Total under 1 year ...	346	323	346	329	274	21.5	20.7	21.8	21.0	19.1
<i>Female Infants—</i>										
Under 4 weeks ...	146	161	181	143	149	9.6	11.0	12.0	9.5	11.0
4 weeks—3 months ...	35	38	31	30	27	2.3	2.6	2.0	2.0	2.0
3—6 months ...	34	33	35	42	24	2.2	2.3	2.3	2.8	1.8
6—12 months ...	16	18	21	22	18	1.1	1.2	1.4	1.5	1.3
Total under 1 year ...	231	250	268	237	218	15.3	17.1	17.7	15.8	16.1
<i>All Infants—</i>										
Under 4 weeks ...	379	371	409	338	329	12.1	12.3	13.2	11.0	11.8
4 weeks—3 months ...	76	80	84	85	65	2.4	2.6	2.7	2.8	2.3
3—6 months ...	75	81	79	87	58	2.4	2.7	2.5	2.8	2.1
6—12 months ...	47	41	42	56	40	1.5	1.4	1.4	1.8	1.4
Total under 1 year ...	577	573	614	566	492	18.5	18.9	19.8	18.4	17.6

Table 7 Neonatal Mortality, 1966-72

		Number of Deaths							Deaths per 1,000 Live Births						
		1966	1967	1968	1969	1970	1971	1972	1966	1967	1968	1969	1970	1971	1972
Under 1 day ...		191	188	199	172	197	163	163	6.1	6.0	6.4	5.7	6.3	5.3	5.8
1—6 days ...		152	161	139	140	142	129	126	4.8	5.1	4.5	4.6	4.6	4.2	4.5
1—4 weeks ...		54	64	41	59	70	46	40	1.7	2.0	1.3	1.9	2.3	1.5	1.4
Total under 4 weeks		397	413	379	371	409	338	329	12.6	13.1	12.1	12.3	13.2	11.0	11.8

Table 8 Mortality by Age Groups, 1968—72

Age Group				1968	1969	1970	1971	1972
Under 1 year	...	...		577	573	614	566	492
1 and under 5	...	...		93	102	88	65	105
5—14	...	...		116	106	93	97	101
15—24	...	...		168	201	170	186	169
25—34	...	...		172	182	195	177	188
35—44	...	...		487	493	449	441	431
45—54	...	...		1,309	1,302	1,280	1,312	1,389
55—64	...	...		3,308	3,409	3,379	3,230	3,427
65—74	...	...		5,834	6,096	6,118	5,859	6,257
75 and over	...	...		8,559	8,334	8,631	8,652	9,397
Totals	...	...		20,623	20,798	21,017	20,585	21,956

Table 9 Principal Causes of Death, 1972

Cause of death	Age at death										Total
	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
B. 1 Cholera	—	—	—	—	—	—	—	—	—	—	—
B. 2 Typhoid fever	—	—	—	—	—	—	—	—	—	—	—
B. 3 Bacillary dysentery and amebiasis	—	—	—	—	—	—	—	—	—	—	—
B. 4 Enteritis and other diarrhoeal diseases	1	11	5	—	—	—	1	3	1	13	26
B. 5 Tuberculosis of respiratory system	—	—	—	—	—	1	—	2	9	2	29
B. 6(1) Late effects of respiratory tuberculosis	—	—	—	—	—	—	1	—	—	2	5
B. 6(2) Other tuberculosis	—	—	—	—	—	—	—	—	2	1	6
B. 7 Plague	—	—	—	—	—	—	—	—	—	—	—
B. 8 Diphtheria	—	—	—	—	—	—	—	—	—	—	—
B. 9 Whooping cough	—	—	—	—	—	—	—	—	—	—	—
B. 10 Streptococcal sore throat and scarlet fever	—	—	—	—	—	—	—	—	—	—	—
B. 11 Meningococcal infection	—	—	2	—	1	—	—	—	—	—	3
B. 12 Acute poliomyelitis	—	—	—	—	—	—	—	—	—	—	—
B. 13 Smallpox	—	—	1	—	—	—	—	—	—	—	—
B. 14 Measles	—	2	—	1	—	—	—	—	—	—	4
B. 15 Typhus and other rickettsioses	—	—	—	—	—	—	—	—	—	—	—
B. 16 Malaria	—	—	—	—	—	—	—	—	—	—	—
B. 17 Syphilis and its sequelae	—	—	—	—	—	—	—	—	—	—	—
B. 18 All other infective and parasitic diseases	2	—	3	—	1	3	2	3	1	2	4
Total—Infective and Parasitic Diseases excluding Tuberculosis	3	13	11	1	2	3	3	3	4	9	62
B. 19(1) Malignant neoplasm, buccal cavity, etc.	—	—	—	—	—	—	—	8	6	24	61
B. 19(2) Malignant neoplasm, oesophagus	—	—	—	—	—	—	—	4	21	33	95
B. 19(3) Malignant neoplasm, stomach	—	—	—	—	—	1	11	36	82	162	444
B. 19(4) Malignant neoplasm, intestine	—	—	—	—	1	2	12	42	122	194	606
B. 19(5) Malignant neoplasm, larynx	—	—	—	—	—	—	—	1	3	5	12
B. 19(6) Malignant neoplasm, lung, bronchus	—	—	—	—	—	3	17	126	316	365	980
B. 19(7) Malignant neoplasm, breast	—	—	—	—	4	4	18	82	100	86	388
B. 19(8) Malignant neoplasm, uterus	—	—	—	—	1	—	8	17	44	44	147
B. 19(9) Malignant neoplasm, prostate	—	—	—	—	—	—	1	2	10	62	149
B. 19(10) Leukaemia	—	—	5	3	1	3	3	5	17	29	91
B. 19(11) Other malignant neoplasms	1	—	6	9	19	21	39	114	255	347	1,078
Total—Malignant Neoplasms	1	—	11	12	22	34	112	437	976	1,351	4,051
B. 20 Benign neoplasms and neoplasms of unspecified nature	—	—	—	2	1	2	—	1	14	18	44
B. 21 Diabetes mellitus	—	—	—	2	1	2	4	12	32	67	207
B. 22 Avitaminoses and other nutritional deficiency	—	1	—	—	—	—	—	—	—	3	7
B. 46(1) Other endocrine, nutritional and metabolic disorders	2	3	3	5	1	1	2	4	11	11	56
B. 23 Anaemias	—	—	—	1	—	—	—	2	8	20	61
B. 46(2) Other diseases of blood and blood forming organs	1	—	—	—	—	—	—	—	2	2	6
B. 46(3) Mental disorders	—	—	1	1	1	1	—	1	5	6	55
B. 24 Meningitis	1	2	2	1	—	1	1	2	2	1	14
B. 46(4) Multiple sclerosis	—	—	—	—	—	1	3	12	14	7	38
B. 46(5) Other diseases of nervous system and sense organs	1	9	8	5	7	11	7	16	17	2	193

Table 9 Principal Causes of Death (continued)

Cause of death	Age at death										Total	
	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
B. 25 Active rheumatic fever	—	—	—	—	1	3	17	45	78	69	57	1
B. 26 Chronic rheumatic heart disease	—	—	—	—	—	3	5	14	44	79	135	270
B. 27 Hypertensive disease	—	—	—	—	—	16	99	438	1,119	1,918	2,363	280
B. 28 Ischaemic heart disease	—	—	—	—	—	3	6	24	72	212	685	5,953
B. 29 Other forms of heart disease	1	1	2	1	1	13	21	86	302	909	1,915	1,008
B. 30 Cerebrovascular disease	—	—	—	—	—	5	6	30	87	212	618	3,248
B. 46(6) Other diseases of the circulatory system	1	—	—	—	—	—	—	—	—	—	—	961
Total—Diseases of the Circulatory System	2	1	2	4	3	43	155	637	1,702	3,399	5,773	11,721
B. 31 Influenza	—	—	—	1	2	2	4	4	14	31	64	122
B. 32 Pneumonia	13	22	8	5	5	4	15	24	103	293	904	1,396
B. 33(1) Bronchitis, emphysema... ..	—	—	—	—	—	—	5	61	236	505	518	1,325
B. 33(2) Asthma	—	—	1	—	2	4	6	7	14	12	8	54
B. 46(7) Other diseases of the respiratory system	—	37	5	—	2	4	7	12	25	58	84	234
Total—Diseases of the Respiratory System	13	59	14	6	11	14	37	108	392	899	1,578	3,131
B. 34 Peptic ulcer	—	—	—	—	1	1	4	6	25	52	63	151
B. 35 Appendicitis	—	—	—	—	1	1	1	1	1	4	3	12
B. 36 Intestinal obstruction, hernia	5	2	—	—	—	—	2	3	5	29	51	97
B. 37 Cirrhosis of liver	—	—	—	1	—	—	2	7	13	14	14	51
B. 46(8) Other diseases of digestive system	2	3	1	1	1	7	5	15	42	68	82	226
B. 38 Nephritis and nephrosis	—	—	—	1	1	2	5	8	18	22	16	73
B. 39 Hyperplasia of prostate	—	—	—	—	—	—	—	—	2	14	27	43
B. 46(9) Other diseases of genito-urinary system	1	3	2	—	—	3	6	4	16	39	67	141
B. 40 Abortion	—	—	—	—	—	—	1	—	—	—	—	1
B. 41 Other complications of pregnancy, childbirth and puerperium	—	—	—	—	—	—	—	—	—	—	—	—
B. 46(10) Diseases of skin and subcutaneous tissue	—	—	—	—	—	—	—	—	—	—	—	—
B. 46(11) Diseases of the musculoskeletal system	1	—	—	—	1	—	1	1	10	4	7	12
B. 42 Congenital anomalies	67	37	20	8	5	2	6	8	9	34	40	93
B. 43 Birth injury, difficult labour, and other anoxic and hypoxic conditions	137	5	—	—	—	—	—	—	—	—	—	142
B. 44 Other causes of perinatal mortality	90	15	1	—	—	—	—	1	2	5	90	92
B. 45 Symptoms and ill-defined conditions...	—	1	1	—	—	—	2	24	26	29	31	116
BE. 47 Motor vehicle accidents	—	8	11	25	78	29	32	22	37	46	179	286
BE. 48 All other accidents	1	—	14	22	19	14	14	32	21	21	20	376
BE. 49 Suicide and self-inflicted injuries	—	—	—	—	9	10	21	32	21	21	3	134
BE. 50 All other external causes	1	—	3	3	6	5	3	11	10	9	3	54
Total—Accidents, Poisonings, Violence (External Causes)	2	9	28	50	112	58	70	89	94	105	233	850
Total—All causes	329	163	105	101	169	188	431	1,389	3,427	6,257	9,397	21,956

Table 10 Percentage Contribution of the Five Principal Cause Groups of Death to All Causes, 1968—72

Cause Group						1968	1969	1970	1971	1972
Circulatory diseases except cerebro-vascular disease						37.3	37.7	37.9	38.6	38.6
Malignant neoplasms						18.4	18.0	18.3	18.9	18.5
Cerebrovascular disease						15.2	14.6	14.9	15.3	14.8
Diseases of respiratory system						14.3	14.6	14.4	12.5	14.3
Accidents, suicide and violence						4.5	4.6	4.1	4.1	3.9
Total						89.7	89.5	89.7	89.4	90.0

Table 11 Cancer Mortality, 1967—72

Year		Stomach	Lung, Bronchus	Breast	Uterus	Other Malignant and Lymphatic Neoplasms	Leukæmia, Aleukæmia	Total All Sites
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
1971	M.	286	793	3	—	994	62	2,138
	F.	184	147	348	153	885	42	1,759
	T.	470	940	351	153	1,879	104	3,897
1972	M.	251	813	4	—	1,092	41	2,201
	F.	193	167	384	147	909	50	1,850
	T.	444	980	388	147	2,001	91	4,051

Table 12 Mortality from Respiratory Diseases, 1967—72

Year	Influenza	Pneumonia	Bronchitis	Other diseases of the Respiratory System	Total
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
1971	24	1,105	1,160	277	2,566
1972	122	1,396	1,325	288	3,131

Table 13 Mortality from Violent Causes, 1966—72

Year	Motor Vehicle Accidents	Accidents in the Home	All other Accidents	Suicide	All other external causes	Total Accidents, Poisoning, Violence
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
1971	278	198	147	166	54	843
1972	286	218	158	134	54	850

Table 14 Mortality from Home Accidents

Cause of Death		Age at Death—Years							All ages
		Under 1	1-4	5-44	45-54	55-64	65-74	75 and over	
Accidental poisoning by solid and liquid substances ...	M.	—	1	1	1	—	1	—	4
	F.	—	—	3	1	—	1	1	6
Accidental poisoning by gases and vapours ...	M.	—	1	1	2	—	1	2	7
	F.	1	—	1	—	1	1	4	8
Accidental falls ...	M.	—	—	3	—	4	7	24	38
	F.	2	—	2	3	1	17	96	121
Accidents caused by burns and scalds ...	M.	—	—	—	—	—	1	1	2
	F.	—	—	1	2	2	1	4	10
Inhalation of food or vomit ...	M.	2	—	1	2	—	—	—	5
	F.	—	—	—	1	2	—	1	4
Accidental mechanical suffocation ...	M.	2	1	—	—	—	1	—	4
	F.	1	—	1	—	—	—	—	2
Other and unspecified accidents	M.	—	1	2	—	—	—	1	4
	F.	—	1	—	—	1	1	—	3
Total ...	M.	4	4	8	5	4	11	28	64
	F.	4	1	8	7	7	21	106	154

Table 15 Suicides

External Agent		Age at Death — Years								All ages
		Under 15	15-24	25-34	35-44	45-54	55-64	65-74	75 and over	
Domestic gas poisoning ...	M.	—	1	—	—	2	—	1	—	4
	F.	—	—	—	—	—	1	—	1	2
Other poisoning ...	M.	—	3	6	7	10	5	4	4	39
	F.	—	3	2	6	13	5	11	7	47
Hanging or strangulation ...	M.	—	—	—	4	1	5	3	—	13
	F.	—	1	—	1	—	—	—	—	2
Drowning ...	M.	—	1	—	—	3	1	—	6	11
	F.	—	—	—	1	—	1	—	—	2
Firearms ...	M.	—	—	—	—	—	—	1	—	1
	F.	—	—	—	—	—	1	—	—	1
Jumping before or lying in path of moving vehicles ...	M.	—	—	1	1	1	—	—	—	3
	F.	—	—	—	—	—	—	—	—	—
Jumping from high places ...	M.	—	—	—	—	1	—	—	1	2
	F.	—	—	—	—	—	—	—	—	—
Other agents ...	M.	—	—	1	1	1	1	1	—	5
	F.	—	—	—	—	—	1	—	1	2
Total—All Agents ...	M.	—	5	8	13	19	12	10	11	78
	F.	—	4	2	8	13	9	11	9	56

Table 16 Child Mortality, 1911-72

Cause of Death	Annual Averages for Quinquennia								1970	1971	1972
	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	—	2	1
Whooping cough	167	67	29	11	5	1	<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	2	5
Tuberculosis, respiratory ...	47	13	5	4	1	—	<1	—	—	—	—
Tuberculosis, other	201	82	37	30	11	2	<1	—	1	2	—
Cancer	3	5	4	4	9	9	11	12	11	4	11
Heart and circulatory diseases	4	3	2	1	—	1	1	<1	2	—	2
Influenza	6	43	10	4	2	2	<1	<1	—	—	—
Pneumonia	457	321	121	42	19	14	14	14	12	10	8
Bronchitis	150	42	10	9	6	6	6	1	2	1	—
Other diseases of respiratory system	49	15	6	3	2	2	1	5	6	8	6
Diarrhoea and other digestive diseases	248	45	38	17	4	4	5	6	6	3	6
Congenital debility, malformations	12	9	7	12	13	12	11	10	7	7	20
Accidents	82	54	50	38	27	23	27	28	20	15	25
Other causes	323	119	52	30	23	12	22	15	16	10	21
All causes	2,352	1,017	467	227	136	97	107	96	88	65	105
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	0.53	0.86

Table 17 Notification of Infectious Disease, 1967-72

Disease	Number of corrected notifications					
	1967	1968	1969	1970	1971	1972
Measles	13,528	15,291	3,392	16,351	4,869	11,137
Dysentery	357	691	476	287	406	124
Scarlet fever	1,145	794	1,053	661	740	683
Diphtheria	—	—	—	—	—	—
Acute meningitis:						
Meningococcus	}	8	48	22	17	18
Other specified organisms				11	8	7
Unspecified organisms ...				22	5	10
Acute poliomyelitis:						
Paralytic	—	1	—	—	—	—
Non-paralytic	—	—	—	—	—	1
Acute encephalitis:						
Infective	5	3	1	2	—	1
Post-infectious	3	1	—	1	—	—
Leptospirosis	+	—	—	—	—	—
Paratyphoid fever	1	1	2	—	2	1
Typhoid fever... ..	—	1	—	2	—	3
Food poisoning	56	204	109	145	114	90
Tetanus	+	—	—	—	—	1
Infective jaundice	+	473	756	694	589	608
Whooping cough	1,805	591	181	694	857	51
Anthrax	—	—	—	—	—	—
Leprosy	—	—	—	—	—	—
† Malaria	1	—	2	4	1	2
Ophthalmia neonatorum ...	5	2	2	7	1	4
Smallpox	—	—	—	—	—	—
Yellow fever	+	—	—	—	—	—
Tuberculosis:						
Respiratory	275	299	268	265	263	215
Other forms... ..	47	46	36	42	48	45

† All the cases were believed to be contracted abroad.

† Figures not available.

Table 18 Notification of Infectious Disease, 1972

Numbers originally notified	Measles (excluding rubella)		Dysentery		Scarlet fever		Acute meningitis due to infection with					
	M	F	M	F	M	F	Meningococcus		Other specified organisms		Un-specified organisms	
							M	F	M	F	M	F
Total (All ages)	5,659	5,483	85	85	334	351	7	10	2	3	7	5
Final numbers after correction												
Under 1 year	281	275	1	3	2	2	3	3	—	1	—	—
1—	583	607	8	7	10	7	—	3	—	1	—	1
2—	528	484	9	4	22	12	1	—	—	—	—	—
3—	555	513	5	7	34	24	—	—	—	—	—	—
4—	799	787	3	5	49	40	—	—	—	—	—	—
5—9 years	2,717	2,626	17	15	173	211	—	2	2	—	2	1
10—14 "	115	118	4	2	28	30	2	—	1	—	1	—
15—24 "	34	23	4	3	8	18	—	1	—	—	1	1
25 and over	10	16	9	16	2	6	2	1	1	1	2	—
Age unknown	34	32	—	2	3	2	—	—	—	—	—	—
Total (All ages)	5,656	5,481	60	64	331	352	8	10	4	3	6	4

Numbers originally notified	Acute encephalitis				Paratyphoid fever		Typhoid fever		Food poisoning	
	Infective		Post-infectious		M	F	M	F	M	F
	M	F	M	F						
Total (All ages)	—	1	2	—	—	1	3	1	357	300
Final numbers after correction										
Under 5 years	—	—	—	—	—	—	—	—	7	14
5—14 years	—	1	—	—	—	—	1	—	10	7
15—44 "	—	—	—	—	—	—	1	—	16	18
45—64 "	—	—	—	—	—	1	—	1	7	1
65 and over	—	—	—	—	—	—	—	—	1	8
Age unknown	—	—	—	—	—	—	—	—	1	—
Total (All ages)	—	1	—	—	—	1	2	1	42	48

Numbers originally notified	Infective jaundice		Whooping cough	
	M	F	M	F
Total (All ages)	305	298	21	30
Final numbers after correction				
Under 1 year	1	1	3	3
1—	1	1	2	7
2—4 years	23	17	9	14
5—9 "	84	111	7	5
10—14 "	76	54	—	—
15—19 "	23	24	—	—
20—24 "	33	17	—	—
25—34 "	32	34	—	—
35—44 "	14	16	—	—
45—54 "	11	11	—	—
55—64 "	5	3	—	—
65—74 "	1	4	—	—
75 and over	—	—	—	—
Age unknown	4	7	—	1
Total (All ages)	308	300	21	30

Table 19 Measles—Incidence and Mortality, 1959—72

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)
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
1964	14,385	5	0.03	1971	4,869	3	0.06
1965	18,175	3	0.02	1972	11,137	4	0.04

Table 20 Incidence of Food Poisoning

Presumed Causal Agent	Family Outbreaks		Other Outbreaks		Sporadic Cases	Total Cases
	Number	Cases Involved	Number	Cases Involved		
<i>Salmonella typhimurium</i>	6	20	1	2	20	42
Other <i>Salmonellæ</i> ...	4	8	1	2	17	27
<i>Cl. welchii</i> ...	—	—	—	—	1	1
<i>Staph. aureus</i> ...	3	10	—	—	—	10
Not discovered ...	2	6	—	—	8	14
All agents ...	15	44	2	4	46	94

In addition there were 41 cases of salmonella infection not food-borne.

Table 21 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, 1972.

Primary Courses	Year of Birth						Total
	1972	1971	1970	1969	1965-1968	Others under Age 16	
Diphtheria	303	19,871	6,124	257	972	477	28,004
Whooping Cough	303	19,720	5,974	231	213	36	26,477
Tetanus	303	19,872	6,125	258	972	759	28,289
Poliomyelitis	289	19,946	6,156	265	990	428	28,074
Reinforcing Doses							
Diphtheria	10	262	979	99	19,381	3,081	23,112
Whooping Cough	10	251	242	66	2,602	263	3,434
Tetanus	10	264	323	175	20,946	8,968	30,686
Poliomyelitis	10	299	323	104	20,749	7,570	29,055

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	-	2	1	7	2	9	4	1	1	21	8	29
Other ...	-	-	-	-	-	-	-	-	-	-	-	1	-	2	-	2	2	2	1	1	3	8	11
Totals ...	-	-	-	-	-	-	-	-	1	-	1	1	2	3	7	4	11	6	2	2	24	16	40

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	3	1	1	7	7	12	15	21	36	31	8	144
Respiratory, Females ...	...	1	-	3	2	2	1	3	14	18	9	7	8	3	71
Non-respiratory, Males ...	...	-	-	1	1	-	1	-	7	4	2	2	-	-	18
Non-respiratory, Females ...	...	-	-	1	-	-	-	5	7	5	3	1	1	4	27
															260
SUPPLEMENTAL NOTIFICATIONS:															
Respiratory, Males ...	...	-	-	-	-	-	-	-	-	1	3	3	7	2	16
Respiratory, Females ...	...	-	-	-	-	-	-	-	-	-	-	1	1	2	4
Non-respiratory, Males ...	...	-	-	-	-	-	-	-	-	-	-	-	1	-	1
Non-respiratory, Females ...	...	-	-	-	-	-	-	-	-	-	-	-	-	1	1
															22

The sources of information of the supplemental notifications were—death returns from local Registrars (6 respiratory, 1 non-respiratory), death returns from Registrar General (4 respiratory) and posthumous notifications (10 respiratory, 1 non-respiratory).

Table 24 Tuberculosis—Number of Cases on Register

Div. No.	Number of cases on register 1st January, 1972				Number of cases added to register				Number of cases removed from register				Number of cases remaining on register 31st December, 1972				Per 1,000 Popu- lation	
	Respiratory		Non-Res- piratory		Respi- ratory		Non-Res- piratory		Respi- ratory		Non-Res- piratory		Respiratory		Non-Res- piratory			
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F		
1	100	39	17	19	7	2	—	—	14	6	—	1	93	35	17	18	163	2.0
3	125	49	10	5	10	5	—	—	29	8	—	—	106	46	9	5	166	3.0
4	123	61	7	7	4	2	1	—	26	21	—	2	101	42	7	6	156	2.2
5	270	146	19	26	11	4	1	—	3	—	—	—	278	150	21	27	476	3.6
7	97	38	1	4	7	4	1	—	18	4	—	—	86	38	2	5	131	1.1
9	128	99	30	20	9	3	3	—	9	4	—	—	128	98	33	23	282	2.0
10	60	37	6	12	3	1	—	—	5	4	—	—	58	34	6	12	110	2.2
11	354	221	59	70	14	6	—	—	22	17	1	2	346	210	58	68	682	5.3
13	74	55	11	22	6	5	—	—	33	27	9	16	47	33	2	7	89	0.9
15	67	55	42	18	10	7	6	—	17	10	3	1	60	52	45	23	180	1.6
18	171	80	11	10	15	13	2	2	32	23	2	1	154	70	11	11	246	2.2
20	88	42	17	21	17	22	5	1	19	15	5	4	86	49	17	18	170	1.7
23	183	113	25	37	10	7	—	—	19	13	1	1	174	107	24	36	341	5.1
Leeds R.H.B.	1,840	1,035	255	271	123	81	22	16	246	152	25	28	1,717	964	252	259	3,192	2.5
22	203	97	62	40	9	2	—	—	48	15	5	3	164	84	57	37	342	3.9
25	146	89	7	16	4	2	1	1	16	8	—	1	134	83	8	16	241	3.1
26	280	150	35	44	21	5	1	—	17	5	—	—	284	150	36	43	513	4.8
27	160	107	74	51	16	7	—	3	62	38	20	11	114	76	54	43	287	2.3
29	55	31	20	5	7	3	—	2	15	3	—	—	47	31	20	7	105	2.6
31	172	68	41	35	8	9	—	1	3	4	—	—	177	73	41	36	327	3.0
Sheff. R.H.B.	1,016	542	239	191	65	28	2	7	161	73	25	16	920	497	216	182	1,815	3.3
West Riding	2,856	1,577	494	462	188	109	24	23	407	225	50	44	2,637	1,461	468	441	5,007	2.8

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 1,400 contacts were vaccinated as follows:

Age (years)			
0-4	5-15	16+	Total
860	409	131	1,400

(b) **SCHOOL CHILDREN.**—A total of 19,330 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	...	...	...	...	...	...	...	27,743
Number found to have been vaccinated previously	...	...	...	...	...	...	...	506
Number of acceptances	...	...	...	...	...	...	...	23,667
Percentage of acceptances	86.9

Pre-vaccination tuberculin test:

Number of children tested	22,118
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Result of test:

			<i>Heaf Test</i>	<i>Mantoux Test</i>		
Positive	1,537	82		
Negative	17,401	2,029		
Not ascertained	...	...	1,018	51	Total	22,118
Percentage positive	...	...	8.1	3.9	...	7.7

Vaccination:

Number vaccinated—

Following negative Heaf Test	...	...	17,328	
Following negative Mantoux Test	...	...	2,002	Total ... 19,330

Tuberculin test 12 months after vaccination:

Number tuberculin tested after 12 months	...	...	...	716
Result of test—				
Positive	...	...	...	608
Negative	...	...	...	27
Not ascertained	...	...	...	81
			Total ...	716

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

No students were tuberculin tested during 1972.

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)...	1,535	2	2	6	10
3 (Keighley)...	212	—	1	4	5
4 (Shipley)...	2,086	1	1	6	8
5 (Horsforth)...	1,848	2	2	4	8
7 (Harrogate)...	3,497	1	2	11	14
9 (Rothwell/Wetherby)...	671	—	—	1	1
10 (Goole)...	1,210	1	2	31	34
11 (Castleford/Pontefract)...	150	—	—	1	1
13 (Morley)...	1,344	1	2	8	11
15 (Spenborough)...	2,666	3	4	6	13
18 (Calder Valley)...	3,738	4	—	25	29
20 (Colne Valley)...	3,101	1	6	13	20
Totals ...	22,058	16	22	116	154

B.—SHEFFIELD UNITS

Survey undertaken in Division No.	Number Examined	Abnormalities Discovered			
		Tuberculosis		* Other	Total
		Active	Inactive		
22 (High Green)...	882	—	—	28	28
29 (Thorne)...	594	—	2	2	4
Totals ...	1,476	—	2	30	32

Totals for the County Area ... 23,534 16 24 146 186

*Details of the 146 " Other " abnormalities are as follows:

	<i>Leeds Region</i>	<i>Sheffield Region</i>
1. Abnormalities of the bony thorax and soft tissues— congenital	1	—
2. Abnormalities of the bony thorax and soft tissues— acquired	1	—
3. Tumours of the bony thorax; primary and secondary	—	3
4. Congenital malformations of the lungs	—	—
5. Bacterial and virus infections of the lungs	15	—
6. Other infections of the lungs	—	—
7. Bronchiectasis	15	1
8. Honeycomb lung	1	—
9. Emphysema	2	4
10. Pulmonary fibrosis—non-tuberculous	20	—
11. Pneumoconiosis	7	5
12. Spontaneous pneumothorax	—	—
13. Benign tumours of lungs and mediastinum	3	—
14. Carcinoma of the lung and mediastinum	11	—
15. Metastases in the lung and mediastinum	1	—
16. Enlarged mediastinal and bronchial glands— non-tuberculous	—	—
17. Sarcoidosis and collagenous disease	4	—
18. Pleural thickening or calcification—non-tuberculous	4	—
19. Abnormalities of diaphragm and œsophagus— congenital and acquired	3	1
20. Congenital abnormalities of heart and vessels	2	—
21. Acquired abnormalities of heart and vessels	14	10
22. Miscellaneous	5	6
23. Pneumoconiosis with tuberculosis	—	—
24. Awaiting classification	7	—
	<hr/> 116	<hr/> 30

Table 27 Venereal and Sexually Transmissible Diseases—New Cases, 1938-72

Year	Syphilis	Gonorrhœa	Other Genital Infections	Other Conditions	Total of New Cases
1938	346	650	Figures not available	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
1971	38	647	2,044	1,759	4,448
1972	44	641	2,271	1,737	4,693

Table 28 Syphilis—Type and Stage of Disease, 1950-72

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
1971	9	26	—	3
1972	9	30	—	5

Table 29 Venereal Diseases etc.—Distribution of New Cases by Treatment Centres

Special Treatment Centre	Syphilis	Gonorrhœa	Other Genital Infections	Other Conditions	Total
Airedale General Hospital	2	39	102	90	233
Barnsley Clinic, Queen's Road	4	33	167	136	340
Bradford St. Luke's Hospital	1	69	238	156	464
Burnley General Hospital	—	5	9	16	30
Dewsbury General Hospital	—	35	110	101	246
Doncaster Royal Infirmary	6	68	445	150	669
Halifax Royal Infirmary... ..	4	29	45	55	133
Harrogate General Hospital	2	29	94	107	232
Huddersfield Royal Infirmary	5	53	77	81	216
Hull, Mill Street Clinic	—	15	—	20	35
Leeds General Infirmary... ..	2	119	379	349	849
Oldham & District General Hospital	—	—	—	3	3
Rotherham Moorgate General Hospital	1	31	203	71	306
Sheffield Royal Infirmary	4	30	82	134	250
Wakefield Clayton Hospital	12	70	280	233	595
York County Hospital	1	16	40	35	92
	44	641	2,271	1,737	4,693

Table 30 Venereal Diseases etc.—New Cases—Sex Distribution

	Males	Females	Total
Syphilis	29	15	44
Gonorrhœa	404	237	641
Chancroid	—	—	—
Lymphogranuloma Venereum	1	—	1
Granuloma Inguinale	—	—	—
Non-specific genital infection	947	86	1,033
Non-specific genital infection with arthritis	22	—	22
Trichomoniasis	27	205	232
Candidiasis	146	380	526
Scabies	38	12	50
Pubic lice	38	8	46
Herpes simplex	65	6	71
Warts	192	94	286
Molluscum Contagiosum	4	—	4
Other treponemal diseases	1	—	1
Other conditions requiring treatment... ..	380	115	495
Other conditions not requiring treatment	737	504	1,241
	3,031	1,662	4,693

Table 31 Gonorrhœa—New Cases—Age Distribution

Sex	Under 20		20 to 24		25 and over	
Males	60	15%	128	31%	216	54%
Females	74	31%	81	34%	82	34%

Table 32 Venereal Diseases etc.—Contact Tracing

Total number of contacts reported	...	36				
Located and examined	...		29			
Not infected	...			6		
Infected	...			23		
Already under treatment	...				—	
Brought under treatment	...				23	
Syphilis	...					—
Gonorrhœa	...					18
Other conditions	...					5
Located	...		3			
Not examined	...			1		
Transferred to other authority	...			2		
Not located	...		4			
Insufficient information	...			—		
Unable to locate	...			4		

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	
15	3	12	2	10	—	8	2

Table 34 Venereal Diseases etc.—Defaulters

Total number of defaulters	Returned to clinic after visiting	Failed to return	Removed, unable to locate	Transferred	Number of ineffective visits	Number of re-visits
46	24	12	10	—	120	110

Table 35 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
1971	406	241	1.7	: 1
1972	404	237	1.7	: 1

Table 36 Divisional Administration

Div. No.	County Districts	Population (Estimated Mid. 1972)	Acreage	Divisional Medical Officer, Divisional Administrative Officer and Divisional Nursing Officer	Address of Divisional Health Office
1	Barnoldswick U. Earby U. Silsden U. Skipton U. Bowland R. Sedbergh R. Settle R. Skipton R.	9,840 4,820 5,550 12,560 5,120 3,580 13,710 26,240	2,764 3,519 7,101 4,211 83,327 52,674 152,087 146,071	Dr. R. Singh Mr. K. A. Knowles Miss F. Stevenson	9, High Street, Skipton BD23 1AB Tel. Skipton 2438/9
		81,420	451,754		
3	Keighley B.	55,690	23,611	Dr. V. P. McDonagh Mr. A. S. Sanderson (D.N.O. Vacant)	3, Bow Street, Keighley BD21 3PD Tel. Keighley 2244/5
4	Baildon U. Bingley U. Denholme U. Shipley U.	14,760 26,530 2,600 28,550	2,831 11,418 2,536 2,184	Dr. V. P. McDonagh Mr. F. G. Falkingham Miss H. J. Watts	P.O. Box 24, Town Hall, Shipley BD18 3EJ Tel. Shipley 51363
		72,440	18,969		
5	Pudsey B. Aireborough U. Horsforth U. Ilkley U. Otley U. Wharfedale R.	38,290 30,060 19,870 22,160 13,230 7,350	5,323 6,856 2,706 8,610 2,934 39,378	Dr. A. Telford Burn Mr. A. Hartley Miss D. Topley	The Green, Horsforth LS18 5JA Tel. Horsforth 5821
		130,960	65,807		
7	Harrogate B. Ripon City Knaresborough U. Nidderdale R. Ripon and Pateley Bridge R.	64,280 11,870 11,770 17,700 14,170	8,320 1,812 2,494 75,009 124,861	Dr. N. V. Hepple Mr. G. W. N. Graham Miss M. L. Griffin	Municipal Offices, Harrogate HG1 2SG Tel. Harrogate 68954
		119,790	212,496		
9	Garforth U. Rothwell U. Stanley U. Tadcaster R. Wetherby R.	26,210 28,300 21,240 35,190 31,160	4,020 10,698 4,866 72,987 64,424	Dr. E. M. Hargreaves Mr. F. H. Attack Mrs. C. B. Macaulay	12 Crossley St., Wetherby LS22 4RT Tel. Wetherby 2738 AND Oulton Lane, Rothwell LS26 0ED Tel. Leeds 822326/7
		142,100	156,995		

Div. No.	County Districts	Population (Estimated Mid. 1972)	Acreage	Divisional Medical Officer, Divisional Administrative Officer and Divisional Nursing Officer	Address of Divisional Health Office
10	Goole B. Selby U. Goole R. Selby R.	17,920	1,267	Dr. M. J. Lowe Mr. R. Towell Miss C. J. Badcock	6/7, Belgravia, Goole DN14 5BY Tel. Goole 4216 and 2923
		11,580	3,848		
		9,500	36,776		
		10,510	32,909		
		49,510	74,800		
11	Castleford B. Pontefract B. Featherstone U. Knottingley U. Normanton U. Osgoldcross R.	37,980	4,394	Dr. J. F. Fraser Mr. W. Carver Mrs. M. Craig	"Castledene," Pontefract Road, Castleford WF10 4AT Tel. Castle- ford 4201 AND Baghill House, Walkergate, Pontefract WF8 1QW Tel. Pontefract 3291
		31,320	4,865		
		15,340	4,424		
		17,050	2,835		
		17,540	3,067		
		9,320	33,954		
		128,550	53,539		
13	Morley B. Ossett B. Horbury U. Wakefield R.	44,860	9,494	Dr. G. Ireland Mr. A. Wright Mrs. A. Hall	Corporation St., Morley LS27 9EA Tel. Morley 7021/4
		17,690	3,333		
		8,970	1,280		
		24,520	21,344		
		96,040	35,451		
15	Batley B. Spenborough B. Heckmondwike U. Mirfield U.	42,310	4,457	Dr. W. M. Douglas Mr. P. Marshall Mrs. J. Pearson	Health Centre, Greenside, Cleckheaton BD19 5AP Tel. Cleck- heaton 3501/4 AND Market Place, Batley WF17 5DD Tel. Batley 3141
		41,430	8,251		
		9,550	696		
		17,480	3,394		
		110,770	16,798		
18	Brighouse B. Todmorden B. Elland U. Hebden Royd U. Queensbury and Shelf U. Ripponden U. Sowerby Bridge U. Hepton R.	34,640	7,873	Dr. S. H. Brock Mr. H. Marshall Miss C. J. Barker	Lawson Road, Brighouse HD6 1NZ Tel. Brighouse 2515 AND Abraham Ormerod Medical Centre, Todmorden OL14 7BY Tel. Todmor- den 2495
		14,950	12,789		
		17,750	5,946		
		8,710	7,084		
		10,810	2,795		
		4,850	13,289		
		16,170	5,763		
		3,340	21,758		
		111,220	77,297		

Div. No.	County Districts	Population (Estimated Mid. 1972)	Acreage	Divisional Medical Officer, Divisional Administrative Officer and Divisional Nursing Officer	Address of Divisional Health Office
20	Colne Valley U.	21,090	16,054	Dr. J. P. Stuart Mr. G. A. Beatson Mrs. S. North	6/8, St. Peter's Street, Huddersfield HD1 1DH Tel. Huddersfield 29526/8
	Denby Dale U.	11,500	10,165		
	Holmfirth U.	19,500	17,648		
22	Kirkburton U.	19,970	13,847	Dr. F. C. Armstrong Mr. P. Fullwood Miss S. Thwaites	Mortomley Hall, High Green, Sheffield S30 4HR Tel. High Green 292
	Meltham U.	6,740	5,906		
	Saddleworth U.	21,260	18,485		
		100,060	82,105		
	Hoyland Nether U.	15,760	1,998		
	Penistone U.	8,260	5,593		
	Stocksbridge U.	13,560	4,630		
23	Penistone R.	7,530	29,002	Dr. J. S. Walters Mr. G. Ellis Miss D. Marsh	Adiscombe House, Barnsley Road, Hemsworth WF9 4NU Tel. Hemsworth 610377/8
	Wortley R.	41,650	48,130		
		86,760	89,353		
	Hemsworth U.	14,800	4,163		
	Hemsworth R.	51,480	29,019		
25		66,280	33,182	Dr. C. G. Oddy Mr. L. S. Wrigg Miss M. E. Pilling	33 Queen's Road Barnsley S71 1AW Tel. Barnsley 2247/8
	Cudworth U.	8,720	1,746		
	Darfield U.	7,840	2,018		
	Darton U.	15,530	4,717		
	Dodworth U.	4,540	1,857		
	Royston U.	8,880	1,423		
	Wombwell U.	18,000	3,838		
	Worsbrough U.	15,340	3,420		
26		78,850	19,019	Dr. D. J. Cusiter Mr. P. Goddard Miss V. Dunford	Dunford House, Wath upon Dearne S63 7DW Tel. Rotherham 872251/2
	Conisbrough U.	16,670	1,593		
	Dearne U.	25,040	3,888		
	Mexborough U.	15,910	1,452		
	Rawmarsh U.	19,860	2,600		
	Swinton U.	15,360	1,718		
	Wath upon Dearne U.	14,950	2,677		
27		107,790	13,928	Dr. R. Stalker Mr. E. K. New Miss D. M. E. Goldthorpe	Arndale Centre, Doncaster DN1 1PH Tel. Doncaster 61571
	Adwick le Street U.	17,870	3,605		
	Bentley with Arksey U.	22,500	4,950		
	Tickhill U.	3,460	5,580		
	Doncaster R.	82,530	75,093		
		126,360	89,228		

Div. No.	County Districts	Population (Estimated Mid. 1972)	Acreage	Divisional Medical Officer, Divisional Administrative Officer and Divisional Nursing Officer	Address of Divisional Health Office
29	Thorne R.	39,980	38,419	Dr. G. Higgins Mr. J. T. Howitt Miss C. J. Badcock	Council Offices, P.O. Box 4, Thorne DN8 5LF Tel. Thorne 3130
31	Maltby U. Kiveton Park R. Rotherham R.	13,980 27,550 68,730	4,788 20,070 28,856	Dr. D. J. Cusiter Mr. A. Hill Mrs. A. Brooks	"Edenthorpe," Grove Road, Rotherham S60 2ER Tel. Rotherham 3131/2
		110 260	53,714		

Table 37 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	1,257	317
Subsequent Visits	914	782
Additional Courses of Treatment commenced ...	101	16
Number of Fillings	1,363	698
Teeth Filled	1,253	644
Teeth Extracted	1,597	661
General Anæsthetics	660	116
Emergencies	278	39
Patients X-Rayed	7	25
Prophylaxis	144	128
Teeth otherwise conserved	119	—
Teeth Root Filled	—	4
Inlays	—	1
Crowns	—	4
Courses of Treatment completed	1,301	226

Prosthetics

Patients supplied with F.U. or F.L. (First Time)
 Patients supplied with Other Dentures
 Number of Dentures supplied

51
 72
 169

Anæsthetics

General Anæsthetics administered by Dental Officers

766

Inspections

Number of First Inspections
 Number in A. and D. requiring treatment
 Number in B. and E. offered treatment

	Children 0—4 (incl.)	Expectant and Nursing Mothers
A.	1,828	D. 296
B.	1,257	E. 282
C.	1,257	F. 282

Sessions

Number of sessions devoted to M. & C.W. patients

For Treatment
 For Health Education

478
 6

Table 38 Antenatal Relaxation Classes

No. of sessions:								
(a)	separate	...	...	...	...	...	...	4,533
(b)	combined with antenatal clinics	...	...	...	...	...	...	49
Total								4,582
No. of women attending:								
(a)	hospital booked	...	...	...	...	...	...	5,397
(b)	domiciliary booked	...	...	...	...	...	...	538
Total								5,935
Total number of attendances:								
(a)	hospital booked	...	...	...	...	...	...	26,356
(b)	domiciliary booked	...	...	...	...	...	...	2,433
Total								28,789

Table 39 Ortolani Testing for Congenital Dislocation of the Hip—Summary of tests carried out, 1965-72

	1965	1966	1967	1968	1969	1970	1971	1972
(a) Cases referred to specialist, confirmed as congenital dislocation of the hip and splinted	17	52	69	64	62	89	142	120
No. included in (a) referred by staff employed by the Authority	9	27	31	27	21	31	79	74
(b) Cases referred to specialist and said not to be congenital dislocation of the hip ...	31	62	43	78	61	108	237	172
(c) Cases referred to specialist, not splinted but given further review appointments	13	24	18	35	45	62	173	143

Table 40 Premature Babies

Total adjusted live births—27,925

Number of live premature births—1,793

Percentage of premature live births to total live births—6.4

Number born dead—209

Weight Group	Number of Premature Births					Number Dying																			Number Surviving over 28 days					Percentage Survival 1972	Percentage Survival in previous years				
	Born Alive					First Week								Second Week								over 28 days													
	A	B1	B2	C	Total	Both								Over 14 up to 28 days								A	B1	B2	C	Total									
						1	2	3	4	5	6	7	8	9	10	11	12	13	14																
5—5½	40	6	217	507	770	22	3	2	—	2	—	1	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	97.6	97.1	97.8	97.1	96.7
4½—5	13	1	146	259	419	22	14	3	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	95.8	94.7	95.5	95.8	94.7	
4—4½	3	—	63	144	210	20	8	7	1	3	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	89.5	91.4	93.4	92.0	89.7	
3½—4	3	—	37	88	128	31	12	1	4	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	81.9	73.5	81.9	81.6	84.1	
3—3½	5	—	24	80	109	37	21	8	2	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	76.0	66.1	72.3	57.3	72.4	
2½—3	2	—	18	34	54	26	14	5	—	3	1	2	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	60.0	46.3	54.2	38.9	57.1	
2—2½	5	—	16	29	50	27	23	6	2	1	2	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	20.5	23.4	28.8	20.7	24.1	
1½—2	1	—	7	33	41	16	32	4	2	1	—	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	3.0	—	8.8	3.2	—	
1½ and under	2	—	—	10	12	8	9	1	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	5.9	
Total	74	7	528	1184	1793	209	136	37	13	10	5	3	2	3	1	2	1	1	—	—	—	—	—	—	—	—	—	—	—	88.6	86.3	88.9	86.6	87.8	

206

8

218

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 41 Distribution of Welfare Foods

Year	National Dried Milk (Packets)	Cod Liver Oil (Bottles)	Vitamin A & D Tablets (Packets)	Orange Juice (Bottles)	Vitamin A, D & C Drops (Bottles)	Vitamin A, D & C Tablets (Packets)
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	—	—
1971	38,783	16,351	19,814	536,351	34,576†	—
1972	46,171	1,113*	3,866*	73,057*	148,179†	11,554‡

* Provision now discontinued.

† New provision from 4th April, 1971.

‡ New provision from 1st January, 1972, to expectant and nursing mothers.

Table 42 Midwifery—Hospital and Domiciliary Confinements

Divi- sion No.	Area	Population (Estimated mid-1972)	Total noti- fied births (Live and Still)	Place of Birth					
				Hospital				Domici- liary	
				No.	No. of Early Discharges			No.	%
					At 48 hours	After 48 hours up to and includ- ing 7th day	After 8 or more days		
1	Skipton ...	81,420	1,035	1,015	16	562	248	20	2
3	Keighley ...	55,690	853	836	17	530	118	17	2
4	Shipley ...	72,440	1,038	994	152	298	295	44	4
5	Horsforth ...	130,960	1,810	1,741	199	629	587	69	4
7	Harrogate ...	119,790	1,559	1,542	288	714	369	17	1
9	Rothwell/Wetherby	142,100	2,265	1,787	503	594	347	478	21
10	Goole ...	49,510	723	613	85	163	79	110	15
11	Castleford/ Pontefrac	128,550	2,020	1,691	219	590	157	329	16
13	Morley ...	96,040	1,592	1,295	345	366	283	297	19
15	Spenborough ...	110,770	1,954	1,853	228	480	386	101	5
18	Calder Valley ...	111,220	1,694	1,394	135	258	54	300	18
20	Colne Valley ...	100,060	1,489	1,363	50	211	95	126	8
22	Wortley ...	86,760	1,449	1,369	282	629	253	80	5
23	Hemsworth ...	66,280	1,088	886	74	540	159	202	18
25	Barnsley ...	78,850	1,165	975	21	445	302	190	16
26	Wath ...	107,790	1,717	1,534	8	985	144	183	11
27	Doncaster ...	126,360	2,230	2,121	88	911	110	109	5
29	Thorne ...	39,980	687	618	48	258	32	69	10
31	Rotherham ...	110,260	1,965	1,802	602	723	218	163	8
Leeds Hospital Board Region ...		1,264,830	19,120	17,010	2,311	5,935	3,177	2,110	11
Sheffield Hospital Board Region ...		550,000	9,213	8,419	1,049	3,951	1,059	794	9
West Riding Administrative County		1,814,830	28,333	25,429	3,360	9,886	4,236	2,904	10

Table 43 Domiciliary Midwifery—Analgesia

Div. No.	Area	Percentage receiving Analgesia			
		Pethi- dine alone	Tri- lene alone	Tri- lene with Pethi- dine	Total
1	Skipton	7	7	73	87
3	Keighley	6	—	53	59
4	Shipley	25	12	51	88
5	Horsforth	14	34	25	73
7	Harrogate	13	27	40	80
9	Rothwell/Wetherby	23	31	25	79
10	Goole	16	24	38	78
11	Castleford/Pontefract	17	20	34	71
13	Morley	12	27	38	77
15	Spenborough	5	24	49	78
18	Calder Valley	21	23	32	76
20	Colne Valley	10	24	52	86
22	Wortley	46	13	22	81
23	Hemsworth	26	28	27	81
25	Barnsley	22	24	24	70
26	Wath	21	21	26	68
27	Doncaster	20	21	45	86
29	Thorne	26	3	64	93
31	Rotherham	34	15	25	74
Leeds Hospital Board Region		18	25	34	77
Sheffield Hospital Board Region		27	18	31	76
West Riding Administrative County		20	24	33	77

Table 44 Health Visiting

Type of Case or Household	Number visited	Number visited at special request of	
		Hospital	General Practitioner
Children born in 1972	27,395	172	398
Other children under 5 years of age	86,593	339	1,529
Persons aged between 5 and 16	6,380	308	1,072
Persons aged between 17 and 64	10,681	1,127	2,780
Persons aged 65 and over	35,103	3,095	7,217
No. of cases included in above who are mentally handicapped	734	27	88
No. of cases included in above who are mentally ill	405	21	154
Households visited on account of tuberculosis	1,482	304	120
Households visited on account of other infectious diseases	1,609	78	713
Households visited for any other reason	1,596	55	247

Health visitors attended 4,969 case conferences lasting more than half-an-hour.

Conferences with social workers	477
Conferences with hospital staff	944
Conferences with general practitioners	2,381
Conferences with any combination of above	234
Conferences with other agencies	933

Health visitors also spent a total of 41,691 hours in schools and made 10,182 home visits in connection with school health activities.

Table 45 Home Nursing—Total Cases Visited

Number of persons treated during year	Place where first treatment during year		
	Under 5	5-64	65 and over
1,695	1,695	1,695	1,695
350	350	350	350
743	743	743	743
170	170	170	170
3	3	3	3
3	3	3	3
1	1	1	1
2,971	2,971	2,971	2,971
32,104	32,104	32,104	32,104
26,506	26,506	26,506	26,506
61,281	61,281	61,281	61,281

Table 45 Health Visiting—Clinic and Health Education Sessions

Health visitors attended 50,682 clinic sessions. Details are given below of the various clinics:

<i>Type of Clinic</i>								<i>No. of Sessions</i>
Child health (infant welfare)	...	...	...	...	...	...	...	28,371
Screening for infant deafness	...	...	...	...	...	...	...	5,943
Cervical cytology	...	...	...	...	...	...	...	1,705
Vaccination and immunisation	...	...	...	...	...	...	...	4,050
Ultra violet light	...	...	...	...	...	...	...	25
Minor ailments	...	...	...	...	...	...	...	542
Cardiac	...	...	...	...	...	...	...	16
Pædiatric	...	...	...	...	...	...	...	470
Family planning	...	...	...	...	...	...	...	973
Ophthalmic	...	...	...	...	...	...	...	1,684
Orthopaedic	...	...	...	...	...	...	...	66
Ear, nose and throat	...	...	...	...	...	...	...	92
Dermatological	...	...	...	...	...	...	...	35
Diabetic	...	...	...	...	...	...	...	216
Chest	...	...	...	...	...	...	...	347
Geriatric	...	...	...	...	...	...	...	480
Developmental assessments	...	...	...	...	...	...	...	5,373
Others	...	...	...	...	...	...	...	294

Health visitors attended 4,419 health education sessions as indicated below:

Health education sessions held in health centres	...	...	...	...	679
Health education sessions held in general practitioners' surgeries	...	...	...	...	100
Health education sessions held in maternity and child welfare centres	...	...	...	...	1,648
Health education sessions held in schools	...	...	...	...	1,605
Health education sessions held in hospitals	...	...	...	...	95
Health education sessions held elsewhere	...	...	...	...	292

Table 46 Home Nursing—Total Cases Visited

Place where first treatment during year by the home nurse took place	Number of persons treated during year aged			
	Under 5	5—64	65 and over	Total
Patient's home	1,695	15,622	23,032	40,349
Health centres	356	3,885	653	4,894
General practitioners' premises (excluding those in health centres)	743	10,420	1,821	12,984
Maternity and child health centres	170	2,049	459	2,678
Hospital	3	52	22	77
Residential homes	3	31	418	452
Elsewhere	1	45	101	147
Totals	2,971	32,104	26,506	61,581

Table 47 Home Nursing—Completed Cases

Classification of Cases by Disease:										No. of Cases
Disease										
Tuberculosis	...	...	...	...	...	...	...	...	...	129
Other infectious diseases	...	...	...	...	...	...	...	...	...	555
Parasitic diseases	...	...	...	...	...	...	...	...	...	123
Malignant and lymphatic neoplasms	...	...	...	...	...	...	...	...	...	2,267
Asthma	...	...	...	...	...	...	...	...	...	200
Diabetes mellitus	...	...	...	...	...	...	...	...	...	579
Anæmias	...	...	...	...	...	...	...	...	...	1,893
Vascular lesions affecting central nervous system	...	...	...	...	...	...	...	...	...	1,739
Other mental and nervous diseases	...	...	...	...	...	...	...	...	...	806
Diseases of the eye...	...	...	...	...	...	...	...	...	...	170
Diseases of the ear	...	...	...	...	...	...	...	...	...	496
Diseases of heart and arteries	...	...	...	...	...	...	...	...	...	1,986
Diseases of veins	...	...	...	...	...	...	...	...	...	1,201
Upper respiratory diseases	...	...	...	...	...	...	...	...	...	968
Other respiratory diseases...	...	...	...	...	...	...	...	...	...	2,468
Constipation	...	...	...	...	...	...	...	...	...	1,340
Other diseases of digestive system	...	...	...	...	...	...	...	...	...	3,010
Diseases of urinary system and male genital organs	...	...	...	...	...	...	...	...	...	1,099
Diseases of breast and female genital organs	...	...	...	...	...	...	...	...	...	812
Complications of pregnancy and puerperium	...	...	...	...	...	...	...	...	...	755
Diseases of skin and subcutaneous tissues	...	...	...	...	...	...	...	...	...	1,718
Diseases of bones, joints and muscles	...	...	...	...	...	...	...	...	...	1,346
Injuries	...	...	...	...	...	...	...	...	...	2,663
Senility	...	...	...	...	...	...	...	...	...	1,146
Other defined and ill-defined diseases or disabilities	...	...	...	...	...	...	...	...	...	2,247
Diseases not specified	...	...	...	...	...	...	...	...	...	505
Total ...										32,221
Nursing Treatment:										
Type										
Injections	...	...	...	...	...	...	...	...	...	6,154
General Nursing	...	...	...	...	...	...	...	...	...	7,389
Enemas	...	...	...	...	...	...	...	...	...	1,391
Dressings	...	...	...	...	...	...	...	...	...	9,810
Bed baths	...	...	...	...	...	...	...	...	...	1,061
Wash-outs, douches, etc.	...	...	...	...	...	...	...	...	...	441
Changing of pessaries	...	...	...	...	...	...	...	...	...	84
Preparation for diagnostic investigation...	...	...	...	...	...	...	...	...	...	616
Others	...	...	...	...	...	...	...	...	...	5,275
Total ...										32,221

The total number of cases receiving injections was 6,960 but, in some cases, the injections were given during the course of a general nursing visit.

Injections:										No. of Cases
Type										
Insulin	...	...	...	...	...	...	...	...	...	275
Drugs for anæmia, debility, etc.	...	...	...	...	...	...	...	...	...	2,609
Antibiotics	...	...	...	...	...	...	...	...	...	1,970
Drugs for cardio-renal diseases	...	...	...	...	...	...	...	...	...	230
Others	...	...	...	...	...	...	...	...	...	1,876
Total										6,960
<hr/>										
Referral of Cases:										
Source										
General practitioners	...	...	...	...	...	...	...	...	...	25,358
Hospitals	...	...	...	...	...	...	...	...	...	5,339
Health department staff	...	...	...	...	...	...	...	...	...	1,024
Others	...	...	...	...	...	...	...	...	...	500
Total										32,221
<hr/>										
Disposal of Cases:										
Convalescent	.....	...	...	...	...	...	...	...	...	18,011
Transferred to hospital	...	...	...	...	...	...	...	...	...	5,129
Died	...	...	...	...	...	...	...	...	...	3,799
Others	...	...	...	...	...	...	...	...	...	5,282
Total										32,221

Table 48 Ambulance Service

	1972		1971		Variation 1972 to 1971	
	Patients	Miles	Patients	Miles	Patients	Miles
Direct Service ...	776,433	4,841,094	753,594	4,614,638	+ 22,839	+ 226,456
Agencies ...	33,266	284,294	39,925	335,581	— 6,659	— 51,287
Hospital Car Service ...	13,995	371,146	11,652	333,133	+ 2,343	+ 38,013
Total ...	823,694	5,496,534	805,171	5,283,352	+ 18,523	+ 213,182

Table 49 Ambulance Service—Accidents Attended

Type of Accident	Number of Accidents	Number of Patients
Road ...	4,687	6,819
Street ...	1,669	1,700
Works ...	1,317	1,337
Home ...	5,944	5,992
School ...	582	591
Sport ...	558	564
Drowning ...	13	17
Miscellaneous ...	105	107

Table 50 Ambulance Service—Training given to other County Departments and Outside Organisations, 1972

Organisation	Subject and Number of Sessions				Number Attending	Hours	
	Essential First Aid	Full First Aid	Emergency Resuscitation	Visits to Ambulance Stations		In Working Time	Outside Working Time
Schools	2	25	18	15	2,015	120	—
Teacher Training	3	—	4	—	207	10	—
Colleges	—	28	—	—	12	22½	—
Further Education	17	—	10	3	579	42½	11
Establishments	4	10	—	—	50	14	20
Other County	—	—	—	—	—	—	—
Departments	—	—	—	21	501	49	2
Other Local	19	—	17	20	1,463	29½	93
Authorities	—	—	—	—	—	—	—
Hospital Staff	—	—	—	—	—	—	—
Other Organisations	—	—	—	—	—	—	—
Total	45	63	49	59	4,827	287½	126

Table 51 Health Education**SUMMARY OF ACTIVITIES**

Subject	Estimated Audience			
	Clinics	Schools	*Other	Total
Ante and Post Natal, Childbirth ...	9,102	3,189	797	13,088
Child Development	7,864	5,317	358	13,539
Personal and Dental Hygiene	5,610	15,108	214	20,932
Personal Relationships including V.D....	1,337	12,305	2,661	16,303
Accident Prevention	5,324	5,805	2,696	13,825
Vaccination and Immunisation... ..	298	618	30	946
Nutrition, Food, Hygiene, General Health	6,966	10,880	1,585	19,431
Cancer Education	1,487	6,871	1,068	9,426
Family Planning	646	566	281	1,493
Local Health Services	415	1,234	2,552	4,201
Aged	—	—	84	84
First Aid and Home Nursing	—	1,690	444	2,134
Totals ...	39,049	63,583	12,770	115,402

*Includes Mothers' Clubs, Women's Institutes, Guides, Scouts, Youth Clubs, St. John Cadets, Darby and Joan Clubs, etc.

SUMMARY OF EXHIBITIONS

Exhibit	Number of venues	Number of days on display
Puppet Exhibition No. 1 (indoor activities)	22	258
*Puppet Exhibition No. 2 (outdoor activities)	16	180
Medicines Display	5	110
Smoking and Lung Cancer Display	17	210
Nursing Stands	7	149
Factors Affecting the Unborn Child	7	149
Other Displays	103	413

*Introduced on 5th May, 1972.

Table 52 Provision of Nursing Equipment in the Home

Item	Total No. available for loan	No. of issues during year
Bath seats ...	55	62
Bedding: blankets, pillows and cases, sheets, etc. ...	1,094	687
Bed blocks ...	126	62
Bed cradles ...	935	1,451
Bed pans ...	2,447	3,753
Bed rests ...	1,189	2,003
Bed tables ...	18	17
Bedsteads: hospital, with self-lifting pole, and other ...	383	579
Chairs: geriatric, relaxing, high rest, 'Amesbury' play, stairway (carrying), etc. ...	107	136
Commodore: chair and other ...	1,454	3,058
Cushions: air and 'Dunlopillo' ...	736	1,141
Enuresis alarms ...	497	1,572
Fracture boards ...	212	253
Hydraulic hoists ...	74	97
Lifting pole and chain ...	94	137
Mattresses: various types ...	485	696
Sleepskins ...	179	283
Rubber/Plastic sheets ...	2,250	2,519
Tables: 'Amesbury' play ...	1	1
Walking aids: 'Amesbury', 'Bonaped', 'Zimmer', tripod, 'Companion', 'Fordham', 'Mycroft', 'Welwyn', 'Winchester', etc., crutches and walking sticks ...	2,887	4,255
Wheelchairs: bath, folding, junior, self-propelled, spinal, stairway, etc. ...	802	1,938
Miscellaneous ...	117	151

Table 53 Chiropody Treatment

	Voluntary Association Schemes	Direct Service by County Council	Total
<i>Number of sessions held:</i>			
In voluntary association premises	2,971	—	2,971
In clinic premises	—	13,608	13,608
	2,971	13,608	16,579
<i>Number of patients treated:</i>			
In chiropodists' surgeries:			
Pensioners	1,938	9,062	11,000
Physically handicapped	31	99	130
Expectant mothers	—	6	6
In voluntary association or clinic premises:			
Pensioners	6,356	25,407	31,763
Physically handicapped	98	537	635
Expectant mothers	1	13	14
Domiciliary treatment:			
Pensioners	2,554	15,999	18,553
Physically handicapped	99	708	807
Expectant mothers	—	—	—
Total number of patients treated	11,077	51,831	62,908
<i>Total number of treatments given:</i>			
Pensioners	44,595	230,410	275,005
Physically handicapped	829	5,698	6,527
Expectant mothers	4	31	35
	45,428	236,139	281,567
Number of patients treated per session	8.9	8.5	8.6
Percentage of total patients treated receiving domiciliary treatment	24.0	31.2	30.8
Percentage of aged population receiving treatment (men over 65 years and women over 60 years)	4.0	18.5	22.5

Table 54 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
3,093	593	1,882	2,370	398

Table 55 Milk (Special Designation) Regulations, 1963 and Milk (Special Designation) (Amendment) Regulations, 1965—Details of Samples obtained from Dealers in the County Area

Untreated			Pasteurised						Sterilised		Ultra Heat Treated	
Methylene Blue Test			Phosphatase Test		Methylene Blue Test			Turbidity Test		Colony Count		
Satisfactory	Unsatisfactory	Void	Satisfactory	Unsatisfactory	Satisfactory	Unsatisfactory	Void	Satisfactory	Unsatisfactory	Satisfactory	Unsatisfactory	
1,963	162	68	1,696	4	1,600	54	46	24	—	120	—	

Table 56 Milk (Special Designation) Regulations, 1963 as amended—Licensed Establishments for Pasteurising and Ultra Heat Treatment of Milk.

PASTEURISED MILK:

Barber, H., Crossley Farm, Crossley Lane, Mirfield.
 Brook, W. H. & Sons, Wheatley Hill Farm, Clayton West.
 Chappell, R. M., Nether End Farm, Denby Dale.
 Co-operative Retail Services Ltd., Doncaster Branch, York Road, Doncaster.
 Co-operative Retail Services Ltd., Goole Branch, Centenary Road, Goole.
 Crawshaw, J., Blake Lea Dairy, 103, Arksey Lane, Bentley.
 Doxey, C., The Dairy, Nutwell Lane, Armthorpe.
 Mawer, C., Glentworth House, Skellow.
 Platts, N. H. & Sons, Home Farm, Bretton.
 Rotherham Dairies Ltd., Progress Drive, Bramley.
 Salmon, P., Ashbrooke, Littlethorpe, Ripon.
 Snowden, F., Lumb Mill Farm, Crosshills.

ULTRA HEAT TREATED MILK:

Settle Creamery Ltd., New Road, Settle.

Table 57 Milk (Special Designation) Regulations, 1963 as amended—Details of Samples obtained from Licensed Processing Plants

Pasteurised					Ultra Heat Treated	
Phosphatase Test		Methylene Blue Test			Colony Count	
Satisfactory	Unsatisfactory	Satisfactory	Unsatisfactory	Void	Satisfactory	Unsatisfactory
512	7	489	14	16	84	—

Table 58 Details of County Premises with Private Supplies of Water

Premises	Source of Supply
Addingham, Farfield Hall	Reservoir—filtered and chlorinated
Aldfield C.E. School, Aldfield, near Ripon	Untreated trunk main—filtered
Arncliffe School, Arncliffe, Skipton	Land spring—filtered
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—filtered
Colne Valley Wilberlee J.M.I. School, Slaithwaite	Land spring—filtered
Cracoe Rylstone District J.M.I. School, Cracoe, Skipton	Land spring—filtered
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—filtered
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 59 Details of Applications for Grants under the Rural Water Supplies and Sewerage Acts, 1944-71

County District or Other Body	Description of Scheme	Date of Application	Estimated Cost of Scheme £
Bingley U.D.	Sunnymount, Haworth Road,	28th March	1,850
Brighouse M.B.	Cullingworth, Water Supply		
Calderdale Water Board	Brookfoot Lane and Church Lane,	5th October	75,832
	Southowram, Sewerage		
ditto	Higham, Dob and Steep Lane	5th January	19,833
ditto	Areas, Sowerby Bridge, Water Supply		
ditto	Blackshaw Head, Water Supply.	16th February	3,300
ditto	Extension of Previous Scheme		
ditto	Stoodley, Todmorden, Water Supply	15th May	3,539
Colne Valley U.D.	Higher Crimsworth, Hepton, Water Supply	19th September	648
ditto	Reddisher Road and Waters Road,	22nd February	3,147
Doncaster R.D.	Marsden, Water Supply		
	Upper Slaithwaite, Water Supply	5th May	55,000
	Adwick on Dearne, Sewerage, and	17th March	87,205
	Cadeby, Sewerage and Sewage Disposal		
ditto	Old Edlington, Sewerage	14th August	42,000
Elland U.D.	Black Brook Valley, Sewerage	28th August	187,300
Fylde Water Board	Colthurst Estate, Waddington, Water Supply	12th June	2,442
Hepton R.D.	Jack Bridge, Sewerage	15th November	22,800
Holmfirth U.D.	Cartworth Fold, Holmfirth, Water Supply	14th February	826
ditto	Cartworth Fold, Damhouse and Rotcher, Water Supply	10th March	5,407
Kirkburton U.D.	Moor Top, Kirkheaton, Sewerage	21st September	2,956
	Carr Mount, Kirkheaton, Sewerage	ditto	6,472
	Square Fold, Lepton, Sewerage	ditto	4,561
	Long Close, Shepley, Sewerage	ditto	3,207
Lakes and Lune Water Board	Hallbank to Branthwaite, Sedbergh, Water Supply	1st August	9,660
Ripon and Pateley Bridge R.D.	High Grantley, Sewerage	26th October	41,100
Ripponden U.D.	Krumlin, Sewerage	3rd July	86,000
Sedbergh R.D.	Dent, Sewage Disposal	31st October	25,000
Selby R.D.	Cawood and Wistow, Sewerage and Sewage Disposal	27th October	374,000
Skipton R.D.	Beamsley, Bolton Abbey and Hazelwood with Storiths, Sewerage and Sewage Disposal	12th December	65,800
ditto	Broughton, Sewerage and Sewage Disposal	12th December	44,645
Tadcaster R.D.	Sherburn in Elmet and South Milford, Sewerage	3rd March	9,203
Tickhill U.D.	Castle Gate, Sewerage	7th September	43,580

Table 60 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	Diatoma- ceous Earth	Automatic Chlorinator	—
Aston Lodge C.P.	10,500	Learner	Diatoma- ceous Earth	Automatic Chlorinator	Pool in planning stage
Bardsey Primary	870	Constructed	Diatoma- ceous Earth	Automatic Chlorinator	—
Bewerley Park Centre for Outdoor Pursuits	12,000	Constructed	Diatoma- ceous Earth	Automatic Chlorinator	—
Bingley Grammar	46,400	Conventional	Diatoma- ceous Earth	Automatic Chlorinator	—
Bishopthorpe C.E.	12,000	Constructed	Sand	Automatic Chlorinator	—
Boroughbridge C.P.	6,000	Learner	Diatoma- ceous Earth	Drip Feed	—
Bridge House Special School, Harewood	4,000	Learner	Diatoma- ceous Earth	Automatic Chlorinator	—
Brighouse Woodhouse Junior	8,800	Learner	Diatoma- ceous Earth	Automatic Chlorinator	—
Collingham C.E.	10,000	Learner	Diatoma- ceous Earth	Automatic Chlorinator	—
Copmanthorpe J.M.	8,000	Learner	Sand	Automatic Chlorinator	—
Darton Barugh J.M.I.	6,000	Learner	Diatoma- ceous Earth	Automatic Chlorinator	—
Darton Kexbrough	6,000	Learner	Diatoma- ceous Earth	Automatic Chlorinator	—

School	Pool		Filtration	Chlorination	Remarks
	Capacity in gallons	Type			
Dinnington High	90,000	Conventional	Sand	Automatic Chlorinator	Pool opened 1972
Ermysted's Grammar Skipton	29,000	Conventional	Sand	Chlorine Gas	—
Featherstone R.C.	46,000	Conventional	Sand	Chlorine Gas	—
Garforth Ninelands	8,000	Learner	Sand	Automatic Chlorinator	—
Goole Riverside E.S.N.	8,000	Learner	Sand	Automatic Chlorinator	—
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	—
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 Two Dales School and Adult Training Centre	5,400	Constructed	Sand	Automatic Chlorinator	—

School	Pool		Filtration	Chlorination	Remarks
	Capacity in gallons	Type			
Hoyland Common J.M.I.	6,000	Learner	Diatomaceous Earth	Automatic Chlorinator	—
Ilkley Grammar	35,000	Conventional	Sand	Chlorine Gas	—
Ilkley Menston Primary	25,000	Constructed	Sand	Drip Feed	—
Ingleton C.P.	11,500	Learner	Sand	Automatic Chlorinator	Pool in planning stage
Keighley Oakbank Grammar	60,500	Conventional	Diatomaceous Earth	Chlorine Gas	—
Kippax North	8,000	Learner	Sand	Automatic Chlorinator	—
Kirkburton Turnshaws School and Adult Training Centre	7,000	Conventional	Sand	Automatic Chlorinator	Pool opened 1972
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	—
Ossett Comprehensive	59,000	Constructed	Sand	Automatic Chlorinator	Pool opened 1972
Otley Prince Henry's Grammar	75,000	Constructed	Sand	Automatic Chlorinator	Pool in planning stage
Penistone St. John's C. E.	8,000	Learner	Canvas Bags	Drip Feed	Pool not used

School	Pool		Filtration	Chlorination	Remarks
	Capacity in gallons	Type			
Rawcliffe Tall Trees School and Adult 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	—
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 High	24,000	Conventional	Sand	Chlorine Gas	Pool in planning stage
Sherburn in Elmet	8,000	Learner	Sand	Drip Feed	—
Sprotbrough The Anchorage	—	Learner	—	Automatic Chlorinator	Pool in planning stage
Stourton C.P.	8,000	Learner	Sand	Automatic Chlorinator	—
Swillington J.M.	8,000	Learner	Sand	Automatic Chlorinator	—
Tadcaster J.M.	8,000	Learner	Sand	Automatic Chlorinator	—
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	—

School	Pool		Filtration	Chlorination	Remarks
	Capacity in gallons	Type			
Todwick J.M.	8,000	Learner	Sand	Automatic Chlorinator	—
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	—
Upton - North Elmsall J.M.I.	21,000	Learner	Diatomaceous Earth	Automatic Chlorinator	—
Wales C.P.	8,000	Learner	Sand	Automatic Chlorinator	Pool opened 1972
Ward Green J.M.I., Worsbrough	12,000	Learner	Diatomaceous Earth	Automatic Chlorinator	—
West Ardsley Redwood Croft School and Adult Training Centre	9,000	Constructed	Sand	Automatic Chlorinator	—
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	—
Worsbrough Bank End	8,000	Learner	Sand	Automatic Chlorinator	—
Worsbrough Birdwell C.P.	13,000	Constructed	Diatomaceous Earth	Automatic Chlorinator	—

Table 61 Atmospheric Pollution

Situation of Instrument	Smoke			Volumetric SO ₂		
	Average Daily Suspended Impurity*	Highest Value	Lowest Value	Average Daily Concentration SO ₂ *	Highest Value	Lowest Value
	Microgrammes per cubic metre			Microgrammes per cubic metre		
Barnoldswick—Health Department, Fernlea, surrounding district residential and commercial with railway nearby	56 for 10 months	259	8	78 for 10 months	425	7
Keighley—First floor of Public Health Department in built-up area in centre of town	57	366	9	104	1,138	Alk.
Keighley—Branshaw View, 20ft. above ground in classroom on south-west side of building, $\frac{1}{4}$ mile south-west of town centre. Surrounding district residential	35	210	3	74	366	16
Bingley—Health Department, Town Hall, $\frac{1}{5}$ th mile outside town centre, surrounding district parkland	37 for 9 months	297	3	56 for 9 months	286	0
Shipley—Health Department, Town Hall, surrounding district residential and commercial	41	232	5	95	516	20
Horsforth—Broadway, in residential area, most properties to the south in Smoke Control Areas	31	204	1	86	554	12
Otley—First floor of Council Offices, in town centre, mainly manufacturing	29 for 3 months	156	4			
Harrogate—Ground floor of Municipal Offices, surrounding district residential and commercial	45 for 11 months	222	3	68 for 11 months	519	Alk.

*For period of full year unless stated otherwise.

Situation of Instrument	Smoke			Volumetric SO ₂		
	Average Daily Suspended Impurity*	High-est Value	Low-est Value	Average Daily Concentration SO ₂ *	High-est Value	Low-est Value
	Microgrammes per cubic metre			Microgrammes per cubic metre		
Harrogate — Ground floor of Regional Office, Milk Marketing Board, surrounding district residential and manufacturing	62 for 11 months	248	10	69 for 11 months	365	Alk.
Knaresborough—Knaresborough House, in parkland surrounded by mixed residential and commercial properties, open country to west	74 for 4 months	200	7	60 for 4 months	261	10
Knaresborough—Castle School, in a mainly residential area	74 for 1 month	131	27	102 for 1 month	238	41
Goole—Health Department, Municipal Offices, Stanhope Street, surrounding area commercial, residential and shipping	65	218	8	65	556	12
Selby—Council Depot in residential and commercial area	54 for 11 months	249	6	70 for 11 months	333	13
Castleford—First floor of Divisional Health Office, in residential area of industrial town	122 for 8 months	535	8	174 for 11 months	273	101
Castleford—The Green, Ferry Fryston—situated 12ft. above ground on E. side of the Pavilion, surrounding district residential with open country to E.	117	461	7	154	397	35
Castleford — Slaughterhouse in Superintendent's office, 20ft. above ground, surrounding district, residential and commercial	44 for 11 months	284	3	93	270	12
Normanton—Neville House. Surrounding district commercial, residential and a few small factories	87 for 11 months	339	8	145 for 11 motnhs	524	24

*For period of full year unless stated otherwise.

Situation of Instrument	Smoke			Volumetric SO ₂		
	Average Daily Suspended Impurity*	Highest Value	Lowest Value	Average Daily Concentration SO ₂ *	Highest Value	Lowest Value
	Microgrammes per cubic metre			Microgrammes per cubic metre		
Pontefract—Municipal Offices. In laboratory on second floor in mixed commercial and manufacturing area	83	546	6	142	435	8
Pontefract—Moverley Flatts. In rear storeroom of Council Depot, surrounding district residential	119	459	18	141	344	38
Pontefract—Carleton Park. First floor landing of flats in residential area	70	358	9	113	286	20
Horbury—Ground floor lobby of Town Hall, facing east 12ft. above ground, surrounding district residential and manufacturing	53 for 8 months	263	3	114 for 8 months	452	19
Morley—Public Health Inspector's Department, Commercial Street, surrounding district residential, commercial and manufacturing	55	346	7	95	357	20
Morley—Spring Avenue, Gildersome in residential area	45 for 11 months	398	6	81 for 11 months	333	24
Ossett—Seemore Arcade. Surrounding district residential and commercial	49	432	4	123	579	23
Batley—Public Health Department, Market Place, in centre of mixed residential, commercial and manufacturing district	85	333	8			
Spenborough—Health Centre, Greenside, in small park, residential and commercial area	59 for 11 months	284	9	126 for 11 months	615	14

*For period of full year unless stated otherwise.

Situation of Instrument	Smoke			Volumetric SO ₂		
	Average Daily Suspended Impurity*	Highest Value	Lowest Value	Average Daily Concentration SO ₂ *	Highest Value	Lowest Value
	Microgrammes per cubic metre			Microgrammes per cubic metre		
Elland—Council Offices, 20ft. above ground in manufacturing area	49	263	5	83	545	4
Hebden Royd (Mytholmroyd)—Redacre Sewage Works, residential and manufacturing area, open country to north	33	209	1	61	391	6
Hebden Royd (Hebden Bridge)—On second floor landing of Council Offices, in centre of mixed residential, commercial and manufacturing district	58	309	6	109	768	11
Sowerby Bridge—Crow Wood Park, in parkland in residential area	35	229	2	76	570	Alk.
Sowerby Bridge—Council Offices, Luddendenfoot, Situated on main road carrying heavy traffic, in a mainly commercial area	45	234	3	91	395	Alk.
Todmorden—In first floor room on south side of Medical Centre, surrounding district mixed residential, commercial, manufacturing and open country	40 for 11 months	142	4	93 for 11 months	376	12
Colne Valley—Town Hall, Cross Street, Slaithwaite, in mixed residential and textile manufacturing district	62	560	6	99	690	0
Denby Dale—Public Health Inspector's Office, surrounding district mixed residential, manufacturing and open country	83 for 11 months	335	14	81 for 11 months	265	5

*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		
Denby Dale—Emley C.P. School. In village in open country	59 for 9 months	329	2	74 for 9 months	234	22
Holmfirth—On second floor landing of Council Offices, surrounding district open country, residential, commercial and manufacturing	86	495	18	106	487	26
Kirkburton—Town Hall in mainly residential and manufacturing area	57	283	5	76	357	11
Saddleworth—Sewage Works, Shaw Hall Bank, Greenfield, surrounding district residential, manufacturing and commercial	37	246	3	73	334	3
Wortley (Grenoside)—Health Dept., Council Offices, surrounding area industrial and manufacturing	17 for 4 months	114	1	84 for 4 months	301	Alk.
Wortley (Oughtibridge)—County School, Church Street, surrounding district industrial and manufacturing	22 for 3 months	57	3	59 for 3 months	198	Alk.
Hemsworth—Divisional Health Office, Adiscombe House, in residential area	105 for 7 months	500	4	112 for 7 months	320	Alk.
Hemsworth—Brierley Hall in residential area	72 for 11 months	283	8	80 for 11 months	316	2
Hemsworth—Grimethorpe, in residential commercial and manufacturing area	76 for 10 months	331	6	85 for 10 months	226	11
Hemsworth—Ackworth, in clinic in a residential area	91 for 11 months	320	6	82 for 11 months	363	12

*For period of full year unless stated otherwise.

Situation of Instrument	Smoke			Volumetric SO ₂		
	Average Daily Suspended Impurity*	High-est Value	Low-est Value	Average Daily Concentration SO ₂ *	High-est Value	Low-est Value
	Microgrammes per cubic metre			Microgrammes per cubic metre		
Hemsworth—South Kirkby in residential, commercial and light industrial area	88 for 11 months	309	5	91 for 11 months	339	27
Darton—Council Offices, in semi-residential colliery district. Coke by-product plant 1 mile to S.E.	136 for 7 months	412	21	101 for 7 months	424	Alk.
Wombwell—The Gables, semi-residential colliery district	148 for 8 months	517	30	89 for 8 months	435	20
Wombwell—The Library, Station Lane, surrounding district residential and commercial	161 for 8 months	668	16	135 for 8 months	538	35
Worsbrough—Savile House—8ft. above ground in out-building, rear of Council Offices. Surrounding country open and low density residential	114 for 11 months	544	12	92 for 11 months	476	13
Conisbrough—Denaby Clinic, in room facing north. Surrounding district residential—high density	92	313	11	115	407	39
Conisbrough—The Priory, in staff dining room facing west. Surrounding district residential—low density	84	390	14	106	465	30
Rawmarsh—Public Health Inspector's Office, in centre of residential and industrial area	74 for 10 months	308	7			
Wath upon Dearne—Town Hall, in commercial and residential area with industrial zone 1-2 miles N. to N.E.	70	397	13	106	467	16

* 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		
Bentley with Arksey—Health Department, Chapel Street, semi-residential colliery district	53 for 3 months	125	12	88 for 3 months	143	50
Doncaster (Barnby Dun)—Barnby Dun School, in residential area 5 miles north-east of Doncaster C.B.	58 for 11 months	234	2	71 for 11 months	452	12
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	60 for 11 months	297	9	126 for 11 months	585	17
Thorne—Council Offices, in semi-residential colliery district	72 for 11 months	234	10			

*For period of full year unless stated otherwise.

Table 62

Certification and Treatment of Blind and Partially Sighted Persons

The following table gives particulars of new registrations during 1972, of Blind and Partially Sighted Persons (other than handicapped school children).

	Disability (B = Blind PS = Partially Sighted)									
	Cataract		Glaucoma		Retrolental Fibroplasia		Others		Total	
	B	PS	B	PS	B	PS	B	PS	B	PS
(i) No. of cases registered during the year in which Section F. recommends										
(a) No treatment					No figures available				176	70
(b) Treatment (Medical, Surgical, Optical or Ophthalmic Medical Supervision)	69	81	37	17	1	—	117	141	224	239
(ii) No of cases at (i) (b) above which received treatment	46	46	29	13	1	—	79	98	155	157

Table 63 Registration of Nursing Homes

Div. No.	Name and Address of Nursing Home	Number of beds registered	
		Maternity	Other
1	Eshton Hall, Malham Road, Gargrave	—	60
3	Beanlands, Colne Road, Crosshills, Keighley	—	21
3	Norwood House, High Spring Gardens Lane, Keighley	—	14
5	Oakbank, 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	—	11
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	Kingsley, 38 Ripon Road, Harrogate	—	25
7	Ellangowan, 26 Queen's Road, Harrogate	—	17
7	Clova, 1 Clotherholme Road, Ripon	—	21
7	Heatherwood, 17 Duchy Road, Harrogate	—	14
7	Hampden House, 120 Duchy Road, Harrogate	—	46
7	Edenfield, 3 Tewit Well Road, Harrogate	—	32
7	Warwick, 10 Warwick Crescent, Harrogate	—	9
7	Follifoot Ridge, Harrogate	—	2
9	Cheshire Home, Spofforth Hall, Spofforth, Harrogate	—	28
15	Cheshire Home, Kenmore, Whitcliffe Road, Cleckheaton	—	27

Table 64 The Medical Inspection of School Children**NUMBER OF PUPILS ON REGISTERS**

Nursery full-time	...	...	...	...	343
Nursery part-time	...	...	...	...	453
Primary	...	...	...	...	205,320
Secondary	...	...	...	...	123,850
Special Schools (Boarding)	...	...	...	...	315
Special Schools (Day)	...	...	...	...	2,304
Special Schools (Hospital)	...	...	...	...	162
Total	...	...	...	...	332,747

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)
1968 and later	6 791	6 789	2	15
1967	14,543	14 514	29	327
1966	8,649	8,610	39	640
1965	2,694	2,639	55	735
1964	2,466	2 441	25	5,770
1963	2,102	2 076	26	4,428
1962	2,011	1,981	30	3,599
1961	1,981	1,961	20	4,751
1960	811	804	7	3,322
1959	356	356	—	665
1958	448	448	—	1 377
1957 and earlier	2,701	2 673	28	4,901
Total	45,553	45,292	261	30,530

Column (3) total as a percentage of Column (2) total ... 99·43%

Column (4) total as a percentage of Column (2) total... 0·57%

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	12,749
Number of Re-Inspections ...	6,200
Total ...	18,949

Year	Periodics	Other Inspections	Number of pupils found not to warrant an examination on Selective Procedures
1971	43,063	19,676	30,758
1972	45,553	18,949	30,530

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
1968 and later	140	430	541
1967	336	1,132	1,385
1966	230	728	875
1965	98	289	350
1964	121	378	457
1963	109	241	323
1962	100	225	302
1961	125	246	358
1960	65	90	147
1959	14	33	46
1958	35	47	80
1957 and earlier	152	216	366
Total	1,525	4,055	5,230

TABLE II
INFESTATION WITH VERMIN

(i) Total number of individual examinations of pupils in schools by the school nurses or other authorised persons	579,087
(ii) Total number of individual pupils found to be infested	11,848
(iii) Number of individual pupils in respect of whom cleansing notices were issued (Section 54(2), Education Act, 1944)	356
(iv) Number of individual pupils in respect of whom cleansing orders were issued (Section 54(3), Education Act, 1944)	27

The percentage of infested pupils found during 1972 was 3.56 as opposed to a percentage of 3.10 in 1971.

TABLE III

DEFECTS FOUND BY MEDICAL INSPECTION IN THE YEAR ENDED 31ST DECEMBER, 1972

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	245	622	67	96	640	1,224	288	175
5	Eyes— a. Vision b. Squint c. Other	773 394 30	1,276 634 130	170 2 2	361 32 27	2,107 538 70	3,355 992 319	341 74 23	872 174 50
6	Ears— a. Hearing b. Otitis Media c. Other	302 87 51	765 556 77	40 2 12	86 35 5	612 209 105	1,723 867 124	219 53 53	588 143 32
7	Nose and Throat	329	1,604	16	91	599	2,535	116	414
8	Speech	349	893	2	16	535	1,225	175	244
9	Lymphatic Glands	20	484	1	11	33	619	8	104
10	Heart	60	416	4	39	112	749	22	261
11	Lungs	121	637	7	59	262	1,218	93	239
12	Developmental— a. Hernia b. Other	61 102	121 707	1 22	3 21	90 242	160 1,044	5 67	27 221
13	Orthopaedic— a. Posture b. Feet c. Other	19 129 53	100 537 352	3 21 15	15 14 63	34 302 130	219 880 663	7 45 28	41 184 153
14	Nervous System— a. Epilepsy b. Other	34 35	100 509	10 15	22 18	114 130	278 857	73 30	89 104
15	Psychological— a. Development b. Stability	61 34	449 846	8 6	16 31	279 208	1,135 1,827	404 327	422 417
16	Abdomen	65	180	8	11	161	381	14	29
17	Other	222	915	35	31	647	1,456	196	567

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
<i>Group 1. Eye Disease, Defective Vision and Squint</i>	
External and other, excluding errors of refraction and squint	1,115
Errors of refraction (including squint)	16,645
Total	17,760
Number of pupils for whom spectacles were prescribed	5,981
	Number of cases known to have been treated
<i>Group 2. Diseases and Defects of Ear, Nose and Throat</i>	
Received operative treatment:	
(a) for diseases of the ear	171
(b) for adenoids and chronic tonsillitis	1,086
(c) for other nose and throat conditions	181
Received other forms of treatment	270
Total	1,708
Total number of pupils in schools who are known to have been provided with hearing aids:	
(a) in 1972	43
(b) in previous years	313
<i>Group 3. Orthopaedic and Postural Defects</i>	
(a) Pupils treated at clinics or out-patient departments	719
(b) Pupils treated at school for postural defects	33
Total	752

										Number of cases known to have been treated
<i>Group 4. Diseases of the skin (excluding uncleanness for which see Table II)</i>										
Ringworm—(a) Scalp	...	...	...	...	...	...	...	...	...	8
(b) Body	...	...	...	...	...	...	...	...	...	4
Scabies	...	...	...	...	...	...	...	...	...	352
Impetigo	...	...	...	...	...	...	...	...	...	194
Other skin diseases	...	...	...	...	...	...	...	...	...	182
Total										740
<i>Group 5. Child Guidance Treatment</i>										
Number of pupils treated at Child Guidance clinics under arrangements made by the Authority										2,571
<i>Group 6. Speech Therapy</i>										
Number of pupils treated by Speech Therapists under arrangements made by the Authority										3,478
<i>Group 7. Other Treatment Given</i>										
(a) Number of cases of miscellaneous minor ailments treated by the Authority	...	...	...	...	...	...	...	...	...	1,032
(b) Pupils who received convalescent treatment under School Health Service arrangements	...	...	...	...	...	...	...	...	...	5
(c) Pupils who received B.C.G. vaccination	...	...	...	...	...	...	...	...	...	19,431
(d) Other:										
1. Ultra Violet Light Treatment	...	...	...	...	...	...	...	...	...	9
2. Audiology	...	...	...	...	...	...	...	...	...	144
3. Abdominal defects	...	...	...	...	...	...	...	...	...	16
4. Chest and Heart	...	...	...	...	...	...	...	...	...	84
Total (a)—(d)										20,721

Table 65 Care of the Handicapped Pupil

The following table gives details of handicapped pupils and particulars of the number of children receiving special education:

Category	Total Ascertained	Number receiving special education			Awaiting Placement	
		In special schools		Other- wise than at school		
		County schools	Other schools			
Blind	50	—	44	1	45	5
Partially Sighted... ..	59	—	49	1	50	9
Deaf and Partially Hearing	262	7	246	—	253	9
Physically Handicapped...	367	—	308	28	336	31
Delicate	117	64	38	—	102	15
Maladjusted	166	82	35	4	121	45
Educationally Subnormal	3,042	2,443	258	3	2,704	338
Epileptic	30	—	27	—	27	3
Speech Defects	6	—	4	—	4	2
Totals	4,099	2,596	1,009	37	3,642	457

Table 66 Audiology Clinics

SUMMARY OF WORK CARRIED OUT

Otley Clinic

<i>Number of Sessions held</i>	8
<i>Number of Individual Children attending</i>	
(a) Referred for first time in current year...	16
(b) Also attended in previous year ...	8
Total	24
<i>Total number of attendances made</i> ...	33
<i>Areas from which referred (i.e. number from each Division)</i>	
Division No. 5	16
Total	24
<i>Ages of children referred</i>	
Under 1	—
1—2 years	—
2—5 years	5
5—8 years ..	13
8—11 years...	5
11+ years	1
<i>Results of Clinical Investigation</i>	
Number of children with significant hearing loss	3
Number of children without significant hearing loss	19
Number of children at present undiagnosed	2
<i>Recommendations</i>	
Hearing aid ordered by the E.N.T. Consultant	1
Front seat in class	2
Speech Therapy required	2
School for the Deaf	—
School for the Partially Hearing	1
Referred to E.N.T. Consultant	8
Special supervision by the Peripatetic Teacher	2
To be seen by Psychologist	—

<i>Number of Sessions held</i>	38
<i>Number of Individual Children attending</i>	
(a) Referred for first time in current year...	83
(b) Also attended in previous year	61
Total	144
<i>Total number of attendances made</i>	164
<i>Areas from which new cases referred (i.e. number from each Division)</i>	
Division No. 10	3
Division No. 11	6
Division No. 22	4
Division No. 23	4
Division No. 25	7
Division No. 26	15
Division No. 27	32
Division No. 29	8
Division No. 31	4
Total	83
<i>Ages of children referred</i>	
Under 1	5
1—2 years	4
2—5 years	20
5—8 years	30
8—11 years... ..	15
11+ years	9
<i>Results of Clinical Investigation</i>	
Number of children with significant hearing loss	69
Number of children without significant hearing loss	65
Number of children at present undiagnosed	10
<i>Recommendations</i>	
Hearing aid ordered by the E.N.T. Consultant	12
Suitable seat in class	20
Speech therapy required	17
School for the Deaf	10
School for the Partially Hearing	2
Referred to E.N.T. Consultant with secretary otitis	25
For special supervision by Peripatetic Teacher	32
For examination by Psychologist	32
To spend half a day in the Nursery Department of the Y.R.S.D.	3

Table 67 The Work of the Psychologists

CHILDREN SEEN

Children seen as part of full child guidance investigation

Age Range

	Below 5	5—7+	8—10+	Over 11	Totals
Boys ...	29	181	268	239	717
Girls ...	17	68	78	111	274
Totals ...	46	249	346	350	991
% age ...	4.7	25.1	34.9	35.3	

Children with Handicaps other than Maladjustment seen for Psychological Assessment

Age Range

	Below 5	5—7+	8—10+	Over 11	Totals
Boys ...	158	368	476	457	1,459
Girls ...	84	176	196	191	647
Totals ...	242	544	672	648	2,106
% age ...	11.5	25.8	31.9	30.8	

VISITS

Schools	Special Schools	Homes	Assessment Centres	Audiology Clinics	Others
1,769	441	285	280	38	124

Table 68 School Ophthalmic Service, 1957-72

Year	No. of children examined (including re-examinations)	No. prescribed glasses
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
1971	18,201	5,668
1972	17,760	5,981

Table 69 Medical Treatment at Local Authority Clinics

Type of Clinic	Number
Minor Ailment and other non-specialised	57
Dental	64
Ophthalmic	56
Speech Therapy	56
Ultra Violet Light	2
Pædiatric	16
Chiropody	2
Consultant E.N.T.	2
Consultant Orthopaedic	4
Consultant Dermatology	—
Consultant Cardiac	—
Orthoptic	—
Remedial Exercises	2
Audiology	2
Immigrants	1
Enuretic	14
School Medical Officers' Special Examination	75

Table 70 Consultant Services**CONSULTANT E.N.T. SERVICE**

No. of sessions held: 87

	Pre-school Children	School Children	Total
No. of individual children seen by consultant, including those continuing attendance from previous year	18	276	294
No. of above referred for operative treatment	10	175	185
No. of children:			
(a) who obtained operative treatment ...	28	288	316
(b) treated at school clinics	—	20	20
No. of attendances at consultant clinics ...	31	576	607

CONSULTANT ORTHOPAEDIC SERVICE*Consultant Clinics*

No. of sessions held: 58

No. of individual patients seen by consultant, including those continuing attendance from previous year	387	333	720
No. of above:—			
(a) referred for operative treatment as short stay cases only	7	7	14
(b) recommended long-stay hospital school	1	1	2
(c) recommended treatment by orthopaedic nurse or physiotherapist:			
(i) at treatment centres	3	3	6
(ii) domiciliary	1	—	1
No. of children who obtained operative treatment	—	6	6
Total number of attendances at consultant clinics	551	439	990

Treatment Centres

No. of sessions held: 670

Total No. of patients treated, including cases continuing treatment from previous year ...	28	149	177
Total number of attendances	428	1,646	2,074

Domiciliary Treatment

	Pre-school Children	School Children	Total
Total number treated	2	—	2
Total number of visits to patient's home ...	1	—	1

Appliances

No. of appliances—			
(a) recommended	4	4	8
(b) obtained	4	4	8

PHYSIOTHERAPY SERVICE

At the end of the year the staff aggregated the equivalent of 0.66 whole-time officers.

ULTRA VIOLET LIGHT CLINICS

Number of sessions held: 106

Number of children treated during the year ...	1	17	18
Total number of attendances	31	391	422

CONSULTANT PÆDIATRIC SERVICE

Consultant Clinics

No. of sessions held: 29

No. of individual patients seen—			
(a) New cases	52	32	84
(b) Cases attending from previous year(s) ...	45	100	145
Total number of attendances at clinics ...	96	133	229

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	1	2	3
Epilepsy	2	5	7
Heart and Circulatory System	10	46	56
Respiratory System, including E.N.T. defects	5	6	11
Speech	1	1	2
Orthopaedic	3	2	5
Cerebral Palsy	1	—	1
Psychological: General	3	—	3
Behaviour	—	2	2
Mental Retardation, including Educational subnormality	4	4	8
Gastro-intestinal system	—	2	2
Genito-urinary system	3	4	7
Nutritional	4	10	14
Developmental: General	10	10	20
Incontinence	2	7	9
Eyes	1	—	1
Obesity	1	1	2
Glands	3	1	4
Clumsy Child	—	1	1
Unclassified	15	4	19

Table 71 Cleanliness, 1953-72

Year	Total number of examinations made by school nurses	Number of individual children found to be infested	Percentage of school population
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
1971	496,869	11,060	3.1
1972	579,087	11,848	3.5

In some areas a system of 'selective' inspections has been introduced as suggested in *The Health of the School Child*, 1962/63.

Division	No. tested	Negative reactions	Positive reactions	Of whom (b)	
				Previous B.C.G. Vaccination	Final Skin Test
(a)	(b)	(c)	(d)	+	-
Kaibiro (Health Unit)	106	68	17	7	10
Referred to Chest Physician					

Table 72 Nutrition, 1960-72

Year (1)	Total number of pupils inspected (2)	Classification			
		Satisfactory		Unsatisfactory	
		No. (3)	% of Col. 2 (4)	No. (5)	% of Col. 2 (6)
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
1971	43,063	42,891	99.60	172	0.40
1972	45,533	45,292	99.43	261	0.57

SCHOOL MEALS

The number of meals provided to school children daily according to a check made in October, 1972, was 209,603 compared with 189,111 in September, 1971. This represents 69.37 per cent. of children in attendance.

Table 73 Protection of School Children Against Tuberculosis**TUBERCULIN TESTING OF SCHOOL ENTRANTS**

Health Division (a)	No. tested (b)	Negative reactions (c)	Positive reactions (d)	Of column (d)		Further investigation
				Previous B.C.G. Vaccina- tion	Final Skin Test — +	
Keighley (Heaf Test)	706	689	17	7	— 10	Referred to Chest Physician.

Table 74 Speech Therapy

(a) Number of children seen for the first time during the year ...	1,809	
(b) Number of children attending for treatment from previous year ...	1,752	
	3,561	
Number of children awaiting treatment at end of year ...	777	
(a) Interviewed and placed on waiting list ...	388	
(b) Not seen ...	479	
Number of visits made to schools ...	1,946	
Number of home visits ...	340	
Analysis of children treated		
Stammerers (Dysrhythmia) ...	Boys	Girls
	248	65
Defects of Articulation due to:		
(a) Cleft Palate ...	43	26
(b) Cerebral Palsy ...	19	12
(c) Other structural malformations ...	106	40
(d) Other causes e.g. neurological ...	49	27
(e) No specific cause found ...	1,311	586
Disorders of Language due to:		
(a) Retarded language development (non-specific) ...	326	162
(b) Retardation with associated subnormality ...	161	86
(c) Retardation associated with deafness ...	33	18
(d) Dysphasia ...	24	12
(e) Aphasia ...	2	—
(f) Other reasons... ..	27	14
Dysphonia ...	11	5
Other Defects ...	6	4

Table 75 Dental Inspections and Treatment Carried Out

Attendances and Treatment

	Ages 5 to 9	Ages 10 to 14	Ages 15 and over	Total
First visit	27,662	27,576	5,953	61,191
Subsequent visits	33,078	61,420	16,057	110,555
Total visits	60,740	88,996	22,010	171,746
Additional courses of treatment commenced	1,598	1,935	596	4,129
Fillings in permanent teeth	33,909	75,491	22,331	131,731
Fillings in deciduous teeth	20,495	1,454	—	21,949
Permanent teeth filled	26,183	64,225	19,578	109,986
Deciduous teeth filled	17,960	1,333	—	19,293
Permanent teeth extracted	2,850	12,147	2,781	17,778
Deciduous teeth extracted	36,797	11,879	—	48,676
General anæsthetics	13,245	7,418	989	21,652
Emergencies	2,670	1,726	319	4,715
Number of Pupils X-rayed				4,160
Prophylaxis				18,040
Teeth otherwise conserved				2,576
Number of teeth root filled				406
Inlays				95
Crowns				548
Courses of treatment completed... ..				50,630

Orthodontics

New cases commenced during year	1,384
Cases completed during year	1,330
Cases discontinued during year	180
Number of removable appliances fitted... ..	2,960
Number of fixed appliances fitted	162
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	3	28	34
Pupils supplied with other dentures (first time)	30	214	124	368
Number of dentures supplied	44	356	267	667

Anæsthetics General Anæsthetics administered by Dental Officers ...

21,178

Inspections

(a)	First inspection at school. Number of Pupils ...	...	...	...	181,293
(b)	First inspection at clinic. Number of Pupils ...	...	...	...	23,775
	Number of (a) + (b) found to require treatment	...	...	...	113,197
	Number of (a) + (b) offered treatment ...	...	...	...	98,983
(c)	Pupils re-inspected at school or clinic ...	...	...	...	11,488
	Number of (c) found to require treatment	...	...	...	6,461

Sessions

Sessions devoted to treatment	...	...	...	*23,417
Sessions devoted to inspection	...	...	...	1,178
Sessions devoted to Dental Health Education	...	...	...	292

*Includes 1,383 Anaesthetic sessions

FOOD AND DRUGS ACT, 1955

Report of County Analyst

During the year, 2,725 samples were submitted by your Inspectors under the Food and Drugs Act, 1955:

	Total Samples	Adulterated or Below Standard	Percentage Adulterated or Below Standard
Milk	859	8	0.9
Milk, 'Appeal to Cow'	1	—	—
Milk — Channel Islands	140	5	3.6
Milk — Channel Islands, 'Appeal to Cow'	2	1	50.0
Milk and Foreign Matter	1	1	100.0
Food and Drugs	1,722	78	4.5
	2,725	93	3.4

NOTES ON ADULTERATED OR OTHERWISE IRREGULAR SAMPLES:

Milk. Eight hundred and fifty-nine samples were analysed; eight were unsatisfactory, six being deficient in fat by amounts varying between 4 per cent. and 44.6 per cent. Two other samples contained added water, 0.8 per cent. and 1.5 per cent. respectively.

Milk—Channel Islands. One hundred and forty samples were taken; five of them contained below the standard of 4 per cent. fat, the worst being 2.78 per cent.; another sample contained 0.8 per cent. of added water. When an 'appeal to cow' sample was taken following the above fat deficient sample, this sample was itself below standard (3.97 per cent. fat).

Colouring Matter in Food. All appropriate samples were tested for artificial colours; no prohibited colourings were found.

Preservatives. All appropriate samples were tested for preservatives. The label of a sample of sausages claimed that they were free from preservatives, yet we found that they contained sulphur dioxide in excess of the legal limit! In 12 other samples of sausage we found preservative without the proper declaration of its presence.

Labelling. Details of all labels supplied with samples were scrutinised for compliance with the *Labelling of Food Regulations, 1953*, making allowances for the new Regulations which came into force on 1st January, 1973.

Fifteen irregularities were reported, five being concerned with the labelling of tinned fruit. Other irregularities were found on the labels of tinned meat, soup, fish, etc.

The label of a prepared meal portrayed *two* baconburgers on a heap of baked beans in tomato sauce, and the wording included 'baconburgers' (plural). When opened, only *one* baconburger was found.

Shandy and Shandy-type soft drinks. For several years, Public Analysts have pressed for shandy to contain sufficient beer to provide at least 1.5 per cent. of proof spirit. Two samples were below this limit, containing only 0.9 and 0.95 per cent. respectively.

Since 1st January, 1973, this minimum of 1.5 per cent. proof spirit is legally enforceable.

Another sample of shandy labelled 'non-alcoholic' had fermented and contained 1.8 per cent. proof spirit, and was quite definitely to the prejudice of a teetotal consumer!

Mouldy Food. Only two samples were condemned: a meat pie, and a consignment of potatoes which were badly damaged in addition to being mouldy.

Drugs. One hundred and thirty-three samples of drugs were analysed. Only three were irregular. In two instances this would be due to long storage, e.g. large crystals of sugar in a Baby Cough Linctus, and low specific gravity of Glycerin of Thymol. The third irregularity involved a packet of Extra Strong Seidlitz Powder—the contents of the blue packet were under-weight.

Tinned Foods. Several hundred samples were analysed. Only three samples were unsatisfactory, all due to corrosion of the inner surfaces of the tins—doubtless due to having been kept too long.

Unsatisfactory composition and samples below standard. This section included 22 samples: two meat paste; two potted meat; one chicken and pork spread; one pork kidneys in gravy; six sausages and four meat pies were all deficient in meat.

Other deficiencies were found in fish cakes, soft drinks, marmalade and non-brewed condiment.

FOREIGN BODIES IN FOOD:

Seventeen samples, all following complaints by members of the public, were submitted for examination.

In four samples of sliced bread there were stains of black lubricating grease.

A splinter of glass was embedded in a teacake.

A tin of tuna and a jar of shrimps both contained a fly.

The purchaser of a packet of salted roasted peanuts complained that they were dirty. The 'dirt' was simply salt discoloured by particles of roasted nuts.

A moth grub was found in a tin of butter beans.

Having poured out his beer, the purchaser found several pieces of paper, bearing printed characters, in the bottle. Presumably these scraps of paper escaped detection before the bottle was filled with beer.

What appeared to be hayseeds on the inner surface of a bottle of milk were shown to be the pupae of drosophila flies, firmly attached to the glass.

The presence of a dead bee in a fruit pie was disturbing, but the finding of mouse droppings in a tin of rice pudding was disgusting.

A revolting situation arose when a consumer had eaten half a creambun—he found half a cockroach exposed in the uneaten half. Where was the rest of the cockroach?

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.

Special emphasis must again be laid on the value of the Joint Assessment Clinic which continued to be held at two monthly intervals at Airedale General Hospital. Attending the clinic were the consultant pædiatrician and one or other consultant orthopaedic surgeon, depending on circumstances, together with appropriate medical, nursing and psychological members of the School Health Service staff.

There is much discussion at the present time regarding the future of the School Health Service. However, there is little doubt that in this area we have already formed an excellent relationship with all the consultants concerned with the health, both physical and mental, of the school child. This, we believe, augers well for the future of the School Health Service within the re-organised National Health Service for this area.

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:

	1972	1971
Nursery	87	45
Primary	5,989	5,895
Middle Schools	2,073	2,027
Voluntary Secondary	610	565
Upper Schools	1,351	1,392
Special Schools	160	165

TABLE 1

**MEDICAL INSPECTION OF PUPILS ATTENDING MAINTAINED PRIMARY AND
SECONDARY SCHOOLS (INCLUDING NURSERY AND SPECIAL SCHOOLS)**

A. Periodic Medical Inspections

Age groups inspected (by year of birth), number of pupils who received a full medical examination together with classification of the physical condition of the pupils inspected, the number of pupils found not to warrant a medical examination in connection with the selective medical examinations and the number of pupils found to require treatment (excluding dental diseases and infestation with vermin).

Age groups inspected (by year of birth)	Number of Pupils who have received a full medical examination	Physical Condition of Pupils Inspected		Number of Pupils found not to warrant a medical examination	Pupils found to require treatment (excluding dental diseases and infestation with vermin)		
		Satisfactory	Unsatisfactory		For defective vision (excluding squint)	For any other condition recorded in Table III	Total individual pupils
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1968 and later	194	194	—	—	4	28	29
1967	662	662	—	—	29	85	99
1966	118	118	—	—	5	27	30
1965	—	—	—	—	—	—	—
1964	209	209	—	545	4	49	51
1963	31	31	—	70	2	7	9
1962	—	—	—	—	—	—	—
1961	—	—	—	—	—	—	—
1960	—	—	—	—	—	—	—
1959	—	—	—	—	—	—	—
1958	—	—	—	—	—	—	—
1957 and earlier	—	—	—	625	—	—	—
TOTAL	1,214	1,214	—	1,240	44	196	218

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	...	1,567
Number of Re-Inspections	...	720
Total	...	<u>2,287</u>

Comparative Table of Inspections carried out:

Year	Periodic	Special	Re-Inspections
1972	1,214	1,567	720
1971	1,301	1,663	1,023
1970	1,255	1,691	747
1969	1,293	1,911	930
1968	1,313	1,963	1,074

SELECTIVE SCHEME:

The selective scheme of medical examination of pupils in the intermediate age groups was continued as described in previous reports. During the year 855 questionnaires were distributed of which 803 were returned, subsequently 240 pupils were invited to attend for a medical examination. Details of the defects found are shown in Table III.

The selective scheme of medical examination of pupils during their last year of compulsory school attendance was continued during the year following the instigation of this procedure in 1967. Questionnaires were distributed to parents for completion and return. These were then scrutinised together with all the available medical records. At the medical interviews, which were afterwards held in the schools, pupils were selected for a full medical examination, to be carried out at the school clinic by appointment. A total number of 625 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.

MEDICAL EXAMINATION OF IMMIGRANT PUPILS:

Fæces specimens were taken in 47 cases; 19 cases had parasites and were treated with Alcopar. The remainder had no ova or cysts or other pathogenic organisms isolated.

CONSULTING SESSIONS:

Consulting sessions are held at the school clinic on Monday and Thursday mornings of each week. Appointments are given to parents, following school medical inspections, to bring their children to the school clinic for consultation and investigation if this is requested by the parents or advised by the senior departmental medical officer who has carried out the medical inspections in

school. Similarly, pupils are referred to these sessions by teachers and education welfare officers. The poor school attender is frequently referred 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. Pupils also attend for advice concerning ear, nose and throat, chest, orthopaedic and skin conditions. Parents who are concerned about their child's general health, behaviour difficulties or disorders such as nocturnal enuresis frequently seek advice about such matters.

If further investigation is considered to be necessary referral is made as appropriate either to the family practitioner, to a specialist, or to the child guidance clinic.

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	...	...	...	21,444
(b)	Total number of individual pupils found to be infected	...	...	...	597
(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 this table, whether or not they were under treatment or observation at the time of the inspection.

Defect Code No.	Defect or Disease	PERIODIC INSPECTIONS								SPECIAL INSPECTIONS	
		ENTRANTS		LEAVERS		OTHERS		TOTAL		(T)	(O)
		(T)	(O)	(T)	(O)	(T)	(O)	(T)	(O)		
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
4	Skin	2	—	—	—	—	—	2	—	216	3
5	Eyes— <i>a.</i> Vision ...	38	1	—	—	6	—	44	1	19	1
	<i>b.</i> Squint ...	59	1	—	—	1	—	60	1	19	1
	<i>c.</i> Other ...	—	—	—	—	1	—	1	—	11	2
6	Ears— <i>a.</i> Hearing ...	13	1	—	—	19	5	32	6	107	40
	<i>b.</i> Otitis Media ...	—	—	—	—	—	—	—	—	24	1
	<i>c.</i> Other ...	21	—	—	—	2	—	23	—	48	2
7	Nose and Throat ...	9	7	—	—	3	—	12	7	27	6
8	Speech	29	5	—	—	9	—	38	5	80	5
9	Lymphatic Glands ...	—	—	—	—	—	—	—	—	1	1
10	Heart... ..	1	2	—	—	—	2	1	4	1	13
11	Lungs	10	2	—	—	4	—	14	2	48	7
12	Developmental— <i>a.</i> Hernia ...	—	1	—	—	—	—	—	1	—	—
	<i>b.</i> Other ...	1	1	—	—	—	1	1	2	4	5
13	Orthopaedic— <i>a.</i> Posture ...	—	—	—	—	—	—	—	—	1	—
	<i>b.</i> Feet ...	1	—	—	—	—	—	1	—	21	2
	<i>c.</i> Other ...	2	2	—	—	—	1	2	3	15	12
14	Nervous System— <i>a.</i> Epilepsy ...	2	1	—	—	—	3	2	4	16	8
	<i>b.</i> Other ...	—	—	—	—	1	1	1	1	5	13
15	Psychological— <i>a.</i> Development ...	4	7	—	—	20	20	24	27	279	85
	<i>b.</i> Stability ...	4	6	—	—	19	21	23	27	292	84
16	Abdomen	—	—	—	—	—	—	—	—	6	1
17	Other... ..	—	—	—	—	—	—	—	—	23	6
18	Totals	196	37	—	—	85	54	281	91	1,263	298

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;
- (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.

A. Eye Diseases. Defective Vision and Squint:

	Number of cases known to have been dealt with	
	1972	1971
External and other, excluding errors of refraction and squint ...	25	15
Errors of refraction (including squint)	265	—
Total	290	15
Number of pupils for whom spectacles were prescribed	163	—

During the year we were successful in obtaining the services of an Ophthalmic Consultant. The figures above relate to the work undertaken in the Ophthalmic Clinic during the year.

SCREENING TESTS OF VISION:

A vision screening test was carried out as part of the medical inspection of school entrants 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 using the Keystone vision screening apparatus which is found to be particularly successful with school entrants.

General:

During the year 25 pupils 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 189.

B. Diseases and Defects of Ear, Nose and Throat:

	Number of cases known to have been dealt with	
	1972	1971
Received operative treatment:		
(a) for diseases of the ear	6	—
(b) for adenoids and chronic tonsillitis	16	—
(c) for other nose and throat conditions	—	—
Received other forms of treatment	109	135
Total	131	135
Total number of pupils still on the register of schools at 31st December, 1972 known to have been provided with hearing aids:		
(a) during the calendar year 1972	3	
(b) in previous years	5	

SCREENING TESTS OF HEARING:

The routine audiometric testing of the 6-7 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 at the school clinic 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 practitioners 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 practitioners 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.

A total number of 41 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 need for special educational help.

Pupils Tested by Pure-Tone Audiometry

		No Number Tested	appreciable hearing loss	Referral for investi- gation	Already attending Otologist
'At risk' categories					
(i) deafness in the family	...	9	2	4	3
(ii) prenatal causes:					
maternal rubella	...	-	-	-	-
other conditions	...	-	-	-	-
(iii) perinatal causes, e.g. toxæmia, anoxia, kernicterus, rhesus incompatability, prematur- ity, etc.		-	-	-	-
(iv) postnatal:					
congenital defects	...	1	-	-	1
cerebral palsy	...	-	-	-	-
middle ear disease	...	35	27	6	2
meningitis or encephalitis		-	-	-	-
speech retardation or defect		6	6	-	-
educational retardation	...	33	32	1	-
Routine test on children in 6/7 year age group	...	1,255	1,244	7	4
Referred for possible hearing loss...		58	29	21	8
Total		1,397	1,340	39	18

C. Orthopaedic and Postural Defects:

			Number of cases known to have been dealt with	
			1972	1971
(a) Pupils treated at clinics or out-patient departments	...	...	105	116
(b) Pupils treated at school for postural defects	...	...	—	—
Total			105	116

JOINT ASSESSMENT CLINIC:

Following the opening of Airedale General Hospital in 1970, a joint assessment clinic has been held bi-monthly at the hospital with the senior departmental medical officers, physiotherapists, speech therapists, Dr. Morgan, consultant pædiatrician and Mr. Cape and Mr. Kilburn, consultant orthopaedic surgeons. This clinic enables all persons concerned with the care and treatment of physically handicapped pupils to exchange opinions on the individual cases and continues to be advantageous to the patients and professional staff.

PHYSIOTHERAPY:

As in previous years the physiotherapist has continued to treat the pre-school child and those at school where this has been advised by the senior departmental medical officer or consultant paediatrician.

The swimming class has had to be transferred to the Oakbank Grammar School Bath due to the alterations being made to the Public Swimming Baths. To have the use of this alternative bath is much appreciated but attendance has not been as good as previously owing to the distance involved and to the temperature of the water and changing rooms which, though satisfactory for normal children, are not fully suitable for handicapped children.

As Whinburn Special School is now a West Riding Residential School for delicate pupils, the physiotherapist has been engaged in giving treatment to pupils in attendance there who suffer from asthma and other conditions which require physiotherapy. Two visits each week have been made to the Special School and one each week to Branshaw View Day Special School for severely subnormal pupils to provide treatment. An hour on Mondays and Fridays is also devoted to the treatment of severely handicapped pre-school children in attendance at Oakworth Road Day Nursery.

The following shows details of the work undertaken by the physiotherapist.

<i>School Children</i>						<i>No. of Cases</i>	<i>Attendances</i>
Breathing ...	...	...	...	...	...	51	625
Cerebral palsy (other) ...	...	...	...	...	...	8	129
Curly toes ...	...	...	...	...	...	1	31
Foot exercises ...	...	...	...	...	...	34	440
Muscular dystrophy ...	...	...	...	...	...	1	28
Posture ...	...	...	...	...	...	5	43
Remedial exercises ...	...	...	...	...	...	3	26
Spina bifida ...	...	...	...	...	...	2	42
<i>Pre-School Children</i>							
Breathing ...	...	...	...	...	...	3	28
Cerebral palsy ...	...	...	...	...	...	6	140
Foot exercises ...	...	...	...	...	...	1	5
Spina bifida ...	...	...	...	...	...	1	4
<i>Treatment Centres:</i>						<i>Pre-School Children</i>	<i>School Children</i>
Number of sessions held ...	...	...	...	...	...	434	
Total number of patients treated (including cases continuing treatment from previous year) ...	...	...	...	...	...	11	105
Total number of attendances ...	...	...	...	...	...	177	1364
<i>Domiciliary Treatment:</i>							
Total number treated ...	...	...	...	...	...	—	—
Total number of visits to patients' homes ...	...	...	...	...	...	—	—
<i>Appliances:</i>							
Number of appliances—(a) recommended ...	...	...	...	...	...	—	—
(b) obtained ...	...	...	...	...	...	—	—

D. Diseases of the Skin (excluding uncleanness for which see Table II):

								Number of cases known to have been treated	
								1972	1971
Ringworm—(a)	Scalp	...	...	...	...	...	...	—	—
	(b) Body	...	...	...	...	...	...	—	—
Scabies ...	...	...	...	...	...	...	...	103	93
Impetigo	...	...	...	...	...	...	...	52	53
Other skin diseases	...	...	...	...	...	...	...	43	49
Total ...								198	195

It will be seen from the figures that the incidence of scabies has increased during the year. As previously, 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 or 'Quellada' 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.

A weekly clinic is held for the treatment of plantar warts.

E. Child Guidance Treatment:

				Number of cases known to have been treated	
				1972	1971
Pupils treated at Child Guidance Clinics	...	...	...	196	199

Location of clinic: School Clinic,
147 Skipton Road,
Keighley

Number of sessions held during the year	...	...	181		
			<i>Boys</i>	<i>Girls</i>	<i>Total</i>
Number of new cases seen	...	...	55	18	73
Total number of cases discharged or admitted for residential treatment	...	...	56	17	73
Number of cases carried forward	...	...	85	38	123

There were changes in the staffing of the child guidance clinic during 1972. The continuity of the investigation and treatment of cases was maintained but it was not possible to carry out extra-clinical surveys in the schools as in previous years. By the end of the year two part-time psychologists were contributing eight sessions a week to the team and during the last quarter of the year the full-time services of a psychiatric social worker were available. The team remained under the direction of the same senior departmental medical officer as formerly.

Children attending the clinic included pre-school children and physically and mentally handicapped children as well as those referred for nervous and behaviour disorders and problems of learning. The counselling of parents at the clinic and in their homes was continued. Visits to schools and special schools were made and valuable contacts with head teachers and staff have been maintained.

The child guidance clinic continues to form an integral part of the School Health Service in Keighley and indeed has been strengthened. The psychologists have undertaken the psychometric examination of pupils prior to the full examination by a senior departmental medical officer for the purpose of ascertaining those pupils who are in need of special education. Following the appointment of a full-time psychiatric social worker it has been possible for the homes of these pupils to be visited, a social report obtained, and helpful contact made with the parents before the child is examined at the clinic. This gives an opportunity too for the parents to obtain advice and counselling if they so wish. Twenty-one homes have been visited by the psychiatric social worker for this purpose since her appointment in addition to the usual visiting and counselling involved in investigating and treating those who are in attendance at the child guidance clinic. An experienced school nurse makes a valuable contribution to the work of the team in the clinic, and particularly by her knowledge of the schools where she is a frequent visitor.

The figures in the following table relate to the work carried out by the psychologists during the year. In addition, a survey into the extent of reading retardation of the first year intake at Oakbank Grammar School was started. Those children who are backward in reading attainment have been identified and further detailed investigations are proposed including intelligence testing.

Children seen for psychological assessment for maladjustment

Age	—5	5—7+	8—10+	11+	Total
Boys	0	9	13	7	29
Girls	0	2	2	2	6
Total	0	11	15	9	35

Children seen for psychological assessment with handicaps other than maladjustment

Age	—5	5—7+	8—10+	11+	Total
Boys	5	23	30	12	70
Girls	5	16	16	11	48
Total	10	39	46	23	118

Learning problems still occupy much of the time of the staff of the child guidance team. Those children of average intelligence and retarded scholastic attainment still give cause for grave concern, not only for their present state of underfunctioning with overlaid anxiety and distress for them and their parents but for the poor prognosis of their mental health as adults. They are regarded as a serious mental health 'risk'. Recommendations are made for special education in the ordinary school with particular reference in the more severe cases to placement in a remedial centre. The recommendation for remedial centre provision has been made repeatedly in this report for many years but another year has passed without this provision being made.

SPECIAL EDUCATION IN THE ORDINARY SCHOOL:

Number of new cases examined by a senior departmental medical officer or psychologist during 1972 and considered as being in need of special education 16

Number of cases examined and considered to be in need of special education in previous years and still in attendance at school 137

Total number of children who have been examined and are considered to be in need of special education in the ordinary school 153

F. *Speech Therapy:*

	Number of cases known to have been treated	
	1972	1971
Pupils treated by speech therapists	308	286

At the beginning of the year the speech therapy service was carried out by three part-time speech therapists but by the end of the year the part-time services of only one speech therapist were available. It has not been possible to continue to provide a regular service at Braithwaite Day Special School but the most severe cases have received treatment. Visits were made to Branshaw View Day Special School by the speech therapist for the purpose of giving guidance to the teachers regarding the speech training of the pupils in attendance there.

The following shows details of the work undertaken by the speech therapists:

1.	Number of half-day sessions held during the year	325
2.	(a) Number of children seen for the first time during the year ...	86
	(b) Number of children attending for treatment from previous year	222
	Total number of children treated	308
3.	Number of children awaiting treatment at end of year	24
	(a) Interviewed and placed on waiting list	—
	(b) Not seen	24

4.	Children discharged during the year:								Boys	Girls
	Total	...	...	...	...	...	...	...	116	54
	Analysis									
	Speech normal	...	...	...	...	...	...	...	20	8
	Speech improved	...	...	...	...	...	...	...	64	32
	Unsuitable for treatment	...	...	...	...	...	...	...	—	—
	Non co-operation	...	...	...	...	...	...	...	15	8
	Admitted to special schools	...	...	...	...	...	...	...	—	1
	Left school	...	...	...	...	...	...	...	6	2
	Left district	...	...	...	...	...	...	...	7	2
	Other reasons...	...	...	...	...	...	...	...	4	1
5.	Number of visits made to schools								95	
6.	Number of home visits								4	
	<i>Analysis of children treated</i>									
1.	Stammerers (Dysrhythmia)	...	...	...	...	...	...	...	Boys 12	Girls 3
2.	Defects of articulation due to:									
	(a) Cleft palate	...	...	...	...	...	...	...	5	—
	(b) Cerebral palsy	...	...	...	...	...	...	...	3	2
	(c) Other structural malformations	...	...	...	...	...	...	...	4	—
	(d) Other causes e.g. neurological	...	...	...	...	...	...	...	—	3
	(e) No specific cause found	...	...	...	...	...	...	...	140	52
3.	Disorders to language due to:									
	(a) Retarded language development (non-specific)	...	...	...	...	...	...	...	29	18
	(b) Retardation with associated subnormality	...	...	...	...	...	...	...	19	16
	(c) Retardation associated with deafness	...	...	...	...	...	...	...	1	—
	(d) Dysphasia	...	...	...	...	...	...	...	—	—
	(e) Aphasia	...	...	...	...	...	...	...	—	—
	(f) Other reasons	...	...	...	...	...	...	...	—	—
4.	Dysphonia	...	...	...	...	...	...	...	—	1
5.	Other defects	...	...	...	...	...	...	...	—	—

G. Other Treatment Given:

						Number of cases known to have been treated	
						1972	1971
(a)	Pupils with minor ailments	...	...	...	...	632	553
(b)	Pupils who received convalescent treatment under School Health Service arrangements	...	...	...	...	—	—
(c)	Pupils who received B.C.G. vaccination	...	...	...	...	578	545
(d)	Other than (a), (b) and (c) above—Ultra Violet Light	...	...	...	...	9	11
	Total	...	...	...	...	1,219	1,109

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 pupil 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	...	...	...	...	...	889
Refused	...	...	...	...	...	63
Absent	...	...	...	...	...	102
Previously examined	...	...	...	...	...	18
Negative	...	...	...	...	...	689
Positive	...	...	...	...	...	17

Of the 17 cases found to be positive, seven had previously been vaccinated with B.C.G. and the remainder were referred to the consultant chest physician for further investigation and/or observation. It was found that one child had already been under treatment at the chest clinic.

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 ... 802

Number found to have been vaccinated previously ... 77

Number of acceptances ... 544

Percentage of acceptances ... 75.03

Pre-vaccination Tuberculin Test—

Number of children tested ... 536

Result of Heaf Test:

(i) Positive, 12, (ii) Negative, 524, (iii) Not ascertained,—

Percentage positive ... 2.24

Vaccination—

Number vaccinated ... 524

In addition to the above 83 immigrant children were offered tuberculin testing and vaccination if necessary as part of a full medical examination which was undertaken prior to their admission to school. Subsequently 80 of these children were tested and 54 vaccinated.

Ultra Violet Light:

Altogether nine pupils received ultra violet light treatment under the supervision of the physiotherapist, of whom five were continuing at the end of the year. Through the inter-availability of clinics, one pre-school child also received ultra violet light treatment. A total of 74 sessions were held at which 209 attendances were made by pupils and 31 by the pre-school child.

Patients are normally referred by their family practitioners.

Care of the Handicapped Child:

Details of the number of handicapped pupils are given in the following table:

TABLE V

	New Ascertainments	Re- Ascertainments	New placings in Special Schools	Total No. attending Special Schools		Number awaiting placement in Special Schools	Number receiving home tuition
				Day	Boarding		
Blind	—	—	—	—	1	—	—
Partially Sighted	3	—	—	1	—	3	—
Deaf	4	—	1	3	2	1	—
Partially Deaf	1	—	—	2	1	1	—
Educationally Subnormal	15	4	10	106	2	10	—
Epileptic	—	—	—	—	—	—	—
Maladjusted	2	—	2	—	5	—	—
Physically Handicapped	1	1	2	11	3	—	—
Suffering from Speech Defect	—	—	—	—	—	—	—
Delicate	—	—	1	1	4	—	—
Total	26	5	16	124	18	15	—

At the end of the year 104 pupils were attending the Braithwaite Day Special School for educationally subnormal pupils. Of these 73 were Keighley pupils, the remainder being admitted from areas situated outside the Borough.

Following the repeal on 1st April, 1971, of Section 57(4) of the Education Act, 1944 as amended, pupils ascertained as being severely mentally subnormal were admitted to Branshaw View Day Special School. At the end of 1972, 54 pupils were attending Branshaw View Day Special School. Of these 33 were Keighley children, the remainder being admitted from outside the Borough. During the year three children were ascertained as being in need of admission to the Special Care Unit of Branshaw View Day Special School. The figures for pupils requiring special education as educationally subnormal, severely subnormal and those requiring placement in a Special Care Unit are all included in Table V under the heading 'Educationally Subnormal.'

Nocturnal Enuresis:

During the year 11 pupils suffering from nocturnal enuresis were issued with an Eastleigh Warning Device on loan, of which seven were still in use at the end of the year.

Health Education:

Health education in schools has taken the form of film strips, sound films, flannelgraphs, talks and discussions given by health visitors. Supplies of leaflets and posters on topical subjects such as water safety, smoking, firework hazards, home safety etc. were issued regularly and help was given to school children participating in school projects regarding health.

Posters on smoking and health have been displayed in schools and public places. The health visiting staff include this subject in their health education programme in schools and give talks and films concentrating mainly on the younger children in an effort to give them some idea of the adverse effects of smoking on health before they enter Secondary Schools.

The Home Safety Committee once again organized a schools home safety competition. The theme selected this year was 'Fire Prevention' in conjunction with the national campaign on this subject, and entries included drawings, paintings, posters and essays, scrapbooks and projects.

The competition was a great success and the entries made a very interesting exhibition at the Fire Station where the prize giving was held and later at an exhibition in Cliffe Castle. Also exhibited at Cliffe Castle in June was an excellent working model puppet home safety show which attracted much public interest.

In September at the Keighley Show the Home Safety Committee organized a home safety picture quiz for children and distributed leaflets and propaganda.

Dental Inspection and Treatment:

Mr. Midgley, Area Dental Officer, reports:

Dental inspection undertaken during the year reveals that the improvement in dental health first noted around 1966 has been maintained. Although 45 per cent. of the pupils inspected are shown as requiring treatment, the majority can be made dentally fit at either the first or second attendance at the clinic and they do not constitute a large pool of dental decay. There is, nevertheless, a small hard core of children who fail to have regular dental treatment despite all the available facilities.

Fissure sealants are being examined but the evidence does not, at the present time, in our opinion, warrant large scale application. The position will be kept under review.

Liaison with the orthodontist at Airedale General Hospital has been expanded and an increasing number of cases are being referred for advice prior to active treatment at the clinic. It is expected that this will be further expanded and eventually replace the County orthodontic service following the re-organisation of the N.H.S. in 1974.

TABLE VI

Attendances and Treatment

	Ages 5 to 9	Ages 10 to 14	Ages 15 and over	Total
First visit	589	902	166	1,657
Subsequent visits	374	1,936	388	2,698
Total visits	963	2,838	554	4,355
Additional courses of treatment commenced	35	83	19	137
Fillings in permanent teeth... ..	582	2,181	493	3,256
Fillings in deciduous teeth	54	10	—	64
Permanent teeth filled	574	2,171	492	3,237
Deciduous teeth filled	54	8	—	62
Permanent teeth extracted	111	498	107	716
Deciduous teeth extracted	1,075	396	—	1,471
General anæsthetics... ..	388	345	53	786
Emergencies	126	77	5	208

Number of pupils X-rayed	107
Prophylaxis	65
Teeth otherwise conserved	25
Number of teeth root filled	19
Inlays	—
Crowns	—
Courses of treatment completed... ..	1,574

Orthodontics

New cases commenced during year ...	52
Cases completed during year	72
Cases discontinued during year	10
Number of removable appliances fitted ..	90
Number of fixed appliances fitted	2
Pupils referred to Hospital Consultant ...	13

Prosthetics

	Ages 5 to 9	Ages 10 to 14	Ages 15 and over	Total
Pupils supplied with F.U. or F.L. (first time)...	—	—	—	—
Pupils supplied with other dentures (first time)...	1	6	4	11
Number of dentures supplied	1	17	13	31

Anæsthetics General Anæsthetics administered by Dental Officers... .. —

Inspections

(a) First inspection at school. Number of pupils	4,772
(b) First inspection at clinic. Number of pupils	738
Number of (a) + (b) found to require treatment	2,558
Number of (a) + (b) offered treatment	2,288
(c) Pupils re-inspected at school or clinic	378
Number of (c) found to require treatment	241

Sessions

Sessions devoted to treatment	440
Sessions devoted to inspection	29
Sessions devoted to Dental Health Education	—

STAFF OF THE HEALTH DEPARTMENT

as at 31st December, 1972

MEDICAL STAFF

County Medical Officer and Principal School Medical Officer	Ronald W. Elliott, C.B.E., M.D., M.SC., F.F.C.M., D.P.H.
Deputy County Medical Officer...	H. W. S. Francis, M.A., M.B., B.CHIR., F.F.C.M., D.P.H.
Principal Medical Officer:	
School Health Service	C. S. Smith, M.B., B.S., M.R.C.S., L.R.C.P., F.F.C.M.
Care of Mothers and Young Children and Nursing Services	Denise E. Robertshaw, M.B., CH.B., M.F.C.M., D.P.H., D.C.H.
Liaison Service	D. E. Jeremiah, M.B., B.S., M.F.C.M., D.T.M. & H., D.P.H.
Epidemiology	G. E. Leyshon, M.B., CH.B., M.F.C.M., D.OBST. R.C.O.G., D.P.H.,
Senior Medical Officer	J. A. Cooney, M.B., CH.B., B.A.O., D.T.M. & H.
Venereologist (part-time) ...	W. C. C. McCreery, M.A., M.D., B.CH., B.A.O.
Obstetrician (Joint appointment with Hospital Service)	J. C. MacWilliam, L.R.C.P., L.R.C.S., L.R.F.P.S., D.OBST. R.C.O.G.
Senior Medical Officers for the Child Guidance Service	Katherine N. Maxwell, M.B., CH.B. R. V. Read, M.R.C.S., L.R.C.P., D.P.M. Hilary Sanderson, B.SC., M.B., CH.B., DIP. ED., D.P.H., D.P.M.

Divisional Medical Officers—

Division No. and Name

1 (Skipton)	R. Singh M.B., B.S., D.P.H.
3 (Keighley)	V. P. McDonagh, M.B., CH.B., D.P.H.
4 (Shipley)	V. P. McDonagh, M.B., CH.B., D.P.H.
5 (Horsforth)	A. Telford Burn, T.D., M.B., B.S., M.F.C.M., D.P.H.
7 (Harrogate)	N. V. Hepple, M.D., B.S., B.HY., D.P.H.
9 (Rothwell/Wetherby)	Elizabeth M. Hargreaves, M.B., B.S., M.F.C.M., D.P.H.
10 (Goole)	Muriel J. Lowe, M.B., B.S., M.R.C.S., L.R.C.P., M.F.C.M., D.P.H., D.C.H.
11 (Castleford/ Pontefract)	J. F. Fraser, M.B., B.S., M.F.C.M., D.P.H., D.OBST. R.C.O.G.
13 (Morley)	G. Ireland, B.SC., M.B., B.CH., M.F.C.M., D.P.H.
15 (Spenborough)	W. M. Douglas, M.B., CH.B., M.F.C.M., D.P.H.
18 (Calder Valley)	S. H. Brock, M.B., CH.B., M.F.C.M., D.P.H.

Divisional Medical Officers—continued

20 (Colne Valley)	...	J. P. Stuart, M.B., CH.B., M.F.C.M., D.P.H.
22 (Wortley)	...	F. C. Armstrong, M.B., CH.B., M.F.C.M., D.P.H.
23 (Hemsworth)	...	J. S. Walters, M.C., M.B., CH.B., M.F.C.M., D.P.H.
25 (Barnsley)	...	C. G. Oddy, M.B., CH.B., M.F.C.M., D.P.H.
26 (Wath upon Dearne)		D. J. Cusiter, M.B., CH.B., M.F.C.M., D.P.H., D.T.M. & H.
27 (Doncaster)	...	R. Stalker, M.B., CH.B., M.F.C.M., D.P.H.
29 (Thorne)	...	G. Higgins, B.SC., M.B., CH.B., D.P.H.
31 (Rotherham)	...	D. J. Cusiter, M.B., CH.B., M.F.C.M., D.P.H., D.T.M. & 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.
3 (Keighley)	...	*J. I. Bennet, M.B., CH.B. *Doreen E. Gledhill, M.B., CH.B., M.F.C.M.
4 (Shipley)	...	*Adaline N. Ambler, M.B., CH.B. Audrey Rodwell, M.B., B.S. Audrey E. Sweeting, B.SC., M.B., CH.B.
5 (Horsforth)	...	*Helen M. Mitchell, M.B., CH.B., M.F.C.M. Agnes A. Crone, M.B., CH.B., D.C.H. Joan M. Murdoch, L.M.S.S.A.
7 (Harrogate)	...	*Isobel B. Alexander, M.B., CH.B., M.F.C.M., D.P.H. *Gertrude M. Polson, B.SC., M.B., CH.B., M.F.C.M., D.OBST.R.C.O.G. Margaret Briggs, M.B., CH.B. 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. Bevyl M. Stringer, M.B., B.S., M.R.C.S., L.R.C.P., D.OBST.R.C.O.G. Eileen A. Wain, M.B., CH.B., D.OBST.R.C.O.G.
10 (Goole)	...	*Eileen M. R. Bell-Syer, M.B., B.S. J. N. Lambton, M.B., CH.B.
11 (Castleford/ Pontefract)	...	K. V. Jackson, M.R.C.S., L.R.C.P. Sheila F. Schofield, M.B., CH.B., D.P.H., D.C.H.
13 (Morley)	...	*Barbara Briggs, M.B., CH.B., M.F.C.M., D.P.H. Doreen M. M. Anderson, M.B., CH.B., J.P. Irene Morgan, M.B., B.S., L.R.C.S., L.R.C.P. Madeline G. P. Moxon, L.R.C.S.I. & L.M., L.R.C.P.I. & L.M.

Departmental Medical Officers and School Medical Officers—continued

- 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.
 A. I. Motala, M.B., B.S., D.P.H.
- 18 (Calder Valley) ... *Marie P. Milligan, B.Sc., M.B., CH.B., D.P.H.
 Sarla Chari, M.B., B.S.
 Rosemary J. Eccles, M.B., B.S.
 W. C. McKerr, M.B., CH.B., B.A.O.
- 20 (Colne Valley) ... *L. Lloyd-Evans, M.B., CH.B.
 G. D. Roworth, M.B., CH.B.
- 22 (Wortley) ... *C. H. Merry, M.R.C.S., L.R.C.P., M.F.C.M.
 Melba R. McGinty, M.B., CH.B.
- 23 (Hemsworth) ... *Josephine Hayes, M.B., CH.B.
- 25 (Barnsley) ... *C. H. Merry, M.R.C.S., L.R.C.P., M.F.C.M.
 C. B. Ball, M.B.E., L.M.S.S.A., J.P.
- 26 (Wath upon Dearne) *Margaret C. J. Bolsover, M.B., CH.B.
 *S. K. Pande, M.B., B.S., M.F.C.M., D.P.H.
- 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.
 Kathleen Hoole, M.B., CH.B.
- 29 (Thorne) ... Vacancy
- 31 (Rotherham) ... *Margaret J. Hallinan, M.R.C.S., L.R.C.P.
 *S. K. Pande, M.B., B.S., M.F.C.M., D.P.H.
 Mary J. Daly, M.B., B.CH., B.A.O., DIP.L.M.
 Patricia J. Elson, M.B., B.S.

* Senior Departmental Medical Officers.

155 General Medical Practitioners who act as Child Welfare Centre Medical Officers and are employed on a sessional basis. This is the equivalent of 17.9 whole-time Departmental Medical Officers.

CHEST PHYSICIANS (Regional Hospital Board Appointments)—

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., M.R.C.P.
J. D. Stevens, M.D., B.SC., M.R.C.S., M.R.C.P.
R. H. Townshend, B.SC., M.B., F.R.C.P., M.R.C.S., D.T.M. & H.

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

OPHTHALMIC

P. L. Bali, D.O.M.S., M.S., D.O.
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.
R. Hawe, M.B., CH.B., B.A.O., D.O.
W. M. Higginbottom, L.R.C.P., L.R.C.S., L.R.F.P.S., D.O.
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.
P. S. Mullhi, M.B., B.S., D.O.M.S., D.O.
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.

ORTHOPAEDIC

J. H. Annan, M.B., CH.B., F.R.C.S.
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.
M. A. Pearson, M.B., CH.B., F.R.C.S.
E. R. Price, M.B., B.S., F.R.C.S., M.R.C.P.

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.
S. B. Mahatme, F.R.C.S.
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.
E. M. O'Neil, M.D., 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.

CARDIAC

W. S. Suffern, M.D., CH.B., M.R.C.P., M.R.C.S.

PSYCHIATRIC

E. Gore, M.D., CH.B., D.OBST. R.C.O.G., D.P.M.
S. 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

Senior Psychologists D. G. Pickles, M.A.
H. B. Valentine, M.A.

Psychologists G. L. Ackroyd, B.SC.
Catherine M. J. Arora, B.A., DIP.ED.
P. W. Atkinson, B.A.
Felicity A. Brown, B.A.
Annette B. Castle, B.A.
D. Clark, B.A.
R. T. Ellis, B.A.
Phillipa A. Elmhirst
Janet Gibson, B.SC.
Joan Gillibrand, B.A., CERT.ED.
Susan M. Goulding, B.SC., DIP. ED.
Jane E. Leach, B.A.
J. B. Mannix, M.ED.
P. A. Phillips, B.SC., CERT.ED.
Rosalind I. Pilkington, B.A.
Eibhlis Scally, B.A., DIP.PSYCH.
C. G. Shelley, B.A.

17 Psychiatric Social Workers (6 part-time).

SPEECH THERAPY SERVICE

Chief Speech Therapist ... Gillian M. Gill, L.C.S.T.

22 Speech Therapists (13 part-time).

DENTAL SERVICE

Chief Dental Officer and Principal School Dental Officer ... H. Taylor, L.D.S.

Dental Specialist ... Joyce Neden, B.D.S., D.D.P.H.

Senior Clinical Dental Officers W. A. Allen, B.D.S., L.D.S.
F. H. Sanderson, L.D.S.

Area Dental Officers ...	...	J. R. Clayton, B.CH.D., L.D.S., D.D.P.H. 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., R.F.P.S. J. M. Laurent, B.D.S., D.D.P.H. Valerie P. Lindsay, L.D.S. E. Lowery, B.D.S., D.D.P.H. C. F. Martin, B.CH.D., L.D.S. A. S. Metcalfe, L.D.S. E. S. Midgley, L.D.S. S. Mitchinson, L.D.S. J. Naftalin, L.D.S., R.F.P.S. M. S. Ormesher, B.D.S. B. Sleight, B.CH.D. H. G. Thorpe, L.D.S. H. M. Yuile, L.D.S., R.F.P.S.
Senior Dental Officers...	...	A. W. Glenn, B.CH.D., D.D.P.H. M. Merrick, B.CH.D.
School Dental Officers	...	Moronke O. Ajayi, B.CH.D. Susan C. Antrum, B.CH.D. D. P. Boyle, B.D.S. J. C. G. Brownlee, B.D.S. R. H. Castle, B.CH.D. Eileen M. Cooper, B.D.S. Joan M. Davison, L.D.S. W. H. Dyke, L.D.S. Jean G. Elliott, L.D.S. Lesley M. M. Fitzharris, B.D.S. D. A. Friedman, B.D.S. D. K. Goodwin, B.D.S. R. F. Grainger, B.CH.D., L.D.S. R. C. Grimwood, B.CH.D. M. Hattan, L.D.S. Hazel M. Hill, B.D.S. F. Kershaw, L.D.S. R. B. Lawrence, L.D.S. M. J. Limb, B.D.S. N. G. Northeast, B.CH.D. D. J. Poole, B.CH.D. M. J. Prendergast, B.D.S. Jessie Rothera, L.D.S. Angela M. Sinnett, B.D.S.

School Dental Officers (continued)

P. Smith, L.D.S.
A. G. Tetlow, B.D.S.
E. Thornton, L.D.S.
M. H. Valji, B.D.S. (Bombay)

5 Dental Auxiliaries

Chief Dental Technician ... K. A. Battersby

8 Technicians

1 Boy Dental Apprentice

61 Dental Surgery Assistants

NURSING AND MIDWIFERY

Director of Nursing Services ... Marjorie G. Atkinson, D.N., S.R.N., S.C.M.,
H.V.CERT., D.T. (Queen's)

Principal Nursing Officers ... Irene Endean, S.R.N., H.V.CERT., N.D.N.CERT.
Naomi I. Harris, S.R.N., S.C.M., H.V.CERT.,
D.T. (Queen's)

Non-Medical Supervisors of Midwives ... Margaret J. Astin, S.R.N., S.C.M., M.T.D.

- 17 Divisional Nursing Officers
- 20 Nursing Officers (Health Visitors/School Nurses)
- 291 Health Visitors/School Nurses (25 part-time)
- 148 Assistant Health Visitors (72 part-time)
- 5 Physiotherapists (4 part-time)
- 1 Tuberculosis Visitor
- 4 Venereal Diseases Social Workers (Qualified Health Visitors)
- 17 Nursing Officers (Home Nurses and Home Nurse/Midwives)
- 353 Home Nurses and Home Nurse/Midwives (51 part-time)
- 9 Nursing Officers (Midwives)
- 165 Midwives (18 part-time)

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 64

Field 673

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 Technical Assistants		

HEALTH EDUCATION

Principal Nursing Officer	...	Mary Tattersall, D.N., S.R.N., S.C.M., H.V.CERT., D.T. (Queen's)
2 Health Education Technicians		

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. (part-time)

ADMINISTRATIVE AND CLERICAL

Chief Administrative Officer	...	J. H. Milne, D.P.A.
Principal Administrative Officers	...	H. Beatson W. J. Battye E. Brown J. W. Ibbotson C. J. Kirk, A.M.B.I.M. R. S. Marshall T. Myton, D.P.A. T. R. Schofield, D.P.A., F.H.A.

Senior Administrative Officers	...	G. Brabant H. V. Brook D. Marshall, D.P.A., L.H.A. D. Ramsbottom P. Ward, D.P.A., L.H.A. P. R. Weaver
--------------------------------	-----	--

19 Divisional Administrative Officers

353 Other Clerical Staff (including part-time)