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THE
ANNUAL
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OF THE
COUNTY
MEDICAL
OFFICER
OF
HEALTH
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OFFICER




ON LOAN

THE
HEALTH
OF
WEST
SUSSEX

1972





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Members
of the
Health
Committee
at Littlehampton
Health Centre.
30th October,
1972.

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The Threshold of Change

It should be borne in mind that there is nothing more difficult to arrange, more doubtful of success, and more dangerous to carry through than initiating changes . . . The innovator makes enemies of all those who prospered under the old order, and only lukewarm support is forthcoming from those who prosper under the new. Their support is lukewarm, partly from fear of their adversaries who have the existing laws on their side, and partly because men are generally incredulous, never really trusting new things unless they have tested them by experience.

In consequence, whenever those who oppose the changes can do so, they attack vigorously, and the defence made by the others is ineffective.

So both the innovator and his friends are endangered together.

Machiavelli, *The Prince* (1513)

To the Members of the County Council of West Sussex

In accordance with the requirements of the *Public Health Officers Regulations 1959*, I present for your information another edition of *The Health of West Sussex*. It comprises my Annual Reports on the Health of the County and of the School Child for the year 1972 and is the thirteenth for which I have been responsible.

Industry and Inflation

The year had its full share of commotion and turmoil. Internationally, it was the year of the terrorist and the hijacker. There were explosions in public places and letter-bombs were delivered through the postal services. At home, 24 million working days were lost due to strikes, nearly twice as many as in 1971. The miners started a national strike on 9th January. Six weeks later they obtained from the Government the pay concessions they sought and they received a further bonus at the end of the year when the Government promised more than £1,000m for the support of the mining industry and gave an undertaking to arrest its contraction. Weekly wage rates increased by 13·8 per cent after an increase of 12·4 per cent in 1971.¹ Food prices as a whole rose by 7·5 per cent² but this was not by any means the whole story. During the last week of the year, meat was up 35 per cent on the same week in 1971; vegetables were 10 per cent up and fish 18·5 per cent. Overall, the fresh food sector showed a 14 per cent increase. It was all the more surprising that the statutory prices and incomes freeze proclaimed on 6th November should exclude price controls on retailed fresh food.

These industrial and inflationary trends are by no means irrelevant to the public health. The inability to keep warm in winter, a common enough experience towards the end of the miners' strike, leaves its mark on some people, particularly the young and the elderly. Whilst the bargaining power of the trade unions enables most of the working population to compensate for inflationary price spirals, the experience of recent years suggests that continuing increases in the cost of basic necessities is making it difficult for some sections of the community, notably the old age pensioners and those living on modest fixed incomes, to buy enough food to keep them in good health.

The Threshold of Change

The 1971 issue of the Report drew attention to the remoulding of the National Health Service which is planned to take place in 1974. During 1972 the pace of the run-up to reorganisation quickened. Increasing quantities of paper thumped through the letter-box of Metropolitan House and at

¹. Department of Employment Gazette. 31st January, 1973.

². The Grocers' Magazine, *Price Index*.

times senior members of the staff were in danger of suffering from documentary battle-fatigue. Quite apart from the White Paper³ and the Bill⁴, there were papers dealing with various aspects of reorganisation such as the Management Arrangements⁵ and the Hunter Report⁶. After four years' consideration of the future of the rehabilitation services, the Tunbridge Committee⁷ reported in June and the Briggs Report⁸, published in October, proposed many radical changes to simplify and modernise the nursing service.

Collectively these, and other, documents pave the way for a restructuring of the National Health Service which will in many ways bring about more radical changes than when the service was started in 1948. All the present health care administrations will be abolished and a unified structure for the delivery of health care will emerge. The Department of Health and Social Security at national level will promote the central strategic planning and monitoring of services through 14 regional health authorities and at local level about 90 new area health authorities will have the function of co-ordinating action with the new local government authorities and be in charge of area operations and the planning of new developments.

These important changes will be introduced from 1st April, 1974 and from that date the office of medical officer of health will cease to exist. Since this is therefore likely to be the last in the long series of statutory health reports which have been submitted to the County Council annually for more than sixty years, it is appropriate to try to forecast what the future may hold.

Although the health and social services of this country stand comparison with those anywhere in the world, it is fair to say that some of them, particularly for old people in need of institutional care, remain seriously underprovided. It is likely that future programmes of development will be dominated by the need to make good these deficiencies both in terms of hospital beds and places in County Council homes. These institutional services will have to be backed by an elaboration of the as yet quite rudimentary domiciliary arrangements.

Although there are examples where governments have failed to act where they should have acted, and the reluctance to bring the fluoride content of domestic water supplies to a level where dental decay would be substantially reduced is an example of this, individual effort may well be the key to future advance. It may be only by a noticeably increased determination on the part of the individual to improve his life prospects that measurably better health indices will be achieved. The marvels of modern science in such procedures as organ transplantations can have no meaningful effect on the generality of human experience or human happiness. The annual toll caused by unnecessary road accidents and premature disability and death through cigarette smoking are examples of social failure which can only be put right

³. National Health Service Reorganisation: England. HMSO. 1972.

⁴. National Health Service Reorganisation Bill. HMSO. 1972.

⁵. Management Arrangements for the Reorganised National Health Service. HMSO. 1972.

⁶. Report of the Working Party on Medical Administrators. HMSO. 1972.

⁷. Rehabilitation. Report of a Sub-Committee of the Standing Medical Advisory Committee. HMSO. 1972.

⁸. Report of the Committee on Nursing. HMSO. 1972.

by individual conviction. The misery of sexually-transmitted disease, the direct product of promiscuity and lack of consideration, again is something which will only respond to changes in the attitude of individuals. It is pathetic that, when so much is known of physiology and the techniques of population control, our overburdened planet – and indeed our country – is undergoing population increases which will have to be controlled forcibly before long if they are not controlled voluntarily by people convinced that, if there is to be enjoyment for anybody, individual freedom must not degenerate into unrestricted licence.

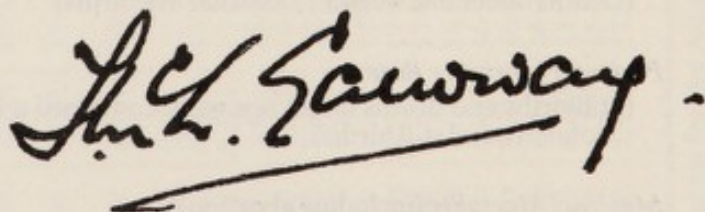
These then may be the lines along which services will develop in future years. There will be a growing emphasis on the provision of services for the old, the disabled, the mentally ill and handicapped and those who are, by modern standards, underprivileged. There will also be a growing emphasis on working together between doctors, nurses, administrators and other professionals who play such a substantial part in the growing totality of health care. An existing example of this is the imaginative programme of health centre provision which will remain as a lasting memorial to the diligence and sustained interest of the West Sussex County Council as a major health authority.

Alongside these developments there must however be some greater concern with the mechanisms whereby people create underprivilege for themselves and their succeeding generations. Political, economic and philosophical considerations are involved as well as those of health and social care. Man's prospects on earth and indeed his entire future happiness must depend on the vitality of his social institutions and his concern for them.

I have a guarded optimism that the future arrangements will represent an improvement on the old but, in terms of its health endeavour, the West Sussex County Council has nothing to be ashamed of. The generations of men and women who have been associated with this enterprise over the years have had more than employment, they have had the satisfaction of being part of an imaginative and worthwhile activity.

Acknowledgements

In no merely formal way I acknowledge the contribution to the work of the Department of so many individuals, organisations and agencies. I am particularly grateful to the Chairman and Members of the Health Committee for all they have done to promote the health of the people and I warmly commend the staff for their good work throughout the year.

A handwritten signature in black ink, reading "J. C. Sawney". The signature is written in a cursive, flowing style with a long horizontal line extending from the end of the name.

County Medical Officer of Health

PART I—GENERAL AND STATISTICAL

Vital Statistics

The Department of Health and Social Security have asked that certain vital statistics relating to mothers and infants should be included in the Report in the following form and detail; those for 1971 are also shown for comparative purposes.

<i>Live Births</i>	1971	1972
Number	6,247	5,933
Rate a 1,000 population	15.4	13.8
<i>Illegitimate Live Births</i> (per cent of total live births)	7	7
<i>Stillbirths</i>		
Number	67	65
Rate a 1,000 total live and still births	11	11
<i>Total Live and Still Births</i>	6,314	5,998
<i>Infant Deaths</i> (deaths under one year)	95	80
<i>Infant Mortality Rates</i>		
Total infant deaths a 1,000 total live births	15	13
Legitimate infant deaths a 1,000 legitimate live births	14	14
Illegitimate infant deaths a 1,000 illegitimate live births	25	21
<i>Neonatal Mortality Rate</i>		
(Deaths under four weeks a 1,000 total live births)	11	8
<i>Early Neonatal Mortality Rate</i>		
(Deaths under one week a 1,000 total live births)	10	6
<i>Perinatal Mortality Rate</i>		
(Stillbirths and deaths under one week combined a 1,000 total live and still births)	20	17
<i>Maternal Mortality</i> (including abortion)		
Number of deaths	2	2
Rate a 1,000 total live and still births	0.3	0.3

The table on page 12 gives details of the population and the main vital statistics for each County district.

VITAL STATISTICS **West Sussex compared with England and Wales**

Year	Population (mid-year estimate)	Live Births			Deaths			Infant Mortality			Neonatal Mortality			Stillbirths			Maternal Mortality		
		West Sussex	Eng- land & Wales	Rate a 1,000 population	No.	West Sussex	Eng- land & Wales	No.	West Sussex	Eng- land & Wales	No.	West Sussex	Eng- land & Wales	No.	West Sussex	Eng- land & Wales	No.	West Sussex	Eng- land & Wales
		No.				Rate a 1,000 population			Rate a 1,000 live births			Rate a 1,000 live births			Rate a 1,000 total live and still births			Rate a 1,000 total live and still births	
1911	176,308	3,386	19.1	24.4	2,203	13.1	14.6	288	85.0	130	†	†	†	†	†	†	6	1.8	3.7
1921	195,795	3,214	17.4	22.4	2,185	11.4	12.1	158	49.2	83	†	†	†	†	†	†	11	3.3	3.9
1931	216,760	3,134	14.5	15.8	2,808	13.0	12.3	139	44.4	66	†	†	†	†	†	†	13	4.1	4.1
1956	358,700	5,021	15.4	15.6	5,138	10.7	11.7	122	24.0	23.8	85	16.9	16.8	105	20.5	22.9	3	0.6	0.6
1957	370,200	5,287	15.4	16.1	4,757	10.2	11.5	103	19.5	23.1	77	14.6	16.5	130	24.0	22.5	1	0.2	0.5
1958	382,500	5,541	15.4	16.4	5,267	11.0	11.7	100	18.0	22.5	74	13.4	16.2	106	18.8	21.5	1	0.2	0.4
1959	390,000	5,656	15.1	16.4	5,537	11.8	11.6	95	16.8	22.2	64	11.3	15.9	121	20.9	20.8	2	0.4	0.4
1960	397,240	5,802	14.9	17.1	5,679	12.2	11.5	118	20.3	21.8	88	15.2	15.5	84	13.7	19.8	1	0.2	0.4
1961	410,930	5,947	14.6	17.5	5,975	12.6	11.9	107	18.0	21.4	79	13.3	15.3	97	16.1	19.0	1	0.2	0.3
1962	418,470	6,183	14.8	18.9	6,122	12.9	11.9	124	20.1	21.7	92	14.9	15.1	106	17.1	18.1	2	0.3	0.4
1963	425,710	6,395	17.3	18.2	6,634	11.2	12.2	114	17.8	21.1	86	13.4	14.3	92	14.2	17.2	—	—	0.3
1964	436,770	6,567	17.1	18.5	5,976	10.0	11.3	108	16.4	19.9	83	12.6	13.8	91	13.7	16.3	3	0.5	0.3
1965	444,690	6,506	17.1	18.1	6,539	9.7	11.5	81	12.4	19.0	57	8.8	13.0	96	14.5	15.8	1	0.2	0.3
1966	450,170	6,375	16.6	17.7	6,618	9.7	11.7	92	14.4	19.0	72	11.3	12.9	75	11.6	15.3	—	—	0.3
1967	455,930	6,420	16.6	17.2	6,665	9.5	11.2	82	12.8	18.3	56	8.7	12.5	90	13.8	14.8	—	—	0.2
1968	465,660	6,394	16.6	16.9	7,403	10.2	11.9	91	14.2	18.3	64	10.0	12.4	92	14.3	14.3	1	0.2	0.2
1969	469,900	6,242	16.2	16.3	7,231	9.7	11.9	95	15.2	18.0	63	10.1	12.0	85	13.4	13.2	1	0.2	0.2
1970	481,330	6,204	15.6	16.0	7,539	9.9	11.7	122	19.6	18.2	89	14.3	12.3	67	10.7	13.0	—	—	0.2
1971	492,710	6,247	15.4	16.0	7,310	9.3	11.6	95	15.2	17.5	71	11.4	12.0	67	10.6	12.5	2	0.3	0.2
1972	500,900	5,933	13.8	14.8	7,670	10.1	12.1	80	13.5	17.2	48	8.1	11.5	65	10.8	12.0	2	0.3	†

Note: The rates given for the Administrative County have been adjusted for age and sex and are therefore comparable with those for England and Wales.
†Not available.

Chief Vital Statistics for each County District in West Sussex

DISTRICT	Estimated population middle of 1972	No. of live births	Birth rates		No. of illegitimate births	No. of deaths	Death rates		Deaths under one year	Infant mortality rate a 1,000 live births	Respiratory tuberculosis		Cancer death rate
			Crude	Standardised			Crude	Standardised			No. of deaths	Death rate	
Urban Districts													
Arundel M.B.	2,400	29	12.1	16.2	4	40	16.7	11.7	—	—	—	—	6.3
Bognor Regis	33,910	392	11.6	14.3	41	678	20.0	10.6	3	7.7	1	0.03	4.8
Chichester M.B.	21,100	223	10.6	11.4	10	335	15.9	9.7	3	13.5	—	—	3.3
Crawley	68,810	984	14.3	13.7	55	463	6.7	10.8	22	22.4	—	—	1.8
Horsham	26,830	351	13.1	14.0	22	328	12.2	10.1	7	19.9	—	—	2.6
Littlehampton	19,480	269	13.8	15.9	31	315	16.2	10.7	3	11.2	1	0.05	3.2
Shoreham-by-Sea	19,050	211	11.1	12.5	18	253	13.3	10.6	1	4.7	—	—	2.7
Southwick	11,970	136	11.4	14.9	9	162	13.5	10.4	4	29.4	—	—	2.3
Worthing M.B.	89,090	825	9.3	13.6	64	2,176	24.4	10.0	16	19.4	1	0.01	4.4
All Urban Districts	292,640	3,420	11.7	13.7	254	4,750	16.2	10.2	59	17.3	3	0.01	3.3
Rural Districts													
Chancetisbury	28,910	352	12.2	14.4	23	385	13.3	10.1	3	8.5	—	—	3.4
Chichester	64,800	722	11.1	13.1	43	866	13.4	10.7	5	6.9	4	0.06	3.2
Horsham	32,360	492	15.2	14.9	22	290	9.0	8.3	4	8.1	—	—	1.9
Midhurst	19,710	191	9.7	11.3	12	291	14.8	8.6	—	—	—	—	2.4
Petworth	11,500	149	13.0	14.8	8	159	13.8	10.6	2	13.4	—	—	2.5
Worthing	50,980	607	11.9	15.8	31	929	18.2	10.2	7	11.5	4	0.08	3.9
All Rural Districts	208,260	2,513	12.1	14.2	139	2,920	14.0	9.9	21	8.4	8	0.04	3.1
Administrative County	500,900	5,933	11.8	13.8	393	7,670	15.3	10.1	80	13.5	11	0.02	3.2

Deaths from Cancer: 1972

Sites	MALES									FEMALES									Total Males and Females		
	Age Groups									Total Males	Age Groups									Total Females	
	0—	1—	5—	15—	25—	45—	65—	75—	0—		1—	5—	15—	25—	45—	65—	75—				
Stomach .	— (—)	— (—)	— (—)	— (—)	3 (1)	15 (12)	30 (33)	37 (26)	85 (72)	— (—)	— (—)	— (—)	1 (—)	— (—)	6 (3)	26 (12)	20 (30)	53 (45)	138 (117)		
Lung, bronchus .	— (—)	— (—)	— (—)	— (—)	5 (2)	111 (85)	125 (138)	88 (75)	329 (300)	— (—)	— (—)	— (—)	— (—)	1 (3)	27 (27)	23 (19)	23 (24)	74 (73)	403 (373)		
Breast .	— (—)	— (—)	— (—)	— (—)	— (1)	— (1)	1 (—)	1 (—)	2 (2)	— (—)	— (—)	— (—)	— (—)	9 (5)	62 (55)	49 (43)	49 (42)	169 (145)	171 (147)		
Uterus .	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	2 (2)	19 (16)	15 (9)	4 (14)	40 (41)	40 (41)		
Other organs .	— (—)	1 (1)	2 (1)	1 (2)	16 (9)	81 (79)	153 (129)	151 (145)	405 (366)	— (—)	3 (1)	1 (—)	1 (3)	11 (11)	81 (96)	109 (114)	196 (153)	402 (378)	807 (744)		
Leukaemia .	— (—)	— (—)	2 (—)	2 (1)	1 (1)	4 (4)	12 (7)	14 (4)	35 (17)	— (—)	— (—)	1 (—)	— (—)	— (1)	6 (4)	3 (5)	7 (7)	17 (17)	52 (34)		
TOTALS .	— (—)	1 (1)	4 (1)	3 (3)	25 (14)	211 (181)	321 (307)	291 (250)	856 (757)	— (—)	3 (1)	2 (—)	2 (3)	23 (22)	201 (201)	225 (202)	299 (270)	755 (699)	1,611 (1,456)		

Note: The figures in brackets relate to 1971.

Causes of Death at Different Periods of Life

Registrar General's Code	Causes of Death	Total all ages		Under 4 weeks		4 weeks and under 1 year		Age in years																			
		M	F	M	F	M	F	1-		5-		15-		25-		35-		45-		55-		65-		75 & over			
								M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
B.1	Cholera	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		
B.2	Typhoid fever	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		
B.3	Bacillary dysentery and amoebiasis	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		
B.4	Enteritis and other diarrhoeal diseases	2	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		
B.5	Tuberculosis of respiratory system	4	3	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		
B.6(1)	Late effects of respiratory tuberculosis	4	3	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		
B.6(2)	Other tuberculosis	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		
B.7	Plague	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		
B.8	Diphtheria	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		
B.9	Whooping cough	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		
B.10	Streptococcal sore throat and scarlet fever	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		
B.11	Meningococcal infection	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		
B.12	Acute poliomyelitis	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		
B.13	Smallpox	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		
B.14	Measles	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		
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	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		
B.19(1)	Malignant neoplasm, buccal cavity and pharynx	12	5	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		
B.19(2)	Malignant neoplasm, oesophagus	21	23	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		
B.19(3)	Malignant neoplasm, stomach	85	53	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		
B.19(4)	Malignant neoplasm, intestine	100	132	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		
B.19(5)	Malignant neoplasm, larynx	10	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		
B.19(6)	Malignant neoplasm, lung, bronchus	329	74	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		
B.19(7)	Malignant neoplasm, breast	2	169	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		
B.19(8)	Malignant neoplasm, uterus	-	40	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		
B.19(9)	Malignant neoplasm, prostate	64	17	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		
B.19(10)	Leukaemia	35	17	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		
B.19(11)	Other malignant neoplasms, including neoplasms of lymphatic and haematopoietic tissue	198	241	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		
B.20	Benign neoplasms and neoplasms of unspecified nature	7	9	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		
B.21	Diabetes mellitus	23	22	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		

The Weather at Worthing: 1972

Month	Air temperature (deg. F.)						Rainfall		Sunshine	
	Highest max.	Lowest min.	Mean max.	Mean min.	Mean	Difference from average	Total (ins.)	Percentage of average	Total (hrs.)	Percentage of average
January .	50	47	44.9	36.6	40.7	—0.2	2.95	99	45.4	64
February .	51	27	46.3	38.1	42.2	+1.3	1.76	88	48.3	57
March . .	65	28	51.6	39.7	45.7	+1.9	1.64	95	173.1	123
April . .	61	35	54.1	42.9	48.5	+0.5	2.19	123	164.9	88
May . .	70	37	57.7	48.2	52.9	—0.6	2.16	131	199.4	87
June . .	67	42	58.9	49.3	54.1	—5.0	1.52	99	209.3	86
July . .	79	47	67.5	54.9	61.2	—1.3	1.12	52	196.8	88
August . .	75	47	68.2	53.7	60.9	—1.7	1.56	70	216.7	99
September .	73	39	62.6	48.9	55.7	—3.7	0.82	38	152.7	93
October .	64	37	59.1	47.8	53.5	+0.6	0.80	27	131.3	106
November .	58	29	50.4	40.4	45.4	—0.8	3.63	106	88.3	121
December .	55	32	49.6	41.4	45.5	+3.7	4.19	144	65.5	107
Means or extremes .	79	27	56.0	45.2	50.6	—0.4	24.34	88	1,691.7	93

PART II—EPIDEMIOLOGY

Notifiable Diseases

The total number of infectious diseases notified in 1972 was the lowest ever recorded. Of the 452 cases notified, 260 (57.5 per cent) were in respect of measles which in itself was the lowest number on record. In addition to the diseases shown in the table on page 18 there were four cases of malaria, all of which were contracted abroad.

Sexually-transmitted Disease

There was a substantial increase (38 per cent) in the total number of new cases seen at special treatment centres in 1972. The next table shows that the number of new cases of syphilis and gonorrhoea increased by 10 and 80 respectively. The physician in charge of the special treatment centre at the Royal West Sussex Hospital, Chichester, reported that the reduction in public transport to and from Chichester from outlying areas caused considerable difficulty for some patients, especially those who attended the weekday evening clinics after work.

Contact-tracing in the western area of the County was carried out by a nurse employed in the special treatment centre by the hospital service; her travelling expenses were paid by the Council. In the eastern parts of the County contact-tracing was carried out by a nurse employed by the Brighton County Borough Council.

<i>Hospital</i>	<i>Number of New Cases</i>			
	<i>Syphilis</i>	<i>Gonorrhoea</i>	<i>Other Genital Infections</i>	<i>Other Conditions</i>
Royal West Sussex Hospital (St. Richard's), Chichester	10 (3)	132 (83)	450 (308)	102 (86)
Worthing Hospital	3 (2)	82 (66)	160 (152)	167 (132)
Royal Surrey County Hospital, Guildford	— (—)	2 (—)	5 (4)	7 (4)
St. Mary's Hospital, Portsmouth	— (—)	3 (—)	22 (23)	7 (8)
Royal Sussex County Hospital, Brighton	2 (3)	45 (51)	108 (120)	99 (123)
Croydon General Hospital	— (1)	— (1)	3 (1)	1 (2)
St. Helier Hospital, Carshalton	— (—)	2 (—)	1 (—)	— (—)
East Surrey Hospital, Redhill	4 (—)	15 (—)	142 (—)	48 (—)
TOTALS	19 (9)	281 (201)	891 (608)	431 (355)

Note: The figures in brackets relate to 1971.

Vaccination and Immunisation

As expected, there was an increase (14 per cent) in the number of primary courses of immunisation against diphtheria, tetanus, whooping cough and

Notification of Infectious Diseases: 1972

COUNTY DISTRICT	Acute encephalitis		Acute meningitis	Acute poliomyelitis		Dysentery	Food poisoning	Infective jaundice	Measles	Ophthalmia neonatorum	Paratyphoid fever	Scarlet fever	Tetanus	Tuberculosis		Typhoid fever	Whooping cough	TOTAL
	Infective	Post Infectious		Paralytic	Non Paralytic									Respiratory	Other			
Urban Districts																		
Arundel M.B.	—	—	1	—	—	—	—	4	143	—	—	1	—	—	—	—	—	1
Bognor Regis	—	—	—	—	—	2	2	1	—	—	—	—	—	3	—	—	—	151
Chichester M.B.	—	—	3	—	—	13	8	8	18	—	—	2	—	2	1	—	—	8
Crawley	—	—	1	—	—	4	2	—	3	—	—	4	—	5	3	3	3	66
Horsham	—	—	—	—	—	—	—	1	1	—	—	2	—	4	—	—	—	18
Littlehampton	—	—	—	—	—	—	21	1	5	—	—	2	—	1	—	—	—	5
Shoreham-by-Sea	—	—	—	—	—	—	1	2	8	—	—	4	—	—	—	—	—	27
Southwick	—	—	4	—	—	—	1	1	12	—	—	3	—	2	1	—	1	16
Worthing M.B.	—	—	—	—	—	—	1	1	—	—	—	—	—	—	—	—	—	24
Total Urban Districts	—	—	9	—	—	19	35	18	190	—	—	16	—	17	5	3	4	316
Rural Districts																		
Chancetonbury	—	—	1	—	—	—	3	2	—	—	—	2	—	3	1	—	—	12
Chichester	—	—	1	—	—	2	1	8	39	—	—	9	—	4	—	—	—	64
Horsham	—	—	—	—	—	3	1	2	7	—	—	2	—	4	—	—	—	19
Midhurst	—	—	1	—	—	—	—	—	16	—	—	—	—	—	1	—	—	18
Petworth	—	—	—	—	—	—	—	—	5	—	—	—	—	—	—	—	—	5
Worthing	—	1	—	—	—	3	—	—	3	—	1	8	—	2	—	—	—	18
Total Rural Districts	—	1	3	—	—	8	5	12	70	—	1	21	—	13	2	—	—	136
Total Administrative County	—	1	12	—	—	27	40	30	260	—	1	37	—	30	7	3	4	452
Total Administrative County 1971	—	—	3	—	—	23	34	76	909	—	—	57	—	17	5	—	61	1,185

Note: Notifications of rubella (14) in Worthing R.D. are not shown in this table.

poliomyelitis compared with 1971 when there was a reduction in the number of immunisations given caused by the postal strike in the early part of that year.

The number of reinforcing injections against poliomyelitis and tetanus showed an increase of 689 (five per cent) but the number of reinforcing injections of diphtheria/tetanus decreased by 227 (four per cent). Vaccinations given against measles decreased by 343 (six per cent) but vaccinations against rubella (offered to girls of 12 years and over) increased by 2,057 (57 per cent). This increase was largely accounted for by the inclusion for the first time of girls in the Borough of Worthing and also by the reduction in the age when vaccination was first offered.

The details of primary and reinforcing immunisations against communicable diseases are given in the next table.

<i>Type of Injection</i>	<i>Primary Immunisations</i>		<i>TOTALS</i>	<i>Reinforcing Injections</i>		<i>TOTALS</i>
	<i>By County Medical Staff</i>	<i>By General Practitioners</i>		<i>By County Medical Staff</i>	<i>By General Practitioners</i>	
Diphtheria and tetanus	85 (99)	129 (99)	214 (198)	1,682 (1,679)	4,601 (4,831)	6,283 (6,510)
Measles	1,473 (1,568)	4,529 (4,777)	6,002 (6,345)	— (—)	— (—)	— (—)
Poliomyelitis	1,576 (1,353)	4,961 (4,366)	6,537 (5,719)	2,456 (2,434)	7,683 (7,558)	10,139 (9,992)
Rubella	3,857 (2,256)	1,658 (1,202)	5,515 (3,458)	— (—)	— (—)	— (—)
Tetanus	— (—)	15 (5)	15 (5)	703 (639)	2,847 (2,369)	3,550 (3,008)
Triple antigen	1,494 (1,296)	4,772 (4,194)	6,266 (5,490)	— (—)	— (—)	— (—)

Note: The figures in brackets relate to 1971.

B.C.G. Vaccination

The vaccination against tuberculosis of children aged 13 years and over was continued. The following table shows the numbers of children skin-tested and vaccinated in each of the ten years since 1963.

<i>Year</i>	<i>Number skin-tested</i>	<i>Number positive</i>	<i>Percentage positive</i>	<i>Number negative</i>	<i>Number vaccinated</i>
1963	6,222	483	7.8	5,459	5,430
1964	4,166	250	6.0	3,801	3,765
1965	4,231	294	6.9	3,745	3,632
1966	5,214	350	6.7	4,767	4,731
1967	5,735	502	8.7	5,083	5,033
1968	5,147	299	5.8	4,631	4,591
1969	5,471	269	4.9	5,202	5,107
1970	5,905	192	3.3	5,430	5,410
1971	5,608	186	3.3	5,170	5,144
1972	6,042	179	3.0	5,533	5,477

PART III—CARE OF MOTHERS AND YOUNG CHILDREN

Ante-natal and Post-natal Care

Details of attendances during the last two years are given below.

	1971	1972
Number of ante-natal clinics provided at end of year	1	1
Number of sessions held a month	4	4
Number of women in attendance:		
(i) for ante-natal examination	378	279
(ii) for post-natal examination	84	27

Child Health Clinics

The number of child health clinics operating at the end of the year was 44. The total number of children who attended decreased by 239 compared with 1971. The numbers of children of various ages who attended the clinics during 1971 and 1972 are given below.

1971		1972	
Born in		Born in	
1971	3,737	1972	3,525
1970	3,476	1971	3,361
1966-1969	2,839	1967-1970	2,927
TOTAL	10,052	TOTAL	9,813

Weighing Centres

The numbers of children who attended weighing centres during 1971 and 1972 are given below.

1971		1972	
Born in		Born in	
1971	561	1972	561
1970	554	1971	509
1966-1969	575	1967-1970	572
TOTAL	1,690	TOTAL	1,642

Health visitors give advice at these centres about infant care to groups which are too small to justify the regular attendance of a medical officer.

Battered Babies

The survey, started in May 1971, into the problem of young children who may be injured by their parents or by those caring for them was continued; the intention is to recognise those children who are at risk of injury before any actual damage occurs.

In the course of the first year, with the help of health visitors and hospital and family doctors, 50 'at risk' situations were identified, and in five of these there was evidence of real injury. With the co-operation of the Social Services Department, it was possible to help most of these cases. It is still too early to make a detailed appreciation of the success of the scheme but it should

produce valuable information on methods of recognising situations where parents and children need help or protection.

Family Planning

In accordance with the policy decision of February, 1971 the County Council assumed direct responsibility for the family planning service on 1st April, 1972. Services in Worthing are administered by the Borough Council under delegated powers.

The smooth transfer of responsibility was due in large measure to the co-operation of the Sussex Branch of the Family Planning Association and of the doctors, nurses, clinic organisers and lay workers concerned. Links with the Family Planning Association will continue on such matters as the training of staff and the provision of publications.

The *National Health Service (Family Planning) Amendment Act 1972* received the Royal Assent on 26th October, 1972. The main purpose of the Act is to place vasectomy (a simple operation to sterilise males) on the same basis as other contraceptive services which local health authorities may provide.

Clinic Services

A policy of steady expansion continued. Additional clinic sessions were provided at Bognor Regis, Chichester, Horsham and Midhurst. In other areas more medical and nursing staff time was made available to increase the capacity of existing sessions.

Clinics	New cases		Total numbers of women in attendance		Total attendances	
	1971	1972	1971	1972*	1971	1972
Bognor Regis	416	368	1,096	1,120	3,018	3,067
Chichester and Selsey	490	834	1,420	1,922	3,377	4,779
Crawley and Tilgate	788	837	2,734	2,742	7,078	7,264
Horsham, Roffey and Billingshurst	466	499	1,790	1,839	4,374	4,489
Lancing	121	206	200	349	594	947
Littlehampton	232	250	467	564	1,095	1,383
Midhurst	23	42	157	187	352	317
Shoreham-by-Sea	265	270	611	649	1,194	1,374
Worthing	883	843	2,616	2,832	6,655	6,834
TOTALS	3,684	4,149	11,091	12,204	27,737	30,454

*Nine months from 1st April to 31st December, 1972

In the full year 1972 there was an increase of 465 (12.6 per cent) in the number of new cases seen in clinics and total attendances increased by 2,717 (9.8 per cent).

During the nine-month period of directly-provided service, 35.4 per cent of the new patients seen in West Sussex clinics were given entirely free service; 32.8 per cent of new patients were single women, the majority of whom were seeking advice prior to marriage.

Domiciliary Service

The domiciliary service continued in the western and south-eastern area of the County. Total coverage of the County was achieved in 1972 with the introduction of a service for the north-eastern area. The results are shown in the following table.

	<i>North-east (Crawley)</i>	<i>South-east (Worthing)</i>	<i>West (Chichester)</i>	<i>Total</i>
New patients visited	13	30	59	102
Pregnancies reported	—	—	1*	1*

*Ectopic pregnancy

Patients are referred to the domiciliary service for medical, psychiatric, social or geographic reasons; almost all are unwilling or unable to obtain advice on family planning in any other way. Without such a service they would be at considerable risk of pregnancy. The fact that no live birth occurred in the 102 new cases treated during the year demonstrates how effectively the service is achieving its objective.

Further evidence is afforded by a review of the results of the first three years of operation in the Chichester and Bognor Regis area. The statistical results are shown in the following table.

Referred by:	Health visitors	.	114	
	Social workers	.	4	
	Gynaecologists	.	6	
	F.P. clinics	.	8	132
Primary reasons for referral:	Medical	.	11	
	Psychiatric	.	17	
	Social	.	87	
	Clinic inaccessible	.	17	132
Average age at referral:			27	
Average number of past pregnancies:			3.4	
Method used:	Oral	.	54	
	I.U.D.	.	62	
	Cap	.	8	
	Condom	.	13	
	None	.	3	1 declined advice 1 already pregnant 1 moved before visit
Pregnancies:			5	1 sterilised after delivery 1 sterilised after termination 1 awaiting delivery and sterilisation 1 spontaneous abortion 1 ectopic pregnancy

I am indebted to Dr. Margaret Chidell for the following comments.

'During the first three years of operation, the domiciliary service has received 132 referrals, nearly 90 per cent of these coming from health visitors, notably those with a particular concern for this aspect of their patients' welfare. Almost all patients referred said they would not or could not have sought advice of their own accord and were grateful.

The younger age of new patients during 1972 gives an encouraging indication that more are being referred at the 'pre-problem' rather than 'problem family' stage.

Eighteen per cent of all families seen had children either in care or requiring special protection, and in 5 per cent of cases there was a known prison record. Twenty-one per cent of the families had five or more children.

As the service has become established it has been found that, with the medical officer available for consultation and good liaison with clinic staff, the domiciliary family planning nurse can make the great majority of home visits. Providing she offers transport she has usually found patients willing to come with her to the clinic for examination or I.U.D. fitting. The number of doctor visits has therefore been substantially reduced. This represents a considerable saving to the service, particularly in travelling expenses, as the nurse can arrange a 'round' of visits to patients (new and old) in each district of the largely rural area covered.

Of the 132 cases referred, 129 accepted advice. The total number of past pregnancies in these women was 439 and the total number of months which had elapsed since they first conceived was 9,505. They therefore had one pregnancy every 21.6 months. The total number of months during which these 129 women were advised by the domiciliary service was 1,560. Before advice, with a pregnancy rate of one every 21.6 months, 72 pregnancies would have been expected. In fact there were five. It may therefore be concluded that in three years the service has probably averted 67 pregnancies, not including permanent prevention following sterilisation.'

Mothercraft and Relaxation Classes

Mothercraft and relaxation classes for expectant mothers and classes in post-natal exercises were held at the nine centres shown in the following table which also gives particulars of the numbers of attendances made in 1971 and 1972. Physiotherapists took charge of some of the classes; others were run by midwives or health visitors.

Area	Sessions held	Total number of attendances	
		1971	1972
Arundel	Weekly	62	—*
Bognor Regis	Weekly	387	285
Chichester	Weekly	944	222
Crawley	Weekly	1,120	681
Horsham	Weekly	1,931	2,140
Lancing	Weekly	348	403
Roffey	Weekly	225	128
Shoreham-by-Sea	Weekly	513	507
Steyning	Weekly	—	126†
Worthing	Weekly	418	192
TOTALS		5,948	4,684

*No sessions held in 1972

†Commenced January, 1972

Welfare Foods

The Council continued to arrange the distribution of welfare foods to expectant and nursing mothers and children under five years of age. In February, the Department of Health and Social Security invited authorities to review their arrangements for the sale of these foods to provide a minimum number of distribution centres required to ensure an adequate service to beneficiaries. As a result of this invitation and the low take-up of sales over the last few years, the sale of welfare foods was discontinued at 36 centres from 1st May, 1972. At the end of the year, 43 centres were still in operation; nine of these were main centres and 34 were sub-centres at clinics, doctors' surgeries, local stores and private houses. The Women's Royal Voluntary Service were responsible for the distribution of welfare foods at five main centres (all of which are on their premises) and at eight sub-centres.

The following table shows the quantities of welfare foods issued to beneficiaries during the year.

<i>Year</i>	<i>National dried milk (packets)</i>	<i>Vitamin drops (bottles)</i>	<i>Vitamin A, D & C tablets (packets)</i>
1972	6,624 (131)	12,887 (247)	1,020 (20)

Note: The figures in brackets indicate the average weekly distribution.

Proprietary Foods

Infant proprietary foods were sold at 53 child health clinics at cost price plus a ten-per-cent handling charge. During the year the purchase price of proprietary foods increased by an average of 20 per cent; there was a small drop in take-up. The cost of purchases rose from £6,409 in 1971 to £6,943 in 1972.

Congenital Malformations

There were 153 births in which a congenital malformation was observed and entered on the birth notification card. The total number of congenital malformations described was 168.

Dental Care

A total of 561 expectant and nursing mothers and pre-school children were examined; 259 needed treatment and 257 courses of treatment were completed.

The rate of decayed, missing and filled teeth per child between four and five years of age was 3.2, a decrease of 0.2 over the figure for 1971.

Information on the dental care of school children is given in Part IX of the Report.

PART IV—NURSING SERVICES

General

Changes in the work of nurses consequent upon the opening of new health centres were detailed in the Report for 1971. Nursing staff attached to practices operating from the two rural health centres opened this year (at Rudgwick and The Witterings) extended their duties to include work in treatment rooms. Staff training for the clinical procedures involved in this work continued in co-operation with the nursing departments of Redhill and Netherne, and Chichester and Graylingwell Hospital Groups.

The Secretary of State for Social Services visited West Sussex in May to discuss with hospital and community nurses the problems of geriatric patients in the area. The meeting afforded an opportunity for a useful exchange of views on the need for care and the prevention of illness.

Informal discussions took place between senior nursing staff of East and West Sussex County Councils and nursing officers of the three hospital groups within the County on matters concerned with the forthcoming reorganisation of the National Health Service.

Nurse Education

Co-operative training arrangements with hospitals in the County were maintained. Experience in community nursing continued to be provided for student nurses from Crawley Hospital; a similar course for students from Southlands Hospital, Shoreham-by-Sea, was started during the year. Integrated training for state enrolled nurses continued at Southlands Hospital. Six health visitor students successfully completed their training in the County.

In-service training for nursing staff of the Department continued. In addition to formal refresher courses, a variety of study days was provided for health visitors, district nurses and midwives, including a two-day appreciation course on family planning in July, 1972.

Home Nursing

Work Undertaken

The number of patients treated and the visits paid during the past three years are given below. Particulars of the staff employed are given in the table on page 73.

	1970	1971	1972
Total number of persons nursed during year .	14,107	17,259	20,247
Number of persons under 5 years	386	398	363
Number of persons over 65 years	10,056	11,659	14,850
Total number of visits	391,501	406,638	404,734

The number of patients treated increased by 2,988 (17.3 per cent) but the total number of visits paid during the year decreased by 1,904 (0.5 per cent). The corresponding figures for 1971 were increases of 3,152 patients (22.3 per cent), and of 15,137 treatments (3.9 per cent). There was an increase in the number of patients who were over the age of 65 years, from 1,603 (15.9 per cent) in 1971 to 3,191 (27.4 per cent) in 1972.

The figures relating to patients shown in the table on page 30 of the Report for 1971 did not include those relating to the Borough of Worthing; the revised figures are given in the last table which, for ease of reference, also shows those for 1970.

Night Nursing

Nursing care at night was provided for 50 patients in the County during the year.

Equipment

There was a further increase in demand for most of the items in the range of available equipment. The additional deliveries and collections were only possible by careful route-planning on the part of the van drivers, who had to carry the increased workload within their normal hours of duty. The nurses helped to distribute smaller items which were left at health centres and clinics and, in the Chichester area, they often called at the central store to collect and return equipment direct.

In September, 1972 the long-awaited change in the national arrangements for the provision of wheelchairs came into effect. General medical practitioners and local health authority doctors are now able to prescribe wheelchairs through the National Health Service without reference to a consultant; this should result in many of the Council's wheelchairs being out with patients for short periods only.

Continuing the trend of the past few years, bath aids remained in great demand. This may be indicative of an ageing population and the popularity of West Sussex as a place to which to retire, but it cannot be over-emphasised that bath aids save nursing time by enabling the patient to get more easily in and out of the bath, and bathing itself generates feelings of well-being in the patients.

No fewer than 5,913 items were issued in 1972 compared with 5,623 in 1971. Collections were 4,614 compared with 3,992 in 1971. The increase in the number of issues in 1971 compared with 1970 was 23.5 per cent; in 1972 compared with 1971 the increase was 5.2 per cent. In 1972 the number of issues was five times greater than in 1964.

Article	Stock		Number of issues		Article	Stock		Number of issues	
	1971	1972	1971	1972		1971	1972	1971	1972
Back rests .	284	333	248	282	Hoists:				
Bath boards .	176	262	97	119	Hydraulic .	39	43	41	52
Bath mats .	1,142	1,462	393	413	King .	21	21	8	2
Bath safety rails .	833	1,040	317	367	Inflatable .				
Bath seats .	879	1,129	468	504	mattresses .	23	23	14	7
Beds .	112	113	102	103	Mattresses .	136	146	103	93
Bed blocks .	274	346	108	122	Poles and chains .	85	85	79	77
Bed cradles .	394	446	306	330	Ripple .				
Bed ladders .	93	93	15	15	mattresses .	26	35	59	82
Bed pans .	283	308	139	147	Sanicushions .	16	16	2	1
Commodes .	779	926	801	848	Sanitary .				
Crutches .	184	184	144	117	pushchairs .	14	14	15	7
Dunlopillo rings .	652	748	323	349	Seat aids .	115	127	87	91
Ejector seats .	50	52	30	44	Toilet seats .				
Exercycles .	9	9	2	—	(raised) .	164	176	77	104
Fracture boards .	142	172	65	72	Urinals .	406	517	176	196
Helping hands .	263	287	68	87	Walking aids:				
					Sticks .	609	734	263	293
					Frames .	797	884	581	539
					Wheelchairs .	347	353	492	450

Midwifery

The number of births notified in 1972, adjusted by inward and outward transfers, decreased by 330. Of the total number of 6,018 births notified, 5,772 (95.9 per cent) were delivered in hospital and 246 (4.1 per cent) were home deliveries. Of the latter, a doctor was not booked in eight cases. In 1972, 52 women who were booked for home confinement had to be transferred to hospital for delivery. Medical aid was summoned by domiciliary midwives on only six occasions, compared with 57 in 1971.

The Council's midwives delivered 306 of their own cases in hospitals within the County compared with 386 in 1971.

In September, 1972 arrangements were made for hospital midwives to undertake the care of mothers discharged from hospital in the Worthing area. Ante-natal care in family doctor practices in that area was undertaken by the one remaining domiciliary midwife.

Maternal Deaths

There were two deaths in the County related to pregnancy and childbirth. Both were investigated in cooperation with the hospitals concerned. One death was due to subarachnoid haemorrhage secondary to toxæmia in pregnancy, the other to cerebral infarction in a woman in very early pregnancy who had sought no ante-natal care.

Health Visiting

Particulars of the staff employed are given in the table on page 73.

Details of the main types of cases visited by health visitors during the year are given below.

<i>Type of Case</i>	<i>Number of cases visited</i>	
	1971	1972
Children under the age of 5 years	23,084	23,939
Persons aged 65 or over	6,252 (2,967)	7,492 (4,042)
Mentally disordered persons	136 (87)	167 (122)
Households visited on account of tuberculosis	60	51
Households visited on account of other infectious diseases	29	24
Households visited for any other reason	*	4,292

Note: The figures in brackets denote the number of persons visited at the special request of a general practitioner or hospital.

* Not available.

PART V—PREVENTION OF ILLNESS, CARE AND AFTER CARE

Health Education

The policy changes referred to in the last Report were implemented; they were unavoidable because an increase in the quantity and sophistication of demand coincided with a reduction of staff. There was therefore less direct communication with the public by the health education specialist but more emphasis was placed on helping and advising those whose work included an element of health teaching.

The extent of nursing staff involvement with group health education varied. Where they have the necessary confidence and support for this work, health visitors have much to give and their help is appreciated by schools and other organisations who make use of their skills.

The health education staff gave advice to other members of the Department's staff, they organised small in-service training courses, and produced audio-visual aids. One health visitor completed the health education course at Highbury Technical College, but it was not possible to send more staff for this training.

A scheme was started for training nursing staff in some basic principles of health education. The main objective was to increase the awareness of nurses of their special health education opportunities in a community – other than by group teaching. Nursing staff from hospitals also joined in. The first courses consisted of a series of four discussion groups with eight to twelve members in each. It is too early to say whether the main objective was attained but the courses showed how useful it is for nurses to have the chance to examine the wider implications of their work in relation to the communities they serve.

Exploratory meetings took place with hospital staff to discuss opportunities for health education in hospitals. Although suggestions were welcomed, some practical problems remain unsolved.

Several meetings to discuss health teaching problems were held at teachers' centres. These showed the need for further in-service training and the importance of passing on new information. Teaching in schools by the health education staff had to be curtailed but advice to teachers and help with special projects, including the loan of visual aids, continued; some of this work was, however, only superficial.

The Working Party organised by the Education Department, upon which the Health Department was represented, met at regular intervals to study the subject of Education for Living.

The health education organisers gave 282 talks to a total audience of about 12,000 people. Excluding projection equipment, 708 audio-visual aids were lent from headquarters. The basic stocks of equipment maintained at centres throughout the County were increased. The high standard of displays and other visual aids produced by the Technical Assistant were the subject of favourable comment not only by those who used them but also by members of the public and the local press – thus further publicising the work of the Department.

Parentcraft Education

Education for family life and parentcraft remained an essential basis for much health education work. Locally this was undertaken by nursing staff in homes and clinics and by teachers in schools. Health visitors have been doing this work for more than a century. Mothers' clubs provided opportunities for further discussion of health and family topics. Nationally, there are many organisations concerned with education for parenthood, and their work might be more effective if it were appropriately coordinated.

Lodge Hill Refresher Course

The Refresher Course for nursing staff held in 1972 was probably the last to be held in the form which has been described in previous issues of the Report. These courses have been held annually since 1949, and were possibly the first to be organised by a local health authority. Thanks are due to all the speakers who have so willingly given their time and who have helped to maintain high standards.

Smoking

A lecture on smoking in pregnancy was included in the Lodge Hill Course. The Health Education Organiser also lectured on this subject to the West Sussex Branch of the Royal College of Midwives. Education about smoking is included in health education programmes in schools but insufficient resources prevented the promotion of concentrated campaigns by the Department. The project organised in 1971 by the Health Education Council at The Boundstone School, Sompting, was followed up in the summer by further questionnaires. The results of this work have not yet been published.

Venereal Diseases

Information about venereal diseases was included in education on personal relationships undertaken by the staff of the Department. The Health Education Organiser participated in a symposium on the Epidemi-

ology of Venereal Disease arranged by the Community Health Group of the Royal Society of Health. This subject was also included in discussions at teachers' centres, with the police, with youth workers and with parents. There was a national dearth of good visual aids materials suitable for teaching young people.

Medical Arrangements for Long Stay Immigrants

The Department received 213 advice notes during the year, compared with 210 in 1971, about immigrants who had given destination addresses within the County; all but 29 came from European or Commonwealth countries. If an immigrant could not be traced at the address given or had moved to another address, the port medical officer was informed and, where a forwarding address was known, the appropriate medical officer of health was also notified.

Chest Clinic Statistics

The details in the next table were supplied by the chest physicians and give an account of the work of the chest clinics. Although there is now a chest clinic in operation at the Royal West Sussex (St. Richard's) Hospital, Chichester, details of patients attending there were not kept for 1972. At the end of the year, the total numbers of patients on the registers of the clinics in the four areas showed a decrease of 26 (307 compared with 333 in 1971); of the new patients first examined, 28 (7 more than in 1971) were found to be suffering from tuberculosis.

	<i>Chest Clinics</i>			
	<i>Bognor Regis</i>	<i>Crawley</i>	<i>Horsham</i>	<i>Worthing</i>
1. Population of area served .	164,050	69,000	58,100	211,000
2. Patients on register on 1.1.72 .	74	127	75	57
3. Additions to register :				
(a) New notifications .	9	4	8	6
(b) Moved into area .	3	3	6	3
(c) Restored to register .	—	—	—	1
4. Removed from register :				
(a) Recovered .	3	1	1	14
(b) Left area or lost sight of .	2	21	15	1
(c) Died .	2	—	4	5*
5. Patients on register on 31.12.72 .	79	112	69	47
6. Number of new patients found to be tuberculous .	9	5	8	6
7. (a) Contacts examined, including those of 6 above .	30	29	18	31
(b) Of these, number found to be tuberculous .	—	—	—	—

*One only from tuberculosis.

Discharge from Hospital

The scheme for reporting the after-care requirements of patients, details of which were given in the Report for 1964, was reviewed because of apparent delays in the receipt of information by the home nurses.

Following discussion by nursing officers of hospitals and the Department, it was agreed that requests for nursing care would be made on a direct nurse-to-nurse basis rather than through the medical social workers of the hospitals and the area nursing officers. It was agreed that the small form used from the start of the scheme in 1964 was unsuitable if comprehensive information about the patients was to be conveyed from the hospital ward to the home nurse. The new form, which was jointly designed by the various nursing officers and subsequently introduced by the hospitals, has greatly improved communications on patients' needs.

Discussions took place between the nursing officers regarding the procedure to be adopted before long-stay patients were discharged. It was agreed that the home nurse should be informed of the proposed discharge well in advance; she could then visit the patient's home to discuss future home care with the relatives and tell the hospital if conditions were unsuitable so that the discharge could be delayed until proper arrangements, particularly for the patient living alone, could be made. Early notice of these discharges would moreover enable the Department to install any necessary home equipment before the patient returned home.

Chiropody

Particulars of the staff employed are given in the table on page 73. The resignation of two chiropodists at Bognor Regis and Littlehampton in September and October respectively resulted in large increases in the waiting lists in those areas, and led inevitably to disappointment amongst the elderly who have become accustomed to regular treatment. It proved difficult to recruit staff to fill these vacancies in the face of a national shortage of qualified chiropodists and the prevailing pay scales laid down by the Whitley Council. Even when appointments are eventually made, it will be several months before the waiting lists in these areas can be substantially reduced.

The numbers of individuals awaiting treatment at the other main centres in the County were considerably reduced by the end of the year; in some clinics, treatment was available to new patients within a matter of weeks.

The mobile chiropody unit was taken out of service at the end of April because of difficulties in manning the unit. The opportunity was taken to renovate the interior and to overhaul the vehicle which is in its seventh year of service. A driver-clinic assistant was appointed and took up her duties in October. By relieving chiropodists of driving duties, this appointment enabled male or female chiropody staff to operate from the unit.

In spite of the staffing difficulties mentioned above, the number of persons treated increased by 2,167 (1,507 in 1971) and there was an increase of 9,501 treatments in the year compared with 7,978 in 1971.

<i>Year</i>	<i>Treatments</i>			<i>Percentage free</i>
	<i>Clinic</i>	<i>Domiciliary</i>	<i>Total</i>	
1968	18,610	3,418	22,028	32
1969	23,746	5,318	29,064	39
1970	25,370	4,188	29,558	37
1971	33,146	4,390	37,536	35
1972	39,393	7,644	47,037	34

In addition, chiropody was provided by 11 voluntary organisations each of which received financial support from the Council. These organisations gave 1,847 treatments at 251 sessions. The corresponding figures for 1971 were 2,201 and 306 provided by 13 organisations. One club which was obliged to suspend its chiropody service to members at the end of 1971 did not open during 1972. The Council assumed direct responsibility for the service previously provided by the Women's Royal Voluntary Service at Lancing.

Intermittent Renal Dialysis

By Circular 2/68 dated 4th January, 1968 approval was given to local health authorities to make arrangements for the adaptation of patients' homes so that dialysis could be given outside hospitals.

During 1972, one adaptation was undertaken, and one portable building sited at the rear of a patient's house to accommodate the machine and its ancillary equipment. Approval was also given for another installation which was deferred because of medical problems with the patient concerned.

At the end of the year there were five patients on dialysis at home, one in Bognor Regis, two in Crawley, one in East Wittering and the other in Upper Beeding.

Retirement Clinics

Reference was made in the Report for 1966 to the two non-therapeutic clinics held at Bognor Regis and Littlehampton. The clinic at Bognor Regis which was suspended in 1971 was not re-opened.

Dr. F. Cockcroft of Littlehampton reports

'Three-quarters of the people were recommended by friends who had attended the clinic and the other quarter came as a result of seeing a notice at the health centre. The general practitioners have always been cooperative in Littlehampton and I am sure there would be more people wanting to come to this clinic if they knew about it but as things are at the moment only a small number directly apply to be seen. Those that attend appear pleased that they have attended.'

The attendances at the Littlehampton Clinic more than doubled in the year ; details are shown in the next table.

<i>Age</i>	<i>Males</i>	<i>Females</i>	<i>TOTALS</i>
50-59 .	— (—)	— (—)	— (—)
60-69 .	9 (2)	11 (—)	20 (2)
70-79 .	8 (6)	6 (5)	14 (11)
TOTALS .	17 (8)	17 (5)	34 (13)

Note: The figures in brackets relate to 1971.

Population Screening Surveys

Phenylketonuria

All babies born in the County are tested for phenylketonuria by the Guthrie blood test method. No case of phenylketonuria was found during the year.

Cancer of the Breast and Cervix

The computer-assisted arrangements continued. The year was the last of the current five-yearly cycle which commenced in June, 1967. By the end of 1972 invitations had been offered to the majority of women in West Sussex.

Clinics have operated regularly in Bognor Regis, Chichester, Crawley, Horsham, Midhurst, Shoreham-by-Sea, Storrington, Upper Beeding, Worthing Hospital and the Worthing Central Clinic. An average of eight clinic sessions a week were being held at the end of the year.

In 1973 a new computer program will automatically recall women who have had a test five years previously and invitations will be sent to women who have moved into the County since the invitations were last sent out in their district.

A total of 4,485 refusals was recorded – relating to the initial invitations sent out during the year. Some of these came from women under the age of 35, but 1,971 women in the age group 34 to 69 years were subsequently visited and 91 of these were persuaded to have the examination. After eliminating those who had died, left the area or had in the meantime been examined, the final total of refusals in this age group was 1,743, giving a consent conversion ratio through health visitor follow-up of 5 per cent which was 2.9 per cent lower than in 1971. With the new computer program the intention is to offer the self-administered pipette to women who are unwilling to attend a clinic or surgery for the test. This should show an improvement on the consent rate and relieve health visitors of visiting patients who are unwilling to have a clinical examination.

Previous editions of the Report have referred to the research study which commenced in 1970 and was completed at the end of 1971. During 1972, 4,980 invitations were sent to women living in the Horsham Urban and Rural Districts who previously had the opportunity of using the self-administered pipette test and 1,934 of these women consented to a cervical smear at a clinic or doctor's surgery. By application of the headings in Table A to this group of women the percentage of consents was 78.8. This is better than the average for the County as a whole in 1972, and appears to indicate that the previous offer of a self-administered test did not affect the willingness of these women to have a cervical smear at a clinic or surgery. Indeed, it may have been an encouragement to some as they already had prior knowledge of the test and what it entailed for them. A preliminary analysis of the data from the survey has been made and the overall response to the offer of a pipette was 52 per cent, compared with 38 per cent accepting a conventional test. These rates were obtained from a population of just over 19,000 women. The response to the pipette was higher in the rural area and the consents to a conventional test were correspondingly greater in the urban area. The pipette was also more acceptable to younger women. Detailed information about this research project is expected to be available during 1973.

Tables A, B and C give summaries of the work done during 1972; the figures for 1971 appear in brackets for comparison. The results following the tables relate to conditions which were discovered on examination to require further investigation and follow-up through family doctors; the cooperation received from general practitioners in providing information on the subsequent clinical diagnosis for all suspicious/positive laboratory results is greatly appreciated.

Table A – Response to Invitations

1.	Invitations sent	37,740	(43,074)
2.	<i>Less:</i> Replies not received by 31.12.72	7,628	(8,827)
3.	Replies received by 31.12.72	30,112	(34,247)
4.	<i>Less:</i> Already examined	4,815	(5,705)
5.	Dead or left area	3,063	(2,949)
6.	Over 70 years	5,338	(6,893)
7.	Awaiting follow-up	460	(3,074)
8.		13,676	(18,621)
9.	Consents and Refusals	16,436	(15,626)
10.	<i>Less:</i> Refusals after follow-up of women aged 35 to 69 years	4,485	(2,672)
11.	Consents	11,951	(12,954)
12.	Percentage of consents (i.e. line 11 as percentage of line 9)	72.7	(82.9)

Table B – Consents, Age Groups and Service Choice

	<i>Clinic</i>	<i>Family Doctor</i>	TOTALS
Under 35 years .	1,409 (1,780)	1,461 (1,320)	2,870 (3,100)
Over 35 years .	6,169 (7,039)	2,912 (2,815)	9,081 (9,854)
TOTALS .	7,578 (8,819)	4,373 (4,135)	11,951 (12,954)

Note: The figures in brackets relate to 1971.

Table C – Examinations Carried Out

	<i>Clinic</i>	<i>Family Doctor</i>	TOTALS
Breast only .	634 (507)	209 (217)	843 (724)
Cervix and breast	7,537 (8,041)	1,798 (2,086)	9,335 (10,127)
TOTALS .	8,171 (8,548)	2,007 (2,303)	10,178 (10,851)

Note: The figures in brackets relate to 1971.

Results

On clinical examination 351 women were found to have gynaecological conditions and were referred to their family doctors for further investigation and treatment if necessary.

Clinical examinations of breasts showed unsatisfactory results in 228 cases, 25 fewer than in 1971. At the time the Report was prepared, follow-up of these women through their doctors showed that in 44 cases no abnormality was found on further examination, 111 merely had a simple condition, 20 were suffering from carcinoma of the breast and 53 were still under investigation or observation.

Laboratory examination of the cervical smears revealed that 257 women had minor vaginal infections and they were all referred to their doctors for advice and treatment. In 32 cases the laboratory findings were suspicious and 10 were positive. The next table gives an analysis of the further investigations that had been completed when the Report was prepared.

<i>Results of further investigation</i>	<i>Cytological Diagnosis</i>	
	<i>Positive</i>	<i>Suspicious</i>
Invasive carcinoma of cervix	1	2
Carcinoma-in-situ	5	4
Amputation of cervix	—	2
Inflammation	—	5
Monilial infection	—	1
Cervical erosion	—	1
Repeat smear or histology normal	—	6
Still under investigation or observation	4	11
TOTALS	10	32

PART VI—AMBULANCE SERVICE

Development

At the end of the year, building work on the new control in Chichester and the replacement ambulance station in Crawley was well advanced. The occupation date for the Crawley premises will be on time, April, 1973, but delays were experienced at Chichester. Consultants reported that the masts on the Home Office site, on which aerials for the new radio system were to be placed, were unstable. Because of this, approvals were sought to erect a temporary mast. It is hoped that the control will become operational during April, 1973.

During the year, a Joint Working Party consisting of representatives of the Department and the Management Services Unit undertook a review of the Service, particularly with regard to vehicle replacement, the collection and processing of information, the determination of performance standards and the management structure. In the opinion of the members, a high standard of professional competence was being achieved and the interests of the patients were being placed first.

Statistics

The work of both the ambulance and ambulance car services increased and much of this was due to additional day hospital and out-patient clinic requirements.

The total number of patients conveyed by ambulances and cars in 1972 compared with 1971 increased by 26,364, and the total distance travelled by 123,926 miles. The average miles per patient conveyed by ambulance was 7.7 compared with 8.0 in 1971. Accident and emergency cases rose from 7,651 in 1971 to 8,638 in 1972 (an increase of 12.9 per cent), and accounted for 3.2 per cent of all patients conveyed. Patients conveyed by rail for part of their journeys numbered 718; this was 68 fewer than in 1971.

Ambulances

<i>Patients</i>			<i>Miles</i>		
1971	1972	<i>Variation</i>	1971	1972	<i>Variation</i>
139,298*	153,014	+13,716	871,306	900,167	+28,861

*Corrected figure

Ambulance Car Service

Area	Patients			Miles		
	1971	1972	Variation	1971	1972	Variation
Chichester	37,143	37,045	—98	342,856	365,012	+22,156
Horsham	26,118	33,058	+6,940	387,707	424,191	+36,484
Worthing	37,580	43,386	+5,806	327,126	363,551	+36,425
TOTALS	100,841	113,489	+12,648	1,057,689	1,152,754	+95,065

Staff and Vehicles

The next table shows the numbers of staff and vehicles at the ambulance stations at the end of each of the past two years.

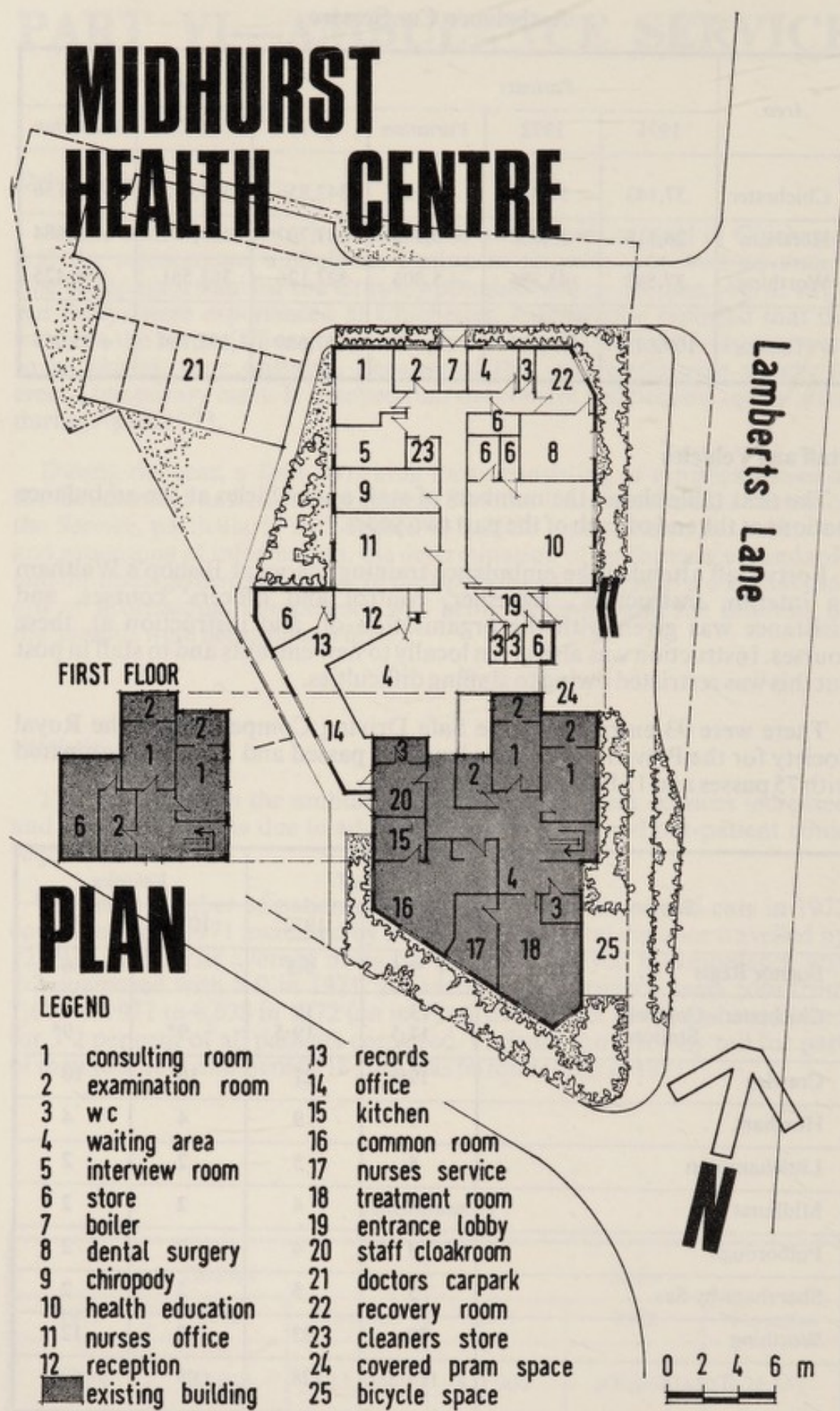
Forty staff attended the ambulance training school at Bishop's Waltham on interim, instructors', refresher, control and officers' courses, and assistance was given with the organisation of, and instruction at, these courses. Instruction was also given locally to new entrants and to staff in post but this was restricted owing to staffing difficulties.

There were 93 entrants for the Safe Driving Competition of the Royal Society for the Prevention of Accidents: 81 passed and 12 failed, compared with 75 passes and 12 failures in 1971.

Station	Staff		Vehicles	
	1971	1972	1971	1972
Bognor Regis	9.5	9.5	6	6
Chichester—Control Station	13 17.5	18 19.5	— 9*	— 9*
Crawley	19.5	21	10	10
Horsham	9	9	4	4
Littlehampton	5	5	2	2
Midhurst	4	4	2	2
Pulborough	3	4	2	2
Shoreham-by-Sea . . .	5	5	2	2
Worthing	29	33	12	12
TOTALS	114.5	128	49*	49*

*Includes one major accident control vehicle

MIDHURST HEALTH CENTRE



PART VII—OTHER SERVICES

Health Centres

Particulars of the health centres which had been opened by the end of the year are given in the next table.

<i>Health Centre</i>	<i>Date opened</i>	<i>G.Ps. working in the area</i>	<i>G.P. consulting suites provided</i>
Shoreham-by-Sea .	February, 1970	12	10 (10)
Henfield .	February, 1971	2	2 (2)
Littlehampton .	May, 1971	13	5 (8)
Crawley (Broadfield) — temporary .	December, 1971	3	2 (3)
Rudgwick .	April, 1972	2	2 (2)
The Witterings .	December, 1972	3	3 (3)

Note: The figures in brackets indicate the numbers of general medical practitioners accommodated in the health centres.

Good progress was made on the building of the health centres referred to in the next table. The plans of the Midhurst centre and of the Durrington scheme (promoted by the Worthing Borough Council acting under their delegated powers) appear on pages 38 and 40; those of the other centres under construction were printed in earlier editions of the Report.

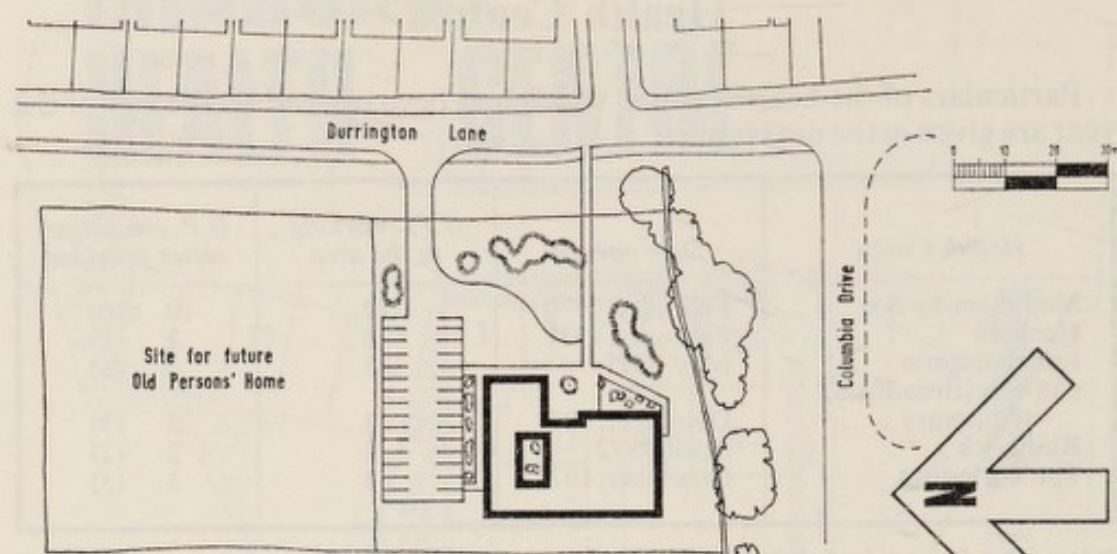
<i>Health Centre</i>	<i>Expected date of opening</i>	<i>G.Ps. working in the area</i>	<i>G.P. consulting suites to be provided</i>
Bognor Regis .	September, 1974	14	6 (5)
Lancing .	August, 1973	8	5 (5)
Midhurst .	January, 1974	5	4 (5)
Selsey .	July, 1973	5	4 (5)
Steyning .	July, 1973	4	2 (2)
Worthing (Durrington)	September, 1973	40	3 (3+)

Note: The figures in brackets indicate the numbers of general medical practitioners who will be accommodated in the health centres upon completion.

+ i.e. one representative of each of three partnerships — which comprise a total of 12 doctors.

The forward capital programme for 1973/74 and subsequently was approved towards the end of the year. The next table gives particulars of the health centre part of this programme. Schedules of accommodation requirements and scheme submissions were approved by the Department of Health and Social Security for the four projects on the 1973/74 Starts List and preliminary consultations took place with the Executive Council for West Sussex and with the interested general medical practitioners regarding the 1973/74 Design List schemes.

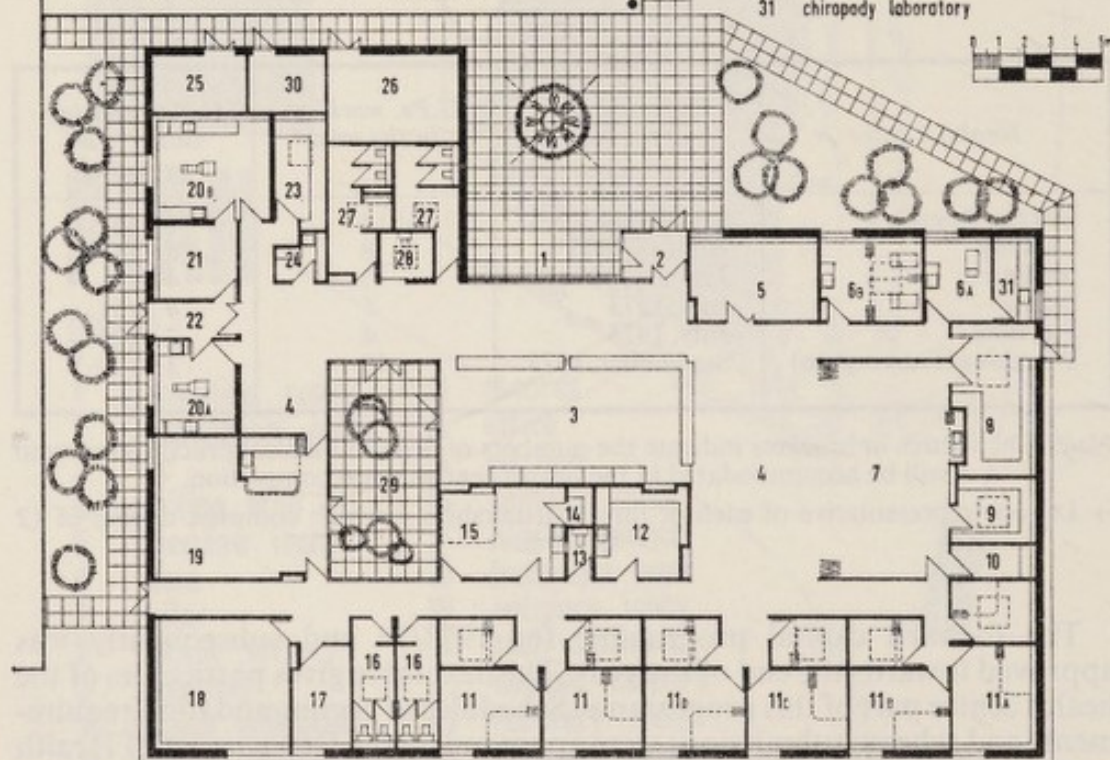
DURRINGTON HEALTH CENTRE



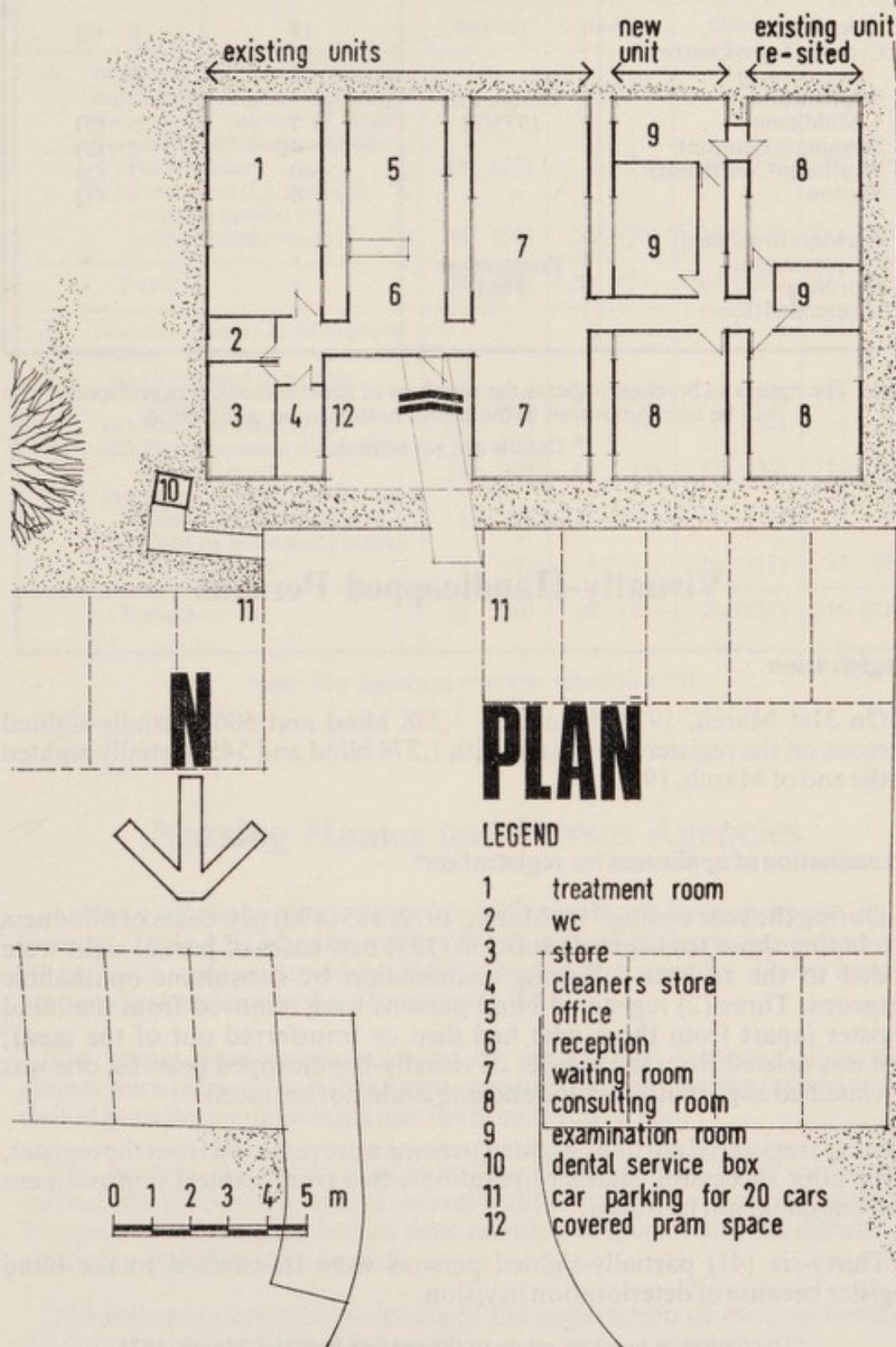
- 1 pram shelter
- 2 entrance lobby
- 3 reception/records
- 4 waiting area
- 5 playroom
- 6 chiropody suite
- 7 health education
- 8 general store
- 9 health education store
- 10 mattress store

- 11 consulting suite
- 12 nurses' service room
- 13 toilet
- 14 drug store
- 15 treatment room
- 16 staff toilets
- 17 interview room
- 18 nurses' office
- 19 common room
- 20 dental suite

- 21 recovery room
- 22 exit lobby
- 23 laboratory/store
- 24 cleaners room
- 25 garden store
- 26 boiler room
- 27 public toilets
- 28 handicapped persons toilet
- 29 courtyard
- 30 p.a.b.x. room
- 31 chiropody laboratory



BROADFIELD [temporary] HEALTH CENTRE



<i>Health Centre</i>	<i>Building programme</i>	<i>G.Ps. working in the area</i>	<i>G.P. consulting suites to be provided</i>
Cowfold	Starts List 1973/74	2	2 (2)
Horsham		17	7 (5)
Partridge Green		3	1 (3)
Wisborough Green		6	1 (6)
Chichester	Design List 1973/74	17	8 (6)
Crawley Town Centre (temporary)		37	*
Felpham and Middleton		7	5 (5)
Steyning (extension)		4	2 (2)
Worthing (Courtlands)		40	3 (5)
Yapton		6	4 (7)
Crawley (Broadfield) - permanent		*	*
Worthing	Preparation Pool	*	*
Unspecified (four)		*	*

Note: The figures in brackets indicate the numbers of general medical practitioners who will be accommodated in the health centres upon completion.

* Details not yet settled.

Visually-Handicapped Persons

Registration

On 31st March, 1972 there were 1,288 blind and 586 partially-sighted persons on the register, compared with 1,274 blind and 545 partially-sighted at the end of March, 1971.

Examination of applicants for registration*

During the year ending 31st March, 1972, 185 (190) new cases of blindness (excluding those transferred) and 130 (123) new cases of partial sight were added to the register following examination by consultant ophthalmic surgeons. Three (2) registered blind persons were removed from the blind register (apart from those who had died or transferred out of the area); one was deleted from the register of visually-handicapped persons, one was re-classified as partially-sighted and one could not be traced.

Six (7) registered partially-sighted persons were removed from the register, three after successful cataract operations, two from natural improvement and one could not be traced.

Thirty-six (41) partially-sighted persons were transferred to the blind register because of deterioration in vision.

*The figures in brackets relate to the year ending 31st March, 1971.

Follow-up action

Where treatment was recommended by consultant ophthalmic surgeons, the following related statistics were ascertained.

	Primary Ocular Disease			TOTALS
	Cataract	Glaucoma	Other	
A. Number of visually-handicapped cases registered during the year in respect of which Forms B.D.8 recommended:				
(i) No treatment	18 (17)	3 (4)	78 (72)	99 (93)
(ii) Treatment (i.e. medical, surgical, optical or hospital supervision)	34 (50)	56 (55)	126 (121)	216 (226)
TOTALS	52 (67)	59 (59)	204 (193)	315 (319)
B. Number of cases at A(ii) above which:				
(i) Continued to receive treatment	15 (29)	42 (43)	57 (72)	114 (144)
(ii) Refused treatment	3 (3)	— (1)	1 (2)	4 (6)
(iii) Had treatment deferred or discontinued	13 (9)	10 (8)	52 (36)	75 (53)
(iv) Were on waiting list for admission to hospital	1 (2)	1 (—)	— (—)	2 (2)
(v) Died or left county before investigation	2 (7)	3 (3)	16 (11)	21 (21)
TOTALS	33 (50)	56 (55)	126 (121)	216 (226)

Note: The figures in brackets relate to 1970.

Nursing Homes and Nurses Agencies

At the end of the year, there were 62 registered nursing homes in the County. Their 1,323 beds provided a substantial geriatric service, as over 90 per cent were occupied by elderly and infirm persons. There were no homes registered under the *Abortion Act 1967*.

The homes were routinely visited by the Medical Inspector. Five complaints were received and these were investigated fully by the Inspector who visited both the complainants and the homes concerned.

The general standard of nursing homes improved; many proprietors carried out redecorations and several built extensions to existing premises. The problems facing the homes were mainly rising costs and the difficulty of obtaining qualified nursing staff.

The following table gives details of the registration of nursing homes in the County during the past five years.

	1968	1969	1970	1971	1972
Registered at 1st January	56	59	62	62	65
New registrations	11	11	3	7	10
Registrations withdrawn	8	8	3	4	13
Registered at 31st December . . .	59	62	62	65	62

The accommodation available at the end of the year in nursing homes registered by the Council is shown below.

Sizes of homes (beds)	Number of homes	Number of beds provided			
		General	Maternity	Psychiatric	TOTALS
25 and over	15 (2)	479	—	126	605
20 to 24	11 (1)	229	—	15	244
15 to 19	16	265	—	—	265
10 to 14	14	169	—	—	169
5 to 9	5 (1)	29	—	8	37
Under 5	1	3	—	—	3
TOTALS	62 (4)	1,174	—	149	1,323

Note: The figures in brackets denote homes (included in totals) also registered as mental nursing homes under the *Mental Health Act 1959*.

Nurses Agencies

Agencies licensed by the Council for the supply of nurses numbered seven, the same as in 1971.

PART VIII—ENVIRONMENTAL HEALTH SERVICE

Following the disbandment of the General Sub-Committee in 1971, responsibility for the environmental health services passed to the Health Committee. Appropriate action was taken on such matters as the control of milk supplies (particularly with regard to brucellosis and the processing and distribution of heat-treated milk) and grants for the extension of water mains and the provision of sewers in rural areas.

Excellent cooperation between the staff of the Department and those employed by district councils and representatives of other public services, such as water boards and river authorities, continued, and enabled matters of joint concern to be dealt with speedily and effectively. Cooperation was

furthered by the Department making available to district officers a considerable number of scientific instruments for monitoring environmental pollution, including noise. These relatively expensive items of equipment are rarely purchased by district authorities as they are not often required. If such items are purchased by the County authority and made available to all district authorities in the area, the cost can however be justified. Two new sound-recording and analysing instruments were purchased during the year. Five district authorities made use of a sound-level meter, built to British Standards Institute specifications, which is capable of providing full octave-band analysis. Several departments of the County Council sought advice on noise problems associated with their work and this is referred to in more detail on page 47.

The county environmental health inspectorate continued to meet demands for instruction in technical subjects connected with health education. Their work on school hygiene and sanitation and on the installation and maintenance of school swimming pools is referred to in Part IX.

Water Supplies and Sewage Disposal

At the end of the year, the Government's final proposals were awaited for the reorganisation of the services concerned with the abstraction, supply and disposal of water. The ten all-purpose authorities suggested for this purpose have yet to be fully defined, as have their powers and duties. Several discussion papers were circulated during the year regarding the various problems to be overcome.

It is clear that in the proposed reorganisation local interests will need to be taken into account. There is much to be said for leaving the administration and technical servicing of sewerage with the county districts. It is here that expertise has been built up, that contact is made with local people, and that the first intimation of trouble, such as chokage, comes to light. But a national master plan is obviously essential in order to regulate the use of scarce natural resources such as water.

Water Supplies

The chemical and bacteriological quality of all mains water supplied throughout the County was satisfactory. There were no reports of plumbosolvency. The following water undertakers serve the area and, apart from isolated dwellings and hamlets, services extend to all parts.

The North West Sussex Water Board
The Portsmouth Water Company
The Borough of Worthing Water Department
The County Borough of Brighton Water Department
The Mid Southern Water Company (formerly the Wey Valley Water Company)

No further action was taken regarding the fluoridation of public water supplies. There was no change in the level of natural fluoride in the various water supplies; all are deficient for the purposes of dental health, most having less than 0.1 mg/L of fluoride present, the maximum being 0.2 mg/L. There is still strong opposition to the initiation of what would be a major improvement in our preventive health care arrangements.

Grants in aid under the *Rural Water Supplies and Sewerage Acts 1944 to 1965* were made in respect of extensions to existing water services in the following areas.

The North-West Sussex Water Board

Chantry Farm, Storrington
Easebourne Street, Easebourne

(Chanctonbury R.D.C.)

(Midhurst R.D.C.)

Sewerage

Grants in aid of sewerage were made in respect of the following schemes.

Horsham R.D.C.
Chanctonbury R.D.C.
Chichester R.D.C.
Worthing R.D.C.

Roffey Sewerage Scheme
Wiston Sewerage Scheme
Mill Lane, Selsey Sewerage Scheme
Clapham and Patching Sewerage Scheme

Refuse Disposal

The bulk of domestic and trade refuse in the area is disposed of by tipping. At most sites controlled tipping is practised and at two sites pulverisation plant is installed. Those tips which are subject to approval and control under the *Town and Country Planning Acts* are visited by the County Environmental Health Inspector to ensure that conditions of approval are adhered to.

A working party of district council engineers and officer representatives of the County Council was formed to consider possible refuse disposal arrangements for the post-April, 1974 period. There was discussion of possible agency arrangements whereby the district councils could operate refuse disposal sites on behalf of the new County Council which will be the local authority responsible for refuse disposal following local government reorganisation. A preliminary survey was carried out of existing (and possible new) refuse disposal sites and alternative methods of disposal were considered. At the end of the year no final conclusions had however been reached.

Lay-By Sanitation and Picnic Areas

The Countryside Act 1968 empowers county councils to develop amenity areas in the countryside with financial aid from the central government. Under this legislation, the County Council successfully operate two picnic area sites, both of which are provided with toilet facilities. One of these sites, at Whiteways Lodge near the top of Bury Hill, provides a convenient pull-in for many lorry drivers and other road users crossing the County. The toilets are heavily used and must be maintained regularly. The recirculatory-type wash-hand units installed in these toilets and in those on the other site continued to operate satisfactorily. They have seldom failed since they were installed nearly three years ago and they can confidently be recommended for use in other isolated locations where no mains water supply is available.

Caravans and Gypsies

In accordance with the requirements of Part II of the *Caravan Sites Act 1968*, the Council advised the central government that, having evaluated the problem in West Sussex, the caravan sites located at Slinfold and Tangmere were adequate for those gypsy families residing in the area at the time of the initial survey.

In common with other pleasantly-situated counties, West Sussex has many holiday caravan sites. Demands for better facilities can only be met by more financial investment by caravan-site owners. If the development of first-class sites such as are found in some parts of Europe is to be encouraged, it is essential, subject to the protection of local amenities, that no unduly restrictive planning consents are imposed either on periods of approval or on permitted types of structure.

Atmospheric Pollution

West Sussex is fortunate in being an area without air pollution problems other than those which are occasionally caused locally by specific industries, uses of land, or processes.

The air pollution survey station at Rogate maintained by the Department for the past seven years on behalf of the Warren Spring Laboratory continued to monitor daily deposits of carbon and sulphur dioxide.

An atmospheric monitoring station was set up at St. Margaret's School, Angmering, to monitor any local pollution which could affect the health of local children. This project is being carried out in association with the London School of Hygiene and Tropical Medicine who are currently evaluating the health of the children attending the school; this is a pilot study which will continue for about five years.

Noise

Requests for assistance in evaluating noise and solving noise nuisances continued to increase. Investigations were made into aircraft, racing car, and general road and rail traffic noise. There was a demand for more detailed analyses of noise problems and the Department's noise monitoring equipment was accordingly improved by the addition of a Rustrak recorder and a statistical analyser.

Items of equipment were lent to several district councils during the year for noise pollution monitoring purposes.

Supervision of Milk Supplies

Whilst the *Food and Drugs Act 1955* places the responsibility for the control of designated milk with the food and drugs authority (in this case the County Council), supervision of retail services continued as a joint arrangement between field officers of the County and district health departments. The system avoids duplication of activities and has allowed the officers of the Council to concentrate their efforts on the sampling of milk from farms for quality control and for the purpose of isolating *brucella* and *salmonellae*.

The joint sampling arrangements carried out by the county environmental health inspectorate and Consumer Protection Department continued to work satisfactorily; they were fully described in the Report for 1969.

A total of 3,151 samples (137 fewer than in 1971) were procured for public health purposes (2,041 of untreated milk and 1,110 of heat-treated milk) and were submitted to the public health laboratory for examination. Of these, 353 samples were from individual cows on farms where previous bulk milk samples had indicated the presence of *brucella* in the herd. A further 571 informal samples of ex-farm milk were collected and deposited with the Consumer Protection Officer so that their quality could be assessed.

Brucellosis

Now that tuberculosis has almost been eradicated from all cattle in this country, efforts are centred on the eradication of brucellosis, an infection which affects both human and animal health. The *brucella* organism, which causes abortion in cattle, produces an undulant fever in man. The infection, which is often masked by other disorders with similar clinical symptoms, exists in rural communities where there is close contact with cattle and where the consumption of untreated milk is common. Undulant fever is not a notifiable disease and it would help considerably if it were so.

The efforts of the Department were concentrated on the isolation of *brucella* in herds at present outside the Ministry's scheme. Details of all laboratory examinations continued to be lodged with the Animal Health Division of the Ministry in order that their divisional veterinary officers could be made aware of any animal infection revealed by the sampling procedures. This assisted the divisional veterinary officers in their evaluation of herds likely to enter the accredited herds scheme and acted as a further check on work carried out by the Ministry's sampling officers. Fewer individual cow samples were procured than in the previous year (353 compared with 724) as there was increasing resistance amongst farmers to sending animals found to be infected with *brucella* for slaughter; they are hoping for an early compensation policy to be introduced by the central government. Of 1,363 samples submitted for the milk ring test, 43 bulk milk and 29 individual cow samples gave positive ring test recordings. Further examinations showed 29 animals to be infected; of these, many may well have been sold on the open market, so possibly passing the infection on to herds free of the disease.

Considerable progress has been made by the divisional veterinary officers of the Ministry of Agriculture, Fisheries and Food in the eradication of brucellosis; two-thirds of the dairy herds in the County are now free of this insidious disease. In November, 1973 West Sussex will become the first mainland area in the south to be declared an official eradication area which means that the writing is on the wall for those farms as yet taking no steps to eradicate brucellosis. It is to be hoped that it will not now be many years before all dairy herds in the County are *brucella* free.

Salmonellosis

In the Report for 1970 attention was drawn to the increase in the prevalence of *salmonella* organisms in the environment. *Salmonellae* are the most

prevalent organisms causing food poisoning in this and other countries. Large reservoirs of infection are building up in animal communities and this is due in part to the use of imported animal foodstuffs which carry the infection. In fact it may now prove to be impossible to clear infection from some farms unless there is a considerable reduction in the virulence of the strains of organism involved. This situation throws a special responsibility on the environmental health services to break the chain of infection in food supplies by ensuring adequate inspection and processing of food, together with high standards of food hygiene in catering and other food establishments.

In support of the Council of Europe resolution which was reproduced in the Report for 1970, 395 ex-farm milk samples taken at random were submitted to the public health laboratory at Brighton for examination. None contained *salmonella* organisms. This result, although surprising, is reassuring. The survey will continue during 1973.

Inhibitory Substances in Milk

The report of the Milk Hygiene Sub-Committee of the Milk and Milk Products Technical Advisory Committee (1963)* drew attention to the possible health hazard where milk containing traces of antibiotics was consumed by persons hypersensitive to such substances. In addition, there is no doubt that the widespread and indiscriminate use of antibiotics has induced the resistance of pathogenic organisms to these substances. This was acknowledged by the Joint Committee on the Use of Antibiotics in Animal Husbandry and Veterinary Medicine (1969)† who recommended a reduction in, or stricter use of, certain antibiotics in the animal husbandry and veterinary field. The Committee also considered that more attention should be paid to other possible ways of modifying the environmental microflora of animals and suggested that research should be undertaken into the consequences (including economic consequences) of influencing the bacterial environment by higher standards of hygiene and other means.

A total of 1,010 samples of farm milk were examined for the presence of inhibitory substances; 24 samples were found to be contaminated. Investigations at the farms concerned showed that in most instances failure to withhold milk from the supply following treatment with intramammary preparations was the cause of contamination. Warning letters were issued and repeat sampling showed all the supplies to be clear.

Heat-treated Milk

The Council license pasteurising plants in accordance with the *Food and Drugs Act 1955*. New licences were issued last year in respect of four plants for the five-year period from 1971 to 1975.

Samples of heat-treated milk procured from pasteurising plants numbered 472; all conformed with the phosphatase test, indicating adequate heat treatment, and all but 12 (six of which were declared void) conformed to the

*Ministry of Agriculture, Fisheries and Food. Antibiotics in Milk in Great Britain. Report of the Milk Hygiene Sub-Committee of the Milk and Milk Products Technical Advisory Committee. London. H.M.S.O.

†Joint Committee on the Use of Antibiotics in Animal Husbandry and Veterinary Medicine. Cmnd. 4190. London. H.M.S.O.

methylene blue test, which assesses the keeping quality of milk. Samples of heat-treated milk collected at dairy depôts and retail outlets totalled 638. All conformed with the phosphatase test and two failed the methylene blue test; four samples were declared void as the ambient air temperatures were in excess of 70°F at the time of examination.

Of 74 samples of bottled, untreated milk collected from dairies and depôts, none failed the methylene blue test. All 219 samples of untreated milk collected from producer/retailers satisfied the statutory tests.

The results recorded above indicate that milk supplies during the period under review were of a high standard of keeping quality; they also indicate a satisfactory standard of dairy hygiene from the time the milk leaves the cow until it is delivered to the customer.

Bottle-washing at Dairies

Of 268 empty, cleansed milk bottles submitted to the laboratory for bacteriological examination, 225 proved satisfactory. Where unsatisfactory results were obtained, dairy equipment was checked and further samples were collected. All water samples collected from dairy mains and private supplies were bacteriologically pure.

Housing Improvements

The table on page 51, compiled from information made available by the central government, gives details of the numbers of houses built and of those demolished and closed in the various districts of the County.

I am obliged to Mr. A. D. Batty, Chief Public Health Inspector of Horsham Rural District, for the following comments.

'Information contained in the 1971 Census recently released provides some most interesting housing statistics.

Fifty-nine per cent (51 per cent) of West Sussex householders owned their own accommodation, 22 per cent (22 per cent) of households in the County were rented from local authorities, 4 per cent (4 per cent) were rented furnished accommodation, and the remaining 15 per cent (23 per cent) were rented, unfurnished, from private landlords. In the Horsham Rural District, 93.1 per cent (79.7 per cent) of all households had the exclusive use of a hot water supply, a fixed bath and an inside W.C. The figures which follow in brackets are those for 1961.

These figures indicate that substandard housing is not a great problem locally. Indeed, figures supplied recently to the Department of the Environment from the Horsham R.D. estimated that only 600 houses remained which are capable of improvement to the 12-point standard. At the present rate of progress of improvement schemes, the vast majority of these houses should be modernised within the next few years and this reflects credit on authorities who have undertaken vigorous housing survey and improvement policies.

Emphasis during housing surveys in the future must change from potential improvement of the dwelling to the suitability of the environment of the dwelling. The occasional house will still be found to be overcrowded or dirty and invariably some houses in a rural area will be found lacking an efficient drainage system. In this district, the problem of the substandard house, with its pail closet, lack of bathroom facility, or whatever, is being replaced as the principal issue by problems of environmental pollution created by new processes and methods of keeping animals on farms, traffic noise and encroaching industrial development. It seems logical therefore that housing survey work in the future should form part of a general duty of local authorities in maintaining a regular surveillance and monitoring of the environment of their districts.'

Housing Progress and Unfit Houses 1972

Area	Estimated population mid-1972 (000s)	Dwellings in tenders approved but not started	Dwellings started				Dwellings under construction at end of period				Dwellings completed			Houses demolished in clearance areas and unfit houses demolished or closed elsewhere		
		Local authorities	Local authorities	Other public sector	Private sector	Public and private sectors	Local authorities	Other public sector	Private sector	Public and private sectors	Local authorities	Other public sector	Private sector	Public and private sectors	In Clearance areas	Elsewhere
West Sussex	500.9	200	904	163	3,217	4,284	1,247	306	3,634	5,187	897	46	2,795	3,738	19	45
Boroughs																
Arundel	2.4	—	10	—	4	14	10	—	4	14	—	2	1	3	—	—
Chichester	21.1	—	91	22	51	164	59	174	91	324	56	—	61	117	2	2
Worthing	89.1	—	28	1	496	525	28	1	497	526	69	—	398	467	—	1
Urban Districts																
Bognor Regis	33.9	—	—	12	310	322	—	—	357	357	—	12	355	367	—	5
Crawley	68.8	115	116	38	235	389	384	37	269	690	170	17	171	358	—	8
Horsham	26.8	—	50	—	26	76	50	—	79	129	75	—	47	122	—	1
Littlehampton	19.5	—	37	—	318	355	37	—	292	329	54	6	364	424	7	—
Shoreham-by-Sea	19.0	—	33	1	13	47	33	—	216	249	36	1	22	59	—	7
Southwick	12.0	—	13	1	19	33	48	—	18	66	17	1	3	21	—	—
Rural Districts																
Chancetonbury	28.9	—	32	—	391	423	26	—	284	310	6	—	263	269	—	—
Chichester	64.8	56	59	—9†	524	574	59	1	546	606	78	3	513	594	—	4
Horsham	32.4	—	76	62	461	599	76	62	461	599	—	—	183	183	—	1
Midhurst	19.7	—	22	2	116	140	58	—	104	162	41	2	85	128	10	3
Petworth	11.5	5	160	—	56	216	160	—	197	357	13	—	14	27	—	8
Worthing	51.0	—	111	33	197	341	115	31	219	365	91	2	315	408	—	5
New Town																
Crawley	—	24	66	—	*83	*149	104	—	*68	*172	191	—	*16	*207	—	—

- Notes: 1. *Figures in italics indicate houses built in a new town area for another local authority.
2. Totals in column at head of table do not include figures set in italics other than those figures from local authority column.
3. ‡Correction from previous year.

PART IX—SCHOOL HEALTH SERVICE

Statistics

Child Population

The following table shows the variation in the child population since last year.

	1971	1972	Variation
Children under 1 year	6,230	5,990	— 240
1 to 4 years	27,370	26,610	— 760
Total under 5 years	33,600	32,600	— 1,000
5 to 14 years	74,300	73,100	— 1,200
Total under 15 years	107,900	105,700	— 2,200

School Population

In January, 1973 there were 78,108 children on the rolls of maintained schools in the County, an increase of 1,484 on the figure for last year. The numbers of children in the various types of maintained schools in the County during the past two years are shown in the table which follows.

Type of School	Number of schools		Number on roll	
	1971	1972	1971	1972
Nursery	4	4	298	301
Primary	148	157	39,252	39,986
First	30	30	4,404	4,122
Middle	8	5	1,861	1,902
Secondary: Grammar	6	5	3,888	3,173
Comprehensive	14	16	17,831	21,349
Modern	13	10	8,316	6,518
Special	9	9	774	757
TOTALS	232	236	76,624	78,108

Medical Inspection

Periodic Inspections

The arrangements made for the full medical examination of children as soon as possible after they start school, in their last year at primary school and in their last year of compulsory school life were continued during 1972.

In the five secondary schools where examination of leavers is based on selection, 206 of the 819 children interviewed during the course of the year were found to require examination. A sample of urine was tested in 815 cases and thirteen were found to show some abnormality; these cases were referred to their family doctors.

The scheme begun in February, 1970 by a partnership of general practitioners for the pre-school examination of children in their practice continued throughout 1972; 94 children were examined and 16 were re-examined during the year.

The numbers of children examined and re-examined during the past two years are shown below.

<i>Type of examination</i>	1971	1972
Entrants	6,699	7,259
Other periodic examinations (Children aged 10-11 years or those who had not been previously examined in this age group)	7,529	8,518
Leavers	4,168	4,751
TOTALS	18,396	20,528
Special examinations	200	105
Re-examinations	7,318	9,739
TOTALS	25,914	30,372

General Physical Condition

The general physical condition of children was good. Of the 20,528 examined at periodic medical inspections 32 (0.15 per cent) were considered by departmental medical officers to be of unsatisfactory physical condition. This compares with 30 children (0.18 per cent) placed in this category in 1971. Sixteen of the 32 children were classified as unsatisfactory because of obesity.

Dr. F. Cockcroft has supplied the following comments.

'The only point of interest that I can recall was that of a child who developed paratyphoid fever following a holiday in Majorca.

This child was ill in hospital for some time and was subsequently a carrier for six months and had to be kept away from school for this time.

This is perhaps a warning to parents taking children abroad that inoculation with T.A.B. vaccine may well be worthwhile.'

Personal Hygiene

During the year, 30,442 individual hygiene examinations were carried out in schools and 162 children were found to have vermin in their hair. Of this number, 110 were in the Borough of Worthing and 52 in the rest of the

County. The corresponding figures for 1971 were 15 in Worthing and 94 in the rest of the County.

The following table shows the number of children found to have vermin in their heads in each of the last ten years.

<i>Year</i>	<i>Total number of individual examinations</i>	<i>Total number of individual children found to be infested</i>
1963	51,795	92
1964	56,028	75
1965	58,908	146
1966	55,072	87
1967	37,962	53
1968	50,482	92
1969	42,558	120
1970	53,777	280
1971	35,575	109
1972	30,442	162

National Study of Health and Growth

In 1971 the Department of Clinical Epidemiology and Social Medicine at St. Thomas's Hospital Medical School announced their intention to commence a five-year national survey of the nutrition of children between the ages of five and ten years. The Department was invited to cooperate in the survey and, with the agreement of the Education Committee, a suitable school was selected.

The Head Teacher concerned was most helpful and an investigation commenced in May, 1972. The parents of children attending the school were asked to complete a questionnaire and there were few refusals. Over the course of four days, health visitors weighed and measured the children and also measured the skinfold thickness. At the request of the Department of Clinical Epidemiology, an air pollution sampling station was established at the school.

The results of the first year of the survey have given interesting information about variations in the height and weight of 237 children.

Medical Treatment

Statistics

Details of the numbers of children examined and of the numbers and types of defects found are shown in the tables on pages 63 and 64.

In the following table the numbers of children examined in the various age groups and the numbers found to require treatment during the year have been compared with the figures for 1971.

Age group	Number of children examined		Number found to require treatment		Percentage found to require treatment			
					West Sussex		England and Wales	
	1971	1972	1971	1972	1971	1972	1971	1972
Entrants .	6,699	7,259	603	738	9.0	10.0	15.0	*
Other periodic inspections .	7,529	8,518	677	913	8.7	10.7		
Leavers .	4,168	4,751	471	363	11.3	7.6		
TOTALS .	18,396	20,528	1,751	2,014	9.5	9.0		

* Not available.

Eye Clinics

Eye clinics for children continued to be held in eight centres in the County. The number of children examined during the year was 2,129 a decrease of 167 on the figure for 1971. The number of examinations was 2,955 compared with 3,491 in the previous year.

Of the 763 pairs of spectacles known to have been prescribed for children during the year, 708 pairs were prescribed at school eye clinics. This was 81 pairs fewer than in 1971.

Thirty-nine school children and 31 children under school age were known to have received operative treatment for squint.

Orthoptists treated 324 children, 42 more than in 1971.

Convalescence

During the year, short-term convalescence was provided for 5 children in accordance with the provision of Section 48 (3) of the *Education Act 1944*.

Speech Therapy

During the year, speech therapists treated 300 children and 422 were seen 'for observation'. The corresponding figures for 1971 were 331 and 593 respectively. Detailed information is shown in the table on page 56.

The senior speech therapists have supplied the following comments.

Miss M. G. A. McCombie states

'The year ended well after many early difficulties.

By the end of the year every post, except the senior one in Crawley, was filled. That area remained a black spot, but elsewhere all is much better, and it has even been possible to make a start on two new projects.

In Horsham, Mrs. A. Smith and Mrs. A. Lewis will be starting a speech playgroup early in 1973 for pre-school children with delayed speech and language, and in Chichester and Midhurst Mrs. S. Maule-Oatway has begun a year's pilot scheme of intensive therapy with educationally subnormal and severely subnormal children, in addition to continuing normal school sessions with Mrs. Richards in the Petworth area and resuming the service in Midhurst.

All of us hope now for a better status and structure for our profession throughout the country, and are encouraged by the developments within this County during the past year.'

SPEECH THERAPY

Area	Defect or disorder of speech								New cases	Number discharged during the year	Waiting list at 31.12.72
	Articulation	Language	Fluency	Voice	Associated with cerebral palsy	Associated with cleft palate	Total number of children	Total attendances			
Bognor Regis . . .	17 (11)	1 (—)	2 (1)	—	—	1 (1)	21 (13)	119 (62)	21	—	*
Chichester . . .	149 (103)	61 (38)	20 (9)	—	4 (4)	3 (2)	237 (156)	1,307 (341)	124	67	24
Crawley . . .	16 (3)	7 (—)	7 (2)	1 (—)	1 (—)	2 (—)	34 (5)	271 (16)	17	13	67
Horsham . . .	91 (41)	20 (7)	26 (14)	2 (—)	—	1 (1)	140 (63)	773 (171)	60	49	15
Littlehampton . . .	33 (23)	4 (4)	6 (5)	—	—	—	43 (32)	237 (101)	42	35	8
Midhurst . . .	16 (6)	3 (—)	1 (—)	—	—	—	20 (6)	30 (6)	20	4	10
Petworth . . .	83 (53)	9 (3)	6 (5)	—	—	1 (1)	99 (62)	530 (59)	48	25	3
Shoreham-by-Sea . . .	73 (51)	27 (19)	12 (6)	5 (2)	1 (1)	3 (2)	121 (81)	591 (146)	21	116	7
Worthing . . .	2 (1)	—	1 (—)	—	4 (3)	—	7 (4)	35 (11)	—	2	1
TOTALS . . .	480 (292)	132 (71)	81 (42)	8 (2)	10 (8)	11 (7)	722 (422)	3,893 (913)	353	311	135

Note: The unbracketed figures indicate the numbers of children treated; bracketed figures show the numbers under observation and are included in the total.

*None kept.

Mrs. C. A. Chalmers reports as follows on the Littlehampton, Worthing and Shoreham-by-Sea areas.

'By the end of the year, both the Littlehampton and Worthing areas had full-time therapists, and the Shoreham area still had the services of a part-time therapist and students. A large amount of new equipment was acquired, including some useful testing equipment.

Because of the shortage of therapists in past years, there was a large backlog of cases who had not been seen for some time. The Shoreham and Littlehampton area lists were reviewed and the Worthing list will be examined as soon as possible.

The outlook for the speech therapy service in this area seems to be more hopeful than for some time past, mainly because of the increase in the number of speech therapists.'

Undescended Testicles

In July, 1971 letters were received from two consultants regarding the age at which boys suspected of having undescended testicles should be dealt with. As there appeared to be some difference of opinion, it was decided to ask departmental medical officers to consider referring cases as soon as they were discovered.

Considerable numbers of boys were referred throughout the year and a sample, taken at random, was followed up with family doctors. The results are given in the next table which shows that, of the 25 cases selected, 18 were referred for a consultant's opinion by the family doctor concerned; of these, 11 required operative treatment. It is interesting to note that, irrespective of age, orchidopexy was considered necessary in all cases where one or both of the testes was established as being undescended.

In view of these findings, it was decided to continue to refer cases for a second opinion as soon as they were discovered without waiting to see whether natural descent occurred.

<i>Action taken</i>	<i>Age</i>							<i>Totals</i>
	5	6	7	8	9	10	11	
<i>By General Practitioner</i>								
Number of children								
(i) referred to G.P.	5	4	4	5	3	1	3	25
(ii) not taken to G.P.	-	-	1	1	-	-	-	2
(iii) whose testicles were considered normal by G.P.	1	-	-	-	-	-	1	2
(iv) not referred to consultants by G.P.	-	1	1	-	1	-	-	3
(v) referred to consultants by G.P.	4	3	2	4	2	1	2	18
<i>By Consultants</i>								
Number of children								
(i) who did not keep appointments with consultants	1	-	-	-	-	-	-	1
(ii) in whose case consultants did not consider action necessary	1	-	-	1	-	-	1	3
(iii) kept under observation by consultants	1	-	2	-	-	-	-	3
(iv) who required operative treatment	1	3	-	3	2	1	1	11

Note: At the time these statistics were compiled, orchidopexy had been carried out on six of the 11 children who required operative treatment.

Enuresis

The treatment of nocturnal enuresis by means of pad and bell alarms was continued during the year and reports were received on 94 boys and girls. The reports showed that complete or partial improvement was achieved by 40 boys and 16 girls.

Handicapped Pupils

Ascertainment

During the year, departmental medical officers carried out 325 examinations of children known or thought to have some physical or mental impairment. A summary of the information sent to the Department of Education and Science showing the number of handicapped children ascertained as needing admission to special schools or boarding homes during 1972, the numbers admitted and awaiting admission and those on the registers of special schools and boarding homes is given on page 59.

Child Guidance

The work of the four clinics continued along the lines described in previous editions of the Report. A statistical summary of their activities is given below.

	1971	1972
1. REFERRAL		
Number of children referred by:		
(a) Departmental Medical Officers	33	63
(b) Courts and Probation Officers	10	13
(c) Parents and others	280	321
(d) Boarding schools and hostels	1	5
(e) General Practitioners	222	208
(f) Social Services Department	36	43
(g) Educational Psychologists	46	86
(h) Other Child Guidance Clinics	8	6
(i) Brought forward from previous year	89	103
(awaiting investigation on 1st January)		
TOTALS	725	848
2. INVESTIGATION		
Number of children investigated during the year found to be:		
(a) In need of child guidance help	440	461
(b) Educationally sub-normal	5	1
(c) Unsuited for education at school	—	2
(d) Not in need of child guidance help	67	67
(e) Withdrawn before investigation	110	109
(f) Awaiting investigation on 31st December	103	208
TOTALS	725	848
3. TREATMENT		
Number of children:		
(a) Receiving help on 1st January	948	822
(b) Receiving help at 31st December	822	955
4. CLINIC ATTENDANCES AND HOME VISITS		
(a) Number of attendances at clinics during the year	6,053	7,038
(b) Number of homes visited during the year	1,377	998

HANDICAPPED PUPILS

	(1) Blind (2) Partially Sighted		(3) Deaf (4) Partially Hearing		(5) Physically Handicapped (6) Delicate		(7) Maladjusted (8) Educationally Sub-normal		(9) Epileptic (10) Speech Defects		TOTALS
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	
IN THE CALENDAR YEAR: Handicapped pupils A. Newly assessed as needing special educational treatment at special schools or in boarding homes .	2	1	2	—	1	4	37	68	7	—	120
B. (i) Included at A above and newly placed in special schools or boarding homes (ii) Assessed prior to January, 1972 and newly placed in special schools or boarding homes .	1	1	1	—	—	3	23	33	3	—	65
	2	—	2	1	8	4	10	35	—	—	62
TOTAL (B (i) and B (ii)) .	3	1	3	1	8	7	33	68	3	—	127
AS AT 20TH JANUARY, 1973 C. Number requiring places in (a) day special schools . (b) boarding .	—	—	—	—	—	—	—	25	—	—	25
	1	—	—	—	1	1	5	4	—	—	12
D. (i) Number on the registers of: (1) Maintained special (a) day pupils schools as (b) boarding pupils . (2) Non-maintained (a) day pupils special schools as (b) boarding pupils .	—	—	—	—	2	—	—	624	—	—	626
	—	—	1	2	8	5	39	161	—	—	216
	10	6	3	8	1	—	5	—	7	1	3
	10	7	4	10	26	11	—	1	—	—	79
TOTAL	10	7	4	10	37	16	44	786	7	2	924
(ii) Independent schools under arrangements made by the authority	—	—	12	9	14	9	34	3	—	—	81
TOTAL (D (i) and D (ii))	10	7	16	19	51	25	78	789	7	2	1,005
(iii) Boarded in homes and not included in (i) or (ii) .	—	—	—	—	—	—	12	—	—	—	12
TOTAL (D (i), (ii) and (iii))	10	7	16	19	51	25	90	789	7	2	1,017
E. Number being educated under arrangements made in accordance with Section 56 of the <i>Education Act 1944</i> (i) in hospitals (ii) in other groups (iii) at home	—	—	—	—	—	—	—	—	—	—	—
	—	—	—	—	13	—	157	—	—	—	170
	—	2	—	—	2	16	3	2	—	—	25

Report of the Principal School Dental Officer

Staff

During the year under review three whole-time dental officers resigned, one to take up an appointment nearer his permanent home, one to move to the Midlands with her husband, and the third to take up an appointment as Chief Dental Officer, Brighton. It is of interest to note that three area dental officers from West Sussex have become chief dental officers during the last six years. Two whole-time and one part-time dental officers were appointed to fill these vacancies. A dental auxiliary was also recruited after over two years of repeated advertising. Much of her time is taken up with the preventive aspects of dentistry, including the use of fissure sealants and topical application of fluoride.

I wish to make special note of the retirement of the Senior Dental Surgery Assistant, Miss R. Cozens. She retired on 11th November, 1972 after fifteen years' service with West Sussex County Council and I consider myself very fortunate to have had such a conscientious person on the staff. I am delighted to say that she has been persuaded to return in a part-time capacity.

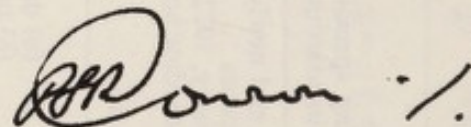
Inspection and treatment

Statistics will be found on page 67. A total of 61,192 children received a first inspection and a further 14,406 received a second inspection; the inspection rate was 161 children per session. Of the children inspected, 41 per cent required treatment and 85 per cent of these were offered treatment.

Courses of treatment completed numbered 8,993, an increase of 406 over the previous year. A further 1,300 courses were commenced, giving an acceptance rate of 44 per cent.

Acknowledgements

Once again, I wish to record my thanks to members of the Council and to my colleagues in the Health, Education and other departments for their help and encouragement. I feel sure that the integrated National Health Service in West Sussex will be able to count on the same helpful cooperation that exists here now.



Principal School Dental Officer

Other Services

School Meals and Milk

The following information, obtained from the Director of Education, shows the numbers of children in maintained schools in the County who had

school dinners and milk on a day in October, 1972 and is compared with similar information for 1971.

<i>Meals</i>	1971	1972
Number of children present on day selected	70,286	71,907
Number of school dinners served	45,074	48,916
Percentage taking dinners	64.0	68.0

Milk

Pupils entitled to free milk on grounds of age, i.e. 5-7, including children at special schools and independent special schools:

	1971	1972
Number of entitled children present on day selected	16,550	16,835
Number of children taking milk	15,528	15,884
Percentage of milk drinkers	94.0	94.3

Pupils entitled to consideration for free milk on health grounds (over 7 years of age in primary schools and junior pupils in middle schools):

Number of children present	—	25,126
Number of children receiving milk	—	128
Percentage receiving milk	—	0.5

The close liaison between the county environmental health inspectors and the school meals service helped to maintain high standards of hygiene in school canteens. Considerable emphasis was placed on the educational aspects of this supervisory service.

The County Environmental Health Inspector provided a course of instruction in food hygiene for second-year catering students at Chichester College of Further Education. The course included lectures, films, practical work and visits to food processing plant. The course concluded with the students taking the Royal Society of Health Examination for the Certificate in Hygiene of Food Retailing and Catering. Of 26 students taking the examination, 23 qualified for the Certificate.

The various in-service training courses run by the school meals service included sessions devoted to food hygiene.

The county environmental health inspectors continued to undertake regular inspection of meat consigned to school kitchens. Few complaints were received but where these arose the matters were dealt with on an informal basis to the satisfaction of all concerned.

School Hygiene and Sanitation

Following their visits to schools, the county environmental health inspectors commented on deficiencies in lavatory accommodation, washing facilities, lighting and other matters affecting the well-being of pupils and staff. The deficiencies were referred to the Director of Education with a view to remedial work being carried out as part of minor improvement programmes. There was greater use of scientific instruments in recording environmental data; these included light meters, electronic thermometers and a sound-level meter.

School Swimming Pools

The County Environmental Health Inspector advised on the installation of swimming pools at County schools.

The current policy is to install the least sophisticated equipment, having due regard to efficiency, thereby reducing maintenance costs and simplifying pool operation, a factor which is essential where unskilled staff are employed or staff changes occur frequently.

By arrangement with the Education and County Architect's Departments the County Environmental Health Inspector was also responsible for supervising the operation of pools and for dealing with the many routine enquiries and maintenance problems that arose. A total of 171 requests for advice were recorded during the swimming season; all were dealt with effectively and, wherever possible, within 24 hours of information being received. In addition, 168 routine visits of inspection were made when water samples were collected for laboratory examination. A total of 676 assays were made of residual chlorine fractions, pH and residual cyanuric acid levels. Where necessary, establishments were advised on necessary adjustments to maintain ideal swimming conditions.

All school swimming pools have been chlorinated with trichloroisocyanuric acid supplied in powder form and made up into seven-ounce pseudo-osmotic sachets. The system has the important advantages to which reference was made in the Report for 1969 and has been readily accepted by unskilled caretakers and other school staff.

With the delegation of certain responsibilities for education to the Crawley U.D.C., those school pools attached to the schools in that area were transferred in 1970 to the general supervision of the public health inspectorate at Crawley. However, the county health inspectorate still continued to offer specialist advice when necessary and arranged to supply water treatment chemicals to each of the establishments in question as part of the bulk purchase arrangements for schools in the County as a whole.

A further four swimming pools were installed during the year. All pools have filtration and an effective system of chlorination and the next table gives an indication of their type and distribution.

<i>Type of School</i>	<i>Open-air Pools</i>		<i>Indoor Pools</i>		TOTALS
	<i>Unheated</i>	<i>Heated</i>	<i>Unheated</i>	<i>Heated</i>	
Primary	58 (60)	14 (8)	1 (1)	1 (1)	74 (70)
Secondary	6 (9)	3 (—)	— (—)	— (—)	9 (9)
Special	3 (3)	— (—)	— (—)	— (—)	3 (3)
TOTALS	67 (72)	17 (8)	1 (1)	1 (1)	86 (82)
Crawley U.D.C. area . (All types of school)	13 (13)	— (—)	— (—)	— (—)	13 (13)

Note: The figures in brackets relate to 1971.

The County Environmental Health Inspector, who is an expert in this subject, continued his work for the Local Government Training Board working party and, with two other local government officers, drafted a reference manual and assessed schemes of training of school swimming pool operators and technicians employed in the public baths service. This work was completed during the year.

RETURN OF MEDICAL INSPECTION AND TREATMENT FOR THE YEAR ENDED 31st DECEMBER, 1972

MEDICAL INSPECTION OF PUPILS ATTENDING MAINTAINED PRIMARY AND SECONDARY SCHOOLS (INCLUDING NURSERY AND SPECIAL SCHOOLS)

Periodic Medical Inspections

<i>Age groups inspected (by year of birth)</i>	<i>No. of pupils who have received a full medical examination</i>	<i>Physical condition of pupils inspected</i>		<i>No. of pupils found not to warrant a medical examination</i>	<i>Pupils found to require treatment (excluding dental diseases and infestation with vermin)</i>		
		<i>Satisfactory</i>	<i>Unsatisfactory</i>		<i>For defective vision (excluding squint)</i>	<i>For any other condition</i>	<i>Total individual pupils</i>
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1968 and later	197	197	—	—	—	9	9
1967	2,513	2,512	1	—	70	134	195
1966	3,799	3,795	4	—	139	239	366
1965	750	750	—	—	58	112	168
1964	484	484	—	—	86	68	152
1963	351	351	—	—	49	55	101
1962	1,929	1,924	5	—	73	100	170
1961	3,732	3,729	3	—	124	156	275
1960	1,575	1,574	1	—	73	84	154
1959	447	447	—	—	37	24	60
1958	1,017	1,016	1	—	36	42	77
1957 and earlier	3,734	3,716	18	613	189	104	286
TOTALS	20,528	20,495	33	613	934	1,127	2,014

Col. (3) total as a percentage of Col. (2)

total 99.83

Col. (4) total as a percentage of Col. (2)

total 0.16

Other Inspections

		1971	1972
Number of Special Inspections	. . .	200	105
Number of Re-inspections	. . .	7,318	9,739
TOTALS	. . .	7,518	9,844

**Defects found by Periodic and Special Medical
Inspections during the Year**

Defect Code No. (1)	Defect or disease (2)	Periodic inspection				Special inspec- tions (7)
		Entrants (3)	Leavers (4)	Others (5)	TOTAL (6)	
4.	Skin T	13	30	37	80	—
	. . . . . O	145	109	198	452	3
5.	Eyes: (a) Vision . . . T	205	194	535	934	7
	. . . . . O	840	551	928	2,319	45
	(b) Squint T	38	5	29	72	—
	. . . . . O	159	11	82	252	15
	(c) Other T	2	1	8	11	—
	. . . . . O	23	20	35	78	2
6.	Ears: (a) Hearing . . . T	108	22	159	289	3
	. . . . . O	413	44	221	678	8
	(b) Otitis Media . . . T	10	3	12	25	—
	. . . . . O	145	10	35	190	2
	(c) Other T	10	12	19	41	1
	. . . . . O	65	32	38	135	1
7.	Nose and Throat . . . T	30	9	68	107	—
	. . . . . O	673	106	297	1,016	11
8.	Speech T	31	2	45	78	2
	. . . . . O	302	9	64	375	45
9.	Lymphatic Glands . . . T	6	—	—	6	—
	. . . . . O	140	17	45	202	1
10.	Heart T	7	3	11	21	1
	. . . . . O	121	24	87	232	4
11.	Lungs T	15	1	15	31	—
	. . . . . O	176	47	154	377	—
12.	Developmental: (a) Hernia . T	9	3	8	20	—
	. . . . . O	13	3	13	29	—
	(b) Other T	43	2	105	150	1
	. . . . . O	173	15	132	320	6
13.	Orthopaedic: (a) Posture . T	3	7	13	23	1
	. . . . . O	39	37	74	150	3
	(b) Feet T	13	8	32	53	3
	. . . . . O	108	41	108	257	8
	(c) Other T	7	4	21	32	1
	. . . . . O	233	83	167	483	17
14.	Nervous (a) Epilepsy . . T	1	—	1	2	—
	System: O	20	17	39	76	7
	(b) Other T	—	—	4	4	1
	. . . . . O	35	20	49	104	4
15.	Psychological: (a) Develop- T	5	1	11	17	—
	ment O	114	23	108	245	20
	(b) Stability T	3	1	13	17	1
	. . . . . O	140	25	123	288	15
16.	Abdomen T	—	—	2	2	—
	. . . . . O	52	11	66	129	2
17.	Other T	34	15	57	106	11
	. . . . . O	124	139	223	486	3

T indicates number of pupils requiring treatment.

O indicates number of pupils requiring observation.

**TREATMENT OF PUPILS ATTENDING MAINTAINED PRIMARY AND
SECONDARY SCHOOLS (INCLUDING NURSERY AND SPECIAL SCHOOLS)**

Eye Diseases, Defective Vision and Squint

	<i>Number of cases known to have been dealt with</i>	
	1971	1972
External and other, excluding errors of refraction and squint	2	2
Errors of refraction (including squint)	2,892	2,520
TOTALS	2,894	2,522
Number of pupils for whom spectacles were prescribed	821	763

Diseases and Defects of Ear, Nose and Throat

	<i>Number of cases known to have been dealt with</i>	
	1971	1972
Received operative treatment:—		
(a) For diseases of the ear	4	10
(b) For adenoids and chronic tonsillitis	187	159
(c) For other nose and throat conditions	—	—
Received other forms of treatment	36	—
TOTALS	227	169
Total number of pupils in schools who are known to have been provided with hearing aids:—		
(a) In year	8	9
(b) In previous years	147	158

Orthopaedic and Postural Defects

	<i>Number of cases known to have been treated</i>	
	1971	1972
(a) Pupils treated at clinics or out-patients' departments	115	48
(b) Pupils treated at school for postural defects	—	—
TOTALS	115	48

Diseases of the Skin

	<i>Number of cases known to have been treated</i>	
	1971	1972
Ringworm: (a) Scalp	—	—
(b) Body	—	1
Scabies	6	4
Impetigo	24	15
Other skin diseases	301	173
TOTALS	331	193

Child Guidance Treatment

	<i>Number of cases known to have been treated</i>	
	1971	1972
Pupils treated at Child Guidance Clinics	822	955

Speech Therapy

	<i>Number of cases known to have been treated</i>	
	1971	1972
Pupils treated by speech therapist	331	300

Other Treatment Given

	<i>Number of cases known to have been dealt with</i>	
	1971	1972
(a) Pupils with minor ailments	409	330
(b) Pupils who received convalescent treatment under School Health Service arrangements	8	5
(c) Pupils who received B.C.G. vaccination	5,144	5,477
(d) Other than (a), (b) and (c) above:		
Orthoptic	282	324
Enuresis (pad and bell alarms)	85	94
TOTAL (a)–(d)	5,928	6,233

DENTAL INSPECTION AND TREATMENT CARRIED OUT BY THE AUTHORITY

ATTENDANCES AND TREATMENT	<i>Ages 5 to 9</i>	<i>Ages 10 to 14</i>	<i>Ages 15 and over</i>	TOTALS
First visit	4,609	3,329	430	8,368
Subsequent visits	6,328	7,198	1,204	14,730
Total visits	10,937	10,527	1,634	23,098
Additional courses of treatment	642	551	107	1,300
Fillings in permanent teeth	3,604	8,677	1,459	13,740
Fillings in deciduous teeth	6,698	700	—	7,398
Permanent teeth filled	3,046	7,509	1,292	11,847
Deciduous teeth filled	6,266	661	—	6,927
Permanent teeth extracted	164	752	118	1,034
Deciduous teeth extracted	1,953	583	—	2,536
General anaesthetics	891	453	34	1,378
Emergencies	531	273	53	857
Number of pupils x-rayed				958
Prophylaxis				2,894
Teeth otherwise conserved				5,149
Number of teeth root filled				34
Inlays				3
Crowns				7
Courses of treatment completed				8,993
ORTHODONTICS				
Cases remaining from previous year				190
New cases commenced during year				219
Cases completed during year				114
Cases discontinued during year				24
No. of removable appliances fitted				268
No. of fixed appliances fitted				—
Pupils referred to hospital consultant				65
PROSTHETICS				
	<i>Ages 5 to 9</i>	<i>Ages 10 to 14</i>	<i>Ages 15 and over</i>	TOTALS
Pupils supplied with F.U. or F.L. (first time)	—	—	8	8
Pupils supplied with other dentures (first time)	2	10	6	18
Number of dentures supplied	3	14	19	36
ANAESTHETICS General anaesthetics administered by dental officers				
				734
INSPECTIONS				
(a) First inspection at school — number of pupils				56,975
(b) First inspection at clinic — number of pupils				4,217
Number of (a) + (b) found to require treatment				25,042
Number of (a) + (b) offered treatment				21,116
(c) Pupils re-inspected at school or clinic				14,406
Number of (c) found to require treatment				5,900
SESSIONS				
Sessions devoted to treatment				3,546
Sessions devoted to inspection				427
Sessions devoted to dental health education				57

Appendix A

HEALTH COMMITTEE

(at 31st December, 1972)

County Council Members

	<i>Sub-Committee ‡</i>
MRS. B. G. ARMSTRONG-CLARKE, J.P.	e
COL. W. H. BLAGDEN, C.B.E.	
MR. T. BOOTHMAN	e
MR. H. BRINTON	
MR. J. W. CHAPMAN, J.P.	
MRS. M. COBBY, O.B.E.	e
MR. E. DODD	e
*MR. E. J. F. GREEN, (<i>Chairman of the Finance Committee</i>)	
MR. PHILIP GREEN	
MR. P. J. HEALY	
MR. C. D. HERNIMAN, J.P.	
MR. W. D. LEDGER	
MAJOR-GENERAL H. M. LIARDET, C.B., C.B.E., D.S.O., D.L. (<i>Chairman</i>)	Ce
LADY MACKINTOSH, J.P.	
*SIR PETER MURSELL, M.B.E., D.L. (<i>Chairman of the County Council</i>)	
MRS. P. B. P. NAUNTON, J.P.	e
MR. A. E. PEGLER	
MR. W. G. S. POPE (<i>Vice-Chairman</i>)	e
MRS. F. M. L. RICHARDS	
MRS. N. B. M. SHARP, J.P.	
MR. T. H. SIGGS	
MR. M. G. SPOFFORTH	
MR. A. H. STOW	
MISS E. M. WARD	
MR. D. L. WHITTAKER	
*MR. J. E. WHITTOME, O.B.E., D.L. (<i>Vice-Chairman of the County Council</i>)	

Other Members

DR. IVAN CLOUT, O.B.E.	representing the South West Metropolitan Regional Hospital Board	e
DR. H. ROSENBERG, O.ST.J	representing the Executive Council for the County of West Sussex	

‡The symbols are explained at the foot of the next page.

EDUCATION COMMITTEE

(at 31st December, 1972)

County Council Members

	<i>Sub-Committee</i>
MRS. E. ATKINSON	S
DR. H. M. AYRES, C.ST.J.	
MR. D. S. W. BLACKER	
MR. H. BRINTON	S
LADY BRUNDRETT	
MRS. E. M. CLARKE	
†MR. L. A. FOSTER (<i>Chairman</i>)	
MRS. P. FOSTER	Cs
*MR. E. J. F. GREEN, J.P. (<i>Chairman of the Finance Committee</i>)	
MR. D. F. HILL	S
MR. A. HOWARD	
MRS. M. KEOGH MURPHY	
MR. E. KIRKBY-BOTT	
MR. W. D. LEDGER	
MR. R. MARTIN	
MR. G. W. MASSÉ	S
MR. R. MAY, O.B.E.	S
LT. CDR. M. G. MORRIS, D.S.C., R.D., R.N.R.	
*SIR PETER MURSELL, M.B.E., D.L. (<i>Chairman of the County Council</i>)	
MR. A. G. W. PENNEY, J.P.	
MRS. D. M. PENNICOTT	S
MRS. F. M. RICHARDS	
MR. P. G. SHEPHERD	
MR. A. A. SHEPPARD	S
BRIG. L. L. THWAYTES, D.L.	
MR. E. L. WALTER	
MR. L. E. WALWIN	
*MR. J. E. WHITOME, O.B.E., D.L. (<i>Vice-Chairman of the County Council</i>)	
MR. C. E. C. WOOLLEY	
(1 Vacancy)	

Other Members

MR. R. P. COOK	representing Worthing Committee for	
MR. S. C. ELLIOTT	Education	S
MR. H. E. WESTON		
MRS. B. M. E. ANDERSON	representing Crawley Committee for	
MR. R. P. BARRY	Education	
MR. A. E. PEGLER		S
THE REV. CANON M. C. LANGTON	representing religious denominations	
THE REV. R. H. SMITH		S
THE REV. J. HULL		
MR. F. NEWBY	representing teachers employed in schools	
MR. D. PAY	maintained by the Local Education	S
MR. F. J. J. PIDGEON	Authority	
MAJOR-GEN. C. LLOYD, C.B.,		
C.B.E., T.D.		
MR. C. W. TONKIN		
MISS W. A. WAITE		S

* Ex-officio member of the Committee and of the Sub-Committee.

† Ex-officio member of the Special Services Sub-Committee.

C Chairman of Sub-Committee.

e Executive Sub-Committee.

s Special Services Sub-Committee.

Appendix B

STAFF

(at 31st December, 1972)

*County Medical Officer of Health and
Principal School Medical Officer:*

T. McL. GALLOWAY, M.D., F.R.C.P., D.P.H., Dr.P.H.

*Deputy County Medical Officer of Health and
Deputy Principal School Medical Officer:*

D. WILD, M.B., Ch.B., D.Obst., R.C.O.G., D.P.H., D.M.A.

Principal Medical Officer:

A. L. BUSSEY, M.B., B.S., M.R.C.G.P., D.Obst., R.C.O.G., D.M.S., A.M.B.I.M.

Principal Administrative Officer:

J. SAUNDERS, F.C.I.S., F.H.A.

Medical Officers of the Department and School Medical Officers:

*J. C. AITKEN, M.B., Ch.B., D.P.H.

*ROSETTA C. BARKER, M.B., B.Ch., B.A.O., D.P.H.

*D. WARREN BROWNE, M.R.C.S., L.R.C.P., D.T.M. AND H., D.P.H.

*F. COCKCROFT, M.A., M.R.C.S., L.R.C.P., D.P.H.

*ANNIE M. EVANS, M.B., B.Ch.

*V. P. GEOGHEGAN, M.D., D.P.H.

*J. A. G. GRAHAM, M.B., Ch.B., D.P.H.

ELIZABETH M. GREEN, M.B., Ch.B.

CHRISTINA A. GUNN, M.B., Ch.B., D.P.H.

*T. M. HUMPHRY, M.R.C.S., L.R.C.P.

*ESTHER S. KERR, M.A., M.B., B.Ch., D.Obst., R.C.O.G.

A. LOWRY, M.R.C.S., L.R.C.P., D.C.H.

*K. N. MAWSON, M.B., Ch.B., D.P.H.

MERLE NEWTON, M.R.C.S., L.R.C.P., D.C.H.

JEAN B. SCOTT, M.A., M.B., Ch.B.

*BARBARA M. TOWERS, J.P., M.B., Ch.B., M.R.C.S., L.R.C.P.

*MURIEL G. WARREN BROWNE, M.B., Ch.B.

Chief Dental Officer and Principal School Dental Officer:

P. S. R. CONRON, L.D.S.

Area Dental Officers:

J. M. BAIN, L.D.S.

N. A. BOSTOCK, L.D.S.

D. E. GIBBONS, B.D.S.

P. TURNBULL, M.A., B.D.S.

Senior Dental Officers:

*P. H. HELLYER, B.D.S.

G. C. KENT, L.D.S.

P. C. ROBERTSON, L.D.S.

*MISS H. M. PHILLIPS, L.D.S.

J. A. W. PURNELL, L.D.S.

ANNIE ROBERTSON, L.D.S.

Consultant Ophthalmologists:

*H. B. JACOBS, F.R.C.S., D.O.M.S.

*P. W. ARUNDELL, M.R.C.S., L.R.C.P., D.O.M.S.

*S. BANERJI, M.B.

*VIVIEN BELL, M.B., B.S., D.O.

*W. B. HEYWOOD-WADDINGTON, M.B., B.S.

*S. CHATTERJEE, M.B., B.S.

*Part-time

Consultant Psychiatrists:

- *M. ALDRIDGE, B.A., M.B., B.Ch., D.P.M.
*KATHLEEN B. COBB, M.A., M.B., Ch.B., D.P.M.
*K. A. O'KEEFE, M.B., BCh., B.A.O., D.P.M.
*J. C. MOUGNE, M.D., D.P.M.
*MARGARET SHEPPERD, M.R.C.S., L.R.C.P., D.P.M.

County Environmental Health Inspector:

A. P. L. WALLIS, F.I.P.H.E., F.A.P.H.I.

Assistant County Public Health Inspector:

G. R. CROWTHER, M.R.S.H., M.A.P.H.I.

County Ambulance Officer:

V. A. GLOVER, F.I.A.O., F.H.A.

Deputy County Ambulance Officer:

L. P. F. WEEKS, A.I.A.O.

Director of Nursing Services:

MISS D. M. SMITH, S.R.N., S.C.M., H.V.CERT.

Divisional Nursing Officer:

MISS P. J. LAMBERT, S.R.N., S.C.M., M.T.D., H.V.CERT.

Area Nursing Officers:

- MISS B. M. GOLDING, S.R.N., S.C.M., H.V.CERT.
MISS M. NASH, S.R.N., S.C.M., H.V.CERT.
MISS A. M. RYDER, S.R.N., S.C.M., M.T.D., H.V.CERT.

Nursing Officers:

- MRS. E. G. M. TAPSFIELD, S.R.N., S.C.M.
MISS A. C. THEAKER, S.R.N., S.C.M., H.V.CERT.

Health Education Organiser:

MISS B. M. JACOB, S.R.N., S.C.M., H.V.CERT., D.M.A.

Assistant Health Education Organiser:

MISS V. K. JONES, S.R.N.

Chief Chiropodists:

- A. C. CAMPBELL, S.R.N., M.Ch.S., S.R.Ch.
E. JONES, S.R.N., M.C.S.P., M.Ch.S., S.R.Ch. (WORTHING)

Senior Chiropodists:

- | | |
|--|---|
| J. ALEXANDER, M.Ch.S., S.R.Ch. | S. KNIGHT, M.C.S.P., S.R.P., M.Ch.S., S.R.Ch. |
| F. ATHERTON, M.Ch.S., S.R.Ch. | A. R. MOLESHEAD, M.Ch.S., S.R.Ch. |
| F. A. BAKER, M.Ch.S., S.R.Ch. | R. A. OGILVIE, M.Ch.S., S.R.Ch. |
| MRS. E. C. CHURCHILL, S.R.N., M.Ch.S., S.R.Ch. | MISS J. A. PARTRIDGE, M.Ch.S., S.R.Ch. |
| MRS. J. A. COLLINS, M.Ch.S., S.R.Ch. | MRS. D. SHENTON, M.Ch.S., S.R.Ch. |
| D. A. COLLYER, M.Ch.S., S.R.Ch. | *S. F. STEFANSKI, M.Ch.S., S.R.Ch. |
| *MRS. M. A. DONKIN, M.Ch.S., S.R.Ch. | MISS F. I. STOKES, M.Ch.S., S.R.Ch. |
| MRS. E. DROMGOOLE, M.Ch.S., S.R.Ch. | C. T. WEBB, M.Ch.S., S.R.Ch. |
| MISS J. M. WILSON, M.Ch.S., S.R.Ch. | |

Senior Speech Therapists:

- *MISS M. G. A. McCOMBIE, L.C.S.T.
MRS. C. A. CHALMERS, L.C.S.T.

*Part-time

Speech Therapists:

MISS J. I. FORD, L.C.S.T.
*MRS. J. M. GIBSON, L.C.S.T.
*MRS. M. HILL, L.C.S.T.
*MRS. A. J. LEWIS, L.C.S.T.

MRS. S. M. MAULE-OATWAY, L.C.S.T.
*MRS. H. RICHARDS, L.C.S.T.
*MRS. E. A. SMITH, L.C.S.T.
*MRS. M. E. SMITH, L.C.S.T.

Head Psychiatric Social Worker:

MISS J. S. PARSONS, A.A.P.S.W.

Psychiatric Social Workers:

*MRS. A. B. GODFREY, A.A.P.S.W.
MISS A. E. B. JENKINS, B.A., CERT. P.S.W.
C. J. MOODY, CERT. A.S.S.

*V. W. J. ROBINSON, A.A.P.S.W.
*MRS. E. T. ROSSELLI, M.A., A.A.P.S.W.
MISS F. P. TOWNSEND, S.R.N., A.A.P.S.W.

Other Child Guidance Staff:

*MISS A. BOWLEY, Ph.D., F.B.P.S.S.
*MISS H. N. BRISTOW
*MRS. D. P. HAIG, dip. soc. science

*P. L. E. GAISMAN
*MRS. R. S. D. INFELD, B.Sc. (ECON.)
*MRS. P. C. STANFORTH

*MRS. P. E. VELMANS

Senior Educational Psychologist:

D. LABON, B.Sc., A.B.P.S.S.

Educational Psychologists:

MRS. S. BAKER, B.A. M.Ed. psych.
G. CROWTHER, M.Sc., A.B.P.S.S.

D. LEACH, B.A., M.Ed. psych.
C. MACPHERSON, B.A.

MISS S. PERRY, B.A., M.Ed., A.B.P.S.S.

Administrative Divisions:

Senior Administrative Assistants

P. R. THATCHER, M.I.S.W.
R. G. BARRY, D.M.A.

Administrative Assistants

L. SHAW, D.M.A.
J. W. SMITH, D.M.A., Grad. I.P.M.
A. C. FISHER, D.M.A., A.C.I.S.
M. G. MOORE
A. G. PENNICOTT, D.M.A.
B. S. HOLMES

GENERAL SERVICES
DIVISION:

NURSING SERVICES DIVISION: J. E. FIELD

SCHOOL HEALTH SERVICES
DIVISION:

A. W. GASKELL

MRS. J. C. MACEY

*Part-time

Medical Officers of Health of District Councils:

ROSETTA C. BARKER, M.B., B.Ch., B.A.O.,
D.P.H.

D. WARREN BROWNE, M.R.C.S., L.R.C.P.,
D.T.M. AND H., D.P.H.

F. COCKCROFT, M.A., M.R.C.S., L.R.C.P.,
D.P.H.

V. P. GEOGHEGAN, M.D., D.P.H.

J. A. G. GRAHAM, M.B., Ch.B., D.P.H.

K. N. MAWSON, M.B., Ch.B., D.P.H.

Chancetonbury Rural District
Shoreham-by-Sea Urban District
Southwick Urban District

Bognor Regis Urban District
City of Chichester

Littlehampton Urban District
Worthing Rural District

Arundel Municipal Borough
Chichester Rural District
Midhurst Rural District

Worthing Municipal Borough

Crawley Urban District
(temporary arrangement)
Horsham Urban District
Horsham Rural District
Petworth Rural District

STAFF: Categories and Numbers Employed

Category of Staff (1)	Establishment 30.9.72 (2)	In post on 30th September				
		Whole-time (3)	Part-time (4)	Whole-time equivalent of Col. (4) (5)	Total whole-time equivalent	
					1971 (6)	1972 (7)
Administrative and clerical:						
Central office	55	50	8	5.0	53.0	55.0
Health centres, clinics, etc.	35.7	13	50	22.1	23.8	35.1
Ambulance operational staff	124.5	117	4	3.4	116.0	120.4
Chiropodists	19.1	18	3	0.3	14.7	18.3
Dentists	12.0	10	2	1.1	11.8	11.1
Dental auxiliary	1.0	1	—	—	—	1.0
Dental surgery assistants	13.0	13	—	—	13.0	13.0
Doctors	20.0	8	49	10.7	16.0	18.7
Health education organiser and assistants	4.0	3	—	—	3.0	3.0
Manual and domestic, including cleaners at health centres, clinics, etc.	8.3	4	14	4.3	9.0	8.3
Nursing and auxiliary:						
Administrative and super- visory nursing staff	6.0	6	—	—	6.0	6.0
Clinic assistants	20.0	13	8	4.0	15.0	17.0
Combined nursing appoint- ments (all services; includ- ing relief staff)	28.0	26	—	—	27.5	26.0
Domiciliary midwives	16.0	16	—	—	16.0	16.0
Family planning nurses	6.0	—	29	6.0	—	6.0
Health visitors/school nurses	71.0	68	—	—	65.0	68.0
Home nurses } S.R.N.	91.0	87	4	1.0	84.5	88.0
} S.E.N.	19.0	17	—	—	14.0	17.0
Nurse/midwives	13.0	12	—	—	14.0	12.0
Nursing auxiliaries	35.0	29	—	—	30.5	29.0
Physiotherapists	0.5	—	4	0.5	0.5	0.5
Public health inspectors and sampling officers	4.0	4	—	—	4.0	4.0
Speech therapists	6.0	3	6	2.3	2.8	5.3
Social workers and therapists in child guidance clinics	12.0	5	11	5.3	8.7	10.3
TOTALS	620.1	523	192	66.0	548.8	589.0

Appendix C

CENSUS 1971

Population

The population of the County at the 1971 Census of Population was 492,495. The municipal boroughs and urban districts accounted for 58·7 per cent of this total, the largest being Worthing M.B. (88,407), Crawley U.D. (67,608) and Bognor Regis U.D. (34,352). Among the rural districts the largest were Chichester R.D. (63,100), Worthing R.D. (50,558) and Horsham R.D. (30,769).

Between 1961 and 1971 the population of the County increased by 80,882, an average annual increase of 1·81 per cent; the corresponding rate of increase between 1951 and 1961 was 2·45 per cent. Apart from a small decrease in Arundel M.B. and Southwick U.D., all urban areas increased their populations. All the rural districts increased their populations between 1961 and 1971, the largest increase being in Chichester R.D. (13,708), Worthing R.D. (12,132) and Horsham R.D. (8,138).

Age and Sex Distribution

The age and sex distribution in urban and rural districts is shown in Table A. The proportion of the population aged under five (6·7 per cent) was lower than that of England and Wales (8 per cent). The proportion aged under 15 was 21·0 per cent compared with a corresponding figure of 23·9 per cent for England and Wales. The proportion aged 65 or over in West Sussex (20·9 per cent) was considerably more than that in England and Wales (13·1 per cent) and has risen compared with the proportion in West Sussex in 1961 (18·8 per cent).

Of the total population of 492,495 persons, 227,130 were males and 265,365 were females, giving a sex ratio of 1,169 females a 1,000 males. This higher-than-average female sex ratio is related to the older-than-average age distribution in West Sussex, the older age groups everywhere tending to have the greater number of females.

The proportion of men aged 15 and over who were married was 73·2 per cent (73·8 per cent in 1961); among women of the same age group, 60·1 per cent were married, compared with 58·9 per cent in 1961.

Housing

In West Sussex 473,180 persons were enumerated in 177,375 private households which occupied 885,080 separate rooms. There were 189,625 structurally separate dwellings, of which 7,235 were wholly vacant. Among the occupied dwellings, 180,750 contained one household space and 1,640 more than one household space. The number of dwellings (occupied and vacant) had risen by 33·2 per cent since 1961; of the occupied dwellings, 11·1 per cent had fewer than four rooms and 11·0 per cent had seven or more rooms. The average size of dwellings had risen slightly since 1961 from 4·9 rooms to 5·0 rooms.

The average number of persons per household had fallen from 2·9 to 2·7. Five per cent of all households occupied one or two rooms, 29·8 per cent occupied three or four rooms, 30·7 per cent occupied five rooms, 23·9 per cent occupied six rooms and the remaining 10·6 per cent seven or more rooms; 2·1 per cent of all households shared a dwelling with at least one other household compared with 3·4 per cent in 1961.

Households Containing Persons of Pensionable Age

There were 122,055 persons (24·8 per cent) over pensionable age in the County. Of these 91,555 were enumerated in one or two-person households; 23,025 were enumerated in other households and 7,475 were enumerated in non-private establishments.

Household Arrangements

In West Sussex 92·3 per cent of households had use of all three household arrangements, *viz.* hot water tap, fixed bath and water closet. The proportion was 93·8 per cent of all households in unshared dwellings in permanent buildings, 38·6 per cent of all households in self-contained accommodation within shared dwellings in permanent buildings, 46·1 per cent of all households in self-contained accommodation within shared dwellings in permanent buildings with exclusive use of both stove and sink, 34·5 per cent of all households not in self-contained accommodation and 45·2 per cent of all households not in self-contained accommodation with exclusive use of both stove and sink. A summary of

District	Sex All Ages	AGE GROUPS																				
		0-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85-89	90-94	95+	
Urban Districts	M	1,125	70	75	85	70	75	45	60	60	65	55	85	100	80	65	35	20	10	*		
	F	1,310	65	75	65	70	50	55	60	60	85	80	115	105	105	100	75	45	20	*		
	T	2,435	130	145	155	145	125	100	120	120	145	135	200	215	180	170	110	65	30	5		
Bognor Regis U.D.	M	15,180	1,020	1,150	970	1,015	845	745	740	755	815	825	955	1,085	1,225	925	585	315	165	35	5	
	F	19,270	1,995	1,095	1,055	1,145	845	760	760	845	1,010	1,065	1,295	1,625	1,740	1,555	1,120	830	390	140	30	
	T	34,450	2,010	2,245	2,025	2,160	1,690	1,505	1,500	1,600	1,825	1,890	2,250	2,710	2,965	2,485	1,705	1,145	555	175	35	
Chichester M.B.	M	9,535	630	785	690	760	550	535	545	550	595	625	635	580	520	340	255	150	65	20	5	
	F	11,115	590	710	670	690	570	530	565	650	700	660	760	720	750	625	530	360	175	65	20	
	T	20,650	1,220	1,495	1,355	1,450	1,120	1,065	1,110	1,200	1,295	1,280	1,395	1,300	1,270	970	785	510	240	85	25	
Crawley U.D.	M	33,420	2,780	3,265	3,490	3,005	2,590	2,145	1,845	2,795	2,830	2,170	1,645	1,090	735	420	255	135	60	15	*	
	F	34,190	2,690	3,240	3,265	2,900	2,615	2,135	1,930	2,915	2,740	1,950	1,490	1,125	890	700	565	330	155	50	10	
	T	67,610	5,470	6,505	6,755	5,905	5,205	4,280	3,775	4,645	5,710	5,570	4,120	3,135	2,215	1,625	1,120	825	465	215	65	10
Horsham U.D.	M	12,610	985	1,170	1,010	815	920	825	705	860	900	740	735	660	590	420	240	140	60	20	5	
	F	13,835	905	1,075	980	865	890	810	730	880	895	755	790	820	800	660	495	345	180	70	15	
	T	26,445	1,890	2,250	1,990	1,680	1,810	1,635	1,435	1,670	1,740	1,795	1,495	1,530	1,480	1,395	1,075	735	485	240	90	20
Littlehampton U.D.	M	8,420	680	705	620	550	585	505	450	455	465	435	490	490	545	460	305	140	60	15	*	
	F	10,275	670	675	780	625	600	530	470	445	520	500	640	720	785	735	530	330	160	55	10	
	T	18,695	1,355	1,385	1,400	1,175	1,185	1,035	920	905	950	980	940	1,130	1,210	1,195	840	470	220	70	15	
Shoreham-by-Sea U.D.	M	8,920	675	705	675	550	525	495	510	570	650	560	570	565	455	355	235	125	50	20	5	
	F	9,985	655	630	675	555	580	530	520	610	650	655	680	685	625	510	375	260	125	50	10	
	T	18,905	1,325	1,335	1,345	1,240	1,110	1,105	1,020	1,030	1,180	1,300	1,215	1,245	1,080	865	610	385	175	70	15	
Southwick U.D.	M	5,560	325	490	405	395	360	305	280	315	365	405	345	410	345	215	145	75	15	15	5	
	F	6,310	365	430	415	345	305	270	320	320	395	405	415	480	460	370	270	185	95	35	10	
	T	11,865	690	920	820	735	665	600	635	730	770	825	760	890	810	585	415	260	115	50	10	
Worthing M.B.	M	36,610	2,330	2,520	2,205	1,920	2,245	1,915	1,760	1,795	1,920	2,005	2,255	2,645	2,985	2,750	1,930	1,150	490	130	30	
	F	51,795	2,150	2,370	2,195	1,980	2,275	2,040	1,715	2,055	2,415	2,645	3,345	4,325	5,295	5,390	4,485	3,070	1,545	550	135	
	T	88,405	4,475	4,890	4,400	3,900	4,520	3,955	3,470	3,850	4,340	4,650	5,595	6,970	8,280	8,140	6,415	4,220	2,055	680	165	
Aggregate of U.D.s and M.B.s	M	131,380	9,490	10,870	10,170	9,135	9,040	7,690	6,855	7,205	8,175	8,605	7,820	7,715	7,485	5,955	3,980	2,250	980	256	55	
	F	158,085	9,080	10,295	10,015	9,140	9,230	7,830	7,035	7,840	8,910	9,420	8,725	9,525	10,615	11,445	10,645	8,455	5,755	2,865	1,020	245
	T	289,465	18,570	21,165	20,185	18,270	18,270	15,520	13,890	15,045	17,085	18,030	16,545	17,245	18,245	18,930	16,600	12,435	8,005	3,845	1,290	300

Continued overleaf

Table A (continued)

District	Sex All Ages	AGE GROUPS																			95 +
		0-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85-89	90-94	
Rural Districts Chancetonbury R.D.	M	13,275	1,095	1,155	745	815	790	745	730	690	730	755	820	960	930	590	375	190	80	25	
	F	15,155	975	1,100	750	825	855	775	750	745	855	900	1,020	1,210	1,200	940	620	420	195	80	
	T	28,430	2,070	2,255	1,495	1,640	1,645	1,520	1,480	1,435	1,585	1,655	1,840	2,170	2,130	1,525	995	610	275	105	
Chichester R.D.	M	30,180	2,220	2,110	1,965	1,990	2,030	1,650	1,630	1,735	1,760	1,675	1,880	2,050	2,155	1,475	870	420	180	35	
	F	32,920	2,100	2,090	1,790	1,875	1,850	1,585	1,705	1,765	1,890	1,965	2,295	2,640	2,605	2,000	1,285	735	330	110	
	T	63,100	4,315	4,200	3,750	3,865	3,880	3,235	3,340	3,500	3,650	3,635	4,175	4,690	4,755	3,475	2,160	1,155	510	145	
Horsham R.D.	M	9,105	625	730	825	530	460	495	490	525	530	475	595	610	610	360	235	160	65	25	
	F	15,365	1,215	1,015	905	1,105	1,150	960	920	920	980	815	915	885	740	590	425	280	180	60	
	T	30,770	2,535	2,720	2,150	2,015	2,270	1,950	1,850	1,830	1,920	1,600	1,745	1,675	1,410	990	670	425	255	85	
Midhurst R.D.	M	9,105	625	730	825	530	460	495	490	525	530	475	595	610	610	360	235	160	65	25	
	F	9,945	590	655	560	615	500	495	540	585	565	600	740	765	680	510	360	260	170	55	
	T	19,055	1,215	1,405	1,385	1,145	960	990	1,030	1,115	1,100	1,075	1,330	1,380	1,290	870	595	425	235	80	
Petworth R.D.	M	5,200	380	450	330	320	295	290	315	320	315	270	300	330	295	195	120	95	45	15	
	F	5,920	425	480	520	330	320	285	330	320	305	305	360	395	370	295	195	140	90	30	
	T	11,120	805	930	740	650	615	575	645	640	620	575	660	730	665	485	320	235	135	45	
Worthing R.D.	M	22,585	1,670	1,635	1,415	1,370	1,350	1,185	1,040	1,065	1,115	1,095	1,380	1,660	1,965	1,635	1,095	520	200	35	
	F	27,970	1,605	1,535	1,310	1,040	1,385	1,220	1,060	1,190	1,385	1,465	1,915	2,550	2,970	2,595	1,770	1,030	445	135	
	T	50,560	3,275	3,175	2,735	2,410	2,735	2,405	2,100	2,255	2,500	2,560	3,295	4,210	4,935	4,230	2,870	1,545	650	175	
Aggregate of R.D.s	M	95,750	7,310	7,565	6,480	5,705	6,045	5,355	5,135	5,240	5,395	5,060	5,805	6,405	6,625	4,650	2,945	1,530	645	160	
	F	107,280	6,910	7,375	6,510	6,090	6,055	5,320	5,305	5,530	5,980	6,045	7,245	8,450	8,560	6,925	4,660	2,860	1,415	470	
	T	203,030	14,220	15,045	14,075	11,790	12,100	10,675	10,445	10,775	11,375	11,105	13,050	14,850	15,185	11,575	7,605	4,395	2,060	630	
Total Administrative County	M	227,130	16,800	18,540	17,730	15,610	14,745	13,735	12,210	12,340	13,415	14,000	13,525	14,035	14,105	10,610	6,930	3,785	1,625	425	
	F	265,365	15,990	17,670	16,530	14,590	15,320	13,890	12,355	13,145	14,445	15,400	14,770	16,770	19,050	20,005	17,570	13,110	8,615	4,280	
	T	492,495	32,785	36,210	34,260	30,200	30,065	27,625	24,565	25,490	27,860	29,400	27,650	30,295	33,095	34,115	28,175	20,040	12,400	5,905	

* Fewer than five persons enumerated

Note: The figures have been rounded to the nearest five; they do not therefore always add up to the figures shown as totals.

District	Total Households	With no Hot Water Supply		With no Fixed Bath or Shower		With Outside Flush Toilet (W.C.) only				With no Flush Toilet (W.C.)		With exclusive Use of Hot Water Fixed Bath and Inside Toilet (W.C.)	
		Households	Per Cent	Households	Per Cent	Exclusive Use		Shared Use		Households	Per Cent	Households	Per Cent
						Households	Per Cent	Households	Per Cent				
Arundel M.B.	950	70	7.4	80	8.4	90	9.5	*	*	*	*	820	86.3
Bognor Regis U.D.	13,050	215	1.6	255	2.0	240	1.8	10	0.1	15	0.1	11,805	90.5
Chichester M.B.	6,920	340	4.9	405	5.9	445	6.4	10	0.1	10	0.1	6,090	88.0
Crawley U.D.	20,280	145	0.7	190	0.9	220	1.1	5	0.0	5	0.0	19,715	97.2
Horsham U.D.	8,960	245	2.7	320	3.6	455	5.1	15	0.2	10	0.1	8,075	90.1
Littlehampton U.D.	6,755	260	3.8	250	3.7	300	4.4	5	0.1	20	0.3	6,030	89.3
Shoreham U.D.	6,565	145	2.2	160	2.4	180	2.7	20	0.3	10	0.2	6,180	94.1
Southwick U.D.	4,290	95	2.2	75	1.7	110	2.6	*	*	5	0.1	4,035	94.1
Worthing M.B.	36,710	680	1.9	680	1.9	490	1.3	30	0.1	15	0.0	32,585	88.8
Aggregate of U.D.s and M.B.s	104,480	2,200	2.1	2,425	2.3	2,520	2.4	95	0.1	90	0.1	95,345	91.3
Chancetbury R.D.	10,275	310	3.0	370	3.6	425	4.1	40	0.4	155	1.5	9,395	91.4
Chichester R.D.	22,640	955	4.2	850	3.8	75	3.2	80	0.4	345	1.5	20,950	92.5
Horsham R.D.	9,655	280	2.9	340	3.5	270	2.8	15	0.2	130	1.3	8,985	93.1
Midhurst R.D.	6,435	190	3.0	225	3.5	195	3.0	10	0.2	75	1.2	6,000	93.2
Petworth R.D.	3,615	175	4.8	225	6.2	160	4.4	5	0.1	105	2.9	3,260	90.2
Worthing R.D.	20,280	155	0.8	170	0.8	195	1.0	15	0.1	40	0.2	19,725	97.3
Aggregate of R.D.s	72,900	2,065	2.8	2,180	3.0	1,965	2.7	165	0.2	845	1.2	68,315	93.7
TOTAL: West Sussex	177,375	4,270	2.4	4,605	2.6	4,485	2.5	260	0.1	1,935	0.5	163,660	92.3

*Fewer than five households enumerated.

Note: The figures for households have been rounded to the nearest five; they do not therefore always add up to the figures shown as totals.

Non-Private Establishments
(The 1961 figures are shown in brackets)

Type of Establishment	Number of Establishments	Total Population			Residents Only (Excluding Staff)		
		Persons	Males	Females	Total	Males	Females
Hotels etc.	365 (498)	3,870 (3,859)	1,785 (*)	2,085 (*)	2,990 (2,676)	1,325 (*)	1,665 (*)
All Psychiatric Hospitals	10 (9)	1,360 (1,551)	650 (688)	710 (863)	1,255 (1,442)	595 (651)	660 (791)
All Other Hospitals	95 (98)	4,070 (3,481)	1,180 (947)	2,890 (2,534)	3,220 (2,622)	1,020 (834)	2,200 (1,788)
Homes for the Old and Disabled	170 (83)	3,275 (1,964)	805 (458)	2,470 (1,506)	2,890 (1,672)	695 (393)	2,195 (1,279)
Children's Homes	45 (41)	690 (695)	320 (321)	375 (374)	500 (537)	255 (260)	245 (277)
Educational Establishments	55 (*)	3,975 (*)	2,665 (*)	1,310 (*)	3,405 (*)	2,445 (*)	960 (*)
Places of Detention	5 (7)	500 (336)	500 (290)	— (46)	500 (316)	500 (283)	— (33)
Defence Establishments	5 (*)	630 (*)	560 (*)	70 (*)	630 (*)	560 (*)	70 (*)
Civilian Ships, Boats and Barges	45 (50)	245 (183)	215 (150)	30 (33)	245 (183)	215 (150)	30 (33)
Miscellaneous Communal Establishments	45 (56)	610 (850)	265 (461)	345 (389)	610 (850)	265 (461)	345 (389)

* Not Enumerated in 1961.

arrangements in urban districts and rural districts is shown in Table B. The following points are of significance in considering the health of the County.

(a) *Hot water tap.* Among households in West Sussex, 95.7 per cent had exclusive use of a hot water tap within the building, 1.9 per cent had shared use and 2.4 per cent were without, compared with 11.0 per cent in 1961.

(b) *Fixed bath.* The proportion of households with exclusive use of a fixed bath within the building was 94.3 per cent; 3.1 per cent shared and 2.6 per cent were entirely without the use of a fixed bath. The period from 1961 to 1971 has seen a general improvement; the proportion entirely without access to a fixed bath has fallen from 8.5 per cent to 2.6 per cent and the proportion with only shared use has fallen from 3.4 per cent to 3.1 per cent.

(c) *Water closet.* The proportion of households in the County with exclusive use of a water closet in the building or attached to it was 94.0 per cent; 2.8 per cent had shared use and 0.5 per cent were without the use of a water closet in the building. Here also there was considerable improvement compared with 1961 when 3.8 per cent of households were without the use of a water closet in the building.

Non-Private Establishments

In 1971, 835 establishments in the County were recorded as 'non private establishments' compared with 842 in 1961. There was a significant increase in homes for old persons and disabled persons from 83 (1,672 residents) in 1961 to 170 (2,890 residents) in 1971. There was a decrease of three 'other hospitals' (but residents increased from 2,622 in 1961 to 3,220 in 1971); an increase in children's homes from 41 homes (487 children) in 1961 to 45 homes (495 children) in 1971, and the number of residents in psychiatric hospitals fell from 1,542 in 1961 to 1,255 in 1971. Details are shown in Table C.

Appendix D

A SHORT NOTE ON THE COUNTY HEALTH DEPARTMENT OF WEST SUSSEX: 1911 TO 1972

As this is likely to be the last statutory report of the County Medical Officer of Health to the authority it seemed an opportune time to make some brief notes on the history of the Department since it was founded in 1911. This note has been prepared from some original studies which have been made by Mr. Nigel Brown, an undergraduate student attached to the Department.

Although authority to appoint a medical officer of health was authorised by the *Local Government Act 1888*, it was not until this was made mandatory under the *Housing, Town Planning, etc. Act 1909* that the first County Medical Officer of Health was appointed (in June, 1911) and the Health Department of the County Council was founded. The departmental work of the time was concerned chiefly with the recently-introduced medical inspections of primary school children and attempts to control standards of midwifery and the spread of tuberculosis. Even with this limited range of functions, the County Medical Officer of Health ran into problems, and Committee minutes of the time refer to his 'want of tact'.

He was succeeded by the second County Medical Officer of Health in 1913. Dr. R. D. Smedley remained the County Medical Officer of Health of West Sussex until he retired at the beginning of 1940. During those years the Department became responsible for a wide range of treatment and preventive health services. It provided, either directly or on an agency basis, hospital accommodation for maternity cases, for the treatment of tuberculosis in its various forms, for smallpox and other infectious diseases, for venereal diseases, and for mental illness and mental deficiency, as well as the 'infirmary' aspects of the public assistance institutions, which culminated in the building of St. Richard's Hospital, Chichester.

On the domiciliary side of the work, close attention was given to the inspection and supervision of midwives and payments were made to general practitioners called in by them. Detailed investigations were carried out regarding every still birth and every death of a child under one year of age, and ante-natal and infant welfare clinics flourished in almost

every town and village, staffed largely by nurses and midwives employed by district nursing associations with grant aid from the County Council and general practitioners employed by the Council on a sessional basis. Health visiting, mainly of children under five, school nursing – involving, in addition to school inspections, minor ailment, ear, eye and orthopaedic clinics, and the treatment of such prevalent conditions as ringworm, scabies and impetigo – and tuberculosis nursing, including the staffing of dispensaries at the Council's clinics, all played an important part in the health of the community immediately before and after the second world war.

It was during this time too that diphtheria immunisation was first started, that a free dental service was provided for school children, and the home help service – originally for maternity cases only – was commenced. The provision of free fresh and dried milk for necessitous cases and a wide range of proprietary foods and vitamin supplements was an important contribution to the health of mothers and young children in a period when poverty and malnutrition were more prevalent than they are today.

Environmental affairs were also of great concern to the Department, which had its own pathology laboratory at County Hall, mainly for the control of milk quality and purity, but also undertaking sputum, blood and other tests. Grants were made to district councils for rural water supplies and sewerage schemes and there was a growing awareness of the need for vigilance in matters affecting the health of the community as a whole.

Dr. J. S. Bradshaw (1940 to 1960) was immediately preoccupied following his appointment with the wartime activities surrounding evacuation, the reception of evacuees and casualties and the organisation of the Civil Nursing Reserve. It was during Dr. Bradshaw's tenure of office that the County Health Department, as we understand it now, was established by the *National Health Service Act 1946*, which brought the National Health Service into being in 1948. Since that time the County Council have had a continuing responsibility for health centres, for services for the care of mothers and young children, for midwifery, health visiting and nursing at home, for vaccination and immunisation arrangements, for ambulance and ambulance car services, for the prevention of illness, for the care and after care of invalids and (until they were transferred to the Social Services Department in 1971) for the provision of domestic help services and for services to those who are mentally ill or handicapped and not in hospital.

During those years the environmental services, the school services and the personal health services have gradually been developed and now one or two of them at least have proved to be of national and indeed of international interest. The story, recorded in detail in successive issues of these annual reports, has been one of continuous refinement of a growing range of services provided for a rapidly-increasing population. West Sussex had 175,000 people in 1911 and now has a population of half a million. This population growth has not been uniform through the age groups since much of the population increase has occurred by selective migration into the County of people on retirement. The County has well over the national proportion of people of pensionable age and along the coast the proportion rises in places to over one in three. The provision of better health care facilities for such of these elderly people as are unable to care for themselves will be one of the major problems to which more attention will have to be paid in the next few years.

The many variable factors affecting the health of the community make it most difficult to evaluate the benefits of the work of the Department and the degree of its success. The achievements have in part been due to national policies, in part to developments in medical and pharmaceutical science, but also in part to the skills and enthusiasms of members of the Department.

During the period under review most of the infectious diseases have been eradicated or controlled. No child now need die of poliomyelitis, smallpox, diphtheria or whooping cough. The terrors of 'consumption' have been dramatically reduced. The infant mortality rate, though it could be lower still, has been progressively improved; deaths from maternal causes have not exceeded three in any year since 1953 and there have been none at all in four of these years. The school population of the 1970s is generally healthier than any of its predecessors. The size of the geriatric problem is in itself a tribute to the fact that people who, in former generations, would have died have survived to old age.

Such indicators as we have suggest that in West Sussex standards at least as good as, and in some instances very much better than, the rest of the country are being achieved, at a cost per thousand population which is 7.3 per cent below the national average.

In recent years close liaison between the three branches of the National Health Service has been fostered and in some directions – notably in health centres and in services managed with the help of the computer – cooperation with general practitioners is of a high order. The Department is well equipped to play its part in the closer integration expected in 1974.

Appendix E

MALIGNANT MELANOMA*

SOME CASES IN GENERAL PRACTICE AND A COMPUTER-ASSISTED INVESTIGATION OF INCIDENCE AND SURVIVAL

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One of the difficulties of investigation in general practice is that an unusual incidence of a rare disease may mean little more than a sampling error. Another difficulty, except in common diseases is obtaining reliable incidence figures.

The practice in which this paper was written contains 9,600 patients, predominately white, British in origin, and of a young-age distribution, as it has been started in the developing areas of a new town.

Nine Patients

During the years 1965–1970 nine cases of malignant melanoma were diagnosed and treated.

(1) Mrs. W. born 1921, seen in 1966 with melanoma of the right foot, referred to a local hospital where lesion was excised and histology confirmed. Progress was satisfactory and patient presumed to be alive and well though follow up is not possible as her address is unknown.

(2) Mrs. D. G. born 1931. Presented in 1966 in the 30th week of pregnancy with a lump in the right breast present for one week. She was referred to a teaching hospital for excisional biopsy. On the operating table it was noted that she had a lesion of the left forearm with the appearance of a small malignant melanoma. Histology of the breast lump showed secondary malignant melanoma. She subsequently gave the history that two and a half years previously a raised hairless mole on her right arm, which had been growing for six months, had been excised and said to be benign. She died following premature labour with a stillborn child at 34 weeks. Post-mortem examination showed multiple metastases in the chest and abdomen.

(3) Mrs. J. A. born 1926. Presented in 1967 with a melanotic lesion about 2.5 cm across on the outer aspect of the right shin, enlarging for a few weeks and mildly irritating. This was excised at a teaching hospital with subsequent endolymphatic radiotherapy. Histology confirmed the diagnosis, and she remains well and in full employment.

(4) Mrs. M. T. born 1926. Presented in December 1968 with acute glaucoma of the right eye from which melanotic material discharged at operation and enucleation was performed. She had first complained of loss of vision in this eye in March 1967 and in the interval had been referred to no less than four consultants on six separate occasions who all considered the lesion due to traumatic cataract and advised no action at present. Histology confirmed malignant melanoma of the choroid and, despite radiotherapy and cytotoxic drugs, she has multiple secondary lesions and is rapidly dying.

(5) R.E. born 1925. Presented in 1969 with a large pigmented mole of the back of the chest with recent increase in size and central ulceration. Referral to a teaching hospital led to excision. Histology confirmed the diagnosis. The patient had a block dissection of the lymphatic glands of the left axilla and remained well until 1970 when it became apparent there were secondaries in the chest wall and the liver. Death occurred in 1971.

(6) J.H. born 1930. Presented in 1969 with loss of vision in the lower half of the right visual field. Dark opacity seen in the anterior vitreous. The eye was enucleated and melanoma of the right ciliary body confirmed by histology April 1969. He rapidly developed liver secondaries from which he died in June 1970.

(7) R.S. born 1926. Presented in 1970 with a melanotic lesion of the front of the left chest, with recent enlargement and itching. A known bronchitic with obstructive lung disease he had been on steroids for three years. The lesion was excised at a local hospital and the histology was confirmed. The patient shows no signs of lymph spread or recurrence and remains well.

*Reprinted (with permission) from Journal of the Royal College of General Practitioners (1972) 22, 508

(8) Mrs. M. G. born 1909. She was referred to the practice by an optician for loss of vision in the right eye which he thought due to a vitreous opacity in 1970. Enucleation of the right eye and histology confirmed the diagnosis of malignant melanoma of the ciliary body. She remains fit and well.

(9) E.W. born 1947. Referred in 1970 to a consultant for a brown lesion of the limbus of the left eye. This was removed and histology confirmed a malignant melanoma.

Nine cases had thus been observed and the problem was then to discover whether or not this was an accidental finding or could be related to any other observable factor.

Review of the literature

The cases divided into five in the skin and four in the eye, so a search was requested of the *Index medicus* through the Royal Society of Medicine library to find any relevant papers in the last decade on the incidence of melanoma. It is clear that skin lesions are more common and their incidence better documented than eye lesions.

Of the ten papers on eye melanoma consulted, as listed in *Index medicus* in the last 11 years, almost all referred to the report of individual cases and only one, Bryson and Blackhurst (1966), referred to a further paper (Rittino and Kelly) citing 43 cases from the literature and adding one of their own. All the authors regarded the condition as 'rare'.

Mortality from malignant melanoma of the skin had been analysed by Lee and Carter (1970) with the general conclusion that in white people it had been increasing in the U.S.A. from 1,256 (9.3 per million) in 1950, the first year in which the disease was grouped

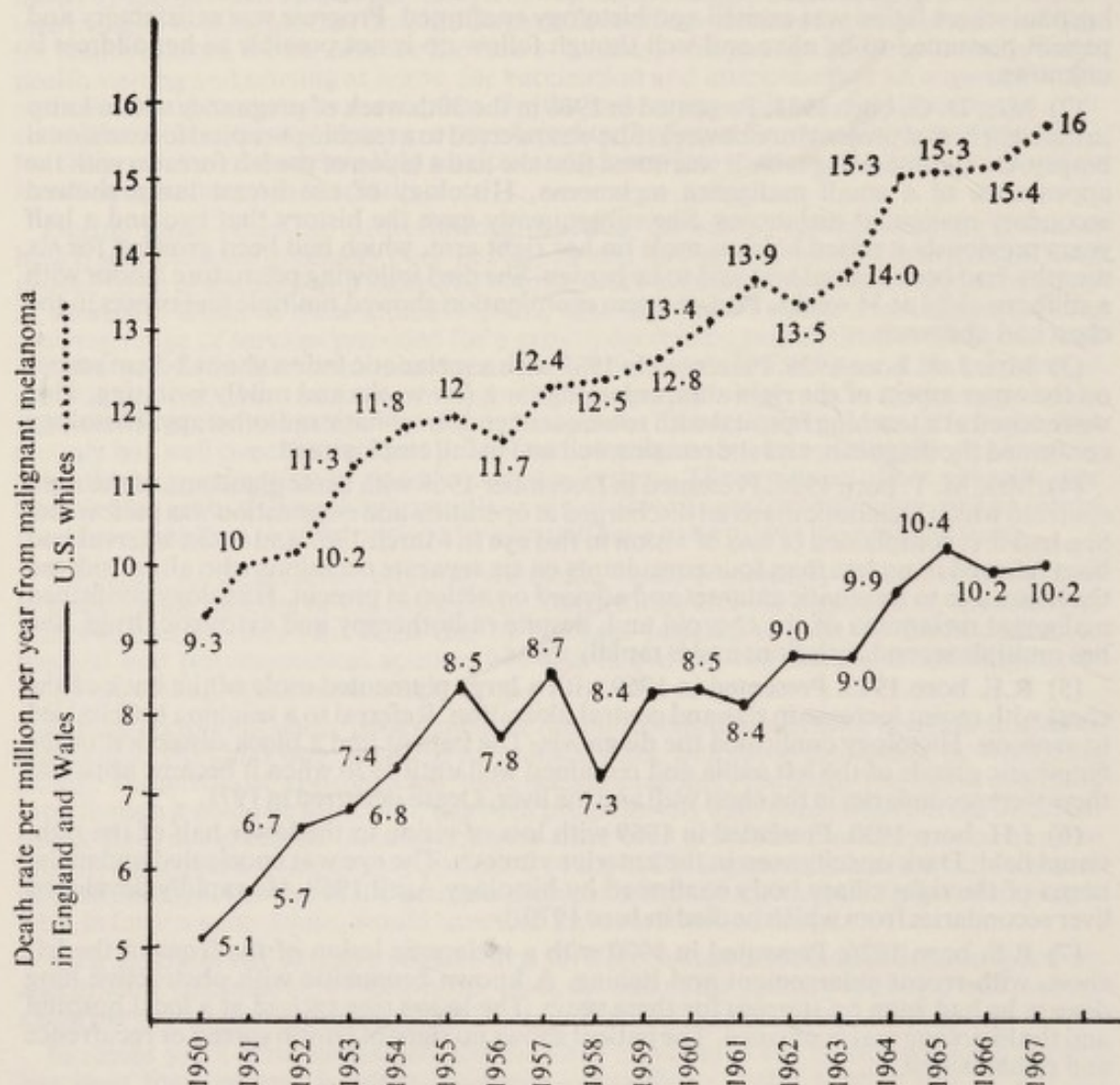


Figure 1
Death rate per million per year (from the *Journal of the National Cancer Institute*)

separately in the international classification of deaths, to 2,802 (16 per million) in 1967. During the same period, the rate rose in England and Wales from 5.1 per million to 10.2 per million. The death rate had also risen in Australia (no figures given). An analysis of the England and Wales' figures shows both a general increase in death rate (figure 1) and also in both sexes an increasing death rate with increase in age (figure 2) reaching a figure of three times the average rate at age 65 and over (figures 1, 2 and 3).

Lee and Carter (1970) studying the birth-cohort figures for England and Wales (figure 3), showed that each successive cohort is producing higher death rates from malignant melanoma than the one born before, and concluded that 'persons born after 1885 have been exposed with increasing intensity to some factor(s) associated with high cancer mortality'.

Death rates are at any rate a measure of an assessment of facts at a particular time by a reasonably skilled observer. They are recorded for countries by statistical departments. Incidence figures are different. Commenting on incidence in his paper on the *Recognition and treatment of melanoma*, Booher (1969) cites figures from U.S.A. and Australia to suggest an increased incidence, while the Queensland melanoma project showed an incidence higher than anywhere else (16 per 100,000 in 1965) and suggested a gradient of mortality from Victoria through Australia towards the equator in every year since 1950. An editorial in *The Lancet* (1971) reports 'Epidemiological studies have indicated that the overall incidence of malignant melanoma varies with latitude and that mortality in Caucasians increases as the equator is approached'.

In the South-west region of England, Bodenham (1968 and 1970) reports an overall incidence amongst a population of 3,000,000 of 3.5 per 100,000 with the oddity that in two counties (Devon and Cornwall) in females it was up to ten per 100,000, arising mostly on the leg between the knee and ankle.

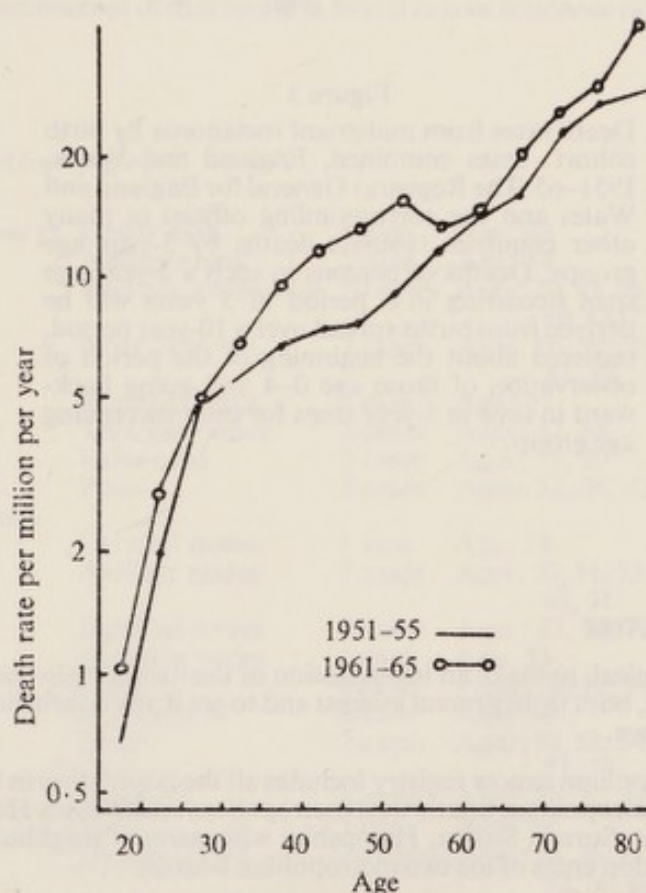


Figure 2

Death rates from malignant melanoma by age: sexes combined, England and Wales, 1951-55 and 1961-65.

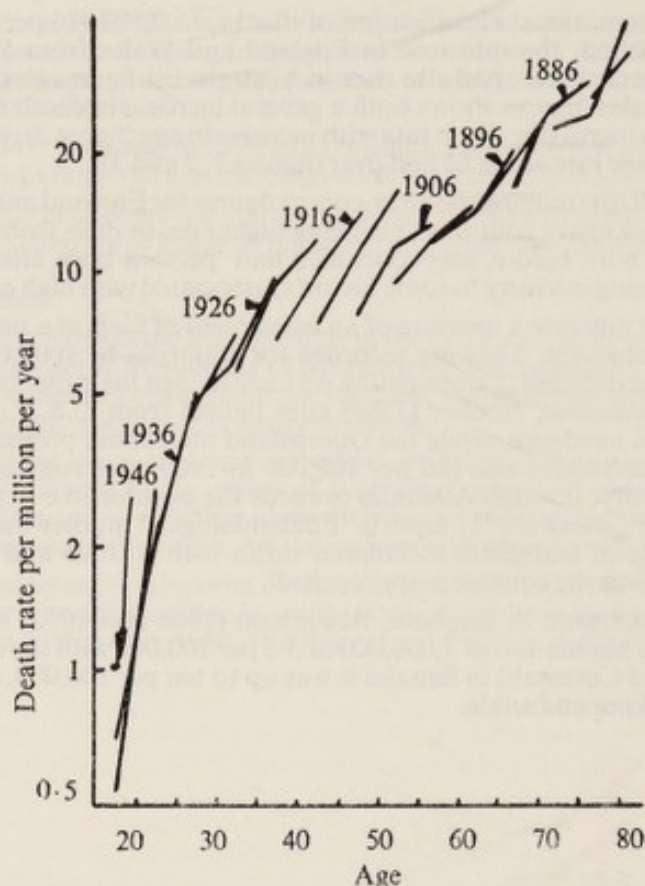


Figure 3

Death rates from malignant melanoma by birth cohort: sexes combined, England and Wales, 1951–65. The Registrar General for England and Wales and the corresponding official in many other countries tabulate deaths by 5-year age groups. Deaths of persons in such a 5-year age span occurring in a period of 5 years will be derived from births spread over a 10-year period, centered about the beginning of the period of observation of those age 0–4 and going backward in time in 5-year steps for each succeeding age group.

South Metropolitan Area

It next seemed logical, to make an investigation of the incidence in the area of England around this practice, both from general interest and to see if any conclusions from our own figures could be drawn.

The South-metropolitan cancer registry includes all the population in the areas covered by the South-east metropolitan, South-west metropolitan and Wessex Hospitals' Boards – the counties of Kent, Surrey, Sussex, Hampshire with parts of neighbouring counties of Dorset and the London areas of the two metropolitan boards.

For the purpose of the study the years 1961–1967 were selected as affording the most factual material since years following 1967 might not yet be complete, and prior to 1961 the developmental period of the registry, which started in 1958, might have led to under-registration. During the years surveyed, the numbers in each year registered as living within the region were as follows.

1961	243
1962	258
1963	250
1964	253
1965	273
1966	276
1967	296

Total cases registered from within the region—1,849 (residential qualification)

Figure 4
Malignant melanomata all sites

These figures cannot be used to support a theory that the incidence of malignant melanoma is rising. While there may have been an increase in the effectiveness of the register as the period progressed, in addition the preliminary report of the 1971 census suggests a population increase in the area of at least one per cent annual average.

Tables I and II confirm and qualify some well known findings. The overall preponderance of melanomata of the skin in females with a gross female/male ratio of 2.1:1 reaching a ratio of eight to one in the melanomata of the calf and skin. There are exceptions to this that on the chest there is a male preponderance 38 to 15, and the fingers and toes where the sex incidences are about equal.

Unlike melanomata of the skin, those of the eye occurred equally in males and females.

Table I shows a marked increase in incidence at ages above 70. Ages may not, however, be recorded accurately in much of the over 70 range, and the population at risk in the last age group (75 years and over) contains a much higher number of women. The incidence curve for females suggests some relaxation of a markedly increased rate from about 45 years of age, a feature reminiscent of that found in breast cancer incidence rates.

Table I (Continued from page 86)

Other Sites, Primary:	Upper gum	1 case	Age: 43	} 29 cases
	Nasopharynx	1 case	Age: 54	
	Rectum, anal canal	10 cases	Ages: 20, 41, 61, 62, 65, 66, 68, 71, 76, 80	
	Nose, internal	7 cases	Ages: 56, 59, 60, 68, 71, 83, 88	
	Ethmoid sinus	1 case	Age: 67	
	Maxillary sinus	2 cases	Ages: 37, 68	
	False cord	2 cases	Ages: 57, 59	
	Penis	5 cases	Ages: 52, 56, 63, 67, 82	
Secondary, Primary Unknown	Cervical nodes	1 case	Age: 78	} 42 cases
	Axillary nodes	7 cases	Ages: 50, 51, 53, 54, 54, 63, 51	
	Inguinal nodes	3 cases	Ages: 27, 76, 77	
	Multiple nodes	1 case	Age: 53	
	Lung	3 cases	Ages: 56, 62, 76	
	Peritoneum	1 case	Age: 64	
	Liver	7 cases	Ages: 52, 53, 54, 58, 67, 71, 73	
	Brain	4 cases	Ages: 43, 62, 63, 64	
	Bone	1 case	Age: 78	
	Disseminated	14 cases	Ages: 24, 26, 27, 39, 45, 52, 60, 60, 72, 72, 76, 77, 78, 47, 47	

ALL MELANOMATA MALE 650

TABLE I
Male Melanomata by Age

ICD 8th Rev.	SITE	0-	5-	10-	15-	20-	25-	30-	35-	40-	45-	50-	55-	60-	65-	70-	75-	Not known	Total
172.0	Skin of Lip					1		1						2	1		1		3
172.1	Skin of Eyelids					1	1	1		1		1	2	1	1		1		9
172.2	Skin of Ear					1	2	1		1	1	1	3	4	3	1	3		14
172.3	Skin of Face	1			2	2	3	3	1	2	6	3	4	6	2	4	20		58
172.4	Skin of Scalp, Neck																7		43
172.6	Skin of Trunk, and																		
174 inc.	Breast			1	2	7	11	17	15	16	22	19	12	14	6	3	7		152
172.7	Skin of Arms		1		2	6	2	3	5	4	3	4	6	6	3	3	8		47
172.8	Skin of Legs			1	1	6	5	3	6	16	14	18	14	8	8	13	17		131
172	TOTAL SKIN	1	1	2	7	18	23	26	27	40	47	50	49	41	24	37	64		457
	{Choroid					1	1	2	5	3	8	9	10	10	6	5	5		62
	{Other specified				2				3	3	4	4	4	3	3	1			30
	{intra-ocular																		
190	Conjunctiva					1				1					1				3
	Eye NOS					1			1	2		2	3	4	8	5	1		27
	TOTAL EYE (exc. eyelids)				2	3	1	2	9	9	12	15	17	17	18	11	6		122

TABLE II
Female Melanomata by Age

ICD 8th Rev.	SITE	0-	5-	10-	15-	20-	25-	30-	35-	40-	45-	50-	55-	60-	65-	70-	75-	Not known	Total
172-0	Skin of Lip					1	1			2	2	1	2	2	1	2	2		7
172-1	Skin of Eyelids				1					1		3							16
172-2	Skin of Ear						1		1										10
172-3	Skin of Face				3		2	4	2	9	8	8	10	10	12	11	50	1	125
172-4	Skin of Scalp, Neck and 174 incl. Breast				6	1	2	1	1	3	1	4	2	5	3	2	5		30
172-5	Skin of Trunk			1		8	7	10	9	18	13	10	16	10	12	11	19	1	151
172-6	Skin of Arms				3		2	13	9	8	18	14	20	16	19	4	12		138
172-7	Skin of Legs				7	12	28	37	58	74	51	42	42	27	30	39	30		497
172-8	Skin, site unspecified							1			1	1					3		
172-9	TOTAL SKIN			1	20	22	43	66	80	109	95	91	92	86	75	61	134	2	977
190	Choroid							1	4	5	3	8	8	6	11	3	11		60
	Other specified intra-ocular						1			3	2	4	3	4	1	3	4		26
	Conjunctiva							1		1	1	1	1	1		1	1		7
	Eye NOS									1	5	1	3	3	4	3	8		28
	TOTAL EYE (exc. eyelids)						1	1	6	10	10	14	15	15	16	10	24		121
184	Vulva, vagina									3	2	1	4	5	8	9	16		48

Table II (Continued from page 87)

Other Sites: Primary	Upper gum	1 case	Age: 61	} 22 cases
	Nasopharynx	2 cases	Ages: 77, 89	
	Rectum, anal canal	8 cases	Ages: 48, 53, 56, 56, 72, 79, 91	
	Nose, internal	6 cases	Ages: 48, 49, 64, 76, 78, 78	
	Ethmoid sinus	1 case	Age: 73	
	Maxillary sinus	1 case	Age: 71	
	Arytenoid	1 case	Age: 70	
	Urethra	2 cases	Ages: 75, 87	
Secondary, Primary Unknown	Cervical nodes	3 cases	Ages: 20, 40, 55	} 31 cases
	Axillary nodes	3 cases	Ages: 51, 56, 75	
	Inguinal nodes	6 cases	Ages: 44, 56, 60, 70, 79, 80	
	Peritoneum	1 case	Age: 84	
	Liver	5 cases	Ages: 50, 58, 61, 74, 80	
	Pancreas	1 case	Age: 53	
	Brain	3 cases	Ages: 37, 52, 67	
	Bone	1 case	Age: 67	
	Disseminated	8 cases	Ages: 41, 68, 72, 73, 76, 77, 79, 79	

ALL MELANOMATA FEMALE 1,199

The possibility of a lateral preponderance of melanomata of the arms and legs was examined and no significant difference between right side and left side was found.

Tables IV–XIV present crude life survival rates by site where numbers were adequate, based on intra-regional cases 1961–67.

Table III (Continued from page 89)

172·7 ARMS	Fingers (excl. nailbed)	12	13	25
	Nailbed	5	5	10
	Palm of hand	—	2	2
	Dorsum of hand	1	4	5
	Wrist	2	12	14
	Forearm	10	45	55
	Elbow	1	8	9
	Upper arm	14	38	52
	Arm NOS	2	11	13
		47	138	185
172·8 LEGS	Toes (excl. nailbed)	15	21	36
	Nailbed	4	2	6
	Sole of foot	10	30	40
	Dorsum of foot	8	15	23
	Ankle, heel	20	67	87
	Foot NOS	8	23	31
	Calf, shin	25	201	226
	Knee	10	20	30
	Thigh	26	54	80
	Multiple areas	1	3	4
	Leg NOS	4	61	65
		131	497	628

TABLE III
Melanoma of Skin
 More detailed Site Classification by sex (excluding category 172.9
 multiple Sites)

		<i>M</i>	<i>F</i>	<i>P</i>
172.0 LIP	Upper	2	3	5
	Lower	1	4	5
		3	7	10
172.1 EYELIDS	Upper	2	2	4
	Lower	3	8	11
	Inner canthus	3	3	6
	Outer canthus	1	1	2
	NOS	—	2	2
		9	16	25
172.2 PINNA	Helix	3	6	9
	Lobule	1	—	1
	Cranial surface	3	—	3
	NOS	7	4	11
		14	10	24
172.3 FACE	Forehead, supra-orbital .	6	14	20
	Nose	9	14	23
	Pre-auricular	6	1	7
	Cheek	36	90	126
	Chin	1	5	6
	NOS	—	1	1
		58	125	183
172.4 SCALP & NECK	Parietal	2	—	2
	Temporal	5	4	9
	Occipital	—	1	1
	Scalp NOS	4	—	4
	Nuchal	4	3	7
	Neck (anterior & lateral) .	20	19	39
	Post-auricular	7	3	10
	Submental	1	—	1
		43	30	73
172.6 TRUNK	Pectoral	38	15	53
	Shoulder	15	17	32
	Axillary	12	8	20
	Upper abdominal	10	15	25
	Lower abdominal pubic, inguinal	7	34	41
	Upper dorsal	35	23	58
	Mid dorsal	20	18	38
	Lower dorsal (sacral, gluteal) .	4	13	17
	Dorsal NOS	6	6	12
	Multiple	2	1	3
	Perineum, anal margin .	3	1	4
		152	151	303

TABLE IVa
Survival Rates for Malignant Melanoma of Eye

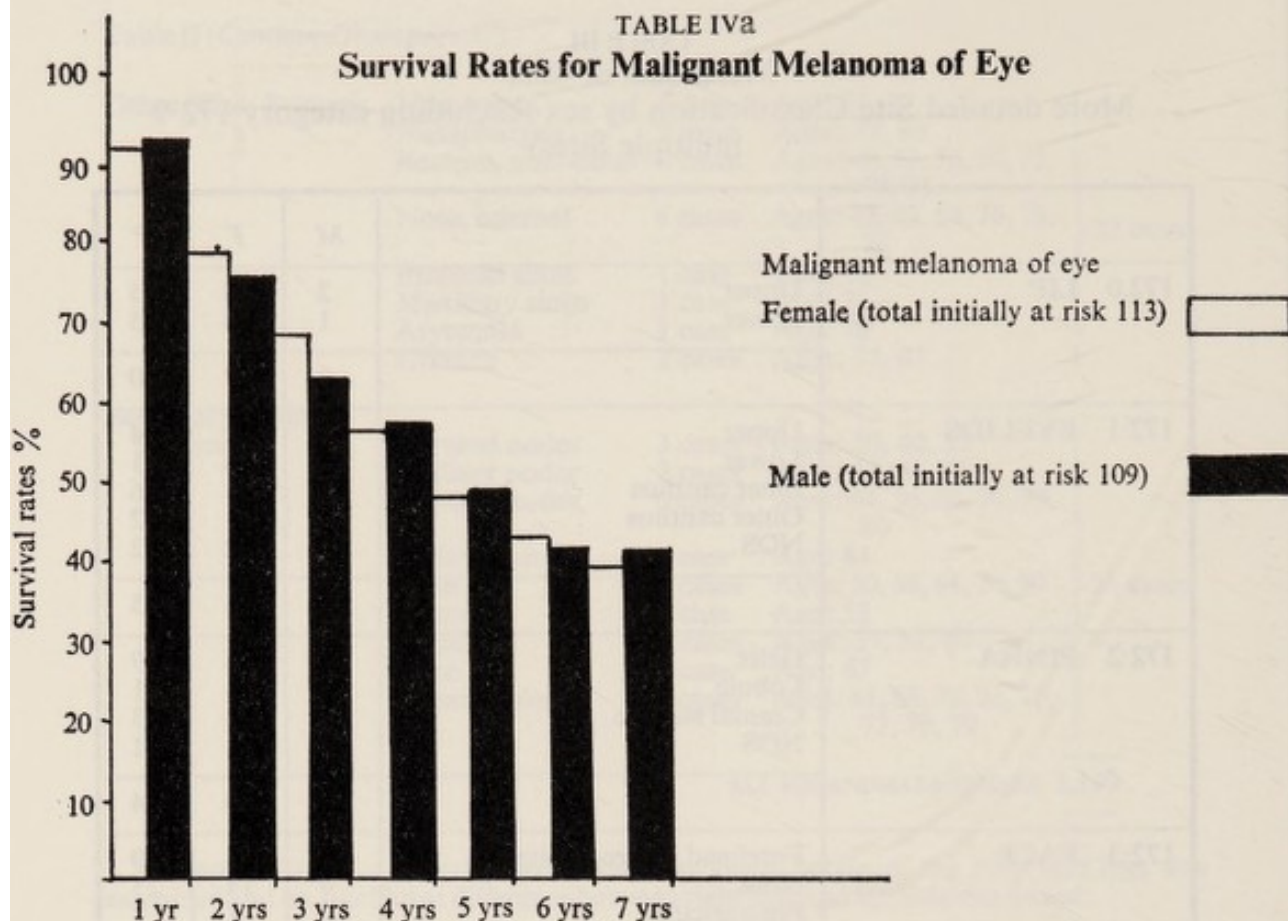


TABLE IVb
Survival Rates for Malignant Melanoma of Skin

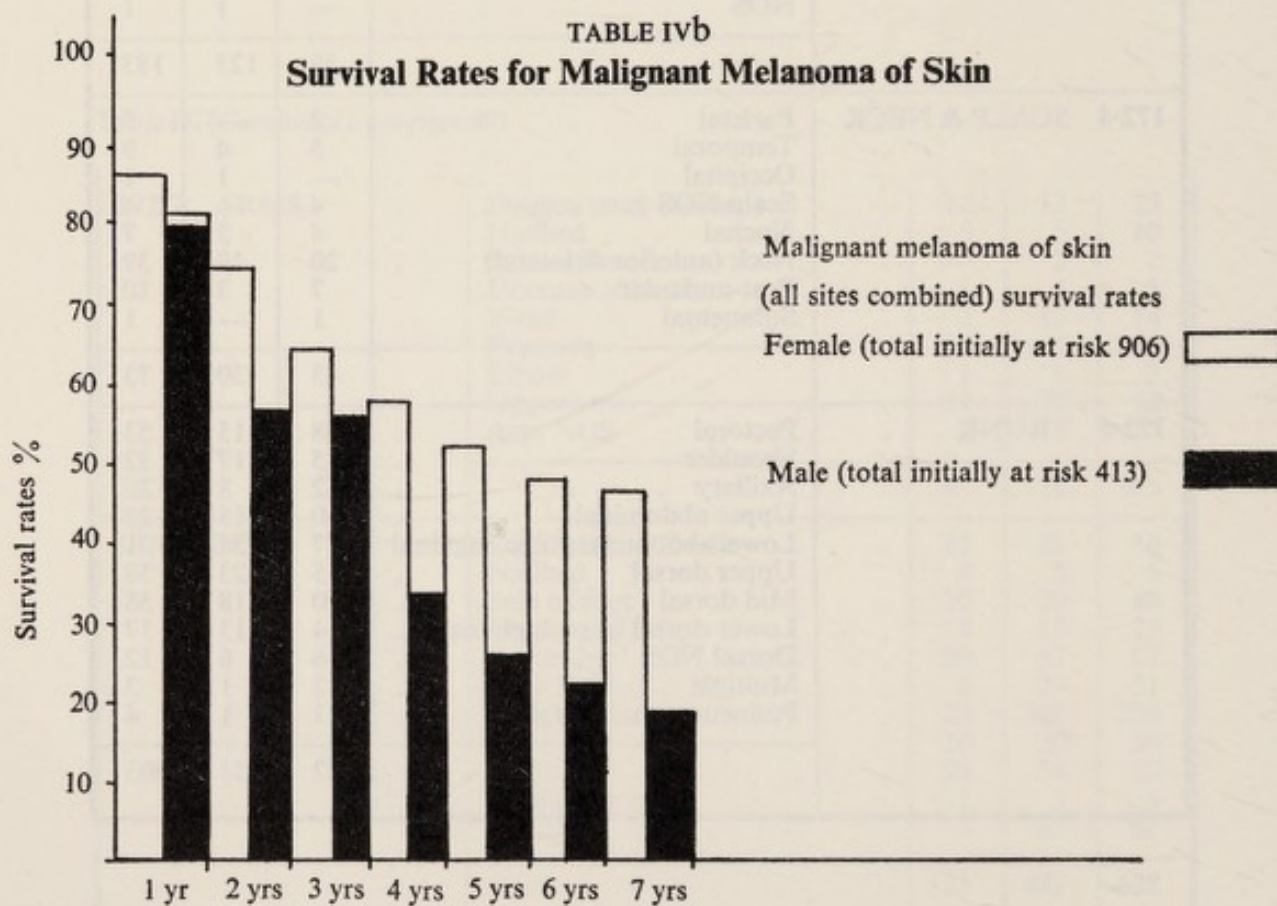


TABLE V
Crude Survival Rates for Skin
All Sites combined (172.0-172.9)
(South Metropolitan Cancer
Registry)

Years	Percentage survival rates		
	Male	Female	All patients
1	79.0	85.5	83.5
2	55.9	74.4	68.6
3	54.4	64.3	58.4
4	33.0	56.6	49.2
5	26.0	51.9	43.8
6	21.7	47.9	39.7
7	19.0	46.7	38.0
Patients initially at risk	413	906	1319

TABLE VI
Crude Survival Rates for Eyes [190]
(South Metropolitan Cancer
Registry)

Years	Percentage survival rates		
	Male	Female	All patients
1	90.8	90.2	90.5
2	74.7	78.3	76.6
3	61.7	68.2	65.0
4	57.6	56.5	56.9
5	48.3	46.7	47.4
6	40.9	44.9	42.8
7	40.9	37.0	39.0
Patients initially at risk	109	113	222

With the possible exception of the trunk, the survival rates for women with melanoma of the skin were distinctly better than those for men. For all skin sites the five-year survival rate for women is 52 per cent compared with 26 per cent for men. Among individual sites the best prognosis seems to be associated with the eyelids, although the numbers are rather small, and the lower limb.

The worst prognosis is for the scalp and neck, trunk and auricle. Melanoma of the eye, to my surprise, had relatively good survival rates, and women with melanoma of the vulva and vagina had the lowest of all survival rates, three-year 30 per cent; five-year 11.5 per cent. Out of the total of 1,849 cases 73 (four per cent) were diagnosed on the basis of metastases, no primary being found.

Despite the accidental finding of a proportionately large number in my own practice sample, neither the death rate figure for England and Wales nor the Cancer Register incidence figures, support an increasing incidence of this disease. Though the United States death rate shows a steady rise, the incidence and death rate in this country suggest a rise between 1956-58 with a subsequent flattening of the curve to a stationary position in the years under review.

Aetiology

The *Lancet* editorial (1971) on *Sunlight and Melanomas* suggested a multi-factorial basis for the lesion - Sunlight direct or indirect the 'solar circulating factor' Lee and Merrill (1970).

Secondly, is the hormonal environment of the patient - a factor supported by the relationship of female incidence to that of breast cancer and perhaps by the higher male mortality, another resemblance to breast cancer. Thirdly perhaps, a virus, particularly an inactive proviral lesion - similar to herpes simplex - activated by sunlight or cold or a leukaemic virus activated by radiation.

Of interest are the following facts:

1 Ultra-violet light

If the operating factor is sunlight, and especially ultra-violet, as Lee and Merrill postulate, then it is odd that the mortality increases towards the equator while the ultra-violet content of sunlight varies according to height above sea level - experience in the war showed that sea level ultra-violet light appeared low with little risk of skin burning in the equatorial regions.

TABLE VII
Crude Survival Rates for Skin,
Trunk including Breast [172·6
& 174]
(South Metropolitan Cancer
Registry)

Years	Percentage survival rates		
	Male	Female	All patients
1	72·1	69·7	70·9
2	52·9	55·0	53·9
3	39·8	41·5	40·6
4	31·3	36·8	34·0
5	24·9	33·4	28·8
6	18·3	33·4	24·6
7	—	33·4	24·6
Patients initially at risk	136	140	Total 276

TABLE VIII
Crude Survival Rates for Skin,
Upper Limbs [172·7]
(South Metropolitan Cancer
Registry)

Years	Percentage survival rates		
	Male	Female	All patients
1	90·8	86·9	87·9
2	58·2	77·1	72·2
3	48·1	66·7	61·8
4	28·2	55·7	48·4
5	23·1	52·2	44·5
6	16·5	49·8	41·0
7	—	49·8	41·0
Patients initially at risk	44	131	Total 175

TABLE IX
Crude Survival Rates for Skin,
Lower Limbs [172·8]
(South Metropolitan Cancer
Registry)

Years	Percentage survival rates		
	Male	Female	All patients
1	77·6	89·9	87·3
2	55·1	77·9	73·1
3	46·7	71·3	66·2
4	37·8	63·6	58·3
5	31·5	58·8	53·4
6	28·5	53·2	48·3
7	20·3	51·7	45·8
Patients initially at risk	122	458	Total 580

TABLE X
Crude Survival Rates for Skin, Face
(Not elsewhere included) [172·3]
(South Metropolitan Cancer
Registry)

Years	Percentage survival rates		
	Male	Female	All patients
1	90·0	86·0	87·2
2	60·7	78·5	72·9
3	51·9	64·9	60·9
4	31·6	58·0	49·8
5	22·1	50·8	41·9
6	18·7	46·8	37·9
7	—	44·3	36·2
Patients initially at risk	51	115	Total 166

2 Radiation

Taking the English figures alone, whatever the factor, it appears to have operated with maximum intensity over the decades 1940–50 and 1950–60 achieving a relatively stable situation by 1961. It is coincidental, to say the least, that this corresponds with the use and testing of atomic weapons with subsequent dispersal of radiation, culminating in the test ban treaty. Perhaps the study of incidence figures compared with long-term records of radiation fall out or the presence of strontium 90 in milk, both of which exist in some files, would be enlightening. Certainly in Australia, where the latitude correlation has been most conclusively studied, all the dirty explosions occurred to the north of the continent, towards or beyond the equator.

TABLE XI
Crude Survival Rates for Skin,
Scalp and Neck [172·4]
(South Metropolitan Cancer
Registry)

Years	Percentage survival rates		
	Male	Female	All patients
1	81·8	86·7	83·9
2	55·0	83·2	67·3
3	40·5	52·2	45·7
4	24·9	37·3	30·1
5	15·6	29·6	20·9
6	15·6	—	20·9
7	10·4	—	16·2
Patients initially at risk	39	30	Total 69

TABLE XII
Melanoma. Crude Life Table
Survival Rates Vagina
and Vulva [184]
(South Metropolitan Cancer
Registry)

Years	% survival rates
	F
1	60·0
2	36·0
3	30·2
4	16·1
5	11·5
6	11·5
7	11·5
Women initially at risk	55

TABLE XIII
Melanoma. Crude Life Table
Survival Rates. Skin, Ear [172·2]
(South Metropolitan Cancer
Registry)

Years	% survival rate
	All patients
1	68·4
2	47·4
3	47·4
4	37·9
Patients initially at risk	19

TABLE XIV
Melanoma. Crude Life Table
Survival Rates. Skin, Lip [172·0]
Not presented. 10 cases only.
2 died within 1 year and 1 died
between 1 and 2 years
Skin, Eyelids [172·1]
(South Metropolitan Cancer
Registry)

Years	% survival rate
	All patients
1	90·5
2	90·5
3	78·4
4	70·9
Patients initially at risk	21

3 Trauma

The *Lancet* editorial did not consider the possibility of trauma as an aetiological factor other than by sunlight.

Eve (1903) reported a series of cases after puncture wounds of the sole. Stevenson (1915) observed 18 cases of melanoma in Bombay Indians, 15 of the foot, and in five there was a definite history of antecedent puncture wound from thorns or stones at the site of the tumour. Hewer (1935) found that of 34 melanomata, 28 were localised to some part of the foot. In a more extensive review, Steiner (1954) drew attention to a habit of walking barefoot in people who developed melanoma of the feet or legs and this observation is confirmed by other authors: Mulay (1963); Shanmugaratnam and La'brooy (1963); Higginson and Oettlé (1960).

The calf and skin in women are especially liable to trauma compared with the same area in men, both from indirect source – sunlight – and direct, such as scratches and thorns. It has, however, a specific hazard in European communities where the use of depilation of the leg, either by razor or by depilatory creams, has become a social habit. Barefoot, bare legged women are common while a whole industry has been built around the depilation of the leg to produce a more socially acceptable appendage.

Acknowledgements

I must acknowledge my deep debt of gratitude to Mr. Payne of the South Metropolitan Cancer Registry in formulating the interrogations of the computerised register and who offered computer time and valuable comments on the tables.

I acknowledge with thanks the permission of the editor of the *Journal of the National Cancer Institute* to reproduce figures used in this paper.

My thanks are due to my partners and my colleagues in the south Metropolitan region, without whom the figures would not have been available for study, to Professor Warren for his help and advice in reading this paper, and to Mr. J. Saunders, Administrative Officer, West Sussex County Health Department, for his help and encouragement, and for contribution to the comment.

Addendum

Additional tables and information are available from Dr. I. Clout, Leacroft, Ifield Road, Crawley, Sussex.

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Appendix F

THE HUNTER REPORT A MEDICAL OFFICER OF HEALTH'S VIEW*

T. McL. GALLOWAY, M.D., F.R.C.P., D.P.H., DR.P.H.

*County Medical Officer of Health
West Sussex County Council, Chichester*

The Report of the Working Party on Medical Administrators will be recognised as a milestone in the evolution of medical care in this country. It is the most recent and possibly the most significant of a series of remarkable publications which taken together do their progenitors great credit and translate ideals into something almost within reaching distance.

The first Report of the Joint Working Party on the Organisation of Medical Work in Hospitals, the Report of the Twentieth Anniversary Conference on the National Health Service and the Scottish Report on Doctors in an Integrated Health Service rank with the Hunter Report and the Report of the Royal Commission on Medical Education as essential and exciting elements in the change from a guerilla activity to a combined operation.

The medical officer of health is no stranger to the problems – or most of them – catalogued in the Hunter Report and considerable progress has been made already, in improving attitudes towards working together, in reducing factional suspicions and in preparing to make the most of organisational change.

The Community Physician

The particular concerns of the future specialist in community medicine summarised in Hunter's paragraph 136 are, without any amendment, the *current* preoccupations of any self-respecting M.O.H. and this includes the very considerable involvement which a growing number of M.O.H.s have had in the hospital activity – not just recently but for years.

Although the working party 'were under the disadvantage of not knowing what would be the management structure of the new regional and area authorities or whether there would be any management organisation at a district level', the Report is more welcome as it is, uncomplicated by detailed definitions of roles and relationships. These are in any case matters of chance and adaptation as well as of design and it is to be hoped that the books of revelations yet to appear will not be too detailed and inflexible in what they prescribe.

Specialists in community medicine will be 'a clearly identifiable group distinct from the other doctors and from other health service administrators' and it was with this in mind that the Society of Medical Officers of Health, the Association of Senior Administrative Medical Officers (of Regional Hospital Boards), the Society of Scottish Medical Administrators and other related interests promoted the Faculty of Community Medicine of the Royal Colleges of Physicians. The Faculty is actively working with the university departments to develop schemes of training which will be vital to the success of our speciality as well as that of the National Health Service and it is accepted, as the Hunter Report suggests, that there should be more contact and exchange between the academic and service staffs.

Until the breed of new community physicians emerges in five to ten years' time the community physicians of that interim period will be heavily dependent on the teaching departments for help, not least in the elaboration of operational research projects, so that there will be a recognisably worthwhile product from the resources committed to these projects. Gordon McLachlan commented some years ago that we needed better rather than more research and called for some discipline in this increasingly important – and expensive – activity. A. L. Cochrane in his recent Rock Carling lecture reinforced this view. Carefully designed testing of existing and modified systems of medical care delivery will, I hope, be done at all levels of the service, but this will require coordination – duplication of effort must somehow be minimized. The people with the necessary skills are too

*A summary of a paper read at a Conference on the Report of the Working Party on Medical Administrators held in the Central Hall, London S.W.1. on 27th July, 1972. Reprinted (with permission) from the Royal Society of Health Journal (1973) 93, 44–45.

few to waste. It will take time to devise better ways and make them operative – it will take time to develop information systems, except on a limited scale. Although it can be argued that more information will be needed to point the way to progress, there are far more obvious impediments to progress than lack of information.

In this connection, Sir Paul Chambers' Report to the British Medical Association is relevant and welcome. He emphasizes – several times – the importance of whole-hearted co-operation in the task of making the National Health Service successful and recommends the reorganization of the peripheral system so as to facilitate 'effective and whole-hearted consultation between the Association and the Government bodies' at all levels in the new Health Service. This too, with Hunter, is good news.

The criticisms of Hunter have been few and trivial; they are not listed here, nor am I tempted to engage in controversy about this report except to defend it.

Those who are convinced that the equation $RHB = RHA$ will be proved must be wrong if, as we have been told on the highest authority, all the existing medical care administrations will be discontinued and that any semblance of 'take-over' will be avoided. The great thing is that the role of the doctor in the administration of the new Health Service has been made clear beyond doubt. As for the 'personal uncertainties' so much will need to be done, the framework in which it will have to be done will be so improved, and the career prospects so transformed for the better – they must be – that I am cautiously hopeful, not just for ourselves, but far more importantly for the success of the service and the well-being of its beneficiaries.

Henry Sigerist in the Heath Clark lecture of 1952 congratulated this country on its 'brave step forward' in the provision of comprehensive medical care, and with a prescience that becomes more remarkable with the passage of time he forecast the changes which many in medical administration have worked to bring about in the past twenty years. He was sixty-three years of age then and, referring to his first academic year as a Swiss student in London in 1911, he said 'I still have the same insatiable curiosity that animated me at that time . . . all my teachers wanted to make me a specialist, but my interests were very broad and I gradually drifted into a field where I could combine all my interests . . . *suddenly there was a demand for people of my unusual training.*'

Sigerist was a medical historian and I have quoted selectively from his preface to his lecture, but it seemed to relate quite nicely to a medical officer of health's view of the Hunter Report.

After twenty-five years of working for the success of the National Health Service but also of being excluded from it in some important respects, I think that with few exceptions, M.O.s.H. will assume the new loyalties and, with Hunter training and retraining, develop a new zest for the bigger problems of 1974 and beyond.

Although this paper states the views of a M.O.H. its last point is to declare an optimism for those in the clinical and other administrative grades in the Public Health branch who will also move from Local Government to the National Health Service. Great works will be expected of them and they have nothing to lose but their anxieties.

Appendix G

HEALTH CENTRES: PLANNING, DESIGN AND FINANCIAL CONSIDERATIONS*

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The idea of the health centre is at least 50 years old. As long ago as 1920, the Consultative Council on Medical and Allied Services, which had been established by the Ministry of Health Act 1919, and which was presided over by Lord Dawson of Penn, concluded that the organization of medicine had become insufficient and that the necessary improvements had become 'less within the power of the individual to provide, but rather required combined efforts.' (Interim Report on the Future Provision of Medical and Allied Services, 1920). One of the improvements suggested by Lord Dawson's Council was the provision of health centres, which were defined as institutions 'wherein are brought together various medical services, preventive and curative, so as to form one organisation.'

That was half a century ago. There must be few creations which have had a longer period of gestation. And the delivery has been uncommonly complicated and prolonged. Little was heard of them for the next 25 years. Even before the National Health Service was launched just after the war, the then Minister of Health stated that he regarded health centres as likely, when properly designed and conducted, to prove a key feature in the general reconstruction of the country's health services (Ministry of Health Circular, 1948). But little was done. Most of the available building resources were needed to replace bombed buildings and the official view was that more research was needed before the new development was launched: only thirty-two had been provided 20 years after the National Health Service was founded.

With the wisdom of hindsight, it is perhaps as well that few health centres were built in those days. There was little incentive for general practitioners to improve their practice accommodation (those who did were seriously burdened with the cost of building and staffing) and the benefits to the public of close working relations between the general medical and local health services were then hardly recognized. But there have been considerable changes in the last two decades. Gradually the work of the family doctor has been supported by the more progressive local health authorities. The unconditional attachment of nursing staff to general practices, the liberal supply of home nursing equipment to enable doctors to care for sick persons at home and, more recently, the free use of computer facilities to promote immunization and screening programmes are all examples of how local authorities have enabled general practitioners to achieve a better all-round standard of work.

These developments were well advanced when the terms of the Seventh Report of the Review Body on Doctors' and Dentists' Remuneration (1966) were published in May, 1966. This new Charter for general practice, which provided for the reimbursement of reasonable expenditure incurred on the rent and rates of surgery premises, was probably the most important single factor in promoting a considerable upsurge of interest in the provision of health centres. The Ministry of Health calculated (Ministry of Health Circular, 1967) in April, 1967 that 300 health centres would be built in the next 10 years, two-thirds of them before 1970. This was in fact a conservative estimate. There are now 280 health centres open in England, with about 1,500 doctors practising from them. By 1974, forecast Lord Aberdare recently, there would be more than 500.

Considering the difficulties which have confronted local health authorities in recent years – the poor administrative structure of the National Health Service, the uncertainties brought about by several proposed reorganizations, and the restraints upon capital expenditure – this is a creditable performance. And it is one which has been achieved only by

*A paper read on 7th April, 1972 at a Conference on the Administrative Aspects of Health Centre Management sponsored by the DHSS at the University of Kent and organized by the University's Health Services Research Unit. Reprinted (with permission) from *Community Medicine* (1972), 128, 185–189.

the determined efforts of many people from a variety of professional disciplines. The county councils have done far more than their county borough counterparts. Whereas health centres have been opened by more than two-thirds of the fifty-eight county councils in England and Wales, fewer than one-third of the eighty-three county boroughs have done likewise. Perhaps it is as well that the boundaries of the area health authorities of the future will be co-terminous with those of the new county councils.

Some schemes better than others

Of the schemes which have so far been developed, it is common knowledge that some are much better than others. It would be surprising if it were otherwise. But it would be arrogant of an administrator working for one local health authority to attempt to compare the achievements of his own authority with what has been accomplished elsewhere. He can do no more than give an account of his own experience and hope that this may be helpful to others.

West Sussex opened its fifth health centre in April, 1972, and work is either in progress, or will start soon, on the building of six others. Apart from these eleven centres, provision has been made in the capital development programme for fourteen other schemes to be started in the next 3 years. Twenty-seven general practitioners (12% of the total) are already working from our health centres. Consultations are in progress aimed at providing such accommodation for more than sixty others.

Our experience suggests that the success of any health centre – measured by patient and professional worker satisfaction – is probably determined long before the first brick is laid; it depends upon the care with which the project is planned. This takes time (on average about 4 years from conception to delivery) and a great deal of energy. Following the early encouragement from central government, we started off in 1966 with a county conference to which all general practitioners were invited. We were surprised at the interest which this conference generated – one-third of our then total of 225 general practitioners turned out on a Sunday evening. We were encouraged by this response to hold further consultations with interested groups of doctors at which detailed consideration was given to the needs and problems of individual urban areas.

The site and accommodation requirements

Once we had determined that there was a demand for general medical and local health authority accommodation sufficient to justify the erection of purpose-built premises, we usually found that the first seeds of possible dissension arose over where the premises should be sited. There were often as many opinions as there were interested medical practices. In consultation with our colleagues in the Planning Department, we soon concluded that in towns accommodating up to about 30,000 people the only sensible course to adopt was to seek, either by agreement or by compulsory acquisition, a good town-centre situation, which was well served by public transport, and which had adequate on-site or adjacent car parking facilities. The site would have to be suitable not only to take the initial building but also to allow future extensions to be added, laterally or vertically. Space would be needed not only to provide for the successors of the unimaginative doctors, who decided to remain in the cottage industry, but also to house the dentists and pharmacists who will undoubtedly come forward when some encouragement is given them to do so by changes in national policy.

We were encouraged to learn that some of our early conclusions on the siting of urban health centres were supported by central government. In his closing address to the National Health Service Twentieth Anniversary Conference held on 5th July, 1968, the then Minister of Health said this:

'Ideally each of us would like to have a health centre at one end of the street and a district general hospital at the other. But none but the very foolish when really needing expert care would prefer a lock-up surgery and a cottage hospital within walking distance to a modern district general hospital a dozen miles away and a health centre within five miles. We cannot build the new and keep the old.'

The siting of the health centre is, then, of fundamental importance. To put it in the wrong place is to invite subsequent trouble. If it is eccentrically situated in relation to the district it is intended to serve, or if it is not readily accessible to the people living in the area, it is likely that there will be demands for more than one health centre to be built and that requests for doctors to make home visits will not diminish as they should.

Another crucial ingredient in the planning of a health centre is the settlement, with those who will work in and from the building, of an acceptable schedule of accommodation requirements. The task of putting on paper the various rooms and room sizes required has, of course, been made much easier since the publication of the draft Design Guide by the former Ministry of Health in 1968. But it is still important to consider in some detail with the users of the building and with the design architect such things as user movement patterns, room relationships, the internal circulation of patients and staff, and the detailed layout of individual rooms.

What does the general practitioner or the receptionist normally do from the time of arrival at until the time of departure from the centre? How should the various rooms be positioned in relation to each other? Once it is established that treatment facilities are needed near consulting and waiting areas, how many treatment rooms are needed? In our first health centre we provided two treatment rooms, each serving five general practice consulting suites, and (since the work done in a treatment room can be regarded as an extension of the home nursing service) it was decided to provide county council nurses in those rooms during normal general practice consulting hours at no charge to the doctors. I doubt whether we should ever provide two treatment rooms in any future scheme, unless it were a very large one. This is partly because the rooms tend to be inconveniently small, partly too because this incurs the cost of equipping two rooms, but mainly because by providing two rooms the wages bill for nurses is almost doubled. About 67% of the revenue expenditure of local health authorities is spent on salaries and wages.

The detailed room layouts should be agreed with those who will work in them. This is much easier to do now that some health centres have been opened. Professional workers can be shown what has been done in premises that are already functioning. But it is still necessary to give them an opportunity to comment and make suggestions. Although it is nowadays rare to find a doctor who says he wants a door between his consulting and examination rooms, very few seem to give much thought to the basic elements of what is to become their workshop: where they will want to hang a coat (in a wardrobe or on a hook), what should be the height of their examination couch and of the basin in which they will wash their hands, the position of their instrument and drug cupboard and the size of the desk at which they will spend much of their professional lives. Most doctors will say, before they move into a health centre, that a consulting room of 120 square feet is far too small. But it is rare to hear such a comment from a doctor who has worked in a room of that size which has been properly planned.

I have yet to learn of any complaints about the wall-to-wall carpet which is now routinely provided in all our health centres, not only in consulting rooms but in all non-treatment areas. This is not part of a lavish spending spree but is a positive economy. The initial capital outlay compared with a thermoplastic floor finish is about two-and-a-half times as great. But this additional expenditure is recovered in cheaper cleaning and maintenance costs within 5 years and on the type of carpet which we use architects have obtained a 10 year guarantee.

Apart from economy, the use of carpets reduces sound transmission and introduces a more friendly and less institutional-like atmosphere. G.P.s and their patients feel more relaxed in a homely, domestic-scale environment.

The provision of a common room is important in promoting staff cooperation. The use of this accommodation takes time to develop. But the first Christmas party and a few group luncheons seem to encourage its regular use by most of the staff, particularly if it is positioned properly. In one of our centres, largely because of site problems, we departed from the Design Guide's advice that it should be near the office. This was a mistake. If the common room is not placed near the office, then the office tends to become the common room, to everyone's irritation.

In other instances, notably the provision of office accommodation for nurses and social workers, we have departed deliberately from the Design Guide recommendations: 'Not more than four health visitors should be asked to share one room,' and 'No more than two social workers should be asked to share a main office'. Why? In all our health centres, office accommodation for nurses and social workers has been provided in large areas properly landscaped in the open manner normally recommended nowadays for purpose-built office accommodation.

The money which would otherwise have been spent on walls and partitions, which create physical barriers, has been spent on making field staff more comfortable during the limited periods they should be sitting at their desks. The fact that there are no partitions has done nothing to hinder the promotion of good working relationships. Interview rooms are of course available for secret seances.

Individual requirements: reception of patients

During the planning of any health centre the time spent with general practitioners in reaching conclusions on their requirements and making suggestions for their consideration is usually time well spent. This is demanding work, particularly with doctors who themselves have an eye for detail. It can be even more taxing with those who display little interest until the building contractor moves on to the site. But if these early consultations are conducted thoroughly, they will have a dramatic effect on the operation and management of the health centre once it is brought into use.

On operation, all sorts of questions need to be considered. Do the doctors intend to run an appointment system? The G.P. who does and who has an average list of 2,500 patients needs only 60% of the waiting area required by a doctor who operates without an appointment system. If building costs are £7 a square foot, about £4,000 can be saved on waiting accommodation alone in a health centre with ten consulting suites where patients are normally seen by appointment. This figure takes no account of the continuing savings on running costs (heating, lighting and cleaning) on the additional 500 square feet of accommodation which would otherwise have to be provided.

Call-system

Having reached a conclusion on appointments, how do the doctors wish to call patients from the waiting area into the consulting room? Doctors are individualists. Some prefer to greet their patients face to face in the waiting area. Others will tell you that a buzzer is all they need. The more sophisticated are attracted by the idea of flashing lights, or the calling of patients by name through a loudspeaker. Some prefer the facility to allocate to each timed appointment an individual number which can be illuminated in the waiting area from the consulting room.

Whatever the views of individual G.P.s may be on matters of this kind, the patient call-system which is introduced should be flexible. What is acceptable to one doctor may be abhorrent to his partner or to both their successors. Options need to be kept open so that ways in which patients are invited into consulting rooms can be decided by the doctors themselves rather than by other people.

To avoid confusion and to assist patients to find their way around buildings with which they may be unfamiliar, it is equally important to consider the patient reception arrangements. Having made an appointment to see a doctor, the patient should be helped on arrival at the health centre to go to the appropriate part of the reception area. The doctor's name (and those of his partners) should be clearly shown above his section of the reception counter, and a coloured symbol (for example, a red circle or a yellow triangle) should be displayed against his name. The receptionist should invite the patient to sit on the chair of the appropriate colour and, when his turn comes, to follow the coloured symbols displayed on the walls until he reaches the door of the consulting room which bears his doctor's name and distinguishing colour symbol.

Good methods of communication within the building can contribute appreciably to the efficient running of the health centre and should be settled at the design stage. The advice of Post Office engineers is freely available on the best telephone installation. It should be possible to transfer an incoming call from the switchboard to the receptionist working for the practice with whom the calling patient is registered. If the receptionist is doubtful whether to commit the doctor to a home visit, it should be possible for her to transfer the call to him if he is in the building so that he can make the decision. These transfers should be effected by push button methods and need not involve directories or dialling. Arrangements of this kind help to promote good patient-doctor relationships and to preserve practice identity, which most doctors seem determined to maintain when health centre discussions are started.

Teledictation

Similarly, a teledictation facility can be incorporated into all the PABX telephone installations. No longer is it necessary for a doctor to call for a shorthand-typist when he wants to dictate a letter or report. From the telephone in his consulting room he can dial, and put his dictation on, one of the recording instruments in the office where it will be transcribed by an audiotypist and then taken to him for signature, or sent on a document conveyor if one has been installed. The DHSS is disinclined to approve expenditure on document conveyors but, in consultation with the Department, we have experimented

with such an installation at one of our health centres and, in our opinion and for the following reasons, they do improve efficiency and promote staff economies.

- (a) They facilitate the transfer of medical records from the reception/office area to the appropriate consulting room (without disturbing a consultation which may be in progress) when a patient wishes to see a doctor;
- (b) they enable a doctor to send written instructions from his consulting room, to a nurse in the treatment room, avoiding the need for patients to handle their own records;
- (c) patients who call at the health centre during consulting hours, for repeat prescriptions of drugs and medicines can have their notes forwarded to their G.P.s so that the prescriptions can be signed and returned to the reception area when convenient to the doctors;
- (d) letters and reports dictated by doctors using teledictation facilities can be returned to them for signature after the dictation has been transcribed; and
- (e) the equipment will enable documents to be sent to and from any station served by the conveyor. There is a direct link for written communications between the office, the treatment room and all the consulting rooms.

These are useful aids to efficiency which should be considered with the interested doctors and with the design architect at the planning and design stage. A document conveyor will impose some restraints upon architectural design. But there seems little doubt that, as general practice embraces the twentieth century, document conveyors will become no more remarkable than telephones or typewriters. In deference to the current views of the DHSS, we have decided to install no more until they become as convinced as we are of the benefits of installing modern equipment in modern buildings.

Storing medical records

Those who forget to give thorough consideration at the planning stage to the storage of medical records may find themselves confronted with tremendous problems later on. Although this is a subject on which some doctors have firm views, most of them are only too glad to receive advice. There are, of course, several ways in which the standard records can be housed, and we have, at various times, considered most of them. But whatever method is adopted, it must be flexible. It must cope with the storage of the present EC 5 and 6 records, which have remained unchanged for about 60 years. It must also be capable of conversion, at minimal cost, to receive records of a different size when a national decision is made.

The Flexiform system which has been adopted in West Sussex matches up to all these basic requirements. The record cabinet will receive up to seven shelves, which move effortlessly on ball bearings, but we normally suggest that, for ease of filing, the top and bottom shelves should not be used for EC 5 and 6 records but should be reserved for the lateral filing of larger documents. Five shelves will house about 3,500 EC 5 records and the lockable roller blind provides some security and protects against dust.

General practitioner costs

One subject which always has some bearing on the smooth running of the health centre is whether the participating general practitioners consider that they are getting value for money. So far as rent and rates are concerned they will display little interest, for the local authority's charges will be met in full by the executive council and no cash will pass from the doctors' pockets. But service charges – the cost of heating, lighting, water, cleaning, furniture and equipment, internal repairs and decorations – are a different matter. Whatever the local authority charges the executive council for services of this kind will be passed on to the doctors, and they are entitled to know as soon as possible in the planning stages, what their financial liability is likely to be.

All health centres are built to standards approved by the DHSS. Comparing one health centre with another, room sizes and the facilities available to general practitioners are much the same, and so it seems right that their financial outgoings on service charges should be the same wherever the health centre may be. This, at any rate, is the arrangement in West Sussex. The current charge is at the rate of £260 a year for each consulting suite and the supporting accommodation, plus additional charges for telephones and £15 a year for the use of a dispensary where doctors are dispensing practitioners. Although there will clearly have to be some increase fairly soon, these charges have remained unchanged for the past two years.

We have not so far had any complaints from doctors that they have suffered a financial disadvantage by moving into a health centre. This, in our opinion, is partly attributable to the policy decision taken at the outset that they should all be treated alike. In the re-organized service which will operate from 1974, there may be a case for applying this principle more widely. The management of health centres would be facilitated if it applied certainly through the area, perhaps the region, maybe nationally.

Experience suggests that the smooth running of the health centre is promoted, particularly in those centres housing more than one practice, if the clerical and reception staff are employed by the local health authority rather than by the doctors. The various ways in which ancillary staff can be employed need to be considered with the GPs during the planning stage. Most doctors seem to settle for the direct employment of their staff by the local authority if the benefits are impartially explained, and if they are given an assurance that the practice allegiance which they have developed with their staff will not be disturbed.

In this I think they are right, for much of the housekeeping of general practice (payment of salaries, accounting for income tax deductions, the purchase of insurance stamps) can thereby be transferred elsewhere. The reception staff themselves very often benefit from the application of national conditions of service, such as regular increments within a recognized salary grade, agreed sickness and annual leave entitlements and, for those who are substantially whole-time, the benefits of a good pension scheme. To the extent that facilities of this kind produce a more contented staff, it is to be hoped that they will be developed more widely in the post-1974 era.

Effectiveness and management

Since, in the foreseeable future, health centres seem likely to become the principal buildings from which community medical and nursing care will be made available to the public, it is relevant to consider the part they may play in assisting a county or area health authority to monitor the performance and cost effectiveness of domiciliary health services. In a unified health service, have health centres any special part to play in the costing and evaluation of preventive medicine? If so, what kind of information and accounting systems should be introduced? There are no straightforward answers to questions of this kind. Much will depend on the administrative framework through which the county or area health authority operates. If, as is the rule in some county health departments, each clinic or health centre or ambulance station is looked upon as a separate entity – the activities which are undertaken in and from those buildings being largely the concern of those who work in them – each health centre could certainly play a part in the evaluation of domiciliary care.

Information systems could be devised which might provide explanations for all sorts of unanswered problems. But the discoveries unfolded in this way would remain relevant to comparatively small units of population.

What is more, if management is localized, as some suggest it should be, information systems devised in one health centre may not be considered suitable, without modification, for introduction elsewhere. Time and effort can easily be dissipated in reinventing the principle of the wheel.

A good example of this, though on a larger scale, but by no means unique, is to be seen in our approach to schemes of vaccination and immunization. Ten years have elapsed since West Sussex County Council devised a system which, according to the DHSS (Chief Medical Officer 1968, 1970) has produced levels of immunity higher than in any other area in England and Wales, and which has been shown to operate at a unit cost which is 36% cheaper than the national average (Saunders, 1970). So far as I am aware, no other area has introduced that system without some variation. The intervening years have been used, not in breaking new ground, but in altering a system which, judged by its results, has yet to be bettered.

This is one reason why I remain unconvinced of the need for fulltime managers in health centres. Good management is a scarce commodity. It should not be haphazardly scattered but should be concentrated in as few places as possible. For the community health services the appropriate place should, in my opinion, be at the county or area headquarters. If it is diluted by being located at district or individual health centre level, standards of administration will never be as good as they might otherwise be.

That is not to say that each health centre should be deprived of an appropriate allocation of administrative skill and support. On the contrary, it should get as much as it needs within the framework of an efficient central administration. It seems reasonable to expect

that that requirement can satisfactorily be met in the larger health centres from about twenty per cent of the time of an administrator – a 'middle manager' – from the headquarters administration. This arrangement has the obvious advantage that, if this administrator is sharing his time amongst several health centres, the standards achieved in the best become common to them all.

The future

We are about to enter a period of far-reaching development in the NHS. So far as the community health services are concerned, the promotion of health centres may eventually be regarded as the most important single contribution to the health of the nation since the Health Service was started in 1948. This development is still in its infancy; even now, nationally, only 7% of our family doctors are working from them. We are therefore confronted with rare opportunities – the opportunity to provide better buildings for professional staff to work in; the opportunity to bring about a re-birth of general medical practice; the opportunity to create integrated medical care facilities in most of our towns and larger villages; the opportunity to make it possible for health workers from many disciplines to operate as a team with the objectives of preventing illness, of detecting as early as possible those whose health has broken down, and of helping to mend bodies and minds. It is just a hundred years this week since Benjamin Disraeli remarked that the health of the people is really the foundation upon which all their happiness depends. It still is, but the foundation needs to be made even more secure.

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Appendix H

A COLLECTION OF CHESTERISMS*

Compiled by J. SAUNDERS, F.C.I.S., F.H.A.

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The World Around Us

(The basic law of human experience). I am as good as everyone else but nobody is as good as me.

In a democracy only the squeaking wheel gets oiled.

Nothing sharpens the wits more than a lack of money.

You do not need to be a cobbler to tell where the shoe pinches.

I do not believe that the best work can only be done by a poor poet with pulmonary tuberculosis living in a hovel.

Human beings have an uncanny knack of identifying their interests with their ideologies.

The basic decisions of life and death are often taken in the Athenaeum over lunch.

All history is a transition from the acceptable to the unacceptable.

In human affairs, reason is sometimes the compass but emotion is always the steam.

A crazy man can sometimes do more good than harm.

In the social services, everybody wants to do research. Mankind would be better served if ninety per cent of it were never conceived.

Most theories are eventually accepted not because of their validity but because of the retirement or death of their opponents.

However you throw the cat it will always land on its paws.

Are people the best judges of their maximum faculties?

In some countries, despite the activities of the secret police, all the doctors seem to have convinced their governments that they should remain in the principal towns.

(The comment of a negro who had witnessed several people in a post office queue being harassed by the counter clerk). It is such a pleasure to be in a country where everybody is badly treated.

(Of a politician). His eyes were gleaming with insincerity.

(The comment of an ambitious man). I don't care what you say about me so long as you say it.

All life consists of multiple contradictory objectives which have to be ironed out by plain common sense.

Health is no longer a privilege; it is now a right.

(Comment of a Habsburg monarch). The position is impossible but not serious.

The perfect is sometimes the enemy of the good.

The English have a great regard for their traditions but they are always ready to start a new one.

*Delivered by Professor T. E. Chester, C.B.E., Department of Social Administration, University of Manchester, during the first and second multi-professional courses in the management of integrated health care held at the University in 1972. Professor Chester does not claim authorship for some of these aphorisms – just a good memory!

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Advice to Administrators

Whoever writes the minutes wields the power.

(Budget preparation). The man who does the first draft usually wins the day.

It's the screaming baby that gets the attention all the time.

When all else fails you will often find it useful to carry a hammer in your pocket.

There are lots of things you can do as long as you don't talk about them.

The man who communicates is the man who leads.

There are two ways of doing this – my way and the wrong way.

(Considering various forms of management). Then there is management by decibel, which means that he who shouts loudest gets most.

If you have fire in your belly you will usually find someone to pay for the fuel.

In large enterprises you have to organise informality.

The truthful answer to the question, 'How many people work here?' should often be, 'About 50 per cent.'

Laws should be short and deliberately ambiguous.

When you come to a boundary line you must employ sensitive staff.

The best British planning has always been retrospective.

Business management courses are not the most efficient in the world.

One of the worst things to do is to work in an organisation with all the freedom and no resources.

(How to obtain information from reluctant colleagues). Set up your own spy network and find out.

Never forget that what you give to one today you will have to give to all tomorrow.

Whilst royalty and the politicians continue to require medical care, doctors do not really need a Whitley Council.

You can drive democracy too far.

You can't co-operate unless you know with whom you should communicate.

The English are past masters at bypassing their own organisation.

People with brains are more useful than computers.

Some doctors try to administer by waving a shroud.

A coordinator is a chap who tells you what you can't do.

Voluntary services are all right so long as they are compulsory.

There is no subject which you can raise with clinicians which argument will not aggravate.

In the Classroom

Don't confuse me with the facts – just let's stick to the argument.

(About to start a talk). So far you have had a good course. The time has come when your luck breaks.

(To a student who asked him to decipher what he had written on the blackboard). I have purposely developed illegibility as a means of education.

I'm still confused – only on a higher intellectual level.

(Encouraging a student to initiate a discussion). Come on——, you're a striker! The world will be a poorer place if we do not have the benefit of your wisdom.

(To a student who unintentionally interrupted him). It's quite all right. I have finished when you want to speak.

(*To a student who started, 'Did you say . . . ?'*). It doesn't matter what I said. I like to hear what people think I said.

No course is ever better than its participants.

(*After describing the contents of a course*). What you select from the menu is up to you.

(*To a student with a battering ram in his hand*). You are running into an open door.

There is less in this than meets the eye.

(*To a student with an ill-conceived argument*). With due humility (to quote you), you are talking rubbish.

(*After a learned professorial dissertation*). I am always astonished at what we do not know.

(*To the final session of a course*). You know where we are. Our files are never closed.

The Present Health Service

Two alternatives frequently determine our standards of care – take it or leave it.

(*In a discussion on the quality of NHS staff*). Who carries more passengers than BEA?

In this country we have millions of health data which are never fed into the human brain.

(*Domiciliary visiting*). In the United States, the last doctor seen visiting a patient at home was 150 years ago – on a horse.

Mass screening merely enables you to write the death certificate a few years before the terminal illness.

Ours is the normal experience of a developed society – less mortality but more morbidity.

It is easier to build a district general hospital than it is to close a useless cottage hospital.

Unless a drug company has a winner every five years it will go bankrupt.

I am a great believer in the untidiness of the National Health Service.

(*A comment on the civil service desk-clearing practice of recommending health service improvements without indicating how they will be financed*). Everybody recommends paradise on earth but few will provide the money.

The NHS is probably the only industry in this country in which capital investment increases revenue costs.

The original structure of the NHS was determined by the enmities within the medical profession.

(*A comparison with the United States health service*). Sometimes we are twenty-five years in front; sometimes they are twenty-five years behind.

(*The NHS in 1948*). (a) We were lucky we had no money. (b) The organisation was no more than a quirk of history.

Reorganisation of the Health Service

There is a documentary battle fatigue setting in in the health service.

It makes little difference what you put on paper – green, blue, white or grey – what really matters is the quality of the people you work with.

If we believe all of what is said in these books, it is evident that by the year AD 2000 any increase in the gross national product will be devoted entirely to the health service.

Consensus management is not possible if one side is losing.

Leaderless groups can lead to the utmost confusion.

(*On a suggestion that numbers of community physicians should be allocated to the new districts*). You don't position heavy artillery at company level.

The new British health service will have nine gaffers and one man doing the job.

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