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CAMBRIDGESHIRE COUNTY COUNCIL

ANNUAL REPORT

OF THE

COUNTY MEDICAL OFFICER OF HEALTH

FOR THE YEAR

1960

P. A. TYSER, M.D., D.P.H.
County Medical Officer of Health

Printed by Crampton & Sons, Ltd.. Sawston Cambridge

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P. A. TYSER, M.D., D.P.H.
County Medical Officer of Health
SHIRE HALL,
CAMBRIDGE
Tel. No. : Cambridge 58811

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To the Chairman and Members
of the
Cambridgeshire County Council.

Ladies and Gentlemen,

The following report is prepared in accordance with Ministry of Health Circular 1/61 which this year calls for particular comment on certain aspects of the health services, as well as the matters which are usually dealt with in Annual Reports of Medical Officers of Health.

Local Government Commission

On March 1st the Local Government Commission's draft proposals for the East Midlands Review Area were received. The main suggestion was a four counties scheme (Cambridgeshire, Isle of Ely, Huntingdonshire and Soke of Peterborough) with the City of Cambridge given County Borough status. During the year, various meetings took place with regard to these proposals. The Commission's final proposals have not been received at the time of writing this report.

Delegation of Health and Welfare Functions

The scheme of delegation of certain health and welfare functions to the City of Cambridge was included as an appendix to last year's report.

On October 1st, the scheme came into operation, except for duties relating to the new Mental Health Act, 1959, which did not itself become fully operative until November 1st; the delegated functions under this Act will be transferred on April 1st, 1961.

Careful briefing of all concerned enabled the changeover to take place smoothly and so far as is known without worry to the users of the services affected. This could not have been achieved without the willing co-operation of everyone, at all levels, concerned with the services, and to them I express my gratitude.

Mental Health Service

Before going on to summarise the year's events, I should like to pay a sincere tribute to the late Alderman Mrs. Mellish Clark who died on April 21st, 1960. I had the great privilege of working with her in her capacity as Chairman of the Welfare Committee, Chairman of the Mental Health Sub-Committee and also as Chairman of the Executive Committee of the Cambridgeshire Mental Welfare Association. Alderman Mrs. Clark had the great task of initiating the Council's policy under the new Mental Health Act and I think no finer tribute could be paid to her and her long career of social service than that one of her last tasks was to guide the Council in determining their policy with regard to the future of the mental health service, thereby laying the foundation stone of a service which is now one of the most important in the field of public health.

It follows that I should now refer to the developments in the mental health service which are discussed in detail on pages 36-42.

It is impossible not to look back with pleasure upon what has been achieved since the passing of the Mental Health Act, 1959. Indeed it gives support and encouragement for the considerable tasks ahead. There can be no doubt that over the next fifteen years the community services will play an ever increasing part in the total mental health service and local health authorities have had a clear challenge held out to them by the Minister in his address to the 1961 Annual Conference of the National Association for Mental Health.

We are fortunate in Cambridgeshire in having a sound basis from which to develop further our services and the relevant section in the report enlarges upon this theme.

Chiropody

During the year the Council took the necessary action under Section 20 of the National Health Service Act to amend their proposals in order that they might operate a chiropody service. This service, details of which are given on page 34 will begin on April 1st, 1961.

Health Education

No specialist officer is employed, reliance being placed upon medical, nursing, mental health and other staff. One particular campaign on dental hygiene has now been pursued for two years and is referred to on page 16 as well as in the Principal School Medical Officer's report. A commentary on health education is to be found on page 34.

Liaison Arrangements

In the framework of the National Health Service, the most costly item is the hospital service which in turn means the cost of maintaining a patient in a hospital bed. It is important therefore that the health services should be designed to enable the most economical use to be made of hospital beds; one important factor in this aim is the availability and use of domiciliary services.

The Council have, since 1949, operated in conjunction with Addenbrooke's Hospital a Home Care and Nursing Service scheme, details of which are given on page 27.

The general development since 1948 of the domiciliary services will undoubtedly have had some influence upon the use of hospital beds. It will be noted in the development plans of the mental health service that considerable emphasis is placed upon the part the domiciliary services are playing and study of the section on mental health will show that in Cambridgeshire we intend to play our part in this connection.

Following the Government's acceptance of the Report on the Maternity Services, liaison committees have been set up at Addenbrooke's and Newmarket Hospitals to cover the Administrative County. So far, experience of these committees has shown that they serve a valuable purpose in many ways, not least of which is in providing a forum for the exchange of views between all those taking part in the maternity services.

With the appointment of a consultant geriatrician in the area, who took up his duties in January, a good start has been made in reorganising the services available for the care of the aged. In this connection a geriatric liaison committee has now been formed under the chairmanship of the secretary to the United Cambridge Hospitals. Members of the hospital service, the county welfare officer and members of the public health and nursing services are represented on this committee which meets approximately every six weeks.

The Council are experiencing difficulty in acquiring suitable sites for the erection of old peoples' homes but during the year great efforts were made, with success, and when the new homes are in operation, a very real improvement will be made in the services at present available for the care of the aged.

It is a pleasure to record the steps that the District Councils are taking to provide special accommodation on their housing sites and elsewhere for old people and in the section on General Information, it will be seen that more of these units have been opened during the year.

It may be of interest to the Council to see in the form of a chart which appears on page 58 the liaison arrangements which exist as between their health department and the various statutory and voluntary bodies concerned with the health services. It will be appreciated that with the passing of the years the Council's responsibilities for matters relating to public health have both altered and increased and an attempt has been made by means of a chart to indicate how the many aspects of the Council's work in the field of public health are administered; this chart appears opposite the one previously referred to.

Child Guidance

In 1959 the Minister issued Circular 3/59 which dealt with the development of Child Guidance Services following the Report of the Committee on Maladjusted Children. In this area, the Local Education Authority does not itself maintain a Child Guidance Clinic but relies on the Child Psychiatric Service operated by the East Anglian Regional Hospital Board and the Board of Governors of the United Cambridge Hospitals. Details of this service are to be found on pages 38-40.

Co-operation with Voluntary Organisations

When the National Health Service Act and other social legislation was passed after the second World War, many people felt that an end had come to voluntary effort in the field of social service. This assessment of the situation has been proved entirely erroneous. In Cambridgeshire there has always been a strong voluntary services movement and much of the success of the County's health and welfare services is attributable to the unstinted and untiring help received from voluntary agencies. In various parts of the report mention will be found of voluntary help as for example with the infant welfare clinics, medical loan, mental health, the unmarried mother and her child and the blind, indicating a few of the instances where voluntary help is invaluable and without which existing services could not be run or maintained without appointing many more staff. To all the voluntary organisations and to the individuals, whether they happen to be mentioned in this report or not, I extend my warmest thanks for their devoted help.

Nursing Services

During the year a comprehensive report on the development and future needs of the nursing, midwifery and health visiting services in the rural area was presented to the Health Committee. Recommendations aimed at improving recruitment, conditions of service, and increasing the staff were accepted by the Council. An abridged form of the report is to be found on pages 18-21.

Administrative Staff

In 1959 the Establishment and Organisation Officer was asked to examine the staffing of the Health Department and his report was considered by the appropriate Committees that year and their recommendations endorsed by the Council. With the appointment in the first trimester of the year of a lay administrative officer the developments necessary to improve the administration of the department have gradually been carried out. I am grateful for the help and advice of the Establishment Officer and for the generous and understanding way in which the Committees and the Council have enabled the department to reorganise to meet the increasing challenges in the field of public health.

Acknowledgments

Throughout this busy year I have had the support and encouragement of the Chairmen and members of the committees having the care of the health and welfare of the people in the county. I gratefully acknowledge this valuable assistance.

Without the loyal support of colleagues and the staff of the department it would not be possible to operate the services and to them all I record my thanks for their work during the year.

I am,

Your obedient Servant,

P. A. TYSER,

County Medical Officer.

May, 1961.

HEALTH COMMITTEE

Chairman: Councillor H. R. Mallett, O.B.E.

Alderman S. T. Bull
„ M. Carter
„ L. M. H. Clark, O.B.E. (Died 21.4.60)
„ P. F. Dennard, O.B.E.
„ E. G. G. Frost, C.B.E., M.A.
„ E. W. Parsons

Councillor A. B. Amey
„ E. W. Bullman
„ M. C. Burkitt
„ J. H. Clark
„ R. J. Davies
„ D. Greaves
„ H. Hartley
„ E. Hepher
„ G. M. Macfarlane-Grieve
„ D. M. Nichols
„ C. Webb
„ E. Whitehead

Chairman of the City Maternity and Child Welfare Sub-Committee
(City Alderman H. R. Mallett, O.B.E.)

Vice-Chairman of the City Maternity and Child Welfare Sub-Committee
(City Councillor E. A. Gill)

Nominated by the Cambridgeshire Local Medical Committee
Dr. E. V. Bevan
Dr. A. Brown

Nominated by the Royal College of Nursing
Miss H. E. Wakelin

CITY MATERNITY AND CHILD WELFARE SUB-COMMITTEE

Appointed by the City Council

Chairman: Alderman H. R. Mallett, O.B.E.
Vice-Chairman: Councillor E. A. Gill
„ G. Y. Burn
„ S. T. Edwards
„ F. W. Hall
„ H. G. Ives
„ M. V. Morse
„ R. F. Reilly
„ F. E. Roden

Appointed by County Health Committee
Alderman M. Carter
Councillor A. B. Amey
„ E. Hepher

Co-opted members
Mrs. D. Greaves
Mrs. D. R. Lockyer
Dr. M. G. P. Reed

MENTAL HEALTH SUB-COMMITTEE

Chairman: Alderman L. M. H. Clark, O.B.E. (Died 21.4.60)
Councillor H. R. Mallett, O.B.E.

Alderman S. T. Bull
„ M. Carter
„ P. F. Dennard, O.B.E.
„ E. G. G. Frost, C.B.E., M.A.
„ E. W. Parsons

Councillor A. B. Amey
„ E. W. Bullman
„ J. H. Clark
„ D. Greaves
„ E. Hepher
„ G. M. Macfarlane-Grieve
„ D. M. Nichols
„ E. Whitehead
Dr. D. Cameron

Co-opted members:
Lady Adrian
Mrs. E. Blackman
Mrs. E. Rawdon Briggs
Mr. J. A. Day
Mrs. R. Rootham (Died 22.12.60)

HOME HELP SERVICE SUB-COMMITTEE

Chairman: Councillor H. R. Mallett, O.B.E.

Alderman M. Carter
„ L. M. H. Clark, O.B.E. (Died 21.4.60)
Appointed by the City Council

Councillor E. Hepher
„ E. Whitehead
Alderman H. R. Mallett, O.B.E.
Councillor E. A. Gill
„ G. Y. Burn
„ M. V. Morse

STAFF

County Medical Officer of Health: P. A. Tyser, M.D., B.S., D.P.H.
Deputy County Medical Officer of Health: J. Drummond, M.B., Ch.B., D.P.H.
Principal Dental Officer: J. R. Toller, M.Sc.D., L.D.S.
County Nursing Officer: Mrs. S. Mee, S.R.N., S.C.M., H.V. Cert., Q.N., Admin. Cert.
Mental Health Staff: See page 42.
Home Help Organiser: Miss O. B. Greenslade
Home Teachers: Miss R. M. Peel
Mrs. M. Sier
E. Wilkinson
Lay Administrative Officer: L. Bly, A.C.C.S., D.M.A.
Chief Clerk: H. J. Sadler

A voluntary scheme of delegation with regard to Maternity and Child Welfare services existed in the City of Cambridge, until 1st October, 1960.

Medical Officer of Health for the City of Cambridge: C. G. Eastwood, M.D., Ch.B., B.Sc., M.R.C.S.
Medical Officers for Maternity and Child Welfare: M. C. K. Patterson, M.B., Ch.B., D.P.H., D.O.
I. M. S. Nicholls, M.B., Ch.B., D.P.H.

N.B. A scheme of delegation of certain health and welfare services to the City of Cambridge began on October 1st, 1960 and resulted in changes in the committees and staff.

GENERAL STATISTICS OF THE ADMINISTRATIVE COUNTY

Area	315,168 acres
Rateable value	£2,818,682
Mid-year population (Registrar General's estimate)	186,260
Census population 1951	166,887
Birth rate	16.9
(corrected)	17.9
Death rate	10.5
(corrected)	10.0
Infant mortality rate	16.5

GENERAL INFORMATION

The area of the Administrative County remains unchanged at 315,168 acres. The mid-year population was divided as to 93,840 persons resident in the City of Cambridge of which some 8,000 are undergraduates of the University. The rural population numbered 92,420 persons.

It will be seen from the tables which appear on pages 48 to 49 that the population of the City has increased by 700, while the rural area shows an increase of 1,060.

There is no heavy industry in the area, the main industry being agriculture. Public transport is orientated toward the City and inter-village communication by this means is not at all times possible. These matters need to be borne in mind in considering the health services in the area.

That mains water is now available throughout the County area is a fine tribute to the endeavours of the rural district councils. The Government has now determined that some reorganisation of water undertakings as suggested in the Spens Report should be effected. Though the logic of some rationalisation of the country's water supplies is not in question some sympathy must lie with those who having striven hard for the improvement of the environment are shortly to be severed from the fruits of their labours.

Vigorous action is taking place in all three rural districts to bring main drainage to the county villages although it will take many years and several million pounds before all the larger villages are completely sewered. In the Chesterton Rural District the schemes for Little Shelford and Stapleford are nearing completion while that for Cottenham is making satisfactory progress. A scheme of priorities was presented to the Council who agreed the spending of over £1,000,000 on sewering the larger villages over the next ten years.

In the Newmarket Rural District area work for the sewering of Burwell and Fordham was started and plans were in the process of preparation for the villages of Dullingham, the remaining part of Stetchworth, Swaffham Prior, Swaffham Bulbeck and Reach.

The sewering of Gamlingay in the South Cambridgeshire Rural District was completed during the year and work was commenced in Meldreth. Schemes are in the immediate course of preparation for Litlington, Bassingbourn and Balsham and for the construction of a modern sewage works at Sawston.

The housing programme of the District Councils continued with special emphasis on slum clearance and provision for the aged. Again, a high proportion of the houses built in the rural area were bungalows and during the year old persons units in Sawston and Linton were completed, and one started in Soham. These were generally on the pattern pioneered by Chesterton Rural District Council in Histon of a number of houses grouped communally under the care of a warden who has a duty to keep a friendly eye on the old people and help them when required.

It has been customary in the past for this report to deal with general policy in the administrative county and all services directly administered, leaving the City Medical Officer of Health to report upon the activities of those health services voluntarily delegated but now the subject of a formal scheme of delegation since October 1st. This practice is continued and the Principal School Medical Officer's report and the City Medical Officer of Health's report should be read in conjunction with this report.

NATIONAL HEALTH SERVICE ACT, 1946

Section 21 Health Centres.

22 Care of Mothers and Young Children

Report on Nursing Services

23 Midwives Service.

24 Health Visiting

25 Home Nursing

26 Vaccination and Immunisation

27 Ambulance Service

28 Prevention of Illness, Care and After-Care

29 Home Help Service

Mental Health Service

SECTION 21. HEALTH CENTRES

No demand for Health Centres in Cambridgeshire has ever been made nor has the need been made apparent, consequently no serious consideration has been given to their provision.

The City is the centre of the hospital, dental and pharmaceutical services of the area whilst in the rural area the fact that the majority of public transport radiates to and from the City brings the facilities not available locally within reach of the population.

In considering sections 22 *to* 25 *of the National Health Service Act* 1946, *it should be understood that in the City a separate service is operated and consists of* 13 *Health Visitors*, 12 *Home Nurses*, 6 *Midwives.*

In the rural area where there are no centres of population greater than 5,000 *it has been found that a service based in the main on the generalised pattern is the most suitable. Details of the development and establishment of the nursing services in the rural area will be found in the report on page* 18.

SECTION 22. CARE OF MOTHERS AND YOUNG CHILDREN

Clinics and Treatment Centres

The combined ante- and post-natal clinic in the City continues to operate but now meets once per month instead of weekly; no equivalent arrangement exists in the rural area. Approximately two thirds of the confinements in the rural area take place in hospital where the mothers are covered by the clinic facilities at the hospitals in addition to general practitioner and health visitor supervision; of the remainder almost all are booked with their general practitioner who attends them ante- and post-natally and in these arrangements the health visitors and midwives participate.

A notable addition to clinic facilities in the City will be the new accommodation to be provided for health purposes in the building of the community centre on the extensive Arbury Road Estate.

Ten infant welfare centres continue to function in the City and 34 in the rural area, one less than in 1959 since the Elsworth Centre has now moved to Swavesey Village College where much more satisfactory facilities are available. Transport continues to be provided to and from the centres in the rural area and further equipment such as screens has been provided at several centres. At the time of writing a scheme for the provision of sterile disposable syringes for immunisation procedures, long carried out at many of the infant welfare centres, is being introduced.

In October 1960 the infant welfare centre held for many years at Coton was transferred to Comberton Village College. With the shortage of nursing staff and the increasing demands on their time by the ever developing community services it is important that the nurses' time should not be used uneconomically; some concentration of clinics is therefore inevitable. On the credit side of such a policy is the possibility in some areas of being able to arrange for two nurses to attend the busier clinics, thus enabling more health education to be carried out. There is also the very considerable advantage of the clinics being held in accommodation more in keeping with their purpose.

Once again it is a pleasure to record my gratitude to the voluntary personnel of the centres and to the medical officers concerned for their enthusiasm and assistance. Facilities are now provided in five village colleges for infant welfare clinics. The department is grateful to the County Education Officer and to the Governors and Wardens concerned for permitting these arrangements.

The following tables give details of the locations of the clinics in the City and the rural area and an account of the work done:—

TABLE 1

CITY ANTE-NATAL and POST-NATAL CLINIC
(held at Auckland Road Clinic 1st Friday in month, p.m.)

	Number of premises in use at end of year	Average number of combined Medical Officers and Midwives sessions held per month during year	Number of women in attendance		Total number of attendances during the year
			Number of women who attended during the year	Number of new cases included in col. 3	
(a) For ante-natal examination	1	1	68	66	89
(b) For post-natal examination			2	1	2

TABLE 2

CITY INFANT WELFARE CLINICS

Clinic		Day and Time Held	
Arbury Road	I.W.C.	Monday	p.m.
Arbury Road	I.W.C.	Tuesday	a.m.
Auckland Road	I.W.C.	Tuesday	p.m.
Auckland Road	Todd.	Friday (3 times a month)	p.m.
Castle Street	I.W.C.	Tuesday	a.m.
Castle Street	I.W.C.	Tuesday	p.m.
Cherryhinton	I.W.C.	Monday	p.m.
Cherryhinton	Todd.	Thursday (once Monthly)	a.m.
Cherryhinton	I.W.C.	Thursday	p.m.
Chesterton	I.W.C.	Thursday	p.m.
Chesterton	Todd.	Friday (once Monthly)	p.m.
East Barnwell	I.W.C.	Tuesday	p.m.
Newnham	I.W.C.	Wednesday	p.m.
Norwich Street	I.W.C.	Wednesday	a.m.
Romsey	Todd.	Monday	p.m.
Romsey	I.W.C.	Wednesday	p.m.
Romsey	I.W.C.	Thursday	a.m.
Trumpington	I.W.C.	1st & 3rd Monday in Month	p.m.

TABLE 3

CITY INFANT WELFARE CENTRE ATTENDANCES

Number of centres provided at end of year	Number of Child Welfare sessions held per month at centres in col. 1	Number of children who first attended a centre of this Local Health Authority during the year, and who at their first attendance were under 1 year of age	Number of children who attended during the year and who were born in:			Total number of children who attended during the year	Number of attendances during the year made by children who at the date of attendance were:			Total attendances during the year
			1960	1959	1958-55		Under 1 year	1 but under 2	2 but under 5	
10	60	1121	1086	947	1389	3422	16776	3806	2656	23238

TABLE 4

RURAL AREA INFANT WELFARE CENTRES

Week	Monday	Tuesday	Wednesday	Thursday	Friday
1st			Cheveley Wicken	Bassingbourn V.C. Dullingham Gt. Wilbraham Harston Swavesey	Isleham Melbourn
2nd	Bassingbourn R.A.F. Gt. Shelford	Burwell Soham	Cottenham	Castle Camps Waterbeach Willingham	
3rd		Bottisham Comberton Fulbourn		Chippenham Foxton Balsham Bassingbourn V.C. Duxford Gamlingay	Fordham Linton Melbourn
4th	Bassingbourn R.A.F. Great Shelford	Fowlmere (always last week) Soham	Bourn (always last week)	Gt. Abington (always last week) Longstanton Swavesey	
			Histon* Girton† Sawston†	Steeple Morden‡	

* Every four weeks with effect from Wednesday, 8th March, 1961.

† Every two weeks with effect from Wednesday, 29th March, 1961.

‡ Every two weeks with effect from Thursday, 30th March, 1961.

TABLE 5

INFANT WELFARE CENTRES—RURAL AREA

CENTRES	No. of Child Welfare sessions held per month at centres in col. (1)	No. of children who first attended a centre of this L.H.A. during the year, and who at their first attendance were under 1 year of age	No. of children who attended during the year and who were born in:			Total No. of children who attended during year	No. of attendances during the year made by children who at the date of attendance were:			Total Attendances during the year
			1960	1959	1958-55		Under 1 year	1 but under 2	2 but under 5	
Balsham	1	30	24	23	28	75	187	40	68	295
Bassingbourn	2	81	57	29	30	116	487	105	120	712
Bottisham	1	31	26	16	4	46	163	25	7	195
Bourn	1	34	30	28	43	101	170	115	144	429
Burwell	1	74	39	41	14	94	380	179	79	638
Castle Camps	1	16	14	10	20	44	66	52	33	151
Cheveley	1	32	27	16	24	67	168	60	58	286
Chippenham	1	5	5	6	11	22	52	30	29	111
Comberton	1	36	32	19	26	77	112	60	69	241
Cottenham	1	22	20	16	30	66	125	107	93	325
Dullingham	1	16	15	11	12	38	115	54	136	305
Duxford	1	46	34	50	33	117	223	271	135	629
Fordham	1	8	8	14	11	33	132	38	49	219
Fowlmere	1	18	16	13	26	55	106	51	116	273
Foxton	1	24	24	20	45	89	192	71	158	421
Fulbourn	1	41	37	22	11	70	141	131	35	307
Gamlingay	1	18	18	18	17	53	87	22	31	140
Girton	2	59	50	29	43	122	211	146	115	472
Gt. Abington	1	20	16	13	35	64	86	33	97	216
Gt. Shelford	2	120	100	91	58	249	1137	252	95	1484
Gt. Wilbraham	1	11	8	13	14	35	56	22	19	97
Harston	1	57	26	45	34	105	231	128	86	445
Histon	1	54	38	47	98	183	288	151	253	692
Isleham	1	14	13	17	5	35	109	39	6	154
Linton	1	31	31	23	36	90	186	47	39	272
Longstanton	1	11	10	13	8	31	84	33	11	128
Melbourn	2	56	47	44	51	142	376	166	260	802
Sawston	2	61	55	60	90	205	892	517	472	1881
Soham	2	57	44	28	30	102	426	182	43	651
Steeple Morden	2	29	23	27	50	100	221	43	91	355
Swavesey	1	27	20	29	23	72	176	71	41	288
Waterbeach	1	50	42	50	22	114	330	87	53	470
Wicken	1	5	5	9	13	27	61	68	56	185
Willingham	1	17	17	16	17	50	135	52	40	227
TOTALS	41	1211	971	906	1012	2889	7921	3448	3137	14506

Premature Infants

The following tables give particulars of premature births in the Administrative County.

It will be noted that two premature births are recorded as having taken place in nursing homes whereas there were none in 1959.

The total number of premature live births, 155, represents a rate of 49.3 per 1000 live births as against a rate of 60.2 for 1959.

TABLE 6
PREMATURE INFANTS—CITY

Weight at birth	Premature Live Births															Premature Still-births		
	Born in Hospital‡			Born at home and nursed entirely at home			Born at home and transferred to hospital on or before 28th day			Born in nursing home and nursed entirely there			Born in nursing home and transferred to hospital on or before 28th day			Born in hospital	Born at home	Born in nursing home
	Total	Died within 24 hrs. of birth	Survived 28 days	Total	Died within 24 hrs. of birth	Survived 28 days	Total	Died within 24 hrs. of birth	Survived 28 days	Total	Died within 24 hrs. of birth	Survived 28 days	Total	Died within 24 hrs. of birth	Survived 28 days			
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)
(a) 3 lb. 4 oz. or less (1,500 gms. or less)	10	4	4	—	—	—	—	—	—	—	—	—	—	—	—	5	—	—
(b) Over 3 lb. 4 oz. up to and including 4 lb. 6 oz. (1,500-2,000 gms.)	16	1	14	—	—	—	1	—	1	—	—	—	1	—	1	2	—	—
(c) Over 4 lb. 6 oz. up to and including 4 lb. 15 oz. (2,000-2,250 gms.)	13	—	11	1	—	1	—	—	—	—	—	—	—	—	—	—	—	—
(d) Over 4 lb. 15 oz. up to and including 5 lb. 8 oz. (2,250-2,500 gms.)	28	—	28	9	—	9	1	—	1	1	—	1	—	—	—	—	—	—
Totals	67	5	57	10	—	10	2	—	2	1	—	1	1	—	1	7	—	—

‡ The group under this heading will include cases which may be born in one hospital and transferred to another.

TABLE 6A
PREMATURE INFANTS—RURAL AREA

Weight at birth	Premature Live Births															Premature Still-births		
	Born in Hospital‡			Born at home and nursed entirely at home			Born at home and transferred to hospital on or before 28th day			Born in nursing home and nursed entirely there			Born in nursing home and transferred to hospital on or before 28th day			Born in hospital	Born at home	Born in nursing home
	Total	Died within 24 hrs. of birth	Survived 28 days	Total	Died within 24 hrs. of birth	Survived 28 days	Total	Died within 24 hrs. of birth	Survived 28 days	Total	Died within 24 hrs. of birth	Survived 28 days	Total	Died within 24 hrs. of birth	Survived 28 days			
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)
(a) 3 lb. 4 oz. or less (1,500 gms. or less)	5	3	1	—	—	—	4	2	2	—	—	—	—	—	—	4	—	—
(b) Over 3 lb. 4 oz. up to and including 4 lb. 6 oz. (1,500-2,000 gms.)	5	—	5	1	—	1	—	—	—	—	—	—	—	—	—	2	—	—
(c) Over 4 lb. 6 oz. up to and including 4 lb. 15 oz. (2,000-2,250 gms.)	15	—	15	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
(d) Over 4 lb. 15 oz. up to and including 5 lb. 8 oz. (2,250-2,500 gms.)	32	1	30	10	—	10	2	—	2	—	—	—	—	—	—	4	—	—
Totals	57	4	51	11	—	11	6	2	4	—	—	—	—	—	—	10	—	—

‡ The group under this heading will include cases which may be born in one hospital and transferred to another.

Dental Treatment of Expectant and Nursing Mothers and Young Children

The serious situation which exists in the local authority's dental service with regard to lack of staff continues and it unfortunately remains true that the amount of work which can be undertaken for expectant and nursing mothers and under school age children falls far short of what is desirable. Particularly is it a matter for concern that the number of children under five who have been able to be treated has fallen considerably from the previous year. It is equally serious that more staff time cannot be devoted to dental education and the prevention of dental troubles when the facilities for remedial treatment are so limited.

The editor of the British Dental Journal has kindly agreed to the reproduction of an article written by Mr. Toller, Principal School Dental Officer, and published in that journal on February 7th, 1961.

DENTAL EDUCATION IN RURAL CAMBRIDGESHIRE

In September 1958, we were faced with the problem of over 12,000 children in the rural part of Cambridgeshire for whom there was the equivalent of half a school dentist. The only school dentist for these 12,000 children was, and still is the P.S.D.O. Cambridgeshire, half of whose time is devoted to the excepted district of the City of Cambridge. In effect this was, and still is, a ratio in the rural part of the county of one dentist to 24,000 children. The incidence and amount of dental caries is very high, probably due equally to a very low fluorine content in the water, poor oral hygiene, and bad feeding habits. The demand for dental treatment was low. All the majority require of dentists is an efficient toothache service. In the southern half of the county during the years 1953 to 1958 the number of children whose mouths showed regular dental care by private practitioners never exceeded 12 per cent and the number accepting the school dentist's offer of treatment—on their own doorsteps, as it were, in a mobile dental clinic—never exceeded 32 per cent of those to whom it was offered, even when every child needing it who was not obviously cared for by a private practitioner was offered it. No effort was made to stimulate a demand for treatment since even at that time the dentist/children ratio was 1 to 6,000 and the local private practitioners were fully occupied. Moreover, by rationing themselves the potential patients saved the school dentist an unpleasant task and ensured for those whoreally cared regular inspection and treatment.

Assault on Toleration of Dental Disease

Not only was treatment not sought by the majority but they were making no effort to prevent the need for it. Since so little treatment could be done and the total need for it was obviously increasing, it was decided to try to prevent some of it. A massive assault was therefore made on the apathetic toleration of dental disease, to the limit of our resources. We were aware that pressures outside local control were operating to increase dental disease much more potent than any local pressure could be.

In September 1958, all head teachers in the rural part of the county were sent a letter to acquaint them with the state of their School Dental Service. With the co-operation of the Local Dental Committee every dentist in the county and peripheral areas was sent a copy. In October 1958, the M.O.H. of the three rural districts in the county responsible for the water supplies in the rural part of the county, brought to his Councils' notice the low fluorine content of their water. As a result letters were sent from each Council to the Ministry of Health urging permission to fluoridate their water as soon as possible. Dr. Tyser, the M.O.H. of these rural districts then, is now the M.O.H. and P.S.M.O. of Cambridgeshire.

In March 1959, through the Local Dental Committee the co-operation of N.H.S. dentists was requested in the treatment of children. At this time the first annual report of the P.S.D.O., embodied in that of the P.S.M.O., was presented to the Education Committee. It explained why it was thought unlikely that there would be any increase of the dental staff.

In January 1960, a memorandum was prepared for presentation to the Education Committee which was received, discussed, and reported in the local Press. As a result, the P.S.D.O. was given positive directions. In September 1960, a booklet, " Dental Health," produced in the county's Press, was distributed to every teacher (more than 500) in the rural part of the county. A month later every child (over 12,000) received a leaflet, produced in the county's Press, of information and advice to take home and addressed to the parents. It is intended to follow this, after an interval, with the distribution to schools and teachers of the posters, booklets and leaflets kindly supplied by the Oral Hygiene Service.

What result this bombardment with paper will have remains to be seen. We are well aware that while the imparting of facts is easy the alteration of habits as a result of knowing facts does not readily follow. This bridge is in fact very difficult to cross. A local climate of opinion, however, is being formed and its emergence is apparent.

Co-operation of Teachers Necessary

It was thought to be of the utmost importance to acquaint the L.E.A. with the facts before proceeding to the dental education of teachers which in turn is necessary before any approach can be usefully made to parents or children. The dental education of the minority of teachers in need of it is the most difficult task of all. It must be done without losing their co-operation, for without it school dentists are disarmed. Indeed it is to win their co-operation in the subsequent dental education of parents and children that it is necessary to educate the teachers in dental health. It is felt to be a waste of time approaching parents and children unless a united front of the authority, its teachers and its dentists is achieved.

While one thing is done and another said, we risk, indeed deserve, the contempt of parents and children. The parents it is thought most important to approach are those of ten years hence, eight out of ten of whom are now in secondary modern schools. I have stated elsewhere that teachers would do well to settle the tuck shop question among themselves as an internal professional matter. "Teaching is the most important of all the professions and one of the least esteemed. Here is a way for them to earn some respect from the many who have yet to learn that teachers are worthy of our highest respect." Dentists too, have little public esteem to lose and much to gain. By their effort to prevent some of the disease by the repair of which they earn their living they may, too, incidentally, repair some of their dis-esteem and gain some public esteem for their profession and their work.

It is necessary to add that even a modest effort such as this can only be attempted with a unity of purpose and the co-operation of the education, medical and dental officers.

The problem in the City of Cambridge, on account of its long tradition of dental care, is different from that in the rural part of the county but the City is receiving no less attention.

The following tables give an account of the work it has been possible to accomplish during the year:—

TABLE 7

DENTAL TREATMENT

A. NUMBERS PROVIDED WITH DENTAL CARE

	Examined	Needing Treatment	Treated	Made Dentally Fit
Expectant and Nursing Mothers	64	63	60	55
Children under Five	173	151	128	118

B. FORMS OF DENTAL TREATMENT PROVIDED

	Scalings and Gum Treatment	Fillings	Silver Nitrate Treatment	Crowns or Inlays	Extractions	General Anaesthetics	Dentures provided		Radiographs
							Full Upper or Lower	Partial Upper or Lower	
Expectant and Nursing Mothers	11	80	—	2	120	21	20	17	6
Children under Five	—	111	89	—	62	18	—	—	—

Distribution of Welfare Foods

The distribution of welfare foods continues to be carried out at infant welfare centres in the City and most of the centres in the rural area. In the rural area there are also some 40 other points, including shops and private houses, from which the foods may be obtained. I would once again record my thanks to the volunteers who help in the distribution, often at inconvenience to themselves.

The main point for the distribution of welfare foods remains at the Old Post Office in the City of Cambridge. As well as the distribution, the bulk of the administrative work is also carried out there. Until the 1st October, the date of the delegation of certain health and welfare functions to the City, the officers concerned had been on the staff of the County Council. It had not been felt reasonable to establish separate arrangements for the distribution of welfare foods in the City with consequent duplication of staff. It was agreed after consultation that the City Council would become responsible for the work in the whole of the Administrative County as had been the County Council until that date. The day to day administration remains unchanged.

The following table gives details of the foods issued in 1960 together with those of 1959 for comparison:—

TABLE 8
WELFARE FOODS

	Total issued		Issued at Old Post Office	
	1959	1960	1959	1960
National Dried Milk (Tins)	27,077	21,535	13,835	10,490
Cod Liver Oil (Bottles)	11,783	11,433	5,013	4,857
A. and D. Tablets (Packets)	10,661	11,347	7,019	7,381
Orange Juice (Bottles)	98,706	96,817	52,655	49,893

Day Nurseries and Nurseries & Child Minders Regulation Act, 1948

The following table sets out the attendances at the single Day Nursery provided by the Authority in the City of Cambridge:—

TABLE 9
DAY NURSERIES

Number of approved places		Number of children on register at end of year		Average daily attendance during year	
Under 2	2–5	Under 2	2–5	Under 2	2–5
14	26 F.T. 3 P.T.	15	32	12	25 F.T. 1 P.T.

(F.T.—Full-time; P.T.—Part-time)

As in previous years no financial assistance towards the operation of other nurseries or to daily minders has been given. At the end of the year, in the Administrative County, 12 nurseries provided for 174 children and 6 daily minders provided for a total of 46 children.

Care of the Unmarried Mother

The arrangements for the care of the unmarried mother and her child are carried out on agency basis by the Ely Diocesan Association, who also maintain a mother and baby home in the City, and by the Cambridge Association for Social Welfare to whom an annual grant of £225 is made. The Ely Diocesan Association employ an " Organising Secretary " who also performs a considerable amount of social work in the rural area but undertakes no duties in connection with adoption, this function being carried out by another social worker employed by the Association; in the City the Cambridge Association for Social Welfare performs both duties.

Grants were made towards the cost of maintenance in mother and baby homes in respect of 8 unmarried mothers, 6 less than in the previous year.

SECTIONS 23, 24 and 25.

Report on the Nursing Services in the Rural Area

In March, the Health Committee considered a comprehensive report on the staffing of the nursing services, an abridged copy of which follows:—

" This report is a review of the past and present needs regarding domiciliary nursing services in the rural area of the County. Some historical background is provided in order to facilitate understanding of the arrangements in force at present and to determine the future pattern of the services.

This year, District Nursing as such celebrates its centenary and is the oldest (*in its present form*) of the domiciliary services. Attendance at childbirth, although older in time, was not the province of the trained woman until after the turn of the century and it took the Midwives Act of 1902 to prescribe rules for the training, registration and supervision of midwives. Health Visiting, the infant of the trio, had its origins even later, beginning as a voluntary movement in Salford where public spirited men and women, concerned at the enormous wastage of child life, sought means to check it.

It was not until 1918, however, that central government took positive action and laid down rules and regulations for the training of Health Visitors. Two of the most important dates in the history of the domiciliary services are 1936 and 1948.

The year 1936 saw the abolition of the handywoman as an attendant at childbirth. Although many of these women were excellent in the practice of their craft, many were not. No training had been given and they relied for their knowledge on what they saw and learned as they went along. There was no antenatal or postnatal care as we know it to-day and both maternal and infant mortality and morbidity were high. The necessity to supply a trained midwife for attendance at every home confinement had far reaching repercussions on the district nursing service also. Until then, large areas of the country, mostly rural, had not had the services of trained district nurses. It appeared that the best way of meeting this new legislation was to set up, where these did not already exist, nursing associations which would be responsible for engaging and paying a trained nurse/midwife capable of coping with sickness and childbirth alike. This system was followed, with variations, until the inception of the National Health Service Act in 1948.

Health Visiting had, meanwhile, not been standing still. Commencing as it did solely with the care of the mother and child, observant people quickly saw the shortcomings of the service and care was extended to the school child in the form of hygiene inspections, attendance at medical inspections, home visits of instruction to mothers and, in urban areas, attendance at minor ailment, sunlight, orthopaedic and other special clinics. Side by side with this came the recognition of similar measures with regard to the spread of tuberculosis and the need to educate the public in methods of prevention. The responsibility for the health visiting service unlike that of nursing and midwifery was placed fairly and squarely on the local authorities. Some authorities, particularly those in the rural areas, delegated their responsibilities in this direction to the nursing associations and this brought into being the all purpose or generalised worker undertaking all three services. Municipal authorities on the other hand tended to run the service separately from that of nursing and midwifery, with a staff of women trained and used only as health visitors.

On July 5th, 1948, the National Health Service Act came into operation and brought an entirely new face to the domiciliary services. Local authorities were themselves to be responsible for providing, either directly or by delegation, the nursing and midwifery services as well as the health visiting service. Health Visiting was to be expanded to cover the entire family field of health problems. Regional Hospital Boards were to provide more midwifery beds and midwives were placed under certain new obligations in the domiciliary field with regard to medical practitioners and the practice of midwifery. Conditions under which nurses had so long worked were reviewed and sweeping changes recommended. Local authorities were given more freedom to design and develop their services according to the need of their areas and this has led to a wide and varied deployment of staff, vastly different from the somewhat rigid pattern previously followed.

Three examples of the commoner patterns of service are given below:—

(1) **The Separate or Divided Service** applicable to urban areas where home nurses, midwives and health visitors are all employed full time and strictly within their own speciality.

(a) Each **Home Nurse** is considered capable of coping with approximately 6000 population depending upon the age and type of this population. But this figure must be regarded as purely provisional.

(b) The case load per **Midwife** under these circumstances is reckoned to be not more than 66 deliveries per annum. This may not sound very onerous but it must be remembered that the present tendency is to discharge mothers and babies from hospital very early after delivery so that their continuing care devolves upon the midwife. Ante and post natal care have both been greatly intensified and added to this, in most urban areas and, wherever possible, in rural areas also, mothercraft, parentcraft and relaxation classes consume a fair proportion of the midwife's time.

(c) Each **Health Visitor** in the past was held to be capable of coping with the requirements of some 6000 population for maternity and child welfare, schools and tuberculosis. A recent Ministry of Health Circular (26/59), however, issued as a result of the Working Party Report on Health Visiting, states that if the all purpose health visitor is to cover adequately all the branches of her work, then her population should not exceed 4,300. Two of the main factors responsible for this recommendation are:—

(1) The provisions relating to Mental Health.

(2) The increasing number of old people within the population.

Over all is the wider sphere of activity resulting from the expansion envisaged by the 1946 Act. Prior to this Act, health visitors were concerned only with four clearly defined groups—the expectant mother, the child under five years, the school child, and the tuberculous. Under the 1946 Act, she became the general purpose, or family social worker and it is difficult to-day to imagine any circumstance of ill fortune, ill health or maladjustment that does not and could not at some point concern the health visitor. It should also be mentioned that policy to-day encourages domiciliary workers to keep in close touch with hospitals and ideally both midwife, home nurse and, where appropriate, the health visitor should be in contact with their patients in hospital. The establishment and maintenance of such relationships requires time to be effective but its effect on the quality of the service provided cannot be questioned. It is also to be realised that it is a matter of agreed medical policy that the health visitor should work more and more closely with the general practitioner, supporting and assisting him in his work with her specialised socio-medical knowledge.

(2) **The Combined Service.** In this type of service seen mostly in rural and small urban areas, the work is so arranged as to combine midwifery with sick nursing, each nurse having a population figure of about 3,000 to 3,500. Health visiting is undertaken separately. This is an arrangement that has become increasingly used and is perhaps the most popular and easy to maintain having regard to present day problems of staff and work.

(3) **The Generalised Service**, used exclusively in rural areas. Here one nurse provides all three services of sick nursing, midwifery and health visiting for a population of approximately 2,300. It is perhaps the most integrated of all the three types of service. Unfortunately, firstly owing to the general shortage of nurses and, secondly, that, of the nurses available, many are reluctant to undergo further extensive training, great difficulty is occasioned in trying to obtain suitably qualified women, or women who are prepared to train to the required standard, in order to fill posts. Variations of all sorts have thus become the rule rather than the exception.

The merits and demerits of each particular type of service have to be carefully considered in a County such as this, presenting as it does conditions to which no one service is at all times applicable. Although in the main the generalised system can be said to be the most suitable, some variation must be an accepted factor if the service is not to suffer. This point will be referred to again later in the conclusion of this report.

At this point, some idea of the varying types of nurse and the training relating to each type seems to be indicated.

State Certified Midwife/State Enrolled Assistant Nurse (SCM/SEAN).

Prior to 1936, it was common practice for nursing associations to send selected women for a two year period of training as village nurse midwives. This meant full midwifery but not full general training. Success in their examination entitled them to enrolment on the State Register of Midwives (SCM.). The period of general training though less than that of the nurse undergoing full general training was, however, of a standard which qualified them for enrolment on the State Roll for Assistant Nurses (SEAN.). This type of training has now ceased but many of the women so trained are still with us, show a strong sense of vocation, and perform excellent work.

State Registered Nurse (SRN.)

This is to-day the basic training for a nurse. It lasts three years and can only be taken in hospitals approved by the General Nursing Council of England and Wales. Registration is only by passing the prescribed examination.

State Certified Midwife (SCM.)

This training to-day lasts one year but is divided into Parts I and II. Part I is taken wholly in a Maternity Hospital. Part II may be partly hospital and partly domiciliary or wholly domiciliary but it must not be wholly hospital. Part I is designed to give to women making their careers in other spheres of nursing (but who do not wish to practise as midwives) a knowledge of midwifery. Part II, taken after Part I, is designed to fill the requirements of the nurse who will later practise as a midwife. Only the woman who has taken both parts of the training and passed both examinations may use the title ' State Certified Midwife ' and act as such.

Health Visitor (HVCert.)

This course of training lasts an academic year and is based on either a University or Technical College. The whole aim of this training is towards preventive rather than curative techniques and it is to be noted that the syllabus to-day deals much more widely than at any time previously with mental health and the social ills of our times. In the more progressive training course, great attention is given to case work on lines similar to social science courses. Indeed, many health visitors later take a Diploma in Social Science. Nurses wishing to train as health visitors must be general trained and State Registered. In addition, they must also have at least Part I of the Midwifery Certificate.

Queen's District Training (QN.)

Hospital training does not in itself provide experience in coping with sickness in the home, nor of the social problems that may be met there. Queen's district training sets out to remedy this omission and teaches firstly the way in which hospital methods and techniques may be adapted to ordinary homes where the facilities of the hospital do not exist and, secondly, what other social agencies may be brought in to assist when there is need of their help. This training lasts six months for the nurse who is State Registered and four months for the nurse who besides being State Registered is also a State Certified Midwife.

The advantages of having nurses trained properly in domiciliary nursing techniques are obvious and important.

The general policy of this County in the past has been to use in the main, the generalised system of service " (*The report then went on to give examples of different types of service applicable to the rural population and the number of nurses required. The Council reaffirmed its policy of basing the service on the generalised system*).

" Recruitment

Shortage of nurses is nation wide and recruitment of necessary and suitable staff is proving extremely difficult. Advertisements in the nursing and lay press are particularly disappointing, often failing, despite repeated appearances, to bring in a single application. The two most fruitful fields of recruitment have been, firstly the County's scheme of granting bursaries to selected applicants for further training as Health Visitor/Queen's Nurses, secondly, the personal contact of the County Nursing Officer with local hospitals whereby the interest of freshly trained nurses who have not yet decided on the sphere of their future activities is, in some instances, directed to the domiciliary field.

Forty nurses are employed in the following capacities:—

Generalised.	*Combined.*	*Separate.*	*Relief.*	*Schools.*	*Health Visiting.*
20	4	2	8	2	4

Of these forty, only thirty-two are on the permanent staff and five of the remaining eight are part-time. Of the eight relief staff only two are midwives and one of these leaves in March. The remainder are all married women and none is qualified to undertake midwifery or health visiting. This places a heavy burden on the remaining qualified staff. The number of such staff is, at the moment, so depleted, as to provide only a token service in some areas.

At present, group relief is possible only in one area and that for general nursing only. This means in effect that each nurse has to relieve her colleague for off duty to the extent of one-and-a-half days per week. By covering two areas she is, therefore, to all intents and purposes nullifying her own off-duty.

As a result of vacancies, four nurses and two Health Visitors are already coping with double areas. Their periodic absences for holidays, refresher courses, and off-duty gives rise to a dangerously low nursing coverage on these areas.

Properly trained adequate relief staff in the proportion of one to each four nurses is, as will be seen, a real necessity.

In profile, of the more highly trained staff, fourteen are qualified health visitors, four work in this capacity full-time and the remaining ten on generalised areas. Eighteen, including nine of the foregoing health visitors, are Queen's nurses. Ten nurses practise as health visitors by virtue of Ministry dispensation. Eleven health visitors and eleven Queen's nurses each took this training by means of bursaries awarded by this Authority. Five further students are now away taking additional training, three as health visitor/Queen's nurses and two, who are already Queen's nurses, as health visitors.

Conclusions

In the foregoing report an attempt has been made to review the development of the rural area domiciliary nursing service and to illustrate how the needs of the area may be covered in different ways. It is believed that no such comprehensive review has been made before and this may account for the fact that the present establishment of nurses, midwives and health visitors is complicated and difficult to interpret.

Firstly it is necessary to determine which method shall be employed to meet statutory requirements and it is obvious that the generalised scheme is the most economical of manpower but has the disadvantage of lacking manoeuvrability. Although one of us (P.A.T.) was originally a strong advocate of a separate health visiting service, it is now our joint opinion that the generalised service is, in the main, the most realistic for the area under review. Areas where this is not the ideal service are those more highly urbanised and where it is an advantage to retain some whole time health visitors, plus specialist health visitors, for particular work, e.g. early ascertainment of deafness, problem families etc.

Secondly it is necessary to consider the question of recruitment to our service. There is no doubt that the Bursary Scheme on the one hand and the County Nursing Officer's contact with Addenbrooke's, and other hospitals in the area, on the other, have done much to save the day. The programme for building nurses' houses and the help given by the rural districts have both contributed in helping to recruit staff.

There is one further item which might assist recruitment and that is the question of concessionary mileage. Examination of schemes in other counties shows no fixed pattern; we are generous in making no stricture on the use of the cars provided by the Council but we also charge more highly for private mileage. 5d. per mile for a Ford Popular is expensive in terms, for example, of a nurse working at Soham and coming into Cambridge privately, the round trip will cost her nearly 20/-. Her colleague in Shelford is more fortunately placed in this respect. We must realise that there is no other town offering the attraction of Cambridge and in recruiting nurses, no doubt they consider the question of access to this important and attractive centre. Practically all new members of staff request to be based on Cambridge and it is suggested that a sliding scale of concessionary monthly mileage might be introduced.

S. MEE
County Nursing Officer.

P. A. TYSER
County Medical Officer".

(February, 1960).

The Health Committee on consideration of this report affirmed their policy of basing the Service in the main on a generalised system and recommended that in addition to the Council's existing scheme of bursaries for training and the provision of good housing that (a) the establishment of nurses should be gradually increased and (b) that each nurse living in a rural area using a County Council car should be allowed a weekly free journey to Cambridge or some other shopping centre, providing the mileage is not greater than that to Cambridge. During the year both these suggestions were adopted by the County Council.

Staff as at 31st December, 1960 (including part-time personnel)

County Nursing Officer	1
Deputy County Nursing Officer (also undertaking relief)	1
Health Visitors	4
District Nurse/Midwife/Health Visitors	20
District Nurse/Midwives	6
Midwives	1
District Nurses	8
School Nurses	2

Vacancies (full-time equivalent)

Health Visitors	1
District Nurse/Midwife/Health Visitors	4

Resignations (including temporary part-time)		7
Retired	2	
For marriage	1	
Domestic reasons	1	
Other work	3	
Appointments (including temporary part-time)		8

Staff shortages more especially on the midwifery side have, from time to time, given rise to anxiety, and without the help of married nurses (temporary part-time and full-time), it would not have been possible to maintain the service.

Staff Education

During the year, Maternity Liaison Committees were set up in the areas based on Addenbrooke's Hospital and Newmarket General Hospital. A representative of the midwives practising in the area of each committee attends meetings and by this means a much closer link has already been forged between the three participating elements of the National Health Service, viz., general practitioners, hospital and local authority staffs. One direct result was an afternoon lecture course which all midwives attended at the Maternity Hospital, Cambridge, on cortico-steroids, the use of routine synkavit and other new drugs and finally on the cold syndrome, its recognition and treatment.

Staff meetings with lectures and discussions continued to be held at intervals throughout the year and at one of them a lecture and demonstration on relaxation was given by a physiotherapist from Addenbrooke's Hospital.

A group of four health visitors dealing with problem families attended a course on Family Psychiatry at Ipswich in May and it is hoped to follow this with a second group next year.

Thanks to Miss Puddicombe, the Matron, arrangements were made for eight district nurses to spend a week at Addenbrooke's Hospital during which time they were able to observe new treatments and take part in new nursing techniques. The scheme was a great success and already requests have been received from other nurses on the staff anxious to be included in the next group.

Attendance at statutory refresher courses for midwives and health visitors continued in the usual way, five midwives attending the former and two health visitors the latter.

Arrangements were made for student nurses from both training hospitals in the area to spend a day accompanying the district nurse/midwife/health visitor on her rounds, followed by a discussion at which the County Nursing Officer was present.

Lectures are also given at Addenbrooke's Hospital on the domiciliray nursing services by the County Nursing Officer.

During the year, four nurses returned from taking further training, two as Health Visitor/Queen's Nurses and two, who were already Queen's trained, as Health Visitors. A fifth nurse was seconded for Health Visitor training. Three observers from abroad spent varying periods in the department, and it was a pleasure to welcome two Sister Tutors newly appointed to the teaching staff of Addenbrooke's Hospital.

Housing

The programme of building houses for nurses contniues to progress. Two houses reached completion (at Soham) and sites for two others were purchased (Shelford and Oakington). Because of the difficulty in obtaining land for nurses' houses, a plot which gives a larger garden than a nurse can reasonably be expected to cultivate often has to be accepted. Generally the gardens are put down to grass and during the year a scheme of maintenance was evolved for the larger gardens which is working satisfactorily.

Local Maternity Liaison Committees

Following Ministry of Health Circular 12/59 local maternity liaison committees have been established to cover the areas served by the Cambridge Maternity Hospital and the Newmarket, Ely and Saffron Walden areas.

The inaugural meeting of the liasion committee for Newmarket, Ely and Saffron Walden was held in January: an inaugural meeting was held in April at Addenbrooke's Hospital to consider the formation of a committee for the area served by the Cambridge Maternity Hospital.

Representation on the laision committees is drawn from the consultant obstetricians, general practitioners, medical officers of health and midwives, domiciliary and institutional.

Both committees meet approximately quarterly and whilst they have only been in existence for a short time, I feel much good has resulted from their discussions and conclusions, not least of which is the appreciation by the constituent members of each others' difficulties. Following discussions, a systematic form of co-operation has now been established in connection with the selection of patients on social grounds for hospital confinements, and for the care of early discharges.

The work of the nurses under the categories of midwifery, health visiting and home nursing is shown in tables 10 to 12A.

With regard to **midwifery,** there is more work than the service can manage in view of the shortage of midwives. **Home nursing** continues to increase and this is not surprising in view of the growing number of old people requiring attention; as is shown in table 12 more than 25% of patients attended were over 65 years of age. These two services are now well accepted as part of the domiciliary services and for the most part work under the day to day direction of the general practitioners.

Since there appears, from time to time, to be misunderstanding as to the purpose of the **health visiting** service, the following brief outline may serve to dispel doubts as to its precise function.

There is an increasing demand for social and socio-medical work in the community, some aspects of which require specialist knowledge, others common sense and willingness to help a ' lame duck '. The health visitor has been performing many different types of social work for more than 50 years and it is to be remembered that the present day interpretation of her duties under the National Health Service Act is that she is responsible for the care of the health of the family. She has the privileged entry to the family in the ante-natal period and her care of the mother and young baby, school child, and grand parents gives her a very wide acquaintance with the social problems of her parish. She is the natural counterpart of the family physician, the family social worker, calling upon her specialist colleagues for assistance as and when necessary, as does the doctor his specialist colleagues. In the face of the established shortage of social workers of all classes and the unlikely recruitment of anything approaching the numbers believed to be required it seems logical that the social services should be based upon the health visitor who by her training and experience is best fitted to fulfil the duties required of a family social worker. A service based on this concept is, of course, most appropriate in a rural area where the health visiting, home nursing and midwifery services are based on a generalised system, since under these circumstances the opportunities for contacts with social problems are even greater. It is also true that the area covered by the nurses undertaking general duties is often coterminus with that of the family doctor thereby creating the partnership so frequently advocated today as the ideal.

Under the rules of the Central Midwives Board, 94 midwives notified their intention to practise:—

	City	Rural Area
Domiciliary	12	36
Institutional	46	—

TABLE 10

MIDWIFERY SERVICE—CITY

Midwives

	No. of Domiciliary Midwives practising in the area of the Local Supervising Authority at end of year
(a) Midwives employed by the Authority	6 (whole time)
(b) Midwives in Private Practice	1
Total	7

Deliveries Attended by Midwives

	Number of Deliveries Attended by Midwives in the Area During the Year				
	Domiciliary Cases				Totals
	Doctor not booked		Doctor booked		
	Doctor present at time of delivery of child	Doctor not present at time of delivery of child	Doctor present at time of delivery of child (either the booked Dr. or another)	Doctor not present at time of delivery of child	
Midwives employed by Authority	6	142	125	135	408
Midwives in Private Practice	—	—	14	35	49
Totals	6	142	139	170	457

No. of cases delivered in institutions but attended by domiciliary midwives on discharge from institutions and before the fourteenth day — 70.

MEDICAL AID UNDER SECTION 14(1) OF THE MIDWIVES ACT, 1951

Number of cases in which medical aid was summoned during the year under Section 14(1) of the Midwives Act, 1951, by a Midwife, whether a fee was payable by the Local Health Authority or not:—

Domiciliary cases:—

(i) Where the Medical Practitioner had arranged to provide the patient with maternity medical services under the National Health Service—79.

(ii) Others — 1.

ADMINISTRATION OF INHALATIONAL ANALGESICS—DOMICILIARY MIDWIVES

	Number of *domiciliary* midwives practising in the area at end of year who were qualified to administer inhalational analgesics in accordance with the requirements of the Central Midwives Board	Number of sets of apparatus for the administration of inhalational analgesics in use at end of year		Number of cases in which inhalational analgesics were administered by midwives in *domiciliary* practice during the year:				Number of cases in which pethidine was administered by midwives in *domiciliary* practice during the year:	
				When doctor was present at time of delivery of child		When doctor was not present at time of delivery of child			
		Gas and air	"Trilene"	Gas and air	"Trilene"	Gas and air	"Trilene"	When doctor was present at time of delivery of child	When doctor was not present at time of delivery of child
(a) Domiciliary Midwives employed directly by the Local Health Authority	6	6	5	12	113	25	205	91	148
(b) Domiciliary Midwives in private practice or employed by organisations not acting as agents of Local Health Authority	1	—	—	4	2	10	—	9	31
Totals	7	6	5	16	115	35	205	100	179

TABLE 10A

MIDWIFERY SERVICE—RURAL AREA

Midwives

	No. of Domiciliary Midwives practising in the area of the Local Supervising Authority at end of year
(a) Midwives employed by the Authority	27 (part time)
(b) Midwives in Private Practice	—
Total	27

Deliveries Attended by Midwives

	Number of Deliveries Attended by Midwives in the Area During the Year				
	Domiciliary Cases				Totals
	Doctor not booked		Doctor booked		
	Doctor present at time of delivery of child	Doctor not present at time of delivery of child	Doctor present at time of delivery of child (either the booked Dr. or another)	Doctor not present at time of delivery of child	
Midwives employed by Authority	—	1	198	390	589
Midwives in Private Practice	—	—	—	—	—
Totals	—	1	198	390	589

No. of cases delivered in institutions but attended by domiciliary midwives on discharge from institutions and before the fourteenth day — 624.

MEDICAL AID UNDER SECTION 14(1) OF THE MIDWIVES ACT, 1951

Number of cases in which medical aid was summoned during the year under Section 14(1) of the Midwives Act, 1951, by a Midwife, whether a fee was payable by the Local Health Authority or not:—

Domiciliary cases:—

(i) Where the Medical Practitioner had arranged to provide the patient with maternity medical services under the National Health Service — 103.

(ii) Others — Nil.

ADMINISTRATION OF INHALATIONAL ANALGESICS—DOMICILIARY MIDWIVES

	Number of *domiciliary* midwives practising in the area at end of year who were qualified to administer inhalational analgesics in accordance with the requirements of the Central Midwives Board	Number of sets of apparatus for the administration of inhalational analgesics in use at end of year		Number of cases in which inhalational analgesics were administered by midwives in *domiciliary* practice during the year:				Number of cases in which pethidine was administered by midwives in *domiciliary* practice during the year:	
				When doctor was present at time of delivery of child		When doctor was not present at time of delivery of child		When doctor was present at time of delivery of child	When doctor was not present at time of delivery of child
		Gas and air	"Trilene"	Gas and air	"Trilene"	Gas and air	"Trilene"		
(a) Domiciliary Midwives employed directly by the Local Health Authority	27	31	8	135	43	279	77	111	183
(b) Domiciliary Midwives in private practice or employed by organisations not acting as agents of Local Health Authority	—	—	—	—	—	—	—	—	—
Totals	27	31	8	135	43	279	77	111	183

The following tables record numerically the work undertaken by health visitors in the City and the rural area.

TABLE 11

HEALTH VISITING (City of Cambridge)

Number of children under 5 years of age visited during year	Expectant mothers		Children under 1 year of age		Children age 1 and under 2 years	Children age 2 but under 5 years	Tuberculous households	Other cases	Total number of families or households visited by Health Visitors
	First visit	Total visits	First visit	Total visits	Total visits	Total visits	Total visits	Total visits	
4985	241	382	1468	7815	2607	5349	361	2731	4401

TABLE 11A

HEALTH VISITING (Rural Area)

Number of children under 5 years of age visited during year	Expectant mothers		Children under 1 year of age		Children age 1 and under 2 years	Children age 2 but under 5 years	Tuberculous households	Other cases	Total number of families or households visited by Health Visitors
	First visit	Total visits	First visit	Total visits	Total visits	Total visits	Total visits	Total visits	
6900	359	653	1704	12288	4796	5910	412	1563	5152

TABLE 12

HOME NURSING SERVICE—CITY

(1)	Medical (2)	Surgical (3)	Infectious Diseases (4)	Tuberculosis (5)	Maternal Complications (6)	Others (7)	Totals (8)	Patients included in (2)-(7) who were 65 or over at the time of the first visit during the year (9)	Children included in (2)-(7) who were under 5 at the time of the first visit during the year (10)	Patients included in (2)-(7) who have had more than 24 visits during the year (11)
Number of cases attended by Home Nurses during the year	1929	651	—	8	24	—	2612	763	47	368
Number of visits paid by Home Nurses during the year	33332	6846	—	284	257	—	40719	17385	226	22522

TABLE 12A

HOME NURSING SERVICE—RURAL AREA

(1)	Medical (2)	Surgical (3)	Infectious Diseases (4)	Tuberculosis (5)	Maternal Complications (6)	Others (7)	Totals (8)	Patients included in (2)-(7) who were 65 or over at the time of the first visit during the year (9)	Children included in (2)-(7) who were under 5 at the time of the first visit during the year (10)	Patients included in (2)-(7) who have had more than 24 visits during the year (11)
Number of cases attended by Home Nurses during the year	1108	601	2	7	29	1697	3444	804	131	339
Number of visits paid by Home Nurses during the year	27885	10424	4	448	178	1722	40661	25805	773	26990

Home Care and Nursing Service

The Home Care and Nursing Service scheme, which started in 1949, whereby patients are discharged from Addenbrooke's Hospital after liaison between the hospital almoner, general practitioner, home nursing service and home help service continued during 1960. The total number of Cambridgeshire patients so discharged was 57 (34 City residents and 23 rural area residents), a considerable fall on the total figure of 124 in 1959. As has been noted in previous years, the majority of cases discharged were following operations for appendicitis and hernia.

SECTION 26. VACCINATION AND IMMUNISATION

General

The work is carried out in the main by general practitioners, particularly in the rural area. Poliomyelitis vaccination has tended to overshadow all other immunisation and vaccination procedures but there has been an improvement in the diphtheria immunity index (i.e. the percentage of children considered to have maximum artificially induced immunity to diphtheria) from 41.8% in 1959 to 45.7% in 1960. The use of antigens in combination considerably reducing the multiplicity of injections may be one reason for the improvement in this index.

Diphtheria

The following tables set out the numbers of children immunised against diphtheria in the City and the rural area:—

TABLE 13

RECORD OF DIPHTHERIA IMMUNISATIONS—CITY OF CAMBRIDGE

Age Group	Primary	Boosters
Under 1	949	—
1-4	225	26
5-14	55	653
Total	1229	679

TABLE 13A

RECORD OF DIPHTHERIA IMMUNISATIONS—RURAL AREA

(Including work carried out at Infant Welfare Centres)

Age Group	Primary	Boosters
Under 1	1330	2
1-4	237	106
5-14	78	812
Total	1645	920

Whooping Cough

The following tables show the numbers of children in the City and the rural area who have been immunised against whooping cough:—

TABLE 14

WHOOPING COUGH IMMUNISATION—CITY OF CAMBRIDGE

	Age at Date of Final Injection		
	0-4 years	5-14 years	Total
Number of children who have completed a primary course (normally three injections) of pertussis vaccine (singly or in combination)	1089	33	1122

TABLE 14A
WHOOPING COUGH IMMUNISATION—RURAL AREA

	Age at Date of Final Injection		
	0-4 years	5-14 years	Total
Number of children who have completed a primary course (normally three injections) of pertussis vaccine (singly or in combination)	1625	72	1697

Poliomyelitis

In accordance with Ministry of Health Circular 3/60 the arrangements for vaccination against poliomyelitis were extended by offering it to all persons who, at the time of application, had not reached the age of forty. The response from this age group was not great and considerably less than that which was experienced when persons born between 1933 and 1942 became eligible for vaccination.

Nearly all general practitioners in the City and the rural area make their own arrangements for the vaccination of their patients but a clinic session is held as and when necessary to deal with those persons whose general practitioners are not carrying out the work and those persons not registered with a doctor in the area. The large number of general practitioners participating in the work has obviated the need for medical officers of the Authority to visit factories and other establishments in order to vaccinate employees and in fact only two visits for this purpose were made to give third injections to 54 persons in two different establishments.

The following table sets out the total number of poliomyelitis vaccinations given during the year:—

TABLE 15
NUMBER OF PERSONS VACCINATED

	1st injection	2nd injection	3rd injection
Children born in years 1943 to 1960	3610	3792	—
Young persons born in years 1933 to 1942	2399	2542	—
Persons born before 1933 who had not passed their 40th birthday	5605	5748	—
Others	115	124	—
Total	11,729	12,206	23,876

Smallpox

Vaccination against smallpox is undertaken by general practitioners and at clinics and the following tables show the number of persons vaccinated or revaccinated during the year.

When related to the 3,144 live births registered during the year, the 1,713 primary vaccinations under the age of one year represent a vaccination acceptance rate of 54.5 per cent as against a national average of 45 per cent.

No cases of generalised vaccinia, post encephalomyelitis or death from other complications of vaccination were notified during the year.

TABLE 16
NUMBER OF PERSONS VACCINATED (or revaccinated) DURING PERIOD
CITY OF CAMBRIDGE

Age at Date of Vaccination	Under 1	1	2 to 4	5 to 14	15 or over	Total
Number Vaccinated	512	309	35	42	49	947
Number Re-vaccinated	5	—	11	46	832	894

TABLE 16A

NUMBER OF PERSONS VACCINATED (or revaccinated) DURING PERIOD

RURAL AREA

Age at Date of Vaccination	Under 1	1	2 to 4	5 to 14	15 or over	Total
Number Vaccinated	1201	21	34	24	73	1353
Number Re-vaccinated	—	1	18	37	321	377

Tetanus

Immunisation against tetanus is carried out by the use of tetanus toxoid either as a single antigen or in combination with others.

It is evident that increasing numbers of people are being thus actively immunised and it is unfortunate that because such information is not always available at the time of an accident anti-tetanic serum continues to be given. At Addenbrooke's hospital, unless there is evidence of active immunisation, patients are given the serum and a card recording the fact and advising them to see their doctor regarding active immunisation.

SECTION 27. AMBULANCE SERVICE

In Cambridgeshire the ambulance service is administered by the Clerk of the County Council to whom I am indebted for the following table which gives details of the vehicles provided and the journeys undertaken.

Ambulances directly provided	7
Cars directly provided	6
Number of journeys by above	
Ambulances	9,718
Cars	3,794
Patients carried by above	
Ambulances	10,586
Cars	7,421
Accident and emergency journeys included in above	
Ambulances	1,153
Cars	160
Mileage run by above	
Ambulances	119,614
Cars	114,861
Journeys by supplementary vehicles	
Ambulances	537
Cars	22,144
Patients carried by supplementary vehicles	
Ambulances	519
Cars	43,915
Accident and emergency journeys by supplementary vehicles	
Ambulances	49
Cars	—
Mileage run by supplementary vehicles	
Ambulances	10,317
Cars	272,184
The number of full time staff on December 31st, 1960	26

SECTION 28. PREVENTION OF ILLNESS, CARE AND AFTER-CARE

Tuberculosis

I am indebted to the Chest Physician, Dr. M. J. Greenberg, for the following notes:—

" As can be seen from the figures (page 33) there is a moderate increase in the number of new cases of tuberculosis both in those first found in this area and in those transferred from other areas.

With improvements in treatment the total number of cases on the register has decreased. However, this should not lead to complacency as while the number of new cases is increasing it means that there is still a considerable pool of infection and it may well be that some of these new cases will be infected with organisms which are resistant to the main anti-tuberculous drugs.

In view of this the B.C.G. campaign, which now appears to be running very smoothly, should continue as energetically as before. This, combined with other case finding methods such as Mass Radiography and the continued improvements in the treatment of tuberculosis will help to eradicate this disease though one cannot expect the disappearance for many years yet."

In 1959 a small outbreak of tuberculosis occurred among teenage girls in the Newmarket Rural District. 1960 saw a further outbreak which appeared to be a direct follow on from this. Six cases occurred amongst three families living close together in a village. Three of the cases (two aged 17 and one aged 19) were close companions and the other three cases (ages 3 months, 13 months and 6 years) were siblings in their families.

It is unfortunate that the patients involved had already left school before the introduction of the Council's scheme for protection by B.C.G. vaccination of school children. The large measure of protection afforded might well have prevented the development of any of these cases.

As a precaution, the Medical Officer of Health of the Newmarket Rural District Council has arranged with the Medical Director of the Mass Radiography Unit of the East Anglian Regional Hospital Board to carry out community surveys of the villages in this area during 1961.

Tuberculosis Care and After-Care

The County Council continued to contribute to the funds of the Cambridgeshire Tuberculosis After-Care Association. The following extract from the report of the Honorary Medical Adviser indicates the value of the functions performed by the Association in assisting patients suffering from tuberculosis:—

" During the year ended 31st December, 1960 a total of 25 patients received grants of either milk or groceries, or both from the Association. Of these 15 were men and 10 were women; 19 were able to work, 5 were not working and 1 had died. This figures was very similar to the previous year when 28 patients received grants.

In addition to the grants of milk and groceries, 5 additional portable oxygen sets were purchased, making 10 in all, and have been lent out to patients who suffer from shortness of breath as a result of their disease. This type of apparatus is not prescribable under the National Health Service, and has proved extremely useful in allowing people who would otherwise be bedridden to become more mobile. All 10 sets are in use at present and it might be justifiable to purchase additional sets."

B.C.G. Vaccination

The scheme offering B.C.G. vaccination to children aged 13 years which was commenced in 1959, was continued in 1960 and is now an annual feature of the services provided by the Authority.

As in previous years, the Consultant Chest Physician, Dr. M. J. Greenberg has continued to make available facilities for the vaccination of persons in contact with tuberculous patients and this year he has kindly arranged for those children who were absent when the B.C.G. team visited the schools to be seen at the Clinic.

I am grateful to Dr. Greenberg also for making available facilities for the X-ray of those children found positive on skin test.

In the rural area visits were made to thirteen schools between October and December and arrangements are in train for a visit to be made to the Cambridgeshire Technical College in order to offer vaccination to students receiving further education.

In the early part of 1960 one school which it had not been possible to visit in 1959 was dealt with and the team also visited Homerton College, a Women's Teacher Training College. The following table summarises the work undertaken there:—

TABLE 17

Number skin tested (Multiple Puncture)	252
Number found positive	86
Number found negative	164
Number vaccinated	161

The following tables give an account of the work undertaken by the B.C.G. team at schools in the City of Cambridge and the rural area:—

TABLE 18

CITY OF CAMBRIDGE

Number skin tested (Multiple Puncture)	3535
Number found positive	750
Number found negative	2785
Number vaccinated	2682

TABLE 18A

RURAL AREA

Number skin tested (Multiple Puncture)	1498
Number found positive	324
Number found negative	1136
Number vaccinated	1102

In the rural area, 94 positives had, by the end of the year, been X-rayed at the Chest Clinic and of this number, one boy has been found to have a tuberculous infection which at the time of writing is thought to be inactive but he is being kept under observation. The health visitors are asked to visit the parents of those children who are found to be positive, and who for one reason or another have not yet taken advantage of the X-ray facilities in an effort to see that all positives are checked.

I should like to take this opportunity of expressing my thanks to the Heads of the schools concerned and their staffs for their help and co-operation in this work.

Contact Scheme

The following figures represent the number of persons dealt with at the Chest Clinic under the Contact Scheme during 1960:—

TABLE 19

Number skin tested	768
Number found positive	381
Number found negative	387
Number vaccinated	263

The following tables indicate the position with regard to tuberculosis in the City and rural areas:—

TABLE 20

CITY TUBERCULOSIS REGISTER 1960

	Respiratory		Non-Respiratory		Total	
	Male	*Female*	*Male*	*Female*	*Male*	*Female*
1. Number of Cases on Register at commencement of year	260	173	40	58	300	231
2. Number of Cases notified for first time during year under Regulations	34	16	1	4	35	20
3. Cases restored to Register	—	—	—	—	—	—
4. Cases added to Register otherwise than by notification under Regulations: (a) Transferred from other Districts	36	18	—	—	36	18
(b) From Death Returns	1	—	—	—	1	—
5. Number of Cases removed from Register	82	66	22	34	104	100
6. Number of Cases remaining on Register at end of year	249	141	19	28	268	169

TABLE 20A

COUNTY TUBERCULOSIS REGISTER 1960
(excluding City)

	Respiratory		Non-Respiratory		Total	
	Male	*Female*	*Male*	*Female*	*Male*	*Female*
1. Number of Cases on Register at commencement of year	198	131	13	15	211	146
2. Number of Cases notified for first time during year under Regulations	16	6	3	6	19	12
3. Cases restored to Register	—	—	—	—	—	—
4. Cases added to Register otherwise than by notification under Regulations: (a) Transferred from other Districts	30	28	3	—	33	28
(b) From Death Returns	1	—	1	—	2	—
5. Number of Cases removed from Register	45	39	—	7	45	46
6. Number of Cases remaining on Register at end of year	200	126	20	14	220	140

Yellow Fever Vaccination

On the 1st July, 1960 the County Council, at the request of the Ministry of Health, opened a clinic for the purpose of offering vaccination against yellow fever (hitherto undertaken by the Blood Transfusion Service). Yellow fever vaccination is required by persons going abroad to certain countries, and under the International Sanitary Regulations must be carried out at centres designated by the Government. A charge to cover the cost of the service is made and sessions are held on Mondays from 9.30 to 10.30 a.m. and on Thursdays from 4 to 5 p.m. From July 1st to the end of the year a total of 222 persons was vaccinated.

Chiropody

During the year the County Council amended its existing proposals under section 28 of the National Health Service Act to enable the operation of a chiropody service. In the first instance the service will be selective and will be confined to those groups referred to in Ministry of Health Circular 11/59, that is:

Men over 65 years of age
Women over 60 years of age
Expectant mothers
Handicapped persons whose disability would be ameliorated by chiropody.

The service is to be provided by chiropodists treating patients in clinics established by the voluntary organisations running old people's clubs, by treating patients in their own surgeries, and in exceptional cases by domiciliary visits.

The Council decided that a standard charge of 3/6 per treatment should be made to each patient but in the case of those in receipt of National Assistance, the charge should be waived. This service will commence on 1st April, 1961.

The planning of the service would not have been possible without the willing co-operation of the voluntary organisations and the chiropodists to whom my sincere thanks are here recorded.

Medical Loan

The increasing emphasis on domiciliary care is illustrated in the number of medical loan items which increases annually. The British Red Cross Society performs a valuable service on behalf of the County Council in operating the medical loan service.

Of recent years there has been a growing demand for hoists in homes where severely handicapped or heavy bed ridden people are living. Following discussions with the British Red Cross Society, it was agreed that items of equipment such as this should be purchased by the Council and loaned out by them.

During the year the British Red Cross Society provided 2,484 items of service to 1,387 patients, a substantial increase on the figures for 1959. The range of items issued remained very wide and during the year the County Council spent over £1,500 on the service.

Health Education

The County Council does not employ a specialist officer for health education but relies on the medical, nursing, mental health staff and others to disseminate information on health education matters in their day to day work. In addition, all members of the staff are encouraged to give talks on health matters to different types of organisations in and out of office hours. Members of the staff do, of course, regularly give talks to schools and infant welfare centres.

The department is also fortunate in receiving the interested and understanding co-operation of the local Press whose help over the years is much appreciated.

During the past two years the Principal School Dental Officer and the staff of the School Health Service have conducted a most energetic campaign concerning dental hygiene, further details of which are to be found on pages 16 and 17.

With regard to health education of the public concerning the connection between smoking and lung cancer, no definite action has been taken. It is generally agreed that education in this matter should be aimed at those who have not yet acquired the smoking habit but the difficulty of interesting school children in the subject was well illustrated at a Village College, the Warden of which has already done excellent work in dental health education. The usual pamphlets and posters about smoking and lung cancer were sent to him at his request and he tried them out on the children. His report on his efforts was succinct; the material had no impact on the children whatever, and the children remarked upon the unlikelihood of following advice against smoking when this is given by adult smokers. It is felt that so long as adults smoke in the presence of children and advertising is aimed at increasing smoking, an anomalous situation arises whenever direct attempts are made to influence this national habit.

A regular feature of health education in Cambridgeshire is the arrangement which exists with the Cambridgeshire Federation of Women's Institutes whereby the local health authority accepts financial responsibility for lectures given by a panel of doctors, approved by the County Medical Officer, to Women's Institutes. During 1960, lectures were given to 14 village institutes.

Venereal Disease

The arrangement whereby two health visitors in the City and two in the rural area take a special interest in the social work connected with venereal diseases continued in 1960.

In addition an opportunity was taken to display posters giving details of the facilities available locally in suitable places in the City and the rural area.

The special clinic at Addenbrooke's Hospital continued to serve a number of areas including Cambridgeshire and the following figures relate to " first time " attendances by patients resident in the Administrative County:—

Syphilis	10
Gonorrhoea	49
Other conditions	251

When compared with the figures for 1959, the number with syphilis remains the same but there is an increase of 19 in the cases of gonorrhoea and the figure for other conditions is more than doubled, 251 as against 114. Unfortunately this local trend is but a reflection of the national experience which is causing concern, particularly in view of the numbers of teenagers attending clinics either because of infection or because the risk of infection has been incurred.

SECTION 29. HOME HELP SERVICE

This service was one of those delegated to the City of Cambridge on the 1st October. Until that date it had continued on the lines of previous years, the central administrative staff consisting of one full time organiser, one full time assistant organiser, one part time assistant organiser and two clerks. There had been an increase of 27 in the number of helps available though there were 4 less working full time.

As from the 1st October the service was divided as between the City and the rural area, the City Medical Officer becoming responsible for the administration of the service in the City with a staff of one organiser, full time, one full time assistant organiser and one clerk; a similar allocation of staff for the work in the rural area was made.

The following statistics indicate the volume of work undertaken and the most marked variation from the previous year is the sharp increase in the number of maternity cases attended.

TABLE 21
HOME HELP SERVICE (CITY)

Number of Domestic Helps employed at the end of the year:

(a) Whole-time	32
(b) Part-time	75
(c) Whole-time equivalent of (b)	69

Number of cases where domestic help was provided during the period 1st October to 31st December, 1960.

	Total
(a) Maternity (including expectant mothers)	98
(b) Tuberculosis	8
(c) Chronic sick including aged and infirm	380
(d) Others	122

TABLE 21A
HOME HELP SERVICE (RURAL AREA)

Number of Domestic Helps employed at the end of the year:

(a) Whole-time	6
(b) Part-time	171
(c) Whole-time equivalent of (b)	53

Number of cases where domestic help was provided during the year:

	Total	Cases included in previous col. in which help began prior to 1960
(a) Maternity (including expectant mothers)	385	81
(b) Tuberculosis	22	21
(c) Chronic sick including aged and infirm	840	635
(d) Others	276	52

There were no changes in the financial aspects of the service. The demand for help exceeded that which was available, and continued efforts to recruit additional helps were made.

The Home Help Organiser for the rural area considers that the pattern emerging from the last three months of the year shows that in the rural area at any rate, there will be a steadily increasing amount of help given to the aged and chronic sick whereas the short term cases are likely to be fewer as these are more likely to be helped by relatives, neighbours and friends.

She also reports that a new feature is the increasing number of requests for help from psychiatric social workers, both for ex-patients of Fulbourn Hospital and for out-patients at the psychiatric clinic.

MENTAL HEALTH SERVICE

I have said elsewhere that the development of the mental health service is one of the most challenging problems presented to local health authorities, and it will for many years be one of their most important public health functions; it must not, however, be allowed to create an imbalance in the development of the other preventive services, all of which have some contribution to make towards the promotion of mental health in the community.

Cambridgeshire has been fortunate in the development of its mental health services, in so far as there has been more than 50 years of voluntary interest and experiment in this field pioneered by the organisation now known as The Cambridgeshire Mental Welfare Association.

In the hospital service, the fusion of the in-patient service, as represented by the Regional Hospital Board's special hospital at Fulbourn, with the psychiatric out-patient department of the United Cambridge Hospitals, into one hospital psychiatric service, has facilitated the development of the total mental health service for the community.

Furthermore, every opportunity has been taken by the staff at Fulbourn to integrate their community with the community at large. A campaign lasting over many years has done much to remove the stigma which used to be attached to the mental hospital. The management of the hospital upon the modern basis of a therapeutic community, the opening of locked doors, the encouragement of visitors, and of the Press in assisting in bringing the hospital's social activities to the notice of the public, have done much to educate them towards the modern concept of mental disorder. The fact that the Medical Superintendent of the Hospital is also Honorary Consultant Psychiatrist to the County Council, and that the County Medical Officer has been Honorary Consultant in Social and Preventive Medicine to the Hospital since January 1958, and will, from April 1st, 1961 be a member of the Hospital Management Committee, are important elements in the integration of the services available to the public. Cross representation as between members of the Local Health Authority, City Council and Hospital Management Committee, is a further most important factor in achieving integration and a common purpose.

Following closely upon the publication of the Mental Health Bill informal approaches were made to members of the joint consultant psychiatric staff and to the Executive Committee of the Cambridgeshire Mental Welfare Association who were undertaking a considerable amount of social work on behalf of the County Council. During the subsequent exchanges of thought, two major administrative factors had to be borne in mind, namely the impending delegation of certain health and welfare services to the City of Cambridge and the uncertainty of the future of certain authorities in East Anglia, having regard to the investigations of the Local Government Commission. From the outset the main concern has been to produce and maintain a service for the patient, readily available to all concerned, with the minimum of administrative difficulty in its usage. The willing determination of all concerned to make this a reality has been a fine stimulus to the many discussions, informal and formal that have gone on over the past months. Two main principles have to be kept in mind. Firstly, that a mentally disordered patient should readily be able to have consultant advice, and secondly, that as far as possible a patient should have the same consultant and social worker throughout his illness.

Circular 9/59 came at a time when the informal discussions referred to had reached a point which gave clear indication of the pattern of service it was hoped to achieve under the new legislation. In last year's report the Authority's proposals as accepted by the Ministry were published as an appendix to the report. In the preparation of these proposals use was made of the pooled knowledge resulting from visits to places in this country and abroad where the most modern techniques and services can be seen in action. Since those proposals were drawn up the community mental health service has developed satisfactorily along the lines indicated.

Early in 1959 the County Medical Officer had begun regular meetings with the social workers of the Cambridgeshire Mental Welfare Association, and those attached to his staff, with regard to the community care of the subnormals. At the same time the Honorary Psychiatric Consultant to the County Council began regular meetings with the social workers of the Cambridgeshire Mental Welfare Association who were dealing with the mentally ill. At a later stage these meetings were merged, so that the spirit of the Act, in speaking of mental disorder, a generic term for both ill health and subnormality, was observed. The County Council has designated the social workers of the Cambridgeshire Mental Welfare Association as mental welfare officers, as of course it has done for the full time mental welfare officer and part time mental welfare officer in its direct employ.

The Cambridgeshire Mental Welfare Association offered to continue to assist the County Council in developing the community mental health service and undertook to re-organise its constitution and administration to meet the new situation. In this re-organisation statutory bodies involved in the development of the service were asked to nominate representatives to the Association's Executive Committee and medical officers to serve on the Association's newly constituted Medical Advisory Committee.The bodies concerned are: The Board of Governors of the United Cambridge Hospitals; The East Anglian Regional Hospital Board; Fulbourn Hospital Management Committee; The County Council and the City Council. The Medical Advisory Committee consists of: The Chairman of the Psychiatric Sub-Committee at Addenbrooke's Hospital; The Consultant Child Psychiatrist to the Regional Hospital Board; The Medical Superintendent of Fulbourn Hospital; The County Medical Officer and The City Medical Officer of Health. With this new organisation the Association has been entrusted by the County Council with certain important community mental health functions. The Association looks forward to making as valuable a contribution to the service in the future as they have done in the past.

The regular meeting of the mental welfare officers now takes place every Monday afternoon in The Cambridgeshire Mental Welfare Association offices and is chaired by a member of the Medical Advisory Committee of the Association; other workers in the field of mental health are invited to these meetings as the occasion arises. This weekly meeting constitutes an important forum for the exchange of views, case discussion, and the consideration of suggestions for, and criticism of, the service; it is indeed the nucleus of the service.

Steps have now been taken to regionalise the mental welfare officers' areas. Thus each rural district has its own mental welfare officer, the City of Cambridge has the equivalent of 2½ mental welfare officers, and one part time officer is in reserve as relief for the administrative county. The telephone number of the Cambridgeshire Mental Welfare Association, which moved its premises into a building adjacent to the Shire Hall, has been designated as the Mental Health Service number, and, by arrangement with the Post Office for transfer of calls, is manned twenty-four hours a day.

With regard to the progress in other aspects of the local authority's proposals, it is a pleasure to recall the continued success of the Winston House experiment. I am indebted to the Editor of The Lancet for permission to publish an annotation about Winston House which appeared in the 17th December, 1960 issue of that journal.

HALF-WAY HOSTEL

Earlier this year Dr. D. H. Clark and Mr. L. W. Cooper described the beginnings of an interesting Cambridge experiment in community medicine. Winston House, with the triple support of the Cambridgeshire Mental Welfare Association and County Council and the S.O.S. Society, was opened in October, 1958, as a hostel for patients who had lately left a mental hospital and were ready to try once more to earn their own living. During its first year, rather surprisingly, it was never completely full, but the report of the second year suggests that this was chiefly because the right people had not yet learned of its existence. For the whole of the second year it has been nearly full, and indeed in the latter half there has always been a waiting-list. The average daily number of residents was 21. There were 57 admissions during the year (compared with 36 in the first year) and 50 departures (22 in the first year).

The 50 departures were made by 46 people, for sometimes residents return after an unsteady independent start. 11 departures were regarded as thoroughly satisfactory, and 15 as fairly satisfactory. Of the others, 7 residents returned to a mental hospital. Only 4 residents (2 alcoholics, 1 aggressive psychopath, 1 inadequate psychopath) had to be asked to leave because their behaviour was disturbing the hostel. Taking the results of the first two years together, 41 people—or about two-thirds of those admitted—have made a satisfactory transition to the outside world.

During the year the age-limits for admission have been widened, and residents now range from sixteen-year-olds to those in their sixties. As the hostel has become more widely known, more patients have been drawn from other hospitals than Fulbourn Hospital and from more distant parts than Cambridgeshire. Last year Dr. Clark suggested that admissions of this kind would be welcome, for they would bring new interests to the hostel; and this has proved to be so. Mr. Cooper, the warden, has also welcomed this year as residents some professional men and women: " Graduates, military officers, and public schoolboys have mixed and learned together with labourers, hospital ward maids, domestics, shop and factory workers.

All have a common meeting ground of recent mental illness and each appreciates the others' need of sympathy, friendship, encouragement, and understanding in a community life." All the residents of Winston House are selected because they are thought to be capable of achieving independence; but a few have failed, and Dr. Clark admits that during the year he has become more and more aware of the need for hostels for people who are never likely to be able to live on their own.

There are no other immediate plans for hostel accommodation for the mentally ill, but the question of a hostel or home for elderly psychiatric patients is included in the Welfare Committee's proposals for building part III accommodation, and it may be that such accommodation will be available in the foreseeable future.

Social Clubs and Evening Class

On Wednesday evenings the Cambridgeshire Mental Welfare Association social workers, with assistance from undergraduates, run a class and social evening for retarded adolescents at the Lady Adrian School. This year 25 boys and 11 girls have attended quite regularly although there are a few more names on the register. Of this number 8 boys and 4 girls are pupils at the Lady Adrian School and in fact attend regularly; they are amongst the older school pupils. The non-school people attending the evening class are from school-leaving age to those in their twenties—some of them later twenties.

Assistance is given at the evening class by the Cambridgeshire Mental Welfare Association social workers, the home teacher, the head master of the Lady Adrian School, undergraduates (the larger body of helpers) and teachers from the local Guild of Teachers of Backward Children. Reading, writing, learning the value of money, and assistance with the highway code are the main teaching activities. After an hour of teaching, tea (made by some of the girl pupils) and biscuits are available, records are played and there is table tennis, card games and such table games as ludo, halma, which themselves have some teaching function.

The Social Club which the hospital and Cambridgeshire Mental Welfare Association social workers have sponsored at Winston House has continued to flourish and now receives a grant from the local authority towards its running expenses. The Warden of Winston House has started a Thursday Evening Club on the premises which is having some success.

World Mental Health Year

The year 1960 was declared by the World Health Organisation as Mental Health Year and local health authorities were asked to undertake some special Health Education programme. In consultation with colleagues in this field of medical practice it was decided that nothing special was needed since, as already remarked, there has been a continuous programme of mental health education over the last few years in which most aspects of the subject have been ventilated.

Child Psychiatric Service

The Ministry of Health in Circular 1/61, para 7, particularly asks about developments arising from Circular 3/59 on child guidance arrangements. The Local Education Authority does not itself run a Child Guidance Clinic but relies upon the Child Psychiatric Service for the Cambridge area of the East Anglian Regional Hospital Board and the Board of Governors of Addenbrooke's Hospital. This could be better designated a Family Psychiatric Service, a term more accurately descriptive of the aims of the service run by Dr. Glennie and his colleagues. It should be understood that the service covers a much larger population than that of the Administrative County of Cambridge.

For some years, Dr. Glennie and I have discussed the question of the closer integration of our services, particularly in relation to the mother, baby and toddler clinics since we consider that in these clinics there is a vast amount of preventive, supportive and curative work needing attention as yet unrecognised and untouched. We realise that many of the problems arising in the early years at school could have been prevented or treated in the pre-school years. We foresee that in this field lies one of the most valuable contributions the family psychiatric service can make to the community.

Unfortunately, for reasons concisely described in Dr. Glennie's report which follows, we are frustrated in the further development of the service at present.

I am grateful to Dr. Glennie for the following report and figures relating to the work of his service:

"CHILD PSYCHIATRIC SERVICE

(United Cambridge Hospitals and East Anglian Regional Hospital Board)

Staff

Consultant Child Psychiatrist ..	R. E. GLENNIE, M.D., D.C.H., D.P.M.
Assistant Child Psychiatrist	B. F. WHITEHEAD, M.A., M.B., B.Chir., D.P.M.
Clinical Psychologist	Miss J. B. CONOCHIE, M.A., Dip.Ed.
Psychiatric Social Worker	Mrs. A. UNVALA
Social Worker and Psychologist ..	Mrs. S. ABRAMS, B.A. (Psychology), Certificate of Social Studies (Oxon)
Secretaries	Miss B. W. HAZZARD
	Miss V. LING

Throughout the year demands upon the Service from the administrative County of Cambridge have been consistently greater. In both City and County areas it will be noted from the attached figures that there has been a decided increase in the number of requests for psychiatric help, particularly in the City, indicating that the Child Psychiatric Service is being used more extensively than ever before. The waiting list is steadily mounting, despite all efforts to keep this as low as possible. It will be appreciated that urgent cases must be seen at once, and cases actively requiring treatment must be taken on, sometimes to the exclusion of those who have been waiting longer for interview.

In last year's report I pointed out that the accommodation of the clinic was totally inadequate to handle these ever-increasing demands, and this situation has really pertained for the last five years. Every endeavour has been made to acquaint both the Regional Hospital Board and the City Council, who own the clinic at Chesterton, that there is need for immediate expansion: without it there is no hope of augmenting the medical staff, and it is quite obvious that this also is urgently needed. No improvement however has resulted to date. The matter has been considered by the City and though they are unwilling to enlarge the clinic, they have given permission for the erection of a temporary extension, which presumably will be supplied by the Regional Hospital Board. The situation is further complicated by the fact that once a week the clinic premises are used for an infant welfare clinic, and once a month they have the use of the waiting room and one other room for a toddler's clinic. This in fact means that over and above the restrictions imposed upon the Service both in respect of staff and inadequate accommodation, the present staff cannot function to capacity. Requests put forward to the City that the time of these clincs be changed to periods when the clinic premises would be available have not been granted, but because of the steadily increasing pressure of work it may be necessary to pursue this matter further.

In addition to the specialised aid in remedial teaching which has been undertaken in the clinic by the psychologist for the most disturbed children who are temporarily unable to benefit from formal education in school, seminars have been held for the speech therapists functioning in the area, and these they have found most rewarding in their approach to their work. Lectures and discussions at schools have also been given. The aid which an educational psychologist could afford would be of considerable help to the Education Department and the Child Psychiatric Service, and it is regretted that the post has been unoccupied for several months. Many children who are seen at the clinic would benefit greatly from special remedial teaching, but both in the City and the County, facilities for this are limited.

The co-operation and help which continues to be extended to us by the School Health Department and the Education Department is very necessary, but is also very much appreciated.

R. E. GLENNIE,

March, 1961. *Consultant Child Psychiatrist*".

CAMBRIDGE CITY CHILDREN

New cases referred and examined in 1960

Chesterton Child Psychiatric Clinic			Addenbrooke's Hospital		
Source of cases	Number examined	Notified to S.M.O.	Source of cases	Number examined	Notified to S.M.O.
School Medical Officer's Dept.	20	20	School Medical Officer's Dept.	2	2
GPs and Consultants	33	19	GPs and Consultants	15	6
Juvenile Court Magistrates	12	3	Others	—	—
Others	15	11			
	80	53		17	8
Number of new cases taken on for treatment:		41	Number of new cases taken on for treatment:		12

Total number of new cases examined: 97
Number of new cases taken on for treatment: 53

Cases under observation and treatment 1960

Chesterton Child Psychiatric Clinic			Addenbrooke's Hospital		
Source of cases	Number examined	Notified to S.M.O.	Source of cases	Number examined	Notified to S.M.O.
School Medical Officer's Dept.	11	11	School Medical Officer's Dept.	3	3
GPs and Consultants	21	16	GPs and Consultants	18	7
Juvenile Court Magistrates	8	5			
Others	6	3			
	46	35		21	10

Number of old cases under observation and treatment: 67
Total number of cases from the City of Cambridge under observation and treatment (including those seen for the first time in 1960): 120

CAMBRIDGE COUNTY CHILDREN

New cases referred and examined in 1960

Chesterton Child Psychiatric Clinic			Addenbrooke's Hospital		
Source of cases	Number examined	Notified to S.M.O.	Source of cases	Number examined	Notified to S.M.O.
School Medical Officer's Dept.	24	24	School Medical Officer's Dept.	2	2
GPs and Consultants	14	8	GPs and Consultants	22	15
Juvenile Court Magistrates	2	—	Juvenile Court Magistrates	—	—
Others	3	1	Others	1	—
	43	33		25	17
Number of new cases taken on for treatment:		30	Number of new cases taken on for treatment:		15

Total number of new cases examined: 68
Number of new cases taken on for treatment: 45

Cases under observation and treatment 1960

Chesterton Child Psychiatric Clinic			Addenbrooke's Hospital		
Source of cases	Number examined	Notified to S.M.O.	Source of cases	Number examined	Notified to S.M.O.
School Medical Officer's Dept.	21	21	School Medical Officer's Dept.	2	2
GPs and Consultants	11	9	GPs and Consultants	10	7
Others	5	5			
	37	35		12	9

Number of old cases under observation and treatment: 49
Total number of cases from the rural area of Cambridgeshire under observation and treatment (including those seen for the first time in 1960): 102

The following figures give an account of the work of the mental welfare officers during 1960:—

Mental Illness

Hospital admissions during the period 1st January to 31st October, 1960

Cases certified	19
Admitted under Section 20	12
Admitted under Section 21(1)	80
Voluntary patients	1
Informal patients	249

Hospital admissions for the period 1st November to 31st December, 1960

Admitted under Section 26 of the Mental Health Act	—
Admitted under Section 25 of the Mental Health Act	11
Admitted under Section 29 of the Mental Health Act	10
Informal Patients	60

It is worthy of note that the great majority of patients were admitted on an informal basis.

Mental Subnormality

During the year 26 new cases of subnormality were considered by the Mental Health Sub-Committee of which 23 were notified by the County Education Committee, 2 by the City Committee for Education and 1 by another local authority. Of these, 25 were placed under Statutory Supervision and one was admitted to hospital.

There were 6 cases on licence from hospitals at the end of the year and there were 8 cases under Guardianship of whom only two had Guardians in Cambridgeshire.

During the year, periods of temporary care in accordance with the terms of Circular 5/52 were arranged for 16 patients, four more than in 1959. This form of relief is much appreciated by parents who are enabled to have a well deserved rest or an opportunity of a holiday away from the patients.

At the end of the year there were still 21 names on the waiting list of patients requiring hospital care, a decrease of 6 on the figure at the end of 1959.

Adult and Junior Training Centres

In its proposals, the County Council provided for the erection of a junior training centre and hostel and the conversion of the existing training centre for use as an adult training centre and sheltered workshop.

During 1960 it was agreed that sketch plans should be prepared for a centre for 60 juniors with hostel accommodation for 12 juniors. Officers of the Ministry of Health have been most helpful in informal discussions upon questions of principle in the preparation of the plans.

To alleviate the overcrowding and to reduce the waiting list for admission to the present centre which takes both juniors and adults, the committee considered the suggestion that two additional classrooms should be provided immediately, within the curtilage of the present junior centre at Coldham's Lane. In considering this matter the committee took into account the need to ensure that the additional accommodation would fit in with the ultimate conversion of the training centre to an adult centre and sheltered workshop and the County Architect prepared sketch plans accordingly.

At the time of writing, this proposal has been approved by the County Council and it is hoped that the necessary work will be put in hand during 1961.

The Council's existing Training Centre continued its work and the revised transport arrangements of which mention was made in last year's report operated satisfactorily. The establishment of attendants was increased from two to four thus allowing the supervisory staff to devote more of their time to instruction, as well as affording some relief from the exhausting effect of continued contact with the children when single handed.

At the end of the year the number on register was 86, divided as follows:—

Males		Females	
Under 16 years	31	Under 16 years	17
Over 16 years	18	Over 16 years	20

There was a waiting list of 8 at the end of the year.

Once again a summer camp at Kessingland was organised from the 9th to 16th July by the Cambridge Society for Mentally Handicapped Children. It may be mentioned that this Society also has plans for the provision of a residental hostel for adults.

Staff

In planning the mental health service in the County we have been fortunate in having on the one hand the relatively well staffed joint hospital psychiatric service and on the other the staff of the Cambridgeshire Mental Welfare Association.

During the year, the Council, on the recommendation of the Health Committee, approved the appointment of a supernumerary trainee mental welfare officer. This appointment is subject to the applicant being accepted for training by one of the three colleges running the two year course for the training of middle grade social workers, as envisaged in the recommendations of the Younghusband Report. A condition of appointment is that after training and qualifying, the candidate selected shall remain in the Council's mental health service for a minimum period of two years.

To assist in meeting the need to have trained personnel available to staff the new training centre which the County Council has undertaken to provide, authority was given for the appointment to the staff of the existing centre at Coldham's Lane of two trainee assistant supervisors, the intention being that they should undergo a period of in-service training followed by attendance at the National Association for Mental Health course for one year to qualify as trained assistant supervisors. The response to advertisements has however been disappointing; the few applicants were not of the required standard and so far no appointment has been made.

Staff of the Cambridgeshire Mental Health Service

1. **Approved Practitioners** (" Being specially experienced")

(a) *Hospital Staff*

Consultant Psychiatrists

Dr. R. L. BUTTLE, Fulbourn Hospital
Dr. D. H. CLARK ,,
Dr. BERESFORD DAVIES, United Cambridge Hospitals
Dr. RUSSELL DAVIS ,,
Dr. BRIAN DAVY ,,
Dr. O. F. O. HODGSON, Fulbourn Hospital
Dr. B. B. ZEITLYN, United Cambridge Hospitals
Dr. R. H. GAMAN, Riversfield Hospital

Dr. R. E. GLENNIE, United Cambridge Hospitals } Child Psychiatric Service
Dr. B. F. WHITEHEAD ,,

(b) *Local Health Authority staff*

Dr. E. M. BRERETON, Cambs. C.C.
Dr. H. P. R. BRODA, Cambridge M.B.
Dr. J. DRUMMOND, Cambs. C.C.
Dr. C. G. EASTWOOD, Cambridge M.B.
Dr. M. C. K. PATTERSON, Cambridge M.B.
Dr. P. A. TYSER, Cambs. C.C.

2. **Social Workers of the Joint Hospital Psychiatric Service**

Miss M. J. FERGUSON, Senior Psychiatric Social Worker
Mrs. A. G. SQUIRES, Social Worker
Mrs. S. M. HILL ,,
Mrs. B. ROSSITER ,,

3. **Mental Welfare Officers**

Cambridge City
Mr. L. TABIZEL*
Miss A. SCOTT*

South Cambridgeshire R.D.C.
Mrs. J. LAWRENCE*

Newmarket R.D.C.
Mrs. J. GARRETT*

Chesterton R.D.C.
Mr. M. BOWYER
Mr. H. BARRETT (part-time)

4. *Mrs UTTING does part-time social work in the City.

5. *Mrs. JOHNSON does home teaching of the severely sub-normals in the Administrative County.

*Officers of the Cambridgeshire Mental Welfare Association.

REPORTS ON INDIVIDUAL MATTERS AND OTHER SERVICES

NATIONAL ASSISTANCE ACT—
WELFARE OF BLIND AND DISABLED PERSONS

REGISTRATION OF NURSING HOMES

VISITORS TO THE DEPARTMENT

MEDICAL EXAMINATION OF STAFF

VITAL STATISTICS

INFECTIOUS DISEASES

NATIONAL ASSISTANCE ACT. WELFARE OF THE BLIND AND OTHER DISABLED PERSONS

General

Until October 1st, when this service was the subject of delegation to the City of Cambridge, no staff changes had taken place except that the establishment was increased to four Home Teachers but no appointment was able to be made despite repeated advertisements during the year. The rural part of the County and some of the outlying parts of the City continued to be covered by Miss Peel and Mrs. Sier using cars and the remainder of the City being covered by Mr. Wilkinson using a bicycle and public transport.

On October 1st, Mr. Wilkinson was transferred to the staff of the City Medical Officer. The records relating to City residents were also transferred thus forming two separate registers as opposed to the one hitherto maintained.

To the end of the year, however, Miss Peel and Mrs. Sier continued to visit, instruct and deal with the needs of those persons in the outlying parts of the City who had prior to October 1st been their responsibility. This arrangement continued until the early part of 1961 when the City Council were able to secure the services of a second Home Teacher.

The statistics that follow have been divided, however, into those relating to City residents and those relating to rural area residents and do not necessarily take into account whether they have been dealt with by City or rural area Home Teachers.

Blind

The following tables show the distribution of cases of blindness by sex and age groups as at 31st December, 1960.

TABLE 22
CITY OF CAMBRIDGE

	0	1	2	3	4	5-10	11-15	16-20	21-29	30-39	40-49	50-59	60-64	65-69	70-79	80-84	85-89	90+	Unknown	Total
Male	—	—	—	—	—	—	2	2	4	5	3	10	11	10	12	8	6	5	—	78
Female	—	—	—	—	—	1	—	1	1	2	3	7	11	9	39	26	17	11	—	128
Total	—	—	—	—	—	1	2	3	5	7	6	17	22	19	51	34	23	16	—	206

TABLE 22A
RURAL AREA

	0	1	2	3	4	5-10	11-15	16-20	21-29	30-39	40-49	50-59	60-64	65-69	70-79	80-84	85-89	90+	Unknown	Total
Male	—	—	—	—	—	—	1	2	—	3	10	11	7	4	15	12	6	3	—	74
Female	—	—	—	—	—	2	2	1	2	1	5	10	4	8	27	16	13	11	3	105
Total	—	—	—	—	—	2	3	3	2	4	15	21	11	12	42	28	19	14	3	179

The total number of blind persons on the registers of the City and the rural area shows an increase of 19 over the figures for 1959 which reverses the trend noted in that year and the City figure remains substantially greater than that for the rural area.

In the City, of the cases of blindness aged 16 and upwards, one man was employed as a home worker in the Council's scheme and 17 (13 men and 4 women) were otherwise employed. One unemployed man was considered to be capable of open employment without training.

Of similar cases in the rural area, one man was employed in a workshop for the blind, one man was participating in the Council's Home Workers scheme and 10 men and 3 women were otherwise employed. One man was considered to be suitable for open employment subject to being trained and one in sheltered employment without training.

The following tables give details of cases newly registered during 1960 indicating the cause of the blindness, show whether treatment was recommended and whether such treatment was carried out.

TABLE 23

CITY OF CAMBRIDGE

CAUSES OF BLINDNESS

	Cause of disability			
	Cataract	Glaucoma	Retrolental Fibroplasia	Other
(i) Number of cases registered during the year in respect of which Section F(i) of Form BD8 recommends:				
(a) No treatment	1	1	—	11
(b) Treatment (Medical, Surgical, Optical and Hospital Supervision)	2	1	—	4
(ii) Number of cases at (i) above which on follow up have received treatment	1	1	—	4

It will be noted that in one case of cataract, treatment was recommended but had not been carried out. The woman concerned was awaiting operation at the end of the year.

TABLE 23A

RURAL AREA

CAUSES OF BLINDNESS

	Cause of disability			
	Cataract	Glaucoma	Retrolental Fibroplasia	Other
(i) Number of cases registered during the year in respect of which Section F(i) of Form BD8 recommends:				
(a) No treatment	1	—	—	11
(b) Treatment (Medical, Surgical, Optical and Hospital Supervision)	2	2	—	7
(ii) Number of cases at (i) above which on follow up have received treatment	1	2	—	7

It will be noted that in one case of cataract, treatment was recommended but not carried out. In this case the woman recommended for surgical treatment was unwilling for it to be undertaken.

No cases of Ophthalmia Neonatorum were notified in accordance with the Public Health (Ophthalmia Neonatorum) Regulations 1926-37 during the year.

Two hundred and thirty eight blind persons and their guides from the City and rural area attended two outings to Felixstowe which were arranged in June and approximately 130 attended the annual party held in September in the Queen Edith School, Cambridge.

Towards the end of the year, the Home Teachers felt that it would be an advantage to hold occasional meetings of individuals who had attended rehabilitation centres so that they might discuss their experiences and exchange ideas. They might also give the benefit of their knowledge to others in whose case a period of stay in a rehabilitation centre was contemplated. These meetings have proved most popular, are held at the homes of the people concerned, and seem to be becoming a regular feature of the service.

Partially Sighted

The following tables give details of partially sighted persons by sex and age groups as at 31st December, 1960

TABLE 24

CITY OF CAMBRIDGE

	0-1	2-4	5-15	16-20	21-49	50-64	65 & over	Total
Males	—	—	2	—	4	2	1	9
Females	—	—	1	1	—	4	3	9
Total	—	—	3	1	4	6	4	18

TABLE 24A

RURAL AREA

	0-1	2-4	5-15	16-20	21-49	50-64	65 & over	Total
Males	—	—	1	2	1	2	1	7
Females	—	—	—	—	1	2	5	8
Total	—	—	1	2	2	4	6	15

The total number of partially sighted persons shows an increase of 8 over the figure for 1959.

In the City, 3 of the children under 16 were receiving education in schools and one in the rural area was at a special school.

Visiting

During the year the Home Teachers paid 3,657 visits to blind and partially sighted persons (1,899 to City residents and 1,758 to residents in the rural area) and gave 870 lessons (467 to City residents and 403 to rural area residents).

For the whole of the year, i.e. including the three months following delegation of the service to the City, the Home Teachers nominally assigned to the rural area undertook the visiting and teaching of blind and partially sighted persons living in the outlying parts of the City.

Disabled Persons

The following tables give the numbers of disabled persons on the registers as at 31st December, 1960.

TABLE 25

CITY OF CAMBRIDGE

	0-5	5-16	Over 16	Total
Male	—	—	19	19
Female	—	—	42	42
Total	—	—	61	61

TABLE 25A

RURAL AREA

	0-5	5-16	Over 16	Total
Male	—	—	20	20
Female	—	—	59	59
Total	—	—	79	79

The total number of disabled persons on the registers of the City and the rural area represents an increase of 9 over the figure for the end of 1959.

Visiting

The Home Teachers paid a total of 1,746 visits (702 to City residents and 1,044 to rural area residents) and gave 491 lessons (214 City; 277 rural area).

Here again the rural area Home Teachers covered the outlying parts of the City for the whole of the year.

Seventy disabled persons attended the annual party arranged for them at the Queen Edith School in September.

Registration of Nursing Homes

Inspections of the registered nursing homes have been undertaken during the year and it has to be recorded that only one has in fact taken patients during the period. It seems unlikely that the others will function as nursing homes again but the proprietors concerned wish to remain registered in case they should wish to take further patients.

The following table gives details of registered nursing homes in the Administrative County.

TABLE 26

REGISTERED NURSING HOMES

	Number of homes	Number of beds provided for:—		
		Maternity	Others	Totals
Homes on the register at end of year	4	4	23	27
Homes exempt from registration at end of year	1	7	40	47

Visitors to the Department

In addition to the visitors mentioned in the report of the County Nursing Officer, and the many students who call at the department seeking information, aspects of the administration of the health services of the County Council were shown and discussed with two overseas visitors, Mrs. N. de Guevara, a public health nurse from Chile and Dr. Speiger, Head of the Department of Mental Health Hygiene, The Hague, Holland, both being sponsored by the World Health Organisation, and a trainee hospital administrator from the Hospital Administrative Staff College, London.

Medical Examination of Staff

In the early part of the year the Consultant Chest Physician indicated that he could no longer continue to undertake the medical examination of candidates for appointment with the County Council,

including teaching staff, and candidates seeking admission to Teacher Training Colleges. His help in this connection over a period of many years has been much appreciated.

From June 1st, the clinical examination of these individuals has been undertaken by one of the medical staff of the Health Department, the x-ray examination of the chest, where required, continuing to be carried out at the Chest Clinic. By the end of the year 93 candidates had been examined and reported upon.

VITAL STATISTICS

Area Comparability Factors

In order to compare the statistics of birth and death rates in the county and county districts with the birth and death rates for England and Wales, it is necessary to make a correction for the difference in age and sex distribution of the different populations. This is done by applying to the crude birth rate and crude death rate of the districts concerned " Area Comparability Factors " which have been estimated by the Registrar General and are shown in Tables B and M.

Population

The population of the Administrative County has increased by 1,760 persons; 700 in the City and 1,060 in the rural area.

Births

The comparable birth rate of 17.9 live births per thousand population for the Administrative County showed an increase of one point on last year and is 0.8 higher than the average for England and Wales.

The number of illegitimate live births increased from 122 in 1959 to 137 in 1960. Shown as a percentage of the total live births occurring in the Administrative County, the proportion of illegitimate live births is 4.4% (4.1% in 1959). The percentage of illegitimate live births in the City is 5.9% (4.9% in 1959); in the rural area 3.1% (3.5% in 1959).

Stillbirths

The number of stillbirths occurring in the Administrative County decreased: the stillbirth rate per 1,000 total births being 14.1 (16.7 in 1959). The rates for the City and rural area were 12.5 (16.0 in 1959) and 15.4 (17.3 in 1959), respectively.

Infant Mortality

The infant mortality rate for the Administrative County (deaths of children under one year of age per 1,000 live births) has fallen from 16.7 in 1959 to 16.5 in 1960. The rates for the City and rural area are 18.3 (21.4 in 1959) and 15.1 (12.6 in 1959) respectively.

The illegitimate infant mortality rate (deaths of illegitimate infants under one year per 1,000 illegitimate live births) shows an increase, 29.2 in 1960, 8.2 in 1959.

The neonatal death rate (deaths in first 4 weeks of life per 1,000 live births) showed a decrease in the Administrative County being 11.1 in 1960 as against 12.2 in 1959. The rate for the City was 11.3 (14.8 in 1959) whilst the rate for the rural area increased to 11.0 (10.1 in 1959).

Since the main loss of young life today occurs either pre-natally or in the first week of life, it is now customary to express the loss as a perinatal mortality rate (stillbirths plus deaths in the first week of life per 1,000 live and stillbirths). The rates for the Administrative County are 24.1 (27.7 in 1959); City 21.6 (29.8 in 1959); rural area 26.2 (26.0 in 1959).

Deaths

The comparable death rate for the Administrative County is 10.0 per 1,000 population and compares favourably with that of England and Wales (11.5).

It will be seen that the biggest causes of death were heart disease (666), cancer (361) and vascular diseases of the nervous system (335).

Deaths of persons over the age of 65 amounted to 71.2% of the total deaths as against a percentage of 73.5 in 1959.

The foregoing is a summary of the more general aspects of the vital statistics which are given in detail in the following tables.

TABLE A

POPULATION

Year	Administrative County	City	Rural Area Aggregate	Rural Area		
				Chesterton	Newmarket	South Cambs.
1951	175,000	89,510	85,490	39,060	20,220	26,210
1952	176,300	90,740	85,560	39,370	20,120	26,070
1953	177,100	90,910	86,190	39,450	20,110	26,630
1954	179,700	91,460	88,240	40,290	20,180	27,770
1955	179,800	91,140	88,660	40,490	20,190	27,980
1956	181,100	91,780	89,320	41,150	20,190	27,980
1957	182,200	91,980	90,220	41,850	20,230	28,140
1958	183,200	92,500	90,700	42,450	19,790	28,460
1959	184,500	93,140	91,360	42,980	19,880	28,500
1960	**186,260**	**93,840**	**92,420**	**43,970**	**20,060**	**28,390**

TABLE B

LIVE BIRTH RATES PER THOUSAND POPULATION

England and Wales 1960=17.1 **County 5 year average (1955-59)=15.1**

	County			City			Rural Area Aggregate			Chesterton			Newmarket			South Cambridgeshire		
	No.	Rate	Comparability factor	No.	Rate	Comparability factor	No.	Rate	Comparability factor	No.	Rate	Comparability factor	No.	Rate	Comparability factor	No.	Rate	Comparability factor
1957	2,809	15.4	1.06	1,257	13.7	1.03	1,552	17.2	1.10	739	17.7	1.10	306	15.1	1.09	507	18.0	1.12
1958	2,892	15.8	1.06	1,324	14.3	1.03	1,568	17.3	1.08	746	17.6	1.06	309	15.6	1.09	513	18.0	1.12
1959	2,942	15.9	1.06	1,354	14.5	1.03	1,588	17.4	1.08	787	18.3	1.06	286	14.4	1.09	515	18.1	1.12
1960	**3,144**	**16.9**	**1.06**	**1,408**	**15.1**	**1.03**	**1,726**	**18.7**	**1.08**	**819**	**18.6**	**1.06**	**340**	**16.9**	**1.09**	**567**	**20.0**	**1.09**

TABLE C

ILLEGITIMATE LIVE BIRTHS (Rate per cent of total live births)

	County		City		Rural Area Aggregate	
	No.	Rate	No.	Rate	No.	Rate
1957	109	3.9	60	4.8	49	3.2
1958	129	4.5	64	4.8	65	4.1
1959	122	4.1	67	4.9	55	3.5
1960	**137**	**4.4**	**83**	**5.9**	**54**	**3.1**

TABLE D

STILL BIRTHS (Rate per thousand total births)

England and Wales 1960=19.7 **County 5 year average (1955-59)=17.1**

	County		City		Rural Area Aggregate	
	No.	Rate	No.	Rate	No.	Rate
1957	47	16.5	17	13.3	30	19.0
1958	42	14.3	17	12.7	25	15.7
1959	50	16.7	22	16.0	28	17.3
1960	**45**	**14.1**	**18**	**12.5**	**27**	**15.4**

TABLE E

Total Live and Still Births

Year	Administrative County	City	Rural Area Aggregate	Rural Area		
				Chesterton	Newmarket	South Cambs.
1959	2992	1376	1616	805	292	519
1960	**3189**	**1436**	**1753**	**831**	**348**	**574**

TABLE F

INFANT MORTALITY (Deaths under one year per thousand live births)

England and Wales 1960=21.7 **County 5 year average (1955-59)=15.1**

	County		City		Rural Area Aggregate	
	No.	Rate	No.	Rate	No.	Rate
1957	52	18.5	25	19.9	27	17.4
1958	52	18.3	19	14.4	33	21.0
1959	49	16.7	29	21.4	20	12.6
1960	**52**	**16.5**	**26**	**18.3**	**26**	**15.1**

TABLE G

INFANT MORTALITY RATE (legitimate)

(Rate per thousand legitimate live births)

	County		City		Rural Area Aggregate	
	No.	Rate	No.	Rate	No.	Rate
1958	47	17.0	18	14.3	29	19.3
1959	48	17.0	28	21.8	20	13.0
1960	**48**	**16.0**	**24**	**18.0**	**24**	**14.4**

TABLE H

INFANT MORTALITY RATE (Illegitimate)

(Rate per thousand illegitimate live births)

	County		City		Rural Area Aggregate	
	No.	Rate	No.	Rate	No.	Rate
1958	5	38.8	1	15.6	4	61.5
1959	1	8.2	1	14.9	—	0.0
1960	**4**	**29.2**	**2**	~~24.9~~ 24.1	**2**	**37.0**

TABLE I

NEO NATAL DEATH RATE (Deaths in first 4 weeks of life per 1,000 live births)

	County		City		Rural Area Aggregate	
	No.	Rate	No.	Rate	No.	Rate
1958	38	13.1	15	11.3	23	14.7
1959	36	12.2	20	14.8	16	10.1
1960	**35**	**11.1**	**16**	**11.3**	**19**	**11.0**

TABLE J

EARLY NEO NATAL DEATH RATE (Deaths in first week of life per 1,000 live births)

	County		City		Rural Area Aggregate	
	No.	Rate	No.	Rate	No.	Rate
1959	33	11.2	19	14.0	14	8.8
1960	**32**	**10.2**	**13**	**9.2**	**19**	**11.0**

TABLE K

PERINATAL MORTALITY RATE (Stillbirths and deaths in first week of life combined per 1,000 total live and still births)

	County		City		Rural Area Aggregate	
	No.	Rate	No.	Rate	No.	Rate
1959	83	27.7	41	29.8	42	26.0
1960	**77**	**24.1**	**31**	**21.6**	**46**	**26.2**

TABLE L

MATERNAL DEATHS (Rate per thousand total births)

	County		City		Rural Area Aggregate	
	No.	Rate	No.	Rate	No.	Rate
1957	3	1.05	1	0.78	2	1.26
1958	2	0.68	1	0.75	1	0.63
1959	1	0.33	—	0.00	1	0.62
1960	—	0.00	—	0.00	—	0.00

TABLE M

DEATH RATES PER THOUSAND POPULATION

England and Wales 1960=11.5 **County 5 year average (1955-59)=11.0**

Year	County			City			Rural Area Aggregate		
	No.	Rate	Comparability Factor	No.	Rate	Comparability Factor	No.	Rate	Comparability Factor
1957	1,952	10.7	0.89	960	10.4	0.96	992	11.0	0.83
1958	1,984	10.8	0.91	974	10.5	1.00	1,010	11.1	0.84
1959	2,026	11.0	0.92	984	10.6	1.00	1,042	11.4	0.85
1960	**1,960**	**10.5**	**0.95**	**917**	**9.8**	**1.02**	**1,043**	**11.3**	**0.95**

TABLE N

TUBERCULOSIS DEATHS (all forms)

(Rate per 1,000 population)

	County		City		Rural Area Aggregate	
	No.	Rate	No.	Rate	No.	Rate
1957	5	0.03	2	0.02	3	0.03
1958	9	0.05	6	0.06	3	0.03
1959	6	0.03	—	0.00	6	0.07
1960	**10**	**0.05**	**3**	**0.03**	**7**	**0.08**

TABLE O

CANCER DEATHS

	County				City				Rural Area Aggregate			
	Male		*Female*		*Male*		*Female*		*Male*		*Female*	
	All Sites	Lung and Bronchus	All Sites	Lung and Bronchus	All Sites	Lung and Bronchus	All Sites	Lung and Bronchus	All Sites	Lung and Bronchus	All Sites	Lung and Bronchus
1958	209	73	170	11	104	36	95	7	105	37	75	4
1959	190	55	159	7	87	26	77	4	103	29	82	3
1960	**191**	**65**	**170**	**9**	**94**	**35**	**85**	**6**	**97**	**30**	**85**	**3**

TABLE P
CAUSES OF DEATH AT DIFFERENT PERIODS OF LIFE
City of Cambridge

	Sex	0-	1-	5-	15-	25-	45-	65-	75-	All Ages	1959
1. Tuberculosis, respiratory	M	—	—	—	—	—	2	—	—	2	—
	F	—	—	—	—	—	—	—	1	1	—
2. Tuberculosis, other	M	—	—	—	—	—	—	—	—	—	—
	F	—	—	—	—	—	—	—	—	—	—
3. Syphilitic disease	M	—	—	—	—	—	2	1	1	4	1
	F	—	—	—	—	—	—	—	—	—	—
4. Diphtheria	M	—	—	—	—	—	—	—	—	—	—
	F	—	—	—	—	—	—	—	—	—	—
5. Whooping cough	M	—	—	—	—	—	—	—	—	—	—
	F	—	—	—	—	—	—	—	—	—	—
6. Meningococcal infections	M	1	—	—	—	—	—	—	—	1	—
	F	—	—	—	—	—	—	—	—	—	—
7. Acute poliomyelitis	M	—	—	—	—	—	—	—	—	—	—
	F	—	—	—	—	—	—	—	—	—	—
8. Measles	M	—	—	—	—	—	—	—	—	—	—
	F	—	—	—	—	—	—	—	—	—	—
9. Other infective and parasitic diseases	M	—	—	—	—	—	1	—	1	2	3
	F	—	—	—	—	2	—	—	1	3	—
10. Malignant neoplasm, stomach	M	—	—	—	—	1	6	3	4	14	15
	F	—	—	—	—	—	2	6	4	12	6
11. Malignant neoplasm, lung, bronchus	M	—	—	—	—	—	21	10	4	35	26
	F	—	—	—	—	1	4	—	1	6	4
12. Malignant neoplasm, breast	M	—	—	—	—	—	—	—	—	—	1
	F	—	—	—	—	2	5	4	1	12	21
13. Malignant neoplasm, uterus	M	—	—	—	—	—	—	—	—	—	—
	F	—	—	—	—	1	1	1	1	4	7
14. Other malignant and lymphatic neoplasms	M	—	—	—	—	4	15	15	11	45	45
	F	—	—	—	1	—	17	14	19	51	39
15. Leukaemia, aleukaemia	M	—	—	—	—	—	—	—	1	1	2
	F	—	—	—	—	1	1	—	—	2	1
16. Diabetes	M	—	—	—	—	—	2	1	—	3	1
	F	—	—	1	—	—	—	3	3	7	3
17. Vascular lesions of nervous system	M	—	—	—	1	—	8	22	29	60	69
	F	—	—	—	—	1	15	21	74	111	136
18. Coronary disease, angina	M	—	—	—	—	—	20	22	30	72	88
	F	—	—	—	—	—	11	22	40	73	74
19. Hypertension with heart disease	M	—	—	—	—	1	3	—	1	5	5
	F	—	—	—	—	—	2	5	8	15	15
20. Other heart disease	M	—	—	—	—	1	3	3	16	23	41
	F	—	—	—	—	—	1	8	38	47	57
21. Other circulatory disease	M	—	—	—	—	1	4	2	9	16	17
	F	—	—	—	—	—	4	6	13	23	35
22. Influenza	M	—	—	—	—	—	—	—	1	1	12
	F	—	—	—	—	—	—	—	—	—	10
23. Pneumonia	M	1	1	—	—	—	4	3	12	21	23
	F	2	1	—	—	—	1	3	12	19	25
24. Bronchitis	M	1	—	—	—	—	6	15	16	38	27
	F	1	—	—	—	—	1	2	8	12	15
25. Other diseases of respiratory system	M	—	—	—	—	—	1	2	4	7	4
	F	—	—	—	—	—	—	1	1	2	1
26. Ulcer of stomach and duodenum	M	—	—	—	—	1	1	2	6	10	5
	F	—	—	—	—	1	2	1	5	9	4
27. Gastritis, enteritis and diarrhoea	M	—	—	—	—	1	—	—	1	2	4
	F	—	—	—	—	—	—	—	1	1	2
28. Nephritis and nephrosis	M	—	—	—	—	1	2	—	1	4	1
	F	—	—	—	—	—	1	1	—	2	1
29. Hyperplasia of prostate	M	—	—	—	—	—	—	2	3	5	9
	F	—	—	—	—	—	—	—	—	—	—
30. Pregnancy, childbirth, abortion	M	—	—	—	—	—	—	—	—	—	—
	F	—	—	—	—	—	—	—	—	—	—
31. Congenital malformation	M	5	—	—	—	—	1	—	—	6	4
	F	1	—	—	—	—	—	1	—	2	4
32. Other defined and illdefined diseases	M	8	—	1	—	—	2	4	11	26	32
	F	5	—	—	—	—	7	5	20	37	38
33. Motor vehicle accidents	M	—	—	—	2	1	3	2	1	9	7
	F	—	—	—	1	—	—	—	—	1	3
34. All other accidents	M	—	2	1	4	—	1	—	6	14	15
	F	—	—	—	—	—	2	—	11	13	11
35. Suicide	M	—	—	—	3	4	3	3	1	14	9
	F	—	—	—	—	2	5	2	2	11	6
36. Homicide and operations of war	M	—	—	—	—	—	—	—	—	—	—
	F	1	—	—	—	—	—	—	—	1	—
ALL CAUSES	M	16	3	2	10	16	111	112	170	440	465
	F	10	1	1	2	11	82	106	264	477	519

TABLE Q
CAUSES OF DEATH AT DIFFERENT PERIODS OF LIFE
Aggregate of Rural Districts

	Sex	0-	1-	5-	15-	25-	45-	65-	75-	All Ages	1959
1. Tuberculosis, respiratory	M	—	—	—	—	2	2	1	—	5	4
	F	—	—	—	—	1	—	—	1	2	2
2. Tuberculosis, other	M	—	—	—	—	—	—	1	—	1	—
	F	—	—	—	—	—	1	—	—	1	—
3. Syphilitic disease	M	—	—	—	—	—	—	—	—	—	1
	F	—	—	—	—	—	—	—	—	—	1
4. Diphtheria	M	—	—	—	—	—	—	—	—	—	—
	F	—	—	—	—	—	—	—	—	—	—
5. Whooping cough	M	—	—	—	—	—	—	—	—	—	—
	F	—	—	—	—	—	—	—	—	—	—
6. Meningococcal infections	M	—	—	—	—	—	—	—	—	—	—
	F	—	—	—	—	—	—	—	—	—	—
7. Acute poliomyelitis	M	—	—	—	—	—	—	—	—	—	—
	F	—	—	—	—	—	—	—	—	—	—
8. Measles	M	—	—	—	—	—	—	—	—	—	—
	F	—	—	—	—	—	—	—	—	—	—
9. Other infective and parasitic diseases	M	—	—	—	—	—	1	—	—	1	1
	F	—	—	—	—	—	1	1	1	3	—
10. Malignant neoplasm, stomach	M	—	—	—	—	1	8	4	3	16	22
	F	—	—	—	—	1	2	1	2	6	8
11. Malignant neoplasm, lung, bronchus	M	—	—	—	—	2	14	11	3	30	29
	F	—	—	—	—	—	1	1	1	3	3
12. Malignant neoplasm, breast	M	—	—	—	—	—	—	—	—	—	—
	F	—	—	—	—	2	6	5	2	15	20
13. Malignant neoplasm, uterus	M	—	—	—	—	—	—	—	—	—	—
	F	—	—	—	—	1	7	2	4	14	8
14. Other malignant and lymphatic neoplasms	M	—	—	1	1	3	13	18	15	51	52
	F	—	—	—	—	—	15	16	16	47	43
15. Leukaemia, aleukaemia	M	—	—	—	—	1	2	2	1	6	—
	F	—	—	1	—	—	1	—	1	3	1
16. Diabetes	M	—	—	—	—	—	—	2	1	3	2
	F	—	—	—	—	—	1	2	1	4	1
17. Vascular lesions of nervous system	M	—	—	—	—	—	12	20	37	69	54
	F	—	—	—	—	1	17	14	63	95	101
18. Coronary disease, angina	M	—	—	—	—	2	23	35	40	100	78
	F	—	—	—	—	—	12	29	34	75	56
19. Hypertension with heart disease	M	—	—	—	—	—	1	3	4	8	6
	F	—	—	—	—	—	1	5	7	13	12
20. Other heart disease	M	—	—	—	—	1	9	10	42	62	77
	F	—	—	—	—	2	3	8	72	85	90
21. Other circulatory disease	M	—	—	—	—	1	7	5	13	26	31
	F	—	—	—	—	1	3	4	15	23	20
22. Influenza	M	—	—	—	—	1	1	—	—	2	11
	F	—	—	—	—	—	—	—	3	3	5
23. Pneumonia	M	—	1	—	—	—	1	5	11	18	30
	F	—	1	—	—	1	—	5	18	25	25
24. Bronchitis	M	—	—	—	—	—	8	7	15	30	35
	F	2	1	—	—	1	—	1	6	11	6
25. Other diseases of respiratory system	M	2	—	—	—	—	1	3	1	7	7
	F	—	—	—	—	—	—	—	3	3	2
26. Ulcer of stomach and duodenum	M	—	—	—	—	—	1	2	4	7	4
	F	—	—	—	—	—	—	—	3	3	3
27. Gastritis, enteritis and diarrhoea	M	—	—	—	—	—	—	—	1	1	2
	F	—	—	—	—	—	—	—	—	—	2
28. Nephritis and nephrosis	M	—	—	—	—	—	1	—	2	3	9
	F	—	—	—	—	—	2	1	—	3	2
29. Hyperplasia of prostate	M	—	—	—	—	—	—	—	3	3	11
	F	—	—	—	—	—	—	—	—	—	—
30. Pregnancy, childbirth, abortion	M	—	—	—	—	—	—	—	—	—	—
	F	—	—	—	—	—	—	—	—	—	1
31. Congenital malformation	M	1	—	—	2	—	—	—	—	3	10
	F	1	—	—	—	1	—	—	—	2	4
32. Other defined and illdefined diseases	M	15	1	1	—	1	6	9	13	46	37
	F	5	1	—	—	2	4	10	19	41	47
33. Motor vehicle accidents	M	—	—	1	9	3	6	—	2	21	16
	F	—	—	—	—	—	—	—	—	—	8
34. All other accidents	M	—	1	1	3	2	3	1	3	14	16
	F	—	—	—	—	1	1	5	16	23	19
35. Suicide	M	—	—	—	1	—	1	1	1	4	5
	F	—	—	—	—	—	1	—	—	1	2
36. Homicide and operations of war	M	—	—	—	—	—	—	—	—	—	—
	F	—	—	1	—	1	—	—	—	2	—
ALL CAUSES	M	18	3	4	16	20	121	140	215	537	550
	F	8	3	2	—	16	79	110	288	506	492

TABLE R
CAUSES OF DEATH AT DIFFERENT PERIODS OF LIFE
Administrative County

	Sex	0-	1-	5-	15-	25-	45-	65-	75-	All Ages	1959
1. Tuberculosis, respiratory	M	—	—	—	—	2	4	1	—	7	4
	F	—	—	—	—	1	—	—	2	3	2
2. Tuberculosis, other	M	—	—	—	—	—	—	1	—	1	—
	F	—	—	—	—	—	1	—	—	1	—
3. Syphilitic disease	M	—	—	—	—	—	2	1	1	4	1
	F	—	—	—	—	—	—	—	—	—	2
4. Diphtheria	M	—	—	—	—	—	—	—	—	—	—
	F	—	—	—	—	—	—	—	—	—	—
5. Whooping cough	M	—	—	—	—	—	—	—	—	—	—
	F	—	—	—	—	—	—	—	—	—	—
6. Meningococcal infections	M	1	—	—	—	—	—	—	—	1	—
	F	—	—	—	—	—	—	—	—	—	—
7. Acute poliomyelitis	M	—	—	—	—	—	—	—	—	—	—
	F	—	—	—	—	—	—	—	—	—	—
8. Measles	M	—	—	—	—	—	—	—	—	—	—
	F	—	—	—	—	—	—	—	—	—	—
9. Other infective and parasitic diseases ..	M	—	—	—	—	—	2	—	1	3	4
	F	—	—	—	—	2	1	1	2	6	—
10. Malignant neoplasm, stomach	M	—	—	—	—	2	14	7	7	30	37
	F	—	—	—	—	1	4	7	6	18	14
11. Malignant neoplasm, lung, bronchus ..	M	—	—	—	—	2	35	21	7	65	55
	F	—	—	—	—	1	5	1	2	9	7
12. Malignant neoplasm, breast	M	—	—	—	—	—	—	—	—	—	1
	F	—	—	—	—	4	11	9	3	27	41
13. Malignant neoplasm, uterus	M	—	—	—	—	—	—	—	—	—	—
	F	—	—	—	—	2	8	3	5	18	15
14. Other malignant and lymphatic neoplasms	M	—	—	1	1	7	28	33	26	96	97
	F	—	—	—	1	—	32	30	35	98	82
15. Leukaemia, aleukaemia	M	—	—	—	—	1	2	2	2	7	2
	F	—	—	1	—	1	2	—	1	5	2
16. Diabetes	M	—	—	—	—	—	2	3	1	6	3
	F	—	—	1	—	—	1	5	4	11	4
17. Vascular lesions of nervous system ..	M	—	—	—	1	—	20	42	66	129	123
	F	—	—	—	—	2	32	35	137	206	237
18. Coronary disease, angina	M	—	—	—	—	2	43	57	70	172	166
	F	—	—	—	—	—	23	51	74	148	130
19. Hypertension with heart disease.. ..	M	—	—	—	—	1	4	3	5	13	11
	F	—	—	—	—	—	3	10	15	28	27
20. Other heart disease	M	—	—	—	—	2	12	13	58	85	118
	F	—	—	—	—	2	4	16	110	132	147
21. Other circulatory disease	M	—	—	—	—	2	11	7	22	42	48
	F	—	—	—	—	1	7	10	28	46	55
22. Influenza	M	—	—	—	—	1	1	—	1	3	23
	F	—	—	—	—	—	—	—	3	3	15
23. Pneumonia	M	1	2	—	—	—	5	8	23	39	53
	F	2	2	—	—	1	1	8	30	44	50
24. Bronchitis	M	1	—	—	—	—	14	22	31	68	62
	F	3	1	—	—	1	1	3	14	23	21
25. Other diseases of respiratory system ..	M	2	—	—	—	—	2	5	5	14	11
	F	—	—	—	—	—	—	1	4	5	3
26. Ulcer of stomach and duodenum ..	M	—	—	—	—	1	2	4	10	17	9
	F	—	—	—	—	1	2	1	8	12	7
27. Gastritis, enteritis and diarrhoea ..	M	—	—	—	—	1	—	—	2	3	6
	F	—	—	—	—	—	—	—	1	1	4
28. Nephritis and nephrosis	M	—	—	—	—	1	3	—	3	7	10
	F	—	—	—	—	—	3	2	—	5	3
29. Hyperplasia of prostate	M	—	—	—	—	—	—	2	6	8	20
	F	—	—	—	—	—	—	—	—	—	—
30. Pregnancy, childbirth, abortion	M	—	—	—	—	—	—	—	—	—	—
	F	—	—	—	—	—	—	—	—	—	1
31. Congenital malformation	M	6	—	—	2	—	1	—	—	9	14
	F	2	—	—	—	1	—	1	—	4	8
32. Other defined and illdefined diseases ..	M	23	1	2	—	1	8	13	24	72	69
	F	10	1	—	—	2	11	15	39	78	85
33. Motor vehicle accidents	M	—	—	1	11	4	9	2	3	30	23
	F	—	—	—	1	—	—	—	—	1	11
34. All other accidents	M	—	3	2	7	2	4	1	9	28	31
	F	—	—	—	—	1	3	5	27	36	30
35. Suicide	M	—	—	—	4	4	4	4	2	18	14
	F	—	—	—	—	2	6	2	2	12	8
36. Homicide and operations of war ..	M	—	—	—	—	—	—	—	—	—	—
	F	1	—	1	—	1	—	—	—	3	—
ALL CAUSES	M	34	6	6	26	36	232	252	385	977	1015
	F	18	4	3	2	27	161	216	552	983	1011

INFECTIOUS DISEASE

The following tables give details of the principal infectious diseases notified in the City and the rural area:—

TABLE 27

NOTIFICATION OF INFECTIOUS DISEASE IN THE CITY IN AGE GROUPS, 1960

Age in Years	Scarlet fever	Whooping cough	Acute Poliomyelitis		Measles	Diphtheria	Dysentery	Meningo-coccal infection	Totals
			Paralytic	Non-paralytic					
Under 1 year	1	2	—	—	—	—	3	—	6
1— ,,	—	2	—	—	9	—	2	—	13
2— ,,	1	3	—	—	6	—	5	1	16
3— ,,	3	5	—	—	5	—	1	—	14
4— ,,	11	2	—	—	8	—	6	—	27
5—9 ,,	34	4	—	—	32	—	18	—	88
10—14 ,,	6	—	—	—	1	—	7	—	14
15—24 ,,	2	—	—	1	—	—	15	—	18
25 and over	1	—	—	—	1	—	22	—	24
Age unknown	—	—	—	—	—	—	5	—	5
Totals	59	18	—	1	62	—	84	1	225
1959 Totals	87	49	—	—	2158	—	53	1	2348

Age in Years	Acute pneu-monia	Small-pox	Acute encephalitis		Enteric or typhoid fever	Para-typhoid fever	Erysi-pelas	Food Poison-ing	Puer-peral Pyrexia	Oph-thalmia Neona-torum	Totals
			Infective	Post-Infecti-ous							
Under 5 years	—	—	—	—	—	—	—	—	—	—	—
5—14 ,,	3	—	—	—	—	—	—	—	—	—	3
15—44 ,,	3	—	—	—	1	—	—	—	—	—	4
45—64 ,,	2	—	—	—	—	—	5	—	—	—	7
65 and over	5	—	—	—	—	—	—	—	—	—	5
Age unknown	—	—	—	—	—	1	—	—	31	—	32
Totals	13	—	—	—	1	1	5	—	31	—	51
1959 Totals	24	—	—	—	1	—	4	—	88	1	118

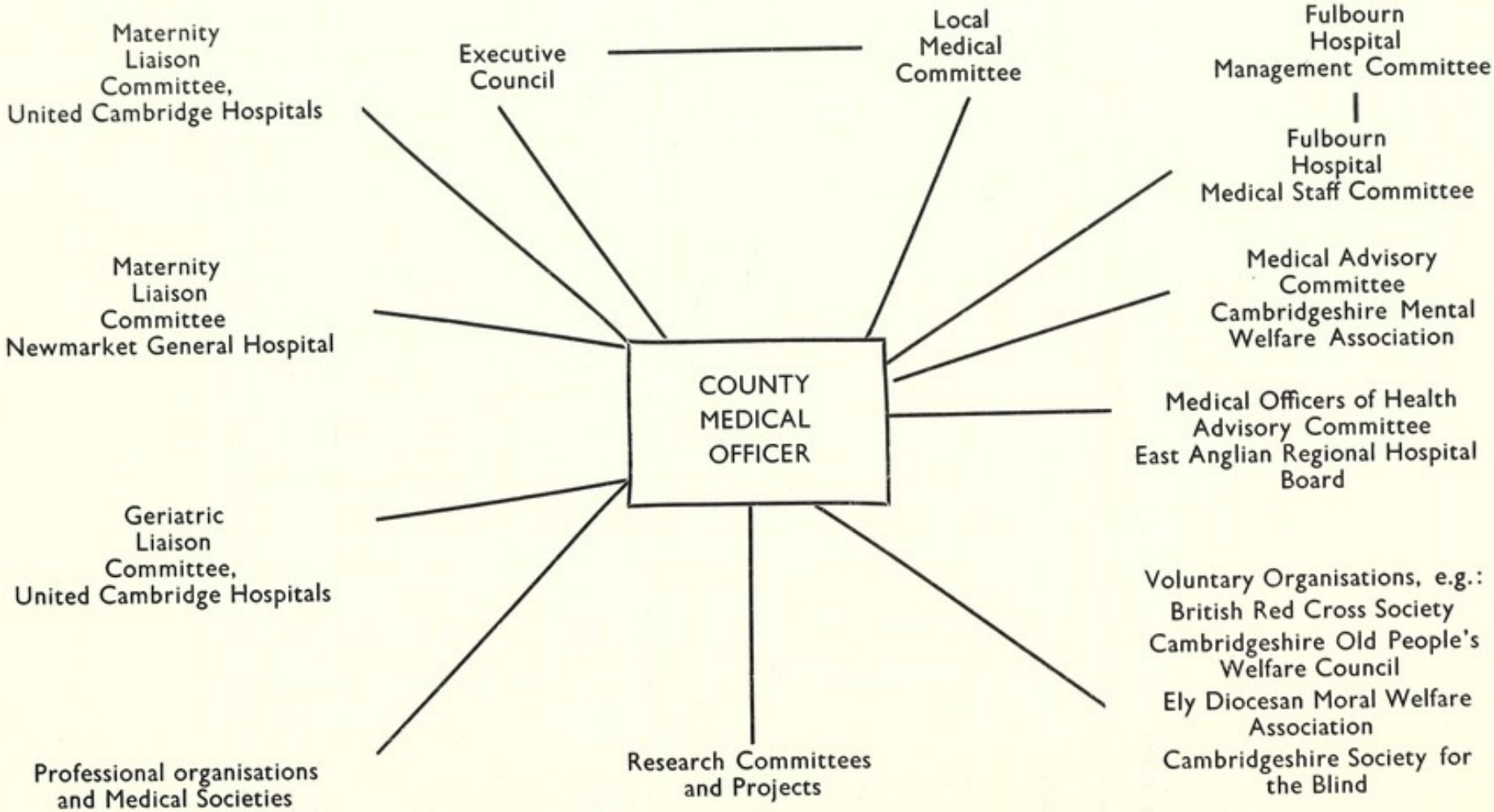
TABLE 27A

NOTIFICATION OF INFECTIOUS DISEASE IN THE COUNTY (EXCLUDING CITY) IN AGE GROUPS, 1960

Age in Years	Scarlet fever	Whooping cough	Acute poliomyelitis		Measles	Diphtheria	Dysentery	Meningo-coccal infection	Totals
			Paralytic	Non-Paralytic					
Under 1 year	2	3	—	—	10	—	2	—	17
1— ,,	1	10	—	—	20	—	7	—	38
2— ,,	5	14	—	—	21	—	5	—	45
3— ,,	7	12	—	—	19	—	6	—	44
4— ,,	13	14	—	—	28	—	4	—	59
5—9 ,,	65	43	—	—	97	—	44	—	249
10—14 ,,	12	10	—	—	7	—	16	—	45
15—24 ,,	4	—	—	—	2	—	14	—	20
25 and over	1	5	—	—	—	—	35	—	41
Totals	110	111	—	—	204	—	133	—	558
1959 Totals	174	121	—	—	2623	—	36	—	2954

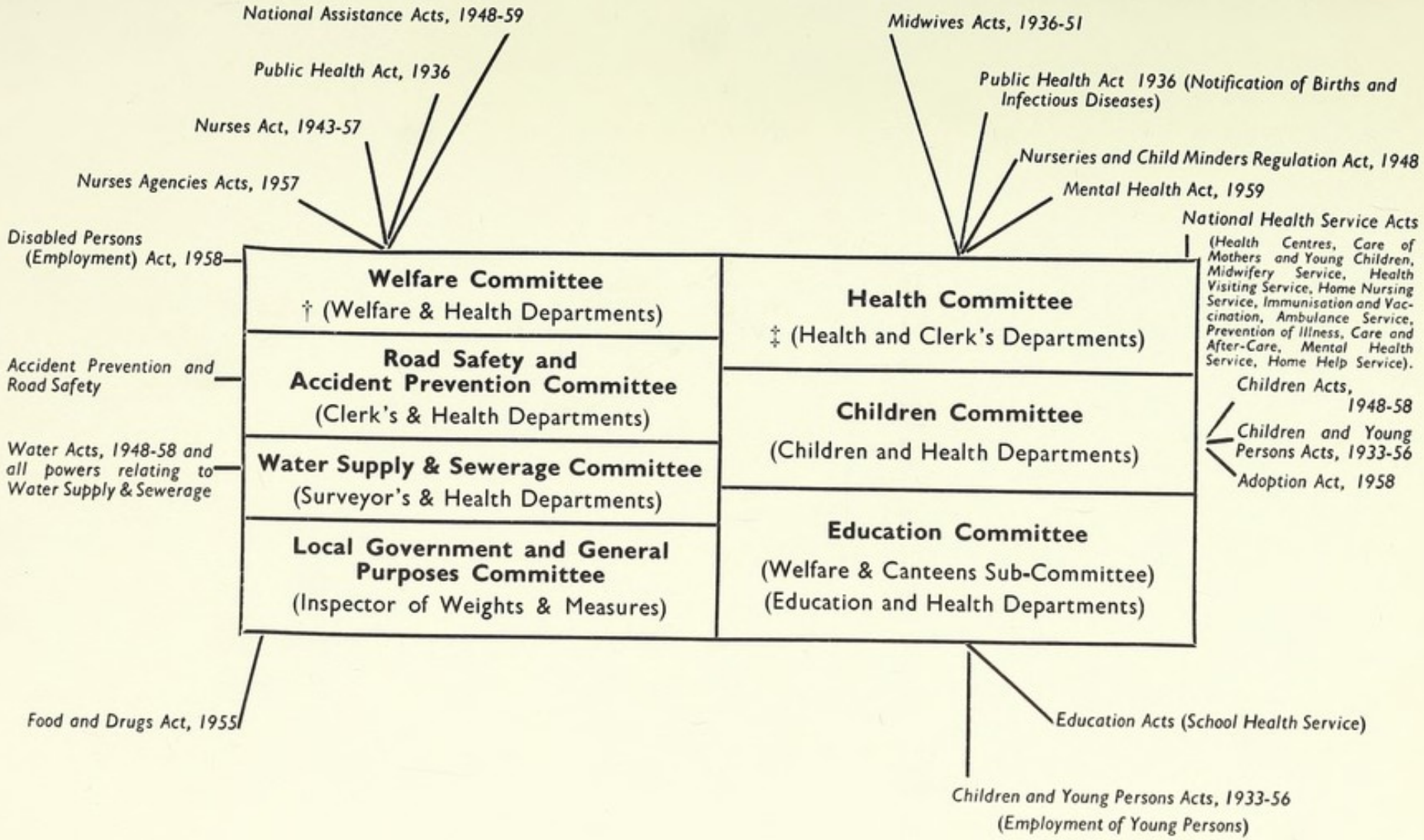
Age in Years	Acute pneu-monia	Small-pox	Acute encephalitis		Enteric or Typhoid fever	Para-typhoid fevers	Erysi-pelas	Food Poison-ing	Puer-peral Pyrexia	Oph-thalmia Neona-torum	Totals
			Infective	Post-Infecti-ous							
Under 5 years	2	—	1	—	—	—	—	1	—	—	4
5—14 ,,	2	—	—	—	—	—	—	2	—	—	4
15—44 ,,	4	—	—	—	—	—	1	6	—	—	11
45—64 ,,	7	—	—	—	—	—	4	2	—	—	13
65 and over	7	—	—	—	—	—	—	—	—	—	7
Age unknown	—	—	—	—	—	—	—	—	2	—	2
Totals	22	—	1	—	—	—	5	11	2	—	41
1959 Totals	25	—	—	1	—	—	6	15	4	1	52

LIAISON ARRANGEMENTS



Close co-operation is maintained between the County Health Department and the Department of Human Ecology in the University of Cambridge.

ADMINISTRATION OF HEALTH, WELFARE AND ENVIRONMENTAL SERVICES WITHIN THE COUNTY COUNCIL



† The County Medical Officer is responsible for the administration of the services for the welfare of blind and other disabled persons.

‡ The Ambulance Service is administered by the Clerk of the Council.