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COUNTY COUNCIL OF CUMBERLAND

Annual Report

ON THE

HEALTH SERVICES OF THE COUNTY

For the Year 1948

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COUNTY MEDICAL OFFICER

INDEX

TO THE CHAIRMAN AND MEMBERS OF THE CUMBERLAND COUNTY COUNCIL.

MR. CHAIRMAN, MY LORD, LADIES AND GENTLEMEN,

I beg to present the Annual Report on the Health Services of the County. The report is a little later than usual, but it has been a difficult report to compile because of the changed conditions affecting the year under revision. The structure of the report has had to be rebuilt, but I hope the form devised may serve as a framework for future reports. It would have been quite easy to have presented a statistical document, and, in respect of duties which have now passed into other hands, merely to record the fact, but the result would have been a document of little value. The report is not long, but is, I hope, informative on all essential points.

There are many references in the report to the work of the Special Area Committee, and a word about this is necessary. Cumberland, Carlisle, and North Westmorland form an area, one of five in the country, in which the Ministry have set up a Special Area Committee off the general pattern. Our Special Area Committee acts on behalf of the Newcastle Regional Hospital Board. The Committee has had delegated to it a substantial degree of autonomy, and its duties, by and large, are those of a Regional Hospital Board on a small scale. The Special Area Committee is in charge of the hospital and specialist services for the area, and therefore we, as a Health Authority, are deeply interested in its proceedings, and, in fact, the services of the two bodies interlock at many points. The Chairman of the County Council, the Chairman of the Health Committee, another member of the Council (Mr. Waddell), and myself, are members of the Special Area Committee, and many members of the Council sit on the hospital management committees and house committees in the area. The members of these committees sit as individuals and not as representing any particular body, but the link remains. Relations between the County Council and the Special Area Committee, and in certain matters between the County Council and the Regional Hospital Board, have, naturally, mainly been at the officer level. These relations have been of the happiest.

The new services with which, among others, this report deals, are chiefly the mental health service, the ambulance & sitting case car service, the home help service, and the home nursing service.

The hospital and specialist services have, on paper, passed completely out of our hands as a Health Authority, but we still retain close links with both, and as I have said later, I hope these links will be developed and extended.

Vital Statistics.

Vital statistics for 1948 call for little comment. The birth-rate has fallen in conformity with the rest of the country.

The death-rate has also fallen, and particularly the infantile death-rate, which has fallen from 42 per 1,000 live births to 37. The maternal death-rate has, unhappily, risen ; deaths from cancer are slightly lower ; deaths from pulmonary tuberculosis are higher.

That, I think, is all that needs to be said here about the principal vital statistics which are discussed in more detail in other parts of this report.

The future of the Public Health Medical Service.

Over the whole future of medicine there hangs, if not the sword of Damocles, at least a big question mark. This does not, in the main, affect those matters which formed the basis of so much controversy prior to the passing of the National Health Service Act ; it concerns something quite different which perhaps could not have been foreseen by anyone.

The situation is this. When a young graduate in medicine leaves his university he has a wide choice of activity before him. He may enter the government service, or the local government service, he may accept a permanent commission in one or other of the forces, he may enter the colonial service, and so on, but in the main his choice lies between general practice and specialisation.

In both of these branches of medicine the *immediate* prospects are good, and very much better than the prospects for young graduates were a few years ago.

From the long term point of view, however, the situation is not so good. If a young doctor desires to specialise, and is approved for specialisation, in due course he becomes a registrar, and there are several grades of registrars who are, in fact specialists in training. The trouble is that on completion of a number of years, about six to eight, in the registrar grade, he may, unless he is successful in obtaining a post in the specialist grade, become redundant, and may have to transfer to general practice or some other branch of medicine.

Appointments of specialists to posts in the hospital service are generally the subject of hot competition. I was

recently a member of a committee making such an appointment and we had to investigate the applications of no less than 54 highly qualified men. Such a situation naturally creates anxiety among the younger specialists in training.

If on the other hand a young doctor decides to proceed into general practice, here again he comes up against a serious obstacle. True he can be engaged as an assistant at a good salary for the time being, but if he desires to go into practice on his own, which is the obvious target, when applying for a vacancy he has again to come into competition with others, and so far as I can see it he may go on for years, perhaps for life, without being a successful applicant. True under certain conditions he can start on his own in an area in which his name is on the approved list, but, unless he is following on a vacancy, his uphill work is going to be very hard indeed.

That then is the problem both as regards specialisation and as regards general practice, namely that the ultimate decision is competitive, and it has to be remembered that many good men are not at their best at interviews at which their future is at stake.

If this situation continues to prevail it is likely that in future parents will have misgivings in sending their sons into medicine, and if that were so the obvious result would mean inadequate recruitment to the profession.

The point which, of course, concerns health authorities is the recruitment of medical staff at an adequate level of experience and in sufficient numbers to keep the service going. I do not think there is any doubt that recent events have had an important bearing on this matter. One of my colleagues* has summed up the matter very well indeed in the following sentence : " To all intents and purposes there has been a severance of the preventive and social from the treatment or curative sides of medicine." There can be no reasonable doubt that, following upon the transfer of the hospital and specialist services to the Regional Hospital Boards, the amount of *treatment* left to medical officers of local health authorities has been very greatly reduced. We have, in this County, now to deal with child welfare clinics, the treatment of minor ailments, and little else. There is, too, the fear that the school medical service (which implies school clinics) may in the future pass out of our hands. All this would mean that the functions of the average assistant medical officer in the employment of a local authority would be confined to little more than *ascertainment*. Such a position would set the

*Annual report of the County Medical Officer for the East Riding of Yorkshire for 1948.

clock back to the time, many years ago now, when ascertainment was, in fact, the sole duty of the average assistant medical officer. I am sufficiently senior to have worked under these conditions, and I can say with confidence that such a situation is of so little interest that it could not hope, in this year of grace, to attract young graduates of initiative and energy. The recent changes have not reduced interest at the top, at least not in anything like the same way. There the work remains varied and interesting and life is busy, but that is of no value in attracting new entrants.

Another important factor, of course, is that the salaries in the public health service have always been very poor. They are still based on the Askwith Scale, which, even with its meagre interim adjustments, is now hopelessly out of date. It is not surprising, therefore, that rumours have got about, which are probably well founded, that the number of students attending post-graduate courses in public health, with a view to making public health their profession, has fallen sharply, and that at some teaching schools there are almost no candidates.

There is probably no question of interest to local health authorities on which there is a wider diversity of opinion than this. Compare these quotations :—

(1) From the British Medical Journal—*September 3rd*, 1949.

"The prospects of a career in public health have never been better. The work is interesting and there is wide scope for experiment and imagination."

(2) From the Medical Officer—*August 13th*, 1949.

"* * * * those working the preventive services saw a bleak outlook before them. The Act was not designed to interfere with preventive medicine, on the contrary, but in practice it threatens to wipe out the service altogether and, as things are going, it looks as if it will do so in a few years time.

Our trouble is that we cannot obtain recruits and have poor prospects of obtaining them because the status and emoluments of the personnel of the Medical Health Service are inferior in their attractiveness."

(3) From A Paper Read before the Royal Sanitary Association of Scotland.

"The powers of the Officers of Local Authorities have been severely weakened."

(4) From a Letter in the British Medical Journal—*September* 17*th*, 1949.

"The opportunities in Public Health are infinite—one can only hope they will be grasped with both hands."

There are those who are optimistic about the future, who talk about socio-medicine, and so on. These men see far horizons that I cannot see. Perhaps the fault is mine. There are those, on the other hand, who have grave misgivings, who have written in the public health press under such titles as "*The Fragments which Remain.*" At the moment I think the balance of evidence is undoubtedly against undue optimism. I suppose most authorities have tested the market on many occasions in the last 18 months or so. I very much doubt if they can have been satisfied with the result. Certainly we in this county have done so on a number of occasions, and the majority of the applications were of a grade which in the past would have been consigned forthwith to the waste-paper basket. Fortunately there were exceptions from among whom we were able to make very satisfactory replacements.

I think the whole position is extremely serious, but I think it can be saved, not by high-faluting ideas about "socio-medicine," but in two ways: (1) by ensuring that men in the public health service, and especially the younger men, have decent salaries, and (2) by linking their work up with the hospital and specialist services of the Regional Hospital Boards.

Thanks.

Having unburdened my soul on the difficulties of the question of recruitment, I am glad to be able to wind up on a more pleasant note.

I am deeply grateful to the members of the Council, and particularly to the Chairman and members of the Health Committee, for their continuing interest and support.

I am grateful to all my staff for the way they have helped in the matter of the change-over. It is usually invidious to mention individuals, but I think I ought to say that I am particularly grateful to the heads of sections—the Senior Dental Officer, the Superintendent Nursing Officer, (who is also now the Home Help Organiser), the Administrative Assistant (Mental Health), and the Orthopædic Sister, who have placed me in their debt throughout, by so carrying out their duties that when matters, frequently complicated, have been referred to them I have been able to put them out of my mind.

I am also greatly indebted to the office staff, who, in spite of many changes, and calls on their services, which at times have been unreasonable, have always pulled their weight. The services of the Administrative Officer, as head of the office staff, have been invaluable.

I am,

Your obedient servant,

KENNETH FRASER,
County Medical Officer.

County Health Department,
11 Portland Square,
Carlisle.

October, 1949.

STATISTICAL AND SOCIAL CONDITIONS OF THE AREA.

The essential vital statistics for the year 1948 are as under :—

Population.

	At 1931 Census.	Estimated by Registrar General, Mid. 1948.
Urban Districts ..	114,459	84,250
Rural Districts ..	91,331	125,770
Administrative County ..	205,790	210,020

Population of Sanitary Districts, 1948.

Urban Districts.		
Workington	28540	
Whitehaven	23380	
Maryport	12040	
Penrith	10500	
Cockermouth	5160	
Keswick	4630	84250
Rural Districts.		
Border	28500	
Ennerdale	28260	
Wigton	22920	
Cockermouth	19530	
Millom	12760	
Penrith	11550	
Alston	2250	125770
Total for Administrative County ..		210020

Rateable Value and sum represented by a penny rate.

The rateable value of the County at 1st April, 1948, was £982,804. The estimated product of a penny rate was £4,014.

Extracts from vital statistics for the year 1948.

LIVE BIRTHS.

	Total Births.	Males.	Females
Legitimate ..	3,863	2,048	1,815
Illegitimate ..	210	106	104
Total ..	4,073	2,154	1,919

Birth Rate per 1,000 population—19.4
(England and Wales 17.9)

STILL BIRTHS.

	Total Still-Births.	Males.	Females.
Legitimate ..	103	55	48
Illegitimate ..	11	6	5
Total ..	114	61	53

Rate of Still-Births per 1,000 total births—27.

DEATHS.

Total Deaths.	Males.	Females.
2,442 ..	1,309 ..	1,133

Crude Death Rate per 1,000 population—11.7.
(England and Wales 10.8)

DEATHS FROM DISEASES AND ACCIDENTS OF PREGNANCY AND CHILDBIRTH.

From Sepsis	0
Other Causes	6

Maternal Death Rate per 1,000 Total Births—1.43

DEATH RATE OF INFANTS UNDER ONE YEAR OF AGE

All Infants per 1,000 Live Births	37
Legitimate Infants per 1,000 Legitimate Live Births	37
Illegitimate Infants per 1,000 Illegitimate Live Births	24
DEATHS FROM CANCER (ALL AGES)	356
DEATHS FROM MEASLES (ALL AGES)	3
DEATHS FROM WHOOPING COUGH (ALL AGES) ..	5
DEATHS FROM DIARRHŒA (UNDER 2 YEARS) ..	10

The 4,073 live-births were distributed among the Urban and Rural Districts, as follows :—

Births, 1948.

URBAN DISTRICTS.	Total Births	Legitimate	Illegitimate	Birth Rate
Cockermouth	96	91	5	18.6
Keswick	48	47	1	10.4
Maryport	227	217	10	18.9
Penrith	202	183	19	19.2
Whitehaven	484	456	28	20.7
Workington	563	542	21	19.7
Aggregate of Urban Districts	1620	1536	84	19.2
RURAL DISTRICTS				
Alston	35	33	2	15.6
Border	535	501	34	18.8
Cockermouth	372	349	23	19.0
Ennerdale	603	580	23	21.3
Millom	242	233	9	19.0
Penrith	206	194	12	17.8
Wigton	460	437	23	20.0
Aggregate of Rural Districts	2453	2327	126	19.5

The 2,442 deaths were distributed among the Urban and Rural Districts, as follows :—

Deaths, 1948.

Urban Districts	Total	Males	Females	Crude Death Rate
Cockermouth	57	24	33	11.0
Keswick	67	28	39	14.5
Maryport	151	78	73	12.5
Penrith	131	69	62	12.5
Whitehaven	271	162	109	11.6
Workington	311	178	133	10.9
Aggregate of Urban Districts	988	539	449	11.7
Rural Districts				
Alston	42	19	23	18.7
Border	315	170	145	11.1
Cockermouth	193	105	88	9.9
Ennerdale	353	198	155	12.5
Millom	152	85	67	11.9
Penrith	127	57	70	11.0
Wigton	272	136	136	11.9
Aggregate of Rural Districts .. .	1454	770	684	11.6

Causes of Death.

	No. of Deaths. 1947.	1948.
Heart Disease	764 ..	743
Inter-cranial Lesions (Cerebral Haemorrhage, &c.)	349 ..	277
Other Circulatory Diseases	95 ..	103
Cancer, Malignant Disease	377 ..	356
Congenital Debility, Premature Birth, &c.	109 ..	93
Pulmonary Tuberculosis	101 ..	116
Other Tuberculous Disease	32 ..	15
Pneumonia (all forms)	87 ..	67
Other Respiratory Diseases	40 ..	31
Deaths by Violence (including Suicide)	181 ..	53
Acute and Chronic Nephritis	60 ..	45
Bronchitis	118 ..	82
Diabetes	17 ..	19
Influenza	15 ..	9
Digestive Diseases	79 ..	83
All other causes	342 ..	338
Road Traffic Accidents	22 ..	12

The above table shows remarkably little variation from that of the previous year, except in the matter of deaths by violence which have fallen to less than one-third of last year's figure. The drop seems surprising until it is recalled that during 1947 the tragic disaster at the Haig Pit occurred. A halt for the time being seems to have been called in the ascending spirals of deaths from heart disease and allied conditions, and from cancer.

Infantile Mortality.

Of the 4073 live births during the year, 149 infants died before reaching the age of 12 months. The infant death-rate per thousand live births is 37 compared with 42 for 1947. The figure for England and Wales is 34. The causes of death, which call for no special comment, are shown in the following table :—

Causes of Deaths.	No. of Deaths. 1947.	1948.
Bronchitis	8	2
Debility, Congenital, premature birth, &c.	°106	*87
Digestive Diseases—Other	3	4
Diarrhoea, &c.	14	10
Whooping Cough	3	3
Diphtheria	—	—
Influenza	1	1
Measles	1	2
Pneumonia (all forms)	31	31
Tuberculosis—Non-Pulmonary	4	—
Tuberculosis—Pulmonary	—	—
Violence—Deaths by	9	1
Other Defined diseases	7	8
Totals	187	149

° Includes 48 premature births

* Includes 27 premature births.

The infantile mortality rate has again fallen to a new low level at 37 deaths per thousand live births. One has again to regret the high proportion of infant deaths due to such causes as congenital debility, premature birth, diarrhœa, and pneumonia. These make up a total of something over 130 out of the 149 deaths which occurred during the year. I have the feeling that surely we ought to do better than that.

The distribution of deaths by sanitary districts is shown in the following table :—

Urban Districts.	No. of Infant Deaths.	Rate.
Maryport	11	48.5
Whitehaven	24	49.6
Penrith	5	24.8
Workington	15	26.6
Cockermouth	2	20.8
Keswick	2	41.7
Aggregate of Urban Districts	59	36.4
Rural Districts.		
Millom	12	49.6
Cockermouth	11	29.6
Alston	1	28.6
Wigton	15	32.6
Ennerdale	26	43.1
Border	16	29.9
Penrith	9	43.7
Aggregate of Rural Districts	90	36.7

1948 Rate for England and Wales .. 34

1948 Rate for Cumberland County .. 37

NATIONAL HEALTH SERVICE ACT, 1946.

Part III.

Part V.

SECTION 21.

Health Centres.

Little progress can be reported in this matter, and frankly I do not see what progress can be made until some general directive on policy is issued by the Ministry. All we really know at the moment is that 10,000 population is generally regarded as the minimum population justifying the provision of a health centre. It is understood that a committee is now sitting at the Ministry on this matter, and no doubt as the result of their deliberations there will, in due course, be issued to local health authorities some sort of directive on policy, accompanied, I should imagine, with draft standard plans suggesting alternative types of centres according to the particular needs of the areas concerned. All this is a guess, but Circular 3/48 issued by the Ministry did indicate that undue hurry in this matter is not desirable.

We have gone so far as to reserve, provisionally, adequate space in one or two of the new building areas in West Cumberland for health centres. Frankly I am not at all sure that even in doing this we are on the right lines. Take, for example, the case of Whitehaven. We have reserved a two-acre site in the new building scheme in the Valley. This site is intended to provide ground floor space for a health centre and for a full clinic and treatment centre. It is generally accepted, I think, that local authority clinics and health centres may well stand on the same plot of land and may even form parts of one large building, alternative to being erected as separate buildings.

It seems to me quite clear that new clinics, possibly on the scale of that recently built at Egremont, or possibly on a smaller scale, of the nature of auxiliary clinics, will have to be built in due course in the Valley at Whitehaven, in connection with the Moor Close-Laverock Hall scheme at Workington, possibly at Ellenborough as regards Maryport, in the neighbourhood of Seascale, and possibly at one or two other points. How far the building of these clinics, if approved, can be linked up with the provision of health centres is far from clear.

I do not know, for example, whether at Whitehaven, with an existing population of say 23,000, estimated as likely to rise in future to say 28,000, those concerned, which phrase obviously includes the Ministry, the County Council, the Cumberland Executive Council and Whitehaven Borough, etc., will consider that one health centre is adequate provision.

I do not think it is the Ministry's intention that a health centre should be planned for each 10,000 of the population. My personal view would be that Whitehaven, with at present nine doctors, (one or two with assistants), in general practice, could not justify more than one health centre. The trouble, as I see it, arises from the fact that a health centre to serve adequately the needs of the population must be *centrally situated*. Does reserving a site for a health centre in the Valley scheme at Whitehaven really meet the needs and reasonable convenience of the people in the Hensingham, Kells, Woodhouse, and Bransty districts ? The answer, I think, is clearly in the negative, even allowing for the fact that once the Valley scheme is in being new bus services will obviously be operating.

As I see it the only really convenient place to locate a health centre in a place like Whitehaven would be somewhere in the centre of the Borough round about Scotch Street. The disadvantages are obvious—(1) probably no adequate site is obtainable or likely to be obtainable, and (2) I imagine that it is desirable that health centres should be planned in such a way as to be attractive in prospect, that is should be provided in really open spaces and surrounded by reasonable amenities in the shape of lawns and flowerbeds.

The problem clearly is not an easy one. The central areas of boroughs and urban districts are usually already fully built up and even congested, and obtaining adequate sites in these central areas will probably be an impossibility. On the other hand to build health centres in new building schemes inconveniently placed for large sections of the population would be a policy which would seem likely to defeat its own objective.

I would venture to recommend that a small sub-committee should be appointed to consider, in consultation with representatives of the Regional office of the Ministry and with our own planning department, the problems outlined above.

SECTION 22.

Care of Mothers and Young Children.

I think it is necessary to preface what one says under this section by pointing out that Sections 22 to 25 inclusive, which might be grouped under the heading of "Nursing Services," and also Section 28, all interlock in such a way that it is completely impossible to deal with these sections in reporting on the year's work as if they were in watertight compartments.

Nearly all of what can be said under Section 22 falls to be dealt with under the midwifery section or under special sections such as dental, orthopaedic, and so on.

It may perhaps be best to start with a few statistics.

Number of child welfare clinics ..	16
Number of children under 1 year of age attending	1615
Number of children between 1-5 yrs. of age attending	1272
Number of attendances	13654
*Defects treated	150

* (Chiefly eye and ear, nose and throat. Dental and orthopædic are given elsewhere).

The above is the general background in respect of the care and supervision of infants and toddlers. To these figures must, of course, be added home visits by health visitors, which are dealt with under Section 24.

With regard to illegitimate children, 121 cases were investigated, and in only 12 of these was there any question that the conditions prevailing were in any way unsatisfactory. The mortality rate among illegitimate children remains extraordinarily low. During the year there were 4 deaths out of 210 live births, which gives a mortality rate of approximately 19 per 1000 live births. This compares with the general infantile mortality rate of 37 deaths per 1000 live births.

There is probably some fallacy in these figures, but I cannot see it. On the face of it it would appear that it is safer to be born illegitimate than legitimate. Few illegitimate babies die from debility and such like causes. Probably the age and vitality of the mothers has a good deal to do with it.

Agency arrangements have been established with St. Monica's Home and Brettargh Holt Home, both at Kendal, for the reception of unmarried mothers, for their care at the actual confinement, for their rehabilitation thereafter, and for the care of their babies.

The arrangements for dealing with premature infants (that is children weighing less than 5½lbs. at birth) are very important. For a long time these have existed at the City Maternity Hospital in Carlisle, and during the year there was established a similar unit at the Workington Infirmary in West Cumberland. The appropriate figures in connection with this small, but important, group of infants are as follows—

Born prematurely at home	..	54 of whom 11 died within 1 month
Born prematurely at hospital	..	54 of whom 7 died within 1 month

Turning now to ante-natal examinations, the figures are as follows :—

Examinations at practitioners surgeries	.. ..	1087
Examinations at patients' homes	.. .. ..	905
Re-examinations		1854
	Total ..	3846
Findings at examinations	.. Normal	1846
	.. Abnormal	146
Recommended for hospital on account of home conditions		509
Recommended for hospital on account of patient's condition		36

In this county we have never had ante-natal clinics carried out by medical practitioners on our own staff or otherwise at our clinics and treatment centres. Our policy has been based on calling in practitioners to carry out ante-natal examinations at least twice in the pregnancy in respect of cases booked by midwives. At the back of this there have been the extensive ante-natal and post-natal clinics carried out by the obstetrical and gynaecological specialists which have been very widely attended and very freely used both in respect of cases referred by practitioners and in respect of cases referred by this department.

Most other matters dealing with the maternity side of our work are dealt with under Section 23. The only other point which seems to call for comment here is that arrangements have been made for the issue of maternity outfits on requisition by the midwives.

With regard to post-natal examinations, the position about this matter following upon the coming into operation of the Health Service Act on July 5th was not too clear, but a letter was sent to all practitioners inviting them to submit reports on post-natal examinations on all midwives cases—for which an appropriate fee would be paid. The number of post-natal reports so received from the 5th July to the end of the year was 151, and in all cases in which this procedure was indicated the case was referred to one or other of the gynaecological specialists.

A word on the question of children's nurseries would seem appropriate under this section. We have two nurseries for

children under 5 years of age, the day nursery at Whitehaven, which was completed as a new building during the year, and the residential nursery at Sandath, Penrith. The Whitehaven day nursery accepts children up to the age of 5, and has accommodation for 40 children. The available accommodation is almost invariably full, and though there are always changes taking place, the position on the 1st January was that there was one vacancy, and that on the 31st December there were two vacancies.

The conditions for admission to this day nursery are : (1) that the child must be under 5 years of age, and (2) that the mother must be working with no one else available to look after the child, or children, at home. Full medical examinations are carried out twice a year.

The residential nursery at Sandath, Penrith, can accommodate 26 children, and here again the accommodation is always full, and frequently there is an overflow of children to the children's homes at Scotby House and Orton Park. At the beginning of the year there were 25 children in residence and 21 new admissions were made during the year. The value of residential nurseries is beyond dispute, for example, when a mother with young children has to enter hospital for perhaps an operation or because of a confinement, or when very young children are abandoned by their parents, or for various other reasons. I think it is highly probable that in the not distant future an additional residential nursery may have to be provided, probably as indicated in the County Council's proposals, in West Cumberland.

There is perhaps one final point. Prior to the 5th July, the County Council had been negotiating with the Committee of Management at the Cumberland Infirmary regarding the appointment of a specialist in paediatrics (diseases of children). It was felt, however, that with the impending coming into operation of the Act, consideration of this appointment should be left to the Special Area Committee. No appointment has yet been made and no actual decision has been taken on this matter. I imagine, however, that such an appointment will not be long delayed. The person appointed will obviously work in close collaboration with the obstetrical specialists, and with those in charge of the day and residential nurseries and children's homes, and in our own child welfare clinics. I think in this connection that reference should be made to the small unit established at the Carlisle Infectious Diseases Hospital by Dr. Milne for the treatment of infantile diarrhoea, the significance and importance of which is referred to elsewhere in this report.

SECTION 23.

Midwifery Service.

It must be appreciated at the outset that many of the observations made under this section really affect equally the following sections—those dealing with health visiting and home nursing. Such questions as the qualifications of the nursing staff, agency arrangements, the provision of cars and the provision of housing or other accommodation for district nurses, whether they are acting as midwives, as general nurses, or in connection with health visiting, affect all three sections. In other words the three sections 23, 24 and 25, necessarily to a large extent, dovetail into each other.

During the year 132 midwives notified their intention to practice. These notifications included 83 midwives employed by Nursing Associations, 12 employed as municipal midwives by the County Council, 7 independent midwives, and 30 midwives working in the maternity departments of hospitals. The number of midwives actually undertaking domiciliary midwifery at the end of the year was 80.

It has been extremely difficult to maintain the staff of district nurse-midwives at full strength ; in fact this has not been possible, and, for this reason, the extension of the staff of relief midwives as included in the Council's proposals has just been impossible. Actually there have always been one or two vacant posts. At the time of writing four areas are without district nurses.

The Superintendent Nursing Officer or her assistants made 173 routine inspections during the year. In addition they paid 120 other visits in connection with puerperal pyrexia and other matters. Visits to hospitals with maternity units amounted to 15, and the midwives inspected at these visits numbered 42.

During the year midwives attended 1620 domiciliary cases as midwives and 451 cases as maternity nurses. In this connection reference should be made to a recent circular, E.C.N. 27, issued to Executive Councils in July, which was similar in import to circular L.H.A.L. 5/49, issued the same month by the Ministry of Health. These circulars were accompanied by a memorandum intended for wide distribution among expectant mothers, setting out the facilities of the midwifery services, and bringing to the notice of expectant mothers certain steps which it is to their advantage to take during the pregnancy. Large numbers of this memorandum were obtained, and these have been distributed wide-spread.

The purpose of the foregoing circulars is to make it clear both to the practitioners undertaking domiciliary midwifery, and to midwives engaged in domiciliary practice, that the Ministry regard a midwife as *acting as a midwife* during the pregnancy, even if the case has been booked by a practitioner in the usual way, unless the practitioner informs the midwife to the contrary. This means, as I see it, that midwives from now on will really cease to act as maternity nurses during the ante-natal period, and will act as midwives at this stage, having all the duties and responsibilities of a midwife in the matter, unless the practitioner informs the midwife that he accepts full responsibility.

During the year midwives sent for medical help on 968 occasions. The chief causes were :—

Delayed Labour	179
Ruptured Perineum	240
Albuminuria	53
Malpresentation	40
Abortions	53
Pyrexia	37
Haemorrhage	71
Discharging eyes in the infant	38

Gas and Air Analgesia.

During the year a further 16 midwives were trained in gas and air analgesia, making a total at the end of the year of 50 midwives certificated in this respect. All these were supplied with the appropriate apparatus, and also with apparatus for estimating blood pressure.

During 1949 a further batch of midwives has been trained and vacancies have been booked for a further 10. When all these have been trained every midwife in the County, other than a few who are at the point of retirement, will have been trained in this respect.

The number of occasions on which gas and air analgesia was employed in domiciliary midwifery by midwives was approximately 600. This seems small in relation to over 2,000 domiciliary confinements. This point has been carefully watched and the reasons given by the midwives include :—

(a) A considerable number of women apparently still do not desire analgesia.
(b) Midwife summoned too late.
(c) The practitioner administers his own anaesthetic.

There are various other reasons, such as that a practitioner may consider the patient unfit to have analgesia, (which accounts for a few cases), but the margin is still much too high. The matter will be very closely followed up.

With reference to circulars 21/49 and 44/49—which circulars deal with the question of motor cars for midwives, and with the necessity of ensuring that analgesia is not withheld because the midwife has no adequate arrangement for the transport of the apparatus—it may be said confidently that this reason does not apply to this area. Fifty-six of the midwives have been provided with cars, and the majority of the others are in the urban areas where distances are short and where adequate alternative arrangements for a taxi service have been made.

In this matter of the provision of cars for district nurse midwives the County Council have up to date purchased 12 cars, the policy being that when a car owned by a District Nursing Association requires replacement the Council accept the financial liability. No doubt in due course the County Council will have taken over, in this way, the entire fleet.

The housing of district nurse midwives is an important matter and the County Council, as noted elsewhere in this report, have under consideration the policy of building their own houses for various groups of the nursing services including the district nurses. Several of the local sanitary authorities have given valuable help in this matter, especially Wigton, Cockermouth, and the Border Rural Districts, amd Maryport Urban District.

Up to date, one way and another, either through the initiative of the district nursing associations concerned, or through the assistance of the local authorities, 33 houses have been provided for district nurses. In addition 24 district nurses either own or rent houses privately.

During the year an agency arrangement between the County Council and the Cumberland Nursing Association has been in operation. In respect of midwifery, the Cumberland Nursing Association practically covers the whole County, Alston being the only exception. The position otherwise was made complete by the affiliation of the Workington Nursing Association to the county organisation during the year. It need hardly be said that, both in respect of midwifery, and of the other nursing services referred to under the following sections, this agency arrangement has been invaluable.

Whether this agency arrangement is likely to continue much longer is a matter of opinion, but whatever may happen in the near future, at least the existence of this agency during the initial stages of the operation of the Act has been of the utmost service to the Council, and our very deep gratitude is due to the Cumberland Nursing Association.

It would be appropriate here to refer to the fact that the Administrative Officer in the Health Department (Mr. Butcher) is also Honorary Secretary of the Cumberland Nursing Association. This liaison has gone very far to smooth the way.

Turning now to other matters, maternal deaths during the year amounted to 6, as follows :—

Puerperal Sepsis	0
Other Puerperal Causes	6

This gives a maternal mortality rate of 1.43, and for comparison the figures for the immediately preceding years are shown below :—

1943—10 deaths equal to a rate of 2.7 per 1,000 births.				
1944—6	,,	,,	1.5	,,
1945—10	,,	,,	2.9	,,
1946—6	,,	,,	1.4	,,
1947—2	,,	,,	0.44	,,
1948—6	,,	,,	1.43	,,

It is much to be regretted that the very satisfactory figures for 1947 have not been maintained, but one has to realise that ups and downs in these figures from year to year are inevitable.

The distribution of deaths by areas is shown in the table below :—

	Puerperal Sepsis.	*Other Puerperal Causes.*
Workington Borough	—	2
Whitehaven Borough	—	1
Ennerdale R.D.	—	2
Border R.D.	—	1

Admissions to hospital for confinement of county cases during the year amounted to 1,695, divided almost equally between the maternity units in East and West Cumberland. The details of the individual hospitals as given in previous reports have not been included, as this matter is, of course, now one for the Special Area Committee. In addition 19 cases were admitted to St. Monica's Home, Kendal, and 2 cases to Brettargh Holt Maternity Home, Kendal. Seventeen confinements took place in the maternity unit at Meadow View House, Whitehaven. Twenty four cases of puerperal pyrexia were notified during the year, of which 7 were admitted to the puerperal sepsis block at the Carlisle Isolation Hospital.

Abortion.

The following table shows the distribution by areas of cases in which medical help was sent for by midwives on account of abortion. As usual Workington Borough is at the head of the list. This year this area provided nearly one-third of the cases. This makes one think. It must be realised that this does not indicate the incidence of abortion in the County ; it merely indicates that proportion of the abortions in which midwives summoned medical aid :—

	1947	1948
Workington Borough	10	17
Whitehaven Borough	6	1
Cockermouth Urban	3	4
Maryport Urban	1	1
Penrith Urban	—	2
Border Rural	6	3
Cockermouth Rural	6	5
Ennerdale Rural	10	8
Millom Rural	—	5
Penrith Rural	1	2
Wigton Rural	5	5
	48	53

SECTION 24.

Health Visiting.

Much that has been said under Section 23 above is applicable also to this section, and no useful object would be gained in repetition.

Our staff of whole time health visitors amounts to 17, which of course falls considerably short of the target of 30 whole-time health visitors mentioned in our proposals. These figures are, of course, exclusive of the substantial number of district nurses who act as part-time health visitors, some 48 district nurses being so employed. Only in this way, in a scattered county like this, and with our inadequate staff of whole-time health visitors, can children under 5 years of age be looked after. Here again, of course, the agency arrangements with the Cumberland Nursing Association come into play.

Repeated advertisements during the year have failed to strengthen our health visiting staff, in fact, these advertisements have produced only one application. Perhaps even

more disturbing, we have not had a single application in response to our advertisements in the nursing press regarding the provision of scholarships for the training of health visitors.

The scope of the functions of health visitors is expanding, and in this connection Circular 118 said this :—

"This involves an extension of the functions now normally assigned to a health visitor, under which she is primarily concerned with the care of mothers and young children. After the appointed day she will be concerned *with the health of the household as a whole*, including the preservation of health and precautions against the spread of infection, and will have an increasingly important part to play in health education. She will work in close co-operation with the family doctor, etc."

Under existing conditions these views are merely academic, because our present staff of health visitors are hard put to it even to encompass the duties assigned to them prior to the 5th July. I doubt if, under existing conditions, they ever see the family doctor.

The amount of work undertaken by the health visitors as such during the year, including district nurses, was as under :—

Visits to children under 1 year	35833
Visits to children 1 to 5 years	29146
	64979

Reference may be made here to the fact that increasing liaison is being established between almoners at the local hospitals (chiefly the Cumberland Infirmary) and this department, seeking our assistance in the aftercare of patients on discharge from hospital. Perhaps this reference applies more particularly to Section 28, but it would not seem to be out of place here. As an example of this liaison mention may be made of contact tracing in connection with venereal disease which is undertaken over the county by selected health visitors.

SECTION 25.

Home Nursing

Our duties as a health authority in connection with home nursing only began on July 5th. Prior to this date home nursing had been undertaken by voluntary nursing associations in the county. Again practically everything which has been said under Section 23 about housing, provision of motor transport, agency arrangements, and so on, applies in connec-

tion with home nursing with equal force. There is one small difference about the agency arrangements, namely that in respect of home nursing the County Council established an agency arrangement with the Penrith Nursing Association in addition to the main agency arrangements with the Cumberland Nursing Association. This agency arrangement with Penrith still continues at the time of writing.

I think the invaluable work done by district nurses in the past, which, especially in rural counties like Cumberland, has often been undertaken under conditions of great difficulty created by frost and snow, flood and storm and tempest, of which dramatic examples have been given in previous reports, is generally recognised. It is therefore not detracting in the slightest from the value I have always placed on the work of district nurses in Cumberland to say that I note with satisfaction the increasing number of these appointments which are being filled by state registered nurses.

At the moment we employ in our districts 14 Queen's nurses, and 22 state registered nurses, so approximately half of our district nurses are fully trained. The number of such nurses employed in this county is steadily rising, and I look forward to the time when every district nurse will be state registered.

One of the first things we did on becoming responsible for home nursing was to review the equipment held by the district nurses. A standard outfit was drawn up and a considerable sum of money has been expended in bringing the equipment held by every district nurse in the county up to this standard. The next step will be the establishment of depots for what might be described as heavy equipment—wheel-chairs, air beds, sorbo mattresses—and things of that kind. This matter is under careful consideration, but one difficulty is to avoid overlapping.

At present much of this equipment is provided by the Ministry of Pensions on behalf of the hospital service, and on behalf of the National Assistance Board in the case, for example, of spastics. Certain voluntary organisations too, chiefly the St. John's Ambulance Association and the Red Cross Society, hold equipment of this kind which they loan out either free or for a small charge. It is not too easy to say where responsibility begins and ends in the matter, but, as I have said, the whole question is under close review, and by the time of the next annual report I hope it will be possible to report that our duties in this connection have been fully covered.

The statistics relative to home nursing in respect of 1948 are as follows :—

Number of cases nursed	6528
Number of nursing visits paid	93588
*Number of casual visits paid	14349
	114465

*(casual visits mean where the nurse is called in to *advise* on some health problem, and things of that kind.)

SECTION 26.

Immunisation and Vaccination.

Arising out of the above section a communication was addressed to all general practitioners practising in the admisistrative county to ascertain whether they were willing to undertake immunisation and/or vaccination. The number of practitioners written to was 106, and of these 86 replied that they were willing to undertake immunisations and 84 that they were willing to undertake vaccinations.

With regard to immunisation, so far as we know the number of children under school age immunised during the year was 3,215. Apart from this, approximately 4,020 school children received either primary or reinforcing injections. Out of this total of 7,235, 610 were immunised under the above arrangement with general practitioners and the remainder by our own medical staff, chiefly at clinics and at school medical inspections. That is the position as far as we know.

The percentages of immunised children in the county have been worked out and are as follows :—

Under 5 years	48.85%
5 to 14 years	84.35%

With regard to vaccination, as from 5th July, 1948, vaccination ceased to be compulsory and what will happen about the continuation of vaccination at the previous level in the future is anybody's guess. The number of registered live births during the year was 4,073. Between 1st January and 5th July, 1096 certificates of successful vaccination were received. Between 5th July and 31st December 504 such certificates were received. So far as we know that is a complete picture, and if that assumption is correct, these two

figures make up a total of 1,600 successful vaccinations for the year compared with 1,639 for 1947. It would appear that from 5th July there occurred a very sharp fall in vaccination.

It must, of course, be realised that neither in respect of immunisation nor of vaccination do the above figures give a full story, because many immunisations and vaccinations may have been carried out of which we have received no record and that is why the phrase occurs "so far as we know."

The Minister of Health in a reply in the House on 26th July agreed that there was no statutory requirement on medical practitioners to report vaccinations or immunisations to medical officers of health or to executive councils. It is true that a general practitioner reporting a vaccination or immunisation will be entitled to a small fee for each report, the amount of the fee not yet having been determined, but whether that means that all vaccinations and immunisations have been or will be reported to the health authority is very uncertain. Personally I doubt if they have been or will be and I therefore assume that the number of vaccinations and possibly of immunisations carried out during the second half of the year may well have exceeded the figures indicated above. I have, of course, no means of verifying this view.

SECTION 27.

Ambulance and Sitting Case Car Service.

(a) Ambulance Service.

This matter is easy to deal with. Prior to the 5th July, 1948, the County Council on the one hand and the Clerks of the Local Authorities concerned and the Secretaries of the Voluntary Ambulance Committees in the County on the other agreed that agency arrangements should be set up. These arrangements involved, in the main, a continuation of the administration of the ambulance services on the existing basis, subject to over-riding supervision by the County Council and subject to the County Council being responsible for footing the bill, including the provision, as and when necessary, of new ambulances.

This agency arrangement has been a great success and we, as a Council, owe a debt of gratitude to the Clerks of the Authorities concerned and to the Honorary Secretaries of the Voluntary Ambulance Committees. From the County Council angle it may be said that the Council have held a light

rein in the matter, and have gone on the policy of leaving the people on the spot, who know their business thoroughly, as much freedom of action as possible. This policy, as will be shown below, has, from the financial angle, been more than justified, and the efficiency of the service has certainly not suffered in any way. All ambulances have been provided with a full set of equipment, in so far as this had not already been provided.

Since the 5th July we have accepted delivery of three new ambulances of different types, the object being to ascertain by trial and error which type of ambulance is most suited to the rather varying requirements of this county. We will, in the near future, have to place further orders, and, by the end of 1951, I anticipate that every general ambulance in the county will have been replaced by a new one, and every infectious disease ambulance replaced from the best of the existing general ambulances.

This policy of total replacement is not precipitate, but, if anything, overdue. The youngest of the ambulances we took over last year is now 12 years old ; the oldest, and there are several in this group, are 1933 models.

For a time after the National Health Service Act came into operation it was almost impossible to place orders for ambulances with any certainty as to dates of delivery. The choice available was also severely limited. The situation has very much improved, and there is now a wider choice and a better prospect of early delivery. During the period of difficulty, we endeavoured to meet the situation in one part of the county by the conversion into ambulances of two fire tenders. The cost involved was not substantial, and while one does not for a moment pretend that these conversions provided ambulances de luxe, they certainly tided us over a difficult period, and will, I think, be available for some time ahead as reserve ambulances. A privately owned ambulance in the south west of the county undertook, very satisfactorily, a substantial number of journeys for us, including many outside Cumberland, and another privately owned ambulance in the east of the county also did a few journeys.

Reference has been made above to the economical working of the agency arrangements. The following table, for which I am indebted to the County Treasurer, provided the supporting evidence and gives certain other information. The period is from 5th July 1948 to 31st March 1949, and excludes the capital cost of new ambulances. The total number of journeys undertaken was in the region of 2,700.

By whom Ambulance managed.	*Mileage during period*	*Running expenditure during period*	*Running expenses in pence per mile.*
		£	
Voluntary Committees or County District Councils (9)	62727	2923	11.18d.
Hospital Management Committees	9434	317	8.06d.
Infectious Diseases Ambulances (4)			
County Council—through garage proprietors (1)	6429	532	1/7.86d.
Carlisle Corporation	816	51	1/3.00d.
Proprietors owning their own ambulances (2)	6345	265	10.02d.
	85751	£4088	11.44d.

(b) Sitting Case Car Service.

This part of the business is not so easy to deal with. Many authorities, chiefly what might be called the industrial counties and large urban areas, deal with the matter of sitting case car transport by maintaining their own fleets of taxis, or through the medium of the hospital car service, to which reference is made later.

In this county no such general arrangement is possible, although that is not to say that the future may not see the establishment of the County Council's own cars in fair numbers in the denser areas of population. It is, however, manifestly impossible to cater for the *whole* of this geographically large but thinly populated county by a general policy of officially owned taxis. The additional mileage involved would represent a waste of money, time and petrol.

We started out, therefore, by advertising before the appointed day to ascertain how many taxi proprietors in the county were prepared to co-operate in this service. We received only a limited number of replies, but eventually started off with a list of some 30 co-operating taxi proprietors. Soon additional requests to be added to the approved list began to be received, and a limited number were added to cater for certain areas not otherwise provided for.

During the current year the matter has been re-advertised, and over 100 applications have been received. Obviously not all these applications were of the same value and certain

areas were over represented, while others were still not adequately provided for. Also the terms submitted by the firms concerned on which they were prepared to operate, naturally varied considerably.

Consideration is now being given to the establishment of standard rates for the whole county but certain difficulties have been experienced, and negotiations are still in progress at the time of writing. Complaints have been received from certain areas, which have been shown to be not without foundation, that the available work has been inequitably distributed in certain places between the taxi proprietors operating the service. Measures to improve this are under consideration.

The service has recently shown an alarming rise in expenditure. From 5th July up to the end of December 1948 the following was the position :—

Journeys Authorised by. —

		No. of journeys	Mileage Run	Cost per Mile
Doctors	2235	3420	108,675	11.15d.
County Health Dept.	160			
Duly Authorised Officers	60			
Hospitals	790			
Others	175			

The situation has, however, since the end of the year changed so completely that the data given above are now completely out of date as a true picture of what is happening. Instead of running at a cost of say £6,800 a year for the sitting case car service, we are now running at a cost of £20,000 a year, the mileage now being at the rate of approximately 350,000 miles a year (and rising), to which must be added, of course, the ambulance and hospital car service figures.

The service has conferred a great benefit on a great many people, but there is no doubt that it is open to abuse and there is no doubt that it has to some extent been abused. Not every person using the service could answer the once famous question—"*Is your journey really necessary?*" There is equally no doubt that it could be more economically used. We are, however, passing through the initial stage of a substantial service and teething troubles were inevitable. It may, I think, confidently be hoped that consultations with the Hospital Management Committees and the Executive Council, which are envisaged at an early date, will help to put things on a better basis. I feel quite certain that these difficulties are not peculiar to Cumberland, and that they must be more or less universal.

A typical point is something like this. John Smith has an accident and fractures his leg. He is admitted to hospital and on discharge a week or two later he is required to

attend perhaps three times a week for 3-6 months, for rehabilitation, but is quite unable to travel by public transport. He may continue to attend three times a week for massage, electrical treatment and so on, but after a period of, shall we say six weeks, he becomes able to travel by public transport. No one cancels the order for a sitting case car and we know nothing about his changed circumstances.

It is this kind of situation which keeps the cost of the service high, because no machinery has yet been devised between Hospital Management Committees and the Authority to switch John Smith at the appropriate time from the sitting case car service to public transport.

Another obvious difficulty is that from an area, or areas of the county there may be two of three persons travelling on the same day to the same hospital, say the Cumberland Infirmary, in taxis ordered by different doctors or other authorised persons. Measures will clearly have to be devised to establish one or more bureaux or clearing houses in the county through which alone, except in emergencies, taxis can be ordered. One would hope that by the time the next annual report is due to be printed, it will be found possible to state that we have devised solutions to eliminate the unsatisfactory features in this valuable service.

(c) Hospital Car Service.

This service is operated for us on an agency basis by the British Red Cross Society, and has proved invaluable. The basis is that we pay the owners of private cars who co-operate in the service 6d. per mile plus subsistence, and we pay the British Red Cross Society a small annual figure to cover administration. At the time of writing some 70 car owners are co-operating in this scheme in different parts of the county. Valuable though the service has been, one difficulty naturally is that it cannot by its very nature be expected to be equally distributed over the county.

All the journeys undertaken by the hospital car service are pre-arranged ; emergencies are not dealt with, and night journeys are not undertaken. Nevertheless, in spite of these qualifications, we remain deeply grateful to those owners who co-operate in this service, and to the British Red Cross Society for organising the service.

Statistics relative to the hospital car service for the period 5th July, 1948, to 31st December, 1948 are as under:—

Journeys Authorised by—

		Number of journeys	Mileage Run	Cost per Mile
Doctors	Nil.			
County Health Dept.	106			
Duly Authorised Officers	Nil.			
Hospitals	364	470	21,165	6.24d.
Others	Nil			

(d) Other Matters.

Other matters may be referred to. We, like all authorities, are under a statutory obligation to provide transport by ambulance, train, car or otherwise, to any part of the country for persons requiring the same and unable, on medical grounds, to travel by public transport. These journeys have been surprisingly numerous and quite often of an emergency nature. They have involved journeys to all parts of the country, as far north as the Outer Hebrides, in connection with which transport by sea had to be arranged, and as far south as Plymouth. The railway authorities have been most co-operative and helpful, and so have other authorities in different parts of the country, in providing ambulances to take patients to their homes after the end of their journeys by rail.

Arising out of the duty of the health authority to return patients to their homes from hospitals, nursing homes, etc., a domestic arrangement has been evolved in this county, whereby we do our best, by instructions issued to incoming ambulances and taxi owners, to relieve Carlisle of their present responsibility for returning county patients to their homes in different parts of the County. We have been glad to undertake this neighbourly service.

Referring as a final point once more to the sitting case car service, experience has shown that there has been a wide divergence in the use made of this service by general practitioners in the county. In one month in which a check was made, which presumably may be taken as an average picture, it was found that individual practitioners, or firms of practitioners had called out the service on up to 80 occasions, whereas others (including the great majority), had called for a sitting case car on less than 10 occasions during the month, and many had not called upon the service at all. No doubt negotiations with the Executive Council will help us to enlist the co-operation of the profession in this matter.

SECTION 28.

Prevention of Illness, Care and Aftercare.

I have never been clear what this section of the Act really implies. Much that could be said under the general heading of "Prevention of Illness, Care and Aftercare" seems to fall more appropriately in other parts of this report. For example, contact tracing for venereal disease is dealt with under "Health Visiting" because that work is undertaken by

selected health visitors. Now that the administration of hospitals, the admission of patients to hospitals, the staffing of tuberculosis dispensaries and specialist clinics, (orthopaedic, ear nose and throat, and so on), are duties transferred to the Regional Hospital Board, or, in our own case, to the Special Area Committee, what is left of public health really more or less all falls under the definition of this section.

The most recent, perhaps the most striking, example of the prevention of illness is the national campaign against diphtheria. Reference to our local position and statistics in this matter is made under Section 26. As an example of how action taken by health authorities under Section 28 dovetails in with action by other bodies, no better example than tuberculosis can be taken. Here the health authority from the domiciliary angle advises the household through the tuberculosis officers and tuberculosis nurses or health visitors, provides shelters, beds and bedding in necessitous cases, deals with extra nourishment in conjunction with the Ministry of Food and so on. On the other hand, mass radiography which really is, I suppose, prevention *par excellence*, falls within the scope of the Special Area Committee.

We have tried one interesting experiment during the year in connection with the use of telephones between tuberculosis shelters and the homes of patients. A small experiment has been tried out, the results tending to show that the installation of such an appliance by placing the patient in the shelter in immediate contact with the home is greatly appreciated in, the case particularly of women who may be nervous at night, and in the case of patients generally who are confined to bed. This point is being further explored.

Take next the case of spastics. It is now recognised that spastics require or may require a good deal of specialised equipment in connection with which a substantial list has recently been issued. Much, if not nearly all, of this equipment could be provided either (a) by the Ministry of Pensions, on behalf of the Ministry of Health, or (b) through depots set up as indicated in our proposals, by the Health Authority. Convalescent treatment is shared between the Special Area Committee and the Health Authority, and it is not easy to draw the line between the two responsibilities. In the matter of ante-natal care, examination of the blood of the expectant mother in connection with Rhesus grouping and Wasserman tests is again a matter which is the responsibility of the Special Area Committee if the patient attends a hospital ante-natal clinic, but may be the responsibility of the Health Authority in many cases where the patient never sees a hospital clinic during the pregnancy.

Certain steps towards the prevention of illness are still more or less in the experimental stage and cannot be yet accepted as of proved value. A good example is the vaccine against whooping cough, the value of which is rated higher in the United States than it is in this country at the moment.

All this really leads up to this, that as a Health Authority we must, (as I hope we are doing), keep our eyes open so as to be abreast of the times in all matters appropriately falling under this important section. As time goes on it will obviously be possible to clarify the position, and to be more definite and precise in commenting upon what is being done, and what is under consideration in this respect, always bearing in mind that the subject matter of this section is definitely more difficult, infinitely more difficult, to apply in a rural county like Cumberland than in a city or urban area.

SECTION 29.

Home and Domestic Help.

The foundations of the home help service in the county were laid in the autumn of 1947. The organisation of a new service of this kind, without any precedent or much guidance to go on, is a considerable affair, and much credit is due to the County Welfare Officer for organising the service on lines which, in the main, are still in operation, and which practically without amendment formed the basis of the County Council's 'proposals' under Section 29 of the National Health Service Act. In a new set-up, which is referred to later, some alteration of procedure and forms has become inevitable and, as a good deal of finance in involved, the County Treasurer has given very useful help in these adjustments. No home help was actually operating until the beginning of 1948, and at the outset, while the set-up was largely experimental, the Women's Voluntary Services, through the County Organiser, co-operated very usefully on an agency basis.

The first appointment, when the numbers were small, was that of a County Home Help Organiser, working on a part-time basis. As the work expanded the appointment became full-time. This organiser resigned on 31st March, 1949. The post was advertised, but no suitable applications were received. Partly for this reason, and partly because, after further careful consideration, there appeared to be a natural link-up between the home help and nursing services, the Superintendent Nursing Officer was appointed during the summer of 1949, to be in charge of the organisation of the service. This arrangement has now, at the time of

writing, operated sufficiently long to be able to say that it is working smoothly. The Superintendent Nursing Officer's staff has been augmented by the appointment of an additional Assistant Superintendent Nursing Officer based on Cockermouth, the three Assistant Superintendent Nursing Officers all sharing, in their respective areas, the work of the nursing services and the home help service. When this new plan was under consideration it appeared likely, and experience has confirmed the accuracy of this view, that the nursing services, with their large staff of health visitors, midwives and district nurses, would form a good network of liaison in every part of the county between those households requiring the services of a home help and the central office. Having agents, if they may be so described, in every part of the county, all in telephone communication with the head office, has greatly simplified administration, and greatly reduced travelling.

I should like to make one point quite clear. The nursing staff do not enter into the financial questions involved. Assessments are carried out by the County Welfare Officer and his staff of Welfare Officers, and the necessary disbursements are made through the Finance Department.

So much for the general set-up, which is, I think, unusual throughout the country, although I do know that one or two other areas have adopted the same procedure. The service has worked well on the careful lines laid down by Mr. Walker, and although a number of problems and one or two hitches have occurred, these have been fairly easily surmounted. One of the difficulties has been the question of adjusting the formula for assessment in a number of households on which the financial burden of meeting the required contributions under the assessment scale has proved too heavy. The Health Committee have sanctioned the adjustment of assessments by the appropriate officers in cases where hardship exists, subject to such adjustments being submitted to the next meeting of the committee for confirmation.

I should like to say one further word on this question of assessments. There is no question that the home help service has been a great blessing to a considerable and increasing section of the community. There is, however, equally no doubt that many households, falling in the group which *economically* is sometimes described as the lower middle class, who desperately need domestic help in cases, for example, of prolonged illness of the mother, have not been able to accept the benefits of the service simply and solely because they have been unable to accept the financial liability involved.

As will be seen from the following table, quite a number of applications for home helps have been cancelled, and these cancellations have largely been on economic grounds. It is clear that in the case, for example, of a household just falling within the assessment of full repayment, when the resources of the home may be already fully taxed by sending children to universities or training colleges or something of the kind, or in some other way, if serious and prolonged illness occurs the question becomes acute. The mother or father may have had what is commonly called a stroke, and thereby there may be the necessity of domestic help daily and practically all day. Multiply 2s.2d. per hour (the repayment figure) by 44 hours a week, and it will be at once seen how the type of household referred to may be very hard hit by the financial liabilities of the service where the situation is more or less permanent. What can be done about all this I do not know, but before this is in your hands the matter will have been considered by the Health Committee. I have only wanted to make it clear that this service, while theoretically equally available to all sections of the community, is, in practice, not by any means always accessible to households which are urgently in need of the help the service can provide.

The quality of the women who have applied for enrolment in the service has, by and large, been good. There have been some misfits, of course. In a young service like this that was inevitable, but these misfits have gradually been eliminated. The need for the service is developing, and applications for the month of August, 1949, were double those for the previous month. Unfortunately the enrolment of suitable home helps has not proceeded at anything like the same pace, and any member of the Council, or indeed of the community, who can put us in touch with likely women will be doing a good service. The County is unequally covered in this matter, and there are areas where no home helps are available. At the moment of writing Penrith (1), Millom (1), Brampton (*none*) and Longtown (*none*), are examples.

It will, of course, be realised that the position changes from month to month. It will also be realised that whereas the need for a home help in a scattered rural county like Cumberland may be as great in the isolated country home as in a town, it is by no means easy always to find a home help who is willing and able to travel to such isolated homes. In other words the problem is much easier of solution in the denser areas of population. The matter could, of course, be met by home helps becoming resident, but there are not many women who are willing or able to take up resident

home help posts, and there are many houses where there is no accommodation for such a person. This aspect also is therefore one in which the value of the service is not, and probably never can be, equitably distributed over the county. Home helps are divided into four groups (1) those who are whole time, (2) those who are part-time, (3) those who are mobile and prepared to go to any part of the county, and if practicable to live in, (4) those who are immobile and work within a certain radius of their own home. The urgent need is for more mobile home helps.

Up to now the selection of home helps has necessarily been somewhat of a 'hit and miss' business, by which I mean that we have had to enrol a certain number of persons who really do not understand what the term home help implies. I think it is probable that in the not distant future we will have to organise short courses for home helps, lasting perhaps two weeks, in different parts of the county.

One final point ; it may be surprising that out of 84 home helps enrolled during 1948, 34 resigned. The reasons have been (a) other employment has been accepted, (b) removals from the district, (c) domestic reasons, (d) because the amount of work available to the home help has not come up to expectations. It is clear, of course, that a home help may be enrolled in a district from which the number of applications for domestic help may have been few or nil. Not unnaturally in these circumstances the home help has been disappointed and has sought other employment.

The following statement shows the position during 1948. The figures have, of course, varied a good deal—mainly by way of expansion,—which, in the matter of *applications* for home helps has been very substantial during 1949.

1st January, 1948, to 31st December, 1948.

Home Helps.

No. of persons enrolled :—

Whole-time	63
Part-time	21
	84
Less : Resigned	34
On Register at 31st December, 1948,	50

Districts in which the home helps on the register at 31/12/48, resided :—

Alston	1
Workington	7
Whitehaven	4
Border Rural	6
Cockermouth	3
Ennerdale Rural	6
Keswick	2
Maryport	7
Penrith	4
Silloth	5
Threlkeld	1
Wigton	4
Total	50

Householders :—

Applications for home helps received during 1948	162
Home helps provided	105
Cancelled or not supplied	57

The reasons for non-supply have been varied :—

(a) householder made other arrangements after application.
(b) householder considered the cost too high.
(c) no home help available.
(d) death of patient, or removal to hospital.

SECTION 51.

Mental Health Service.

The Ministry, in circular 3/49 have laid down with some precision how they desire information in respect of the mental health service to be submitted. The following notes, broadly speaking, follow the headings suggested in that circular.

1. **Administration.**

(a) The County Mental Health Sub-Committee consists of 17 members of whom 13 are members of the Council and 4 co-opted. The co-opted members include the Medical Superintendent of the Mental Hospital, and the Medical Superintendent of Dovenby Hall Hospital for mental defectives.

(b) The mental health section is housed in separate office accommodation adjacent and easily accessible to the health department head office. The mental health service is carried on under the general super-

vision of the County Medical Officer, who is also certifying officer for the county for the purpose of the Mental Deficiency Acts. Two psychiatrists—the Medical Superintendent of Garlands Mental Hospital (Dr. Braithwaite), and the Medical Superintendent of the Dovenby Hall Hospital for mental defectives (Dr. Ferguson)—hold key positions in the service in the east and west of the county respectively, their services being loaned to the County Council by arrangement with the Special Area Committee. Reference is made to this later. Dr. Braithwaite is Medical Director of the county child guidance clinic in Carlisle and also directs outpatient clinics in respect of mental disorder at the Cumberland Infirmary, the Workington Infirmary and the Whitehaven Hospital. These hospital clinics are, of course, under the direction of the Special Area Committee. Dr. Ferguson is in charge of the child guidance clinic, shortly to become two clinics, serving the west of the county and also undertakes the annual medical examination of mental defectives under guardianship. Dr. Ferguson also undertakes the greater part of the Court work in connection with cases of mental defectives, or alleged mental defectives, who have committed offences against the law.

Eight medical officers, including 5 assistant school medical officers, are approved by the Ministry of Education in connection with the ascertainment of educationally sub-normal children.

An Educational Psychologist, although not directly on the staff of the health department, has an office in the mental health section and works in close collaboration with the psychiatrists and social workers.

The position as regards social workers in the mental health service is a little difficult to explain. During the year the county employed one social worker in connection with mental deficiency whose services were seconded to the Voluntary Mental Welfare Association to which reference is made later. On the other hand the Voluntary Mental Welfare Association in consultation with the local authority appointed a social worker (mental deficiency) whose services were in effect seconded to the County Council. In addition the Organising Secretary of the Voluntary Mental Welfare Association herself did a considerable amount of field work in connection with mental deficiency. In the west of the county, the county employed the services

part-time of a psychiatric social worker in connection with the child guidance clinics in that part of the county. In the east of the county the psychiatric social worker attached to the county child guidance clinic at Carlisle is seconded from the Special Area Committee.

With regard to the question of duly authorised officers, the county appointed, with effect from July 5th, a proportion of the former relieving officers, or their successors, to undertake this work. The actual number of persons employed in this work is 9. It has to be realised that their work as duly authorised officers only occupies a fractional part of their time which is otherwise occupied in registration and certain other duties.

No occupation centre supervisors were employed during the year but the appointments of an occupation centre supervisor and assistant supervisor are impending following upon the anticipated early opening of an occupation centre in West Cumberland.

The foregoing is the best short summary which can be given to a rather complicated set-up.

The general administration and supervision of the service among mental defectives, including the direction of the work of the social workers and the control of the office organisation, is in the hands of the Administrative Assistant, (Miss Greenwood).

(c) There is close co-ordination between the Local Health Authority and the Regional Hospital Board at the officer level, and also between the officers of the Local Health Authority engaged on mental deficiency and the officers of the Hospital Management Committee in charge of Dovenby Hall Hospital. At the request of the Dovenby Hall Hospital Management Committee all defectives on licence from that hospital are kept under the supervision of the social workers of the authority. Similarly, work is undertaken in the county at the request of various hospital management committees in different parts of the country who have defectives on licence from one district or another, linking up with Cumberland in this matter of mental deficiency. The social workers are responsible for obtaining reports on the home conditions of the patients as required from time to time for the information of hospital management committees. On the other hand, as has been indicated above, the Medical Superin-

tendent of Dovenby Hall Hospital helps us materially with our work in connection with mental deficiency. This two-way liaison is, I think, working satisfactorily, and to the benefit of all concerned. The Authority does not undertake any supervision of patients on licence from the Mental Hospital.

(d) As noted elsewhere in this report, during the year the Cumberland and Carlisle Mental Welfare Association acted as agents for the Local Health Authority in respect of the ascertainment, supervision and home visiting of mental defectives. The rather complicated arrangements between the two bodies have been briefly indicated in paragraph (b) above. At the time of writing it seems likely that this agency arrangement entered into during 1948, may shortly terminate.

It would be, I think, inappropriate in a report of this kind to let the occasion pass without recalling the indebtedness of the community at large to the work of the Voluntary Mental Welfare Association over many years, and, in particular, to the work of Miss Moclair, the retiring Organising Secretary.

In common fairness it should be placed on record that Miss Moclair and her committee, and the social workers employed by the committee, have for many years been carrying on pioneer work in the mental health service at a time when such work was not popular, nor in the minds of the community as a whole considered to be of any great value. Now that the perspective has been rectified let us not forget the pioneers.

(e) No schemes of training have been initiated in connection with the training of duly authorised officers in connection with mental health work. The position in Cumberland is that the other and more exacting duties undertaken by the duly authorised officers in registration etc., are such that any considerable employment of these officers in connection with mental health work is quite impracticable. Their duties are at the moment confined to dealing with cases of mental disorder who are brought to their notice, and the removal where necessary of such cases to the mental hospital. They need no training in this respect because they have done this work for many years, and as has been indicated, they are not concerned with the other problems of the mental health service.

2. Work Undertaken in the Community.

(a) This sub-section deals with "Prevention, Care and Aftercare" in respect of mental health. The position as regards mental defectives is that their care and after-care is a continuous service undertaken by the mental health workers who pay in the region of 2,500 visits a year in this connection. Manifestly, the expanding work of the child guidance clinics also comes in here appropriately. The story here is that one child guidance clinic has been operating for a few months in Carlisle, another in Workington, and a third is about to be opened in Whitehaven. Cases are referred to these clinics by medical practitioners, our own medical and nursing staff, the Children's Officers, the Probation Officers and others, and there is no doubt that the work of these expanding clinics is likely to prove a considerable asset in the community. With regard to the prevention of mental disorder, reference has already been made to the outpatient clinics held at the three principal hospitals in the county by the Medical Superintendent of Garlands Mental Hospital and his staff. These come, of course, under the control of the Special Area Committee, as does aftercare of patients on licence or discharged from the mental hospital, which is undertaken by the Psychiatric Social Worker employed by the Hospital Management Committee. As has been previously noted the aftercare of patients on licence or discharged from Dovenby Hall Hospital for mental defectives is undertaken under the Authority's general arrangements for social work among mental defectives.

(b) Cumberland cases dealt with under the Lunacy and Mental Treatment Acts (1890 to 1930) during the year amounted to 145 of whom 92 were voluntary and 53 certified. Of the total, 97 were women and 48 men. The arrangements for the admission of these patients to the Mental Hospital are undertaken by the duly authorised officers who have, of course, at their disposal all the facilities of the sitting-case car service.

(**c**) (**i**) **Ascertainment.** During the year 22 persons were ascertained as mental defectives. Of these 17 were reported by the Local Education Authority to the Local Health Authority for the purposes of the Mental Deficiency Acts under Section 57 (subsections 3 or 5) of the Education Act, 1944. It is realised that the number of children *ascertained* as mentally defective

during the year is low, but bearing in mind the multifarious duties performed by the medical officers approved by the Ministry of Education for this purpose, and bearing in mind the time involved in ascertainment, including the assessment of the intelligence quotient and the completion of the appropriate form, I see no immediate prospect of any great increase in the number of cases ascertained.

A very valuable step forward could be taken in this matter if the Ministry of Education would be prepared to recognise intelligence quotient figures worked out by educational psychologists for inclusion in the medical officers reports on Form H.P.2. If this concession were granted considerable forward strides could, I think, be made.*

At the end of the year there were 24 cases awaiting admission to institutions for the reception of mental defectives and most of these 24 were urgent. Several of them were so urgent that domestic tragedies had threatened if the defectives had not been removed. The lack of accommodation at Dovenby Hall Hospital, and in fact the general lack of such accommodation all over the country, means two things—(a) that many patients who could and would benefit from institutional training cannot receive this training and (b) that a burden which, as all mental workers very well know, is often almost past human endurance to carry, cannot be lifted from homes on whom this burden has fallen.

(ii) Guardianship and Supervision. On the 31st December, 1948, there were 72 Cumberland cases under guardianship. These are mostly under the guardianship of a parent or relative, and a weekly grant is made towards their maintenance. In view of recent legislation, such grants will in future be made in respect of persons over 16 years by the National Assistance Board and not by the Local Authority, but the patients will continue to be visited by the mental health workers.

On the 31st December, 1948, there were 99 patients under statutory supervision and 23 patients under voluntary supervision. Many of these are children of school age and would be suitable for an occupation centre, whilst others are awaiting accommodation in Dovenby Hall Hospital.

*Administrative Memorandum 341 issued 28/10/49 authorises this.

The social workers visit periodically all patients living within the community under guardianship or supervision. Contact is usually made with the patient's doctor, and also with anybody interested in the patient's care and training. In a few instances it is possible to place the patient in employment, provided suitable work can be found. The social worker is usually in a position to advise about this, and there is always close co-operation between employer, officers of the labour exchanges and social workers. The parents and guardians usually welcome the social workers, and rely on their guidance and help.

(**iii**) **Training.** The County Council has not as yet been able to open any occupation centre for mental defectives in the county, but plans are far advanced for the establishment of a small centre in Whitehaven, and also to make a start with home teaching, particularly for children, based on the centre. There is a small handicraft class for defectives in Workington, held two afternoons each week, somewhat off the general pattern. A small amount of home teaching, generally for adults, is also undertaken in Workington and Maryport.

I would like at this point to enter a plea for the establishment of more occupation centres for mental defectives. Many people do not understand what these occupation centres imply, and they are frequently regarded as rather fancy and expensive propositions serving no very useful purpose. In point of fact they do mean that some relief comes to the harassed mother and to the home on which the burden of the mentally defective inmate has been placed. This burden frequently means that nerves are frayed to an extent that a complete breakdown or even a tragedy, such as suicide, lies on the not distant horizon. The establishment of an occupation centre means that responsibility for the defective is lifted from the home or mother, and transferred to the staff of the centre for a few hours on three or four days a week. There is no better method that I know of lending a helping hand to those in difficulties through no fault of their own. I would, therefore, plead for an extension of this service.

3. Ambulance Service.

The facilities of the ambulance and sitting-case car service are available when patients have to be moved to mental deficiency hospitals or transferred to institutions as may be required.

4. Institutional Treatment.

It may be useful to give a list of the Cumberland patients in institutions or on licence therefrom as at 31st December, 1948. The list is as follows :—

On 31st, December 1948, there were 286 Cumberland patients in Institutions or on licence therefrom.

Dovenby Hall Hospital	202
Milnthorpe Institution, near Kendal	45
Durran Hill House, Carlisle	8
Totterdown Hall Colony, Weston-Super-Mare	2
The House of Help, Bath	1
Rampton State Institution, Notts.	5
Moss Side State Institution, Liverpool	1
The Royal Albert Hospital, Lancaster	8
Hortham Colony, Bristol	1
St. Mary's Home, Alton, Hants., ...	4
Lemmingon Hall Certified Institution, Alnwick ..	1
Howbeck House, West Hartlepool	1
Bishop Auckland Institution, Durham	2
Lisieux Hall Colony, Nr. Chorley, Lancs.	5
	286

One final point ; we have approached the mental health service as one in which it is not possible, nor desirable, to draw a sharp deciding line between the school health service and the duties accruing to the Council under Section 51 of the National Health Service Act. The staff concerned is really largely involved in both of these services, and, therefore, we divide the cost equally between the school health service and the general health service of the county, apart from the costs of guardianship and occupation centres, none of which are allocated to the school health service because that would not be applicable nor appropriate.

REPORTS AND NOTES ON INDIVIDUAL SERVICES AND OTHER MATTERS.

Tuberculosis.

Dental Service.

Orthopaedics

Venereal Disease.

Cancer.

Infectious Diseases.

Food and Milk.

Housing.

Water and Sewerage.

Agency Arrangements.

Laboratory Services.

TUBERCULOSIS.

As has been previously pointed out tuberculosis is now a joint service shared between the Special Area Committee, and the Local Health Authority, the Special Area Committee shouldering the greater part including the provision of sanatorium beds, and the responsibility for the provision of tuberculosis dispensaries. The Local Health Authority is responsible for the domiciliary care and supervision, apart from day to day medical treatment, and for the preventive side and after-care. Reduced to fractions, which will probably apply to the financial adjustments, these proportions are respectively 8/11ths and 3/11ths.

In saying that the Special Area Committee carry the major part of the responsibility, one has to admit that at the moment this responsibility is largely prospective. Sanatorium beds adequate to the needs of the area do not yet exist, in fact, through nobody's fault, we have really fewer beds now available than we had some years ago. In due course that will be fully rectified.

With regard to the conduct of the dispensaries, we carry these out at the moment on behalf of the Special Area Committee on an agency basis. This position still holds good at the time of writing this report, and, so far as I can see, is likely to continue for a long time to come. There will, of course, have to be appropriate financial adjustments made between the two bodies. In this, as in many other matters, one may, I hope, bring to notice certain matters which fall strictly within the purview of the Special Area Committee. Perhaps the first comment to make is that the structural and other improvements at Blencathra Sanatorium which were initiated by the County Council, prior to the 5th July, 1948, are being pressed forward as quickly as circumstances allow, and in addition some new developments and improvements, which we had not contemplated are also in hand. The County Architect, who is acting in most of these matters for the Special Area Committee, in continuation of work and schemes begun while the County Council were responsible, is proving an invaluable liaison between the two bodies.

The staff of the sanatorium became transferable to the Ministry on the 5th July, 1948, and treatment at the refill clinics, referred to later, is carried out by the Medical Superintendent, as an officer loaned by the Special Area Committee.

Up to the end of 1948 the County Council carried on the administration of the sanatorium on an agency basis for the Special Area Committee, at the Officer level.

The above all goes to show that the two bodies have been mutually indebted to each other in these matters, as in many others.

Developments which have occurred at the time of writing this report include a definition of policy, to the effect that when building of new hospitals, on a site, or sites, to be determined, is practicable, the provision of sanatorium beds will have the very highest priority.

There is, too, the possibility that from another angle (still sub-judice) the number of sanatorium beds available in the area may, before long, be increased by a substantial figure. Other developments which have taken place are the establishment of a streptomycin unit for the treatment of certain types of tuberculosis at the Infectious Diseases Hospital, Carlisle, and the allocation of a mass radiography unit, which will have its headquarters at the City General Hospital, Carlisle, but which will be mobile, and capable of being moved to different parts of the County. When this mass radiography unit gets into operation it will prove a valuable asset for the discovery of early, and unsuspected, cases of tuberculosis. One cannot overlook the fact, of course, that it will for a time, until additional sanatorium beds are available, inevitably create fresh problems, because through its operation new cases calling for sanatorium treatment will be discovered, possibly in considerable numbers, and the waiting list, and the time-lag for admission will thereby inevitably be increased.

A chest clinic is to be established at the City General Hospital, Carlisle, and a chest physician is likely to be appointed in the near future,* to have charge of the mass radiography unit, and the chest clinic generally, and to advise us on the development of a complete chest physician service throughout the area, including, of course, as the most important item, full consideration of the adequacy, or otherwise, of the present service and of necessary further developments. I need not add that the arrival of such a colleague will be very welcome.

The number of cases of pulmonary tuberculosis notified as primary notifications was 185 which is about the average for the past five years, but higher than for 1947. Non-pulmonary notifications at 45 are substantially down on the average. In addition 54 cases came to notice in other ways. Of these, 45 were pulmonary and 9 non-pulmonary. "Other ways" means cases in connection with which information has been obtained from death certificates, and by transfers from other areas.

* *Since appointed.*

Table A.—Notifications.

	Pulmonary.	Non-Pulmonary.
1943..	164	70
1944..	178	61
1945..	182	71
1946..	197	48
1947..	162	58
1948..	185	45

The total deaths from tuberculosis are shown in the following table :—

Table B.—Deaths.

	Pulmonary.	Non-Pulmonary.
1943..	93	33
1944..	95	23
1945..	122	26
1946...	97	28
1947..	101	32
1948..	116	15

The death rate on the Registrar General's figures for the Administrative County in respect of pulmonary tuberculosis for 1948 is .55 per thousand of the population, and in respect of non-pulmonary tuberculosis .07 per thousand of the population. These figures compare with .5 per thousand, and .16 per thousand, respectively for 1947, and call for no comment.

The tables which follow show the deaths and death rates in the urban and rural districts of the County. The same areas as usual provide the black spots, with some variation up and down, of course, in different districts. Outstanding again is Ennerdale Rural District, which shows much the highest death rate in the whole county. One of the first matters I will ask the new chest physician, when he arrives, to consider, will be the problem of certain areas in Ennerdale Rural District, which have, as you are well aware, caused us anxiety for many years. It may be well at this stage to recall that the problem of Cleator Moor was investigated exhaustively by Dr. K. J. Thomson, who was in charge of the Cleator Moor dispensary for a number of years, and whose opinion on this matter I value very highly. The results of the investigation were submitted to a statistician, but it has to be admitted that the results were inconclusive, and there is no doubt that a number of factors, which are well known, contribute to the high incidence of tuberculosis in this part of the county.

Deaths from pulmonary tuberculosis were distributed among the sanitary districts as under :—

Urban Districts.	*Deaths*	*Death Rate.*
Cockermouth	1	.. .19
Keswick	3	.. .65
Maryport	5	.. .42
Penrith	3	.. .29
Whitehaven	14	.. .60
Workington	18	.. .63
Aggregate of Urban Districts	44	.. .52
Rural Districts.	*Deaths*	*Death Rate.*
Alston	1	.. .44
Border	11	.. .39
Cockermouth	8	.. .41
Ennerdale	36	.. 1.27
Millom	3	.. .24
Penrith	4	.. .35
Wigton	9	.. .39
Aggregate of Rural Districts	72	.. .57
Total for the Administrative County	116	.. .55

Your health committee have always been much interested in the question of non-notification of tubercular persons prior to death, and of notification immediately prior to death. The point is, of course, that late notification makes any question of treatment almost impracticable. During 1948 out of the 116 deaths from pulmonary tuberculosis only 13 were un-notified prior to death. This a very low figure. In some previous years the corresponding figure has amounted to nearly 50% of the total.

Our approximate average bed accommodation for pulmonary cases occupied at different institutions during the year was as follows :—

	Beds.
Blencathra Sanatorium	54
Meathop Sanatorium	20
Stannington Sanatorium	5

The accommodation above is by no means adequate to our needs. It is regrettable, too, that the average number of beds available to us at Blencathra Sanatorium fell substantially

during the year. At the time of writing, it is tending to creep up again, and it is my earnest hope that the developments planned at the sanatorium will enable the occupation of beds once more to reach a figure of nearly 100%. This will be an immense help to us.

I am seriously concerned at the heavy waiting list, which has reached the figure of 70 cases, involving a time-lag for admission of up to nine months.

I believe the position in many other parts of the British Isles is relatively as bad, or even worse. I have heard of areas where admission within 12 months is not practicable. The trouble is that the situation appears to be worsening, and is certainly complicated by the occurrence of tuberculosis amongst displaced persons from the continent of Europe, and of labourers from Eire. These patients having in the main no domicile in this country, when they enter a sanatorium, unless recovery occurs, continue to occupy a bed until there is a fatal termination, and there is no doubt that this has been a factor affecting the time-lag for our Cumberland patients. I have made representations on this matter personally to the Ministry and have asked that consideration be given to the establishment of some national arrangement for dealing with these unfortunate people, so that they should no longer be a burden on the inadequate sanatorium facilities in an area like this.

I am bound to refer to a very regrettable shortage of beds for children. We used, at one time, to have 20 children's beds at Stannington Sanatorium. Now, as will be seen from the preceding and following tables, we have only the use of five beds and *only one child was admitted during the year.* Cases of children with a positive sputum are not admitted. The problem of these children is very sad, because they, obviously, do not fit in well in a sanatorium which is occupied to 95% by adult cases.

There is nothing more distasteful than the matter of deciding priority in respect of admission to sanatorium beds. I suppose that the allocation of houses is as bad a headache, but happily this does not concern us as a County Council. There is hardly a case which comes to our notice in which urgent admission to a sanatorium is not indicated, either because the patient is at an early stage, and may respond favourably to treatment, or because the patient is advanced and is a dangerous source of infection to the contacts, many of whom in the ordinary course of events are young children. All we can do is to weigh carefully the relative claims and do the best we can, with the means at our disposal, but no man can make bricks without straw.

The Year's Work.

The total number of cases admitted to institutions for diagnosis or treatment was as follows :—

	Males.	*Females.*	*Total.*
Adults in Meathop and Blencathra	71	56	127
Children in Stannington	—	1	1
Other Institutions	5	8	13

Tuberculosis of bones and joints.

Ethel Hedley Hospital and Shropshire Orthopaedic Hospital	18	9	27

The admissions of pulmonary cases to sanatoria during 1948, and the preceding years, are shown below :—

1944	166
1945	160
1946	210
1947	149
1948	141

The main statistics for the year are as under :—

New Cases examined at dispensaries	166
Number of contacts examined	960
Number of pulmonary cases on the dispensary registers, at the end of the year	741
Consultations with practitioners	401
Visits to homes of patients by tuberculosis officers	419
Visits to homes of patients by tuberculosis nurses	2325
Sputum examinations	577
X-ray examinations	845
Attendances at dispensaries	3155
Shelters in use	20
Cases receiving extra nourishment	20

These figures call for no comment. They are substantially the same as for the previous year ; in some cases they are higher.

The number of patients attending the refill clinics at Carlisle and Workington continues to increase quite substantially. Weekly clinics are now held at both centres. The attendances at Carlisle amounted to 433, and at Workington to 867.

We continue to receive a number of suspected cases for examination from the National Service Medical Board. The number of ex-service patients suffering from tuberculosis shows some tendency to fall. We undertake a fair number of examinations for the Ministry of Pensions (these are increasing) and for the Ministry of Labour in connection with the register of disabled persons.

Memo 266/T

This Memorandum which governed the provision, through the County Council, of financial assistance to certain groups of cases has now lapsed, the service having been taken over by the National Assistance Board as from the 5th July, 1948. During the period 1st January, 1948, to the 5th July, 1948, there was paid out in allowances approximately £1,675.

DENTAL TREATMENT.

Report by the Senior Dental Officer (A. C. S. Martin, L.D.S.)

"For many years the County Health Service has included provision for the dental treatment of expectant mothers where such cases were notified, following ante-natal examination by a medical practitioner as requiring this, but usually only those cases were referred in whom gross defects were in evidence. There is no doubt that this service was of great value in preventing post-natal complications, but there is also no doubt that from the viewpoint of preventive medicine it left much to be desired. In the same way treatment was available for pre-school children when the parent asked for it, usually because of pain, and, though a few cases were attended to, it was not possible to carry out any real programme of conservative work.

The introduction of the National Health Service has changed this completely, in that, while local health authorities have been relieved of certain of their responsibilities, the dental treatment of expectant and nursing mothers and pre-school children has been left in their hands, and has been placed in a position of first importance. There is no question that this is a step in the right direction, and every endeavour is being made in Cumberland to implement fully the Minister's intention in this regard.

It was felt that the only satisfactory basis to work on was a direct approach to the persons concerned, and as far as possible this is being done as follows :—

While all expectant mothers cannot be offered dental examination and treatment, contact can be made with a large proportion through the midwives' service, as the County Health Department have a record of all those who book midwives for their confinements. To all these a notice is sent informing them of the facilities available, a tear-off part of the notice being returned by the patient, duly signed, if treatment is desired. On receipt of this, an appointment is made for the patient to attend at the most convenient clinic. At the same time a certain number of cases make enquiries regarding treatment, and this is given, provided a

certificate is produced from a medical practitioner or other reliable source, stating that the patient is an expectant or nursing mother. The response from the notices up to 31st December, is interesting, 117 out of 520 accepting treatment. This is not a very good result, but it must be borne in mind that many of these already have dentures, while a fair percentage will attend dentists under the National Health Service, so that the number not accepting necessary treatment is probably not as large as would appear.

With regard to the pre-school children, a complete list is available in the child welfare section, and this is made the basis of the approach, a notice being sent to the parent of each child aged three years or over, offering regular inspection and treatment. This notice has a detachable portion for signature and return if treatment is desired. As the scheme develops and experience is gained, it may be found advisable to start at an earlier age, but it is felt that for a commencement three years is young enough for the average child. These notices entail a great deal of clerical work, but it will bring the pre-school children on to the same basis as the school children in the county and so one scheme will dove-tail into the other. It was not possible to commence this scheme during the year under review, but it is hoped that it will be brought into full operation during 1949, providing staff difficulties do not prevent this.

It is questionable if the general public fully realise the need for regular dental supervision of young children, and it may be some time before a satisfactory acceptance rate is secured. At the same time dentistry has been so much in the news recently that the public is becoming more dental minded and so parents may be more ready to avail themselves of the facilities provided. One thing is certain from a purely statistical point of view—dental treatment of "under fives" is a failure. In normal circumstances the child has not been under the control of anyone but the parents, and consequently is not easily managed—quite a different proposition to children who have been at school and so have been under a measure of discipline with strangers. This one fact often involves much time being taken up before any treatment is even attempted, while treatment itself has to be carried out with due regard to the age and normal outlook of the patient, and hence takes far longer than in an older child or an adult. At the same time, there is no question that a move is being made in the right direction, and if children and parents are properly handled, and conscientious work carried out, not only will the children themselves benefit, but the school dental service will be placed in a much more favourable position through the children entering school dentally fit.

This, of course, raises a question of propaganda, and it is possible that much might be achieved by carefully planned talks through organisations such as the Women's Institutes, and at the same time health visitors can render a great deal of assistance by explaining to mothers the desirability of regular care for the " under-fives." Until recently very little concern has been shown for deciduous teeth apart from the relief of pain, so that it need not occasion surprise if parents do not see the need for treatment as " they will come out soon, anyway." On the other hand, there is no doubt that the best propaganda is the indisputable evidence that healthy mouths and sound teeth can alone provide, and it is up to the dental officers to produce this evidence. At the present time it is apparent that the "under-fives" are not likely to receive much treatment from private practitioners, so that it becomes increasingly important for the local authority dental service to be maintained and gradually expanded to meet a demand that will doubtless increase as the advantages of treatment are gradually realized by the parents.

*It reflects great credit on the staff that so far no one has left the service for the El Dorado of private practice, and the county is most fortunate in this. At present the staff is only one short, the vacancy being caused by the resignation of Miss D. M. Stark ; this negatived the increase which was intended by the appointment of Dr. T. D. Thompson. Under present conditions little can be done about this, and it is feared that the hoped-for expansion must await the settlement of the salary question which has caused such an upheaval in the country as a whole, as apart from the lay press it is not possible to advertise for staff."

*Since the above was written, one assistant dental Officer has resigned to take up private practice. At the time of going to press advertisements are being accepted by the dental journals.

(a) Adults.

Service.	*Cases brought forward from* 1947.	*Cases Referred in* 1948.	*Cancelled.*	*Treatment completed.*	*Cases carried forward. to* 1949
Ante-natal	65	210	99	85	91
Welfare	33	25	21	37	—
Tuberculosis	1	4	2	3	—
Tuberculosis (*Blencathra*)	25	59	—	37	*
Total	124	298	122	162	91

*All patients transferred to the Regional Hospital Board on 5th July, 1948.

Service.	*Fillings.*	*Extractions*	*Anaesthetics. Local.*	*General*	*Dentures provided.*
Ante-natal	125	358	139	6	57
Welfare	3	106	19	1	51
Tuberculosis	6	1	1	—	6
Tuberculosis (*Blencathra*)	56	55	38	—	15
Total	190	520	197	7	129

(b) Children under 5 years.

Number treated	80
Number of cases completed	39
Number of attendances for treatment	114
Fillings	36
Extractions—(Permanent Teeth)	—
(Temporary Teeth)	78
Other Operations—(Permanent Teeth)	2
(Temporary Teeth)	25
Anaesthetics—Local	20
General	45

ORTHOPAEDIC TREATMENT.

The same clinic arrangements have prevailed during 1948 as in 1947. The work of the orthopaedic clinics continues to be divided between the orthopaedic surgeon attached to the Cumberland Infirmary, Carlisle, (Mr. McKechnie) and the medical superintendent of the Ethel Hedley Hospital, Windermere, (Miss Bucknell), the general arrangement being that Mr. McKechnie sees the adult cases and some of the older children, while Miss Bucknell sees the younger group of school age and children under five. This is a good paper arrangement because among the children in the latter group are found candidates for admission to the children's orthopaedic hospital at Windermere.

Bearing in mind the scattered nature of the area, the long distances involved in travelling to the orthopaedic clinics at the Cumberland Infirmary, and also bearing in mind that the county orthopaedic scheme has now been in existence for over 25 years, has dealt with some 7,000 patients, (I think very efficiently), it is a little disappointing that there seems to be a growing tendency among certain practitioners

to by-pass these field clinics and to send patients direct to the Cumberland Infirmary who, previous to July 1948, would have been dealt with at our county orthopaedic clinics. This has, I think, two disadvantages. The first is that patients (a) may be involved in long travelling, which, in the case of crippling conditions, may be particularly difficult, and (b) I think must add unnecessarily to the already extremely busy orthopaedic clinics at the Cumberland Infirmary.

An increasing number of quite minor orthopaedic conditions are referred to our clinics, the actual number of rickets and flat feet referred during the year amounting to nearly 250 as opposed to 130 in 1947. For the reasons given above, I think, it would be a great pity if, especially in the case of children, our County Council orthopaedic clinics ceased to be a clearing house, as they have been for so many years, for orthopaedic conditions and become merely places to which such minor conditions as rickets and flat feet were referred.

The following tables show the general position. We have had to deal with the aftermath of the 1947 epidemic of infantile paralysis which, fortunately, did not involve many serious cases. The general figures for the year remain very much the same, apart from the above comment, as they have in previous years. In a few cases there has been difficulty in providing boots for the fitting of simple surgical appliances such as knock-knee irons. These boots are not in any sense surgical boots but merely require piercing for irons, and in some households of restricted means the provision of these boots has presented a little difficulty. Prior to July we bought these boots in necessitous cases either directly through the health department or through the children's fund. The boots, being ordinary boots, cannot properly be requisitioned under the Ministry of Pensions arrangements and the matter seems to fall within the province of the Assistance Board. The clothing grant from the Board, however, has in some cases been expended on other clothing and when these boots, which form an integral part of the treatment of certain orthopaedic conditions, were required they could not be provided. No doubt this problem, like many others, will sort itself out.

One satisfactory point which emerges from the year's working is that more mothers seem to be willing and anxious to co-operate in the treatment of comparatively minor orthopaedic conditions such as knock-knees and postural defects. There is less objection to the wearing of irons and a rather better tendency to attend intermediate clinics and to see that the children carry out remedial exercises.

Crippling conditions affecting children under five years of age.

Rickets	175
Flat Foot	64
Congenital defects	19
Club Foot	11
Injuries	7
Infantile Paralysis	22
Torticollis	16
Hemiplegia	6
Congenital Dislocation of Hips	12
Tuberculosis	5
Birth Palsy	9
Poor Posture	4
Hallux Valgus and Deformed Toes	8
Talipes and Pes Cavus	50
Scoliosis	4
Pseudo Coxalgia	4
Other conditions	54
	470

Tuberculosis of the bones and joints.

	Adults.	*School Children.*	*Children Under 5.*
Spine	45	11	2
Hip	17	6	—
Knee	10	5	—
Sacro-iliac Joint	4	—	—
Femur	1	1	1
Wrist	2	—	—
Elbow	2	—	—
Shoulder	3	—	—
Ankle	4	2	—
Tibia	1	1	—
Foot	—	—	2
Finger	1	—	—
	90	26	5

Adult Non-tubercular cases.

Infantile Paralysis	21
Arthritis	11
Scoliosis	3
Congenital Dislocation of Hip	9
Osteochondritis	2
Flat Foot	3
Osteomyelitis	11
Injuries	6
Other Conditions	41
	107

TABLE A.

Number on After-care Register, 1/1/48	387
New cases during 1948	245
Cases re-notified after discharge previously	6
Number removed from Register	202
Number remaining on Register on 31/12/48	436
Attendances at After-care Clinics	593
Seen by Consulting Surgeons (not included in above) ..	2
X-ray examinations during 1948	88

TABLE B.

Number of Attendances at After-care Sister's Clinics ..	454
Home Visits by Aftercare Sister	300
Plasters applied at Intermediate Clinics	119
Plasters applied at home	30
Appliances supplied and renewed	60
Surgical clogs and boots supplied	13

TABLE C.

Hospital Treatment.

Name of Hospital.	*In Hospital* 1/1/48	*Admitted during year*	*Discharged during year*	*In Hospital* 21/12/48
Ethel Hedley Hospital Windermere ..	16	12	18	10
Shropshire Orthopaedic Hospital, Oswestry ..	11	19	18	12

VENEREAL DISEASES.

Responsibility for the treatment of venereal diseases passed, on 5th July, from the County Council to the Special Area Committee, although we still play some part in contact tracing through our health visitors, to which reference is made in another part of the report. I am indebted to Dr McMurtrie, who held the post as Assistant Medical Officer for venereal disease up to the 5th July, and then transferred temporarily to the employment of the Special Area Committee, for the following notes on the V.D. position during 1948. The report, as noted, is not quite complete because Dr. Martin Edwards, a general practitioner in Workington, who conducted the treatment of cases of V.D. at his consulting room on behalf of the County Council, left the district, and no figures are available in this respect. The figures, however, are always small, and would not materially affect the general statement which Dr. McMurtrie has made.

"The decline in the incidence of venereal diseases reported in 1947 continued in 1948. The decrease in the number of new early cases of syphilis was very striking. In 1947 there were 66, while in 1948 only 25 are recorded. This is slightly misleading because no report from Dr. Martin Edwards at Workington was received as he had left the district. It is unlikely that more than three would be added, making perhaps 28.

The figures for new early cases of gonorrhoea show a similar result. In 1947 there were 167, in 1948, 97. This comparison is entirely satisfactory, but both figures undoubtedly fall far short of the real number of infections. The reason is largely that penicillin has come into general use in the treatment of gonorrhoea, and one injection can usually effect a cure. Consequently many cases receive treatment elsewhere than at the clinics.

In the following table comparative figures for 1948 and the previous year are given :—

	1947.	1948.
Syphilis (new cases, early stage)	66	25
Gonorrhoea (new cases, early stage) ..	167	97
Congenital syphilis	15	15
Found not to have venereal disease..	258	283
Total attendance	5308	4417

It is of interest to note that the number of people found not to have venereal disease has increased considerably. A large part of the Medical Officer's time is necessarily taken up by these. It is not by any means a waste of time, for the value to a man or woman to know that his or her troubles are not attributable to venereal disease is inestimable.

A drug known as streptomycin has now been released for the treatment of venereal disease. Formerly its use was restricted to certain forms of tuberculosis. It should fill a gap in our armament in selected cases. Other new bacteriostatic drugs are being evolved chiefly in America, and should appear soon in our country. Of these, aureomycin seems to have an important future.

The National Health Service Act, 1948, has an important bearing on venereal diseases. On 5th July, 1948, the treatment of venereal diseases passed out of the hands of the Local Health Authority and was taken over by the Special Area Committee. The whole of the equipment in the treatment centres was handed over and became the property of the two hospitals concerned. The staff, formerly employed by the County Council, is now under the control of the Special

Area Committee or the hospital. The Medical Officer no longer has his office in the County Health Department, but conducts his affairs from the Cumberland Infirmary.

Apart from these administrative changes, the work in the two treatment centres was carried on very much as before."

CANCER.

This is a matter which has almost entirely passed out of the purview of Local Health Authorities into that of the Regional Hospital Board. One way of approaching the matter would simply be to record the mortality statistics, but I think it would be quite wrong to leave it at that. The relevant statistics do, in fact, follow these few notes, and include in a summarised form a statement of the treatment undertaken by the Cumberland Infirmary.

The total deaths from cancer during the year amounted to 356, which is a little lower than for the previous year, but considerably higher than the average of past years. Details of these deaths in age groups and sanitary districts, are given below and call for no comment.

CANCER DEATHS DURING 1948—BY SANITARY DISTRICTS.

	Males	*Females*	*Total*
URBAN DISTRICTS.			
Cockermouth	5	7	12
Keswick	2	4	6
Maryport	7	9	16
Penrith	16	10	26
Whitehaven	21	15	36
Workington	27	21	48
Aggregate of Urban Districts	78	66	144
RURAL DISTRICTS.			
Alston	1	1	2
Border	19	23	42
Cockermouth	16	14	30
Ennerdale	31	20	51
Millom	14	12	26
Penrith	7	14	21
Wigton	20	20	40
Aggregate of Rural Districts	108	104	212
Whole County	186	170	356

CANCER DEATHS DURING 1948—BY AGE GROUPS.

	15-45		45-65		65+		All Ages Totals.	
	M.	F.	M.	F.	M.	F.	M.	F.
URBAN DISTRICTS	2	5	33	22	43	39	78	66
RURAL DISTRICTS	4	5	41	41	63	58	108	104
Whole County	6	10	74	63	106	97	186	170
	16		137		203		356	

Prior to 5th July there was a cancer committee sitting in Newcastle representative of all the health authorities in the North Eastern Region. This parent body had a complementary medical advisory committee, and between them these two committees explored and took action on the problems arising out of the building up of this service, including the rather specialised problems of this area. This committee was automatically dissolved by the coming into operation of the Health Service Act, and was replaced by a small sub-committee of the Regional Hospital Board which, in its turn, will be replaced by a joint co-ordinating committee of the Board, and of the Board of Governors of the teaching hospital (The Royal Victoria Infirmary, Newcastle). This committee will, it is anticipated, appoint a medical advisory committee, and I imagine its proceedings will be very similar to those of the original cancer committee.

The situation at the Cumberland Infirmary has developed considerably since the time of the last report. Two deep x-ray plants have been installed at the Cumberland Infirmary. A radiotherapist from the staff of the Director of the cancer organisation is, happily, now resident in this area. A visiting physicist attends from the headquarters staff at Newcastle. These changes mean that a number of local patients are able to obtain deep x-ray therapy treatment here, (being brought from their homes by the sitting-case car service), which arrangement is naturally a very great convenience.

When it is possible to provide more adequate accommodation for this department, the turnover of patients will obviously be much greater, but at least an important beginning has been made.

A certain number of cases as shown below, including certain types of cancer which need not here be specified, are dealt with by transfer to other hospitals. A general picture of the work undertaken at the Cumberland Infirmary is given in the following statistics for which I am indebted to the Secretary of the East Cumberland Hospital Management Committee. As will be seen, some of the figures refer to cases other than cases from the administrative county, but as these will be of general interest I have also included them.

NUMBER OF CANCER CASES ATTENDING THE CUMBERLAND INFIRMARY AS OUT-PATIENTS DURING 1948 :—

	First attendance	*Subsequent attendance*
County Cases	159 ..	918
Carlisle Cases	76 ..	520
Other districts	32 ..	187
		1625

Number of cancer cases *admitted* to the Cumberland Infirmary during 1948 :—

County cases	161
Carlisle cases	73
Other districts	33
	267

Number of cases transferred during 1948 for treatment to other hospitals (including the Royal Victoria Infirmary, Newcastle ; Shotley Bridge Hospital, the Queen Elizabeth Hospital, Gateshead ; the Newcastle General Hospital ; the Royal Infirmary, Edinburgh ; Glasgow Royal and the Christie Hospital and Holt Radium Institute, Manchester 106

PREVALENCE OF, AND CONTROL OVER, INFECTIOUS AND OTHER DISEASES.

During 1948 there was no considerable epidemic of infectious disease in the county, unless one could record the occurrence of nearly 2,400 cases of measles as such. This figure is not abnormal, although it is somewhat larger than for 1947, but well below the figure of 1945, as will be seen from the attached table. There was no substantial recurrence of the 1947 epidemic of infantile paralysis. The incidence of diphtheria again remained at a very low figure, and it will be seen by reference to the following table that diphtheria, as a cause of anxiety, if the present incidence is maintained,

has practically ceased to exist. This is, of course, due to the national policy of immunisation in connection with which certain figures of local statistics are given elsewhere in this report.

I have included as usual, some tables showing the incidence of certain infectious diseases during the past six years, together with a note of any fatalities. I think a closer analysis of these tables is not without interest. The table which immediately follows shows the deaths from certain of the commoner infectious diseases in respect of the past two years and in respect of the past six years. A glance at this table would appear to make it abundantly clear that, as I have often said in previous reports, we have not got this matter of deaths resulting from infectious disease in the proper perspective. Most people still would regard scarlet fever as a potentially more important matter than measles or whooping cough, and yet, as will be seen, only one death has occurred from scarlet fever during the past six years, and as far as diphtheria is concerned, there has only been one death in two years. On the other hand, measles, whooping cough and infantile diarrhoea show a different picture, and I again venture to repeat what I have often said before, that far more use should be made of the vacant beds in isolation hospitals for the treatment of these diseases, which have a far higher mortality than is generally recognised, and in respect of complicated cases of measles and whooping cough, and in respect of all cases of infantile diarrhoea do justify the most energetic hospitalisation and treatment for the saving of child life. *I would venture to suggest that the following table should be brought to the notice of the Special Area Committee.*

Deaths from certain Infectious Diseases.

	Scarlet Fever.	*Diphtheria*	*Measles*	*Whooping Cough*	*Infantile Diarrhoea*	*Total*
1947 } 1948 }	0	1	6	8	10	25
1943 to 1948 inclusive	1	23	15	30	91	160

Here follow the tables above referred to :—

Scarlet Fever.

In 1943	there were	291	cases with	0	deaths
In 1944	,, ,,	324	,, ,,	1	death
In 1945	,, ,,	369	,, ,,	0	deaths
In 1946	,, ,,	152	,, ,,	0	deaths
In 1947	,, ,,	150	,, ,,	0	deaths
In 1948	,, ,,	189	,, ,,	0	deaths

Diphtheria.

In 1943	there	were	77	cases with	7 deaths
In 1944	,,	,,	195	,, ,,	11 deaths
In 1945	,,	,,	69	,, ,,	2 deaths
In 1946	,,	,,	73	,, ,,	2 deaths
In 1947	,,	,,	8	,, ,,	1 death
In 1948	,,	,,	13	,, ,,	0 deaths

Enteric Fever.

In 1943	there	were	5	cases with	1 death
In 1944	,,	,,	2	,, ,,	2 deaths
In 1945	,,	,,	Nil	,,	
In 1946	,,	,,	2	,, ,,	1 death
In 1947	,,	,,	Nil	,,	
In 1948	,,	,,	1 case	,,	0 deaths

Measles.

In 1943	there	were	6 deaths
In 1944	,,	was	1 death
In 1945	,,	were	2 deaths
In 1946	,,	,,	0 deaths
In 1947	,,	,,	3 deaths
In 1948	,,	,,	3 deaths

Whooping Cough.

In 1943	there	were	5 deaths
In 1944	,,	,,	8 deaths
In 1945	,,	,,	5 deaths
In 1946	,,	,,	4 deaths
In 1947	,,	,,	3 deaths
In 1948	,,	,,	5 deaths

Cerebro-Spinal Fever.

In 1943	there	were	14	cases with	3 deaths.
In 1944	,,	,,	11	,, ,,	3 deaths
In 1945	,,	,,	11	,, ,,	5 deaths
In 1946	,,	,,	13	,, ,,	4 deaths.
In 1947	,,	,,	10	,, ,,	2 deaths.
In 1948	,,	,,	6	,, ,,	2 deaths.

The following table shows the notifications of the common-er diseases by districts. The table is exclusive of notifications of puerperal pyrexia and of opthalmia neonatorum, which are dealt with elsewhere.

NOTIFICATIONS OF CASES OF INFECTIOUS DISEASES IN THE COUNTY OF CUMBERLAND DURING THE YEAR 1948.

DISTRICT	*Scarlet Fever*	*Whooping Cough*	*Diphtheria*	*Measles*	*Pneumonia*	*Polio-myelitis*	*Enteric Fever*	*Erysipelas*
URBAN DISTRICTS.								
Workington	19	67	2	245	9	1	—	16
Whitehaven	16	60	—	243	5	—	—	—
Cockermouth	3	1	—	—	—	1	—	—
Keswick	5	12	2	74	—	1	—	—
Maryport	23	3	—	430	—	—	—	1
Penrith	10	137	—	73	16	—	—	2
RURAL DISTRICTS.								
Alston	2	49	—	3	7	—	—	—
Border	28	56	3	210	7	1	—	4
Cockermouth	19	14	—	172	6	—	1	—
Ennerdale	25	65	3	380	10	—	—	2
Millom	10	9	1	207	19	1	—	8
Penrith	23	33	—	146	12	2	—	1
Wigton	6	116	2	179	23	—	—	15
TOTALS	189	622	13	2362	114	7	1	49
1947	150	286	8	1960	147	74	—	41
1946	152	418	73	591	138	3	2	47
1945	369	199	69	2937	140	2	—	88

Perhaps a word on the hospitalisation of infectious diseases would be appropriate. A few years ago there were 11 infectious diseases hospitals in the county, with 212 beds, and we had also, by arrangement, part user of the Carlisle Infectious Diseases Hospital at Crozier Lodge. A number of these hospitals were really derelict or inadequate and have properly been closed, and today the Special Area Committee control two isolation hospitals in West Cumberland (Ellerbeck and Galemire) and three in East Cumberland (the Carlisle I. D. hospital at Crozier Lodge, and the Longtown and Penrith Isolation Hospitals). So far as the west is concerned, important improvements are planned at Galemire Hospital, and as regards Ellerbeck, this hospital is, on account of unsuitable construction and certain defects, unsatisfactory, and I do not imagine that its life as an I.D. hospital will be prolonged. The infectious diseases hospital at Crozier Lodge is now partly used for a number of other purposes such as a streptomycin unit for the treatment of tuberculosis. These various changes have greatly reduced the number of infectious diseases beds on paper, but steps are under consideration which, by providing additional cubicles, will greatly improve the quality and user of the beds which remain. The whole matter, of course, is one entirely for the Special Area Committee who have given close attention to the problems involved.

INSPECTION AND SUPERVISION OF FOOD.

Foods other than Milk.

The report of the County Analyst is not included as this has already been circulated to the County Council.

The widespread development of canteen feeding in association with schools, industrial concerns etc., has undoubtedly increased the risk of epidemics of food poisoning due to the possibility of the dissemination of infections through the preparation or distribution of food by persons suffering from carrier or other infectious conditions, or due to a disregard of the elements of personal hygiene. Anyone may see in the daily press from time to time, reports of such outbreaks of food poisoning. During the year under review, no such outbreak of any significance occurred in Cumberland, although one or two minor outbreaks occurred.

During the summer of 1949, a one-day course of lectures and demonstrations was held at the Central Kitchen, Wigton, in which Dr. Faulds and members of the staff of the County Council, Carlisle City Council, and the Wigton Rural District

Council took part. The course was held under the auspices of the Central Council for Health Education and to this short course were invited all the canteen supervisors associated with the school meal services and also all known canteen supervisors in the County and City, mainly of course, associated with industrial concerns. The course was very well attended and, I feel, aroused much interest.

Milk.

This report marks the swan song of our association as a County Council with the issuing of graded licences, with milk sampling on the present scale, and generally, with the supervision, in association with the local sanitary authorities, of the production and distribution of milk throughout the County. By an order in Council dated 25th August, 1949, 1st October, 1949, is named as the date on which responsibility for these matters passes with certain exceptions from the County Council to the Ministry of Agriculture.

We relinquish these duties with some regret and not without some apprehension as to the future.

The new regulations regarding milk, just issued, are complicated, and the exact spheres of responsibility as affecting county councils, district councils and the Ministry of Agriculture appear to overlap.

The main object of the regulations appears to be to continue and expand the campaign for the better keeping quality of milk. Bacteriological examinations in this respect are in the main to be carried out by the Ministry of Agriculture or by the trade on behalf of the Ministry. Local health authorities and local sanitary authorities will either have to have made available to them on request the results of these investigations, for example as regards school milk supplies other than pasteurised, or, alternatively, they will also have to undertake such sampling themselves.

The public health aspect of these regulations appears to be small and is of course, primarily concerned with tubercle. In this respect county councils and district councils both have duties, and sampling for tubercle also naturally forms a part of the organisation of the divisional inspectors of the Ministry of Agriculture. To make the regulations effective and to provide an efficient service without overlapping and waste of manpower and travelling, it will clearly be necessary that there should be close co-operation between the various bodies concerned.

Cumberland being an agricultural county, in which milk production forms one of the key industries, the campaign,

extending over many years, to raise the standard of milk production in the county has been a matter in which the County Council and more particularly, the Milk and Dairies Committee, have always taken a lively interest.

The work of the Milk and Dairies Committee has been far from easy. The committee have had at their meetings to balance their legal duties and the instructions of the Ministry and their duty to protect the community and perhaps particularly the children, from the dangers of bacteriologically impure and especially from tuberculous milk supplies on the one hand, and on the other, to bear in mind that the farming community have, during and since the war, laboured under considerable difficulties. These difficulties have been shortage of workers, shortage of equipment, especially sterilising equipment, in some places inadequate water supplies and so on.

Milk producers whose cases were under investigation have frequently been well known to members of the committee and may sometimes have been close neighbours. To hold the scales under such circumstances is not an enviable task, and I hope it is not improper for me to say as an official, that I have watched with respect the fairness of the decisions of the committee, and the care with which they have conducted their investigations.

In this closing episode, for I do not propose to refer to this matter in my next annual report, it is also incumbent upon me to pay a well deserved tribute to the extremely valuable assistance which has been given us over the years by the sanitary inspectors of the local sanitary authorities throughout the county.

The scheme devised in 1932 by the late Mr. Simpson, who was at that time Chief Veterinary Officer to the County Council, laid the foundation on very sound lines for co-operation between the officers of the County Council and those of the local sanitary authorities in milk sampling, and it has really been the fruits of this scheme which have enabled the Milk and Dairies Committee to do its work.

Even under the pressure of many other duties arising out of the war and post war conditions, and even under the difficulties of shortage of staff, the sanitary inspectors have never let us down.

We have also been greatly indebted to the divisional inspectors of the Ministry of Agriculture for their help and co-operation.

There are one or two other general points which I think should be made. There has been a rapid, in fact, almost dramatic rise in the number of tuberculin-tested herds in the

county in recent years. This may also be true of the other agricultural areas in England, I do not know, but in Cumberland five years ago, we only had 171 tuberculin-tested herds, whereas, at the time of writing, we have 639. Mention should also be made of the development of facilities, mainly official, under the auspices of the Milk Marketing Board as at Egremont, and occasionally private, for the pasteurisation of milk.

It is not part of my duty to know, and I do not know, what proportion of milk produced in Cumberland is pasteurised within the county and what proportion without the county and what is not pasteurised at all, but it is safe to say that the position in this respect has greatly changed for the better during recent years.

I think I should also refer to a curious and rather disturbing situation which emerged following an investigation into the discovery of tuberculosis in a milk sample from a certain source in the Penrith area. In the discussions with the Medical Officer of Health which have followed I have been informed that tuberculin-tested milk from farms in and around Penrith is sent out of the county to Appleby for distribution. In return the Penrith area gets ungraded and unpasteurised milk from Appleby. This hardly seems a fair crack of the whip for the people in the Penrith area.

Milk and Dairies (Consolidation) Act.

Of the 2786 samples taken during the year, including samples of pasteurised milk, 1171 were subjected to guinea pig inoculation. From these, nine positive reports were received. No reports involving the finding of tubercle in areas of delivery outside the county regarding milk produced in Cumberland were received.

Investigations into the nine positive samples referred to above resulted in the finding of eight animals with tuberculous udders, the animals being, of course, destroyed.

One other case was investigated in which a child had developed tuberculous glands. In this case the infected cow was also discovered and destroyed.

Milk Sampling.

As has been noted, 2786 samples were taken during the year, including all grades of milk, designated, pasteurised and ungraded, and also including school supplies. Of these samples 72 have had to be discarded for the purpose of the table below, which refers to cleanliness, because on arrival at the laboratory, they were either too old for examination

or no age was shown on the sample. They are however, included in table II, in connection with biological sampling. This leaves a net figure of 2714 samples examined for cleanliness, including 446 ungraded samples. The position regarding the ungraded samples is set out below, in table I. The position regarding graded samples is set out in the schedules at the end of this section.

TABLE I.

Sanitary Area.

	Satisfactory.	*Unsatisfactory.*	*Total.*
RURAL.			
Alston	5	1	6
Border	52	21	73
Cockermouth ..	47	28	75
Ennerdale ..	22	16	38
Millom	63	21	84
Penrith	8	12	20
Wigton	44	33	77
URBAN.			
Cockermouth ..	—	1	1
Keswick	7	—	7
Maryport ..	2	—	2
Penrith	10	10	20
BOROUGHS.			
Workington ..	13	6	19
Whitehaven ..	11	13	24
	284	162	446

The above table calls for little comment, except that the proportion of satisfactory to unsatisfactory samples has risen very substantially. This is very satisfactory, particularly as the total number of samples examined is considerably higher than for 1947. I do not wish to start hares in this closing analysis of the position, but it is, of course, obvious at a glance, that the results are much better in some districts than in others and much the same position prevails in this matter as in the previous year.

In addition to the above 2786 samples, a considerable quantity of qualifying samples, actually 398, were taken in connection with applications for tuberculin-tested and accredited licences.

The following table shows the percentage of samples positive for tubercle in the past six years. :—

TABLE II.

Year.	*Number submitted to the Biological Test.*	*Percentage Positive for tubercle.*
1943	1323	2.04%
1944	1273	1.6%
1945	1112	0.99%
1946	1245	1.3%
1947	1125	0.7%
1948	1171	0.77%

The figure for 1948 as will be noted, remains practically at the same low level as for 1947 and is, of course, well below the average for previous years. Sustained effort on the pars of all concerned is obviously producing permanent results. At mentioned previously, the attested herd scheme no doubt also has an important bearing on this matter.

Milk (Special Designations) Regulations.

Following unsatisfactory milk samples and other records, three licences were revoked during the year ; one has since re-qualified. Warning letters were issued to producers in 80 cases. Milk Production Officers of the Cumberland Agricultural Executive Committee paid 49 advisory visits, including a number of repeat visits.

The number of producers holding licences to produce tuberculin-tested milk still continues to rise substantially, and there are now 639 producers of tuberculin-tested milk in the county compared with 480 at this time last year. Only a few years ago, there were less than 100 producers of tuberculin-tested milk in the county. The number of accredited producers remains practically unchanged, at 120. As has been noted earlier, 398 qualifying samples in respect of applications for these licences were taken by the sanitary inspectors during the year.

During the year, 85 samples of pasteurised milk were collected for examination, but 19 were either over-age or the age was unknown when they reached the laboratory, leaving a net 66 samples to be classified. Of these, 57 were reported to be satisfactory and 9 unsatisfactory.

School Milk Supplies.

During the year, 443 samples of school milk were collected for examination, but of these 21 were either over-age or the age was unknown when they reached the laboratory, leaving a net 422 samples to be classified. Of the 422 samples, 311

were satisfactory and 111 unsatisfactory. This is a substantial improvement on the previous year. Guinea-pig inoculations were carried out for tubercle in 237 cases, and, of these, one was found to be positive for tubercle. Appropriate steps were taken in the matter.

Veterinary Inspection of Dairy Herds.

I am again indebted to Mr. Reid, Divisional Inspector of the Ministry of Agriculture for this area, for the following figures relative to the results of inspections of dairy herds, and also to the number of cattle which have been slaughtered under the Tuberculosis Order in the county during the year :—

No. of confirmed cases of tuberculosis 76

Clinical Inspection of Dairy Herds.

Class of Herd.	*No. of Herd Inspections.*	*No. of Cattle Examined.*	*Number of Cattle dealt with under the Tuberculosis Order.*
"Tuberculin Tested"	712	39,925	1*
"Accredited"	164	4,258	10
"Ungraded"	2,635	54,416	65

Tuberculin Testing of "Tuberculin Tested" Herds.

No. of cattle tested	39,768
No. of reactors found	168

**The tuberculin-tested licence which operated at the farm where this animal was found was afterwards withdrawn, and an accredited licence is now in force.*

STATEMENT SHOWING THE NUMBER OF TUBERCULIN TESTED LICENCES IN OPERATION IN EACH SANITARY DISTRICT, WITH THE RESULTS OF MILK SAMPLING, AND CLINICAL EXAMINATIONS OF THE HERDS.

Sanitary Districts.	*Licences in operation.*	*Samples taken.*			*Conditions other than Tuberculosis, found on Clinical Examination.*
		Number taken.	*Tuberculin Tested Standard.*	*Below Standard.*	
RURAL					
Alston	9	23	18	5	—
Border	219	617	492	125	66
Cockermouth	51	221	170	51	1
Ennerdale	31	108	88	20	13
Millom	9	24	19	5	—
Penrith	98	304	229	75	15
Wigton	93	317	245	72	2i
URBAN					
Cockermouth	1	4	3	1	—
Keswick	1	3	3	—	—
Maryport	1	2	1	1	—
Penrith	9	24	14	10	—
BOROUGHS					
Whitehaven	2	26	24	2	—
Workington	4	15	8	7	—
	528	1688	1314	374	116

NOTE:—One animal which was excreting tuberculous material was found in one Millom herd and slaughtered under the Tuberculosis Order. The herd thereafter had the tuberculin tested licence withdrawn and an accredited licence granted.

STATEMENT SHOWING THE NUMBER OF ACCREDITED LICENCES IN OPERATION AT THE END OF 1948, IN EACH SANITARY DISTRICT, WITH THE RESULTS OF MILK SAMPLING AND CLINICAL EXAMINATIONS OF THE HERDS.

Sanitary Districts.	*Licences in Operation*	*Samples taken.*			*Cases of Tuberculosis Detected on Veterinary Examination or Reported.*			OTHER CONDITIONS
		Number taken.	*Accredited Standard.*	*Below Standard*	*Tuberculous*	*T.B. Udder.*	*Emaciation.*	*Chronic Cough, &c.*	*Atrophy, Mastitis Induration Non-T.B., etc.*
RURAL.									
Alston	—	—	—	—	—	—	—	—	—
Border	24	66	48	18	—	1	—	—	10
Cockermouth	11	59	45	14	2	1	—	—	2
Ennerdale	18	54	38	16	1	2	—	1	4
Millom	10	41	33	8	—	—	—	—	3
Penrith	9	25	12	13	—	—	—	—	2
Wigton	28	99	72	27	1	4	—	—	6
URBAN.									
Cockermouth	1	3	3	—	—	—	—	—	—
Keswick	—	—	—	—	—	—	—	—	—
Maryport	2	6	4	2	—	—	—	—	—
Penrith	1	3	3	—	—	—	—	—	—
BOROUGHS									
Whitehaven	13	52	37	15	—	1	—	—	—
Workington	3	9	8	1	—	—	—	—	2
	120	417	303	114	4	9	—	1	29

HOUSING.

As noted last year, on account of legislative changes, no housing in respect of rural workers was undertaken by the County Council. The Central Housing Advisory Committee made recommendations on this matter, some of which were included in the Housing Act, 1949. This act gives county district councils power to make immediate grants for the reconditioning and conversion of houses for all sections of the community, not merely for agricultural workers, but does not give power to county councils to do so except by agreement with district councils.

The County Council are now, however, increasingly becoming interested in housing from a different angle. The council have for long been considerable owners of housing property in respect principally of teachers and the police. Now increasingly there is a tendency for the council to build houses for certain groups of members of the staffs of different departments. The council have approved plans for the erection of 25 houses in the vicinity of Carlisle for the lower income groups of the headquarters, administrative, technical and clerical sections, and some of these houses are now building. The building of new police houses and rural-type stations is now proceeding satisfactorily ; in all about 60 are in hand. In the not distant future it is almost certain that a policy of building houses throughout the county for district nurse midwives, municipal midwives and, in one or two areas, possibly for health visitors, will be put in hand. A number of houses are also at the stage of tender for use by firemen in the county fire service.

WATER & SEWERAGE SCHEMES.

(A) Water.

Major Schemes.

(1) North Cumberland Water Board Caldew Head Scheme.

Although the preliminary work of sinking boreholes, constructing measuring gauges and the building of an approach road has been continued, the North Cumberland Water Board have not been able to commence work on the full scheme.

In spite of the Parliamentary powers which were obtained by the Board under the North Cumberland Water Board Act, 1947, the Ministry of Health were not prepared to give either their approval to the work on the scheme commencing, or any indication as to grants to be made to the constituent

authorities, until a public inquiry into the particulars of the scheme and into the schemes of distribution proposed by the constituent authorities of the Board had been held.

Accordingly, a lengthy and detailed public inquiry and inspection were held by an inspector of the Ministry of Health in November and December, 1948.

It is to be hoped that the result of this inquiry will be given at an early date and that this much needed and excellent scheme will be able to proceed as soon as possible.

(2) Ennerdale Scheme.

After discussions between Whitehaven Corporation and the Ennerdale and Millom Rural District Councils, it was decided that it was impracticable and uneconomic to supply any part of the Millom Rural District by means of a revised scheme.

However, Whitehaven Corporation and Ennerdale Rural District Council agreed upon a revised scheme and made application to the Ministry of Health for the approval of this scheme, which would supply Whitehaven with 4 million gallons per day, and Ennerdale with up to 1.25 million gallons per day, at an estimated cost of £321,000.

This revised scheme has been approved in principle by the Ministry of Health, but has not yet been approved by the County Council for the purposes of grant.

Local Schemes.

During the year five schemes for the improvement of local water supplies have been submitted to the County Council for their observations under the Rural Water Supplies and Sewerage Act, 1944. These were as follows :—

Border R.D.C.	1
Ennerdale R.D.C.	3
Millom R.D.C.	1
Total	5

The estimated cost of the above five schemes is £30,250. In connection with these schemes, one scheme, which provides for an extension of a diversion to an existing supply at Egremont, has been deferred by the county council for further consideration pending a decision being reached in regard to the Ennerdale Lake Scheme. With regard to the four remaining schemes, in one case the Minister of Health having intimated that he is unable to make a grant towards the cost of the scheme under the Rural Water Supplies and Sewerage Act, 1944, in view of the small burden which would be imposed on the rates, the county council informed the district council that

they would be unable to make a grant under the provisions of that act ; one scheme was approved by the county council subject to minor amendments, and in the remaining two schemes the district councils were informed that the county council considered the schemes sound and adequate and had no further observations to offer.

(B) Sewerage.

During the year two sewerage and sewage disposal schemes have been submitted for the observations of the County Council in accordance with the Rural Water Supplies and Sewerage Act, 1944, one by the Keswick Urban District Council and the other by the Ennerdale Rural District Council at a total estimated cost for both schemes of £4,563. With regard to the scheme submitted by the Keswick Urban District Council the county council were of the opinion that the works proposed were of a maintenance and reconstructional character, and in the circumstances were unable to make a grant towards the cost under the act.

Subject to certain amendments the county council considered the scheme submitted by the Ennerdale Rural District Council sound and adequate, but subsequently the Ministry of Health informed the district council that although the Minister was prepared to approve the scheme in principle he was not prepared to make a grant towards the cost under the Rural Water Supplies and Sewerage Act, 1944, and here also in view of the Minister's decision, the district council were informed that the county council were unable to make a grant towards the cost under the act.

AGENCY ARRANGEMENTS.

The council, during the year, established agency arrangements from two angles. First of all the council have made arrangements with a number of voluntary bodies or individual persons to undertake on their behalf certain of their statutory duties. Secondly, at the request of the Special Area Committee certain agency arrangements have been undertaken by the county council on behalf of the committee at the officer level.

(a) In the former group the Council have made arrangements as follows :—

1. With the Cumberland Nursing Association and the Penrith District Nursing Association for the carrying out of duties in connection with domiciliary midwifery and general nursing, and to some extent health visiting, under sections 22 to 25 of the National Health Service Act.

2. With the Town Clerks of Workington and Whitehaven, with the Clerks of the Wigton and Cockermouth Rural Districts, with the Clerks of the Keswick and Penrith Urban districts, and with the Honorary Secretaries of the Brampton, Maryport and Millom Ambulance Committees for the carrying out of the councils' duties as an ambulance authority, under section 27 of the act.

3. With the Carlisle Diocesan Council for Social and Moral Welfare, and the Lancaster Diocesan Protection and Rescue Society, in connection with the care of unmarried mothers at their confinements and otherwise, and in connection with the care of their children, at St. Monica's and Brettargh Holt Maternity Homes, and at Coledale Hall in Carlisle.

4. With the Cumberland and Carlisle Mental Welfare Association in respect of the domiciliary care and supervision of mental defectives over a large part of the county.

5. With the British Red Cross Society in respect of the Hospital Car Service.

6. With the Carlisle Workshops for the Blind in respect of the care of the blind under the National Assistance Act.

7. With the Diocesan Mission to the Deaf and Dumb, in respect of the care of the deaf and dumb under the National Assistance Act.

8. With the Special Area Committee in respect of domiciliary nursing in the Alston area.

9. With the Cumberland branch of the Womens' Voluntary Services in respect of the Home Help Service.

(b). For the second part, we acted as agents at the officer level on behalf of the Special Area Committee during the latter half of 1948 in respect of Garlands Mental Hospital, Blencathra Sanatorium and the maternity home at Penrith. The Council have also acted as agents of the Special Area Committee in respect of tuberculosis by providing the majority of the Tuberculosis Officers undertaking work at the tuberculosis dispensaries.

LABORATORY SERVICES.

No health authority can operate efficiently unless adequate laboratory services are available, and, therefore, a short note on this is relevant.

We are very fortunate in this area in this respect, and the co-operation, and advice, of Dr. Faulds, the Pathologist in charge of the Cumberland Infirmary Laboratory, and his staff have been invaluable to us on many occasions.

On and after July, 1948, when the pathological laboratory service centred on the Cumberland Infirmary was taken over by the Ministry of Health, little change was involved in this area, because, prior to that date, this laboratory had been recognised as a dual purpose laboratory doing the public health work for the local authorities under the auspices of the Medical Research Council, the clinical pathology for general practitioners and hospitals throughout the area, and the milk and water samples submitted by local authorities. These arrangements continue to work smoothly, the only difference being that responsibility for payment is transferred from the practitioners and the local health authority and local authorities to the Ministry of Health or to the Medical Research Council with the exception of the chemical analyses in respect of water and sewage, and of samples of milk taken between the producer and the retailer which still remain a local authority responsibility.

The advantage of an associated laboratory is obvious, in that the general public health aspect is linked up with the clinical or pathological aspect, and, therefore, the control of infectious disease is facilitated, and the laboratory staff is able to devote particular attention to specimens coming in from practitioners and others from areas in which infectious diseases exist either in the epidemic or sporadic form.

The infectious diseases hospitals, as noted before, are now no longer the responsibility of local authorities but have been transferred to the control of the Special Area Committee, and all the bacteriological investigations of infectious diseases in the county are now carried out in Carlisle. Notification of the results of the examinations of these specimens is sent to the appropriate medical officer of health as well as to the practitioner in charge and to any consultant concerned. The County Health Department is also notified when appropriate.

The total number of samples examined for the 12 months before the 5th July, and the 12 months after the 5th July, 1948, are interesting showing as they do a substantial increase :—

July 1947 to June 1948	17614 specimens.
July 1948 to June, 1949	23703 specimens.

The increase above referred to is partly due to increased use of the laboratory service by sanitary authorities, and partly due to increased use by the hospital service and general practitioners as shown by the following figures :—

Pathological Specimens.

1st July, 1947 to 30th June 1948	13534
1st July, 1948 to 30th June, 1949	18958

Local Authority Specimens.

1st July, 1947 to 30th June, 1948	4080
1st July, 1948 to 30th June, 1949	4745

THE WELFARE SERVICES.

I am indebted to the County Welfare Officer (Mr. Walker) for the following comprehensive Report on the Welfare Services, the administration of which is in the hands of the Welfare Sub-Committee of the Health Committee.

(a) NATIONAL ASSISTANCE ACT, 1948.

The general object of this Act, which came into operation on the 5th July, 1948, was to substitute for certain existing services, a comprehensive scheme of assistance and welfare services which would complete the main pattern of the new social legislation, of which the Family Allowance Act, the National Insurance (Industrial Injuries) Act, the National Insurance Act, and the National Health Service Act, are other principal features. The fundamental object was to achieve the final break-up of the Poor Law and to create entirely new services founded on modern conceptions of social welfare. Local Government responsibility for the relief of destitution gave place to a new unified state service of financial aid according to need administered by the National Assistance Board. Although responsibility for casual poor persons or vagrants was also transferred to the Board who were required to make provision whereby persons without a settled way of living were to be influenced to lead a more settled life, and for their temporary accommodation in reception centres, Local Authorities were required by the Board to provide and maintain such centres on their behalf with reimbursement of approved expenditure.

The Act required Local Authorities (i.e. County and Borough Councils) to provide :—

(a) Residential accommodation for persons who by reason of age, infirmity or any other circumstances are in need of care and attention which is not otherwise available to them.

(b) Temporary accommodation for persons who are in urgent need thereof, being need arising in circumstances which could not reasonably have been forseen or in such other circumstances as the authority may in any particular case determine.

(c) Welfare and health services for persons accommodated therein.

(d) Welfare services for the blind, deaf, deaf and dumb, and other persons who are substantially and permanently handicapped by illness, injury or congenital deformity, or such other disabilities as may be prescribed by the Minister of Health.

Residential accommodation of the type envisaged by the Act is to be provided in homes or hostels designed to meet the varying needs of the persons concerned, local authorities thereby ceasing to be merely a " reliever " of destitution, and becoming the provider of comfortable accommodation with care and attention for those who, owing to age and/or infirmity, cannot wholly look after themselves.

ADMINISTRATIVE ARRANGEMENTS.

The arrangements made by the County Council for the discharge of their functions under the Act provide :—

(a) that the functions in relation to registration of Charities for Disabled Persons (Section 41) be discharged by the General Purposes Committee of the Council ;

(b) that the functions other than those referred to in (a) above stand referred to the County Health Committee;

(c) for the constitution of a Welfare Sub-Committee of the Health Committee (consisting of 12 members together with the Chairman of the County Council and the Chairman of the County Health Committee) to exercise on behalf of and subject to the general supervision of the Health Committee, the functions referred to in paragraph (b) above, and to exercise on behalf of the Council all matters relating to the day to day administration of the said functions within approved financial estimates as may from time to time be agreed ;

(d) for the constitution of two Area House Committees (each consisting of 9 members, together with the Chairman of the County Council and the Chairman of the Welfare Sub-Committee) responsible to the Welfare Sub-Committee for the day to day management of homes and hostels ;

(e) that for the purpose of the discharge of the functions referred to in (c) and (d) there should be appointed an Officer to be known as the County Welfare Officer, who would be directly responsible to the Welfare Sub-Committee for all matters arising in connection with the performance of his functions, and adequate staff to assist him in the exercise thereof ;

(f) that the County Medical Officer as chief executive officer of the Health Committee, should generally supervise the discharge of the functions of the Welfare Sub-Committee in so far as they relate to medical matters.

PART III RESIDENTIAL ACCOMMODATION.

Included in the scheme for the exercise of the Council's functions under Section 21 of the Act are the following statistics :—

(a) Total estimated mid-1947 population of the area of the Council 202,460.

(b) Estimated number of aged, infirm and handicapped persons for whom residential accommodation is required :—

(i) Aged	188
(ii) Physically and Mentally infirm	132
(iii) Blind and Partially Sighted	16
(iv) Deaf or Dumb	4
(v) Epileptics	28
(vi) Crippled	32
	400

(c) Basis of estimate in (b) above :—

	Aged	Physically & Mentally Infirm	Blind & Partially Sighted	Deaf or Dumb	Epileptics	Crippled	Total
(a) No. of Persons for whom accommodation is at present being provided	105	73	9	2	16	18	223
(b) No. of persons on present waiting lists.	—	—	—	—	—	—	—
(c) Allowance for growing demand for accommodation	83	59	7	2	12	14	177
Total :	188	132	16	4	28	32	400

The care of old people which is no longer a family or individual matter, is a social problem growing year by year. In 1911 there were 1,880,000 people over 65 years of age. In 1948 there were 4,480,000. The country is faced with a definite ageing in population. It has been estimated that by 1961 there will be about 8,000,000 persons over 65 years of age, and that in the administrative County of Cumberland residential accommodation for approximately 400 persons will be required by 1954.

Part III residential accommodation is at present provided in three former public assistance institutions attached to which are small hospitals or sick ward blocks, catering in the main for the chronic sick, together with a small maternity block at Meadow View House, Whitehaven, of 3 beds and 3 cots. The three establishments are :—

	Number of Beds					
	Part III Accommodation			Hospital		
	Male	Female	Total	Male	Female	Total
Station View House, Penrith	57	26	83	18	18	36
Highfield House, Wigton.	42	17	59	24	21	45
Meadow View House Whitehaven	136	97	233	42	50*	92
	235	140	375	84	89	173

* includes small maternity ward of 3 beds and 3 cots.

As the predominant user of the three institutions, prior to the 5th July, 1948, was for other than hospital purposes, sub-section (2) of Section 6 of the National Health Service Act, 1946 (which provides for the transfer to the Minister of Health of hospitals, and property and liabilities connected therewith), did not apply in relation to the institutions mentioned, which remain vested in the County Council.

Pursuant to the provisions of Paragraph 7 (1) of the 6th schedule to the National Assistance Act, 1948, arrangements were entered into with the Regional Hospital Board whereby, until the Minister of Health otherwise determines, the beds in the hospital or sick ward sections of the three establishments, to the total number of 173 (see details above) were reserved to the Regional Hospital Board for the maintenance and treatment of persons for whom the Board became responsible as from the 5th July, 1948.

The following tables show the number of admissions, discharges and deaths during the twelve months ended 31st December, 1948 :—

POOR LAW ACT, 1930.

(1st JANUARY, 1948, to 4th JULY, 1948).

	Station View House, Penrith.			*Highfield House, Wigton.*			*Meadow View House Whitehaven.*		
	House	*Hosp.*	*Total*	*House*	*Hosp.*	*Total*	*House*	*Hosp.*	*Total*
Admissions ..	13	29	42	34	50	84	33	133	166
Discharges ..	11	11	22	33	63	96	34	105	139
Deaths ..	—	14	14	—	22	22	—	42	42

NATIONAL ASSISTANCE ACT, 1948
NATIONAL HEALTH SERVICE ACT, 1946
5th JULY, 1948, to 31st DECEMBER, 1948).

	Station View House, Penrith.			*Highfield House, Wigton.*			*Meadow View House Whitehaven.*		
	Part III	*Hosp.*	*Total*	*Part III*	*Hosp.*	*Total*	*Part III*	*Hosp.*	*Total*
Admission	14	16	30	37	44	81	61	94	155
Discharges	19	7	26	35	50	85	76	67	143
Deaths ..	—	9	9	—	11	11	—	37	37

MEDICAL ATTENTION FOR RESIDENTS.

General medical supervision of the Part III establishments is undertaken by the former institution medical officers, who are also medical officers responsible to the Regional Hospital Board for the treatment of persons in the accommodation reserved to the Board. Residents have been given the right and freedom to choose their own doctor as if they were living in their own homes, and where they select the doctor responsible to the committee for the medical supervision of the premises, the matter of capitation fee payable lies between the doctor and the Executive Council appointed under the National Health Service Act, 1946.

HOSTELS—Future Provision—Existing Establishments—Upgrading of.

The future policy is to provide accommodation in establishments of the nature of small homes or hostels for the aged, and ultimately to vacate completely poor law or public assistance and other similar institutions for this class of person. Whether it will be possible to achieve this desirable end, time alone will tell, but at the moment it would seem that it may be necessary to retain one or two small public assistance institutions for the category of persons who could not be considered suitable for accommodation in the small homely hostels.

Local authorities have, since the 5th July, 1948, been relieved of the burden of (*a*) domiciliary assistance and medical relief, and (*b*) hospital treatment of the chronic sick and mental patients ; whilst on the other hand persons resident in Part III accommodation have been given financial assistance from exchequer funds to enable them to meet the minimum charge of 21/- per week as a contribution towards the cost of their maintenance. For these contributions, the Ministry expect higher standards of comfort and amenities in existing institutions until such time as the type of residential hostel envisaged by the Act can be provided.

Housing is at present No. 1 priority in the matter of new buildings, and in the absence of suitable existing premises becoming available for purchase and adaptation as hostels for old people, local authorities are required to improve the standards of accommodation, facilities and amenities at present provided in the former public assistance institutions, until such time as permission is given to build hostels of an approved design.

Over the past nineteen years the former Social Welfare or Public Assistance Committees have closed redundant and out-of-date institutions, and brought about considerable improvement in the standard of accommodation etc., in the remaining establishments, provision having been made in the estimate for 1949/50 for further improvements and extended amenities, pending the establishment of hostels for which plans are in course of preparation should it be necessary for the Council to have to resort to building.

Meantime, and in connection with the provision of hostels, the Welfare Sub-Committee, at its meeting on the 10th December, 1948, resolved :—

> "That the County Welfare Officer bring to the notice of this Sub-Committee any properties which, subject to adaptation, might be considered as suitable for acquisition for purposes of hostels for old people on the lines envisaged by the Act of 1948, and that meantime this Sub-Committee fully endorses the proposals contained in these minutes for improving the amenities and facilities at the existing Part III establishments."

Covering estimates have been submitted to and approved by the County Council so as to enable action to be taken on the resolution, and whilst in Cumberland suitable properties situate within or adjacent to town areas are conspicuous by their absence, negotiations have been opened for the purchase of one mansion, whilst consideration is being given to the possibilities of two others.

(b) WELFARE OF THE BLIND.

The following statistical summary shows the number registered with the Council of blind persons of each sex, by age groups so far as is known, and the total number so registered of blind persons ordinarily resident in the area of the Council on the 31st March, 1948 :—

Age Group	*Total Number* M	F	*Total*
0-1	—	—	—
1-5	—	—	—
5-16	3	3	6
16-21	2	1	3
21-40	22	13	35
40-50	21	17	38
50-65	43	36	79
65-70	18	20	38
70+	90	92	182
	199	182	381

Under the Blind Persons Acts, 1920/38, and pursuant to a scheme thereunder, the County Council decided to exercise their powers through the Further Education Committee who in turn appointed a Sub-Committee known as the Blind Persons Act Sub-Committee. The arrangements provided for the working of the scheme through the agency of the Cumberland & Westmorland Home and Workshops for the Blind, and the Barrow and District Society for the Blind. The services include the keeping and maintaining of a register of blind persons; employment in workshops and as home workers and in open industry, home teaching and visiting; the provision of homes and hostels and general social welfare; the granting of financial assistance to unemployed necessitous blind persons being undertaken by the former Social Welfare Committee of the County Council.

WORKSHOP EMPLOYMENT.

The types of employment and the approximate number of blind persons (both men and women) at present provided with employment of each type, are as follows :—

Trade.	*Men*	*Women*	*Total*
Firewood Department ..	2	—	2
Bed and Mattress Making ..	3	—	3
Bedding Labourers	2	—	2
Brush Making	2	—	2
Basket Making	2	—	2
Upholstery	1	—	1
Piano Tuning	1	—	1
Machine Knitters	—	3	3
Re-seating Chairs (in cane) ..	—	1	1
	13	4	17

HOME EMPLOYMENT.

On the 31st March, 1948, there were 7 blind persons in the home workers scheme employed in the following occupations :—

Occupation	*Men*	*Women*	*Total*
Braille Copyist	—	2	2
Piano Tuning	2	—	2
Farming	1	—	1
Basket Making	1	—	1
Boot Repairing	1	—	1
	5	2	7

HOME TEACHING AND VISITING SERVICES.

There are 3 home teachers (2 qualified and 1 unqualified) on the staff of the Cumberland and Westmorland Home and Workshops for the Blind, who cover the administrative County to as far south as Egremont (taking in North Westmorland), whilst the home teacher employed by the Barrow Furness and Westmorland Society for the Blind covers the southern part of the County, which in the main consists of the Rural District of Millom.

GENERAL SOCIAL WELFARE OF THE BLIND.

Pursuant to the Council's approved scheme under Section 29 of the National Assistance Act, 1948, and by virtue of Section 30 (1) of the Act, it has been decided that the Cumberland and Westmorland Home and Workshops for the Blind should continue to act as agents of the County Council in the discharge of the Councils' functions under Part I of the scheme, for a period not extending beyond the 31st March, 1950, on the basis of the arrangements in force on the 14th April, 1949, (the date the scheme came into operation) or such amendments or modifications thereof as may subsequently be approved and adopted by the Welfare Sub-Committee, it being the intention of the sub-committee to review the whole of the arrangements and decide as to how far and to what extent the functions under Section 29 should be discharged directly by the Welfare Sub-Committee. A similar arrangement has been entered into with the Barrow, Furness and Westmorland Society for the Blind.

(c) WELFARE OF THE DEAF AND DUMB AND HARD OF HEARING.

Section 29 of the Act contemplates that local authorities will provide for the deaf and/or dumb welfare services similar in character to those at present provided for blind persons, and paragraph 16 of part II of the Council's Scheme

under Sections 29 and 30 of the Act provides that in making a survey of the needs of their area for the purpose of the provision of such services, regard shall be had to the welfare services already available, and to discussions which have been opened up with voluntary organisations concerned.

At the present time the Carlisle Diocesan Association for the Deaf and Dumb is the only association in the area providing a welfare service for deaf and dumb persons of all denominations. This association is affiliated to the National Institute for the Deaf, and has for its objects :—

(i) Spiritual instruction ;

(ii) Ascertainment and registration of deaf and dumb persons ;

(iii) Visitation of the sick and others in their own homes ;

(iv) Rendering assistance in securing the admission of deaf and dumb children into suitable schools ;

(v) Education as far as practicable of the adult deaf and dumb whose education has been neglected ;

(vi) Placing of deaf and dumb persons in employment ;

(vii) Provision of recreational facilities.

The association operates throughout the geographical counties of Cumberland and Westmorland, the Furness area of the Lancashire County Council and in the area of the County Borough of Barrow-in-Furness. In the whole area, on the 31st March, 1948, there were 260 deaf and dumb persons on the register, distributed and classified as follows :—

Category	*Area*					*Total*
	Cumb. C.C.	*Westd. C.C.*	*Lancs C.C. (Furness Area)*	*Barrow-in-Furness C.B.C.*	*Carlisle C.B.C.*	
School age or under	19	2	2	5	9	37
In institutions ..	2	1	1	1	1	6
In mental hospitals	4	—	—	—	2	6
In full-time employment	71	10	9	16	19	125
Married women at home	14	4	3	6	10	37
Single women at home	—	1	—	3	—	4
Unemployable by reason of age ..	8	2	1	5	6	22
Unemployable by reason of infirmity	7	2	—	5	1	15
Incapacitated over whole of year ..	1	—	—	—	—	1
Unemployed ..	1	—	1	1	1	4
Private means ..	—	—	—	—	3	3
	127	22	17	42	52	260

The association has institutes in Carlisle and Barrow, with centres in Kendal and Workington, where the deaf and dumb may enjoy special services by means of finger spelling and gesture. Deaf and dumb persons cannot enjoy the cinema, the theatre or the radio but in the institutes and centres they can meet together, converse freely and take part in indoor games. These lighter activities tend to lessen the burden of their disability, a burden which might well lead to introspection and mental depression. Socials, whist drives and indoor games enable them to meet the hearing on an equal footing, which is a most important psychological consideration.

The Carlisle Diocesan Association (an organisation with many years practical experience in a work which is highly specialised) is desirous of placing its services at the disposal of local authorities by way of acting as agents for them in the discharge of their functions, and negotiations have been opened and are continuing with the Lancashire and Westmorland County Councils and the Barrow-in-Furness and Carlisle County Borough Councils, with a view to the preparation of a joint welfare service scheme which, subject to the approval of the Ministry of Health, would operate from the 1st April, 1950, and provide for the Carlisle Diocesan Association acting as agents for the authorities mentioned.

(d) HANDICAPPED CLASSES (OTHER THAN BLIND, DEAF AND DUMB).

A survey of the needs of the area of the Council in relation to the provison of appropriate welfare services for the residual group of handicapped persons is to be undertaken, when account will be taken of such services already available and provided through voluntary organisations and other authorities operating in the County.

(e) RECEPTION CENTRES.

PERSONS WITHOUT A SETTLED WAY OF LIVING.

The Act imposes a duty on the National Assistance Board to make provision whereby persons without a settled way of living may be influenced to lead a more settled life and to provide and maintain reception centres at which temporary board and lodging may be afforded to such persons. The Board are, however, empowered by the Act to require Councils of Counties and County Boroughs to provide and maintain reception centres on their behalf, the authorities to be reimbursed the expenditure incurred by them.

In 1930, there were 10 casual wards in the administrative County of Cumberland. The western part of the County being classified as a special area, the then policy was to discourage casuals from wandering in or through the area, where there was little or no prospect of securing employment of any description. Under that policy all but three casual wards (Penrith, Keswick and Wigton) were closed and later during the course of the last war those three establishments were closed.

Having regard to that policy, and on the directions of the National Assistance Board that centres should be maintained by the Council at Penrith and Whitehaven for the like purpose as reception centres, representations were made to the Board against the opening up of the West Cumberland route to casual wayfarers, with the result that the centre at Meadow View House, Whitehaven, was temporarily closed as from the 1st March, 1949, for an experimental period.

The future of the Whitehaven centre has not yet been finally decided, but it is significant to note that since the official closing of the centre on the 1st March, there has been a substantial drop in the number of admissions, viz :—

Quarter.	*No. of Admissions*
September, 1948	43
December, 1948	70
March, 1949	44
June, 1949	31
September, 1949	17

The position will be made the subject of further discussions with the National Assistance Board before a final decision is reached as to whether the centre should remain permanently closed.

(f) MISCELLANEOUS SERVICES.

Appropriate committee and/or administrative action has been or is being taken in regard to such matters as :—

(a) The constitution of a county old people's welfare committee to bring together in a spirit of co-ordination those voluntary bodies who are at present interested in, and, working for old people.

(b) Grants to old people's clubs.

(c) Registration and inspection of disabled and old people's homes.

(d) Temporary protection for property of persons admitted to hospital &c.