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COUNTY COUNCIL OF CUMBERLAND

Annual Report

ON THE

HEALTH SERVICES OF THE COUNTY

For the Year 1950

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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 for 1950.

Vital Statistics

The vital statistics for the year hardly call for any comment. Variations from the previous year are mainly negligible. It is worth drawing attention to the fact that deaths from cancer have fallen substantially, and that deaths from non-pulmonary tuberculosis have also fallen to a very low figure. No doubt this result is due to the intensive efforts made over the years to eradicate tuberculous cattle from the herds of the county.

"The Decline and Fall"

One of the classics of literature, under the above title, describes the waxing and waning of one of the imperial administrations of the past. One of the leading public health papers recently opened an editorial comment with these words, "Public health is in a bad way." That is an understatement, for unless drastic action is taken by the Ministry of Health and by the associations of local authorities, public health, as we have known it for generations, is on the way out. There has been much talk about new horizons for public health in the shape of prevention of illness, health propaganda, socio-medicine, and matters of that kind. Under the acid test of recruitment to the service, and there is no other test of equal significance, the attractions of these new horizons, which have been so eloquently expounded, are proving a miasma. Young medical graduates are not adopting public health as their profession. Hardly any of the universities and colleges of the country are thinking it worth while, or finding it possible, to conduct post-graduate courses in public health for the diploma or corresponding qualification. I think this year the exact number is three. It is a sign of the times that the London School of Hygiene has, by what has been described as an "act of faith," thought it desirable to offer scholarships and free tuition to students desiring to take the Diploma in Public Health. Even those classes which are being held,

are largely composed of graduates who do not propose to practice public health in this country.

Just as a year or two ago it became apparent that to advertise for assistant dental officers was a waste of money, now it is becoming apparent that to advertise for assistant medical officers is likely to be very nearly as unproductive. Applications are few and far between, and, *in general*, of a very poor quality. Our most recent experience at the time of writing, has been to advertise an assistant county medical officer post on the new salary scale, with the result that two applications were received, of whom one withdrew her application, and the other, when offered the appointment at a starting point well above the minimum of the scale, declined it. The post was re-advertised and four candidates were selected for interview. Before the interview three withdrew their applications, and the fourth failed to turn up without sending an apology. It will not be disputed that without the recruitment of assistant medical officers in sufficient numbers, and of adequate quality, the public health service must necessarily, through wastage, die of inanition.

The recent award of the Industrial Court on the salary of medical officers, has done nothing to help this position. The scale awarded by the Court for assistant medical officers is £850 x £50 to £1,150. The scale is less than that for assistant dental officers, on the grounds that the assistant medical officer has prospects of promotion. But has he *reasonable* prospects of promotion? I think something like one in ten may hope to become, after many years, a medical officer of health. Others may become senior or divisional medical officers, or may obtain combined appointments, or mixed appointments. There are, however, many fewer senior medical officer posts now available than formerly, because such services as tuberculosis and venereal diseases and others, have now gone over to the regional hospital boards. I think, too, that it is inevitable that the number of combined and mixed appointments will diminish as local sanitary authorities form combinations whereby one medical officer of health undertakes, as he easily could, the medical officer of health work for a number of sanitary authorities. This is actually happening, and its extension is foreshadowed and indeed advocated in Circular 27/51, which I interpret as meaning that well qualified

and experienced medical officers of health are likely to be in short supply.

The scale for assistant medical officers at £850 to £1,150, compares most unfavourably with the remuneration obtainable in other branches of medicine. I know of a case where, quite recently, in a practice not a hundred miles from where I am sitting, the assistant was paid £1,600 per annum plus a car. The pay of senior registrars in the hospital service, the remuneration of medical officers in industrial medicine, and of course the remuneration in general practice, all combine to put this new scale for assistant medical officers out of court as attractive, even before it has begun to operate. In the negotiations, the management side, that is the associations of local authorities, offered an even lower scale, to which the award of the court approximated much more closely than to the proposals of the staff side. If, therefore, this new scale for assistants proves quite unattractive as a stimulus to recruiting, the fault, and the ultimate effect on the public health service, lies squarely on the shoulders of the management side.

The management side in presenting their case, described a medical officer of health as an " administrator doing administrative work demanding a knowledge of medicine." This somewhat contemptuous description places the medical officer of health in the same category as the marine, who, in Kipling's words, is

> " A sort of a giddy harumphrodite,
> Soldier and sailor too."

The real description of a medical officer of health is, of course, *the exact reverse.* He is *a doctor with a knowledge of administration,* which is a very different thing.

The award has drawn what appears to be a most unfortunate distinction between the value of county council work and district council work. This distinction, which is expressed in substantially different rates of remuneration, will, I fear, have unfortunate repercussions in the future. It will, I hope, not be considered disparaging to the district council side to say that it is difficult to see why the work of a doctor engaged in looking after the health and well-being of children, whether of school age or under school age, in immunisation against diphtheria, in the domiciliary side of

tuberculosis, sometimes in the ante - natal care of women, and so on, which things constitute the chief part of an assistant medical officer's working day, is of less value to the community than examining nuisances and advising on epidemic disease and things of that kind.

I would like to quote from a letter received from a very promising assistant medical officer who has now left. "I have now been qualified ten years and receive a salary which is less than the assistant in general practice can get, having newly qualified and completed perhaps a year in hospital and a few locums. We younger men feel that we have joined a sinking ship."

Public health in this country attained its zenith between 1920 and 1940. Since the passing of the National Health Service Act of 1946, the decline and fall have begun. Surely it is not too late to do something about it. Surely public health—the justification of which, since its inception, lies in the decline in infectious diseases almost to the vanishing point, in the decline in the death rate, the halving of the infantile mortality rate, in the fall in tuberculosis and venereal diseases, in improved standards of housing, water supplies, sewage disposal, in the immensely improved standards of health of school children, and of children under school age, and in progress in many other directions—deserves a better fate than to be discarded like a worn-out garment. We do not, of course, claim all the credit, but we do claim a substantial share. It is because I, like many others who have given their professional lives to the service, feel intense anxiety as to the future, that I have said what I have said. I hope it may not fall on deaf ears.

Frustration

Apart altogether from the assistant medical officer position referred to above, the prospects of recruiting staff in other directions are not improving. We have recently advertised for assistant dental officers, orthopaedic physiotherapists, speech therapists, occupational therapists, psychiatric social workers, etc., *without receiving a single application.* While less vital perhaps than the assistant medical officer position, the situation, beyond dispute, is pretty grim. It may be, of course, and I imagine probably is, that the available personnel is trending to London and the home counties, to the

large cities, and to other parts of the country having attractions which we here are unable to offer.

I find it, too, disturbing that so little progress is being made with our new building proposals. These are modest in the extreme. We want at the moment, to build one new clinic and treatment centre in Millom, and a few houses for nurses. Health centres and any substantial building of new clinics and treatment centres, badly needed as these are, we have, apart from the reservation of sites, simply put out of our minds. We submitted an application to the Ministry, in connection with the proposed new clinic at Millom, twelve months ago. The area has been visited by officers of the Ministry, and every possible question has been answered, but after twelve months, we have not yet even got our compulsory purchase order for the acquisition of the site, let alone approval of the building.

In the matter of providing new houses for our nurses, some of which are very badly needed, it seems almost impossible to make any headway. After all, a new clinic even at today's prices, only costs about £12,000; a nurse's house somewhere about £2,200, and I cannot help casting envious eyes at another department which has building schemes *actually in progress* amounting to well over £1,000,000, while we, in the health department, have literally nothing in hand at all. After a life-long experience of this kind of thing, one has become inured to frustrations of this kind, but one cannot help feeling that occasionally a few crumbs might fall from the rich man's table. One doubts if the national perspective in these matters is really understandable.

We have recently received from the Ministry of Local Government and Planning a brochure on "Housing for Special Purposes." One of the chapters deals with the housing needs of nurses, and paragraph 87 reads as follows:—

> "In many areas it will be necessary to consider the special requirements of the district nurses and midwives, who will serve the local communities."

This is exactly what we have been doing for the

past two years, and we have submitted our proposals, but we do not seem to get much further.

Special Enquiries

We have been engaged in a number of special enquiries of one kind or another during the year, and during the early months of 1951. These enquiries have come from various sources — Ministry of Health, Ministry of Education, Medical Research Council, the Nuffield Hospitals Trust, the Marie Curie Memorial, and the Queen's Institute of District Nursing. Some little detail about these enquiries which are, in my opinion, all useful, and in which we have been glad to participate, may be worth giving.

1 *Enquiry into Virus Infections during Pregnancy*

This is an enquiry, the object of which is to ascertain how far the occurrence of certain infective conditions such as mumps, measles, chickenpox, infantile paralysis, in the mother during the pregnancy may result in the occurrence of congenital defects in the child. This enquiry is to spread over two years, and the supervision period will obviously cover another two years.

Memories are short and a great many people are involved in collecting the information, but we hope, by the issue of appropriate reminders, to play a useful part.

The enquiry is an extension to this country of an enquiry on similar lines which started in Australasia.

The numbers involved are small, and so far we have only come across four cases of pregnant women who have contracted any of the conditions applicable to the enquiry. We have registered some dozen control cases. These figures seem small but appear to be proportionately up to the average for the country.

2 *Job Analysis of Public Health Nursing*

This calls for little comment beyond saying that it is part of a national investigation into the distribution of available nursing personnel so far as the domiciliary side of public health nursing is concerned. This enquiry is now concluded.

3 *Domiciliary circumstances of Cancer Patients*

This was an enquiry covering a short period of a few months to ascertain through the reports of district nurses whether a cross-section of cancer patients living at home were short of any material item affecting their comfort during their illness.

This investigation, so far as this county is concerned, has shown that, broadly speaking, the domiciliary circumstances of cancer patients do not appear to call for any action, apart possibly from the provision of additional bed linen, such as sheets, draw sheets and night clothes. These appear to be in short supply in a number of cases because, of course, the circumstances of this disease in a considerable number of cases make an abnormally heavy demand on these articles.

4 *Infantile Paralysis. Investigations into the cause of spread*

This enquiry promises to be lengthy. The first phase has been the selection of a few towns and villages, (a) where there have been cases of this disease accompanied by paralysis — that is not merely toxic—within the last three years, (b) using as controls towns or villages of similar size where there have been no such cases within the past three years.

This investigation is carried out by means of large numbers of swabs lowered into the sewers for a period of 72 hours, or thereabouts, from which it is hoped, in the former group, to recover the virus, thus indicating the possibility of spread by carriers through sewage.

Dr. Faulds has been most helpful in this investigation, as have the medical officers of health and the sanitary inspectors of the Alston and Penrith Rural Districts, and of Maryport and Penrith Urban Districts.

5 *Physically Handicapped Children not at School*

This enquiry, of course, has more properly a place in the report on the School Health Service, and reference to the enquiry has been made in that report.

The object here is to compile a register of

children who, on account of physical handicaps, are unable to receive normal school education, and to assess the need for, and scope of, the building of residential schools under a national policy.

Staff

In these days staff changes are so frequent, that it is only possible and desirable to refer to them in special circumstances. This year Dr. Towers retires from the service of the County Council after thirty years. No member of the staff has been better liked or more respected, and all who knew him will regret that his health has brought about his retirement before he reached the normal retiring age.

I have already, in the report on the school health service, referred to the long and valuable service of Miss Nelson, who retired at the end of the year.

Before this report is in your hands, Miss Greenwood will have retired from her position as Administrative Assistant in the Mental Health Section. Miss Greenwood is, comparatively speaking, a newcomer. She retires on her marriage, and while she leaves with all our good wishes, her departure will be a great loss to the Mental Health Section, in which, during her short period of service, she has done extremely valuable work.

Thanks

I have again to express my thanks to the Chairman and members of the Health Committee and the various Sub-Committees for their continued interest and support, and to the members of the staff of the department who have given of their best under circumstances which have not been too easy.

I am,

Your obedient Servant,

KENNETH FRASER.

County Medical Officer.

County Health Department,
11 Portland Square,
Carlisle.

July, 1951.

STATISTICAL AND SOCIAL CONDITIONS OF THE AREA

The essential vital statistics for the year 1950 are as under :—

Population

	At 1931 Census	Estimated by Registrar General, Mid. 1950
Urban Districts	114,459	86,110
Rural Districts	91,331	129,790
Administrative County	205,790	215,900

Population of Sanitary Districts, 1950

Urban Districts.		
Workington	29,050	
Whitehaven	24,340	
Maryport	12,210	
Penrith	10,670	
Cockermouth	5,160	
Keswick	4,680	
		86,110
Rural Districts.		
Border	29,220	
Ennerdale	30,190	
Wigton	24,160	
Cockermouth	19,400	
Millom	13,070	
Penrith	11,450	
Alston	2,300	
		129,790
Total for Administrative County ...		215,900

Rateable Value and sum represented by a penny rate

The rateable value of the County at 1st April, 1950, was £1,049,312. The estimated product of a penny rate was £4,005.

Extracts from vital statistics for the year 1950.

LIVE BIRTHS

	Total Births	Males	Females
Legitimate	3,652	1,827	1,825
Illegitimate	154	78	76
Total	3,806	1,905	1,901

Birth Rate per 1,000 population 17.6
(England and Wales 15.8)

STILL BIRTHS

	Total Still-Births	Males	Females
Legitimate	99	62	37
Illegitimate	6	2	4
Total	105	64	41

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

DEATHS

Total Deaths	Males	Females
2,716	1,433	1,283

Crude Death Rate per 1,000 population 12.6
(England and Wales 11.6)

DEATHS FROM DISEASES AND ACCIDENTS OF PREGNANCY AND CHILDBIRTH.

Pregnancy, Childbirth and abortion 5

Maternal Death Rate per 1,000 Total Births—1.28

DEATH RATE OF INFANTS UNDER ONE YEAR OF AGE.

All Infants per 1,000 Live Births 35
Legitimate Infants per 1,000 Legitimate Live Births 35
Illegitimate Infants per 1,000 Illegitimate Live Births 39

DEATHS FROM CANCER (ALL AGES) 315

DEATHS FROM MEASLES (ALL AGES) ... ... —

DEATHS FROM WHOOPING COUGH (ALL AGES) ... 2

DEATH FROM GASTRITIS, ENTERITIS AND DIARRHOEA (UNDER 1 YEAR) 12

The 3,806 live-births were distributed among the Urban and Rural Districts as follows :—

Births, 1950.

Urban Districts	Total Births	Legitimate	Illegitimate	Birth Rate
Cockermouth	82	77	5	15.9
Keswick	53	49	4	11.3
Maryport	229	218	11	18.8
Penrith	192	183	9	18.0
Whitehaven	484	471	13	19.9
Workington	512	494	18	17.6
Aggregate of Urban Districts	1,552	1,492	60	18.0
Rural Districts.				
Alston	34	34	—	14.8
Border	473	453	20	16.2
Cockermouth	324	315	9	16.7
Ennerdale	575	548	27	19.0
Millom	258	240	18	19.7
Penrith	177	171	6	15.5
Wigton	413	399	14	17.1
Aggregate of Rural Districts	2,254	2,160	94	17.4

The 2,716 deaths were distributed among the Urban and Rural Districts, as follows :—

Deaths, 1950

Urban Districts	Total	Males	Females	Crude Death Rate
Cockermouth	68	34	34	13.2
Keswick	83	35	48	17.7
Maryport	185	95	90	15.2
Penrith	147	79	68	13.8
Whitehaven	305	168	137	12.5
Workington	369	206	163	12.7
Aggregate of Urban Districts	1,157	617	540	13.4
Rural Districts				
Alston	46	21	25	20.0
Border	375	207	168	12.8
Cockermouth	245	138	107	12.6
Ennerdale	340	178	162	11.3
Millom	167	88	79	12.8
Penrith	114	54	60	10.0
Wigton	272	130	142	11.3
Aggregate of Rural Districts	1,559	816	743	12.0

Causes of Death

	No. of Deaths
Heart disease	915
Vascular lesions of nervous system	378
Cancer	315
Bronchitis	117
Tuberculosis—respiratory	101
Tuberculosis—other	15
Other circulatory diseases	82
Pneumonia	78
Influenza	38
Hyperplasia of prostate	30
Motor vehicle accidents	29
All other accidents	72
Nephritis and nephrosis	27
Congenital malformations	23
Gastritis, enteritis, and diarrhoea	22
Diabetes	21
Other diseases of respiratory system	20
Ulcer, stomach and duodenum	20
Suicide, homicide and operations of war	15
Acute poliomyelitis	5
Whooping-cough	2
Mennigococcal infections	1
Other infective and parasitic diseases	9
Leukaemia	6
Pregnancy, childbirth, abortion	5
Other defined and ill-defined diseases	368

The above table shows a number of new headings, so that no complete comparison with previous years is possible.

Infantile Mortality

Of the 3,806 live births during the year, 134 infants died before reaching the age of 12 months. The infant death-rate per thousand live births is 35, compared with 34 for 1949. The figure for England and Wales is 29.8.

Causes of Death

	No. of Deaths
Tuberculosis—respiratory	1
Tuberculosis—other	2
Whooping-cough	1
Other malignant and lymphatic neoplasms	1
Influenza	1
Pneumonia	19
Bronchitis	2
Gastritis, enteritis and diarrhoea	12
Congenital malformations	16
Other defined and ill-defined diseases	74
Accidents	5
	134

The only comment that I wish to make on the above table is to record that 79 children died within the first four weeks of life. Many of these cases were premature. Reference is made elsewhere in this report to the question of prematurity.

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

Urban Districts	No. of Infant Deaths	Rate
Maryport	7	30.6
Whitehaven	19	39.3
Penrith	3	15.6
Workington	19	37.1
Cockermouth	2	24.4
Keswick	1	18.9
Aggregate of Urban Districts	51	32.9
Rural Districts.		
Millom	17	65.9
Cockermouth	14	43.2
Alston	1	29.4
Wigton	10	24.2
Ennerdale	22	38.3
Border	17	35.9
Penrith	2	11.3
Aggregate of Rural Districts	83	36.8

1950 Rate for England and Wales ... 29.8
1950 Rate for Cumberland County ... 35

NATIONAL HEALTH SERVICE ACT, 1946

Part III.

Section 21—Health Centres.

The Nursing Services.

Section 22—Care of Mothers and Young Children.

Section 23—Midwives Service.

Section 24—Home Nursing.

Section 26—Vaccination and Immunisation.

Section 27—Ambulance Service.

Section 28—Prevention of Illness, Care and Aftercare.

Section 29—Home and Domestic Help.

Part V.

Section 51—Mental Health Service.

SECTION 21

Health Centres.

Little effective action—effective, in the sense of being likely to lead to any result—has been possible.

As I see it, the provision of health centres over the country, on account of the civil defence programme and for other reasons, has receded into the background. There are, I understand, over the whole country, only one or two centres either in operation, or approved for construction. It is obvious that the type of health centre which may ultimately be built in the relatively small boroughs and urban areas of Cumberland, will necessarily be very different from the health centres to be provided in London and the large towns. No directive has yet been received from the Ministry, arising out of the deliberations of the departmental committee, which is understood to have been considering the matter for some considerable time, which directive when it comes, will, it is hoped, give local health authorities guidance as to optional types of health centres suitable to their requirements.

Progress has been made in the matter of earmarking sites in Workington and Whitehaven. Conferences were held in these boroughs in March, 1951, at which representatives of the Ministry of Health, the local authorities, the Executive Council, the Special Area Committee, the medical practitioners, and others were present. As the result of these deliberations, it was decided to reserve from the planning angle, a site in Whitehaven town centre of approximately 1 acre for a health centre, to include ancillary services and clinic facilities. This site may be available in about five years' time.

In Workington, it was decided to reserve two sites --one of about 1½ acres, in the town centre, and one of approximately ¾ acre in the Moorclose area, the town centre site to provide for ancillary services, and the Moorclose site to provide for ancillary services and clinic facilities. It is anticipated that the town centre site will be available in about ten years' time.

In Maryport, one site under consideration was not of adequate size to provide both health centre and clinic facilities, and it was therefore decided to look

for a suitable site for a health centre in the centre of the town.

Clinics.

The provision of clinics is so closely linked with the provision of health centres, that it seems appropriate to deal with this matter here.

The Health Centres and Clinics Sub-Committee have considered possible sites for new clinics in the Valley Estate Whitehaven, at Maryport, Penrith, Keswick, Wigton, Seascale, Silloth and Longtown. The site for a new clinic at Maryport is to be purchased immediately.

With regard to Seascale, it was decided that on the evidence available, there is no case for establishing temporary clinic facilities.

Our most urgent need is for a new clinic at Millom, in connection with which plans have been approved and forwarded to the Ministry. Whether authority will be given to proceed with this building, we do not, at the time of writing, know. Negotiations have been protracted, and therefore the future building of health centres and the provision of new clinics can only, at the moment, in general, be regarded as very long term policy.

THE NURSING SERVICES

SECTION 22—Care of Mothers and Young Children
Section 23—Midwives Service.
Section 24—Health Visiting
Section 25—Home Nursing

Now that we have taken over the nursing services complete, under the direct control of the Council, it will, I think, be useful to survey the position as a whole, so that the set up may be seen at a glance.

The Council employ in all 109 nurses as follows :—

Superintendent Nursing Officer	1
Assistant Superintendent Nursing Officers	3
Health Visitors	17
School Nurses	3
District Midwives	10
District Nurse Midwives	66
District Nurses	9

Of the district nurse midwives and district nurses at the end of 1950, 18 were Queen's Nurses, and 22 State Registered Nurses. The ultimate target is that every nurse in this group should be either a Queen's nurse or an S.R.N., with the health visiting certificate. The County Council " proposals " under the National Health Service Act, envisage the extension of the health visiting staff to 30, but in the meantime, with the approval of the Ministry, much of the health visiting is carried out by 48 district nurses approved by the Ministry for this purpose.

In the nursing services, particularly in respect of district nurses and district midwives, housing is coming more and more into prominence. Nurses are no longer content to live in lodgings without even a bath, as used to be, if not the rule, at least quite common, until only a few years ago. At the moment, the housing position is as follows :—

Owned by the County Council ... ... (All except 1 purchased from former Nursing Associations).	10
Houses rented by the County Council ... ... (Including 3 rented during the year from district councils).	16
Houses owned or rented by nurses	43
Nurses in rooms	7

Anyone reading the above list may wonder why the Nursing Sub-Committee have recommended at a recent meeting the provision of something like 30 new houses for nurses in one group or another. The answer is that although only 7 nurses (excluding health visitors) live in rooms, nevertheless a not inconsiderable proportion of the nurses who are not living in rooms, own their own houses, or have direct tenancies, and when these nurses retire or resign, the housing problem for the nurse's successor immediately crops up. In some cases, too, the houses presently occupied by nurses cannot be regarded as adequate by modern standards. We shall therefore, never be in a really satisfactory position until the County Council owns, or rents, an adequate house for every district nurse and midwife. I would like to see the time when similar provision can be made for the administrative nursing staff, and for the health visitors.

In an endeavour to accomplish the necessary building programme, this programme was submitted to the Ministry, who have directed that in the first instance the

Council should approach the local sanitary authorities with a view to the provision by the sanitary authorities for rent or purchase by the County Council, of an appropriate number of houses. The sanitary authorities have therefore been approached, and some have been most helpful, while others have not been able to see their way to assist in the solution of the problem. At the time of writing, there seems a good prospect that within a reasonable time, two houses will be provided by the Wigton Rural District Council, one by the Maryport Urban District Council, at least one by the Cockermouth Rural District Council and one by the Alston Rural District Council, and no doubt the position will get clearer as time goes on.

The present indication is that the County Council will have to build their own houses to the number of something like 14 or more, in various districts. Perhaps the area in which a district nurse's house is most urgently required is Bewcastle, and in this connection, plans were submitted to the Ministry, and after prolonged negotiation, authority was given to proceed. Unhappily, by the time approval was received, and consequent upon the severe weather, the brick-layer employed by the contractor who undertook the building of this house, had departed elsewhere.

The above figures and generalisations in the main refer to nurses working in specified areas, whose duties require them to reside in the area, that is to say district nurses and district midwives.

Scarcely less important than housing to the modern nurse is the question of transport. The County Council now own 58 cars, and 12 nurses own their own cars. The majority of the above cars were purchased from the former district nursing associations, and the replacement of cars of varying degrees of antiquity has caused some anxiety, but we have been able to secure sufficient new cars during 1950 to replace those that were quite worn out. The real trouble in this matter of transport concerns the administrative and health visiting staff, in respect of whom there is no priority for purchase, such as exists in the case of midwives and district nurse midwives. Orders have been placed long ago for the necessary replacements, but nothing has been forthcoming, and I think we will have to do the best we can before very long in the second-hand market.

The districts without any motor transport are perhaps worth mentioning; these districts are Brampton, Flimby, Clifton, Nenthead, Penrith, Cleator Moor. In Whitehaven there is only 1 car for the use of the 4 general nurses. One midwife in Whitehaven has not yet got a car, and the 4 Workington midwives have no cars. We expect that one or two of these blanks will presently be filled, and it may be worth mentioning that in any district where the midwife has not a car she has authority to hire a taxi for the transport of her gas and air apparatus, or for long distance journeys, or otherwise when circumstances justify it.

Every district nurse and every midwife should be on the telephone. At the moment 55 nurses, including all whole time midwives, have telephones, and 10 districts are without. A few telephones were installed during 1950, and it is hoped that, if the engineering situation allows, the number of districts without may be reduced during the current year.

During 1950, all groups of nurses, engaged on domiciliary nursing of one kind or another, received an increase of salary. The maximum in each case was raised by £60. The only exception to the above was the administrative nursing staff, whose case is under consideration. It may be worth while setting out in a short table what are the new salary scales for each group.

	Minimum		Maximum
Health Visitors	£370	...	£495
District nurse midwives. S.R.N. & S.C.M.			
(a) With Queen's district training	360	...	485
(b) Without district training ...	350	...	475
District midwives, S.R.N. & S.C.M. ...	370	...	495
District midwives, S.C.M. only	350	...	485
District nurses. S.R.N.			
(a) With district training	340	...	465
(b) Without district training ...	330	...	455
School nurses S.R.N. with health visitor's certificate	370	...	495
School nurses S.R.N. without health visitor's certificate	330	...	465
Assistant nurse midwives, S.E.A.N. & S.C.M.	330	...	455

In the matter of uniforms, the uniform allowance for district nurse midwives was increased from £18 to £21 during the year, with effect from 1st April 1951, and in the case of wholetime midwives for whom we had been accustomed to provide uniform, a uniform allowance of £21 has been substituted, again with effect from

1st April 1951. The above are annual replacement figures, and each district nurse midwife, or whole-time midwife joining the county staff now receives an initial grant of £30 on appointment.

During the year, two nurses with the S.R.N. and S.C.M. qualifications were granted scholarships to obtain the health visitor's certificate. These nurses completed the training and passed the examination early in 1951, and are now on the staff. Three nurses with the S.R.N. and S.C.M. qualifications were sent for district training under the Queen's Institute during the year, and all three have completed the training and rejoined the staff.

It must be admitted that the response to the County Council's offer (a) of scholarships to enable nurses to take the health visitor's certificate, and (b) of Queen's District Training, continues to be disappointing.

One or two general matters call for comment. The first affects the recruitment of staff to fill vacancies. The position has not been too bad, but there are vacancies on the health visiting staff, and advertisements have brought no response, and there are one or two districts in which there are vacancies for district nurse midwives, which we could fill to-morrow if we had houses.

The agency arrangement with the East Cumberland Hospital Management Committee to provide domiciliary nursing in Alston and district (excluding Nenthead) will terminate in May, 1951, and thereafter we will supply our own nurses. The Alston Rural District Council have been asked to help us by renting to the County Council one of their houses now under construction. At the time of writing, we await their decision, but there is, I think, good reason to believe that they will do all they can to help us. The plan is to have two nurses living in Alston with a car, or possibly two cars, to cover the Alston/Nenthead area. We hope to establish a nurse's surgery at Nenthead, which one of the nurses will visit daily. We have offered Northumberland County Council to continue the nursing of the Slaggyford area from Alston, if desired, and await their decision.

The Nurses' Benevolent Fund.

Perhaps the biggest thing which has happened in the nursing service during the year has been the establishment of a trust fund for the benefit of nurses who

have already retired, or nurses who may retire in the future, by supplementing their retirement pensions. This fund was originally established in 1946 by the Cumberland Nursing Association, the objects of the fund being " to supply special help (e.g. in cases of prolonged sickness) among district nurses, and more particularly to make grants to nurses about to retire, or who have recently retired, and who are not entitled to an adequate pension." The fund was wholeheartedly supported by the district nursing associations affiiliated to the Cumberland Nursing Association, and an agreed annual subscription from each district nursing association of £3. 3. 0 per annum was the target at the time.

The need for such a fund was well known to those concerned with the administration of the Cumberland Nursing Association. There were nurses whose only income after long years of service was the old age pension. In one instance, a district nurse had to retire on the grounds of ill-health, after 26 years' service, and her only pension was £5 a year. It has to be remembered, that in days gone by, the remuneration of district nurses was on a very low scale, and saving for old age was practically out of the question.

When the National Health Service Act 1946 transferred the responsibility of the domiciliary nursing services to the local health authorities, the idea was conceived that the assets possessed by the district nursing associations might be applied to the objects of this fund. These assets were sometimes in kind in the shape of houses, furniture, motor cars, or other equipment, and sometimes in cash, and the County Council have taken over the assets in kind, practically entire, at approved valuations. The result of all this up to date is that the monies now standing to the credit of the fund amount approximately to £38,000, with the prospect of another £4,000 still to come. A trust has been created with 18 trustees, and the money available should be amply sufficient to meet the needs of all the district nurses referred to above. Twelve nurses are now in receipt of grants, which are paid monthly, and the target is to ensure that no nurse on retirement is allowed to continue in financially straightened circumstances.

The credit for the success of the establishment of this fund, lies chiefly with Mr. Butcher, in whose mind the idea originated during his period as Honorary

Secretary of the Cumberland Nursing Association, and he has been most ably supported by Mr. Williams, who at the same time was the Honorary Treasurer of the Association. Those who have served as district nurses in this county during, say, the last twenty years have good reason to regard themselves as fortunate in having worked in an area where such foresight has been shown.

SECTION 22

Care of Mothers and Young Children

The statistics for the year are as under :—

Number of child welfare clinics	16
Number of children under one year of age attending	2,041
Number of children between 1-5 years of age attending	1,544
Number of attendances	14,343
*Defects treated	205

(*Eye defects 121, ear, nose and throat defects 84. Dental and orthopaedic are given elsewhere.)

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

With regard to illegitimate children, 95 cases were investigated, and in only 9 of these was there any question that the conditions prevailing were in any way unsatisfactory. Six of these cases were referred to the Children's Officer for further investigation.

As noted elsewhere, the agency arrangements for the reception of unmarried mothers, for their care at the actual confinement and for their rehabilitation thereafter, and for the care of their babies at St. Monica's Home and Brettargh Holt Home, both in Westmorland, continue.

Premature Infants.

Units for the reception of premature infants (that is children who weigh less than 5½lbs. at birth) are in operation at the City Maternity Hospital, Carlisle, and the Workington Infirmary in West Cumberland. The appropriate figures, compiled locally, required by

Ministry of Health Circular L.N.A.L. 1/49, are as follows :—

(a) Premature infants born at home		54
Died in the first 24 hours	4	
Died within 28 days	—	
*Transferred to hospital	10	
Survived 28 days	40	
(b) Premature infants born in hospitals or nursing homes		146
Died within 28 days	33	
Survived 28 days	113	

*Of the 10 cases in (a) transferred to hospital, 8 died. These figures are not included under (b).

Last year, I drew attention to the high mortality among premature infants. I still think this gives cause for great anxiety. The above figures, which deal with premature infants born at home, premature infants born in hospitals or nursing homes in the administrative county, and premature infants from the county area born in Carlisle hospitals and nursing homes, show that out of 200 premature births, 45 died within 28 days. No doubt an additional number died under one year. Possibly these are not numerous, and I do not think that the labour involved in working this out is justified. It is disturbing enough to know that approximately one in four of all premature infants died within 28 days, even with hospital care in special premature units. It is curious to note that the proportion dying in hospital was *higher* than the proportion which died at home. The answer to this cannot lie in the argument that all serious cases go to hospital, because in fact only 10 cases out of the 200 were *transferred* to hospital. Even if none had been transferred to hospital and all the 8 had died at home, the percentage of premature infants born and dying at home, works out at 22 per cent. The percentage born and dying in hospital, works out at almost exactly 24 per cent. It is worth noting that we have in the county, ready for immediate issue, 12 premature baby cots, each complete with electric heating pad, hot water bottles, blankets and Belcroy feeders. Admittedly obstetric complications, such as ante-partum haemorrhage, must be an important factor in the matter. Naturally most of these obstetrical complications go to hospital.

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

Examinations at practitioners' surgeries ...		897
Examinations at patients' homes		407
Examinations by practitioners at clinics ...		127
Re-examinations		1,355
	Total ...	2,786
Findings at examinations ...	Normal ...	1,073
	Abnormal ...	358
Recommended for hospital on account of home conditions		279
Recommended for hospital on account of patients' condition		60
Recommended to be examined by specialist ...		92
Post-natal examinations		401

The reference to clinics in the above table, refers to County Council clinics at Maryport, Workington, Cleator Moor and Egremont, at which local practitioners attend for the examination of their ante-natal cases. In addition to the figures given, there is of course a very large amount of work undertaken at the hospital ante-natal clinics by specialists attached to the hospitals, which is outside the province of the local health authority. We do, in practice, send a fairly large number of cases for ante-natal examination and advice to the specialists at these hospital clinics.

The number of women from the administrative county confined in hospital during the year was 2,060, considerably more than half being confined in the West Cumberland hospitals. In addition, an unknown number were confined in private nursing homes, some of which are in the administrative county, and some in Carlisle. During the year 295 women received ante-natal care in hospital as in-patients.

Reports received from practitioners in respect of post-natal examinations amounted to 401. This is a small figure, smaller even than last year, but I imagine that most of the post-natal examinations are either made in hospital or are made by the practitioners under their arrangements with the Executive Council for doctors' cases.

With regard to children's nurseries, our day nursery provision is confined to the day nursery at Whitehaven. Our residential nursery provision is primarily at Sandath, Penrith, with an overflow as required, to the children's homes at Englethwaite, Scotby, and Orton Park. The new children's home at Greenhill, Wigton, will open during the summer. The other proposed

home at Geltsdale, Wetheral, is not expected to open during 1951. When Greenhill is open, the total available beds in children's homes will be approximately 150. *This is not adequate. The opening of Geltsdale, when that happens, will not make it adequate.* I am constantly applying to the Children's Officer for accommodation for children, especially young children, as emergencies occur, often due to illness, and although I gratefully acknowledge the help which the Children's Officer has given, she is not in a position to make bricks without straw, and the required beds, in my view, are just not there. As B.C.G. vaccination develops and if segregation is still desired by the Ministry as national policy, the situation will become more acute.

SECTION 23

Midwives Service

During the year 125 midwives notified their intention to practise. These notifications include 66 district nurse midwives, 10 employed as district midwives by the County Council, 6 independent midwives, and 43 midwives working in the maternity departments of hospitals. The number of midwives actually undertaking domiciliary midwifery at the end of the year was 72.

With reference to the problem of recruitment and staffing, the situation throughout the year has been that we have been able to hold our own fairly well, but there are always one or two vacant districts which have to be covered by adding additional duties to adjoining districts. The position with regard to relief midwives is a little better than it was, but is still far from adequate.

The Superintendent Nursing Officer, or her assistants, made 117 routine visits of inspection during the year. In addition, 177 other visits were paid in connection with the midwifery services. Visits of inspection to hospitals with maternity units amounted to 24, and the midwives inspected at these visits numbered 29.

During the year our midwives attended 1,115 domiciliary cases as midwives, and 554 cases as maternity nurses. These figures, especially those relative to attendance as midwives, show a further fairly substantial fall from 1949, and a fall of about 400 compared

with 1948. The reason is the increased number of patients admitted to obstetric units of hospitals for their confinements. Frankly I think there has been some over-booking by the hospitals, and I understand that the Ministry are somewhat concerned at the national position in this respect. The inevitable result, is that women may have to be discharged home before the 10th day, sometimes, especially in West Cumberland, much sooner. The obvious solution is to vet more closely applications for confinement in hospital on domestic and social grounds. Everyone agrees that obstetrical emergencies have priority, and that, so far as possible, all women having their first babies should be confined in hospital.

Over-booking, when it occurs, I think arises out of the group of cases admitted on social and domestic grounds. Sometimes it is a mere question of convenience; sometimes there is an economic basis, because confinement at home involves expenditure which does not arise in hospital. There are of course many cases in which the home conditions are quite unsuitable for confinement, and there are many cases of young married couples living in rooms, where domiciliary confinement is out of the question.

I have had a conference with the obstetricians concerned on this matter, and as a result, steps have been taken which it is hoped will alleviate the position. This sorting out of priority for admission, based on social or domestic grounds, is a matter in which I personally feel that the advice of the midwives and district nurses, who know the home conditions intimately, ought to come into the picture, and it may happen later that this will be necessary. Discharge from an obstetrical unit before the 10th day means that the domiciliary midwife has to take up the nursing at a half way stage, which frankly the midwives do not like. In any event it is essential that in the interests of both mother and child we should receive immediate notification of these cases.

The following short table shows the position in respect of ante-natal and post-natal visits by midwives, covering both midwifery and maternity.

Home visits	14,372
Attendances at nurses' clinics ...	6,486
	20,858

During the year, midwives sent for medical help for domiciliary cases on 505 occasions.

Gas and Air Analgesia

During the year a further two midwives were trained in gas and air analgesia, making a total at the end of the year of 65 midwives certificated in this respect. At the moment, 6 midwives have not received this training. It is intended to train 3 of these when vacancies are available. The remaining 3, for various reasons, will not be trained. All new appointments to the staff have, of course, their gas and air certificates.

The number of occasions on which gas and air analgesia was employed in domiciliary midwifery or maternity cases by midwives during the year was 736, of which 553 were midwives' cases. These figures are lower than for the previous year, and mean that gas and air analgesia was employed in less than half of the domiciliary confinements attended by our midwives. Practically every woman gets the offer of analgesia at her confinement, unless this is ruled out on medical grounds, and the reasons why more than half of the women do not have gas and air, are the same as before, viz:—

(a) A considerable number of women apparently still do not desire analgesia.

(b) Midwife summoned too late.

(c) The practitioner administers his own anaesthetic.

MATERNAL MORTALITY

Maternal deaths during the year amounted to 5. This gives a maternal mortality rate of 1.28, and for comparison the figures for the immediately preceding years are shown below :—

1945—10 deaths equal to a rate of 2.9 per 1,000 births.
1946— 6 „ „ „ „ „ „ 1.4 „ „ „
1947— 2 „ „ „ „ „ „ 0.44 „ „ „
1948— 6 „ „ „ „ „ „ 1.43 „ „ „
1949— 7 „ „ „ „ „ „ 1.74 „ „ „
1950— 5 „ „ „ „ „ „ 1.28 „ „ „

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

Whitehaven Borough	2
Alston R.D.	1
Millom R.D.	2

E. C. N. 27

Under the above reference number the following circular was issued by the Ministry in July, 1949, and as will be noted the circular was to be issued widespread to practitioners, midwives, and others. The reason for the issue of the circular was the confusion existing in the minds of many, if not most, midwives arising out of the changed circumstances brought about by the National Health Service Act, 1946. The object of the circular was to define clearly the respective roles of practitioners and midwives in domiciliary midwifery:—

"NATIONAL HEALTH SERVICE
THE MATERNITY SERVICE

A statement prepared by the Standing Maternity and Midwifery Advisory Committee of the Central Health Services Council and endorsed by that Council. The Council have asked that it should be given wide publicity and it is being circulated by Local Health Authorities to midwives, health visitors and clinic staffs and by Executive Councils to general practitioners.

Misunderstanding exists about the nature of the medical services available for the expectant mother who is to be confined in her own home. In certain areas, the terms of service of the doctor providing maternity medical services have been correctly interpreted and the service is working smoothly, but, in others, difficulties have been encountered.

The principal cause of the trouble is the widespread belief among general practitioners and the public that the agreement between a doctor and a patient by which the doctor undertakes to provide maternity medical services as laid down in the terms of service, converts the case into what is commonly known as a "a doctor's case," that is the doctor accepts full responsibility for the ante-natal care, for the labour and for the lying-in period. This was certainly not the intention; it was not intended in any way to diminish the importance of either the ante-natal clinics or the midwives by the introduction of the maternity medical services.

In the past, about three-quarters of the domiciliary confinements were conducted by midwives who were booked early in pregnancy. The ante-natal care was primarily the responsibility of the midwife who, in most cases, worked in close association with an ante-natal clinic. The medical officer in charge of the clinic could accept no responsibility if an abnormality arose, and the midwife had, therefore, to call in a general practitioner who had not previously seen the patient. This has long been recognised as unsatisfactory and the maternity medical services were designed to get over this difficulty. At the same time it should be appreciated that a good service was being provided before 5th July, 1948; the progressive reduction in the maternal mortality and still birth rates bears witness to this fact.

If the best possible maternity service is to be provided under the National Health Service, the general practitioner, the midwife ,and ante-natal clinic and the pathologist, as well as the hospital and specialist services, all have a part to play as members of a team.

The midwife and the ante-natal clinic have at their disposal all the services of the local health authority. If the patient fails to attend as advised she is visited without delay. Blood examinations are carried out as a routine and instruction given in hygiene and mothercraft. If any abnormality arises the general practitioner will be informed.

For the payment of a comprehensive fee, a general practitioner providing maternity medical services undertakes

1. To examine the patient at the time of booking.
2. To examine the patient at about 36th week.
3. To make a post-natal examination about six weeks after confinement.
4. To provide any medical attention additional to the above either if he considers it necessary, or in response to a call from the midwife.

He is not required to undertake the more frequent routine ante-natal supervision that is essential, nor to attend the labour, unless such attendance is considered necessary by himself or by the midwife. The doctor, may, of course, provide additional services if he so desires. His remuneration is not affected whether or not he gives such additional services.

By the rules of the Central Midwives Board, the midwife must undertake regular ante-natal supervision even if this duplicates the examination of the general practitioner, unless the doctor makes it quite clear that he accepts full personal responsibility for the case during pregnancy, labour and lying-in period. The general practitioner may, of course, assume these full responsibilities if he considers it necessary. But it is the hope of the Minister that in domiciliary midwifery, the midwife will continue to be regarded as the normal attendant, supported by the ante-natal clinic during the pregnancy, and working in co-operation with the general practitioner who has had the opportunity to satisfy himself that there are no deviations from the normal in the patient's general health during pregnancy nor obstetric complications towards the end of pregnancy and will come to her aid if trouble arises during labour or the lying-in period. The midwife will consider herself to be acting as a practising midwife unless she has been informed to the contrary by the doctor. The success of this arrangement will depend on the close co-operation and understanding beween the general practitioner obstetrician and the midwife.

The arrangements for the introduction of a maternity medical service under the National Health Service were meant to be an addition to—not a substitute for—the facilities previously available for the care of the expectant and nursing mother. There has unfortunately been some misunderstanding about this in some parts of the country, but it is hoped that this statement will help to clarify the position as the services gradually settle down."

The terms of the above circular seem clear enough, but there is still a good deal of confusion. In an

attempt to eliminate this confusion another Local Health Authority has issued to all practitioners the following form:—

"Booking of Midwife For Domiciliary Case

To Nurse .....

re Mrs. ..... E.D.D. .....

of .....

.....

I have have arranged to look after this patient under the Maternity Medical Service.

1. I intend to be present at the delivery

   or

   I do not intend to be present at the delivery unless called by you.

2. I will be responsible for the whole of her ante-natal care

   or

   I wish to see her at the following stages of pregnancy:—

   ..... weeks, and would like you to be responsible for the rest of her ante-natal care.

Date ..... Signed ....."

It is understood that in the particular area in question the issue of this form has largely been successful in eliminating the confusion referred to above, and I shall be glad to have the instructions of the Council as to whether a similar form should be issued to practitioners in this County with a request for their co-operation.

Apart from those county cases admitted to local hospitals for confinement during the year, 11 cases were admitted to St. Monica's Home, Kendal, 2 to Brettargh

Holt Maternity Home, near Milnthorpe, and 18 to Meadow View House, Whitehaven.

Nine cases of puerperal pyrexia were notified during the year. No cases were admitted to the isolation block at the Cumberland Infirmary, the plain truth being that with the introduction of anti-biotics, puerperal sepsis has become a matter of relatively minor importance. This is a marked change from a few years ago, when the County and Carlisle Local Health Authorities felt it necessary to establish a puerperal sepsis unit of 6 beds at what was then known as Crozier Lodge, and is now the isolation block at the Cumberland Infirmary.

Abortions.

The following table shows the distribution by areas, of cases in which medical help was sent for by midwives on account of abortion. The number of cases involved is less than half the figure for 1949, and is less than one-third of the figure for 1948. The figures do not, of course, represent the whole story, because they relate *only* to cases in which medical help was summoned by the midwives. The question mark which we had in our minds for some years in respect of two areas, may now, I think, be discarded, at least for the time being.

It is curious to note that all of the 14 cases shown in the two years for the Wigton Rural District, occurred in Aspatria. I have had these cases investigated, and while some of the cases were undoubtedly spontaneous, in others there remains a doubt. The position is being carefully watched.

	1949	1950
Workington Borough	6	6
Whitehaven Borough	1	—
Cockermouth Urban	1	—
Maryport Urban	3	—
Penrith Urban	—	—
Border Rural	2	1
Cockermouth Rural	10	3
Ennerdale Rural	5	1
Millom Rural	—	—
Penrith Rural	2	1
Wigton Rural	9	5
	39	17

SECTION 24

Health Visiting

Our staff of whole-time health visitors at the end of the year, amounted to 16, which left one vacancy on the authorised staff. One of our senior health visitors has retired early in 1951, and the two vacancies have been filled by the completion of training of two scholarship candidates. As I said before, I wish there were a better response to the Council's offers of scholarships for nurses prepared to undertake the health visitors' course, but, at the moment, this response seems to be lacking. We are, therefore, as far as ever from any prospect of reaching our target of 30 whole-time health visitors. In addition to the whole-time staff, a substantial number of our district nurses act as part-time health visitors, under temporary year-to-year approval by the Ministry, 47 district nurses being so employed. Reference is made to this matter elsewhere in this report. It need hardly be said that, with no additional staff available, the expansion in the duties of health visitors, envisaged in circular 118, has not taken place.

The work undertaken by our health visitors and district nurses during the year was as under:—

Visits to children under one year	...	33,682
Visits to children aged 1 - 5 years	...	31,557
		65,239

The health visiting service continues to bring us into close association with the children's department, and all cases calling for the attention of the Children's Officer are brought to her notice.

SECTION 25

Home Nursing

The statistics relative to home nursing in respect of 1950 are as follows:—

Number of cases nursed	...	6,957
Number of nursing visits paid	104,203	
Number of casual visits paid	... 11,670	—115,873

Our nurses undertake a certain amount of work at the request of the hospital service, sometimes prior

to admission or investigation, but usually in the nature of aftercare on discharge. I do not think that the liaison between the hospital service and the local health authority in this matter is as close as it might be, and I think that our domiciliary services, such as our nursing service and our home help service, could usefully do *much* more to help the hospitals than we do at present. We are very willing to do this. I think, for example, that the district nurses could do a lot of dressings and thereby save the strain on the out-patient departments, and, not less important, on the patients —often elderly—and I also think we could, if desired, usefully help to investigate the reasons why patients have not kept appointments.

SECTION 26

Immunisation and Vaccination

(a) Immunisation.

The number of children under school age immunised during the year was 2,587. The number of school children receiving either primary or reinforcing injections was 4,574, making a total of 7,161 immunisations. The above total includes 1,026 reports received from general practitioners in respect of immunisations carried out privately. The great majority of the immunisations by practitioners were in respect of children under school age. I do not doubt that the figures relative to the number of cases immunised or vaccinated by general practitioners are incomplete, because we have to depend on claims by practitioners for payment for reports of work undertaken, and it is my guess that a good deal of work may be undertaken by practitioners in both matters, in respect of which no claims are submitted.

The total number of immunisations, whether carried out by our own medical staff or by general practitioners, subject to what is said above, is substantially lower than for the previous year. There are one or two areas in the county where immunisation figures are somewhat, or even substantially, below the average, but taken by and large over the whole county, every encouragement is given to mothers to have their

children immunised within the first twelve months of life. We adopt a system in this county, which may perhaps be peculiar to ourselves, in that to every child's health visiting card, that is to say the card on which the health visitor's visits to, and observations on, the child are recorded, there is attached a conspicuous yellow card dealing with immunisation, *which is never detached until the child has been immunised.* Apart, therefore, from all the usual methods of propaganda, health visitors are constantly reminded by the presence of this yellow card, and themselves constantly remind the parents at their visits, that the child has not yet been immunised. In spite of all this, as I have said, immunisation figures are tending to fall quite substantially. In this connection, Dr. Hunter, Divisional Medical Officer for West Cumberland, who has taken particular interest in this matter, observes as reasons for the falling off:—

(a) "A successful procedure in the prevention of a particular disease tends to kill its own object. Now that diphtheria is rare among the population, parents do not have the same stimulus towards having their children protected.

(b) The scare of the possibility of poliomyelitis following inoculation has been, in my opinion, a marked deterrent.

(c) It has been, and still is, particularly difficult to persuade mothers that inoculation should be done by the age of twelve months rather than wait until the children go to school."

It may be, and I think also it is the fact, that the figures for 1949 have been above those of an average year, because in one area there were substantial arrears to be made up, which were in fact made up during 1949.

The Ministry's target for immunisation of infants during the first year of life, as set out in circular 20/51, is "at least 75 per cent." I fear that we are well below this target, and I should guess that we are not alone in that, but I do not see what more we can do about it.

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

Under 5 years	54%
5 to 15 years	92%

(b) Vaccination.

In common, I suppose, with the rest of the country, we have found a very substantial drop in vaccination since this ceased to be compulsory on 5th July, 1948. No vaccination is undertaken by our county medical staff, all vaccination being undertaken by general practitioners who have indicated their willingness to co-operate in this work. During the year 1,290 reports of successful primary vaccinations were received, and 301 reports in respect of re-vaccination. Of the 1,290 primary vaccinations, 1,055 concerned infants under twelve months of age. It is very difficult to be precise about the matter, but broadly speaking, the above figures mean that about 1 in 4 of all children born in the county, are being vaccinated during the first year of life. This, of course, represents 25 per cent., and I think that this is somewhat higher than the average for the country. Until, and unless, smallpox actually occurs in this area, or in adjoining areas, the position, I imagine, will remain substantially unchanged. It is difficult, and perhaps somewhat outside my province, to express an opinion on the relative importance of the fall in immunisation and vaccination, but, for what my opinion is worth, I think the fall in immunisation is much the more important of the two.

SECTION 27

Ambulance and Sitting-Case Car Service.

(a) Ambulance Service.

During the year, a number of new ambulances were delivered and other new ambulances have been delivered early in 1951. It is anticipated that by mid-summer, 1951, all the general ambulances in the county will have been replaced by new vehicles of high quality, except the ambulance stationed at Alston, where the amount of work involved is small, and in addition the ambulances at the infectious diseases hospitals will all be of recent manufacture. Considering the age of the fleet we took over in 1948, the change is eminently satisfactory, and the credit for the smooth transition from what was old to what is almost entirely new, lies with the Senior Dental Officer, Mr. Martin, whose

interest in, and grasp of the whole situation, has made matters easy.

This must be one of the few health authorities which have not appointed whole-time ambulance officers with a separate staff, and apart from the purchase and equipment of new vehicles, which, as I have said above, has been handled by the Senior Dental Officer, the administration of the ambulance and sitting-case car service is taken by the appropriate members of the staff of the department as part of their normal duties. Our small administrative costs are reflected in the economical running of the ambulance service, which is referred to in a later table.

The following table gives information regarding the running of individual ambulances. The total mileage figure is up by about 10,000 on the previous year. This appears to be largely due to calls made by the hospitals in respect of the fracture and rehabilitation departments, and to the chest service. It will be noted that our ambulance service is operated in different ways. Part is still done by agency arrangements with voluntary bodies, although the voluntary share is decreasing. Part is run by contract with individuals or garages. All the ambulances are the property of the Council, except those which operate the general ambulance service in the Whitehaven district, which are owned by a private firm.

The ambulances are all first class and completely equipped, and in the matter of ambulance attendants, while not maintaining a costly service of whole-time attendants on a rota system, which would be quite uneconomical in a county like this, we have been able to maintain over the greater part of the County under the arrangements detailed in last year's report, an efficient service of ambulance attendants in the shape of retired or practising nurses, or of St. John and Red Cross trained men and women, whose services we call on as required.

In order to cut down waiting time, as an experiment at the Cumberland Infirmary a special conspicuous red card has been printed which is attached to the papers of incoming ambulance patients, and accompanies these papers to the department or departments at which the patient is being seen or investigated. It is hoped that the card will be a constant reminder to those concerned with the patient that *an ambulance is waiting.* The card is as set out below:—

AMBULANCE CASE

An Ambulance is waiting for this Patient

It is accordingly requested that the examination be expedited. If it is necessary for the patient to be admitted to hospital, please inform the transport officer immediately so that the ambulance can return to the depot without delay.

Ambulance Service.

Year ended 31st December, 1950.

Directly Provided Ambulances.	Total No. of journeys in year.	Total No. of Patients carried.	No. of accidents and emergencies.	Total Mileage.	Remarks.
Alston (1) ...	20	20	11	525	Service commenced 1/10/50
Brampton (1)	181	198	51	4,577	
Carlisle (3) ...	748	791	138	17,974	2 new ambulances June, 1950 & Sept., 1950.
Cockermouth (1).	248	257	95	7,228	
Keswick (1)	232	240	33	6,517	New ambulance, Nov., 1950.
Wigton (1)	233	250	117	9,324	New ambulance July, 1950.
Workington (1)	543	560	328	9,253	New ambulance July, 1950.
Ellerbeck ..... I.D.H. (1)	173	154	57	5,248	
Galemire ..... I.D.H. (1)	145	137	8	6,855	
Longtown ... I.D.H. (1)	123	144	—	2,193	
Penrith ..... I.D.H. (1)	92	88	3	2,906	
Reserves (3)					
Agency Services—					
Maryport (1)	343	347	94	6,158	
Millom (1) ...	116	120	60	6,831	New ambulance, June, 1950.
Penrith (1) ...	610	703	176	20,373	
Whitehaven ... (3)	847	962	670	20,876	
Private ..... Service. (Out County Journeys)	88	118	21	15,009	
	4,742	5,089	1,862	141,847	

(b) Sitting Case Car Service.

This service in Cumberland is operated in a manner which is off the pattern for the country as a whole. We do not maintain our own fleet of cars; indeed in a rural area like this county to do so would, I think, prove very uneconomical. We have adopted the alternative of entering into arrangements with large numbers (over 100) of garages and taxi proprietors all over the county, to transport patients as and when required, by night or day, and often in emergency, to hospitals and clinics inside the county, and to places far beyond the county boundaries. This method of approach has worked well, and although there have been some headaches, these have not proved insurmountable, and generally speaking, have been less troublesome than might have been expected . The whole set-up was fully detailed last year, including the regulations for the calling out of vehicles, and there is no advantage in entering into details again.

Prolonged negotiations took place with the taxi-hirers in one part of the county as to the scales of remuneration. Eventually these were settled by agreement, and it may be well here to repeat the scales which were in operation for the greater part of the year. These were as follows:—

(a) 9d. per mile, plus 2s. 6d. for the first completed hour of waiting time and 1s. 3d. for each completed half hour of waiting time thereafter.

(b) A minimum charge of 3s. for short journeys, except between the hours of 12 midnight and 8 a.m., when the minimum charge is 4s. 6d.

Rising costs of petrol, oil, tyres, and rising wages costs, have necessitated a revision of these scales early in 1951, to the following rates:—

(a) 10d. per mile, plus 2s. 8d. for the first completed hour of waiting time and 1s. 4d. for each completed half hour thereafter.

(b) A minimum charge of 3s. 6d. for short journeys, except between the hours of 12 midnight and 8 a.m., when the minimum charge is 5s. 0d.

It seems likely at the time of writing, arising out of representations which the Council have received from one or two quarters, that these new scales may have to be further reconsidered.

It being common knowledge that the ambulance and sitting case car service, particularly the latter, were open to grave abuse, and were in fact frequently called upon without adequate reason, and it being also realised that there was a great amount of overlapping and avoidable duplication of journeys, the Council decided

towards the end of the year to establish calling-out bureaux to effect economies and to eliminate waste. Two call-out bureaux were therefore established, with effect from 1st October, 1950. One for East Cumberland is at the Cumberland Infirmary, and one for West Cumberland was at the Divisional Health Office, Whitehaven, which latter bureau has now been transferred to the Whitehaven and West Cumberland Hospital. It is already clear that these bureaux will fully justify their existence. The work of the bureaux is complicated, and calls for much tact and quick decisions, and the clerks in charge are to be congratulated on the way in which they have handled their constantly recurring problems.

While frankly admitting that there are still some gaps to be stopped, the hospitals and the medical profession generally have co-operated well with the arrangements laid down by the Council. The co-operation of the hospitals and of the profession is absolutely essential to an efficient and economical transport service, and considering how many persons are in a position to call on the transport service, and how much the personal equation comes into the matter, it is surprising how few causes of complaint arise, either from the Council, the medical profession, the hospitals, or the general public.

At the outset, one of the difficulties was the tendency for the patient to be accompanied by a retinue, large or small, of relatives or friends when making his or her journey, but this point is gradually being straightened out.

The following short table shows the general position. For comparison the figures for 1949 are given in brackets:—

Sitting Case Car Service.

Journeys authorised by :—

			No. of journeys.	No. of patients.	Mileage run.
Doctors	8,964	(9,094)			
Hospitals	8,202	(5,473)			
County Health Department	304	(280)	18,023	22,288	472,710
Duly Authorised Officers	63	(129)	(15,430)	(16,834)	(401,064)
Others	490	(454)			

No. of accident or other emergency journeys = 4,492

It will be noted from the above comparative table that the number of journeys, of patients carried, and the total mileage run, all increased very substantially during the year. There is reason to believe for the current, and, one would hope, future years, with the

call-out bureaux in full operation, that the number of journeys involved and the total mileage, will show a substantial reduction. The number of patients to be carried is not, of course, a matter within our control. It will also be noted that the calls on the service by practitioners have remained practically the same, but that the calls on the service by hospitals increased by nearly 3,000. The hospital departments which make by far the greatest number of calls on the ambulance and sitting case car services are the fracture and rehabilitation departments, which between them, probably account for at least 60 per cent. of the calls made by hospitals. It is, to mention only one point, the custom when a patient has been brought to hospital with, say, a fracture of the leg, and the fracture has been set and the patient discharged in plaster, for the patient to be recalled to the hospital the following day to ensure that the plaster is not causing pain, or swelling, or discolouration of the limb, and is satisfactory to the orthopaedic specialists. Another substantial cause of the rise in hospital demands on the service, has undoubtedly been the newly established chest service. Other factors have also influenced the position. I think the position may fairly be summed up by saying that although the cost of the transport service placed upon local health authorities by legislation is heavy, no authority will grudge the cost, provided (a) that the patient is really unable to travel for treatment by public transport (b) that the patient is required to travel by public transport as soon as the progress of his treatment makes this practicable, and (c) that the journeys are properly co-ordinated so that two ambulances or two cars are not put on the road when one would suffice.

(c) Hospital Car Service

This service, which is operated on an agency basis for the Council by the British Red Cross Society, continues to prove very valuable. The extent to which this service is utilised by different health authorities varies, I understand, greatly. Some authorities, I believe, depend on the Hospital Car Service for the greater part of their transport, other than ambulance. Other authorities, like ourselves, regard it as supplementary to the main service. This is a matter on which it is better to be perfectly frank. On the one hand complaints have been received from taxi proprietors that they have to do all the night work, because the hospital car service does not operate at night, that they have to do most of the bad weather work, when snow and frost are about; that

their drivers get no subsistence allowance, whereas the hospital car service drivers do, if they care to claim it, which, by the way, many do not, and generally the complaint from the point of view of certain taxi proprietors is that they get all the rough, and not enough of the smooth. On the other hand, many hospital car service drivers say that although they are perfectly willing, as a community service, to take part in this work, and are enrolled for the purpose, they, in fact, get very little, in some cases nothing, to do, and some have dropped out for this very reason. The truth probably lies between these two extremes. I do not think it is true to say that hospital car service drivers hesitate to turn out when the roads are bad—we have not found that to be the case. It is true that the hospital car service drivers can claim subsistence, but on the other hand they get no allowance for waiting time. It is true that many taxis owned by garages are much larger than private cars used in the hospital car service, and it is frequently economic to use the larger vehicle, but my view is that both the contract service, if one may so call it, with the taxi proprietors, and the supplementary arrangements with the hospital car service, have their parts to play in a scattered rural county like Cumberland. There are, for example, areas where we have a hospital car service driver, but no taxi proprietor, on our list.

The rate per mile paid to the hospital car service driver is 7d. under a national agreement, with a reduction after so many miles. To this must be added subsistence, if claimed. The rate at present paid to taxi proprietors is 10d. plus waiting time, and with a minimum figure for short journeys. In general, the taxi proprietors have larger vehicles than the private owners, so that it is clear that sometimes it is better to use one service and sometimes the other.

One point which affects a certain number of taxi proprietors and hospital car service owners alike, is this. With the co-ordination of journeys operators in either branch on the periphery are likely to get more work to do than others stationed at intermediate points on the way. If, for example, one patient is coming to the Cumberland Infirmary from Whitehaven, another from Workington, one from Aspatria, and one from Wigton, on the same day about the same time, obviously the Whitehaven vehicle collects the lot, and there is less work available for those stationed at the intermediate points.

The number of hospital car service drivers enrolled in the county at the moment is 60, as follows:—

Penrith	20
Keswick and Cockermouth	10
Whitehaven	13
Wigton Rural	3
Workington	3
Border Rural	11
	60

The service is administered through area transport officers and conferences have been held with those responsible, to ensure as far as possible an equitable distribution of the available work among the enrolled drivers.

The following table shows the position with the figures for the previous year in brackets:—

Hospital Car Service.

Journeys authorised by :—

Doctors	12	(nil))	No. of	No. of	Mileage
Hospitals	1,160	(1,096))	journeys.	patients.	run.
Department	229	(450))	1,413	1,889	52,963
County Health		)	(1,546)	(1,857)	(62,860)
Others	12	(nil))			

Financial Position

I am indebted to the County Treasurer for the financial assessment of the position which follows. *The period in question relates to the financial year 1st April, 1950, to 31st March, 1951.* The mileage figures, therefore, do not synchronise with those in other parts of this section which are based on the *calendar* year 1950.

The gross running cost of the ambulance and sitting-case car service for the financial year 1950/51 was £28,309, made up as follows :—

Ambulance Service	£8,550
Sitting-case car service	18,215
Hospital car service	1,544
	£28,309

The above costs are *purely running costs* and exclude loan charges on new vehicles, administration, and the costs of the call-out bureaux which were in operation for the last six months of the financial year.

On the above basis the running costs per mile of the three sections were as follows:—

Ambulances	1/0.77d.
Sitting-case cars	9.69d.
Hospital car service	7.12d.

The costs of the excluded items are as follows:—

Loan charges (ambulances)	£364
Carlisle Corporation—filter service ...	£281
Other expenses, including garaging of reserve ambulances ...	£214
Call-out bureaux (salaries, printing and stationery, etc., 6 months only)	£775
Administration	£1,698

Those who are mathematically inclined may find it interesting to calculate the cost per mile for the three sections under the above items.

It is extremely difficult in an authority which has *not* set up a separate staff for the ambulance and sitting-case car service to weigh up exactly the precise cost of the time of the individual officers who have taken this additional work in their stride, and inevitably the administration charge figure must be arbitrary. The division of the administrative charge, and other items of expenditure such as the bureaux, printing and stationery, telephone calls, etc., between the ambulance, sitting-case car, and hospital car service must necessarily also be somewhat arbitrary, and is quite outwith the scope of a medical officer. Nevertheless, summing it all up and after taking all the above factors into consideration we may, I think, fairly claim that we are running in this county an extremely economical transport service under section 27. The figures obviously compare favourably with the recommendations made by their financial advisers to the Associations of Local Health Authorities to have effect from 1st April, 1951, which are as follows:—

Ambulance charges—2/9 per mile.
Sitting-case cars—1/3 per mile.

The following tables set out the position in detail. With regard to ambulances, the exact allocation of cost, mileages, etc., between the various headings A to F is not easy because during the year there was a considerable change in the organisation, a number of ambulances passing during the year from the administrative control of local committees direct to the County Council.

(1) Ambulances.

Statement showing the cost of the service to the County Council (excluding loan charges, cost of call-out bureaux and central administration) for the year ended 31st March, 1951, and comparison with the previous 12 months.

	Year ended 31st March, 1951.			Year ended 31st March, 1950.		
	Mileage.	Running expenses.	Running expenses in pence per mile.	Mileage.	Running expenses.	Running expenses in pence per mile.
		£			£	
By whom ambulance managed :						
(a) Voluntary Committees or County District Councils	33,294	1,677	1/0.09d.	72,938	3,522	11.59d.
(b) Hospital Management Committees (4 Infectious Diseases Ambulances)	17,494	480	6.58d.	15,715	430	6.56d.
(c) County Council — through garage proprietors	63,553	3,677	1/1.89d.	18,015	1,386	1/6.47d.
(d) Carlisle Corporation	2,098	259	2/5.63d.	4,880	528	2/1.97d.
(e) Other Local Health Authorities' ambulance charges	4,762	477	2/0.04d.	210	22	2/1.14d.
(f) Proprietors using their own ambulances	39,575	1,980	1/0.01d.	17,417	762	10.50d
	160,776	£8,550	1/0.77d.	129,175	£6,650	1/0.36d.

(2) Sitting Case Cars.

Running expenses (excluding cost of bureaux and administration)—

Mileage as adjusted to allow 4 miles for each short town journey charged at 3/- rate. ...	440,174 miles.
Other Local Authorities	11,012 miles.
Cost for year—subject to note re bureaux and administration	£18,215
Cost per mile	9.69d.

(3) Hospital Car Service.

Mileage	52,012 miles.
Cost (including block payment to the British Red Cross Society for administration £105)	£1,544
Cost per mile	7.12d.

SECTION 28

Prevention of Illness, Care and Aftercare

As I have said before this is a somewhat indefinite section of the act, and it is not too easy to know just exactly what appropriately comes within this section. A great deal of the normal activities of a health department are linked up with the heading of this section—health visiting is quite a good example, but it is obviously desirable to be rather more precise.

A new and expanding service which clearly falls under this section is B.C.G. vaccination which is the prevention of illness par excellence. A start was made with this during 1950, and up to the end of March, 1951, or thereabouts, 81 children had been vaccinated, and a substantial number were undergoing the preliminary stage of Mantoux testing. In this connection the difficulties which we had anticipated in carrying out the Ministry's desire for segregation for six weeks before and six weeks after vaccination of cases where the vaccinated person was in contact with an *infective* case of tubercle have fortunately not materialised. The Chest Physician has found it possible to have segregation arranged by relatives or friends of the families concerned, and it has not been necessary either to seek vacancies in our children's homes for this purpose, or to utilise the powers the Council gave me to board out these children for the three months' period with foster parents. No doubt, as time goes on, cases will arise in which segregation with relatives, or friends, will not be practicable, and then one or other of the alternative steps will have to be taken.

The view of the Ministry, of course, is that, while segregation is desirable, vaccination without segregation is preferable to no vaccination at all.

Another quite important matter coming under the heading of this section is our loan equipment scheme. We have arranged depots at Carlisle, Penrith, Whitehaven, Workington and Maryport where stocks of wheel chairs, crutches, air or water beds, rubber mattresses, premature baby cots, etc., are stored. In Carlisle the depot is at our own premises in Portland Square. In Penrith we have an arrangement with

the Penrith Rural District Council for storage. In Maryport the arrangement is with the St. John Ambulance Service. At Workington the depot is at the County Council clinic in Park Lane, and at Whitehaven the equipment is stored at the District Nurses' Home in Irish Street.

It may be interesting to give a few figures about the chief items of equipment stored at these depots. A very sketchy list is as follows:—

Invalid Chairs	42
Self-propelled chairs	1
Metal telescopic crutches	24 pairs
Air, or water beds, or rubber mattresses	20
Premature cots with electrical heating pads, etc.	12

In addition to this major equipment, the list of which it will be appreciated, does not pretend to be complete, we have equipped all district nurses with very adequate supplies of minor equipment such as air rings, bed pans, bed rests, inhalers, feeding cups, steam kettles, bed cradles, and so on for issue as required.

In the matter of orthopædics, it might almost be said that the whole service comes under this heading, and as I have said elsewhere in a note on orthopædics, I hope that the amount of aftercare we will undertake in future in co-operation with the hospitals, will greatly increase.

Reference is made elsewhere in this report to special enquiries which are being undertaken at the request of one Ministry or another, or of other public bodies. These enquiries, which are outlined in some little detail elsewhere, are, of course, true prevention.

In the matter of tuberculosis we maintain some 30 or 40 shelters for tuberculous patients, one or two of which are equipped with communicating telephones between the shelter and the patient's home.

Reference is also made elsewhere in this report to the anticipated start of occupational therapy in the County. If this materialises and we are successful in obtaining trained personnel, this again will be an item of no small importance coming under the heading of aftercare.

We continue to help the consultant in venereal diseases in the matter of tracing contacts, and in securing the attendance of patients, particularly mothers and children, at the appropriate clinics.

Our health visitors, including our district nurses, acting as health visitors undertake a large number of visits annually of an advisory nature, which, of course, is one of the true functions of the health visitor. Such visits may be to tuberculous households, to elderly persons, to cancer cases, and so on, with the object (a) of the prevention of disease, and (b) of seeing that so far as is practicable no stone is left unturned to ensure that all the above groups, and many others, are receiving adequate aftercare, and have no social problems which we can remedy. The total number of visits paid under the above general heading during 1950 amounted to 4,513, involving 853 individual households.

Provision is made for convalescent treatment in appropriate cases not falling within the jurisdiction of the hospital service.

SECTION 29.

HOME HELP SERVICE

This service has continued smoothly on an expanding basis. Our administration of this service is off the general pattern, because instead of having a separate organiser and staff as is usual, the Council have placed the organisation of this work under my general supervision in the hands of the Superintendent Nursing Officer. The supervision of this service entails a very great deal of visiting to households, and to the home helps, both before and after their enrolment. During the year 1,833 visits were paid by Miss Mansbridge and her Assistant Nursing Officers, 1,091 visits being paid to households and 742 to home helps. The link-up between this service and the nursing services with the co-operation of the assistant nursing officers, and of the district nurses and health visitors, enables all this visiting to be done economically, and, what is perhaps equally important, promptly.

There was some shaking of heads in various quarters both inside and outside the County when we made this link-up between the two services, but events have

clearly proved the wisdom of this step. I do not think the arrangement would have worked so smoothly had a clear line not been taken from the outset that the nursing services were not to be concerned with the financial side. Assessments are undertaken by the County Welfare Officer and his district welfare officers, and contributions are collected by the County Treasurer. The nursing personnel continue to be concerned solely with the finding of suitable persons to enrol in the service, and with fitting these persons into households requiring help under many varying circumstances.

This is a most difficult service to administer, because supply and demand can never balance. On the one hand we enrol home helps—based on past experience which justifies us in thinking that their services can be reasonably employed—but applications for assistance from that particular area may not be maintained, and therefore we have always a number of women on our books to whom we cannot offer employment, and naturally these women tend to hand in their resignations. On the other hand, we get applications from households for home helps in areas where we have failed to enrol sufficient, or perhaps none at all. This headache is obviously permanent. Miss Mansbridge reports that a very good type of woman is now applying for enrolment. Many of these women are unsparing in their services, often undertaking extra duties and working overtime on their own initiative.

The figures in the attached table are interesting, and show that the number of home helps on the register is tending to grow, though slowly. We have tried by every means in our power to accelerate the rate of enrolment without great success. On the other hand, the number of applications received for home helps has very substantially increased, as will be seen from the comparative figures for 1949 and 1950. It is regrettable that not far short of half of the applications received were subsequently withdrawn, the figures being 200 withdrawals out of 458 applications. The reasons are given at the end of the table, and have not varied from the previous year. Undoubtedly, one chief cause of the cancellation of applications is the high cost to the household. This cost might well rise still further from its present figure of 2/2 per hour, *since raised to* 2/8 *per*

hour, which is the figure of repayment above a certain income level, because the wages of home helps have been increased from 1/9 per hour to 1/10½d. per hour, and it is understood that a new national scale is under consideration.

The Health Committee, recognising the importance of these problems, have instructed the appropriate officers to report on this problem of repayment. I would have liked to have seen this service, if not free, at least greatly reduced in cost to the households. It is, of course, free to a great many households, but *it is very disturbing to know that many households who urgently need this help because of illness of one kind or another, or because of advancing years or for some other cause, just cannot have it because they cannot afford it.* It is very difficult to understand why in this year of grace when so much is free in the National Health Service, in education, and in many other directions, the usefulness of this vital home help service is curtailed or ruled out to so many homes because of the cost of repayment.

There is something wrong here. It does not seem logical to provide, as was until recently the case, free dentures, and free spectacles, and as is still the case, free ambulance and sitting-case car transport, because the need for these things is *incidental*, whereas the need for help in the home on account of age, infirmity, or illness is often *a continuing need*, and in very many households owing to the changed circumstances of these times has become a need of the utmost urgency.

I do not know that there is much more that need be added. Perhaps it is worth while mentioning that the average attendance of home helps in individual households is three to four hours per day for five days per week. Home helps in tuberculous households continue to be under close supervision. Our greatest need continues to be the lack of of home helps who are willing to enrol as resident and mobile within the county. At present we have out of 93 on the register only three who are mobile and willing to be resident. In a rural county that is obviously totally inadequate.

Subject to these general observations the statistics for the year are as under:—

1st JANUARY, 1950, to 31st DECEMBER, 1950.

Home Helps	**1950**	**1949**
No. of persons who have accepted and enrolled on the Register—		
Whole-time	67	49
Part-time	70	57
Mobile	3	—
	140	106
Less persons resigned from Service ...	47	26
No. on Register at 31st December, 1950	93	80
Districts in which the Home Helps reside:—		
Alston	—	—
Aspatria	1	—
Border Rural	8	9
Cockermouth	6	9
Ennerdale Rural	12	8
Keswick	3	1
Maryport, Dearham & Great Broughton	22	14
Millom and District	4	3
Penrith	3	2
Silloth	6	5
Threlkeld	—	2
Whitehaven	13	8
Workington	11	13
Wigton	4	6
Total	93	80
Householders:—		
No. of applications received for Home Helps	458	290
No. provided with Home Helps:—		
Confinements	46	65
T.B. Cases	6	5
Old age and Infirmity	87	—
Mental health	2	—
Cardiac	5	—
Blind	4	—
Illness of long duration	21	—
Illness of short duration	87	—
Other	—	123
	258	193
No. cancelled or not supplied	200	97
	458	290

The reasons for non-supply have been more or less varied as before.

a. Householder considered the cost of contributions beyond his ability to meet.

b. Householder made other arrangements after application.

c. No home help available.
d. Death of patient or removal to hospital.
e. Inaccessibility.

It may be of interest to add some figures regarding the cost of this service, with which the County Treasurer has kindly supplied me. The figures are for the financial year to 31st March, 1951.

Expenditure:—

(a) Wages, travelling expenses, insurance, badges and overalls, etc. ...	£8,445
(b) Administration — proportion of salaries, travelling, printing and stationery, etc.	1,118
Making a total of ...	£9,563
Income — being contributions recovered from households	£1,586
Net Cost of the Service, subject to 50 per cent. Grant	£7,977

The total hours worked during the period by home helps amounted to 73,640, and on the above figures the gross cost to the Council was 2s. 7¼d. per hour and the net cost, allowing for contributions received, was 2s. 2d. per hour. The contributions represent 17 per cent. of the gross cost of the service.

It may be anticipated that the gross expenditure during the current financial year will be higher because there has already been an increase in the rate paid per hour to home helps from 1s. 9d. to 1s. 10⅛d., and it is understood that negotiations are at the moment in progress which may lead to a further increase.

SECTION 51

Mental Health Service

The Ministry have given a general indication of the headings under which information regarding the mental health service is to be submitted, and the following notes, broadly speaking, follow these headings.

1. **Administration.**

The mental health work which falls within the duties of the Council, is now directly administered,

the agency arrangements with the Voluntary Mental Association having terminated at the end of 1949. The service works very smoothly, the key officer being the Administrative Assistant (Miss Greenwood) who is directly responsible to the County Medical Officer.

No staff changes took place during the year, but I am glad to report that early in 1951 Mrs. Campbell, who had for a number of years undertaken work for us on a part-time basis as a psychiatric social worker in West Cumberland, was able to resume duty again on a part-time basis. The Educational Psychologist, Miss Burrows, has been seriously overworked, and a decision has been taken early in the current year to advertise for a second Educational Psychologist.

The staff employed in the mental health service, which the Ministry request should be detailed, is set out below. It will be noted that the part-time services of certain of the personnel continue to be seconded to us by the Special Area Committee.

Certifying Officer (Mental Deficiency Act, 1913): Dr. Kenneth Fraser.

Approved Medical Officers: Dr. Fraser, Dr. Gavin, Dr. Gilloran, Dr. Hunter, Dr. Jones, Dr. Knox, Dr. McMurtrie, Dr. Thomson, †Dr. Ferguson and †Dr. Braithwaite.

Psychiatrists : Dr. Braithwaite, Dr. Stuart and Dr. Ferguson (Seconded from the Regional Hospital Board).

Administrative Assistant : Miss Greenwood.

Educational Psychologist: Miss Burrows, M.A.

Psychiatric Social Workers :

(a) West Cumberland. This post was vacant during 1950. Mrs. Campbell, who had previously been employed by the County Council in this capacity, resumed part-time duty in January, 1951.

(b) East Cumberland. Miss Mildred Lamb, seconded from the Special Area Committee, in connection with the East Cumberland Child Guidance Clinic.

Mental Health Workers: Miss E. F. Hall and Miss M. G. Taylor, B.A.

Occupation Centres Supervisor: Mrs. Lax.

Occupation Centres Assistant Supervisor and Home Teacher : Mrs. Todhunter took up duty in January, 1951.

Handicrafts Teacher : Miss Cooper.

Duly Authorised Officers : (Part-time): Mr. J. J. Brown, Mr. W. H. Coulthard, Mr. T. J. Archer, Mr. J. Housby, Mr. W. J. Wilson, Mr. J. Calvert, Miss E. A. Fox, Mr. H. Sewell, Mr. J. H. Hocking.

Deputy Duly Authorised Officers: Mr. D. W. Jack, Mr. J. D. Messenger, Mr. J. Gibson, Mr. A. Glaister.

†Approved for cases in connection with the Child Guidance Clinics.

2. **Work undertaken in the community.**

(a) Under Section 28, National Health Service Act, 1946.

Child Guidance Centres are held in Whitehaven, Maryport and Carlisle. One whole day per week is allocated to the Whitehaven centre, and a half day per week each to the Carlisle and Maryport centres. Child guidance is, of course, primarily an educational problem, and the appropriate statistics have been given in the Annual Report on the School Health Service. Nothing, therefore, more than this brief reference is indicated as appropriate to this report.

(b) Under the Lunacy and Mental Treatment Acts, 1890-1930.

Cumberland cases dealt with under the Lunacy and Mental Treatment Acts, 1890-1930, during the year numbered 199. Of this number,, 32 were certified, 163 were voluntary patients and 4 were temporary. Four of the voluntary patients were admitted following their discharge from permanent certificate, which is a not infrequent procedure. In the course of the year 34 patients died and 152 were discharged. Of the number discharged, 29

were certified cases and 123 voluntary. It may be of interest to note that of the 29 patients referred to, 15 had been admitted earlier in the year, and of the 123 voluntary patients discharged, as many as 108 had been admitted within the year. It will thus be seen that many of the patients discharged had actually been admitted the same year.

(c) Under the Mental Deficiency Acts, 1913-1938.

(i) *Ascertainment.*—During the year 1950, 321 cases were referred to the department for investigation. Of these, 23 were ascertained as mentally defective, and as 17 of the 23 were children of school age they were reported by the Local Education Authority for the purposes of the Mental Deficiency Act, 1913. Of the remainder, 44 children of school age were recommended for special education either at residential schools or special classes, and 91 were referred to the child guidance centres. At the end of the year there were 45 patients awaiting hospital accommodation, many having been on the waiting list for a number of years.

(ii) *Guardianship.*—On the 31st December, 1950, there were 62 patients under guardianship. Of this number, 5 are under the age of 16 years, and the County Council make a grant towards their maintenance. For those over 16 years of age the National Assistance Board is now responsible for any financial assistance required. At the end of the year there were 135 patients under statutory supervision.

(iii) *Training.*—There are now two occupation centres in operation, one at Whitehaven, which has 12 names on the register, and caters for children living within a radius of approximately eight miles. The second centre was opened at Maryport in June, 1950, and at the end of the year there were 11 names on the register. School dinners and free milk are provided for all children attending the centres, and the children have regular medical inspection in the same way as those attending school. A handicrafts class is held two afternoons weekly for 5 adult patients living in the

Workington area, and as the staff increases it is intended to provide a certain amount of home teaching for those patients who are unable to go to a centre and would benefit by some training. Arrangements are in hand to open a full time occupation centre in Wigton in September, 1951.

3. Institutional Treatment.

On the 31st December, 1950, the County Council was responsible for 543 mental defectives. Of these, 298 were in Institutions, or on licence therefrom, as follows:—

	1950	1949
Dovenby Hall Hospital, Cockermouth	200	202
Milnthorpe Institution, Kendal	43	48
Durran Hill House, Carlisle	7	7
Totterdown Hall, Weston-Super-Mare	1	1
The House of Help, Bath	1	1
Rampton State Institution, Notts.	6	7
Moss Side State Institution, Maghull	3	3
The Royal Albert Hospital, Lancaster	14	11
Hortham Colony, Almondsbury, Bristol	1	1
St. Mary's Home, Alton, Hants.	3	4
Lemmington Hall, Alnwick	3	3
The General Hospital, West Hartlepool	2	1
Bishop Auckland Institution, Durham	1	1
Lisieux Hall, Whittle-le-Woods, Chorley	5	5
Calderstones Institution, Whalley	1	1
Aycliffe Hall, Heighington, Darlington	3	2
St. Raphael's, Barvin Park, Herts.	1	1
Prudhoe & Monkton Hospital, Prudhoe	2	1
†Morpeth & Northgate District Hospital	2	—
	299	300

†One of these patients was resident only as a temporary measure, and was returned to his own home in January, 1951.

It will be noted that the number of Cumberland patients in the Royal Albert Hospital, Lancaster, is 14, which is 3 more than at the end of 1949. Unhappily, this is not due to the fact that additional accommodation has been secured, but that 3 patients have been transferred from Milnthorpe Institution. The County Council have, in fact, two fewer patients in mental deficiency hospitals and institutions than they had at this time last year.

The situation regarding the admission of mentally deficient patients to institutions continues to cause the greatest anxiety. I am well aware that this position is, speaking generally, national, although some areas are better off than others. Cumberland has been badly hit by the passing of the National Health Service Act, 1946, *in this respect, because institutions all over the country in which we were able to obtain vacancies with comparative ease, are now closed to us, because, rightly or wrongly, they are admitting cases only from their own regions. Although it is stated under* (c) (*i*)—*Ascertainment. above, that we have* 45 *patients awaiting institutional care, that is merely a token figure, and merely represents that proportion of cases who are most urgent.*

The present situation is leading to broken homes and broken lives, and I know of not a few homes in which the presence of the defective is wrecking the home life, and is not merely leading towards a breakdown in the health of the parents, and particularly of the mother, but is most prejudicially affecting the well-being of normal children in the home. In several instances threats of suicide or of homicide have reached me verbally or in writing. Fortunately so far, none of these threats have materialised.

In another capacity, I am aware of the building prospects in respect of mental deficiency, and from that aspect, it is safe to say that there is little prospect of any substantial relief for some years ahead.

All that we, as a Local Health Authority, can do in this disastrous situation, is to expand our provision of occupation centres, which by taking away the defective from the home for a number of hours per day on 5 days per week at least does give the harassed mother some relief.

REPORTS AND NOTES ON INDIVIDUAL SERVICES AND OTHER MATTERS

Tuberculosis and the Chest Service.

Dental Service.

Orthopaedics.

Venereal Disease.

Cancer.

Infectious Diseases.

Food and Milk.

Housing.

Water and Sewerage.

Agency Arrangements.

Laboratory Services.

TUBERCULOSIS AND THE CHEST SERVICE

I am indebted to Dr. Morton, Consultant Chest Physician, for the report which follows, regarding the work of the chest service as affecting the county area during 1950. The Consultant Chest Physician holds a joint appointment, being primarily an officer of the Regional Hospital Board, but being also for part of his time an officer on the staffs of the Local Health Authorities concerned, including the county of Cumberland.

As will be seen, Dr. Morton has in his review dealt with many matters, such as the question of bed accommodation, which are out-with the province of the County Council, but which will be found of great interest. Not the least important paragraph in his report is the last one which emphasises the need for close co-operation between regional hospital boards, local health authorities, and other bodies or groups of persons concerned in the campaign against tuberculosis.

We look forward with hope and with the greatest goodwill to the results which may, in the course of time, be expected to materialise through the operations of this new service.

The chest service as now established, and I am thinking principally of the campaign against tuberculosis, is equipped for this campaign not only with money, but with working tools to an extent which was beyond our wildest dreams when we, as officers of local health authorities, were operating with what tools we had under the designation of tuberculosis officers.

Some criticism, in my view not very fair criticism, has from time to time been levelled against the County Council who must, of course, ultimately be held responsible, and against this department, for the quality of the tuberculosis service which we used to maintain prior to July, 1948. I would like to make it quite clear that no hint of this criticism has come from Dr. Morton, but the criticism has been made, and as the chest service develops, and the greater the success which attends its progress, and we have high hopes that this measure of success may be very great indeed, there will, beyond question, be a tendency for comparisons to be drawn between what may happen in the future and what has happened in the past.

In fairness therefore, I would ask past, present and

future critics to remember that not only will the chest service have financial resources at its disposal which were not available to a county which suffered from twenty years of industrial depression, but that recent advances in chemo-therapy have provided weapons of offence against tuberculosis in the shape of paramisan and streptomycin, which are perhaps the most powerful weapons in the anti-tuberculosis campaign to-day, and which were, in the case of paramisan not known, and in the case of streptomycin still at the experimental stage, during the period of our responsibility, that a mass radiography unit for investigation is now available whereas we were not alloted one by the Ministry as these units were reserved at that time for large centres of population, that thoracic surgery, major and minor, has made great strides in the last few years, and so on and so on. Let us hope therefore, that this matter may be viewed in a proper perspective. The campaign in Korea could not be waged very successfully with the weapons of the South African war !

Since Dr. Morton's report was received, the distribution of deaths from pulmonary tuberculosis by areas has been received from the Registrar General, and this is set out below.

The death rates from pulmonary and non-pulmonary tuberculosis for 1950 work out at .47 and .07 per thousand of the population respectively, compared with .5 and .12 per thousand for 1949.

Urban Districts	Deaths	Death rate
Cockermouth	1	.19
Keswick	2	.43
Maryport	10	.80
Penrith	5	.47
Whitehaven	20	.82
Workington	12	.41
Aggregate of Urban Districts	50	.58

Rural Districts	Deaths	Death rate
Alston	1	.43
Border	3	.10
Cockermouth	8	.41
Ennerdale	22	.73
Millom	6	.46
Penrith	2	.17
Wigton	9	.37
Aggregate of Rural Districts	51	.39
Total for the Administrative County	101	.47

Dr. Morton's report is as follows :—

COUNTY OF CUMBERLAND

(a) Tuberculosis

"Tuberculosis continues to be the chief problem of chest diseases. Whilst the statistical data for 1950 show a substantial change from that of 1949, the fact that work was limited by short staffing and by inadequate facilities, leaves no doubt in my mind that much field work is still to be carried out.

During the whole of 1950, work was carried out from an office at 11, Portland Square, Carlisle, kindly lent by Dr. Kenneth Fraser, the County Medical Officer.

At the beginning of 1950 there were no less than 13 dispensaries throughout the County area where cases were seen by the Assistant Tuberculosis Officers of the County. These dispensaries were sited in combined clinic buildings, and with one exception—viz., Egremont, generally possessed completely inadequate facilities for the diagnosis and supervision of tuberculous and other chest diseases. None were equipped with x-ray facilities, and as in previous years our x-ray examinations were carried out either by Dr. Connell and Dr. Scott Harden at their Warwick Road rooms, or at the x-ray departments at Whitehaven and Workington Hospitals.

It was obvious that considerable re-organisation had to be undertaken, as the successful control and assessment of tuberculosis will initially depend on adequate facilities for diagnosis. One is no longer satisfied to-day with a simple stethoscopic examination; one should be able to carry out a thorough and complete investigation of each new case at the centre, including full radiological and blood investigations. The centre should preferably be sited in close association with one of the general hospitals, so that all specialist investigations are readily available, if required.

A start was made last year when the building of a new chest centre at the City General Hospital, Carlisle, was commenced. It was expected that this would be open before the end of the year under review, but this was delayed until January, 1951.

The dispensaries at 14, Portland Square, Carlisle, Aspatria, and Maryport were closed down during the year. Patients formerly seen at 14, Portland Square were seen at George Street Clinic in Carlisle; patients who previously attended at Aspatria were seen at Wigton Dispensary. Later, Maryport Dispensary was also closed, the patients from this area being transferred to Workington. The latter change was made possible by the appointment of an assistant in the Chest Service, when we were directly able to take over Workington Dispensary area. At the end of the year arrangements were made for the closure of the dispensaries at Wigton, and Brampton, consequent on the opening of the new Chest Centre at Carlisle in January, 1951.

New centres are envisaged at Workington in close association with the Workington Infirmary, and at Whitehaven in close association with the Whitehaven Hospital. When these new centres are opened it will no longer be necessary to retain dispensaries at Cockermouth, Frizington and Cleator Moor. Owing to the considerable distance involved, however, we shall obviously require to retain facilities at Millom, and possibly at Penrith. The Egremont dispensary, although not equipped with x-ray facilities, is very useful to us in this interim period as it is the only dispensary which has a complete wing in the clinic building to itself. This means that we should be able to use it, if necessary, several days per week.

Notifications of Tuberculosis

The number of notifications for the year 1950, and the preceding 5 years are as given in table 1:—

Table 1.

	Pulmonary.	Non-Pulmonary.
1945 ...	182	... 71
1946 ...	197	... 48
1947 ...	162	... 58
1948 ...	195	... 45
1949 ...	222	... 32
1950 ...	231	... 48

The table shows a still further increase in the number of cases of pulmonary tuberculosis as compared with previous years, and I regret to say that there is every indication that this figure will again be surpassed during 1951.

Every effort has been made to secure that the Notification Regulations are strictly followed, as much of the success achieved in controlling the disease depends on this. I feel that it is also most important that the apparently simple conditions, such as pleural effusions, should also be notified, unless the effusion has been definitely proved to be the result of trauma or of some condition other than tuberculosis. It is a well established fact that a pleural effusion, unless successfully treated by rest, is often followed later by parenchymatous disease of a more incapacitating character.

The primary infection in a young child, however, comes into a different category, and it is generally agreed that in such cases there should be a high threshold for notification. In other words, such cases should only be notified if the primary infection entails gross symptoms and signs.

Whilst a large number of cases of pulmonary tuberculosis are non-infectious there remains a hard core of infectious cases, and unless they are notified and brought under supervision and treatment they will continue to infect others. Family contacts of such cases are in particular danger, and examination of the contacts is rightly stressed as one of the chief functions of the Chest Service. Much is also achieved in educating patients, when they come under our care, so that they will cease to be a danger to others. In this connection the Health Visitors and nurses employed in the County Service play a most vital part.

Deaths from Tuberculosis.

The deaths from tuberculosis are as set out in table. 2.

Table 2.

	Pulmonary.	Non-Pulmonary.
1945 ...	122 ...	26
1946 ...	97 ...	28
1947 ...	101 ...	32
1948 ...	116 ...	15
1949 ...	107 ...	25
1950 ...	101 ...	15

Dispensary Register Statistics

Table 3 shows the total number of cases on the Dispensary Registers for the year 1950. From this it

will be noticed that the number of cases of pulmonary tuberculosis in adults has increased. One would particularly comment on the comparatively large number of patients, as noted in the last line of the table, who have positive sputa, and must therefore be considered to be infectious. Many of these are at present under treatment, both at home, and in sanatoria, but should our responsibility for educating these patients be 100 per cent. successful they should not be a danger to others. It is the unsuspected open case with a positive sputum, who is not under our control. who is the public danger.

Table 3.

Cases on Dispensary Register.

	Respiratory.			Non-Respiratory.			Totals.			Grand Total
	M.	W.	Ch.	M.	W.	Ch.	M.	W.	Ch.	
Cases on Clinic Registers on 1st January, 1950 ...	453	341	74	17	18	48	470	359	122	951
Additions to Register during 1950	116	91	10	2	9	11	118	100	21	239
	569	432	84	19	27	59	588	459	143	1190
Written off Register during 1950	108	75	28	5	7	8	113	82	36	231
Number on Register at end of year	461	357	56	14	20	51	475	377	107	959
Number of above known to have had a positive sputum within the preceding six months	111	85	3	—	—	—	111	85	3	199

Table 4 shows the number of examinations carried out at the dispensaries, the City General Hospital, and the Workington Infirmary throughout the year:—

Table 4.

(a) **At the dispensaries.**

	1949	1950
No. of new cases seen	189	341
Total number of contacts examined	1140	1465
Total attendances at dispensaries ...	4106	4198

(b) **At hospitals**

No of attendances at the City General Hospital for A.P. and P.P. refills	594	723
No. of attendances at Workington Infirmary for A.P. and P.P. refills	1003	1123

The marked increase in the number of new cases seen at the dispensaries is to be noticed, and is in part due to the fact that well over half of these were seen at the George Street Clinic, Carlisle.

Throughout the year the co-operation of the general practitioners has been excellent, and we have reciprocated by sending reports on each patient examined, to the doctors concerned. I believe that has been greatly appreciated.

Many cases of pulmonary tuberculosis have again been discovered to be living in unsuitable housing conditions. The relationship between overcrowding and tuberculosis is now a well established fact, and as in previous years representations have been made to the local sanitary authorities for rehousing, through their Medical Officers of Health. It is very gratifying to know that these cases receive sympathetic consideration.

Examination of Contacts.

The figures for contact examinations are given in detail in tables 5 and 6.

Table 5.

	No.
1947	881
1948	960
1949	1140
1950	1465

Table 6.

(a) Total number of contacts examined during the year.

Adults.		Children.		Total.
316	...	1149	...	1465

(b) Total number of new contacts examined during the year.

Adults.		Children.		Total.
177	...	534	...	711

(c) Number of contacts vaccinated with B.C.G.

Males.		Females.		Males.		Females.		Total.
—	...	1	...	4	...	10	...	15

Although the figures for contact examinations show a gratifying increase over previous years, there is still no room for complacency, and it is safe to say that with the greater facilities available at the new Chest Centre (which was opened in January. 1951) these figures will be increased again next year.

The Local Authorities are vitally interested in the vaccination of susceptible contacts with B.C.G. vaccine. One of the most significant features of infection by the tubercle bacillus is that it does not always cause disease; in fact, in the majority of instances no signs or symptoms are experienced when the body is primarily invaded by that organism. From this it may be concluded that the human body possesses considerable " native resistance " to tuberculosis and that it is only when this is low, or the initial dose of bacilli large, that noticeable constitutional changes follow the primary infection. Although this may be silent, it nearly always produces changes in the tissues which cause them to develop a hypersensitivity towards any subsequent dose of tubercle bacilli, or certain products derived from them. In addition an " acquired resistance " is built up which enhances the native resistance and increases the powers of the tissues to overcome the harmful effects of the tubercle bacilli, and to suppress their power of reproduction. Advantage is taken of the development of hypersensitivity following primary infection to determine, by means of tuberculin skin tests, if infection has taken place.

The knowledge that a healed primary lesion confers a certain degree of protection against subsequent infection has led to the use of a vaccine, consisting of a strain of tubercle bacilli of low virulence, for the production of a controlled primary focus, and the consequent

improvement of resistance, without the danger which attends natural exposure to infection by unknown quantities of bacilli. The vaccine used for this purpose consists of an attenuated strain of bovine tubercle bacilli known as Bacillus-Calmette-Guerin or B.C.G.

It is of value for many reasons connected with diagnosis and also in preventive medicine, and in particular in anti-tuberculosis vaccination work, to know if a person has been infected by the tubercle bacillus. This is recorded by a positive result following a tuberculin skin test.

The procedure carried out is by two intradermal tests with a six week's interval elapsing. All patients giving a negative reaction to test No. 1 are given a second test in six weeks with a tuberculin ten times stronger than the first. Should the second test also be negative, then that person is suitable for vaccination with B.C.G.

At the commencement of our operations in 1950 we carried out a large number of modified tests using Tuberculin Jelly, but we were not entirely satisfied with this, and we are now undertaking the primary test with the Mantoux intradermal test. All child contacts below the age of 15 are now tested as a routine measure, at Carlisle and Workington centres.

B.C.G. vaccination is at present limited to contacts of cases of tuberculosis, and to nurses and medical students who come in contact with such cases. It is not yet available for the general public.

The comparatively small number of persons actually vaccinated in 1950 results from the fact that this scheme of B.C.G. vaccination was only commenced in the latter quarter of the year. The figures for 1951 will show a much larger number, and in fact, at the time of writing (5th June) there have already been 96 children and one nurse vaccinated in the County area.

As mentioned in the report for the year 1949 the chief problem anticipated in connection with B.C.G. vaccination was that of arranging for the segregation of the vaccinated children from the infected case, for a period of three months, and it was anticipated that we would have considerable difficulty in carrying this out. I am happy to say, however, that the parents and

relatives of the children have given us full co-operation and we have been able to arrange for the satisfactory isolation of the child contacts. In a few cases where this has proved of real difficulty to the parents we have delayed vaccination until we have been able to admit the patient to a hospital or sanatorium bed.

Institutional Treatment.

As in previous years hospital treatment of patients has been greatly handicapped by the shortage of beds, both in sanatoria and in hospitals. It is considered that for the whole of the Special Area 350 beds are required for the diagnosis and treatment of cases of pulmonary tuberculosis. At the beginning of 1950 the beds available for the treatment of pulmonary tuberculosis for the Special Area were as follows:

	Beds
Meathop Sanatorium	25
Blencathra Sanatorium	100
Stannington Sanatorium	5
City General Hospital, Carlisle	12
Cumberland Infirmary, Carlisle	10

Unfortunately, however, for the greater part of the year 20 per cent. of the beds at Blencathra Sanatorium were out of commission, because of structural alterations, which are now happily completed.

Admissions to Meathop Sanatorium had also to be curtailed drastically because of shortage of nursing staff.

The waiting list consequently grew, and for the greater part of the year under review, hovered around 120 for the whole of the Special Area. Although large sanatorium waiting lists pertained throughout the whole of the country during 1950, the problem was particularly acute in this area. The Special Area Committee considered the situation, and they appointed a Tuberculosis Committee, one of whose tasks it was to provide further bed accommodation for our cases. As a result we have been able to secure, as an interim measure, a small, but gratifying increase, in the number of beds at our disposal. The long term policy is, of course, one of a new sanatorium within reasonable distance of Carlisle. There is also a mid-term policy whereby Camerton Hospital, near Workington, may become available for treatment of cases of tuberculosis,

after certain structural alterations, etc., have been carried out. I understand that this scheme has gone to the Ministry for their approval.

Additional beds now available are located at:—

Ormside Hospital, Appleby	9 beds
Longtown I.D. Hospital	7 beds
Ellerbeck I.D. Hospital, Workington	7 beds

but it was only possible to bring the beds at Longtown into use towards the end of 1950.

Table 7.

Beds occupied at the end of the year by cases from the County of Cumberland:—

	Beds
Blencathra Sanatorium	66
Meathop Sanatorium	14
Stannington Sanatorium	5
Cumberland Infirmary	2
City General Hospital	9
Longtown Isolation Hospital	5

Table 8.

Total number of county cases admitted to institutions for diagnosis and treatment during the year:—

	Adults	Children
Blencathra Sanatorium ...	70 ...	—
Meathop Sanatorium ...	21 ...	—
Stannington Sanatorium ...	— ...	5
Longtown Isolation Hospital	5 ...	—
Cumberland Infirmary ...	4 ...	—
City General Hospital ...	25 ...	8

Of the 25 adult cases admitted to the City General Hospital 18 cases were transferred from Blencathra Sanatorium with a view to adhesion section, phrenic evulsion, etc. The number also includes one case where an artificial pneumothorax was induced, and one case where a pneumoperitoreum was induced.

Very fortunately it has been possible in a vast majority of cases to commence treatment at home, and the extensive employment of Paramisan and Streptomycin throughout the year, and given to patients at home, has more than justified its use. One would say, in fact, that treatment with these drugs has revolutionised our outlook on the disease. One realises that there is a class of patient with considerable disease in the chest, and in an infectious state, who cannot satisfactorily be nursed at home, or where the danger of infection, e.g., to young members of the family, is acute. These cases are given some measure of priority to a

hospital bed, although little improvement can usually be expected as a result of in-patient treatment. The problem of weighing up the two priorities for hospital beds, viz.:—Priority to prevent spread of infection to other people, or priority of admission in a case which is likely to respond to treatment which can be given in hospital, is a very real difficulty.

In a not inconsiderable number of cases the disease has responded so well to bed rest treatment plus chemotherapy at home, that admission to sanatorium or hospital has not been necessary later. The sheet anchor of treatment is undoubtedly rest of the diseased lung. The fact that we are getting such results should reassure those patients who feel that they will not get better unless they go to a sanatorium. Moreover, those patients who have disease, which in our opinion needs more than chemotherapy, are placed on a priority waiting list, so that as little time as possible is wasted before they are admitted.

(b) Chest Diseases Other Than Tuberculosis

Bronchietasis

During 1950 large numbers of cases of chest disease other than pulmonary tuberculosis have been seen. The condition which concerns us most is that of bronchiectasis, and in this connection we have worked in close association with the Thoracic Surgery Unit at Shotley Bridge. One of the Thoracic Surgeons attends at Carlisle weekly, and during this weekly session the best line of treatment, for a particular case, is discussed jointly. Many of the cases do not require surgical treatment, and in these treatment is purely one of physiotherapy, breathing exercises and postural drainage. It is unfortunately not possible to give the total number seen in the County area during 1950, but steps have been taken to give this figure in further reports.

There is also an acute shortage of beds for Thoracic Surgery for the Region; although, compared to other chest divisions in the Newcastle Region, the Special Area has been somewhat more fortunate. In a disease such as bronchiectasis, however, the delay in admission to a surgical bed, with a view to possible lobectomy, is not necessarily a serious one, as the interval can be

spent in continuation of breathing exercises and postural drainage, so that the patient ultimately comes to operation in a better condition than he was previously.

Neoplasm

The number of cases from the county area found to be suffering from pulmonary neoplasm has been very small, and such cases are investigated by the Thoracic Surgeon, and should they be considered as suitable for operative treatment they are given priority in admission to Shotley Bridge.

Pneumoconiosis

We continue to see large numbers of persons suffering from pneumoconiosis in the west of the area, and more particularly around Cleator Moor, Egremont and Millom.

Cases presenting radiological evidence of an ordinary straightforward pneumoconiosis present little difficulty, but where isolated pneumoconiotic nodules have coalesced into larger areas, as a result of, presumably super-added infection, it takes considerable time—often examinations on several separate occasions with frequent bacteriological examinations to ensure that they are not suffering from a super-added *active* tuberculous lesion. In many cases the coalescence is possibly due to a super-added simple pyogenic infection, but the distinction between this and a super-added tuberculous infection is difficult; whilst even when super-added tuberculous disease is accepted there still remains the problem of assessing the activity of such a lesion. In many cases the lesion is inactive when first seen.

I shall have more to say on this subject next year, particularly as a result of our experience with the Mass Radiography Unit.

(c) Mass Radiography

Mass Radiography surveys are the responsibility of the Special Area Committee, but the discovery of cases of tuberculosis, by this method, is a preventative measure, and as such, vitally concerns the Local Authority.

Unfortunately, principally owing to our inability to recruit radiographers, we were unable to commence operations in 1950. This defect was not remedied until the early spring of this year. Since then the unit has been in continuous operation.

The detection of symptomless or latent tuberculosis by mass radiography has been subject to much careful investigation over the past 20 years, and the present method of surveying a large section of the population is based on the findings resulting therefrom.

The complete apparatus is contained in a mobile van with full x-ray equipment, camera, developing room, etc., whilst a trailer houses the generator.

The method is quick, and persons can pass through the unit at a rate varying between one and two every minute. The pictures are taken on 35 mm. films and after developing are read. A small number of persons will be recalled for large film examinations. This number will include those whose miniature films are unreadable for technical reasons, and those who have definite abnormalities in the chest requiring further investigation. On an average survey the number recalled usually does not exceed 6 per cent.; while the number of persons found to have tuberculosis, and requiring further investigation, should be about 1 per cent. The actual number of cases requiring treatment, on an average survey, will, however, be considerably less than this.

Our experience to date shows that in West Cumberland particularly, we must expect a higher recall rate, due not only to tuberculosis, but also to the frequency with which other chest conditions, such as pneumoconiosis, are encountered in that area.

The whole service is free, voluntary, and confidential. I cannot stress the confidential nature of the examination too much, and in cases where some abnormality is found requiring treatment, it is my usual practice to get in touch with the person's own doctor, with the person's permission. Should that person refuse his consent, then I cannot do anything further.

I would point out that patients passing through a mass radiography examination do not now require to strip to the waist. Men are examined with jackets off

and braces down, and similarly with women. This is a decided asset and tends to raise the percentage response in a survey.

The ground floor of the Warwick Hotel has become the base of the unit. In dealing with a large number of the population considerable records require to be retained, and reports furnished to the Ministry and Regional Hospital Board. In addition the base at the Warwick Hotel will be available for carrying out public sessions for persons within reasonable distance of Carlisle. We shall be prepared to arrange appointments for any smaller factories, or groups of individuals to pass through.

As mentioned before, the unit has been working to full capacity since it commenced to function, and although the report of its activities will only appear in the report for 1951, I would say now that the results we have already obtained are more than justifying its use in the Special Area. Indeed, the number of cases meriting further investigation at dispensaries has created a problem at the moment in the western areas of the county, principally because of the lack of fully equipped Chest Centres, and the shortage of chest service staff.

(d) After Care and Rehabilitation

The object of after care is to prevent, as far as possible, any deterioration in the living standards of the tuberculous patient and his family, as a result of the patient's disability.

A wide range of help is possible, ranging from the loan of beds and bedding to patients, to the provision of shelters in cases where the home conditions are overcrowded.

The home help service has also been called upon, and fills a long felt want. Home helps in homes of cases of pulmonary tuberculosis are medically examined, and have x-ray examinations carried out. In general terms it is desirable that home helps employed in tuberculous households should be over the age of 35, as young adults would undoubtedly be more susceptible to the disease.

Close contact has also been retained with the local Resettlement Officers of the Ministry of Labour, both

at Carlisle and Whitehaven, and full advantage is taken of the fact that active pulmonary tuberculosis entitles a patient to be registered as a disabled person.

(e) Further Developments in the Chest Service

The question of improving the Chest Service facilities in West Cumberland has already been mentioned, as has also the aspect concerning bed accommodation, within the next five years for the treatment of pulmonary tuberculosis. There is, however, one further item which I should mention, and that is that a second Consultant appointment to the Chest Service, will, in all probability, be made in the near future. It is quite impossible under present conditions to adequately cover West Cumberland from Carlisle, and the operation of the mass radiography unit in this area has further accentuated the difficulties, and it is my earnest hope that this appointment will be made in the very near future.

In conclusion I would like to express my appreciation of the services rendered to this chest division by the Assistant County Medical Officers who have acted as Tuberculosis Officers throughout the year. I would also tender my sincere thanks to Dr. Kenneth Fraser, the County Medical Officer, and the staff of the County Health Department for their valuable co-operation during 1950.

Although the responsibilities of the Chest Service are divided between the Regional Hospital Board, and the local authority, it is obvious that prevention, treatment, and after-care are very closely linked, and that there must be a high percentage of co-ordination between the various authorities concerned, and the officers of these authorities.

W. H. MORTON,
Consultant Chest Physician.

DENTAL TREATMENT

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

"The procedure outlined in a previous report in relation to pre-school cases was continued during the year under review, but after careful consideration it has been decided to discontinue the attempt to cover all pre-school

children in the County. Not only was the response to notices disappointing in view of the work involved, but the staffing position definitely precluded the possibility of doing justice to those cases for which regular supervision was desired. The scheme is being modified and the approach is being made through the health visitors with the co-operation of the Superintendent Nursing Officer. Instructions have been issued accordingly to the health visitors that treatment for these cases is available if desired—a supply of forms being issued so that one of these may be handed to any parent requesting treatment for her child. The parent returns the completed form to the dental section and arrangements are then made for the necessary treatment to be carried out. It is felt that this procedure will eliminate a great deal of wasted effort, and at the same time will not hinder any child from obtaining treatment which may be desired.

As indicated on the attached table fewer children have been examined, but a greater proportion have been found to require treatment. This is the logical result of the present position as fewer routine inspections are carried out and a much greater number of cases are seen for the relief of pain. This is confirmed in the increasing number of extractions and general anaesthetics, though it is also gratifying to note that the number of fillings has also increased considerably.

With regard to nursing and expectant mothers the position, if anything, has deteriorated still further. In all 1,391 notices were sent out during the year, and of these only 222 were returned asking for inspection and treatment if necessary. Of these quite a number did not attend when sent for, while a further proportion failed to complete treatment when this was of a conservative nature. While these facts give little cause for satisfaction there does not appear to be any way by which the position can be improved. There is little doubt that the majority of cases are receiving treatment under the National Health Service and, after all, this is the chief matter for concern. It is intended to continue the present system of notices for 1951, though even this may need to be considered at a later date in the light of experience.

The attached table of work carried out does not appear to call for any comment."

Dental Inspection and Treatment, 1950.

	Examined.	Needing treatment.	Treated.	Made Dentally fit.
Expectant and Nursing Mothers	244	187	187	92
Children under five ...	607	389	389	194

	Extractions.	Anaesthetics		Fillings.	Scaling or scaling and gum treatment.	Silver Nitrate treatment.	Dressings.	Radiographs.	Dentures Provided	
		Local.	General.						Complete.	Partial.
Expectant and Nursing Mothers	405	125	12	118	80	—	204	18	59	32
Children under five ...	333	78	100	193	—	95	99	6	—	—

ORTHOPAEDIC TREATMENT

The statistics for the year which follow do not vary very materially from the previous year. There has been a substantial increase in the number of cases of bow leg and knock knee and some rise in other groups of comparatively minor defects such as flat feet. Attendances at surgeon's clinics have risen substantially, as have the number of plasters applied at the aftercare clinics, and the number of surgical boots and appliances supplied. While it is true that new cases to the number of two hundred and seventy-seven were dealt with during the year, these cases with few exceptions, were referred by county medical and nursing staffs, and the number of orthopædic cases referred to our orthopædic clinics by general practitioners was very limited indeed. This of course is completely the reverse of the position prior to 1948, when the general practitioners made very free use of our orthopædic clinics as clearing houses for the investigation and treatment of orthopædic conditions of all kinds.

Meantime the out-patient clinics at the Cumberland Infirmary have become congested to a degree, and long periods have to elapse before cases can even be seen for the first time. The number of beds available for orthopædic in-patient treatment in the Special Area is far from adequate. At the end of March, 1951, the waiting list for admission to the Cumberland Infirmary amounted to three hundred and thirty-two cases, of whom thirty-six were children. The time-lag for the admission of children to the Cumberland Infirmary is considerably longer than for admission to the Ethel Hedley Hospital, Windermere, and, while perhaps inevitable, this is regrettable. The opening of the peripheral unit at the Keswick Cottage Hospital, where there are to be four beds for children, may relieve the position to some extent.

All this is leading up to a review of policy which was brought before a conference on orthopædics held at the Cumberland Infirmary early in 1951 and was accepted by the conference as part of the future policy in the following resolution :—

" That in order to reduce the pressure on the accommodation at the Cumberland Infirmary greater use should be made of the County Council orthopædic clinics, and of the Council's aftercare services, and that an approach should be made to the County Council with the suggestion that the Council should strengthen their resources in this field, by the appointment of an additional orthopædic physiotherapist."

I do not doubt that we could do much to help to relieve the congestion in the orthopædic services in the Special Area if two things were to happen :—

(a) If the position could revert to that in operation prior to July, 1948, whereby our county orthopædic clinics were real clearing houses for orthopædic conditions of all kinds and not merely clinics to which cases are referred by the county staff, such cases being mainly minor conditions like flat feet and knock knees.

The above resolution can only be implemented if the general practitioners throughout the area, with the full knowledge and consent of the Special Area Committee as expressed in the resolution, and with the approval of the consultant in orthopædics revert to their previous practice of referring cases freely, especially children, but by no means excluding adults, to the

county orthopædic clinics, which have, after all, served as very adequate clearing houses indeed for over thirty years and which have dealt with not less than ten thousand cases of orthopædic conditions of all degrees of severity. This, in addition to relieving the congestion at the Cumberland Infirmary out-patient clinics, would be of enormous benefit to the orthoædic patients by dispensing with long journeys from all parts of the county to the Cumberland Infirmary, and this particularly applies to West Cumberland.

(b) Another aspect of the work in which I think the County Council could give substantial assistance would be to second the services of county orthopædic physiotherapist staff for the supervision, at home, of patients in plaster, decanted from hospital during the plaster stage of treatment. Certain orthopædic conditions are in plaster for long periods, and certain of them involve the changing of the plaster to permit of new positions being taken up in the correction of defects, such as congenital dislocation of the hip. In between these applications of plaster the patients do not require active treatment, and if we could undertake the supervision of such patients in plaster in their own homes, we could, I think, do something very useful to relieve the congestion of the short supply of orthopædic beds. For many years our orthopædic physiotherapist has, in fact, done exactly this, sometimes as many as thirty cases at one time being under home supervision in plaster, and this is the second major thing which we could do to help.

I may be permitted to refer here once more to the findings of the orthopædic conference mentioned above and to say that the conference have in mind the desirability of appointing an additional orthopædic consultant to the Special Area, primarily, I think, for duties in West Cumberland and possibly to be stationed there. This would, of course, alter the whole set up.

The Council will note that an approach will shortly be made by the Special Area Committee, and will probably have been made before this report is in their hands, requesting the Council to endeavour to obtain the services of an additional orthopædic physiotherapist. This strengthening of the staff would be necessary before we could do very much about the two lines of co-operation indicated above. It would also permit of

minor postural defects—flat feet, etc., being dealt with in classes or groups rather than individually, as at present, which is a waste of time, and does not permit the close attention to the following up which is desirable.

Perhaps a final note with reference to hospital admission would be useful. We still maintain, to our great benefit, our long association with the Shropshire Orthopædic Hospital, Oswestry. To this hospital we have been sending cases for thirty years, and we still, through the co-operation of the hospital authorities, are able, with very little delay, to obtain beds for our long stay adult orthopædic cases, such as tubercular bones and joints or severely paralysed cases of poliomyelitis.

Crippling conditions affecting children under five years of age.

Bow leg and knock knees	276
Flat foot	74
Congenital defects	20
Congenital deformities of feet	42
Injuries (including fractures)	4
Infantile paralysis	16
Torticollis	8
Cerebral palsy	10
Congenital dislocation of the hip	14
Tuberculosis	4
Birth palsy	14
Hallux valgus	12
Scoliosis, lordosis and kyphosis	4
Synovitis	2
Poor posture	6
Pseudocoxalgia	1
Other conditions	84
	591

Tuberculosis of Bones and Joints.

	Adults.	School Children.	Under 5 years.
Spine	48	13	1
Hip	18	7	1
Knee	2	9	—
Sacro iliac joint	7	—	—
Thigh	—	—	—
Wrist	1	1	—
Elbow	2	—	—
Shoulder	4	1	—
Ankle	3	—	2
Tibia	1	1	—
Foot	—	1	—
Femur	—	1	—
	86	34	4

Adult Non-Tubercular Cases.

Poliomyelitis	20
Arthritis	9
Scoliosis, lordosis, kyphosis	7
Congenital dislocation of the hip	10
Flat foot	4
Osteomyelitis	8
Vertebral disc protrusion	13
Hallux valgus	5
Injuries (including fractures)	14
Cerebral palsy	2
Pes cavus	2
Slipped epiphysis	2
Pseudocoxalgia	1
Synovitis	2
Congenital defects	3
Other conditions	13
	115

General Statistics.

Number on aftercare register 1-1-50	505
New cases during 1950	277
Cases renotified after previous discharge	14
Number of cases removed from register	171
Number remaining on register at 31-12-50	625
Attendance at Surgeon's clinics	887
X-ray examinations during 1950	104
Waiting for X-ray	32
Number of attendances at aftercare clinics	803
Home visits	187
Plasters applied at aftercare clinics	151
Plasters applied at home	20
Surgical boots and appliances supplied	250

Hospital Admissions.

Name of Hospital	In hospital at 1/1/50	Admitted during year.	Discharged.	In at 31/12/50.
Ethel Hedley Hospital, Windermere	10	21	18	13
Shropshire Orthopædic Hospital, Oswestry	9	25	23	11

Patients Awaiting Hospital Admission

(Including School Children).

	Adults.	School Children.	Under 5 years.
Ethel Hedley Hospital, Windermere	—	16	1
Cumberland Infirmary, Carlisle	13	13	11
Shropshire Orthopædic Hospital, Oswestry	—	—	—

VENEREAL DISEASES.

I am indebted to Dr. H. J. Bell, Consultant Venereologist, for the following extracts from his report to the Special Area Committee:—

1 " Statistics.

In so far as the number of fresh cases of Venereal Disease which were treated in the Clinics during 1950 reflects the incidence of the disease in the County, this incidence has continued to decline. " Fresh Venereal Disease cases," for the purpose of this report, means " Acute Gonorrhoea and Early Syphilis." The total attendances of patients at the Clinics are not related to the incidence of Venereal Disease, but indicate the volume of work carried out at these Centres. The volume of work shows a slight increase as compared with 1949.

Nobody knows how many cases of early infection fail to apply to the Clinics for treatment in this country. The tendency for general practitioners to treat cases of Gonorrhoea in the surgery becomes more general as therapy becomes easier and more simple. The problem of untreated syphilitics is much more dangerous to the community, but I believe that nearly all patients who apply to the family doctor are ,in turn, referred to me. Nevertheless, I have the impression that the numbers presenting themselves to the Clinics for treatment of early syphilis are but a fraction of the numbers infected in the county. The impression that a significant fraction fail to apply for treatment is formed from evidence of an indirect kind—patients referred with a positive Wassermann Test from blood-transfusion organisations, from ante-natal clinics, and young children suffering from congenital syphilis. Such cases lead to the investigation of the family and from the family to the individual. In many instances, the individual will agree that he or she suffered from an early lesion of the disease, but that its significance was not recognised, or that the necessity for treatment was carelessly or wilfully neglected. The United States Public Health Service spends large sums of money in Venereal Disease campaigns, and have employed screen tests of entire county populations by Wassermann serological examination. They call the method a ' serological drag-net.' A recent survey of this kind (County of Lehore, Mississippi, 1947), revealed a total of early cases of syphilis which was three to five times the " discovery rate " at the official clinics.

These short notes then, illustrate why the prevalence of early Venereal Disease in the county can never be more than guessed at, and my reasons for explaining that the true morbidity rate bears no reliable relationship to the figures produced at the Clinics.

When the results from the two Clinics at the Cumberland Infirmary and Whitehaven Hospital are compared an interesting estimation of the local situation is apparent; the following table shows the steady reduction of new cases in the north and the curious increase in the south of the county:—

Year.	Early Venereal Infections.		Total Attendances.	
	Carlisle.	Whitehaven.	Carlisle.	Whitehaven.
1945	156	53	5181	2304
1946	201	81	5274	1821
1947	139	38	3764	1362
1948	94	28	3473	944
1949	69	44	3212	995
1950	47	48	3089	1396

Furthermore, the table shows that the fresh infections at Whitehaven have now increased beyond the figure for Carlisle. This feature was anticipated early on in the year 1950 and is explained in a later paragraph as being caused by the influx of Irish labourers into camps serving the atomic works at Sellafield.

The abnormal situation created at Whitehaven was entirely the result of peripatetic labourers bringing their infection with them from elsewhere. The infection was "Primary Syphilis," for the most part. The increased incidence of fresh Venereal Disease at Whitehaven occurs only in the category "Primary Syphilis," and the increase can be accounted for numerically by the sum of cases of this stage of the disease occurring in Nethertown and Sellafield Camps.

It was anticipated, with reason, that the continuing introduction of fresh syphilis into a rural area would eventually spread to the normal population and cause a minor epidemic of syphilis. Accordingly, every possible step was taken to prevent this by enlisting the interest and co-operation of camp welfare officers, health visitors, the police and others. These measures represent the usual routine adopted in attempting to confine the spread of an epidemic of venereal disease. To a small extent they can be effective. In this particular outbreak, fortunately, the epidemic did not develop——for reasons unknown.

It is interesting to comment that the really effective counter measures to be taken in face of a danger of this

description cannot be applied in this country, because the law is unsympathetic. They are—

1 To enforce treatment and continuation of treatment of known cases of syphilis.

2 To enforce examination of contacts—especially the prostitutes who, in this instance, flocked to the public-houses at week-ends.

3 To allow managers of public-houses to refuse admision of women notified to them as prostitutes.

4 Police campaign against prostitutes.
Such measures are possible in Scandinavia.

Cases of early syphilis at Nethertown Camp reached a peak incidence in the month of July and declined rapidly—largely because the numbers of workmen at the Camp were reduced at that time.

The origin of new cases (venereal disease and non-venereal diseases) is shown by this table;—

Town or Area.	To Carlisle Clinic.	To Whitehaven Clinic.	Total.
From Carlisle and Suburbs ...	142	0	142
Alston	1	0	1
Aspatria	6	1	7
Cockermouth	3	6	9
Dumfriesshire	7	0	7
Frizington	0	8	8
Longtown	10	0	10
Maryport and Area ...	15	12	27
Millom	2	3	5
Nethertown Camp ...	5	55	60
Penrith and Area ...	26	0	26
Shap and Westmorland ...	9	0	9
Whitehaven	2	73	75
Wigton	5	0	5
Workington and Area ...	9	47	56
Outside Cumberland Area	15	3	18
Other Scottish Counties	6	8	14
Total 1950 ...	263	216	479
(Total 1949 ...	356	142	498

The table illustrates the relatively large numbers of men from Nethertown Camp who sought help at Hospital, and the increase of new cases (50%) dealt with at Whitehaven as compared with the previous year, in contrast with a like reduction (25%) at Carlisle.

The work of the Medical Officer at each Clinic is indicated by the figures of the "Total New Cases" and "Total Attendances for individual attention of the

Medical Officer" (Item 3 and Item 12(a) of the Medical Annual Report). The comparison in the Whitehaven and Carlisle figures poses a new problem—

	Total New Cases, 1950	For attention of M.O., 1950
Whitehaven ...	216	... 1155
Carlisle	263	... 2531

The Medical Officer attends five clinical sessions at Carlisle and only two at Whitehaven. Column 1 above would seem to indicate that he distributes his time unfairly in favour of Carlisle: Column 2 shows at once that this is not so.

2 Treatment.

In the report of last year, comment was made regarding the extraordinary advances in treatment of venereal disease. Some modification of these notes is now necessary. For example, there has been some difficulty in the treatment of female gonorrhoea. The dose of penicillin which is found adequate in the case of the male is not always curative in the female. To increase the dose of penicillin is not a complete answer to the difficulty. The sulpha drugs have been taken into use again to boost the action of penicillin in these female cases. Nevertheless, this is not to suggest that the gonococcus has become resistant to penicillin. There is no bacteriological evidence of such resistance so far. It is possible that some other bacteria—a commensal in the female genital tract—may interfere with the action of penicillin against the gonococcus. The production of such a penicillinase, by this means, is conjectural and has not been proved so far.

An even more interesting phenomenon is the occasional resistance to treatment of non-gonococcal urethritis in the male. This disease is on the increase and causes much distress, since it frequently occurs in people who have been married for years and in circumstances wherein there is no suggestion of extramarital intercourse. Evidently the organism is not pathogenic to the female. Even more curious is the suspicion that the male partner seldom suffers an attack more than once. The smear of discharge on microscopical examination is found to be abacterial. The aetiology is a subject for speculation at the moment, and the most likely agent is a virus. Unfortunately, no simple laboratory technique is as yet available for staining the virus and the clinician must work largely in the dark. Last year the disease was cured by small doses of streptomycin, but recently—and particularly

during the influenza epidemic—some cases were resistant to all types of antibiotic therapy available, including that of chloramphenicol. Recourse was made to the old-fashioned methods of treatment with urethral irrigation and even with oral sandalwood oil; this proved successful.

Last year's comment regarding treatment of syphilis by penicillin, and the decision to reduce the use of arsenic to a minimum, require very little revision. It is known now that even neurosyphilis is best treated by penicillin procaine, given in daily injections as an out-patient routine. The optimum dose is ten mega units, given over a period of 10—15 days, and fever is not required. Nevertheless, congenital neurosyphilitics who come under treatment for the first time in adult life may need artificial fever in addition to penicillin. Malaria is being used to treat these patients. A rare disease elsewhere, there are many cases in this area of the country.

General practitioners throughout the county have shown their willingness to help in the treatment of syphilis. This is the case without any exception. Their kindly interest has been a source of much encouragement. It seems that in the past it was the giving of arsenic that represented the stumbling block. Weekly injections of penicillin procaine along with bismuth, given by the intra-muscular route, have caused no difficulties so far. General practitioners have been asked to help, for the most part, only those patients who live far from the Clinic and to whom travelling presents insuperable difficulties; for example, women with large families ,children attending school, cripples and such like.

As mentioned above, general practitioners are treating more cases of male gonorrhoea themselves, and using the Clinic less than they used to do. From the point of view, both of the practitioner and his patient, this is often most convenient. Nevertheless, any practitioner who reads these notes would agree that it would be wise to send the patient to the Clinic eventually. For there is more to the treatment of gonorrhoea than the administration of one penicillin injection. At the Clinic, the patient is kept under surveillance for three months to ensure that he is not incubating a concomitant infection of syphilis; and the machinery of contact-tracing is used to bring his infected partner to treatment. The method advised is that the doctor should make a smear on a glass slide, administer 300,000 units

of penicillin procaine, and advise the patient to visit the next clinic bringing his slide with him for micro scopic examination. If the diagnosis proves not to be gonorrhoea, the appropriate treatment will be given at the Clinic. With this routine, no time is lost and no mistakes are made.

Treatment of pregnant women with syphilis has been completely successful this year. No mother, so treated, has lost her baby because of syphilitic infection, and no mother so treated has given birth to a syphilitic child. At Whitehaven, two ante-natal patients suffering from early syphilis were given their penicillin course during the last week of pregnancy, and the babies were protected from the infection. If every pregnant mother in the county had a blood test taken at the fourth month of pregnancy, congenital syphilis could almost be eradicated in the county. Would the County Medical Officer of Health consider sending a circular letter to all practitioners in his area, giving the substance of these last two paragraphs?" ,

Dr. Bell then comments on the work of the clinics at the Cumberland Infirmary and the Whitehaven Hospital. The points he raises are on matters solely for the Special Area Committee to consider, but it is of interest to note that it was possible during the year to resume in-patient treatment for patients suffering from venereal diseases at the Cumberland Infirmary. Dr. Bell also refers to the work carried out by a general practitioner in Workington. This work is mainly among seamen, and is in effect a continuance of the arrangements made by the County Council prior to the National Health Service Act coming into operation.

The statistics are as follows:—

	Syphilis.		Gonorrhoea.		Non-Venereal Conditions.		Total.
	M.	F.	M.	F.	M.	F.	
Cases attending for first time ...	17	8	43	—	42	14	124
Defaulters	3	1	—	—	—	—	4
Numbers remaining on register at 31st December, 1950 ...	12	7	4	—	—	—	23

Of the 124 fresh cases in the above table, 71 were seamen. During 1949 185 out of 205 new cases were seamen. Dr. Bell points out that these figures illustrate the importance of this service in Workington.

In addition to the work among seamen on ships entering the port, a certain amount of work, which is

apparently increasing, is carried out among the civilian population.

Finally, with regard to the request by Dr. Bell that I should circulate a letter to all practitioners in the area regarding certain aspects of treatment, and particularly regarding the Wassermann examination of expectant mothers, I am considering, in consultation with Dr. Bell, with the Consultant in Obstetrics in administrative charge of the Special Area, and with Dr. Faulds, what steps can be taken to deal with this matter. I have long been dissatisfied with the present position in this respect, but the difficulty of arranging for these examinations in a scattered rural county like Cumberland is very great, and the fact that an increasing number of domiciliary confinements come under the category of doctors cases, does not make the matter any easier.

CANCER

Deaths from cancer during the year amounted to 315, which shows a very substantial fall from the previous year. Details of these deaths by age groups and sanitary districts are given below.

Cancer Deaths during 1950—By Sanitary Districts.

	Males	Females	Total
Urban Districts :			
Cockermouth	8	8	16
Keswick	2	8	10
Maryport	10	12	22
Penrith	11	9	20
Whitehaven	12	20	32
Workington	25	20	45
Aggregate of Urban Districts	68	77	145
Rural Districts :			
Alston	3	2	5
Border	26	22	48
Cockermouth	12	8	20
Ennerdale	21	23	44
Millom	10	7	17
Penrith	7	10	17
Wigton	8	11	19
Aggregate of Rural Districts	87	83	170
Whole County	155	160	315

Cancer Deaths during 1950—By Age Groups

	0-45		45-65		65+		All Ages Totals	
	M.	F.	M.	F.	M.	F.	M.	F.
Urban Districts ...	5	8	23	34	41	35	69	77
Rural Districts ...	8	6	33	25	46	51	87	82
Whole County ...	13	14	56	59	87	86	156	159
	27		115		173		315	

The hospital side of this matter is entirely one for the Special Area Committee. The Council's side is relatively small, and is confined to the provision of domiciliary nursing in cases requiring this, and to the provision of aftercare under Section 28 of the Act in respect of which, up-to-date, little or nothing has been done. It is in fact doubtful whether there is much which needs to be done, or can be done. Elsewhere in this report, reference is made to a special investigation carried out at the request of the Marie Curie Memorial and the Queen's Institute of District Nursing, the object of which was to ascertain whether cancer patients were being adequately cared for in their own homes. The period of the enquiry was short, only three months, which in my opinion was much too short for any useful information to be elicited. Arising out of some 40 cases reported on in this county *if* these could be taken as a cross-section of the group in question, the comfort and necessities of the patients seem to be adequately provided for. The main need appears to be the issue of bed linen, because, of course, in certain cases the wear and tear of bed linen for obvious reasons, is considerable. There also appearss to be one or two cases in which extra nourishment might be helpful. I shall be glad to have instructions as to whether this inquiry is to be carried further with the object of obtaining more definite and perhaps more valuable evidence.

As regards the hospital side I pointed out last year that two deep X-ray therapy plants had been installed at the Cumberland Infirmary. Treatment by deep X-ray started in June 1949.

A general picture of the work undertaken at the Cumberland Infirmary during the year follows. For these figures I am indebted to the Secretary of the East Cumberland Hospital Management Committee. The

figures include the whole work of the cancer section, and include figures other than those of the administrative county, but as these are of general interest I have also included them. One or two notes are necessary in order to make these figures intelligible. The first is that it should be clearly understood that diagnosed or suspected cases of cancer may come to any out-patient department of the Infirmary, may come direct to the cancer clinic, or direct to the radiotherapy clinic.

Number of diagnosed or suspected cancer cases attending the Cumberland Infirmary as out-patients during 1950

	First Attendances 1950	Subsequent Attendances 1950
County	318	1,726
City	218	1,095
Other Districts	117	323
	653	3,144

Number of cancer cases admitted as in-patients to the Cumberland Infirmary during 1950 with the figures for 1949 for comparison

	1949	1950
County	173	154
City	89	126
Other Districts	44	47
	306	327

The figures for out-patients for 1950 are greatly in excess of those for 1949, particularly the first attendances. These figures, of course, include as stated above, patients coming to the radiotherapy clinic which opened about the middle of the year, as well as patients coming to the general out-patient clinics, or to the cancer out-patient clinic. During 1950, 251 new cases —included in the figure of 653 above—came direct to the cancer out-patient clinic. These patients made 2,592 attendances.

Number of cases treated by radiotherapy with the figures for the half-year of 1949 given for comparison. About one third of the figures relate to non-malignant conditions.

	New		Attendances	
	1949	1950	1949	1950
Deep Therapy	88	181	745	1,698
Superficial Therapy (Mainly malignant)	57	93	80	182
Others	100	155	100	168
	245	429	925	2,048

The number of treatments given in the radiotherapy department during 1950 amounted to 3,905 compared with the figure (for six months) of 2,756 during 1949. To my mind the most important point in all these figures is that of the 3,905 treatments given in the radiotherapy department during 1950, 187 were for *superficial* therapy, and 3,718 for *deep* therapy. The reason why this is important is that owing to the resignation of the resident Senior Registrar about the time of the writing of this report, there is a possibility, I put it no higher than that, that owing to shortage of staff deep therapy may for a time, no-one can say for how long, be discontinued at the Cumberland Infirmary. This is a great blow to those of us who strove strenuously in the days of the old North of England Cancer Committee to have the Cumberland Infirmary recognised as a cancer centre. As I see it this situation, if it materialises, will involve a tremendous hardship on a great number of people from all parts of the county who are afflicted by this dread disease. These people instead of being able to get their deep therapy treatment at the Cumberland Infirmary will have to travel to Newcastle, or Shotley Bridge in Durham, for this treatment, and this, in some cases, will involve a return journey of over 200 miles. It will, I am afraid, mean that many people will feel themselves unable to make the necessary attendances, even although ambulance and sitting-case car transport is provided, as of course it will be, by the Council at very great additional expense.

One final point perhaps should be noted in respect of first attendances as out-patients. The number has gone up substantially compared with 1949, but I take this largely to mean that more patients are being sent up for investigation, and not that the disease itself is on the increase. I understand that probably a quarter of the attendances might be classified as pre-cancerous or of doubtful diagnosis.

PREVALENCE OF, AND CONTROL OVER, INFECTIOUS AND OTHER DISEASES

No epidemic of infectious disease of any significance occurred during the year. We received 28 notifications of infantile paralysis, of which 22 were of the paralytic type and 6 not paralytic.

Reference is made elsewhere to the investigations which are being carried out at the request of the Medical Research Council and Society of Medical Officers of Health in connection with the transmission of this condition.

It will be noted that there were 121 cases of dysentery notified during the year. These were all, or practically all, cases of Sonné dysentery, a condition which is apt to be troublesome in hospitals and in institutions, and occasionally in connection with canteens due to the presence of a carrier.

Apart from these two matters the notification statistics for the year call for no comment.

Two cases occurred in which there was a suspicion of possible smallpox. Both cases were immediately investigated with negative results.

In the matter of the provision and use of isolation hospital accommodation which is, of course, the province of the Special Area Committee, the adaptation of Galemire isolation hospital, or at least the first stage of this, to bring the hospital up to modern standards, was undertaken during the year. Ellerbeck isolation hospital has now been closed for infectious cases. In the east of the County the provision of cubicles in the isolation block at the Cumberland Infirmary (formerly Crozier Lodge) is proceeding. The provision of cubicles in isolation hospitals makes the accommodation in these hospitals much more valuable and enables, under proper precautions, cases other than infectious to be admitted.

It is obviously undesirable, at a time when the number of hospital beds is inadequate to meet the demands, to leave isolation hospital beds empty waiting for cases of infectious disease requiring hospital accommodation which are now relatively small in number.

It is now generally recognised that the great majority of the cases of scarlet fever can safely be looked after at home.

Now that diphtheria has practically ceased to exist as a factor of importance, and the same may be said of puerperal sepsis, the demand for isolation hospital accommodation is not a fraction of what it used to be. I am, of course, still firmly of the opinion that many

more cases of whooping cough and measles, especially when complicated with broncho-pneumonia, should be admitted to isolation hospitals, than are in fact admitted, and the same is true, perhaps even more true, of infantile diarrhoea.

The day of the antiquated fever hospital is gone, or is going, and the greatly reduced number of beds now being provided on a cubicle basis, will be able to do much better work, and to admit a much wider variety of infectious disease than was the case until quite recently.

How marked the change has been, is made clear by looking up a report issued round about 1935. I find at that time there were eleven infectious diseases hospitals in the geographical county, with a possible complement of about 225 beds, available for county patients. To-day in the whole of the Special Area there are only four isolation hospitals, or isolation blocks receiving infectious cases, because, in addition to the closure of Ellerbeck infectious diseases hospital, Ormside infectious diseases hospital in North Westmorland, has also been closed during the year, and even the four hospitals refered to are not restricted to the admission of infectious cases as commonly understood. Some of the beds are being used for pulmonary tuberculosis, or for other purposes, which of course is obviously more sensible than leaving them empty.

As a matter of interest I set out below the records of deaths from the commoner infectious diseases in respect of the past few years:

Scarlet Fever.

In 1945	there were	369	cases	with	0 deaths.
In 1946	„ „	152	„	„	0 deaths.
In 1947	„ „	150	„	„	0 deaths.
In 1948	„ „	189	„	„	0 deaths.
In 1949	„ „	182	„	„	0 deaths.
In 1950	„ „	280	„	„	0 deaths.

Diphtheria.

In 1945	there were	69	cases	with	2 deaths.
In 1946	„ „	73	„	„	2 deaths.
In 1947	„ „	8	„	„	1 death.
In 1948	„ „	13	„	„	0 deaths.
In 1949	„ „	2	„	„	0 deaths.
In 1950		Nil.			

Enteric Fever.

In 1945 there were Nil.
In 1946 „ „ 2 cases with 1 death.
In 1947 „ „ Nil.
In 1948 „ „ 1 case with 0 deaths.
In 1949 „ „ Nil.

Measles.

In 1945 there were 2 deaths.
In 1946 „ „ 0 deaths.
In 1947 „ „ 3 deaths.
In 1948 „ „ 3 deaths.
In 1949 „ „ 5 deaths.
In 1950 „ „ 0 deaths.

Whooping Cough.

In 1945 there were 5 deaths.
In 1946 „ „ 4 deaths.
In 1947 „ „ 3 deaths.
In 1948 „ „ 5 deaths.
In 1949 „ „ 8 deaths.
In 1950 „ „ 2 deaths.

Infantile Diarrhoea (including gastritis and enteritis).

In 1950 there were 12 deaths under 1 year of age.

NOTIFICATION OF CASES OF INFECTIOUS DISEASES IN THE COUNTY OF CUMBERLAND DURING THE YEAR 1950.

District.	Scarlet Fever	Whooping Cough.	Dip.	Measles.	Pneu-monia.	Acute poliomyelitis. Paralytic.	Acute poliomyelitis. Non-paralytic.	Acute encephalitis. Infective.	Acute encephalitis. Post infectious.	Dysen-try.	Erysip-elas.	Chicken Pox.	Enteric Fever.
URBAN DISTRICTS.													
Workington	68	27	—	79	13	5	—	—	—	12	5	61	—
Whitehaven	14	26	—	1	17	1	1	—	—	2	4	—	—
Cockermouth	2	1	—	—	—	1	—	—	—	—	—	—	—
Keswick	2	—	—	7	—	1	—	—	—	—	—	—	—
Maryport	16	2	—	12	—	—	—	—	—	—	—	—	—
Penrith	9	89	—	219	13	1	—	—	—	42	2	—	—
RURAL DISTRICTS.													
Alston	4	4	—	23	7	4	2	—	—	—	—	38	—
Border	46	58	—	42	9	3	—	—	—	12	1	5	—
Cockermouth	32	20	—	11	[illegible]	3	1	—	—	—	1	—	—
Ennerdale	42	55	—	52	24	2	2	—	—	12	—	—	—
Millom	2	44	—	13	6	1	—	—	—	1	5	—	—
Penrith	18	87	—	85	16	—	—	—	—	40	3	—	—
Wigton	25	84	—	75	17	—	—	—	—	—	4	—	—
Totals	280	497	—	619	129	22	6	—	—	121	25	104	—
1949	182	447	2	657	158	31	—	2	—	—	48	—	—
1948	189	622	13	2362	114	7	—	—	—	—	49	—	1
1947	150	286	8	1960	147	74	—	—	—	—	41	—	—

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. No epidemic of food poisoning of any significance occurred in the county during the year under review.

Milk

Last year, I reviewed at considerable length the changed position in regard to the supervision of milk supplies, arising out of recent legislation. I referred to the conferences which had taken place, first at officer level, between the County Council, local sanitary authorities, the Ministry of Agriculture Executive Committee and the laboratory services, and later, at member level between the County Council and the local sanitary authorities. The recommendations of these conferences summarised, were as follows:—

(1) that sampling for cleanliness so far as the County Council is concerned, should be suspended for the present.

(2) that sampling for tubercle should be discontinued in respect of tuberculin tested and attested herds.

(3) that testing for tubercle in respect of accredited and ungraded herds (the milk from which is consumed in the county and is not pasteurised), should be undertaken twice a year.

(4) that the County Council should seek the co-operation of the local sanitary authorities in the carrying out of (3).

(5) that sampling records should be interchangeable between the Ministry of Agriculture, the County Council and the local sanitary authorities, on request.

The important and operative recommendation is, of course, (3).

The basis of these recommendations is fairly obvious. The supervision of *cleanliness* of milk supplies is now the duty of the Ministry of Agriculture, and is largely on a commercial or production basis,

rather than on a public health basis. The sampling of milk from tuberculin tested and attested herds has been discontinued, because of their very nature. The milk from these herds ought, with the rarest exceptions, to be tubercle free. The real problem lies in the supervision of herds of a lower grade—that is accredited and ungraded—from the tubercle angle, to ensure that milk from these herds which, without being pasteurised, is consumed in the county, does not constitute a danger to the population, and especially to the child population.

The amount of milk so consumed in the county without protection and usually on small local milk rounds, is considerable. There were in the county at the end of 1950 some 1,800 ungraded producers and 95 accredited producers, none of which are included in the attested herd group. It is estimated that of the above, some 800 distribute milk in the county on small milk rounds without previous pasteurisation. The target for sampling is therefore fairly clear; it is in fact approximately 1,600 biological samples annually. These proposals, for reasons which need not be gone into here, did not come into effective operation until July, 1950, although the nominal date for starting the scheme was May 1st. We are therefore dealing statistically with a half-year, and in the half-year, there should have been taken some 800 samples in respect of tubercle, from the type of herd indicated above. The actual position to the end of the year of samples taken for biological examination was as follows:—

Sanitary District	Estimated approximate number of ungraded and accredited herds involved.		Quota of samples not to be exceeded per month		Number of samples actually taken July to December, 1950.
Rural.					
Alston	28	...	10	...	1
Border	165	...	30	...	66
Cockermouth	152	...	30	...	31
Ennerdale	34	...	10	...	68
Millom	99	...	20	...	9
Penrith	164	...	30	...	1
Wigton	114	...	20	...	119
Urban.					
Cockermouth	6	...	—	...	6
Keswick	5	...	—	...	8
Maryport	8	...	—	...	28
Penrith	nil	...	—	...	nil
Boroughs.					
Whitehaven	10	...	—	...	26
Workington	13	...	—	...	25
	—	...	—	...	—
	798				388
	—	...		...	—

The situation revealed by the above table cannot, with the best will in the world, be described as other than "patchy," and it may well be that the health committee would desire the council to approach one or two of the authorities with the object of increasing the volume of sampling. It is obviously illogical that 119 samples should have been taken in one large rural district and only one in an adjoining rural district of similar size. In one important district, no sampling has been undertaken since August, up to the time of writing this report. I am well aware that there are many reasons for these patchy results—illness is one reason, shortage of staff is another, pressure of other duties is a third. This work of milk sampling is not easy. It means scouring the countryside either at unearthly hours of the morning or after working hours at night, and nothing I have said implies criticism of anyone. Nevertheless, the position cannot be regarded as satisfactory *and this is one point to which I would direct the especial attention of the health committee.*

Now as to results. Out of the 388 samples taken, only two were positive for tubercle, that is approximately .5 per cent. This is an astonishing figure, because for many years the results of sampling for tubercle, which used to be confined largely to designated herds (tuberculin tested, attested, and accredited) never fell below .7 per cent. and, on the average, were approximately 1.2 per cent. positive for tubercle. It is all the more astonishing because there is no check on the intake to ungraded and accredited herds. A cow may be, and no doubt often is, thrown out of an attested herd through failing to pass the test, and is passed into the open market, the ultimate destination in all probability being an ungraded herd. One would therefore have expected the incidence of tuberculosis to be higher in ungraded herds than in the other groups, but events have proved the contrary, so far as sampling is concerned. Attention is however, drawn to the findings of the *clinical* inspection of dairy herds which follow.

Unfortunately the Milk and Dairies Regulations, 1949, made under Sections 20 and 92 of the Food and Drugs Act, 1938, as amended by later acts, completely eliminates any mention of county councils as authorities to be supplied with information regarding tuberculous milk. This information is now only supplied to local sanitary authorities, presumably for the purpose of section 20 of the above regulations. Whether sanitary authorities do in fact use their powers under this Section, I do not know. That is not our concern, but it is regrettable that information regarding tuberculous milk need not be sent to county councils, who are primarily the authorities responsible for controlling the safety of school milks. As a purely local arrangement and through the courtesy of the Divisional Inspector of the Ministry of Agriculture, however, I do know the history of the two cases mentioned above, in which samples of milk were found to contain tubercle. One cow suffering from tuberculosis of the udder was detected and slaughtered from each of the herds concerned.

It is satisfactory to note that no tubercle was found in any school sample during the year, but while on the subject of school milks, I would like to say that

with regard to recommendation (5) of the conferences, dealing with the interchangeability of information, this, with the above exception, seems to be more or less a dead letter. Whether our school milks are clean or dirty, I do not know.

I am also indebted to the Divisional Inspector for the following figures relative to the results of inspection of dairy herds, and also to the number of cattle which have been slaughtered under the Tuberculosis Order in the county during the year:—

Number of confirmed cases of tuberculosis 62

Clinical Inspection of Dairy Herds

Class of Herd.	No. of Herd Inspections.	No. of Cattle Examined.	No. of Cattle dealt with under the Tuberculosis Order.
Tuberculin Tested	950	50,968	3
Accredited	79	2,241	4
Ungraded	1,947	32,805	55

Tuberculin Testing of Tuberculin Tested Herds

No. of cattle tested	65,503
No. of reactors found	310

Pasteurised Milk

There are three pasteurising plants in operation in the administrative county, one at Egremont and two in Millom, one of which was licensed for the first time during the year. Sampling is carried out through the co-operation of the sanitary inspectors of the respective district councils, and for their co-operation we are grateful. Forty-three samples have been taken and submitted to the phosphatase and methylene blue tests. Of these, forty-one were satisfactory and two unsatisfactory. Of the forty-three samples, four, being school supplies, were submitted to a biological test for tubercle, and all were negative.

County Milk and Dairies Advisory Committees

The County Milk and Dairies Advisory Committee, to the functions of which I referred last year with a certain amount of criticism, has not yet met, and, in fact, does not seem to have been appointed.

HOUSING

I am indebted to the County Architect for these notes :—

" Although the County Council is not a Housing Authority, it is becoming a house-owner on an increasing scale. During the last few years the Council has taken over a number of houses from the former Voluntary Nursing Association and there have also been houses included in the estates around mansions which have been acquired for other County purposes. Sometimes, as at Carleton Hall, a proportion of the cottages are in such poor structural condition that they would in normal times have been scheduled for demolition. There are further instances, such as the cottages overlooking Eamont Bridge, whose only asset is perhaps their picturesque grouping in close proximity to the bridge which has been scheduled as an ancient monument.

" In addition to these comparatively recent acquisitions there are a number of houses chiefly acquired for the Education Committee or the Police Committee, but not in every case still occupied by the official for whom they were originally intended. Cases in point are where schools have been closed and the former school house is no longer required for the head teacher of the school for whom it was originally built. A recent review of the provision of school houses has shown a total of 70. Not all these houses are occupied by the headmaster, but have sometimes been let to other teachers, to the school caretaker, or to private individuals; nor do these figures pay any regard to either voluntary controlled schools or voluntary schools.

" To the above two classes must now be added the Post-war Building Programme which is well under way, and this is reviewed below under specific Committees.

Health Committee.

" As the result of enquiries made to Local Authorities to see to what extent they would be able to provide houses for nurses out of their allocations, it has emerged that in something like 18 cases it is probable that the County Council will have to provide the house. There may be additions to this list as four Local Authorities still have the matter under consideration; one has offered accommodation for the time being, and three

Local Authorities may be in a position to provide houses. Of the above requirements, the tender has been let for one house at Bewcastle, but the start of building operations has been delayed by severe weather conditions. In three other cases negotiations for the sites are already under way.

Fire Brigade Committee.

" At Workington twelve houses for firemen and one for the Fire Officer are under consideration on a site immediately adjacent to the Fire Station.

Police Committee.

" Of the post-war programme, thirty-four houses have been completed and are in occupation; twenty-two are building, and work will be started during the current year on a further forty-one.

Education Committee.

" The present holding is 70 houses, but there will be caretakers' houses at some of the new schools; approval has been received in the case of Maryport School; and also for a flat in the original mansion at Lairthwaite, Keswick.

Children's Committee.

" At the Millhouse Remand Home two houses are at present being built to accommodate the Assistant Superintendent, and the Handyman/Gardener, with their families.

Joint Agricultural Committee.

" The programme of houses for the agricultural workers at Newton Rigg has now been completed with four more houses, making a total of eight built since the war, and in addition to the five already existing over and above the Principal's house.

County Property Committee.

" Six of the houses for the County Council's own staff have been completed at Scotby and are in occupation; twelve more are being built at the present time at Wetheral on a small estate together with ten houses for the Border R.D.C. Sites for four houses at Whitehaven and four houses at Workington are in process of being acquired, and it is hoped that building operations will be started during the year. These staff houses were

specifically designed for the low-income group members of the staff, usually young married couples with a small family. The Committee, bearing these requirements in mind, and the fact that no housing subsidy was available so that an economic return on the capital invested must be reflected in the rent, obtained permission to build houses of 780 sq. ft., that is 245 sq. ft. less than the minimum then permitted under the Ministry of Health standards. In occupation, the tenants have not found this restriction a hardship and expressed satisfaction at their comfort. It is interesting to note that the recent nation-wide competition organised by "The Builder" has been won by a design where the area is 781 sq. ft. There has been widespread feeling amongst architects that comfortable and adequate houses can be erected of a smaller total floor area than 1,000 sq. ft. and this is now reflected in the advocacy by the new Minister of Local Government Planning of one and two bedroom houses."

WATER AND SEWERAGE SCHEMES

(A) Water

Major Schemes.

(1) North Cumberland Water Board—Caldewhead Scheme :

The hope that the Board's revised scheme might receive Ministerial approval during the year and that in consequence work on the scheme might commence at an early date has not yet been fulfilled.

The revised and reduced scheme to supply 2,750,000 gallons per day to Cockermouth, Maryport and Penrith U.D.C.'s and to the Border, Cockermouth and Penrith R.D.C.'s, at an estimated cost of £750,000, was submitted, in full detail, to the Ministry in May, 1950. Later, at the Ministry's request, applications for grant were made by Maryport U.D.C. and by Border and Penrith R.D.C.'s under the Distribution of Industries Act, 1945, and the Rural Water Supplies and Sewerage Act, 1944, respectively.

In January, 1951, the Minister of Health informed the Water Board that, having consulted the President of the Board of Trade and the Minister of Agriculture, he was of the opinion that the expenditure of the order

proposed could not be regarded as urgent, necessary or justified for either industry or agriculture and that he had come to the conclusion that in these circumstances he would not be warranted in authorising the execution of the work.

The Board decided unanimously to make a new approach to the Minister of Local Government and Planning, who was then taking over Ministerial responsibility for water supplies.

The Board now hope that the new Minister will see his way to enable an early commencement of the revised scheme, which would provide adequate supplies of water for the domestic, agricultural and industrial needs of North Cumberland.

The area of the Board has, throughout the year, continued to suffer from serious and increased water shortages.

(2) Ennerdale Scheme.

Work on the revised scheme has been in progress during the year.

Representatives of the Whitehaven Corporation, Ennerdale Rural District Council and the County Council have discussed the question of the use and distribution by the Rural District Council of their water resources, including water to be obtained from the revised Ennerdale Scheme. It is not anticipated, however, that any bulk supplies from the scheme will be available for distribution in Ennerdale Rural District before the summer of 1952.

Local Schemes.

(a) New Schemes.

During the year four 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 Rural District	2
Ennerdale Rural District	1
Penrith Rural District	1

The estimated cost of the above four schemes is £96,326. In all these cases the County Council were of

the opinion that the schemes appeared sound and adequate, subject to a small number of modifications suggested by the County Engineer being incorporated in the schemes.

With regard to the scheme submitted by the Ennerdale Rural District Council, as the estimated cost of the scheme is only £650, the Minister of Health decided that he would not be justified in making a grant in this case. The other three schemes are still under consideration by the Minister.

(b) GRANTS.

Information was received from the Minister that grants totalling £9,450 would be paid in respect of five schemes submitted by the following District Councils :—

Border Rural District Council ...	£2,000	(1)
Cockermouth „ „	£650	(1)
Millom „ „ „	£6,600	(2)
Wigton „ „ „	£200	(1)

The County Council decided to pay a grant equivalen to that of the Minister in the cases of the Border, Cockermouth and Wigton Schemes and in the cases of the Millom schemes, to make grants equivalent to one half of the net cost of the schemes (i.e. cost less Ministry grant). The total grant payable by the County Council would therefore be £6,494. The Minister decided that he would not be justified in making a grant towards the cost of the Egremont Trunk Main Diversion as he considered the work to be a replacement of an existing worn-out main. There would also be no grant in respect of the Ennerdale Rural District's Parton Scheme.

(c) COMPLETED SCHEMES.

The following three schemes were completed during the year and arrangements were made for the payment of the County Council grants totalling £2,950.

Cockermouth Rural District	—	Rosthwaite
„ „ „	—	Holme Beck, Loweswater
Border „ „	—	Cotehill

(B) Sewerage

(a) NEW SCHEMES.

Eight new schemes were submitted by the following Rural Districts for the observations of the County Council under the Rural Water Supplies and Sewerage Act, 1944.

These were as follows :—

Border Rural District	...	...	1
Cockermouth „	...	...	1
Penrith „	...	...	6

The estimated cost of these schemes is £61,743. This is a considerable increase over the number of schemes submitted last year, when only one new scheme was submitted for the Council's observations.

Seven of these new schemes were considered to be sound and adequate without any further observations.

In the case of the remaining scheme, High Hesket, two alternative proposals were submitted, one scheme costing £6,900 provided for a discharge to Wilson Beck. The alternative to this was a gravitational scheme discharging to an irrigation area West of the village costing £5,200. Both schemes were considered by the County Council, and it was finally decided that the Penrith Rural District Council should decide which scheme they wished to put forward to the Ministry. It was, however, suggested to the Penrith Rural District Council that the gravitational scheme might be more appropriate at the present time.

All these schemes are still under consideration by the Minister and no information has been received regarding the payment of grants..

(b) GRANTS.

Information was received during the year that grants totalling £8,500 would be made by the Minister of Health in respect of four schemes submitted by the Border Rural District Council. In all these schemes the County Council decided to make a grant equivalent to that of the Minister.

Three schemes submitted by the Border and one by the Ennerdale Rural District Council were refused grants by the Minister, and, in view of this, the County Council were unable to give financial assistance towards the cost of these schemes.

(c) Completed Schemes.

The following five Cockermouth Rural District schemes were completed and arrangements were made for payment of the County Council grants amounting to £6,668 :—

(1) Great Clifton.
(2) Grange.
(3) Parish of Gilcrux—Greengill Scheme.
(4) Parish of Plumbland—Ellen Villa Scheme.
(5) Wardhall Guards Scheme.

Summary.

Grants totalling £17,950 have been made by the Minister during the year in respect of nine Sewerage and Water schemes. This shows a considerable increase in the amount of grants for the previous year.

LABORATORY SERVICES

We are fortunate in having at the Cumberland Infirmary, as has been noted in previous reports, a dual purpose laboratory, doing public health work for the local authorities, clinical pathology for hospitals and general practitioners, and examining and reporting on milk and water samples sent in for bacteriological or chemical investigation. Dr. Faulds, the Pathologist in charge, is a tower of strength, and we are greatly indebted to him and to his staff for advice in many difficulties.

Our chief contact with the laboratory on any large scale is in connection with the examination of milk samples for tubercular infection. A good deal is said about this in the Milk Section of this report.

I am afraid that the change over from the old order, under which the laboratory examined some thousands of samples for milk cleanliness and a lesser number for tubercle, to the new order, which as far as we are concerned deals with tubercle only, caused considerable inconvenience to the laboratory. The start of the new set-up as regards tubercle, was necessarily somewhat delayed, and negotiations took some months, and the question of the supply of guinea pigs for inoculation

presented a real difficulty. I hope, now that milk sampling for tubercle has settled down on the new basis fairly satisfactorily, that these difficulties will not recur. All this work is done for us by the laboratory without charge, except in respect of the examination of samples of pasteurised milk, which are our liability.

No major epidemic occurred, although sporadic cases of infantile paralysis cropped up here and there over the county. Sonné dysentery has been present intermittently in hospitals and other institutions, and the appropriate bacteriological investigations were undertaken. There has been no occurrence of food poisoning of any significance.

Dr. Faulds has given me statistics showing the units of work undertaken during 1950 under various headings, and also showing the comparison on a summary basis between 1949 and 1950. These figures cover of course the whole field of the laboratory's work, and only a fraction relates to the County Council, but the figures are interesting, and therefore I have included the table as received.

PATHOLOGICAL DEPARTMENT, CUMBERLAND INFIMARY, CARLISLE.

Number of Specimens received during 1949 and 1950

Year	Milks	Post-Mortems	Pathological Specimens	Total
1949	3,877	357	21,777	26,011
1950	639	460	25,834	26,933

Units of work done during 1950

	Pathological Specimens		Waters			
	Public Health	Hospitals & General Practition's	Bacterio-logical Examinat'ns	Chemical Analyses	Milks	Post-Mortem Investiga-tions
Jan./Mar.	7556	37519	414	648	977	2212
Apr./Jun.	7335	39053	428	607	1336	1893
Jul./Aug.	6845	38764	708	668	5106	1390
Sep./Dec.	8769	43858	306	430	2426	2614
Total	30505	159194	1856	2353	9845	8109

Total Number of Units = 211,862

AGENCY ARRANGEMENTS

These are gradually fading out.

1. The agency arrangements with the Cumberland Nursing Association, which was by far the biggest, terminated at the end of March, 1950.

2. At the time of writing, the agency arrangements with the Penrith Nursing Association continue in a very modified form.

3. The agency arrangements with the Cumberland and Carlisle Mental Welfare Association lapsed at the end of 1949.

4. The arrangements 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 and their children, continue.

5. The Carlisle Workshops for the Blind continue to act as our agents in respect of the care of the blind under the National Assistance Act.

6. While not in any sense an agency, the Council have exercised their powers under the National Assistance Act, 1948, to contribute to the funds of the Diocesan Mission for the care of the Deaf and Dumb.

7. With regard to the ambulance and sitting case car service, the British Red Cross Society continue to give valuable help in the transport of patients through the hospital car service.

8. One or two of our ambulances are still operating under agency arrangements with voluntary committees, although the vehicles are now all the property of the County Council.

9. Domiciliary nursing in the Alston area, excluding Nenthead, continued during the year to be undertaken by the Nursing staff of the Alston Cottage Hospital under an agency arrangement with the East Cumberland Hospital Management Committee. At the time of writing, this arrangement is about to terminate.

The above agency arrangements, in so far as they still continue, have been made with the co-operation of the voluntary bodies concerned, for the benefit and convenience of the County Council.

From the opposite angle, we, on our part, have placed at the disposal of the Special Area Committee in respect of the chest service, the services of certain of our medical officers, together with the use of certain dispensary premises. With the development of the chest service in East Cumberland, to which reference is made elsewhere, these arrangements terminated during the year in respect of the Wigton and Border rural districts, and in West Cumberland although we still provide the premises at Workington, the actual clinical work formerly undertaken by our tuberculosis officers at Workington and Maryport, is now undertaken by officers of the Special Area Committee.

At Penrith, Cockermouth, Cleator Moor, Egremont and Millom, the agency arrangements continue for the time being, and our medical officers undertake the clinical work. At Whitehaven, we provide the premises, but the medical officer is appointed by the Special Area Committee.

In the course of time, as additional chest centres in West Cumberland are established, and as additional specialist staff is provided by the Special Area Committee, the bulk of the present arrangements will cease, although I think that the arrangement at Millom is likely to continue permanently, and this may also apply to Penrith. The decision is not in our hands.

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.

NATIONAL ASSISTANCE ACT, 1948

The period of twelve months from the 1st April, 1950, to the 31st March, 1951, covered in the main by this report, was the third year of the exercise of the Council's functions under the above Act. The characterestic feature of this period was a firmer consolidation of the measures which had been taken since July, 1948, to establish the new system of welfare services in the County.

Housing and Part III. Residential Accommodation

In making provision for old people under the Housing Acts, the primary object is to enable them to live normal and independent lives for as long as possible in their own homes. Housing Authorities should therefore plan housing accommodation for old people as part of their programmes of house building as a whole. The Housing Manual 1949 recommends that accommodation for aged persons should be provided in self-contained dwellings in either one or two-storey cottages, two-storey blocks of flats, or on the lower floors of higher blocks

The time may come, however, when, even with the help of the man social facilities now provided by welfare and other authorities, the old people can no longer look after themselves, and it is at this stage that they will be in need of that care and attention which the County Council will provide under the National Assistance Act. Accordingly transfers from home to hostel life should be made with the least possible change from familiar surroundings.

During the course of the year, further properties in Cumberland have been inspected with a view to their purchase and adaptation as hostels for old people in need of care and attention, but, owing to size and/or situation, they have regrettably had to be turned down as unsuitable. Residents must be happy as well as comfortably housed, and much of their happiness will rest on the extent to which they can regard themselves as forming part of the community in and around them.

Hostels should therefore be established in a friendly and welcoming neighbourhood within easy access of churches, shops and entertainments, and with

fairly good transport to make visiting by, and to, relatives and friends reasonably possible. This does not mean that all hostels should be sited in town areas. Village life has its appeal as well as town life, and if hostels are established in rural areas, easy public transport facilities to the nearest town centre (which should not be too far distant) should be available, or some alternate provision made.

The housing needs of old people (including the disabled), which cannot be fully met by the type of accommodation normally provided by housing authorities, has now been taken a stage further by the issue by the Ministry of Local Government and Planning of a supplement to the 1949 Housing Manual, dealing with "Housing for Special Purposes," which will be welcomed by local authorities as giving information, for the first time, of long-term standards recommended for disabled and old people's residential hostels. This publication, which would seem to complete the long process of getting the post-war housing programme into balance, deals not only with hostel services for those in need of care and attention, but touches on such important communal services as meals, heating, laundry, supervision and social facilities. It gives local authorities the wey-note on which to prepare plans (not necessarily of a standard type) for the modern hostel of the future, and contains many valuable recommendations which, in relation to the disabled and the old people, will need the careful study of County and District Councils.

On the basis of the estimated number of aged, infirm and handicapped persons in the administrative county for whom residential accommodation may have to be provided, it is estimated that some 13 to 20 hostels will be required to replace completely the Public Assistance Institutions which now provide residential accommodation under the Act. Not all residents are, however, suitable for hostels, and continued provision for these persons in the Institutions has to be envisaged with a consequent reduction in the final number of hostels which will be required.

The alterations to Grange Bank, Wigton (to be used as a hostel for 16/17 residents) are nearing completion,

and this, the first of County hostels for old people, should be in use in the very near future.

The report of the Housing Manual Sub-Committee now gives a note of general standards and other information on hostels, and it will now be possible to prepare plans which, subject to Ministry approval, can be held in readiness for the time when permission to build is given.

Hostel Provision for Short-term Cases and as a Holiday Centre.

In the last report reference was made to the need for a hostel for old people in need of care and attention for short periods when relatives or other persons looking after them were unable, owing to their own temporary illness or absence on holiday, to continue their arrangements, or make other arrangements, for the care of the old people. It was indicated that such a hostel might well be the means of encouraging persons to continue to look after their ageing relatives and thereby avoid applications which might otherwise be made for the admission of the relatives permanently to Part III. Accommodation. Such a hostel suitably sited in a coastal district of the county could also be used as holiday accommodation for Part III. permanent residents, and thus avoid the need of having to go outside the County for accommodation and facilities. It may be mentioned that a number of old people from Part III. Accommodation were recently sent for a week's holiday to the seaside in Northumberland under the arrangements for early and late season holidays at reduced charges. The holiday was greatly appreciated.

The County Council has approved the principle of a short-term hostel, and if a suitable property does not present itself for acquisition and adaptation, it will now be possible to proceed with the preparation of plans for a new building.

Present Accommodation and Hospital Facilities for Chronic Sick

Part III. Residential Accommodation is at present provided in three establishments, attached to which are small hospitals or sick ward blocks catering in the main for the chronic sick, together with a small

maternity unit of three beds and three cots at Meadow View House, Whitehaven. The three establishments are:—

Establishment.	Number of Beds. Part III. Accommodation.			Hosptial.		
	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 establishments prior to 5th July, 1948, was for other than hospital purposes, they remain wholly 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 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 5th July, 1948.

The modernisation and improvement of Part III. Accommodation existing in July, 1948, and the amenities therein provided, has proceeded on normal lines during the past year, and the results have been favourably commented upon by Ministry officials.

A chiropodial service, under which visiting chiropodists will, as from 1st April, 1951, attend periodically and provide treatment within reasonable limits to residents in Part III. Accommodation who may be suffering from foot troubles, has been introduced.

Two Committees (the Northern and Southern Area House Committees) are responsible to the Welfare Committee for the day to day management of the Part III. Accommodation and separate accommodation reserved for the use of the Regional Hospital Board.

The following tables shows the number of admissions, discharges and deaths during the twelve months ended 31st March, 1951:—

	Station View House, Penrith.			Highfield House, Wigton.			Meadow View House Whitehaven		
	Part III.	Hosp.	Total.	Part III.	Hosp.	Total.	Part III.	Hosp.	Total.
Admissions ...	22	54	76	69	114	188	178	215*	393
Discharges ...	21	19	40	71	63	134	184	120	304
Deaths ...	—	32	32	—	47	47	—	101	101
Residents and Patients maintained on 31/3/51 ...	32	31	63	56	37	93	145	78	223

*Included in this figure are 22 births.

Due to lack of nursing staff it has been necessary, to a small extent, to restrict the admission of patients to the reserved accommodation at Penrith. Generally, and throughout the year, requests from general practitioners and general hospitals for beds for chronic sick cases could not always be met, with the resultant preparation of a waiting list, a position hardly ever encountered in the years prior to 1948. Efforts to obtain nursing staff by advertisement and through the agency of the Nursing Appointments Office of the Ministry of Labour and National Service, have been practically unproductive. The difficult position was brought to the notice of the Special Area Committee, who were asked if there was any way in which they could help in securing the necessary nursing staff. The Committee were also asked to consider whether an arrangement could be made whereby nurses in training at hospitals in the county could be transferred for temporary duty in chronic sick hospitals, and replaced at periodical intervals of say three months. The position has not yet been finally resolved.

Unless some such arrangement can be made whereby some part of a nurse's training period can be spent in hospitals catering for the chronic sick, it would seem that in the none too distant future, and apart from a Matron (S.R.N.) and perhaps one or two fully trained nurses, the nursing staff in chronic sick hospitals will consist of untrained women who, in some cases, have a vocation for nursing but are not prepared to undertake training so as to secure a recognised qualification.

This difficulty in securing trained nursing staff may or may not be peculiar to Cumberland, but it is nevertheless a fact which cannot easily be turned aside if an efficient nursing service for the chronic sick is to be maintained.

Charges for Accommodation.

In accordance with the provisions of Section 22 (2) of the National Assistance Act, 1948, the County Council fixed 58/4 per week as being the standard charge in respect of all Part III. Residential Establishments. This rate, which operated from 1st October, 1950, remains in force until reviewed by the Committee after considering the costing statement for the financial year ended 1st March, 1951. During the year ended 31st March, 1951, and with the exception of 17 residents who have paid for their accommodation, etc., at rates between the minimum charge of 21s. per week and the standard charge, the remaining residents have made payments at the minimum charge, the total payments by residents in all three establishments during the year to 31st March, 1951, amounting to £12,856. In a few cases only did the respective Area House Committees find it necessary to write off small outstanding amounts as irrecoverable.

Monetary Recompense to Residents Rendering Assistance.

Residents who voluntarily give a substantial measure of regular assistance in the running and maintenance of Part III. accommodation may have their accommodation charges waived up to a maximum of 10s. 6d. per week for such period as the House Committees may decide. The anomalous position that payments cannot be waived under Section 23 (3) of the Act in respect of services rendered in hospital accommodation, still remains, and any payment made by a Hospital Management Committee to Part III. residents giving such services, must be taken into account in assessing the resident's ability to pay for his or her Part III. accommodation. As previously stated, and in the case of establishments where there is joint user by the local authority and the Regional Hospital Board, it is unfair that there should be this discrimination between persons giving assistance in the Part III. section and

those giving similar assistance in the hospital section. The position is, however, in complete accord with the the provisions of the National Assistance Act, and must be accepted until amending legislation is introduced.

At the end of March, 1951, 37 male and 20 female residents were reciving remissions of 2s. 6d. or 5s. per week, having regard to the measure of regular assistance given. The total remissions or reduction in collections amounted to £9 17s. 6d. per week, or after the rate of approximately £514 per annum. The position in each case is reviewed monthly by the Area House Committees, when consideration is also given to new or other cases qualifying for inclusion within the arrangement.

Medical Attention for Residents.

General medical supervision of the Part III. Accommodation is undertaken by the former Medical Officers, who are also responsible for the treatment of patients in the accommodation reserved to the Regional Hospital Board.

Residents have the right and freedom to select their own doctor, as if they were living in their own homes, and the matter of the capitation fee payable to the doctor lies between himself and the Executive Council appointed under the National Health Service Act, 1946.

Residential Accommodation Provided by Voluntary Organisations.

The arrangement with the Carlisle Diocesan Council for Social and Moral Welfare, whereby residential or temporary accommodation is made available in their establishment at Coledale Hall, Carlisle, for a like purpose as that provided by the County Council under the Part III. provisions of the Act, continues to operate. It is of value to the County Council to the extent that persons concentrating on Carlisle from the county area, and for whom the County Council may be under an obligation to provide accommodation, may, in case of necessity, be provided with such accommodation by the Diocesan Council. The arrangement is reviewed each year on the basis of records kept by the Diocesan Council of county cases received into Coledale Hall.

Welfare of the Old People in General—Voluntary Effort.

Public concern for the welfare of old people has increased very much in recent years. This is partly due to the fact that longer expectation of life and a low birth rate are increasing the proportion of old people in the population. Whilst in 1948 about one person in eight was of pensionable age, it was anticipated that within 30 years the proportion would rise to one in six. Concern is also due to the realisation that shortages of houses, food, fuel, hospital accommodation, nurses and home helps bear specially heavy on old people.

Increased Old Age Pensions and supplementations thereof by National Assistance have not solved the problems of the aged. The National Assistance Act envisages not merely a service limited to defined statutory provisions for the aged poor, but a wide field of welfare services for the aged as a whole, and where, concurrently with the statutory provisions, voluntary effort and services of a more personal kind could be provided by workers actuated by a spirit of good neighbourliness.

Personal visiting of the aged in their own homes lessens that sense of loneliness often felt by many old people. Assistance in shopping, the exchange of library books, the service of " meals on wheels," and the provision of clubs and other services of a non-statutory nature, are avenues in which voluntary effort can play a useful part and add materially to the comfort and happiness of people in their old age.

With the support and encouragement of the Ministry of Health, the establishment of Old People's Welfare Committees on a voluntary basis has been pressed forward, and in January, 1951, there were 517 such committees in the country, with county committees in 36 counties.

On the initiative of the National Old People's Welfare Committee, and with the co-operation of the County Council, a Cumberland Old People's Welfare Committee (consisting of representatives of local authorities, voluntary organisations and other interested bodies) was formed in October, 1949, in an effort to promote the general good of old people in the county, and the introduction of personal services of the kind mentioned above.

Surveys as to what was being done in various parts of the county in the provision of clubs, meals, organised visiting, cheap holidays, etc., have been undertaken, and consideration given to the establishment of local committees to further advance, in their respective areas, the objects of the county committee. Matters under general discussion have ranged from clubs, meals, visiting, chiropodial services for old people in their own homes, laundry work, sick visiting and assistance in households, holidays and other personal services, to the establishment of geriatric units.

On the question of services for old people, the matter of hot mid-day meals can be placed about third in importance, "visiting" and "assistance in households" being placed respectively as first and second. A "meals on wheels" service was at one time operated in Workington by the W.V.S., but due to several considerations was abandoned. The committee is at present exploring, through the County Director of Education, and as a common policy for the major part of the county, the possibility of hot mid-day meals being obtained through the School Meals Service. Problems of supplies, charges, transport, etc., promptly arise, and these issues have been taken up with such Ministries as may be concerned with the same.

On the matter of a chiropodial service—a service from which many old people could derive considerable benefit—the county committee has taken the view that chiropody should form part of the Health Services, and it is understood the matter is now being dealt with at high level through the National O.P.W. Committee.

Local Old People's Welfare Committees have been formed at Penrith, Keswick and Cockermouth, and consultations are taking place with a view to the establishment of similar committees in Maryport, Workington, Whitehaven and other areas. The General Council of the Women's Institutes have recommended to their local committees that they should interest themselves in the welfare of old people. Contact is being made with the Cumberland Women's Institutes with a suggestion for a concentrated interest in the problem by means of a survey in each village to ascertain whether in fact the old people were being properly

cared for and receiving the assistance and services they need.

The Penrith and District Committee was formed in May, 1950. A survey of the area was made, and the first part of the plan put into operation in November, 1950, when nearly 300 men and women of over pensionable age were entertained to tea and a social. This preliminary event was arranged so that the old people could get together and be informed of the proposed activities of the committee, and thus ventilate in a friendly way what they most needed in the way of services and help. An Old People's Club has been established, and 50 old people gathered for the opening ceremony, which took the form of a social function, entertainment and tea. 120 old people have expressed a wish for visitors to their homes, and visiting is allocated amongst the town's various organisations which form the committee. Whilst "Scouts" and "Guides" have undertaken to assist with shopping, the Penrith Committee feel that independent visiting of old people in their homes, and the rendering of the more personal kind of service, is the most important part of the scheme, but that it is not easy to get people to do the sort of visiting required. Further, that the solution may well be a system of house-to-house, neighbourly contacts. This is a problem to be settled by the local committee.

In October, 1950, a Cockermouth O.P.W. Committee was formed, consisting of about 30 representatives from the various organisations in the town. The committee quickly got under way, and each member is taking a part in the visiting arrangements, the town having been divided into areas. An Old People's Club has been established and 20/30 men are in attendance every day. Efforts are being made to discover actually what are the needs of the old people with a view to the services provided by the state, local authorities and voluntary organisations being invoked for their benefit.

A similar local committee, consisting of 31 representatives of the various local organisations, was formed at Keswick in December, 1950, and is proceeding on similar lines to the committees at Penrith and Cockermouth.

It must not be inferred from these activities that the people of Cumberland are at last awakening to the realisation that the old people of to-day, being the mainstay of the country in the past, have every moral right to "expect" (or shall one say "hope"?) that the younger and more active members of the community will come to their aid in their declining years by rendering assistance of a personal kind which is sometimes beyond the physical and mental capacities of the old people to obtain or get for themselves.

There are many and numerous local organisations who for a number of years have been tireless in their efforts to bring added pleasures and comforts to old people, and the success or otherwise of the local committees will depend on their endeavours to concentrate and co-ordinate these efforts, prevent overlapping, and bring to old people that particular service or assistance which they most need.

GENERAL WELFARE

Notwithstanding the advancement of the services provided by local authorities and voluntary associations, one has that sense of feeling in relation to old people and their needs, that there is a "missing link" or absence of the "human touch" as exemplified by the Relieving Officer, who was looked upon as the real friend of those in need of help and advice. The benefits of the National Health and Assistance Acts must be acknowledged and not under-estimated, and, whilst no one advocates a return of the Poor Law, it is generally agreed by some of those who, in the past, were in daily contact with the difficulties and problems of the service, that there should be available to old people a local officer to whom they could turn in times of trouble, sickness or distress, and who would not only have the necessary powers to arrange hospital, hostel or such other home care, help and other incidental services as may be required, but be under a statutory obligation to see that they were provided.

More hospital accommodation is required, and also more residential accommodation of the kind envisaged by Section 21 of the National Assistance Act. Section 21 (1) (a) of the Act imposes a duty on local authorities to provide residential accommodation for persons

who, by reason of age, infirmity or other circumstances, are in need of care and attention which is not otherwise available to them. Whilst this would not include sick persons needing active hospital treatment, it would comprise a wide range of elderly, infirm or disabled people unable to look after themselves in their own homes. Accordingly, the establishment of Homes or Hostels, linked with Hospitals, would go a long way in mitigating the plight of those aged persons who, although not in need of active hospital treatment, may, on a technical interpretation of the Act, be considered as outside the scope of the Section 21 provisions of the Act. Section 21, however, covers a wide range of people and, with a generous interpretation of the section, and bearing in mind the need mentioned in the previous paragraph, it is considered that Local Authorities, given power and encouragement and the necessary financial assistance, would not be found wanting in initiative and enterprise in taking steps to meet these two urgent and pressing welfare needs in a spirit in keeping with the Act.

One would also hope that Local Authorities will be allowed to proceed with the development of their services, and that every encouragement will be given by the Ministry for an expansion of residential accommodation by the building of new Homes or Hostels if properties suitable for adaptation are not available.

Temporary Accommodation

The County Council is under a duty to provide temporary accommodation for persons who are in urgent need thereof, being a need arising in circumstances which could not reasonably have been foreseen, or in such other circumstances as the County may in any particular case determine.

This provision is not for dealing with the inadequately housed or persons without a settled way of living. It is primarily intended to cover persons temporarily without accommodation as a result of such circumstances as fire, flood or eviction which could not have been foreseen.

During the year ended 31st March, 1951, 56 cases (representing 24 men, 22 women and 35 children) were provided with temporary accommodation due to

evictions from houses or rooms, or inability to find suitable lodgings, etc., the highest number maintained in any one week being 28 persons (11 men, 6 women and 11 children). The 56 cases consisted of 19 family units —4 units of husband, wife and child/ren, 1 unit of husband and wife, 14 units of mother and child/ren (including 2 mothers and 3 children E.V.W.'s), 19 men and 3 women.

On the 31st March, 1951, temporary accommodation was being provided for 11 men, 3 women and 8 children, as follows :—

Meadow View House, Whitehaven :

1 man, wife and 5 children.
9 single men.
1 child (Children's Committee).

Highfield House, Wigton :

1 man and wife.
1 woman and 2 children.

Problems (not yet unsurmountable but nevertheless creating administrative difficulties) have been experienced in providing this accommodation, especially in the case of families where children are involved. The need for accommodation arises mainly from eviction from lodgings with " in-laws " and other persons, more so than from evictions from Council and other houses where the persons have been tenants. The present accommodation is not adapted for families living together as separate units. Children have to be accommodated in the Nursery (where one is provided), whilst the parents are respectively given accommodation in the male and female sections of the establishment. At a recent conference of Children's Officers, at which was introduced the subject of " the care of children of homeless families," the Assistant Under-Secretary of State, Home Office, said that the interest of all was to secure that homeless families, mostly evicted and many difficult, should be dealt with as families; children should not be parted from their parents unless there was need for this on grounds other than that the family was homeless. The lack of organised plans to keep families together was a cause of concern, and there had been too great readiness in some areas to look to the Children's Committee to take the children.

When the County Council can provide for old people hostels of the type envisaged by the Act, one solution for the provision of temporary accommodation for families would be the adaptation of certain parts of the present establishments whereby accommodation could be provided on a unit basis, thereby preventing the break-up of family life. The Welfare Committee decided that this idea be borne in mind for possible implementation as and when necessary adaptations to existing premises could be carried out. One must, however, stress the point that if temporary accommodation is made too comfortable and convenient, there may be little effort on the part of the persons concerned to endeavour to obtain accommodation elsewhere.

Meantime, and in accordance with the memorandum adopted by the Local Authority Associations in July, 1950, co-operation will be established with Borough and District Councils who have been requested by the Ministry of Local Government and Planning not to take proceedings for the eviction of families from properties held under requisition, without first consulting the Ministry.

Welfare Services for the Blind
Register

The following 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 County Council on the 31st March, 1951:—

Age Group	Men	Women	Total
0- 1	—	—	—
1- 5	—	—	—
5-16	5	2	7
16-21	4	3	7
21-40	19	11	30
40-50	19	17	36
50-65	42	46	88
65-70	27	24	51
70+	90	106	196
	206	209	415

General Welfare of the Blind

The year 1950/51 has continued the era of development which opened on the 5th July, 1948, with the

coming into operation of the National Assistance Act, 1948.

As was stated in the last report, the Welfare Committee decided that the agency arrangements with the Cumberland and Westmorland Home and Workshops for the Blind, and the Barrow, Furness & Westmorland Society for the Blind, should be extended for a further period to the 31st December, 1951, in order to afford the Carlisle Workshop Committee an opportunity of putting into effect a re-organised and expanded service of welfare arrangements. During the year, much help and advice has been given to the Voluntary Association on matters of general administration, and in particular to a composite scheme of workshop and hostel facilities at Petteril Bank, Carlisle. The new scheme, estimated to cost £31,436, provides for (a) adaptations to, and furnishing of, the Hostel at an estimated cost of £6,476, and (b) the erection on the site of new workshops (including administrative offices for the Voluntary Association), at an estimated cost of £24,960. The scheme has been the subject of protracted negotiations with the Ministry of Labour and National Service, who have now offered a grant of £10,000 (subject to certain conditions) towards the cost of (b). Negotiations are still proceeding between the two local authorities (the County Council and the Carlisle City Council) with a view to the implementation of the scheme as early as possible.

The welfare of the blind is only one section of the large scheme of welfare services envisaged by the National Assistance Act. It is, however, a fairly comprehensive and important service for which the Cumberland & Westmorland Home and Workshops for the Blind act as agents for the Carlisle County Borough Council as well as the County Council. In order to obtain a picture of the organisation and services as a whole for that part of the geographical county covered by the agency, a planned and sectionalised form of report was prepared, leaving it to the agency to complete the statistical portions and comment on the various services.

The first of these reports for the quarter ended 31st March, 1951, is reproduced in the appendix. One important aspect of the report is that relating to home teaching, visiting, handicrafts and general social

activities. The importance of an adequate and well organised home teaching and visiting service cannot be over-stressed, and the matter of the further development and expansion of the service will engage the attention of the Welfare Committee before the end of the present agency period. With the additional teaching staff now available, it has been possible to devote more time and attention to the teaching of Braille and Moon, and this is reflected in the increase from 11 to 28 in the number of readers registered with the National Library.

Training and Employment of Blind Persons

The report of the Working Party set up by the Ministry of Labour and National Service to investigate the facilities existing for the employment of blind persons in industry, and in public and other services, and to make recommendations for their development, reveals that there are about 87,000 registered blind persons in Great Britain. About 36,400 are within the normal working age-range of 16/65, and of these about 11,000 are at present in employment or undergoing training. Of the remaining 25,000, the Working Party have come to the conclusion that there are a further 3,000 blind persons who would be capable of taking up employment if given an opportunity. With the efforts now being made to bring newly blinded persons into the employment field, it is considered that the blind can be expected in the future to provide a contribution of some 16,000/17,000 to the effective working population.

The Consultative Panel for the County (consisting of the County Welfare Officer, the Supervisor for the North Regional Association for the Blind, the Local Disablement Resettlement Officer of the Ministry of Labour and National Service, the Blind Placement Officer and the Secretary/Manager of the Workshops for the Blind) and established for the purpose of

(a) reviewing from time to time the Register of Blind Persons;

(b) interviewing such unemployed blind persons as may be considered suitable for and/or desiring training or employment; and

(c) considering the possibilities of extending the Home Workers Scheme to those persons who, though fit for training and/or sheltered employment, live too far away from the Workshops

and are not desirous of residing in the hostel at Petteril Bank, Carlisle;

has held two sessions and interviewed several blind persons in the 16/65 age group thought to be suitable for training and/or employment in sheltered or open industry.

Whilst possibilities in the training and employment of blind persons are somewhat difficult to determine, the Panel found there was a general desire on the part of many of the blind persons interviewed, for some kind of training and/or employment, not only as a means of earning money, but to help to improve their physical and mental outlook, one man making the comment "It is very demoralising having nothing to do." The establishment of the Panel has been well worth while, results from the two sessions being as follows:—

(a) Admitted to America Lodge for Social Rehabilitation	1
(b) Awaiting admission to America Lodge for Social Rehabilitation	1
(c) Admitted to America Lodge for Industrial Rehabilitation	2
(d) Refused to accept Industrial Rehabilitation ...	1
(e) Accepted approved training in Workshops for the Blind	2
(f) Placed in open employment	2
(g) Placed in sheltered employment (i.e. Workshops)	2
(h) No action taken (sickness &c.)	5
(i) Cases pending	4
	20

Employment of Blind Home Workers

The County Councils Association has considered proposals by the Ministry of Labour under which county and county borough councils would receive, for the purpose of encouraging the provision of facilities for the employment of home workers, a grant of 75% of the actual expenditure on administration costs of approved Blind Workers Schemes, subject to an annual maximum of £20 per capita. The present view is that the grant is an inadequate contribution towards the expenditure of local authorities for this purpose, particularly as such contribution is in effect intended to satisfy the obligation of the Ministry of Labour and National Service under the Disabled Persons (Employment) Act, 1944. The financial equity of the proposals is being further investigated.

Minimum Wage Schemes (Workshop Employees)

In last year's report one expressed concern at the apparent lack of uniformity throughout the country in the method of augmentation of earnings of blind persons employed in workshops, and of blind home workers, and reference was made to the action of the County Councils Association in discussing, in conjunction with the Ministry of Labour and the National Library for the Blind, proposals for the establishment of machinery to recommend a National basis upon which augmentation rates might be paid to blind workers in the Workshops.

The County Councils Association is now able to report some progress by way of general agreement to the constitution of a new National Advisory Committee consisting of representatives of the County Councils Association, the Association of Municipal Corporations and the National Association of Workshops for the Blind. The representatives on the National Advisory Committee will meet together for the purpose of advising local authorities and the managements of workshops, upon the basis of augmentation and earnings and the conditions of service of blind employees. With this end in view, the National Advisory Committee would confer with, and consider any representations made by, the National Library for the Blind, who have accepted the arrangement mentioned.

Barrow, Furness & Westmorland Society for the Blind South Cumberland Area

The arrangement under which the above Society acts as Agents of the County Council in the discharge of the Council's functions for promoting the welfare of blind persons in the southern part of the County (Millom Rural), has also been extended to the 31st December, 1951. The blind persons on the register total 22, classified as follows :—

Age Group	Men	Women	Total
0- 1	—	—	—
1- 5	—	—	—
5-16	—	—	—
16-21	—	—	—
21-40	1	—	1
40-50	—	4	4
50-65	—	2	2
65-70	2	1	3
70+	7	5	12
	10	12	22

Although the problems to be faced by this Society (confined as it is to the southern part of Cumberland) are not nearly so great as those in the major part of the administrative County, the Society nevertheless continues to function quietly and efficiently. No special comment arises on the activities of the Society during the year under review.

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 paragrah 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.

Whilst local authorities are under an obligation to exercise their powers under Section 29 in relation to blind persons, no similar direction has as yet been given in regard to the deaf and dumb and other classes.

With a view to securing uniformity throughout the country in the development of welfare services, the Minister of Health appointed an Advisory Council to advise him on questions relating to the welfare of persons to whom Section 29 applies, and hoped to give local authorities further suggestions for extending their welfare schemes for the blind, to other handicapped persons.

The Carlisle Diocesan Association for the Deaf and Dumb (affiliated to the National Institute for the Deaf) 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, and is the only Association in that area providing a welfare service for deaf and dumb persons of all denominations. 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.

In the whole area on the 31st March, 1951, there were 259 deaf and dumb persons on the register, distributed and classified as follows:—

Category	Area					Total
	Cumbd. C.C.	Westd. C.C.	Lancs C.C. (Furness)	Barrow C.B.C.	Carlisle C.B.C.	
School age or under ...	17	7	2	9	10	45
In Institutions ...	2	—	1	2	1	6
In Mental Hospitals ...	5	—	—	—	1	6
In full - time employment	60	7	10	12	21	110
Married women at home	15	2	2	6	11	36
Single women at home ...	8	1	—	3	—	12
Unemployable—age ...	6	3	1	5	6	21
Unemployable—infirmity	8	2	2	5	—	17
Unemployed ...	1	—	1	—	—	2
Private means ...	—	—	—	1	3	4
Total ...	122	22	19	43	53	259

In the early part of 1949, discussions were opened with the Diocesan Association who indicated a keen desire for the fullest possible co-operation between the local authorities and the Association in the provision and development of welfare services for the deaf and dumb.

The local authorities agreed (with one exception) that the Association should be encouraged to develop and expand, on agreed lines, its welfare services for the deaf and dumb, and that pending receipt of suggestions from the Ministry of Health for extending their welfare schemes for blind persons to other handicapped persons, financial assistance should be afforded to the Association pursuant to the powers given to local authorities by Section 30(2) of the National Assistance Act.

During the year 1950/51, the Association put into effect several of the proposals contemplated in 1949.

The Secretary/Superintendent is now employed on a whole-time basis. A trainee in deaf welfare was appointed in July, 1950, and a fuller programme of individual welfare is now possible.

Consideration has been given to alterations and additions to the Carlisle Institute, and a social centre has been opened in Workington.

The Secretary/Superintendent reports that excellent attendances at this latter centre, drawn from Workington, Whitehaven, Cockermouth, Maryport and Flimby, show how great was the need for such a meeting place, and that deaf persons will travel such dis-

tances for the sake of enjoying each other's company for the short space of two or three hours is but another example of the necessity for providing such amenities for this handicapped class of the community.

On the industrial side, the Secretary/Superintendent reports:—

> "The position over the whole area has continued to be highly satisfactory and cases of unemployment are comparatively rare. It is usually found that when these do occur, they are the result of a dual disability or of approaching old age. For the greatest part enquiry has shown that our employable deaf persons have continued to give satisfaction and we have had more than one example of an employer approaching us with a request for suggestions in filling a vacancy. During the year the Association has maintained its union with the local offices of the Ministry of Labour and, in particular, with the Disablement Resettlement Officers."

The normal activities of the Association have continued throughout the year, and although it was deemed that for the time being at any rate, welfare services should be centred on the deaf and dumb, approaches have been made to the Association and to the County Council by newly established clubs for the hard of hearing, for assistance in the provision of accommodation. Having regard to present day difficulties, it is considered that every encouragement should be given to such bodies, and the Diocesan Association has placed the Institutes at Carlisle and Barrow at their disposal for weekly meetings. A club for hard of hearing persons (with a membership so far of 63) has recently been formed for the Maryport district, and the immediate need is for premises. The position is being explored to see what advice, help, or assistance can be given by the County Council.

The local authorities concerned in this development and expansion of services for the deaf and dumb have decided to again give financial support to the Diocesan Association for the year 1951/52.

Whilst further suggestions from the Ministry of Health on an extension of their welfare schemes are still awaited by local authorities, it is felt that already we have a sound basis for a scheme which would

require little alteration when the machinery is put into full operation.

Handicapped Classes (other than Blind, Deaf and Dumb)

No definite scheme has yet been considered for the provision of appropriate welfare services for the residual group of handicapped persons and, pending any advice or guidance which may be given by the Minister of Health on this issue, and which it is hoped will clarify the position, individual needs will be considered and dealt with by the Welfare Committee as and when cases arise.

It is understood that the Associations of Local Authorities have now received from the Ministry of Health, copies of draft documents dealing with outline schemes for the provision of welfare services for handicapped persons other than the blind, and no doubt local authorities themselves will, in the near future, receive full information and advice on the extension of their existing welfare schemes to these groups.

Reception Centres
Persons Without a Settled Way of Living

The Act imposes a duty on the National Assistance Board to encourage persons without a settled way of living to lead a more settled life, and to provide and maintain reception centres at which temporary board and lodging is made available to such persons, but that duty is still undertaken on behalf of the Board by County and County Borough Councils.

Whilst the Board are alive to the difficulties and problems confronting them, it is understood that as yet there is no immediate prospect of local authortites being relieved of the duty to maintain reception centres.

In the administrative county there is only one reception centre which is at Station View House, Penrith, an establishment providing Part III. Accommodation and treatment for a number of chronic sick patients. The centre at Meadow View House, Whitehaven, was closed on the 1st March, 1949, and has not been re-opened, although there is an understanding with the Board that if wayfarers turn up at Whitehaven and it is not possible to get them by public transport to the nearest open centre, they are given accommodation for the night.

The following table shows the number of wayfarers provided with temporary board and lodging, and the extent to which the number has gradually increased quarter by quarter:—

	Penrith				Whitehaven			
Quarter ended	M.	W.	Ch.	Total	M.	W.	Ch.	Total
30/9/48	221	6	—	227	48	2	—	50
31/12/48	255	16	—	271	60	4	—	64
31/3/49	336	6	—	342	44	—	—	44
30/6/49	398	17	—	415	24	3	4	31
30/9/49	453	16	—	469	17	—	—	17
31/12/49	456	24	—	480	7	—	—	7
31/3/50	515	17	4	536	6	—	—	6
30/6/50	627	28	—	655	9	—	—	9
30/9/50	686	20	1	707	6	—	—	6
31/12/50	542	15	—	557	8	—	—	8
31/3/51	548	27	3	578	5	2	1	8

The comments and observations on the service, contained in last year's report, still apply, and apart from repeating the same there is little one can say regarding this service.

Civil Defence

Issues connected with Civil Defence, and in particular those relating to the welfare section, have received considerable attention during the year. Increased efforts in which the W.V.S., W.I. and other women's organisations are being asked to take part, are being made to imbue potential recruits with a greater sense of the urgency of enrolment and training.

General Observations

During the year the general day to day administrative arrangements have proceeded smoothly, and collaboration established where necessary with the various Government Departments concerned, and other sections of the County administration, where services additional to those provided under the National Assistance Act could be invoked for the benefit of individuals concerned. Helpful advice continues to be given to many persons on issues completely outside the statutory duties of the County Council.

It is emphasised, in conclusion, that what has been set out above must not be taken as an exhaustive survey covering the whole field of activities of the Welfare Committee. This report merely touches upon some of those main features of the administration which it is thought would be a useful supplement to the County Medical Officer's Report.

APPENDIX

CUMBERLAND AND WESTMORLAND HOME AND WORSHOPS FOR THE BLIND

Welfare Services, etc.. for blind persons resident in the Administrative County of Cumberland and the City of Carlisle

1. Register.

The number and classification of Blind Persons on the Register on 31st March, 1951, was as follows:—

Age Group	Number						
	Males		Females		Total		Grand Total
	City	Cnty.	City	Cnty.	City	Cnty.	
0 - 1 ...	—	—	—	—	—	—	—
1 - 5 ...	—	—	—	—	—	—	—
5 - 16 ...	1	5	2	3	3	8	11
16 - 21 ...	2	4	1	2	3	6	9
21 - 40 ...	5	18	7	11	12	29	41
40 - 50 ...	2	19	5	13	7	32	39
50 - 65 ...	8	42	13	44	21	86	107
65 - 70 ...	4	25	7	23	11	48	59
70+ ...	19	83	27	101	46	184	230
Total ...	41	196	62	197	103	393	496

2. Workshops

(a) Types of Employment and numbers employed at 31st March, 1951 (excluding trainees)

Trade	Males		Females		Total	
	City	Cnty	City	Cnty	City	Cnty
Agents and Collectors	—	2	—	—	—	2
Firewood Department	2	2	—	—	2	2
Bed and Mattress Making	1	2	1	—	2	2
Bedding Labourers ...	—	2	—	—	—	2
Brush Making ...	1	2	—	—	1	2
Basket Making and Rush Seating ...	2	2	—	—	2	2
Upholstery ...	—	1	—	—	—	1
Piano Tuning ...	—	1	—	—	—	1
Machine Knitters ...	—	—	2	4	2	4
Re-seating Chairs (in cane) ...	—	—	1	1	1	1
Total ...	6	14	4	5	10	19

(b) Training—Blind Persons receiving training with the approval and recognition of the Ministry of Labour in Carlisle Workshops.

Training in	Males		Females		Total	
	City	Cnty	City	Cnty	City	Cnty
Firewood Department	—	—	—	—	—	—
Bed and Mattress Making	—	1	—	—	—	—
Bedding Labourers ...	—	—	—	—	—	—
Brush Making ...	—	—	—	—	—	—
Basket Making ...	—	—	—	—	—	—
Upholstery ...	—	1	—	—	—	1
Piano Tuning ...	—	—	—	—	—	—
Machine Knitters ...	—	—	—	—	—	—
Re-seating Chairs (in cane) ...	—	—	—	—	—	—
Total ...	nil	2	nil	nil	nil	2

(c) General Observations on:—

(i) *Employment*

Employment has been maintained on a full time level, with some measure of overtime in brush making. During the earlier part of the quarter there was a falling off in trade in the mattress and bedding department, but towards the end of March the expected seasonal improvement began. The basket shop has not been quite so busy as heretofore, but all workers in the department have been kept fully occupied and despite the scaling price of knitting wools, the women and girls employed on machine knitting have orders booked for several weeks ahead.

(ii) *Training*

There are at present 2 adult male trainees in the Carlisle Workshops, viz.:—

1 (County case) for mattress making and upholstery.

1 (County case) for soft bedding and featherwork.

The mattress and upholstery trainee commenced a two years course of training on 1st February, 1951, and being a keen pupil, should do very well.

The trainee in featherwork, etc., who commenced a six months course at the same time is not nearly so self reliant or adaptable and it is doubtful if he will achieve efficiency in the time allowed.

There is also one man from Barrow training in Carlisle Workshops.

(iii) *State of Workshops—Adequacy of facilities*

Including the trainees mentioned above, and a further Westmorland case, there are 21 blind men and 9 women employed by the Workshops; 12 of them, all men, are at the Harraby works and the remainder are employed at Lonsdale Street. In view of the preliminary general agreement now reached between the City and County,

the Workshops Committee and the Ministry of Labour, to dispose of the Lonsdale Street premises and rebuild a new factory at Harraby to accommodate all activities in one centre, criticism of existing premises and suggestions for improvement in them would be superfluous.

(d) Blind Persons in Training at other recognised Centres.

Centre.	Training in	Men		Women		Total	
		City	Cnty	City	Cnty	City	Cnty
Newcastle	Bedding and Upholstery	1	—	—	—	1	—
Royal Normal College	Shorthand and Typing ...	1	—	—	—	1	—
Oldbury Grange	Do. ...	—	1	—	—	—	1
Royal Normal College	Do. ...	—	—	—	1	—	1
	Total ...	2	1	—	1	2	2

(e) Blind Children at School

School.	Males		Females		Total	
	City	Cnty	City	Cnty	City	Cnty
York	—	1	1	—	1	1
Newcastle	—	2	—	1	—	3
Liverpool	—	—	1	—	1	—
Chorley Wood ...	—	—	—	—	—	—
Council Schools						
Cleator Moor ...	—	—	—	1	—	1
Grasslot	—	1	—	—	—	1
Brigham	—	1	—	—	—	1
Total ...	—	5	2	1	2	7

N.B. The three children still at Council Schools are all partial cases—educationally blind—and may or may not, in time, be received into Schools for for the Blind.

3. Open Industry.

(a) Types of Employment and numbers employed at 31st March, 1951.

Trade	Men		Women		Total	
	City	Cnty	City	Cnty	City	Cnty
Factory operatives ...	—	2	1	—	1	2
Labourers	1	5	—	—	1	5
Telephone Operators	1	2	—	—	1	2
School Teachers ...	—	—	1	—	1	—
Shop Assistants ...	—	—	1	—	1	—
Agricultural Workers	—	4	—	—	—	4
Physiotherapists ...	—	—	—	1	—	4
Poultry Farmers ...	—	4	—	—	—	4
Other open employment and St. Dunstaners not included above.	—	5	—	1	—	6
Total : ...	2	22	3	2	5	24

(b) General Observations.

Of the 29 cases set out above, 8 are St. Dunstaners and well cared for by that Institution. Of the remainder quite a number have a good deal of vision and are well able to do the work allotted to them, e.g., the shop assistant and some of the labourers. Of the three telephone operators, two are totally blind and the other, who is partial, is now an established civil servant.

4. Hostel—Petteril Bank.

(a) Number of Residents in Hostel on the last day of each month of the quarter.

Month 1951	Men		Women		Total		Total eng'd in w/s		
	City	Cnty	City	Cnty	City	Cnty	City	Cnty	Others
January ...	1	6	—	1	1	7	9	18	1
February ...	1	6	—	1	1	7	10	18	1
March ...	1	6	—	1	1	7	10	19	1

(b) General Observations on Maintenance, Social Activities and other matters of interest.

Hostel conditions leave much to be desired but again criticism of these conditions or suggestions for more than minor improvements, would, at this stage, be out of place in view of the proposals to re-model and adapt the building to better advantage in the near future.

The blind residents and sighted staff are provided with wireless sets and an adequate supply of dominoes, braille playing cards and draughts suitable for blind people is maintained.

Several whist and domino matches have been played against blind teams drawn from the County social centres as well as against sighted teams from the City and a social club for blind workshop employees run by the members themselves, meets each week.

5. Home Employment (not Pastime Workers).

On the 31st March, 1951, there were 4 Blind Persons in the Home Workers' Scheme in the following occupations:—

Trade	Men		Women		Total		Visits in Quart'r
	City	Cnty	City	Cnty	City	Cnty	
Braille Copyist	—	—	—	1	—	1	13
Piano Tuning ...	—	1	—	—	—	1	3
Farming ...	—	1	—	—	—	1	2
Boot Repairing	—	1	—	—	—	1	3
Total ...	—	3	—	1	—	4	21

Braille Copyist—Employed by the National Library for the Blind and her wages and augmentation are paid by that body. She is visited at least once every week by the Home Teacher, who assists if necessary with the work.

Piano Tuner—Making quite a success of his business and in addition to tuning work has a music shop and a good connection in radio repairs and sales.

Boot Repairer—Has been finding business somewhat slack but, as a sideline, has small general business—sweets, tobacco, haberdashery, etc.—which helps him along.

The remaining Home Worker, *a partially blind farmer*, is doing very well. He was established on a poultry farm some years ago by a substantial capital grant from the Institution's funds in addition to grants from the National Institute for the Blind and Gardners Trust for the Blind. Since that time he has built up farm stock, taken over a much larger farm and is now well established.

6. Hospitals, Institutions and Hostels (Other than Petteril Bank).

The number of Blind Persons in Hospitals, Institutions, Homes and Hostels on 31st March, 1951, was as follows :—

Hospital, Institution or Hostel	Men		Women		Total	
	City	Cnty	City	Cnty	City	Cnty
Part III. Accommodation	1	8	1	3	2	11
Other Residential Homes	2	—	7	—	9	—
Mental Hospitals	1	1	1	1	2	2
Total :	4	9	9	4	13	13

7. Home Teachers.

No. of Home Teachers—

County Area 5

City Area ... ... 1 Total : 6

No.	Districts & Home Teacher	Cert. or Uncert.	No. of Blind Pers'ns in District	No. of Home Visits during Quart'r	No. of other visits on behalf of Blind
1	**City.**				
	Miss Speight	Cert.	103	141	27
	Cumberland Rural Areas				
2	Miss Fairhurst	„	97	253	30
	Maryport & District.				
3	Miss Hetherington ...	„	54	150	22
	Workington, Whitehaven & Districts				
4	Mr. Hilland (M) ...	„	81	288	41
5	Miss Hogarth (F) ...	„	81	287	39
6	Mrs. Todd (Very old folk)	Uncert.	80	404	16

General Observations.

The numbers shown on the list of each Home Teacher are the respective lists at March 31st, 1951.

These " case loads " are regularly revised according to deaths, removals and new cases in order to maintain a visiting list compatible with the area and with the travel facilities available.

8. Handicraft Classes.

Location	No. of Class's held during quarter	Avge. Attendance	No. of lessons	Instruction given in	Instructor
Penrith ...	11	8	67	Basketry Pulp cane work	Miss Fairhurst
Cockermouth	8	6	45	Chair caning Knitting	Miss Hethering-
Maryport ...	10	9	80	Raffia work Weaving Rugs	ton Do. Do.
Whitehaven	12	19	125	Stool seating Embroidery Tea cosies	Miss Hogarth) and Mr.) Hilland)
Carlisle ...	10	10	84	Straw bags	Miss Speight

General Observations

The handicraft classes are proving popular as well as instructive and both beginners and advanced pupils are turning out attractive and useful articles, some of which are disposed of in the Sales Shop in Carlisle. A further class (or the recommencement of a previous one) is visualised for Workington and should be in operation at an early date.

The City class, a very live one, is held at Petteril Bank House with an average attendance of 10. The class has its own " Thrift Club " enabling members to purchase materials and produce useful articles for themselves and as presents, any surplus funds being utilised by the members for club trips in the summer in addition to the usual summer outing. Fares to the handicraft classes are refunded where necessary or transport provided.

Instruction in handicrafts has also been given to 4 people in their own homes and unable to venture out to attend the classes, necessitating 20 visits—one of the cases having recently returned from an Institution classified as uneducable and sub-normal.

9. Clubs.

Social Clubs and Social Centres for Blind Persons are as follows :—

Location of Club.	Open Daily i.e. Weekly Monthly, &c.	M/ship (B.P.)	Avge. Attend. (B.P.)	Short note of Activities
Penrith	Monthly	12	9	Dominoes, Concert Party Rehearsals, Talks and Music.
Cockermouth (including Maryport)	Do.	23	20	Dominoes, Readings, Music and Entertaiments by local parties.
Whitehaven	Fortnightly	41	23	Entertainments, do., etc., arranged by Social Committee of the Blind members.
Workington	Weekly	30	25	As above, plus games and dancing. Own choir formed.
Carlisle	Monthly	30	20	Dominoes, Readings, Music and entertainment by local parties.

General Observations and Report.

The Social Clubs are proving very popular and whilst there has been some widening of activities, the very severe weather during the quarter resulted in a diminution of attendances. At all meetings, teas or light refreshments are provided out of voluntary funds together with transport or bus fares if these exceed more than a nominal amount.

Each centre has its own domino team and in addition to internal competitions the teams compete against the remainder of the teams in the County and City in an Annual Tournament for which a shield is provided the winners this season being Dearham. The Maryport and Dearham Team has a joint membership of 14 and in addition to matches played against blind competitors, 10 matches have been played against sighted teams and all of them won.

The Workington Club celebrated its birthday party in January when a birthday cake was given by the wife of one of the blind men. Despite the difficulty of obtaining entertainers for these functions, all of which have, of necessity, to be held during the day, a varied programme of concerts, talks., etc., has been arranged including a party to Whitehaven Pantomime and two entertainments given by the Penrith Club Blind Concert Party. Tickets have been obtained and parties of the City Blind taken to several concerts arranged by local musical societies and bodies.

The Annual Braille Reading Competition took place at Petteril Bank House in March and attracted 11 competitors from the City and County whilst the City Bulb Competition secured 24 entries. In the latter event, the bulbs must be planted and cared for by the blind competitors.

10. Braille and Moon—Readers and Instructional Activities.

	City		County	
	Brl.	Moon	Brl.	Moon
(a) No. of readers registered with the National Library (Northern Branch)	15	2	19	9
(b) No. of other readers ...	7	2	3	2
(c) No. of blind persons receiving lessons in Braille and/or Moon ...	1	2	4	8
(d) No. of lessons given during the quarter ...	2	13	23	33

General Observations

The number of lessons shown above are those given in the homes of the blind, no account being kept of any Braille or Moon lessons given at either the Handicraft Classes or on Club days. One old lady in the city, 74 years of age, very bravely tackled Moon and during the quarter had her first library book, whilst the City case in the Sanatorium still continues her lessons.

11. General Social Activities, Entertainments, Outings &c.

(a) *County Area*

In all centres in the county Xmas parties have taken place in addition to the regular Club days and incidental activities previously noted. The Penrith Blind Concert Party in addition to entertaining at Blind Social Events, has given concerts at Hayton W.I., Penrith (Women's) British Legion, Station View House, Penrith, and to a private audience consisting of a household, friends and neighbours, whilst Cockermouth Social Club have in turn been entertained by the Cockermouth Inner Wheel.

(b) *Workshops Dinner*

The annual dinner for the blind workers at the Workshops took place at Petteril Bank House on 21st December, 1950. Among those present were Councillor Cummings (Hon. Treasurer), Councillor Burrow and other members of the Committee, and a very enjoyable evening was terminated by a dance which, by request, the blind workers organised themselves.

12. Wireless and Talking Books for the Blind.

(a) *County*

Wireless sets supplied last year by the Wireless for the Blind Fund reached approximately 60% of the number applied for. Of these all had been issued except 2 sets which were distributed during the March quarter. Seven used sets have been repaired and where necessary paid for out of voluntary funds and either re-issued or returned to the former users. Similarly batteries have been ordered and delivered to those needing them but there is still some delay with deliveries of component parts, valves, &c.

(b) *City*

In the City all new sets had been previously issued and during the quarter 4 were repaired. As all repaired sets are not proving entirely satisfactory it is hoped to replace them out of this year's allocation.

Talking Books.

There are 9 Talking Book Machines in use, i.e. 8 in the County and 1 in the City and altogether 13 books have been in circulation with a total of 180 double-sided records.

13. Home Help Service and General Matters of Interest.

Home Help Service.

In the County 9 blind persons have availed themselves of the Home Help Service. The blind people in the City are very reluctant to avail themselves of this Service and at the present time no blind person has a Home Help, despite the fact that some would benefit greatly from such help.

Assistance from Workshops.

During the quarter apart from assistance with Wireless Sets, repairs, batteries, etc., and talking books as previously stated, several cases have had special grants from the National Assistance Board, whilst others have had help from the Voluntary Funds of the Institution.