[Report 1952] / Medical Officer of Health, Cumberland County Council.

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COUNTY COUNCIL OF CUMBERLAND

Annual Report

ON THE

HEALTH SERVICES OF THE COUNTY

For the Year 1952

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COUNTY MEDICAL OFFICER.

INDEX

TO THE CHAIRMAN AND MEMBERS OF THE CUMBERLAND COUNTY COUNCIL

Mr. Chairman, My Lord, Ladies and Gentlemen,

I beg to present the annual report on the Health Services for 1952

Vital Statistics

The vital statistics for 1952 for the most part show little change from the previous year. The birth rate is slightly up, the death rate and infantile death rate are both slightly down. The most interesting point which emerges from a study of the statistics is the drastic reduction in the mortality from pulmonary tuberculosis which has fallen by almost one half to a new low level of 43 deaths. This fall is the subject of some comment later in this report.

With regard to infantile paralysis only 12 cases were notified during the year. Of these, 3 were of the non-paralytic type, which of course is relatively unimportant, and bearing in mind that over 4,000 cases occurred in England and Wales during the year, and that this condition was epidemic in a number of other countries, including the Continent of Europe we may count ourselves indeed fortunate in being able to record this low incidence figure.

What is not so pleasing is the rise in the number of deaths classified as maternal deaths from one in 1951 to three in 1952. This figure of 3 maternal deaths calls, I think, for a little comment. One of these deaths was due to an attempt to produce an abortion by mechanical means. A second was due to a maternal condition which originated at a confinement 16 years before death, and the third to a maternal condition in a confinement which occurred 21 years before death. We have always, in this county, taken an intense interest in striving for a low maternal mortality through our midwifery services in co-operation with the consultants and general practitioners. The part we play in this, of course, is now much less than formerly but we are still deeply interested. Without, therefore, in any way criticising the classification of maternal deaths in use in the Registrar General's Department it is, I think, fair comment to say that as far as my information goes none of

these 3 cases was a maternal death as that phrase is generally understood.

It has been my custom, since the National Health Service Act of 1946 came into operation in July 1948, to divide the annual report on the health services into two sections, the first dealing with services as they fall into the various sections of Part III. of the Act, and the second section dealing with individual services which do not appropriately so fall, such as tuberculosis, cancer, milk and food, water and sewage, and so on.

During 1952 the Ministry asked that an interim report should be prepared to be in their hands by the end of February, 1953. The instructions were that this interim report was to be incorporated in the normal annual report to be prepared later in the year. This, of course, is not so easy as it sounds. At the beginning of the year we have few statistics to go on, the picture is far from complete, and may well change materially by the time the normal annual report comes to be written during May or June. The Ministry's headings under which they desired this advance report to be written did not in all respects synchronise with the sections of Part III. of the Act, and introduced new headings. All this, as will readily be understood makes the already cimplicated task of preparing the annual report still more complicated, and if discrepancies occur in this final document, due allowance must be made for the circumstances under which thest two reports have been written.

The object of the Ministry in asking for an interim report seems to be quite clear. By July 1953 the Health Service will have completed its first five year period, and my guess would be that the Ministry desire to make the first quinquennial review of the operations of the National Health Service. Where necessary and appropriate I have quoted the actual words from the Ministry's directive, so that what has been written, which is naturally off the usual pattern, and why it has been written, may be clearly understood. Circular 29/52 from the Ministry which initiated this matter stated that " the survey should deal with, though not necessarily be restricted to, the points mentioned in the appendix." I took this to mean that the Ministry in desiring to take soundings of the operation of the National Health Service Act, did not wish the comments

merely to be made from the necessarily limited windows of health departments. In other words that where a medical officer of health, through his membership of bodies connected with the hospital service (regional boards, hospital management committees, etc.), or of bodies connected with the general practitioner service (executive councils, local medical committees, etc.) has a wider view point than one limited to his office chair, he was expected to incorporate in this interim report, and later in the full report for the year, his views on such matters as might appear to be relevant. On this basis I venture to put forward one or two points of view on the operation of the National Health Service since its inception. I trust that none of these points of view will be found to be controversial—they are not aimed at any body or any person.

1. *The Hospital Service.*

Here undoubtedly much has been accomplished. A certain amount of new building has materialised. A good deal of adaptation, reconstruction and up-grading of poor or inadequate buildings has become fact. Equipment has been almost revolutionised and brought into line with modern needs. New services have been opened in many areas, and the appointment of large numbers of highly trained men and women to consultant appointments has greatly strengthened the teams of hospitals all over the country. Nevertheless there has been one great source of disappointment. The capital sum available for new hospital construction has been severely limited and is completely inadequate, and those engaged in the development of the hospital service, noting the very large sums which have been made available for building in connection with other services, must I fear have broken the tenth commandment many times. In this respect the optimism which prevailed in 1948 has naturally changed to pessimism. The vistas and new horizons before our eyes at that time have largely, so far as this matter of buildings is concerned, proved to be mirages, and as things are to-day we have got to accept the fact that new building on any substantial basis looks likely to be something which may or may not happen ten years hence. There can be no doubt that this is increasingly causing a feeling of frustration among those concerned with the hospital service and I think there can equally be no

doubt that large sections of the community feel keen disappointment that the hopes of 1948 are not materialising in this respect. Perhaps this disappointment is chiefly felt in connection with the mental health service.

2. *Shortage of Hospital Beds.*

For the reason that nothing like adequate money is available to the hospital boards for new building, certain very serious shortages of hospital beds exist. In certain respects, these difficulties have become enormously increased by the passing of the National Health Service Act. This particularly applies to beds for chronic sick, and principally among the aged, and to beds in Part III. accommodation of institutions previously maintained, and to some extent still maintained, by local health authorities. It is twice as difficult now to get elderly patients accommodated institutionally, either for simple care and maintenance, or for attention to some medical condition as it was prior to the passing of the Act. I continually get frantic appeals from medical practitioners for help in dealing with cases of this kind. These appeals are frequently accompanied by comparisons between the past and the present in this respect, not to the advantage of the present.

Perhaps the most important speciality in which new building and the provision of more and up-graded accommodation is involved, is the mental health service. That includes mental hospitals and mental deficiency institutions. This difficulty is of course well known, and there is no point in elaborating it. There is no doubt however that the intensified ascertainment of mental defectives, arising out of recent legislation, has magnified the problem very greatly, and in this particular county contacts which were available to us before the passing of the Act are now no longer available. Here again I am afraid that it will be many years before the need is met, if indeed it ever is.

3. *Recruitment and Prospects.*

Undoubtedly one of the principal effects of the coming into operation of the National Health Service Act has been its disturbing effect on young medical graduates in that they can no longer look forward with

full confidence to an assured future in the profession, however hard they work, and whatever higher qualifications they may obtain. Admittedly those who specialise and are lucky enough to obtain consultant posts, in the face of the fierce competition which prevails in many specialities, have an assured future in front of them, but many in the senior registrar grade are bound to fall by the wayside, and in early middle life may have to switch from specialisation to some other form of medical activity. I am sure that it would be a very desirable step to establish a permanent grade between that of senior registrar, which of course is temporary, and that of full consultant which is permanent. Such a grade might well be designated as " Assistant Consultant ", and might carry an intermediate scale of remuneration and clinical responsibility under a certain amount of supervision. In general practice too, because of the difficulties inherent upon the competitive element, no young medical graduate, unless he has a family or other practice into which he is co-opted as a junior partner, knows what his future will be. After 1st April, 1953, the financial assistance to young practitioners setting up in open areas, at the rate of £300 per year, at the outset apparently ceased. Thereafter, young doctors going to what might be called unpopular areas will get a grant of £600 from the Ministry during the first year. This grant falls to £200 in the third year, and is only payable if the total earnings do not exceed £1,100. The position therefore appears to be that young doctors are left with the option : —

(a) of trying to get into established practices as partners if they can.

(b) of setting up in open areas without any financial assistance, or

(c) of going to the unpopular areas with some financial assistance for a year or two, and probably with the prospect of remaining in these unpopular areas for the rest of their professional lives.

In public health, while there is no difficulty in entering the service, the number of well paid posts is relatively few, and the salary of the assistant medical officer, unless he manages to leave this grade, was, until amended by the latest award, by comparison meagre indeed.

There remain, of course, the appointments in the services, in the Colonial Service, in industry, and so on, but I for one feel that inevitably the risk indicated above is bound to have its repercussions in the years ahead in the number and quality of the men and women who decide to take up medicine as a profession.

Tuberculosis.

Your attention is drawn to the statistical table on page 127 giving the notifications of, and deaths from, pulmonary tuberculosis in the administrative county over a period of years . It will be noted that the *notifications* in the last two or three years have risen substantially. That is not surprising because, with the introduction of a chest service with whole-time specialist officers, and with the introduction to the area of the mass miniature radiography unit this was only to be expected. A very large number of the notifications refer to cases discovered at an early stage when they are most amenable to treatment. It will be noted that the deaths from pulmonary tuberculosis for 1952 have fallen sharply to a new low level. At 43 deaths for the year this means, as will be seen, a reduction of more than half the average figure for the years 1946 to 1950, inclusive. It is, of course, too soon to prophesy, but as the Chief Medical Officer of the Ministry of Health has said recently there are grounds for " qualified optimism in the death returns," and it looks as if the tide may have turned.

Admittedly this is not the whole story, because the introduction of chemo-therapy, and other new lines of treatment, has also resulted in an appreciable number of cases which would previously have died becoming stationary at the chronic fibroid stage. While the expectation of life of these patients has been prolonged it must not be overlooked that a great many will have a positive sputum, and are therefore infectious to their contacts. There can, however, be no doubt that the chest service initiated under the provisions of the National Health Service Act of 1946 is paying its way. Comparisons, as one has said before, between the efficiency of the chest service as we now know it and the tuberculosis service which existed prior to 1948, which are, or were often made to the detriment of the latter, are in my view completely unprofitable because the chest service works with new weapons, both medical

and surgical, which were not available to the tuberculosis officers of former days.

It may be worth noting that by the time this report is in your hands the number of sanatorium beds available for patients in the Special Area will have been raised to about 230, with the addition in a year or two's time of some 40 further beds in West Cumberland should the need for these still exist when the beds are ready. The loss of the proposed beds at Camerton was a serious blow, but the steps which have been taken since the Camerton proposal had to be abandoned have gone some considerable way to providing compensatory accommodation.

Immunisation and Vaccination

There has been nationally a falling off in the percentage of babies immunised before their first birthday, and *the Ministry are most anxious that every publicity should be given to the fact that, while the menace of diphtheria has largely been removed from the population as a result of immunisation, if we as a country get slack about this the menace will undoubtedly occur.* Diphtheria is as deadly a disease as it ever was, and there are no grounds for complacency even admitting that the results of the immunisation campaign have been dramatically successful. The target is to get 75 per cent. of the infant population immunised before their first birthday. The curious thing is that in this county we find hesitation among parents to have their children immunised at a very early age. Immunisation figures during the first year are not satisfactory. They improve during the second year, but the desired percentage is not reached until the children are about to enter school on their fifth birthday.

So far as the school population is concerned, the figures are good, and probably not less than 95 per cent. of school children have been immunised. It is quite impossible to be more precise for reasons which need not be entered into here. We have not "let up" in any way in our efforts to maintain a high level of immunisation at the earliest possible age, but the position is as stated above.

With regard to vaccination, the position is not satisfactory either. A very considerable proportion of the population of this county is unvaccinated. People

just will not be bothered until a case of smallpox arises in the district. When that happens they run to the vaccination centres like sheep. In saying this I am, of course, not speaking of the local, but of the national position. We have been very fortunate in not having had a case of smallpox in this county for many years, but we have had reminders more than once in recent years, and even months, that virulent smallpox is still a danger to be guarded against, perhaps particularly in these days of increasing international travel. We have been reminded of this by quite serious, if small, epidemics at no very great distance from our county boundary.

Care of the Aged

I said something about this in last year's report, and in the meantime there has been evidence all over the country of increasing interest in this question. Locally, I have on your instructions ascertained the views of the district nurses and health visitors on this problem in their respective areas. The Joint Health Consultative Committee also has had the matter under consideration, and the Cumberland Old People's Welfare Committee have approached the Cumberland Federation of Women's Institutes to enlist their co-operation. In this connection the appropriate officers of the County Council were invited to attend the annual meeting of this body. All these various efforts at the moment are primarily fact-finding in their approach. Before we attempt to grapple with this problem we must be clear what the problem is, and what is its scope. In this connection it is rather astonishing to realise that the 1951 census showed that there are in the administrative county something like 22,000 people over the age of 65. The problem, therefore, is very wide in its scope, and complicated in its definition. The problem is to find out how many of these old people are lonely and bored with life, or suffer from ailments of one kind or another which we, as a health and welfare authority, could do something to alleviate.

The general impression gained from the replies from the district nurses and health visitors *is that one of the most definite needs is for a chiropody service.* There are two other obvious directions in which help could be given; for example, a number of nurses have

asked whether old persons in their areas could be provided with hearing aids. Others have drawn attention to failing sight. These may well be matters which the old people concerned have just accepted as inevitable, and may not even have mentioned to their family doctors. All this is going to take some time to sort out, but it should prove to be well worth doing, and let us not forget that this problem as the population ages, which it is steadily doing, will become as the years pass ever more pressing.

The British Red Cross Society have issued a valuable list of "Aids to the Disabled" and I think it is clear that investigation will show that in a proportion of the cases of aged persons which we have under review, these aids could be of great benefit.

Home Help Service

At the time of writing this report the scales on which contributions are recovered from the households concerned have just been revised. The need for the new scales, which are set out in detail later in the report, arose because of the wide margin between the gross expenditure on the wages, travelling expenses, etc., of home helps on the one hand, and the contributions recovered from the households concerned on the other. For 1952-53 our estimate of expenditure in respect of wages, travelling expenses, etc., to home helps was £10,000. In actual fact the expenditure during the year was over £16,000 and the estimate for the current financial year was raised to £18,000. Nevertheless, between the time that the estimates were prepared, and the time that they were submitted in the annual budget for approval by the Council, demands for this service had increased so much that the approved estimate of £18,000 appeared likely to be exceeded during the current financial year by £5,000 or thereabouts. In view of the need for all departments in their respective services to keep within the estimates approved by the Council this position, which had become apparent even before the financial year had actually started was sufficiently serious. All of the 200 cases on the books were carefully reviewed with a view to reduction of the hours for which the home help services were provided to bring the expenditure into line with the estimate. This frankly proved impossible, and the position is that after six months of the financial year

have gone there will be a stock-taking to see where we stand.

There is no lack of evidence from the medical profession, from the district nurses, from such organisations as those concerned with the blind, of the immense value of this home help service as a social provision. It must not be forgotten that if the service is expensive on the one hand, nevertheless on the other it is an economy, because it allows aged and infirm persons to remain living in their own homes instead of having to be transferred to our crowded Part III accommodation, and also prevents our children's homes, already crowded, from becoming overcrowded.

Mental Deficiency

I am extremely glad to say that in this matter we are beginning to see a certain amount of daylight. At Dovenby Hall Hospital the new in-patient blocks are likely to come into occupation later in the year, and there has been a certain amount of transfer of patients from this area to accommodation on the East Coast part of which is really a re-transfer of patients who came from the East Coast during the war. All this will make an appreciable easing of the accommodation position, but it will to some extent be offset by a reduction in the gross overcrowding at Dovenby Hall Hospital which has hitherto been unavoidable because of the bed position.

Health Centres and Clinics.

No progress has been made in the county in the matter of the provision of health centres using these words in the strictly limited sense now in general use. Very little appears to be happening in this matter in the country as a whole. In the matter of the Flatt Walks site at Whitehaven to which reference is made below, there have been informal consultations with the Ministry as to the type of health centre which might ultimately be built there if space is available and if the need for such a health centre is ultimately demonstrated. In the matter of clinics and treatment centres the long awaited new treatment centre for Millom is now at last under way. Provision is made in the capital estimates for the current year for new clinics and treatment centres in the Valley scheme at Whitehaven and

at Penrith. Our clinic at Penrith—the first to be established in the county—which is a converted private dwelling, has now been in operation for 40 years, and clearly requires replacement.

I am far from satisfied with the buildings associated with this department which we use in Whitehaven. These are the divisional office, the principal clinic for the area at Sandhills Lane and the subsidiary clinic at 10 Scotch Street which is at present used as an occupation centre, as a child guidance centre and for other purposes. These premises are far from adequate, are cramped and inconvenient, and I venture to suggest that the time has now come when a scheme for the erection of modern buildings for all the above purposes on the site at Flatt Walks, which is a good site and central, should be considered and, I would hope, approved in principle.

Nothing, of course, can be done in the current financial year because there is no provision in the estimates, but I would hope that in the next financial year it might be possible to make a start. I would venture to remind you that our requests for new buildings for the work of this department have been extremely moderate. Within the last 20 years we have only asked for new clinics at Aspatria, Egremont, and more recently at Millom, and for the provision of a handful of houses for our district nurses. It is, therefore, with some confidence, even in view of the current financial position, that I venture to submit the Flatt Walks development scheme.

Thanks

I have again to record my thanks to the members of my staff for the way in which they have carried out their duties during the year, and to the members of the Council, and particularly the chairman and members of the Health Committee. and its sub-committees, for their active and continuing interest in all branches if the work.

The preparation of a report of this kind is necessarily a complicated business and I have to depend on help from many sources in its compilation. Each year I am indebted to the Clerk of the County Council, the County Treasurer and the County Architect for their help in the sections on water and sewage, finance and

housing repectively. I am indebted to the County Welfare Officer for his analysis of the Welfare Services. In my own department I am indebted to heads of sections, chiefly for their assistance in the preparation of the mental health, nursing, and dental sections. I am indebted to members of the clerical staff for much help in the preparation of the statistics. I am indebted to the consultant chest physicians for their sections on tuberculosis and the chest service, to the consultant venereologist for permission to use his report to the Special Area Committee on venereal disease, to Dr. Faulds for the note on laboratory services, and to the secretaries of the East and West Cumberland Hospital Management Committees for statistical information.

Summary

In accordance with the instructions of the Health Committee, I am to summarise each year the recommendations contained in the report, and to draw attention to any parts of the report which may be of particular interest. The points to which attention may be drawn in this particular report seem to me to be as under :—

1. The substantial fall in the death rate from pulmonary tuberculosis is noted.
2. The care of the aged in their own homes is becoming of increasing importance, and has been the subject of discussion at various conferences, and at officer level. Contact has been established with the County Federation of Women's Institutes who have in a considerable number of districts appointed members to work in close co-operation with the district nurses as friends of the ages in their respective districts. Something has been done to investigate cases of failing sight, increasing deafness, and certain other groups, to see what can be done to alleviate the impact of these disabilities on their lives.
3. Reports have been received on the problems of the aged from all health visitors and district nurses in their respective areas. Various valuable suggestions arise from these reports, but the one service which stands out above all others in this matter as required all over the county, is the institution of a domiciliary chiropody service. Obviously such a service will necessarily be extremely difficult to organise and

and would not be inexpensive, but I would be glad to have your instructions as to whether this matter should be further explored.

4. I will be glad of instructions on the question of the provision of " Aids for the Disabled " to selected aged persons.
5. Attention is drawn to the increasingly difficult problem of guardianship in the care of mental defectives.
6. The mortality among premature infants remains high, and authority is sought for the provision of special equipment in two ambulances, one in East Cumberland and one in West Cumberland to ensure greater safety in the transport of premature infants from their homes to the premature units in the hospitals when necessary.

With regard to the question of drawing attention to those parts of the report which seem to merit special attention, it is as I said last year, extremely difficult to place any sections in an order of priority. While I venture to hope that the report as a whole merits study, perhaps one might particularly refer to the sections on tuberculosis, mental health, the home help service, and the ambulance and transport service, and the section by the Council Welfare Officer on the welfare services.

I am, my Lord, Ladies and Gentlemen,

Your obedient Servant,

KENNETH FRASER,
County Medical Officer.

County Health Department,
11 Portland Square,
Carlisle.

July, 1953.

STATISTICAL AND SOCIAL CONDITIONS OF THE AREA

The essential vital statistics for the year 1952 are as under:—

Population

	At 1951 Census.	Estimated by Registrar General Mid. 1952.
Urban Districts	86,335 ...	85,900
Rural Districts	131,118 ...	129,150
Administrative County ...	217,453 ...	215,050

Population of Sanitary Districts, 1952

Urban Districts		
Workington	28,780	
Whitehaven	24,630	
Maryport	12,310	
Penrith	10,350	
Cockermouth	5,170	
Keswick	4.660	
		85,900
Rural Districts		
Border	30,200	
Ennerdale	28,580	
Wigton	23,510	
Cockermouth	19,390	
Millom	13,700	
Penrith	11,510	
Alston	2,260	
		129,150
Total for Administrative County ...		215,050

Rateable Value and sum represented by a penny rate.

The rateable value of the County at 1st April, 1952, was £1,103,329. The estimated product of a penny rate was £4,206.

Extracts from vital statistics for the year 1952.

LIVE BIRTHS

	Total Births	Males	Females
Legitimate	3.582 ...	1,772 ...	1,810
Illegitimate	132 ...	60 ...	72
Total	3,714 ...	1,832 ...	1,882

Birth Rate per 1,000 population 17.3 (England and Wales 15.3).

STILL BIRTHS

	Total Still-Births	Males	Females
Legitimate	92 ...	50 ...	42
Illegitimate	2 ...	2 ...	—
Total	94 ...	52 ...	42

Rate of Still-Births per 1,000 total births 25.

DEATHS

Total Deaths	Males	Females
2,603	1,409	1,194

Crude Death Rate per 1,000 population 12.1
(England and Wales 11.3)

DEATHS FROM DISEASES AND ACCIDENTS OF PREGNANCY AND CHILDBIRTH.

Pregnancy, Childbirth and abortion 3

Maternal Death Rate per 1,000 Total Births—0.79

DEATH RATE OF INFANTS UNDER ONE YEAR OF AGE.

All Infants per 1,000 Live Births 32
Legitimate Infants per 1,000 Legitimate Live Births 31
Illegitimate Infants per 1,000 Illegitimate Live Births 53

DEATHS FROM CANCER (ALL AGES) 361

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

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

DEATHS FROM GASTRITIS, ENTERITIS AND DIARRHOEA (Under 1 YEAR) 10

The 3,714 live-births were distributed among the Urban and Rural Districts as follows:—

Births, 1952.

Urban Districts	Total Births	Legitimate	Illegitimate	Birth Rate
Cockermouth	98	95	3	19.0
Keswick	52	50	2	11.2
Maryport	245	238	7	19.9
Penrith	162	154	8	15.7
Whitehaven	481	462	19	19.5
Workington	478	463	15	16.6
Aggregate of Urban Districts	1,516	1.462	54	17.6
Rural Districts.				
Alston	43	41	2	19.0
Border	426	410	16	14.1
Cockermouth	286	274	12	14.7
Ennerdale	543	522	21	19.0
Millom	240	235	5	17.5
Penrith	222	215	7	19.3
Wigton	438	423	15	18.6
Aggregate of Rural Districts	2,198	1,920	78	17.0

The 2,603 deaths were distributed among the Urban and Rural Districts as follows:— ,

Deaths, 1952

Urban Districts	Total	Males	Females	Crude Death Rate
Cockermouth	76	38	38	14.7
Keswick	68	33	35	14.6
Maryport	156	88	68	12.7
Penrith	134	72	62	12.9
Whitehaven	329	167	162	13.4
Workington	348	205	143	12.1
Aggregate of Urban Districts	1,111	603	508	12.9
Rural Districts				
Alston	32	18	14	14.2
Border	322	181	141	10.7
Cockermouth	239	125	114	12.3
Ennerdale	341	170	171	11.9
Millom	160	83	77	11.7
Penrith	119	67	52	10.3
Wigton	279	162	117	11.9
Aggregate of Rural Districts	1,492	806	686	11.6

Causes of Death.

	No. of Deaths.
Heart disease	962
Vascular lesions of nervous system	409
Cancer	361
Bronchitis	84
Tuberculosis—respiratory	43
Tuberculosis—other	9
Other circulatory diseases	106
Pneumonia	73
Influenza	9
Hyperplasia of prostate	15
Motor vehicle accidents	36
All other accidents	40
Nephritis and nephrosis	35
Congenital malformations	22
Gastritis, enteritis and diarrhoea	17
Diabetes	14
Other diseases of respiratory system	28
Ulcer, stomach and duodenum	24
Suicide, homicide and operations of war	17
Acute poliomylitis	1
Syphilitic disease	6
Meningococcal infections	4
Other infective and parasitic diseases	2
Leukaemia	7
Pregnancy, childbirth, abortion	3
Other defined and ill-defined diseases	276

Infantile Mortality.

Of the 3,714 live births during the year, 119 infants died before reaching the age of 12 months. The infant death-rate per thousand live births is 32, compared with 34 for 1951. The figure for England and Wales is 27.6.

Causes of Death.

	No. of Deaths.
Tuberculosis—respiratory	1
Influenza	1
Pneumonia	22
Bronchitis	4
Gastritis, enteritis and diarrhoea	10
Congenital malformations	17
Other defined and ill-defined diseases	59
Accidents	4
Meningococcal infections	1
	119

Of the above 119 deaths among infants under the age of twelve months, 40 represented deaths of premature infants within the first 28 days. 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	28.6
Whitehaven	17	35.3
Penrith	4	24.7
Workington	11	23.0
Cockermouth	4	40.8
Keswick	1	19.2
Aggregate of Urban Districts	44	29.0
Rural Districts.		
Millom	4	16.7
Cockermouth	16	55.9
Alston	1	23.3
Wigton	10	22.8
Ennerdale	24	44.2
Border	12	28.2
Penrith	8	36.0
Aggregate of Rural Districts	75	34.1

1952 Rate for England and Wales ... 27.6
1952 Rate for Cumberland County ... 32

PART I.

National Health Service Act, 1946

Administration

Co-ordination and co-operation with other parts of the National Health Service

Joint use of staff

Voluntary organisations

The Nursing Services

Care of expectant and nursing mothers, and children under school age

Child welfare

Care of premature infants

Supply of dried milks

Dental Care

Domiciliary Midwifery

Health visiting

Home nursing

Vaccination and immunisation

Ambulance service

Prevention, care and after-care

Domestic help

Health education

Mental health

1. ADMINISTRATION

"*Brief description of administrative organisation, including arrangements for control, supervision and co-ordination of the services at officer level and, in counties, of any arrangements made for decentralised management of particular Local Health Services, through Area Sub-Committees or otherwise, indicating whether decentralisation operates over whole county or in some parts only, functions devolved, and general lines of constitution of Area Sub-Committees (e.g. whether members of Local Health Authority or members nominated by County District Councils are in a majority and what other interests are represented). Joint arrangements, if any, with other local health authorities.*"

The administration of the health services, apart from matters concerning the school health service, rests, subject to the general control of the County Council, in the hands of a Health and Housing Committee of 41 members of whom 26 are members of the County Council and the remainder co-opted members representing the medical, nursing, dental and pharmaceutical professions, hospital management committees, the mental health services, together with persons representing those formerly specially interested in the district nursing associations, etc. The committee is therefore widely representative. The standing sub-committees are as follows :—

Joint (Health and Education) Sub-Committee
Ambulance and Sitting Case Car Sub-Committee
General Purposes Sub-Committee
Health Centres and Clinics Sub-Committee
Mental Health Sub-Committee
Nursing Sub-Committee
Welfare Sub-Committee

The Welfare Sub-Committee while a sub-committee of the parent committee, nevertheless largely acts independently and is advised on general policy by the County Welfare Officer, and on medical matters by the County Medical Officer.

Arising out of circular 118/47 which gave local health authorities the alternative—

(a) of setting up decentralised administration (paragraph 20), or,

(b) of setting up a system of care committees (paragraph 41)

the Council decided on the former course, and established two health area sub-committees, one for the east of the county, based on Carlisle, and one for the west, based on Whitehaven.

A divisional office was set up at Whitehaven, and divisional medical officers were appointed for the two areas. The functions of these area sub-committees were defined as shown by the following extract from the County Council minutes :—

"Functions of Area Sub-Committees

"The following Health Authority matters shall, subject to the subsequent clauses hereof, stand referred to the appropriate Area Sub-Committee on behalf of the Health Committee together with such other matters as the Health Committee may from time to time decide:—

(a) The appointment, within such establishment as may from time to time be approved by the County Council, of officers of the Council engaged exclusively in health work relating to the area, whose salary (excluding emoluments and cost of living bonus) does not exceed £450 per annum.

(b) The day to day administration of :—

(i) the School Health Service, subject to the concurrence of the Education Committee

(ii) child welfare

(iii) the Nursing Services, excluding midwifery, under the general supervision of the Superintendent Nursing Officer.

(iv) vaccination and immunisation

(v) the Ambulance and Sitting Case Car Services

(vi) clinics and treatment centres but excluding the provision of new buildings.

(vii) Health centres
(viii) Day nurseries

(c) Power to make recommendations to the Health Committee on any health matters affecting the area.

"The Area Sub-Committee shall have power to expend on maintenance, repairs and equipment of clinics and treatment centres, and on other Health Services up to a figure not exceeding £200 on any individual item provided that the item is included in the annual estimate of expenditure of the Health Committee.

"All questions of policy to be subject to final confirmation by the Health Committee.

"In accordance with the general principle already adopted by the County Council, the Health Services under the National Health Service Act 1946, will be under the general supervision and administration of the County Medical Officer.

"The Area Sub-Committees shall not have the power:—

(i) Of raising a rate or borrowing money.
(ii) Of purchasing or other acquisitions of any land or buildings.
(iii) Of the sale, letting or other disposal of any land or buildings.
(iv) Of revision of any scales or salaries or wages which have been approved by the County Council.

"The following services are specifically excluded from the functions of Area Sub-Committees:—

(i) the Mental Health Service
(ii) the Orthopaedic Service.
(iii) the Dental Service
(iv) the appointment of specialists and arrangements for specialist treatment whether institutional or domiciliary.

"The Area Sub-Committees shall report to the Health Committee their actions and recommendations.

"This scheme is subject to the right of the County Council from time to time to make such amendments

as they may think fit and to such directions as the County Council or their Health Committee may from time to time give.

"The Clerk of the County Council shall act as Clerk of the Area Sub-Committee."

The composition of these area sub-committees was as follows:—

East Cumberland—23 members, 15 being members of the County Council, or co-opted members of the Health Committee, and 8 being nominated by the councils of county districts in the area.

West Cumberland—25 members, of whom 15 were members of the County Council, or co-opted members of the Health Committee and 10 were nominated by the councils of county districts in the area.

The implementation of these very desirable proposals for bringing the work of the local health authority into co-operation with the work of the local sanitary authorities as expressed through their appointed representatives, has not been easy. To take a typical example—the Ambulance and Sitting Case Car Service has involved policy decisions, and negotiations with contractors of one kind or another, which could only be carried out on a county basis. The same difficulty has arisen under several, if not most of the other matters referred to the area sub-committees. In practice it really amounts to this — decentralised administration can work, and is probably desirable in the very large counties, particularly those which are highly industrialised, but in a county with the population of Cumberland, decentralised administration is extremely difficult to effect, and probably not productive of the objects aimed at.

Some years ago the divisional medical officer for East Cumberland, who was also the deputy county medical officer, resigned and left the county, and this appointment has not been filled. In practice it was found that having a divisional medical officer for East Cumberland working in the headquarters office, with separate responsibilities, was cumbersome and led to overlapping and confusion.

In West Cumberland, arising out of the awards of the Industrial Court, the post was re-classified as Senior Assistant County Medical Officer, West Cumberland. In practice the health area committees have

met infrequently, and the matters calling for attention have mainly been concerned with clinics and treatment centres.

Joint arrangements with other local health authorities are few, and for the most part concern matters of detail, as for example, Cumberland, Carlisle and Westmorland have a joint arrangement with regard to their financial liabilities at St. Monica's Diocesan Maternity Home, Kendal.

The county have arrangements with Carlisle Corporation for the filtering of certain emergency ambulance calls through their ambulance headquarters. The county ambulance service at Penrith undertakes by arrangement, responsibilities in North Westmorland. Certain other instances might be given—for example one or two county children are, with the approval of Carlisle Corporation, admitted to the occupation centre at Kingstown.

Broadly speaking however, there are no major matters on which there are joint arrangements with other health authorities.

2. CO-ORDINATION AND CO-OPERATION WITH OTHER PARTS OF THE NATIONAL HEALTH SERVICE.

" General arrangements in the area for securing co-ordination between Local Health Services and the Hospital and Specialist Services and the General Practitioner Services. Ways in which medical officers, health visitors, midwives or nurses employed in the Local Health Services are co-operating in the care of patients under treatment (a) at hospitals (b) by general medical practitioners. Assessment of effectiveness of these arrangements and any suggestions for improving them."

Steps taken to inform

(a) general practitioners

(b) the public

about services available and how their help may be obtained. (If a guide to the Local Health Services has been issued it will be helpful if a copy of it may be forwarded with the advance copy of the survey)."

Following upon a preliminary conference and local negotiations a Local Joint Health Consultative Committee has been set up to cover the Special Area (Cumberland, Carlisle and North Westmorland). This com-

mittee is representative of the local health authorities, the Special Area Committee, the hospital management committees and the executive councils in the whole of the Special Area. According to present arrangements, this committee is likely to meet six-monthly. It is, of course, generally recognised that the deliberations of the committee are almost inevitably to be at policy level, and it is I think realised that co-operation between hospital consultants and general practitioners and medical officers of health must mainly be a matter of individual co-operation.

To further this latter approach, a conference was held at the Cumberland Infirmary in November, 1952. The conference was arranged by the Medical Advisory Committee for East Cumberland, and those invited to attend included the consultants on the staff of the Cumberland Infirmary, representatives of local medical committees, and the medical officers of health for the component parts of the Special Area. The conference was well attended and a frank and friendly exchange of views took place, which, it was hoped on all hands, would result in closer co-operation between the various sections of the health service in this area. Arising out of the conference, a meeting between the local medical committee for the county of Cumberland (comprising twenty-five general practitioners from all parts of the county) and myself as County Medical Officer took place during the month of February.

The eye, ear nose and throat, and orthopaedic clinics formerly run by the County Council under the direction of part-time specialists employed by the council, are now continued—for the most part on premises maintained by the County Council—under the direction of consultants (largely the same personnel as before) now seconded without charge by the Regional Hospital Board.

Reference should probably be made here, although this service falls more properly under the school health service, to the fact that consultant psychiatrists have also been seconded to our child guidance centres by the Regional Hospital Board.

In the chest service (referred to in greater detail under Section 11) there is, of course, a joint arrangement whereby the local health authorities contribute three/elevenths of the salaries of the consultant chest physicians, and in various ways have co-operated, and to

some extent still co-operate in the provision of premises and nursing staff. At the time of writing the salary position is under review.

The other branch of co-operation in actual treatment lies chiefly in the district nursing service, in which our district midwives and district nurse/midwives all over the county co-operate closely, in the first instance with general practitioners in their respective areas in the nursing care of their patients, and, as requested by the hospital, with the knowledge and concurrence of the general practitioners, in the aftercare of hospital patients on their discharge. The County Council are anxious, if possible, to extend this co-operation by our nursing staff, and last year made an approach to the Special Area Committee with this object in view. The proposal filtered through the hospital management committees and the medical advisory committees and the Local Medical Commitee, but so far nothing material has developed.

In one branch there has been developing between a member of the County Council staff and the hospital department concerned a close co-operation. This lies in the orthopaedic service, where our senior orthopaedic physiotherapist, at the invitation of one of the consultant orthopaedic surgeons, has the entrée to the Cumberland Infirmary in respect of his in-patients and out-patient clinics. There has been some development in the direction of our orthopaedic physiotherapy staff co-operating in the aftercare of orthopaedic patients on their discharge from hospital, particularly in respect of those discharged in plaster.

It is difficult to assess the effectiveness of these arrangements and to make suggestions for improving them. I think it is generally agreed that co-operation could be closer to the benefit of the various branches of the service, and particularly to the benefit of the patients, and I feel sure that goodwill to that end is general. The steps indicated above to initiate closer co-operation will, I feel sure, produce results in due course, but this clearly is not a matter which can be rushed.

With regard to the question of steps taken to inform the general practitioners of the services provided by the

council, I think it may safely be said that in all important matters the practitioners have been kept fully informed. Examples of this are : —

(a) A card setting out the arrangements for the ambulance and sitting-case car service.

(b) A card setting out the arrangements for the home help service.

(c) Certain letters issued to all practitioners on the Wassermann and Rh. testing of expectant mothers.

These are merely examples of the steps taken by circulation to all practitioners to keep them fully informed. Perhaps in addition, it should be added that both to the conference of consultants and practitioners held at the Cumberland Infirmary, and to the conference with the Local Medical Committee held in February, there was circulated detailed information as to the services provided by the County Council.

With regard to the dissemination of information among the general public, this is not such an easy matter in a scattered rural county. To take, however, as examples, two services, the ambulance and sitting-case car service, and the home help service, cards have been distributed widespread to the number of not less than one thousand copies, and probably many more, among representative bodies and sections of the community throughout the county. As a further example, leaflets relative to vaccination and immunisation against diphtheria are distributed, through the registrars, to all persons registering births in the county. In our clinics and offices we exhibit considerable numbers of posters in the direction of health education, and our health visitors distribute large numbers of leaflets on these matters or on such other matters as the prevention of accidents in the home, in the normal course of their duties. There is, however, one great difficulty in this matter of the exhibition of posters. The number of posters which reach this department in connection with one form of propaganda and another is so large that the walls of all our clinics could be covered from top to bottom with them. To exhibit on that scale is to defeat its own ends, and therefore the conclusion we have come to is to select the most striking and informative posters and leaflets and exhibit or distribute these. No posters or handbills have been

locally initiated other than such things as the ambulance and home help cards referred to above. No guide to the local health services has yet been issued, but one is in contemplation.

3. JOINT USE OF STAFF

"*Extent doctors in general practice work for the authority on a part-time or sessional basis, and kind of work carried out by them; also note of any arrangements for medical or other officers employed by the authority to work part-time in the Hospital and Specialist Services and of arrangements for consultants or other medical staff employed by Regional Hospital Boards or Boards of Governors to work in the authority's service.*"

No general practitioners undertake work for the authority on a part-time or sessional basis other than the long standing arrangement dating back some twenty-five years under which the County Council, with the approval of the Ministry, instead of setting up their own system of ante-natal clinics throughout the county, have employed general practitioners to conduct and report on the ante-natal condition of expectant mothers, and latterly to conduct post-natal examinations in addition to the arrangements whereby medical practitioners accept responsibility to the Executive Council for the ante-natal and post-natal care of women booked by them. The volume of this work undertaken on behalf of the County Council, has markedly decreased; nevertheless it still operates in all cases booked by midwives in the administrative county, which still means something like one thousand cases a year.

The medical practitioners in the county also, as will be seen under the section dealing with vaccination and immunisation, undertake considerable numbers of vaccinations and innoculations against diphtheria under financial arrangements which have been referred to in previous annual reports. More recently the County Council, as will be seen later under Section 6, have asked practitioners to co-operate with this department in the taking of blood samples from expectant mothers.

In the Alston district a local practitioner has been appointed part-time assistant county medical officer to deal with the school health and child welfare service, and holds what really is an off the pattern mixed

appointment. Reference has been made under Section 2 above, to the valuable work done by the consultants seconded by the Regional Hospital Board in the direction of certain specialist clinics.

No medical officers employed by the authority take any share in the hospital work in the area, but the Senior Dental Officer and one of his assistants hold, with the permission of the council, part-time appointments as dental officers in the hospital service. One of these dental officers has specialised in oral surgery and his services have, I know, been much appreciated by the hospital authorities. Until recently one of our dental officers specialised in orthodontics until his resignation in 1952 to take up a university appointment as lecturer in orthodontics. He co-operated when requested on orthodontic problems.

4. VOLUNTARY ORGANISATIONS

"General statement of use made of voluntary organisations in the Local Health Service."

Until a year or two ago, the County Council had extensive connections with voluntary organisations for the carrying out of certain of their services under agency arrangements. These were chiefly with the Cumberland Nursing Association and with the Association for Mental Welfare, both, of course, voluntary bodies. With the progress of time, most of these arrangements with voluntary bodies have lapsed, and at the moment the chief association between the health authority and voluntary associations is :—

(a) In the welfare of the blind, in co-operation with the Cumberland, Carlisle, and Westmorland Workshops for the Blind.

(b) In the care of the deaf in co-operation with the Carlisle Diocesan Association for the Deaf and Dumb.

We also have continued our association with the Church of England and Roman Catholic diocesan associations for moral welfare, and we send unmarried mothers to maternity homes run by these voluntary bodies, as circumstances arise. Both of these diocesan organisations give us valuable help through their contacts with these young girls from the domiciliary aspect, both before and after their confinements, and in some cases

are able to give us valuable help in the problems concerning the future disposal of the children.

The council send patients for convalescence to a number of convalescent homes run by voluntary bodies, perhaps, in particular, children to the Sunshine Home at Allonby, whose affairs are administered by a voluntary committee.

NURSING SERVICES

Before coming down to the detailed consideration of what might be called the subsections of this service, midwifery, general nursing, and so on, it may be well to make one or two comments on the development of the nursing services since this was taken over by the County Council from the Cumberland Nursing Association in April 1950. There have been four essential targets:—

1. To replace the village nurse/midwife, whose training was limited to twelve months (six months midwifery, six months district training) and in some cases was less, by state registered nurses with the full three to four years training and with twelve months midwifery training in addition, and to obtain the services of as many nurses as possible holding the certificate in district training of the Queen's Institute, and to recruit as many nurses as possible with the health visitor's certificate, or alternatively to arrange for the training of our district nurses in this respect.

2. To see that all nurses engaged in domiciliary practice were provided with telephones, and in the great majority of cases, with motor cars.

3. To see that all our nurses were properly housed.

4. To provide post-graduate training on a definite rota.

These targets imply, let me emphasise this very strongly, no disparagement whatsoever of the magnificent work done by the village nurse/midwives over long periods of years, working under conditions far less favourable, going to their cases on foot or on bicycles, often inadequately housed, not on the telephone, in receipt of the most meagre salaries, and generally working under conditions which would have disheartened any but the most stout-hearted. Nor is there the slightest criticism of the equally magnificent

work undertaken by the Cumberland Nursing Association and its affiliated district nursing associations for over 50 years. The facilities they were able to provide were naturally less, because, being voluntary bodies primarily depending on voluntary support, they simply had not the funds to play with. It is remarkable that they accomplished what they did in the circumstances.

The above targets are gradually in process of being achieved. We now have 44 Queen's or State Registered Nurses, and 33 State Enrolled Assistant Nurses all with one exception being State Certified Midwives.

The housing position unfortunately has made little progress during the year. Only one new nurse's house has been built at Bewcastle. We hope however that during the coming financial year the number of houses specially built for nurses will have increased by about 10. Of these, it is anticipated that two will be built by the Cockermouth R.D.C., and two by the Wigton R.D.C., both of which housing authorities have been consistently helpful. Most of the remainder will be built by the County Council. There remain some 15 houses to be provided in one way or another before the position could be regarded as satisfactory.

In the matter of transport the County Council now own 62 nurses cars and 12 nurses own their own cars. Only 4 district nurses are without motor transport. The midwives in Whitehaven have now all cars, and one car has been provided for the midwives in Workington and another will shortly be provided. The facilities for engaging taxis for the transport of gas and air apparatus or in emergency, are of course still available to those midwives who are not yet provided with cars.

The number of district nurses not yet on the telephone has been reduced to 6, and it is anticipated that several of these will be provided with telephones during the coming year.

Twelve months ago I referred to two nursing districts which were vacant. We were able to fill one of these during the year, but another district fell vacant on 31st December. The position therefore today, is that there are two vacant districts, the work in which is covered by adjoining nurses or relief nurses, as the case may be, but it is rather disturbing to note that repeated

efforts to endeavour to fill these vacancies have produced little or no response. All this emphasises the importance in a scattered rural county, of improving the housing conditions of our nurses, to make our posts, as they become vacant, more attractive.

5. CARE OF EXPECTANT AND NURSING MOTHERS AND CHILDREN UNDER SCHOOL AGE

"Expectant and nursing mothers. General statement of facilities provided for ante-natal and post-natal care (including specialist clinics, assistance given at clinics in general practitioners' own premises, blood testing arrangements and unmarried mothers) and mothercraft training and of extent to which used. Arrangements for supply of maternity outfits."

As noted above, the arrangements for ante-natal care in this county have long been off the general pattern. Some 25 years ago, owing to the scattered rural area of the county, its geographically large size with a relatively small population, having in mind the difficulty of expectant mothers having to come long distances to ante-natal and post-natal clinics, the County Council submitted to the Ministry a proposal to meet this situation. The proposal was that the Ministry should recognise ante-natal care being carried out by general practitioners of the patient's own choice, either in the homes of the expectant mothers, or at the practitioners' own surgeries. This approach to this problem in a rural area has now been in operation for many years and has worked smoothly and efficiently.

Naturally as the result of the National Health Service Act with its provision for the booking of midwifery patients by general practitioners under arrangements controlled by the executive councils, the responsibility of the County Council as a local health authority, and as a supervising authority under the Midwives Acts has markedly diminished.

At the present time the position is that when an expectant mother books a midwife for her confinement, arrangements are made for the practitioner of the patient's choice to conduct two or more, as may be indicated, ante-natal examinations, and after the confinement to conduct a post-natal examination. At the back of all this, under the arrangements which have

been much expanded in the hospitals since the coming of the Health Service Act into operation, there are three centres located at the City Maternity Hospital, Carlisle, Workington Infirmary, and Whitehaven Hospital, at which out-patient ante-natal clinics and post-natal clinics are conducted by the local consultant obstetricians. Occasional consultant ante-natal and post-natal clinics are also held at Maryport Cottage Hospital.

In addition to the above the local practitioners at Alston, Maryport, Egremont, Frizington, Cleator Moor, Workington, conduct ante-natal examinations at the County Council clinics—in the case of Alston, at the Cottage Hospital, with which we have made arrangements. At Cockermouth the district nurse midwives attend ante-natal sessions at a general practitioner's surgery. At the maternity home at Penrith and at Maryport Cottage Hospital well attended ante-natal clinics are also held.

With regard to blood testing, reference has been made to this under 2 above. This service, which was only started comparatively recently, has got well into its stride.

Reference has also been made to the arrangements for unmarried mothers under 4 above. Perhaps it may be well to elaborate a little on this. These cases come to our notice through midwives, diocesan social workers and others, and thereafter arrangements are made with the voluntary maternity homes referred to under section 4 for the admission of these unmarried mothers for varying periods before the confinement up to several months and for their post-natal care for several months after the confinement. When these girls return home they are kept under special supervision by the health visiting staff for twelve months. As a half-way house before admission to the Church of England maternity home at Kendal if the home circumstances are unsatisfactory, these unmarried mothers are admitted for varying periods to Coledale Hall, Carlisle.

With regard to mothercraft training in the larger urban areas this is being developed, and is likely to expand considerably in the near future. Well established and successful mothercraft classes are held at the City Maternity Hospital, Carlisle, in which expectant

mothers from the area of the administrative county share, and at Workington Infirmary.

Maternity outfits are issued without charge, to all expectant mothers confined in their own homes.

"Child Welfare. General statement of facilities provided for child welfare (including consultant clinics, any other special clinics and any assistance given at clinics held by general practitioners in their own premises) and extent to which used."

The statistics for the year are as under :—

Number of child welfare clinics	15
Number of children under one year of age attending	2184
Number of children between 1-5 years of age attending	2380
Number of attendances	19397
*Defects treated	255

(*Eye defects 161, ear, nose and throat defects 94. Dental and orthopaedic are given elsewhere).

No consultant clinics in respect of child welfare are held. The appointment of a consultant pediatrician for the Special Area has been under consideration for some time, and when funds permit this will materialise. The County Council as a health authority closely concerned with the welfare of young children would welcome such an appointment, and I am sure would gladly share in the financial arrangements. The value of having a pediatrician available not wholly tied up with hospital duties, but available to visit the outlying child welfare clinics, need not be stressed. In the interim it is only right to acknowledge the valuable assistance which has been given us by the appropriate consultants either under the Category II. arrangements or otherwise in respect of quite a substantial number of selected cases which we have referred to them.

There are no arrangements for the holding of clinics by general practitioners on their own premises, but at Alston a general practitioner, as noted above, deals with the child welfare clinics which, by arrangement between the County Council and the Special Area Committee, are held at Alston Cottage Hospital.

"*Care of Premature Infants. Domiciliary provision, including equipment provided; liaison with hospitals (if not already covered under heading 2 above)*".

Special equipment provided for the care of premature infants remaining in their own homes consists of 12 premature baby cots, hot water bottles, electric blankets, Belcroy feeders, and the other ancillary equipment. These items are dispersed at appropriate points over the administrative county, so as to be quickly available.

Reference has been made elsewhere under section 10, to the desirability of installing special equipment in two or three selected ambulances by which the transport of premature infants from all parts of the county to those hospitals in which premature baby units have been established can be carried out under conditions of maximum safety to the infant.

The following tables show the general position in respect of premature infant births for the year 1952. The figures show that 223 children were born alive prematurely during the year—83 of these being born at home, 7 in nursing homes and 133 in hospital. Twenty-six premature children born at home were transferred to hospital after birth.

Of the 223 premature births 40 infants died within 28 days. The proportion of deaths therefore remains approximately the same as for the previous year. The proportion of deaths among premature children born in hospital, and premature children born at home (including deaths among those transferred to hospital) was equal. The proportion of deaths in each group being 1 death to every 5.5 births.

PREMATURE CHILDREN

Premature still-births.	Births at Home. Premature live births. Nursed entirely at home. Died in first 24 hrs.	Died on 2nd to 7th day.	Died on 8th to 28th day.	Survived 28 days.	Total.	Transferred to Hospital	Birth weight	Premature still-births.	Births in private nursing homes. Premature live births. Nursed entirely in nursing homes. Died in first 24 hrs.	Died on 2nd to 7th day.	Died on 8th to 28th day.	Survived 28 days.	Total.	Transferred to Hospital.
2	2	—	—	—	2	—	2 lbs. 3 oz. or less	—	—	—	—	—	—	—
2	—	—	—	—	—	6	Over 2 lbs. 3 oz. up to and including 3 lbs. 4 oz.	—	—	—	—	—	—	—
1	1	1	1	1	4	10	Over 3 lbs. 4 oz. up to and including 4 lbs. 6 oz.	—	1	—	—	—	1	—
1	—	—	—	11	11	3	Over 4 lbs. 6 oz. up to and including 4 lbs. 15 oz.	—	—	—	—	1	1	—
2	—	—	—	40	40	7	Over 4 lbs. 15 oz. up to and including 5 lbs. 8 oz.	—	—	—	—	5	5	—
8	3	1	1	52	57	26	TOTALS	—	1	—	—	6	7	—

TABLE SHOWING PREMATURE BABIES BORN ALIVE AT HOME—SUBSEQUENTLY TRANSFERRED TO HOSPITAL.

Weights in lbs. oz.	Died in first 24 hours.	Died on 2nd to 7th day.	Died on 8th to 28th day.	Survived 28 days.	Total.
2 lbs. 3 oz. or less ...	—	—	—	—	—
Over 2 lbs. 3 oz. up to and including 3 lbs. 4 oz.	3	—	2	1	6
Over 3 lbs. 4 oz. up to and including 4 lbs. 6 oz.	1	1	—	8	10
Over 4 lbs. 6 oz. up to and including 4 lbs. 15 oz.	1	—	—	2	3
Over 4 lbs. 15 oz. up to and including 5 lbs. 8 oz.	—	2	—	5	7
TOTALS	5	3	2	16	26

TABLE SHOWING PREMATURE BIRTHS IN HOSPITAL

Weights in lbs. oz.	Died in first 24 hours.	Died on 2nd to 7th day.	Died on 8th to 28th day.	Survived 28 days.	Total.
2 lbs. 3 oz. or less ...	5	2	—	—	7
Over 2 lbs. 3 oz. up to and including 3 lbs. 4 oz.	3	4	—	4	11
Over 3 lbs. 4 oz. up to and including 4 lbs. 6 oz.	4	1	—	20	25
Over 4 lbs. 6 oz. up to and including 4 lbs. 15 oz.	3	1	—	29	33
Over 4 lbs. 15 oz. up to and including 5 lbs. 8 oz.	—	—	1	56	57
TOTALS	15	8	1	109	133

"Supply of Dried Milks, etc. Arrangements made in co-operation with Ministry of Food for Distribution of welfare foods available under the Government Welfare Foods Scheme, and arrangements made by authority for other dried milks and nutrients to be obtainable, under the authority's arrangements for the care of mothers and young children, when required for medical reasons."

Some years ago, by arrangement with the local offices of the Ministry of Food, arrangements were in operation whereby weekly sessions were held at a

number of the County Council clinics for the distribution of dried milks and welfare foods. These arrangements have largely lapsed because in practice it was found that the attendance of the mothers at the local food offices was equally, if not more, convenient. The arrangements still however persist rather off the general pattern at one or two County Council clinics at different parts of the county.

A limited quantity of dried milks and welfare foods, including vitamin supplements, are distributed, at cost price except in necessitous cases, to the mothers of young children attending the child welfare clinics in the county.

DENTAL CARE

Arrangements made for dental care of expectant and nursing mothers and young children, and steps taken during the year under review to expand these arrangements.

The Senior Dental Officer (Mr. A. C. S. Martin, L.D.S.) submits the following figures in respect of the priority groups referred to above, and a covering note dealing with the general position, as follows :—

" During the year there has been steady improvement in Cumberland as far as dental staff is concerned, and now the position is that from 1st April, 1953, there will be a staff of eight full-time dentists and, in addition, one part-time. The present approved establishment is nine full-time and it is proposed to complete this figure in the near future.

" While this is much better than might have been anticipated a year ago, it is not sufficient to develop fully the dental services, both school and priority, within the county. Much lost ground has to be made up, but there is little doubt that with proper organising this can be accomplished in time, and provided no more wholesale staff disturbances take place, should not of itself call for any additional staff. What has to be recognised is that since the above establishment was approved the Education Act 1944 has come into force. This made two considerable increases as regards the numbers of school children coming under the scheme. First, the raising of the school leaving age to fifteen adds another three thousand or more, and secondly,

the inclusion of the grammar schools for the first time represents another four thousand.

" Under the National Health Service Act, and under the joint circular issued by the Ministries of Health and Education in 1952, the priority note in respect of nursing and expectant mothers, and of children under school age, was again emphasised. The volume of treatment arising out of the cases of expectant and nursing mothers who apply for this treatment, is not large. The policy is that every case of an expectant mother falling into the category of midwives' cases, is offered dental treatment Out of this, during 1952, 1,023 expectant mothers were offered dental inspection and treatment, of whom only 177 returned the form, and of these only 147 actually attended for examination or treatment. Of the above, 78 failed to keep subsequent appointments, so that the number in whose cases treatment was completed amount to 69 for the year.

The position with regard to the treatment of pre-school children is very different. There are in the administrative county some 7,000 to 8,000 children in the three and four year age groups to be catered for. These are, of course, the age groups in which conservative treatment first becomes important. Up till about the end of 1950, the offer of dental inspection and treatment was made to the parents of all children in the county in these age groups. As the dental staff gradually contracted owing to resignations, the procedure had to be abandoned, and during 1952 the approach made through the health visitors and district nurses and not by letter, was very limited, and really dealt only with emergencies. It is hoped during 1953, now that the dental staff has returned to nearly its original strength, to re-institute to some degree the issue of these letters offering service. For the information of the Ministry, copies of the letters referred to are attached.*

" One thing is perfectly clear, and that is it will not be possible to deal with the additional children in the 15 year age group, and in the grammar schools and also deal with the priority groups of expectant mothers and children under five, without quite a substantial increase of dental staff.

" It is curious how disinterested large sections of the public are in conservative dentistry. This attitude

of mind on the part of large sections of the community will, I think, chiefly affect the volume of work undertaken in the priority classes. For reasons which are fairly obvious, attendance at a dental clinic in a rural county. where, in respect of the expectant mother or of the pre-school child, this means in very many cases a journey of some distance by bus, and unless and until the community as a whole appreciate the value of conservative dentistry, people will not take the trouble to utilise the services offered."

(a) Numbers provided with dental care.

	Examined.	Needing Treatment.	Treated.	Made Dentally Fit.
Expectant and Nursing Mothers ...	147	136	136	69
Children under five	190	189	189	81

(b) Forms of dental treatment provided.

	Extractions	Anaesthetics. Local	Anaesthetics. General	Fillings	Scalings or scaling and gum treatment.	Silver Nitrate treatment.	Dressings.	Radiographs.	Dentures provided Complete	Dentures provided Partial
Expectant and Nursing Mothers ...	362	53	30	66	12	—	106	21	47	15
Children under five	273	16	117	63	—	18	50	8	—	—

*Dear Madam,

In accordance with the National Health Service Act, 1946, provision has been made by the County Council for the dental inspection and treatment of expectant and nursing mothers. If you wish to avail yourself of this provision will you please complete the attached form and return it to me at the address overleaf. An early appointment will then be made for you to attend for inspection at the nearest centre.

Yours faithfully,

A. C. S. MARTIN,

Senior Dental Officer.

*Dear Sir or Madam,

In accordance with the National Health Service Act, 1946, provision has been made by the County Council for the dental inspection and treatment of all children in the County under the age of 5 years, in addition to that available for all school children. If you wish to avail yourself of this provision will you please complete the attached form and return it to the address overleaf. Arrangements will then be made for regular examination and treatment as necessary, at the most convenient centre.

Yours faithfully,

A. C. S. MARTIN,

Senior Dental Officer.

6. DOMICILIARY MIDWIFERY.

General arrangements for the service. Arrangements for medical and non-medical supervision and extent of supervision of midwives not employed on the authority's domiciliary services. Administration of analgesics by midwives. Arrangements for ante-natal supervision by midwives. Co-operation with general practitioners undertaking maternity medical services insofar as not covered under heading 2 above. Arrangements for selecting women whose confinement in hospital is recommended on social grounds. Refresher course for midwives. Arrangements, if any, for training pupil midwives."

The domiciliary midwifery service from the nursing angle is carried out by the district midwives and the district nurse midwives employed by the Council. The establishment of nurses undertaking domiciliary midwifery or maternity is 76. Of these 10 are district midwives doing whole-time midwifery in the boroughs of Workington and Whitehaven, and in Cleator Moor and Penrith. The balance are district nurse midwives. The total number of midwives who notified their intention to practise during the year was 125—this includes independent midwives (6) and midwives employed in hospitals (40), and allows of course for changes in personnel from time to time. Of the independent midwives, 2 undertake private domiciliary work, and 4 are employed in private nursing homes.

The work of the midwives is supervised by the Superintendent Nursing Officer. The aim in the supervision of midwives not actually employed in the authority's domiciliary service, that is to say, those working independently or in hospital, is a six monthly visit of inspection by the Superintendent Nursing Officer or her assistant nursing officers, all acting as supervisors of midwives.

With regard to the administration of analgesics by midwives, the position is that 71 of our domiciliary midwives have the certificate for the administration of gas and air, and in addition 19 midwives undertaking domiciliary practice have been authorised to administer pethidine.

The number of domiciliary confinements undertaken during the year was 1673 (compared with 1495 during the previous year), of which 646 were maternity cases and 1027 midwifery. Of the above 933 women had gas and air analgesia administered during their confinements. This represents a substantial increase on the previous year, the figure for which was 750, out of, as noted above, 1495 domiciliary confinements.

Ante-natal supervision in the case of women who have booked midwives to attend their confinements at home is on the following basis :—

> Each midwife pays a monthly visit to the expectant mother until the 32nd week, a fortnightly visit until the 36th week, and a weekly visit thereafter until the confinement.
>
> When the need arises these visits are increased as the case requires. The taking of blood pressure, and the examination of urine is of course automatic.

The question of co-operation with general practitioners undertaking maternity medical service is a little bit confused. On the whole co-operation is very good indeed, but the part which the midwife plays acting as a maternity nurse in doctors' cases varies very much with the approach of the individual practitioner. Some practitioners personally take responsibility for the complete ante-natal supervision of the women—others leave much of the supervision to the midwife. This variation is of course inevitable in any service, and I think it is safe to say that in by far the greater part of the county ante-natal supervision is really good, and

over a large part of the county the co-operation between the practitioners and the midwives could not be better.

The following table shows the extent to which practitioners were concerned in the ante-natal and post-natal examination of expectant mothers in cases booked as midwives' cases :—

	1952	1951
Examinations at practitioners' surgeries ...	704	728
Examinations at patients' homes	184	225
Examinations by practitioners at clinics ...	124	93
Re-examinations	1,174	1,057
	2,186	2,103
Findings at examinations— normal	793	827
abnormal	219	219
Recommended for hospital on account of home conditions	100	174
Recommended for hospital on account of patient's condition	45	41
Recommended to be seen by Specialist ...	30	37
Post-natal examinations	234	367

The following short table shows the volume of ante-natal work undertaken by the midwives themselves :—

Home visits	13,862
Attendances at nurses' clinics ...	6,922
	20,784

During the year midwives sent for medical help in domiciliary cases on 396 occasions.

It became apparent that the candidates for admission to maternity units in the area considerably exceeded the capacity of the available beds. Negotiations were therefore undertaken through the Special Area Committee with the hospital management committees, and a system was initiated whereby in all cases where a woman applied for a hospital bed for her confinement on social or domestic grounds, the midwife submitted a report to this department, which was transmitted to the appropriate consultant obstetrician giving the relavant data. The points to which special attention was paid were such matters as isolation, overcrowding, lack of adequate facilities, for example no water in the house, etc. These reports have, I think, been welcomed by the

consultant obstetricians, and have considerably eased their difficulties in the allocation of beds. It is appropriate here to acknowledge our debt to the Children's Officer for providing temporary accommodation for young children in our residential nurseries in cases where a woman was to be confined in hospital and was unable to make other arrangements for the care of the children during her lying-in period.

With regard to refresher courses for midwives, the position is that each year one of the supervisors is sent to the refresher course organised by the Association of Supervisors of Midwives, and six midwives are sent each year to refresher courses arranged by the Royal College of Midwives. The matter of providing training for pupil midwives, we have initiated during the year, in co-operation with the West Cumberland Hospital Management Committee, a course of Part II. midwifery training. The arrangement provides that there will be in training at any given period four pupil midwives in West Cumberland—two will be undertaking the hospital side and two will be receiving domiciliary training under the instruction of one or other of the four district midwives in Whitehaven, who are all approved for this purpose by the Central Midwives Board.

As a final point the following short table may be interesting:—

DOMICILIARY CONFINEMENTS

	Attended by nurses as midwives	Attended by nurses as maternity nurses	Population (est. mid-1952)
East Cumberland ...	127	307	82,490
West Cumberland ...	900	339	132,560

THE Rh. FACTOR AND WASSERMAN TESTING

The scheme for initiating this service was fully explained in last year's Annual Report. Since the scheme was initiated (December, 1951), up to the end of December, 1952, 568 blood examinations of expectant mothers have been carried out at the Pathological Laboratory of the Cumberland Infirmary under this scheme. The result has shown 3 cases Wasserman positive, and 4 cases Rh negative with anti-bodies. The appropriate consultants are of course informed of these cases.

MATERNAL MORTALITY

According to our local records (subsequently corrected by the Registrar General to three) only one maternal death occurred during the year—in the Wigton Rural District. 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 „ „ „
1951— 1 „ „ „ „ „ „ 0.76 „ „ „
1952— 3 „ „ „ „ „ „ 0.79 „ „ „

In addition to the figures given in this section of the report, a very large amount of work is of course undertaken at the hospital ante-natal and post-natal clinics by specialists attached to the hospitals with maternity units. These are outside the province of the local health authority, but we do in practice send a fairly large number of cases for ante-natal examination and advice to the specialists at these hospital clinics, who co-operate with us extremely well.

The figures for hospital admissions which are interesting, are shown in the following table. To these should be added 10 unmarried mothers admitted to St. Monica's Maternity Home, Kendal, and 1 to Brettargh Holt Maternity Home, Kendal. The statistics which follow have been supplied by the hospital management committees.

Hospital ante-natal cases		Patients admitted for	Patients delivered	Children	No. of	No of infants born in hospital
Patients	Attendances	ante-natal treatment	in hospital	born in hospital	maternal deaths in hospital	died before discharge
			EAST CUMBERLAND			
756	3,420	98	912	923	—	15
			WEST CUMBERLAND			
1,141	7,390	233	972	996	—	19
1,897	10,810	331	1,884	1,919	—	34

7. HEALTH VISITING.

"*General description of the service. Extent to which visiting is undertaken beyond visiting of expectant and nursing mothers and young children, and arrangements, if any, made to link up the health visiting services with the work of the local general medical practitioners and with that of local hospitals insofar as not covered under heading 2 above. Arrangements made to help suitable officers who do not already possess the health visitor's certificate to obtain it, and facilities offered by Council for student health visitors. Facilities for refresher courses.*"

The staff of the health visiting service consists of 18 whole-time health visitors, all except one with the health visitor's certificate. These whole-time health visitors for the most part work in the urban areas. In the rural areas the health visiting is undertaken by the district nurses under the temporary year-to-year approval of the Ministry. There are 47 district nurses concerned, of whom two hold the health visitor's certificate.

These health visitors pick up the threads of their work in respect of children under five at the stage when midwives leave off, i.e., generally the fourteenth day after the confinement. Naturally in the rural areas this merely means that the same nurse who dealt with the case as a midwife continues to deal with the welfare of the infant as a health visitor. During the first twelve months of a child's life the health visitor visits the home once a month. From the end of the first year until either the fifth birthday, or until the child enters a nursery or primary school, whichever is the sooner, the health visitor visits the home at least every six months, and more often as required. The great majority of the health visitors in their respective areas also act as school nurses and tuberculosis visitors. Broadly speaking, the work of the health visitors is confined to routine visiting, on the above lines, of children under five years of age.

In Circular 118 issued in July, 1947, the Ministry, in paragraph 30, said this :—

> "Under Section 24 it becomes the duty of the Local Health Authority to provide a complete health visiting service, either by themselves

employing health visitors or by making arrangements for a voluntary organisation to do so, for the purpose of giving advice as to the care of persons suffering from illness (which by the definition in Section 79 includes mental illness and any injury or disability requiring medical or dental treatment or nursing), to expectant mothers and nursing mothers, and to mothers and others with the care of young children. This involves an extension of the functions now normally assigned to a health visitor, under which she is primarily concerned with the care of mothers and young children. After the appointed day she will be concerned with the health of the household as a whole, including the preservation of health and precautions against the spread of infection, and will have an increasingly important part to play in health education. She will work in the closest co-operation with the family doctor and will not encroach on the province of the nurse provided under the authority's home nursing scheme, or of the sanitary inspector."

While I agree that far too large a proportion of the health visitor's time is devoted to the routine visiting of children under five on the above lines, and while in this County, and I suppose in most counties, health visiting is practically confined to this aspect, yet on the other hand I have never been able to visualise the health visitors expanding the ambit of their activities to the extent indicated in the above extract from Circular 118. With respect I would suggest that the Ministry's directive in the above circular went much too far, as for example in the matter of " giving advice as to the care of persons suffering from illness including mental illness and any injury or disability requiring medical or dental care or nursing." It is clear that any health visitor endeavouring to carry out this idea would at once come into conflict with the family doctor, and, in an area where she was not also the district nurse, would come into conflict with the district nurse, and in the case of infectious illness with the district medical officer of health and the sanitary inspector.

This directive was, I think, unfortunate, but there is no doubt that there are many directions in which the work of the health visitor could be at once more useful

and more interesting. There is, for example, the domiciliary care of the aged in their own home, which matter is at the moment being explored by the Health Committee. There is the question of close co-operation with the family doctor which, of course, should be easier where the health visitor is also the district nurse, than in the case of the whole-time health visitor. I think the health visitors and district nurses, acting as such, could do much to help the hospitals in the investigation, with the approval of the family doctor, into cases of patients who have been offered appointments at the hospitals, and, in which, for one reason or another, the appointments have not been kept, and in the cases of patients who have defaulted while under treatment. I am certain that the health visitors could do useful work by " fact finding " in cases of this kind.

I am certain, too, that if the family doctor and the health visitor could be brought into contact there is much which the health visitor, perhaps especially when she is also the district nurse, could do to help the family doctor. I am sure that this is the Ministry's desire. *The trouble is that the paths of the family doctor and the whole-time health visitor do not cross.* In other words they do not meet, and useful co-operation with a person whom you have not met is difficult, if not impossible. There is no doubt that sometimes the family doctor feels that the health visitor is interfering with what is his province. This is unfortunate but understandable, and the question of how to bring the family doctor and the health visitor into contact was one of the subjects discussed at the conference I had with the Local Medical Committee for the County. In some areas of the County the health visitors have, on their own initiative, called on the practitioners in their areas, and where this has happened the difficulties indicated above seem to be in process of solution.

Our health visitors have no direct contact with the hospitals, except at Workington Infirmary where the health visitors have been invited to visit the maternity wards and establish contact with the mothers before they leave hospital. That is all to the good.

Reference is made later, under Section 11, to the close co-operation between the consultant chest physicians and the health visitors in their capacity as tuberculosis visitors. For my part I would be glad to

see much closer contact between the health visitors and the hospitals. I believe that much closer co-operation between the health visitors, the hospitals and the family doctors will come in time.

With regard to the question of assisting nurses not holding the health visitors' certificate to obtain this, the Council have established a system of scholarships amounting to £225 to cover the period of training for the health visitor's certificate (nine months), and six nurses have already taken advantage of these facilities. The Council have agreed to provide up to four such scholarships in any one year.

With regard to refresher courses we normally send two or three of our staff of whole-time health visitors away each year for such courses. These courses are arranged either by the Royal College of Nursing or by the Women Public Health Officers' Association.

The statistics showing the work undertaken by our health visitors and district nurses acting as such, during 1952, are as under :—

Visits to children under one year	... ...	37,581
Visits to children aged 1-5 years	... ...	37,888
		75,469

8. HOME NURSING

"General arrangements for the service. Co-operation with general practitioners. Description of any arrangements for liaison with hospitals. Classification and proportions of main types of cases attended by home nurses. Particulars of any night service. Refresher courses for nursing staff and arrangements, if, any, for district nurse training."

The County Council since the Cumberland Nursing Association disbanded on the 31st March, 1950, have continued the home nursing service, broadly speaking, on the same lines as were then in existence. Two nursing associations have been amalgamated but otherwise the areas of the various nursing districts remain unchanged. There are at present in the county 59 nursing districts, of which a few are served by two or more nurses.

The facilities which have been referred to earlier in this report in respect of housing, motor cars, telephones, etc., apply as before. Every district nurse, as will be noted later, is provided with a full complement of equipment, not only for her own personal use in dealing with her patients, but for distribution on loan, to patients as required.

Co-operation with general practitioners is excellent.

Liaison with hospitals generally is reasonably good and improving.

The general classification, taking 1952 as an example, of the types of cases which the district nurses are called upon to attend—for nursing attention—may be given as under :—

Medical	4,166
Surgical	2,766
Tuberculosis	211
	7,143

The Ministry's new classification will be brought into operation for the current year.

With regard to the question of night service, no special night service exists in the county, and none has been found necessary. The nurses answer emergency night calls as these arise.

Two of our district nurses are sent each year for refresher courses arranged by the Queen's Institute of District Nursing. This number may seem small, but it has to be taken in conjunction with the refresher courses arranged for health visitors and midwives, many of whom involve the same personnel.

The Council have approved arrangements for training each year up to six state registered nurses in district nurse training.

Statistics for 1952 relative to home nursing are as follows :—

Number of cases nursed		7,143
Number of nursing visits paid ...	127,029	
Number of casual visits paid ...	11,719	138,748

9. VACCINATION AND IMMUNISATION

"Extent to which organised effort is sustained to secure the vaccination and immunisation of the child population, particularly as regards infant vaccination and primary diphtheria immunisation of children approaching the age of twelve months. Arrangements for "boosting" injections of diphtheria prophylactic. Arrangements for immunisation against whooping cough with special reference to age at immunisation."

Every possible effort is made to maintain high figures for immunisation and vaccination. As will be seen by reference to Section 2 above leaflets have been printed which are handed by registrars to all persons registering births. In addition a yellow card is stapled to the health visiting cards of children under 5 years of age, and serves as a constant reminder to the health visitor if the child has not been immunised. Still further posters are exhibited in the clinics, and leaflets distributed by the health visitors to the homes they visit.

The importance of immunisation is also continually brought to the notice of the health visitors, including the district nurse health visitors, at regular meetings held three or four times a year. "Booster" injections are usually given after the child has entered school. In this connection leaflets are circulated to head teachers for distribution to parents. Copy attached.

All this makes for as complete a supervision in this respect as can be devised.

Immunisation is shared between the Council's own medical officers and general practitioners. Vaccination is undertaken by general practitioners only; none of the Council's medical officers participate in this service.

It is difficult to be precise about the figures either for vaccination or immunisation because practitioners who undertake these services for their patients privately are under no obligation to notify the health authority. The health authority pays for records of successful vaccination and immunisation, but there is no doubt in my mind that the picture we have is, for the above reason, not complete.

During the year 1,183 reports of successful primary vaccinations were received and 214 reports in respect of re-vaccinations. Of the primary figure 975 were in respect of infants under one year of age.

The attached graph shows the position with regard to vaccination between the year 1930 and 1952. It will be seen that there was a gradual falling off prior to the war years, and that the figures rose sharply at the outbreak of war, and began to fall sharply at the close of the war. One curious point has always been noted in this county and that is that in the rural districts the percentage of vaccinations has always been substantially higher than in the urban and industrial areas of West Cumberland. I recollect that as far back as 1932 it was recorded that the vaccination in infants in Workington, a port authority, was in the region of 20%. Since vaccination ceased to be compulsory by law (with the escape clause of conscientious objection) the public quite frankly have become apathetic.

With regard to immunisation against diphtheria, the following table shows the position in respect of children of all ages up to 15 immunised or re-immunised during the past 10 years :—

1952	...	8915*
1951	...	6489
1950	...	7161
1949	...	10409
1948	...	7235
1947	...	5491
1946	...	7318
1945	...	3747
1944	...	3936
1943	...	4345

It will be appreciated that for the reasons given above these figures cannot be regarded as completely accurate. For the same reasons and because the Registrar-General's *estimated* population of school age is not very accurate either the 5-15 year percentage of children immunised in the county at the present date can only be regarded as approximate. The figures are :—

Under 5 years	...	...	...	...	52%
5 to 15 years	...	...	...	...	95%

No arrangements have yet been made by the authority in initiate a scheme for immunisation against whooping cough. We have been advised that action at this stage in this direction might be regarded as premature pending the production of a completely satisfactory vaccine.

*Including 2,588 children under school age, and 1,056 reports received from practitioners in respect of immunisation carried out privately.

CUMBERLAND COUNTY COUNCIL

County Health Department,
11, Portland Square,
Carlisle.

DIPHTHERIA IMMUNISATION

Dear Sir/Madam,

Now that your child is at school, I should like to remind you of the importance of diphtheria immunisation.

Every child should have had two injections to protect him against this deadly disease in early infancy. Four or five years later, usually after starting school, one other injection is necessary to give full protection throughout the early years at school. The injection does not upset the child in any way, and if you will fill in Part B. of the attached form, and return it to the head-teacher I will arrange to have this protection given.

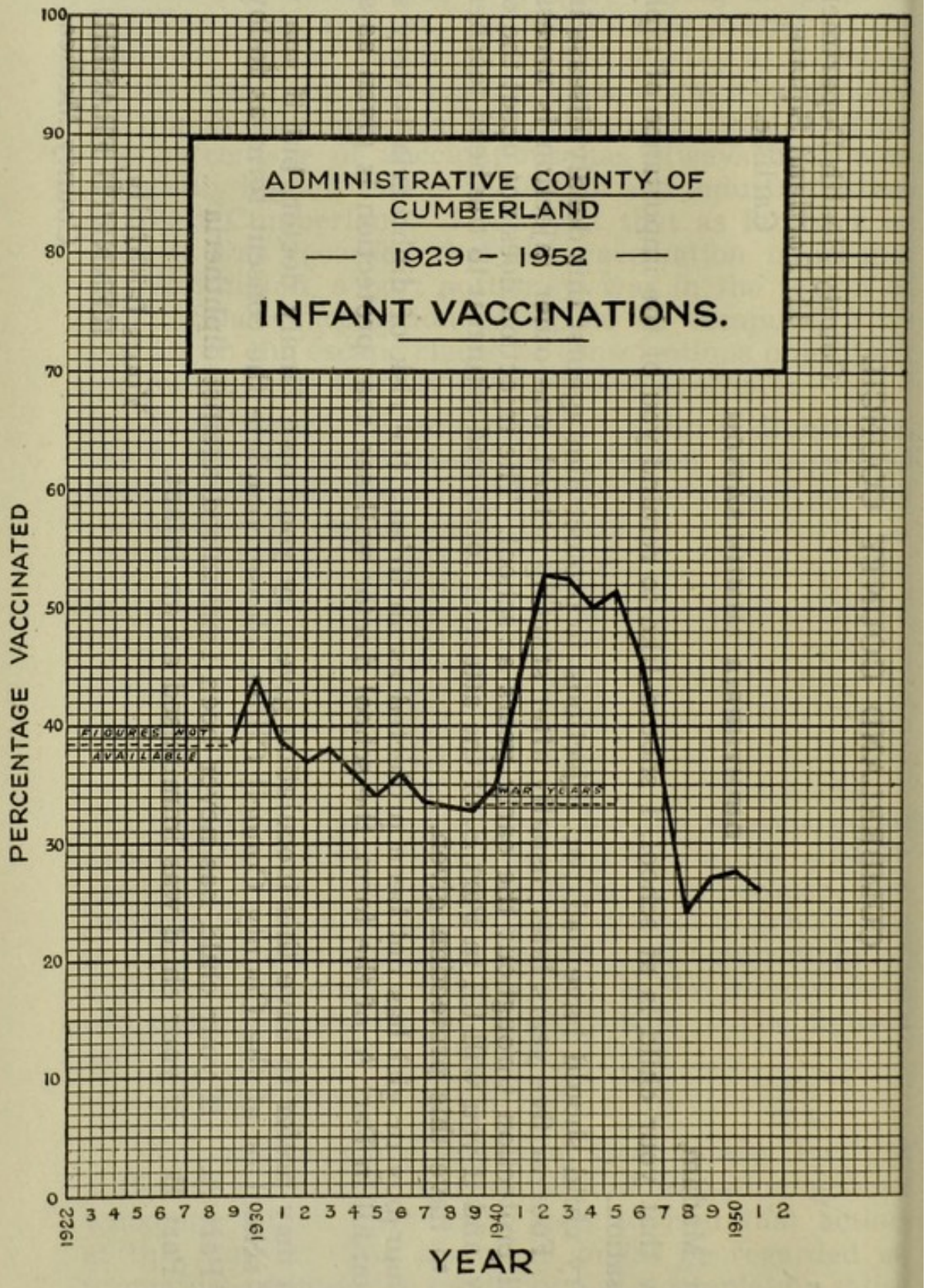
If your boy or girl has not been protected as an infant, the risk of diphtheria is very serious, but if you fill in Part A. of the form, the school doctor will see that protection is given as soon as possible.

You may prefer to have this inoculation given by your own family doctor, but if you wish it done at school or at the County Council Clinic, please complete the consent form as follows:—

Part A. If your child has never been immunised against diphtheria

Part B If your child was immunised as an infant.

Yours faithfully,
KENNETH FRASER,
County Medical Officer.



NOTE PRIOR TO 1929 THE COUNTY WAS NOT A VACCINATION AUTHORITY.

10. AMBULANCE SERVICE

"General statement of work done by service during 1952 and trend as compared with previous years. Any special arrangements in force with hospitals and general practitioners to ensure the proper and economical use of the ambulance service, any abuses observed or difficulties encountered, any new types of equipment brought into service."

In previous years I have dealt with the ambulance, sitting-case car and hospital car branches of the transport service in separate sub-sections of this part of the annual report. This year, in view of the form of the Ministry's directive, I think it would be better to amalgamate the essential statistics into one comprehensive table. Such a table has been prepared and is given below. It shows the actual figures under a number of headings (journeys, patients carried, total mileage) in respect of each of the three sections. The table shows also the totals under the same headings for the current financial year ending 31st March, 1953, and the variations in these figures for the same year, compared with two years ago, that is the year ended 31st March, 1951. The reason why that comparison may be useful, is that it was during 1951 that the calling-out bureaux were established at the Cumberland Infirmary and Whitehaven Hospital with the object of co-ordinating journeys, eliminating overlapping and waste, and generally with the object of reducing the cost of the service while maintaining and, if possible, improving its efficiency.

The service continues to run smoothly. It is very rarely indeed that any complaint reaches the department either from medical practitioners, hospitals, or patients, and the whole transport service is now working on such clearly established lines, and the efficiency of the service not, I think, being open to question, the future target must clearly be to continue to take all possible steps to eliminate overlapping, wasteful use of service, and possible abuses.

The general trend can be gauged best by examination of the statistics given in the summary of all three branches of the service. The comparison between the total for the year 1951/52 with the totals for the year 1952/53 shows an increase in total journeys of 1,650, an increase in patients carried of nearly 11,000, and

an increase in total mileage of 54,000. Perhaps the more interesting comparison is between *1950/51* and *1952/1953*, that is to say the lower half of the table. This shows that during this two year period there was a reduction of 211 journeys, and an increase of 10,562 miles while the number of patients carried rose by 31,786. As will, however, be seen by the footnote to the table this figure of 31,786 has to be read in conjunction with the Ministry's directive that as from the 1st April, 1951, a patient making a return journey from home to hospital and back on the same day counts as two patients. The actual total increase in patients carried, therefore, in this two year comparison is probably more near the 20,000 figure than 31,786.

Certain other facts emerge from a very careful analysis of all the statistics and returns relative to this service. The first is that the great majority of the general practitioners in the county are co-operating with the County Council very well in the administrative arrangements, and the number of cases called out under the emergency arrangements, which are not really emergencies at all, is not sufficiently large to give grounds for any great anxiety.

The second point is that the calling-out bureaux established by the County Council at the two hospitals in East and West Cumberland have fully paid their way.

The third point is that two branches of the hospital service are making increased demands on our transport arrangements. These departments are:—

(a) the rehabilitation departments of the hospitals, and

(b) the chest service.

During the nine months ended 31st December, 1951, the rehabilitation departments of the hospitals asked us to arrange for the transport of 8,717 patients. For the corresponding nine months to 31st December, 1952, this figure had risen to 10,256 patients. The increase is, of course, 1,539 patients, but here again it has to be remembered that after 1st April, 1951, a patient making a double journey (which would be the usual procedure) on the same day, counts as two patients. The real increase therefore is probably somewhere in the region of 700 to 800 additional patients, which of course is important enough.

In connection with the chest service, the comparable figures are nine months to 31st December, 1951, 577 patients, nine months to 31st December, 1952, 1,252 patients, giving an increase of 675, or divided more or less by half for the above reason, say 350 additional patients carried. Part of this is due to the opening of the chest centre in West Cumberland, but there has been a very substantial additional demand from the chest centre in East Cumberland, accounting for more than half of the increase.

A further analysis up to date of the rehabilitation requests from the Cumberland Infirmary, as the largest hospital in the area, shows that six months ago we were transporting 28 individual patients to the rehabilitation department at that hospital, making 61 attendances weekly. Some patients came once, some came twice, and one or two three times. By December 1952 these figures had risen to 42 patients, making 102 attendances weekly, and by the middle of January, when this report was being prepared, the figures had rocketed still further to 55 patients on the transport list, making 135 attendances weekly. The claims of the rehabilitation department at the Cumberland Infirmary for the provision of transport have therefore almost exactly doubled in the last six months. All these points are being further investigated with the department or consultants concerned, as the case may be, with a view to ascertaining why these rises are taking place, and to check up as far as possible that no unnecessary requests for motor transport are being submitted.

No new vehicles were added to our fleet of ambulances during the year 1952/3, but three new ambulances are on order and will be delivered and brought into use in the late spring or early summer of this year. Two of the new vehicles will be dual purpose vehicles for carrying stretcher cases, or up to nine sitting cases. This type of vehicle has proved its economic value. The third new vehicle will allow one of our most modern ambulances to be placed in what might be described as strategic reserve for the whole county. This means that if any one of our vehicles has to be off the road for some repair or overhaul, as is bound to happen from time to time, and has in fact actually happened more than once, we are able at once to put into commission a reserve ambulance of modern type, which has been in service for about three years. The total

number of ambulances in regular use after the early summer of 1953 will be 17 ambulances owned by the County Council, with four ambulances provided under contract by a firm in West Cumberland. The ambulances we inherited, most of which are of 1930/40 vintage, have been placed in reserve under the civil defence arrangements.

Another point which emerges from the statistics is that an increased number of patients are being taken by dual purpose vehicles, and that there has been a substantial increase in the work undertaken by the hospital car service. These two factors have meant a considerable reduction in the statistics of the sitting-case car service, which operates under arrangements with taxi-hirers all over the county.

No new type of equipment has been fitted in any of our ambulances during the year. All our ambulances are, I think, fully equipped with every conceivable type of equipment which is necessary. Arrangements have been made however during the year, for the establishment of pressure disinfecting outfits at all the ambulance depots in the county except one. This means that more and more of our ambulances are tending to merge into one general pool, and the old distinction about keeping certain vehicles completely isolated for cases of infectious disease is gradually disappearing. It is true that three ambulances do in fact carry most of the infectious cases, but with these new disinfecting outfits the placing of all ambulances into a general pool for all purposes, which procedure is common in many other areas, is gradually coming into operation.

There is one small point which is at present under investigation, and that is the possibility of equipping two, and possibly three, ambulances in the county with special outfits for the transport of premature infants to those hospitals which have arrangements for the reception of premature infants. It stands to common sense that there is not much use providing in hospital, oxygen, an appropriate room temperature, oxy-incubators etc., if prior to admission to hospital an infant, whose life is in the balance, has to travel by ambulance with its mother 30 or 40 miles on a winter's day. This point, as I have said, is under consideration to see what can be done about it.

	AMBULANCES.			SITTING CASE CARS.			HOSPITAL CAR SERVICE			SUMMARY OF ALL SERVICES.		
	Total No. of Journeys.	Total No. of Pats. Carried.	Total Mileage.	Total No. of Journeys.	Total No. of Pats. Carried.	Total Mileage.	Total No. of Journeys.	Total No. of Pats. Carried.	Total Mileage.	Total No. of Journeys.	Total No. of Pats. Carried.	Total Mileage.
Totals for year ended 31st March, 1952 ...	6,390	12,006	199,887	14,053	33,544	348,097	1,871	4,791	71,498	22,314	50,341	624,553
Total to year ended 31st March, 1953 ...	8,293	22,086	263,123	13,817	34,172	335,093	1,857	4,794	79,866	23,967	61,052	678,082
Increase for year ended 31st March, 1953, compared with 1950/51	3,551	*16,997	121,276	——	*11,884	——	444	*2,905	26,903	——	*31,786	10,562
Decrease for year ended 31st March, 1953, compared with 1950/51	——	——	——	4,206	——	137,617	——	——	——	211	——	——

*As from 1st April, 1951, any patient making a return journey on the same day is classed by the Ministry's instructions as 2 patients.

Financial Position.

I am indebted to the County Treasurer for the statement of costs which follows.

It is of interest to note that the Ambulance Services Costing Return issued by the Ministry of Health on 18th June, 1953, in respect of the financial year ended 31st March, 1952, shows that the all-in cost per vehicle mile in Group 2 counties, in which group Cumberland falls, amounted to 1/7d. per vehicle mile. This figure included ambulances, sitting-case cars, hospital car service, and rail transport, and all costs including running, maintenance, loan charges, administration expenses, etc.,

Our corresponding figure for the year 1951/52 *was just under* 1/3d. *per vehicle mile, so that we were, for the financial year in question, well below the average of comparable counties.*

The County Treasurer's financial statement follows:—

(1) Ambulances.

Statement showing the cost of the service to the County Council (excluding capital cost of ambulances, loan charges, cost of call out bureaux and administration) for the year ended 31st March, 1953, and comparison with the previous twelve months.

	Year ended 31st March 1953.				Year ended 31st March, 1952.			
	Mileage.	Running expenses.	Running expenses per mile.		Running expenses per mile.		Running expenses.	Mileage.
		£	s.	d.	s.	d.	£	
By whom ambulance managed:								
(a) Voluntary Committees or County District Councils	43,317	2,922	1	4.2	1	1.7	2,693	47,122
(b) Hospital Management Committees ...	26,292	1,303		11.9		9.9	742	17,946
(c) County Council — through garage proprietors	113,527	7,463	1	3.8	1	3.3	5,645	88,504
(d) Other Local Health Authorities' ambulance charges	3,533	352	1	11.9	2	5.5	647	5,265
(e) Proprietors using their own ambulances	79,987	5,459	1	4.4	1	2.8	2,863	46,315
	266,656	£17,499	1	3.7	1	2.7	£12,590	205,152

(2) Sitting Case Cars.

Running expenses (i.e., excluding cost of bureaux and administration expenses)

	Year ended 31st March 1953.	Year ended 31st March, 1952.
Mileage of hire car proprietors	335,093 miles	348,097 miles.
do. local authorities ...	7,109 ,,	5,063 ,,
Cost for year—subject to note re bureaux and administration ...	£17,206	£17,054
Cost per mile	1/0.3d.	11.6d.

(3) Hospital Car Service.

	Year ended 31st March 1953.	Year ended 31st March, 1952.
Mileage	79,866 miles	71,498 miles
Cost (including block payment to Red Cross Society of £105 per annum, but excluding cost of bureaux and central administration)	£2,501	£2,233
Cost per mile	7.5d.	7.5d.

Items excluded from above costing:—

	£
Loan charges—ambulances	1,239
Carlisle Corporation—Filter Service ...	250
Call-out Bureaux	1,107
Other expenses, viz. uniforms, medical supplies, printing and stationery, etc.	419
Administration	2,405
	£5,420

11. Prevention, Care and After-Care

"Description of what is being done in carrying out this service in relation to (1) *tuberculosis and* (2) *illness generally. As regards tuberculosis, a report as to the manner and degree in which the arrangements for prevention, care and after-care are being co-ordinated with the diagnostic and treatment services (in so far as not covered under heading 2 above)."*

As I have said in previous reports, it is never very easy to be precise about the activites under this section, because these naturally merge into the activites of other sections. To take first tuberculosis, we have I

think, co-operated to the absolute limit of our capacity in assisting to establish the consultant chest services in the county. There are in the Special Area (Cumberland, Carlisle and North Westmorland), two chest consultants appointed by the Regional Hospital Board. Areas are divided into East Cumberland and West Cumberland, North Westmorland coming into East Cumberland. Co-operation with the East Cumberland chest service is exceedingly good. The chest service in West Cumbreland has only recently been established, but I am confident that once the inevitable teething troubles have been got over, co-operation with the West Cumberland chest service will be at the same level.

In East Cumberland the chest centre has now been in operation for two years. The chest centre in West Cumberland at Workington Infirmary, is not yet completed. Meantime, the County Council are continuing to place at the disposal of the Chest Physician in West Cumberland our former tuberculosis dispensaries in Whitehaven, Egremont and Millom, and arrangements have been reached with the Special Area Committee for the use of the tuberculosis section of the Egremont Clinic as a modified chest centre with x-ray facilities. The County Council are building a new clinic at Millom and the plan includes provision of what will in effect be another modified chest centre, on lines approved by the Special Area Commitee. In addition, the County Council have seconded one of their health visitors to be tuberculosis nurse attached to the Workington Chest Centre and are providing motor transport for her to cover a large part of West Cumberland. Others of the County Council health visiting staff will act in a similar capacity at the Egremont Centre and at Millom. Both of the consultants in East and West Cumberland now keep the health visiting staff, including the district nurses in their respective areas, fully informed about their tuberculosis patients attending the respective centres. This is a most useful form of co-operation.

In the matter of B.C.G. vaccination while duplicate records are kept in this department, the original records are kept in the chest centres. All this work of course at present is undertaken by the medical officers of these centres. I look forward to the time when the assistant county medical officers may be able, in their respective areas, to relieve the medical staff of the chest centres of

a considerable amount of this work,particularly in the scattered rural areas. The total number of contacts of tuberculous cases vaccinated up to the end of 1952, has been 284, of whom 149 were vaccinated during 1952.

We still issue, at the request of the chest physicians, on loan to households able to find space for their erection, open air shelters to the number of about 26 at any given time. This number is much smaller than that for say five years ago, but the increase of beds for early cases, and certain other factors, provide the reason.

The number of visits paid by our nurses to tuberculous households during the year 1952 (apart from nursing visits) amounted to 5,313, involving 1,392 patients. In a number of cases we have provided beds and bedding to enable the infected patient to sleep alone. We have been able to provide domestic help to an increasing number of households where there are tuberculous patients. We provide clothing as and when this is required. We take children from tuberculous households into our children's homes to enable the mother to have her full period of sanatorium treatment free from anxiety. In a limited number of cases of overcrowding we have also taken the children into our children's homes. We have been able to do something in collaboration with the housing authorities, most of whom give this matter high priority, towards finding suitable accommodation for tuberculous families. Beyond these steps, there is not very much of practical value which health authorities can do under the limited powers and duties still left to them under the new set-up, beyond, of course, the provision of transport to sanatoria and to chest centres, which, as will be seen by reference to section 10 of this report, is a very important factor in our transport service.

With regard to other forms of care and after-care, and the prevention of illness, reference has been made under section 5 to the expanding volume of work undertaken in the blood examination of expectant mothers.

Our loan equipment scheme, both in respect of major and minor nursing equipment, is being utilised to an increasing extent. In last year's report, an indication was given of the chief items of major equipment such as invalid chairs, air or water beds, premature cots etc., which are stored at various depots in different parts of the county. Minor equipment comprising air rings,

bed-rests, steam kettles, etc., are stored for the most part in the nurses' homes and distributed on loan as required to patients in the nurses' areas. Co-operation with the hospitals in the matter of the after-care of orthopaedic patients discharged from hospital has developed to some extent, but I could wish that the rate of progress was faster.

It has still not been possible to make a start with occupational therapy in the county. I regret this very much. There is no doubt that the institution of this service would be of great value to home bound persons suffering from tuberculosis or crippling or other conditions which limit their activities. The fact however still is that, although the Council have approved the establishment of the service and the recruitment of the necessary staff and the provision of vans and equipment, we have, up to the present time, not been able to attract a single application in response to our advertisements.

We continue to help the consultant venereologist in the matter of contact tracing. Our health visitors, including our district nurses acting as health visitors, continue to undertake a substantial number of visits annually of an advisory nature, which is, of course, one of the true functions of the health visitor. The total number of such visits paid under the above general heading during 1952 was 734.

Co-operation with the hospitals in the aftercare of patients on discharge in such matters as the provision of domestic help and nursing care is increasing. We continue to send a number of persons for convalescent treatment in appropriate cases not falling within the jurisdiction of the hospital services.

12. Domestic Help

"Brief description of service and its work. Any facilities for training."

The arrangements in this county for the organisation and administration of the home help service are off the general pattern. At one time a home help organiser, acting in close co-operation with the Women's Voluntary Services for the county, was responsible for the administration of this service. On her resignation the County Council, visualising that in a scattered rural county like Cumberland a link up

between the nursing services and the home help service would be an efficient and economical arrangement, appointed the Superintendent Nursing Officer also as home help organiser for the county. This arrangement has worked smoothly and efficiently, and, from the point of view of the County Council, economically, and the association of the nursing services with the home help service has in my view been extremely beneficial to the home help service, without in any way impairing the efficiency of the nursing service.

The requests for domestic help received during 1952 have risen substantially as compared with the previous year. These applications amounted to 497 during the year, compared with 440 in 1951, but the number of new cases provided with home helps rose to 263 in 1952, compared with 197 in 1951. There have been comparable rises in all sections of this service. For this reason, and because among other things the wages of home helps have twice been raised during the financial year by decisions of the Whitley Council Non-Trading Services Committee, the provision in the estimates for the financial year 1953-54 has been raised by approximately 100 per cent. over the figure for the financial year 1952-53.

During 1952 the standard charge for persons paying the full cost of the service, without an assessment of income has varied quite considerably. At one time it was as high as 2/9½ per hour and was then reduced to 2/4 per hour. It has recently been raised to 2/7 per hour to meet the rise in the wages of home helps. The policy of the Council is that the standard charge should represent the out-goings of the County Council in providing the service, except the cost of central administration. In spite of the fact that the standard charge at its highest figure for the year, and indeed even at its lowest figure, exceeded the rate per hour for domestic help workers privately employed in most parts of the county, nevertheless during the year 43 householders agreed to pay the standard charge without an assessment of income. Admittedly the great majority of these were for short periods of a few weeks. As will be seen from a glance at the tables which follow, 220 cases during the year were assessed in respect of their contributions. The great majority of these assessments were quite small, not exceeding 15/- for

a full week of 44 hours and 94 were cases in which no assessment for repayment was made under the scale.

In an effort to bring this service within the reach of all who might need it, irrespective of their means, the Council decided that any person utilising the service, assessed at a certain figure for a 44 hour week, would only repay to the Council that proportion of the above assessment which is appricable to the number of hours worked by the home help. In other words if a person were assessed to pay, say, 15/- per week for 44 hours, and the home help only worked 22 hours, the assessment in that case would be 7/6.

There is no doubt that the quick rise in the cost of this service is causing anxiety, and perhaps the chief anxiety lies in the fact that out of an estimated expenditure for 1953-54 of £18,000 it is estimated that not more than £1,500 will be recovered in contributions. There is a widespread feeling that, having regard to the value of the service to the households concerned, the gap is much too wide. It is felt, and I think with reason, that in a household where there are a number of sons and daughters working, the benefit of the service is a benefit to the whole household, and is not confined to the head of the household who formally makes the application, and on whose income primarily the assessment is based. The Health Committee have decided that this matter will be re-examined in detail during the early months of the current year.

This re-examination took place as planned, and the new scales follow on page .

The Superintendent Nursing Officer or her assistants paid 2,103 visits in connection with the service, of which 1,268 were to households desiring to avail themselves of the service, and 835 were to home helps either before or after enrolment. These figures show a substantial increase on the previous year.

The rising demand for this service is shown by the following table:—

1949	193	households supplied
1950	258	,, ,,
1951	286	,, ,,
1952	387	,, ,,

One or two additional points call for comment. The number of mobile home helps, that is to say home

helps willing to live in the household requiring assistance away from their own homes, has increased slightly and at the time of writing we have five.

During 1952 a new basis of assessment was arrived at, calling for higher contributions from the households concerned. This new basis of assessment has not so far resulted in any reduction in the number of applications, and of households helped. In fact as will be seen from the figures the position is quite the opposite.

The position as regards financial contributions by the households during 1952 was as under :—

Households with a nil assessment	94
Households paying 5s. per week	91
Households paying 5s. to 10s. per week	43
Households paying 10s. to 15s. per week ...	23
Households paying over 15s. per week	96
Households paying the full standard charge ...	40
	387

With regard to these assessments it has to be remembered that these are the full assessments for a 44-hour week, and as a very large number of households only require the services of a home help for 22 hours or less, the above table really means that in not far short of 250 cases, the assessment in practice worked out at nil or a negligible figure.

It will be noted that the number of home helps on the register at 31st December, 1952, was not far short of double the figure for 31st December, 1951. The number of persons resigning from the service during the year is very much smaller than in previous years. All this means that this service is gradually becoming more stable.

Taking the county as a whole, the only areas in which the number of enrolled home helps is much below the figure required are Alston, Keswick, and Millom. The remainder of the county is well, or reasonably well, supplied.

The increase in applications for home helps, while it has concerned all categories, has chiefly concerned short term assistance in confinements, and long term assistance in cases of old age, infirmity, blindness, and

things of that kind. Subject to these general observations, the statistics for the year are as under:—

Number of persons who have been accepted and enrolled on the register :—

Wholetime	70
Part-time	120
Mobile (resident)	5
	195
Less persons resigned from service	25
Number on register at 31st December, 1952	170

The position as regards enrolled home helps at 31st December, 1952, was as follows:—

Alston	2	
Aspatria	18	
Border rural	27	
Cockermouth	8	
Ennerdale rural	24	
Keswick and Threlkeld	2	
Maryport, Dearham and Great Broughton	21	
Millom and district	4	
Penrith and Penrith rural	14	
Silloth	9	
Whitehaven, Distington and St. Bees	11	
Wigton and Mealsgate	16	
Workington	14	
	—	170

Householders:—

Number of applications received for home helps	497
Number cancelled or not supplied	187
Number of new cases helped	263
Number of cases on books 1st January, 1952 ...	124
Cases pending	47

Analysis of cases helped:—

Confinements	94
Tubercular cases	25
Old age and infirmity	101
Mental health	4
Cardiac	25
Blind	12
Cancer	8
Illness of long duration (cerebral haemorrhage, rheumatoid arthritis, etc.)	82
Illness of short duration (post operative influenza, etc.)	36
	387

The new scales for the recovery of contributions

referred to earlier in this section of this report were adopted by the Council (*during* 1953) as follows :—

"HOME HELP SERVICE—SCHEME FOR THE ASSESSMENT OF CHARGES

1. The charge for the services of a help will be based on the weekly assessable income, such amount being the gross income less certain deductions.

(i) Gross income comprises :—

(a) Income and other resources of the householder—in the case of husband and wife living together, their combined income and other resources.
(b) Income and other resources of any dependent member of the household.

As adjusted in accordance with the National Assistance Act, 1948 and Regulations, unless varied by this scheme.

(c) All service and family allowances.
(d) Contributions towards the household expenses as follows :—
(1) from earning members or lodgers—
Aged 21 and over—30/-week; 18, 19 and 20—24/- week; under 18—15/- week, provided that the assessing officer is empowered to adopt a lower figure than that specified in a special case of abnormally low wages of an earning member
(2) from other members—an amount to be fixed by the assessing officer according to the circumstances.

(ii) Deductions allowed :—

(a) Rent and rates. Actual amount—normally not exceeding 25/- week; although the assessing officer is empowered to allow a higher figure in a special case.
(b) Interest and repayments under a mortgage by the householder for the purchase of his residence.
(c) Statutory insurance contributions and income tax
(d) Life insurance premiums.
(e) Trade Union, sick club and pension contribution
(f) Travelling expenses to and from work.
(g) Other necessary expenses in special cases, at the discretion of the assessing officer.

Actual amount.

(h) Personal allowances in respect of the householder and dependent members, other than earning members or lodgers—at the rates for the time being adopted by the National Assistance Board.

2. The charge for the number of hours of service provided in any calendar week will be the amount ascertained by reference to the weekly assessable income and the scale of charges set out in the appendix, hereto provided—
   (a) that in cases where a grant is received from the Assistance Board which includes an amount for the services of a help, the charge shall not be less than the amount so allowed by the Board.
   (b) That in special cases—particularly in cases of service after 13 weeks—the appropriate chief officers may abate or waive the scale of charge where its imposition would involve undue hardship.
3. Only where the householder requests a remission from the standard charge will a return of income and expenditure be required.
4. The right is reserved to verify the accuracy of statements of income and expenditure."

HOME HELP SERVICE—SCALE OF CHARGES

Weekly Assessable Income 1.				Subject to a minimum charge of 3s. per calendar week, charge per hour as below : First 11 hrs. 2.		Next 11 hrs. 3.		Excess hrs. 4.	
	£	s.	d.	s.	d.	s.	d.	s.	d.
Not over ...		6	8		2		1		—
„ „ ...		13	4		4		2		—
„ „ ...	1	0	0		6		3		1
„ „ ...	1	6	8		9		4		1
„ „ ...	1	13	4	1	0		5		1
„ „ ...	2	0	0	1	3		6		2
„ „ ...	2	6	8	1	6		8		2
„ „ ...	2	13	4	1	9		9		3
„ „ ...	3	0	0	2	0		10		4
„ „ ...	3	6	8	2	3		11		5
„ „ ...	3	13	4	2	6	1	0		6
„ „ ...	4	0	0	*2	7	1	3		7
„ „ ...	4	10	0	2	7	1	7		9
„ „ ...	5	0	0	2	7	1	11		11
„ „ ...	5	10	0	2	7	2	3	1	1
„ „ ...	6	0	0	2	7	*2	7	1	3
„ „ ...	6	10	0	2	7	2	7	1	7
„ „ ...	7	0	0	2	7	2	7	1	11
„ „ ...	7	10	0	2	7	2	7	2	3
Over ...	7	10	0	2	7	2	7	*2	7

*—Present Standard Charge.

The above scales came into operation in respect of new cases on the 7th May, 1953, and in respect of existing cases the new scales were to be brought into operation if found practicable as from 1st July, 1953, or from such later date as the Chairman of the Health General Purposes Sub-Committee might decide.

Financial Statement

The County Treasurer has kindly supplied me with the financial statement for the year to 31st March, 1953.

(a) Number of hours for which helps paid wages.

Details are:—	1952/53	1951/52
Hours—worked	126,236	82,357
„ —travelling, holidays and sick pay	22,545	13,640
Total hours for which wages paid	148,781	95,997

Note the substantial rise —1952/53, 148,781; 95,997 1951/52.

(b) Cost of service.

		Per hour worked 1952/53		Per hour worked 1951/52	
Expenditure—					
Helps—wages, national insurance, travelling expenses, badges, overalls, etc.		2/9¼	...	2/6	
Administration and supervision (excluding Central Departments) ...		2¾	...	3¾	
	£18,948	3/-	...	2/9¾	£11,575
Income—charges to households	1,719	3¼	...	4¼	1,441
Net cost subject to 50% grant	£17,229	2/8¾	...	2/5½	£10,134

Points which should be noted are:—

(a) Helps—Wages, insurance, travelling expenses, etc. (including travelling time, holidays and sick pay).

Note that the cost in 1952/53 is 2/9½ hour; 2/6 hour being the cost in 1951/52. The rise is due to wage increases and increased rates of National Insurance contributions.

(b) Charges to households.

Note that recoveries in 1952/53 averaged 3¼d. hour; 4¼d. hour being the comparable figure in 1951/52.

(c) Net cost subject to 50% grant.

Note the rise—1952/53, £17,229; £10,134 in 1951/52.

(c) Households assisted and charges—1952/53.

	Cases helped. No.	%	Charges to households. Amount	%
Assessed cases.				
Nil	95	23	... —	—
*Not over 10/- week ...	151	36	... £167	10
	246	59	... 167	10
*Over 10/- but not over £2 week	96	23	... 520	30
*Over £2 but not over £4 week	31	8	... 326	19
Standard charge cases.				
From 1st Nov., 1951— charge 2/9½ hour) From 1st June, 1952— charge 2/4 hour) From 1st Jan., 1953— charge 2/6 hour) From 1st Feb., 1953— charge 2/7 hour)	42	10	... 706	41
TOTALS	415	100%	£1,719	100%

*These rates of contribution relate to 44 hours' service per week, a proportionate reduction being made for a less number of hours, payment being waived if less than 2/6 for any week.

Points which should be noted are:—

(a) 10% of all the cases helped were standard charge cases yielding 41% of the total income of £1,719.

(b) 59% of all the cases helped were assessed to pay either nothing or a contribution at the rate of not over 10/- for a week of 44 hours.

13. Health Education

"Action taken, including any taken in regard to accidents in the home. (It will be helpful if copies of any current leaflets or posters specially prepared for use in the Council's area may be forwarded with the advance copy of the Medical Officer of Health's survey."

Posters on a variety of subjects are exhibited in our clinics. Talks are given to mothers at the child welfare clinics by health visitors. Leaflets on such

subjects as infant feeding, care in tuberculous households are distributed. Some thousands of leaflets on protection of young children against fire have been distributed by the nurses.

It is hoped that with the recent appointment of a deputy superintendent nursing officer the whole campaign of health propaganda, including propaganda against accidents in the home will be speeded up.

Reference is, of course, made in various other sections of this report to the issue of propaganda leaflets of one kind or another under the appropriate headings.

A club for mothers is successfully run by the health visitor in one urban area.

No leaflets or posters specially prepared for use in this county have been issued. None are in contemplation except that leaflets recently prepared on infant feeding are issued widespread to mothers by the nurses.

14. Mental Health.

" Manner in which the proposals approved under Section 28 (so far as concerns mental illness and mental defectiveness) and Section 51 of the National Health Service Act, have been implemented, covering in particular the following matters:—

(i) *Administration*

(a) *Committee responsible for service.*

(b) *Number and qualifications of staff employed in the Mental Health Service (Medical Officers, Psychiatric Social Workers and other Mental Health Workers, Duly Authorised Officers, Occupation Centre Supervisors, etc.)*

(c) *Co-ordination with Regional Hospital Boards and Hospital Management Committees (Joint use of Officers; supervision of patients on trial from Mental Hospitals or on licence from Institutions for Mental Defectives, etc.)*

(d) *Duties delegated to Voluntary Associations.*

(e) *Whether arrangements have been initiated for the training of staff.*

(*ii*) *Account of work undertaken in the community*

(*a*) *Under Section 28, National Health Service Act,* 1946; *Measures taken for prevention of mental illness, care and after care of the mentally ill and defective.*

(*b*) *Under the Lunacy and Mental Treatment Acts,* 1890-1930, *by duly authorised officers/ mental health staff.*

(*c*) *Under the Mental Deficiency Acts,* 1913-1938 :—

(*i*) *Arrangements for ascertaining and supervising mental defectives.*

(*ii*) *Guardianship.*

(*iii*) *Arrangements for carrying out the statutory duty to provide occupation and training for defectives in the area (occupation centres, industrial centres for adults, home teaching—of individual or groups.)*"

1. Administration

The mental health services of the local health authority remain under the immediate control of the Mental Health Sub-Committee of the Health Committee. Comment was made in my last report on the flexibility of the scheme as a whole as typified by the co-option to the Mental Health Sub-Committee of a number of members who are not members of the Council itself, but who are able to offer very valuable contributions in the field of community service, with special emphasis of course on the mental health aspect of that service.

Although there have been considerable staff changes during the year under review, the position at the end of the year was substantially more satisfactory than at any period since the implementation of the National Health Service Act. It is not easy to secure properly trained staff to work in a rural area such as Cumberland, particularly when that area is so far removed from large centres of population with corresponding social amenities. So far as the mental health service is concerned, it is, therefore, very pleasing to record almost a full complement. It was thought desirable to designate an officer to act when necessary as

deputy to the Certifying Officer for the purpose of the Mental Deficiency Act, 1913, and Dr. Gilloran, the Deputy County Medical Officer, was accordingly nominated—the appointment being approved by the Minister in June.

There were a number of changes in the medical officers approved by the Minister of Education for the purpose of the Handicapped Pupils and School Health Service Regulations, 1945, mainly as a result of staff changes in the major positions which these officers occupied. Dr. Gavin resigned his appointment as Assistant County Medical Officer in August to take up another appointment; Dr. Thomson, whilst continuing his duties as an Assistant County Medical Officer, moved from Millom R.D.C. to the Border R.D.C. in which latter area his services remain available as an approved medical officer. Dr. Perrott was appointed Assistant County Medical Officer for the Millom area and was approved for the purposes of the Handicapped Pupils Regulations by the Minister of Education in July.

We were fortunate enough to secure the services of a whole-time psychiatric social worker for West Cumberland by the appointment of Miss Simpson, who commenced her duties in October. The Mental Health Worker for East Cumberland (Mrs. Fowle) resigned in February and Miss O'Regan took up the post in June. Miss Page, who was appointed supervisor in the Wigton Occupation Centre before its opening and whose services were used as a home teacher in the meantime, resigned in February, and Miss Magee was appointed supervisor in the Wigton centre in June. Mrs. Todhunter, who had been employed as an Occupation Centre Assistant Supervisor at Maryport and as a home teacher, resigned her appointment during the year. It was felt that greater benefit would accrue by utilising the services of her successor at both Whitehaven and Maryport Occupation Centres with the abandonment of a little home teaching, and Miss Cox was appointed to the vacancy in July.

The Ministry request that the whole of the staff employed in the mental health service should be detailed, and a list is therefore set out below.

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

Deputy Certifying Officer (Mental Deficiency Act, 1913): Dr. Gilloran.

Approved Medical Officers : Dr. Fraser, Dr. Gilloran, Dr. Hunter, Dr. Jones, Dr. Perrott, Dr. Thomson, *Dr. Ferguson, *Dr. Braithwaite.

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

Administrative Assistant : Mr. Froggatt.

Psychiatric Social Workers : (a) West Cumberland —Miss Simpson; (b) East Cumberland—Miss Lamb, seconded from the Special Area Committee in connection with the East Cumberland Child Guidance Centre.

Mental Health Workers: Miss Hall, Miss O'Regan.

Occupation Centre Supervisors: Mrs. Lax, Miss Magee.

Occupation Centre Assistant Supervisor : Miss Cox.

Handicrafts Teacher : Miss Cooper.

Duly Authorised Officers (part-time): Mr. T. J. Archer, Mr. J. J. Brown, Mr. J. Calvert, Mr. A. Corlett, Mr. W. H. Coulthard, Miss A. E. Fox, Mr. A. Glaister, Mr. J. Gibson, Mr. J. Housby, Mr. J. H. Hocking, Mr. D. W. Jack, Mr. J. D. Messenger, Mr. H. Sewell, Mr. W. J. Wilson.

*—Approved for cases in connection with the Child Guidance Centres.

It will be noted that a number of specialist officers of the Special Area Committee continue to be seconded for part-time services to the local health and education authorities. In like manner, the services of the local health authority's field workers are freely available to the hospital management committees in the supervising of cases on licence from mental deficiency colonies or for domiciliary visits, reports, etc. The supervision of defectives on licence from institutions in strict theory is the prerogative of the hospital management committee of the institution, but, apart from the fact that few institutions are able to undertake community care work in respect of defectives on licence, there are distinct advantages in this work being undertaken by the staff of the local health authority. Local officers have knowledge of the patient, his home and his background, since, generally speaking, the case has been

under their supervision before admission to institutional care and training. They can, therefore, serve as intermediaries between the home and the institution and are able, as a result of detailed knowledge of the sociological factors involved, to offer a more personal approach to the problems surrounding a patient's re-adjustment to normal civilian life.

No specific duties have been delegated by the local health authority to voluntary associations; the County Council, however, makes an annual contribution of £15 (with the approval of the Minister), towards the funds of the National Association for Mental Health, whose excellent and often pioneer work in the many aspects of mental health is already widely known and appreciated. It is not possible in an authority of this size to initiate training courses for mental health staff, nor is it considered practicable to join with other authorities in such schemes.

2. **Work undertaken in the Community**

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

The power, and to the extent that the Minister directs, the duty, to make arrangements for care and after care of persons in the community suffering from mental illness or mental defectiveness, which was imposed upon local authorities by Section 28 of the National Health Service Act, presents a considerable extension of the powers which were previously conferred upon local authorities. The intention is, so far as after-care is concerned, to supplement whatever services are provided along these lines by the mental hospitals or institutions for defectives.

In the matter of mental illness, therefore, patients attending psychiatric clinics, those on trial at home following a period of treatment in a mental hospital and patients discharged from such hospitals remain primarily the responsibility of the mental hospital. Section 28 does, however, permit the local health authority to assist the hospital in the preventive and after-care aspects of their work. Mainly because trained psychiatric social workers were not available, it has so far not been possible for the local health authority to offer any assistance in the after-care of persons suffering from mental illness.

The out-patient psychiatric clinics continue to be held at the three principal hospitals in the county by the Medical Superintendent of Garlands Hospital and his staff. These clinics serve as an example of a positive attitude to mental health in the *prevention* of illness by providing facilities for early diagnosis so that any treatment which is indicated can be initiated (often without admission to hospital) with the result that the progression of a minor disturbance to the stage of a serious mental illness can very often be halted.

The care and after-care of mental defectives in the community is now a long established service in which the mental health workers play a major role, but in carrying out these duties, it is unavoidable that an almost unending listing of officers, public authorities, voluntary associations, etc.—not directly connected with the local health authority—are called in to supplement this necessary social service.

Mention must also be made of the child guidance service, which, although primarily the responsibility of the school health service, does a great deal of valuable preventive work. Centres are now established at Whitehaven (one day a week), Maryport (three days a month), Carlisle (one half day a week) and Millom (one day a month). The demands upon the child guidance centres continue to grow, but the service will, of course, materially benefit as the result of the appointment of a whole-time psychiatric social worker in West Cumberland.

To summarize this section, therefore, I suggest that under Section 28 of the National Health Service Act, one of the most important tasks falling to be undertaken by the local health authority as a community service lies in the prevention of mental ill-health, including neurosis. By definition, deficiency of mind is a condition of incomplete or arrested development which is generally inherent or inborn, so that comparatively little can be done to lower the incidence of mental deficiency in the community without (or perhaps even with) the introduction of highly contentious legislation. This is not the case with mental illness where much positive preventive work can usefully and successfully be undertaken. When it is realised that more than one third (about 150,000) of the hospital beds in the country are in use for patients suffering from

mental illness, and that neurotic illness causes between a quarter and a third of all absence from work due to illness, the urgent need for strenuous preventive measures, as an economic as well as a social necessity, will be appreciated.

(b) UNDER THE LUNACY AND MENTAL TREATMENT ACTS, 1890-1930.

It is the duty of the local health authority to appoint officers who are authorised to take initial proceedings in providing care and treatment for sufferers from mental illness. These "duty authorised officers" in Cumberland are primarily engaged in other work such as registration, and duties under the Lunacy and Mental Treatment Act occupy only a small proportion of their time. By far the greater number of patients entering a mental hospital for treatment do so without legal implication and at their own request as voluntary patients. In these cases the services of the duly authorised officer are rarely required.

During the year 1952, a total of 226 patients from the county area were admitted to mental hospitals under the provisions of the Lunacy and Mental Treatment Acts. Of these all but four (who were admitted to Lancaster Moor Hospital) received treatment at Garlands. It is pleasing to note the large percentage of cases voluntarily entering mental hospitals for treatment. Only 29 patients were certified under the Lunacy Act, all the remainder (197 patients) being admitted as voluntary patients. No patients in the temporary class were admitted during the year. Discharges from mental hospitals totalled 201 (certified 28, temporary 2, voluntary 171).

(c) UNDER THE MENTAL DEFICIENCY ACTS, 1913-38.

(i) *Ascertainment and Supervision.*

During the year 228 cases were referred to the department for investigation. Of these, 35 were ascertained to be mentally defective and as 22 were children of school age, these cases were reported by the local education authority for the purposes of the Mental Deficiency Act, 1913, as ineducable within the scholastic system. In addition, 30 children were considered to be educationally sub-normal, and were recommended for education either in special school or in special classes

for backward children in ordinary schools. In 70 cases behaviour disorders, maladjustment, etc., resulted in those children being referred to the child guidance centres.

At the end of 1952 there were 183 defectives " subject to be dealt with " under the Mental Deficiency Acts under statutory supervision in their own homes. This number increases annually, corresponding figures for 1951 and 1950 being 152 and 135 respectively. The task of supervision of these defectives falls largely on the shoulders of the mental health social workers, who also exercise the necessary supervisory care in respect of 37 defectives under voluntary supervision, these latter cases being recognised as defectives within the meaning of the Act, but not " subject to be dealt with " for the time being. Because of the serious deficiency in hospital accommodation for the mentally defective, the work of the field workers is magnified out of all proportion. All too frequently they have the unenviable task of trying to make effective what is often an inherently unsatisfactory supervision of the patient in the home.

The introduction of a new scheme for the short term care of mental defectives in cases of urgency by Circular No. 5/52 of the Ministry of Health, dated 21st January, 1952, helps appreciably in surmounting domestic crises within households which contain low-grade defectives among their members. This circular authorised local authorities to arrange for the removal of a mental defective from home for short periods when such an action became necessary because of a serious situation arising within the household. This very necessary action can now be undertaken, without legal formality and without the implication of certification under the Act, in one or two ways; either by the admission of the patient to a mental deficiency institution if a bed is temporarily available therein or to some other place which is suitable for the reception of a defective. Prospects of finding a temporary abode for a mental defective outside a hospital for such cases are very remote, but to legalise the position from the point of view of Section 28 of the National Health Service Act, the Council's proposals for carrying out

its duties under the Act were amended by the insertion of the following paragraph :—

> "The Authority will in cases of urgent need on financial grounds or for other reasons find and in appropriate cases pay for, the whole or the part of the cost of maintaining defectives in suitable accommodation elsewhere than at home for short periods normally not exceeding two months."

Although no defective has been removed from home under this scheme except to Dovenby Hall Hospital, I must place on record our appreciation of the extent to which it has been possible to meet really desperate situations during 1952 by the generous co-operation of the Medical Superintendent of that hospital (Dr. Ferguson). During the year ten defectives were admitted to Dovenby Hall Hospital for "short term care" often at very short notice, because of some domestic situation which had arisen in the family unit. The bulk of these are accounted for by the sudden illness or confinement of the mother of the defective. Apart from the easing of a crisis within the household, which often proves to be of a temporary character, there is no doubt that this form of temporary residential care, enables those defectives participating in the scheme at least to have a modicum of training and socialisation away from their homes.

(ii) *Guardianship.*

There were 54 patients under statutory guardianship at the end of the year. This number is six fewer than the corresponding figure for 1951, the decrease being the result of two deaths, the admission of two guardianship cases to institutional care, and the fact that in the remaining two cases the orders lapsed by operation of law. No new cases were admitted to guardianship during 1952 for the simple reason that it was not possible to find persons who were willing to accept the onerous role of guardian. Only four of the fifty-four cases under guardianship were juveniles, and in these four cases the local health authority affords financial assistance towards maintenance and to assist with clothing, mainly because these particular defectives suffer from physical as well as mental handicaps.

The majority of cases under guardianship remain under the control of close relatives (27 of parents, 17 of

either a sister or a brother, and 2 of either an aunt or a niece). In only 8 cases is the guardian not related to the defective. A survey of the ages of adult defectives under guardianship reveals the following interesting (though alarming) facts. Of the 50 adults under this form of care, 2 are over 70, 6 between 60 and 70 years of age, and 13 between 50 and 60 years of age. In other words, 42% of the defectives under guardianship are now over 50 years of age. Generally speaking, the guardians are older than the defectives so that *the average age of guardians is disturbingly high,* with the inevitable conclusion in many cases that a guardianship which may have been entirely satisfactory when the orders were originally made, possibly up to twenty years ago, can no longer be considered to be satisfactory, because of the increasing ages of both guardian and defective. Defectives are often physically handicapped; they obviously need much greater care and attention that the average person, and not infrequently do we find that the defective exhibits senile changes at a comparatively early age. The result is, of course, that a number of cases at present remaining under guardianship ought properly to be placed under institutional care and control. In fact thirteen of the present guardianship cases for some reason or other are not regarded as being completely satisfactory, and the defectives' names appear on the waiting list for institutional care.

I would like to quote three specific examples where guardianship which has been entirely satisfactory in the past has, through no fault of the guardian or the defective, become quite the reverse. Firstly, a cot and chair male defective, aged 52 under the guardianship of his mother aged 76; secondly, a 52 years old female defective of medium grade who is sullen, sly and occasionally violent, but who remains under the guardianship of her 75 year old mother. Finally, again a 52 years old female defective, prematurely aged and increasingly difficult to manage who remains under the guardianship of a sister whose family also consists of a husband, eight children and a brother. In my last annual report I emphasised the fact that the guardianship provision, which is a most valuable method of retaining suitable defectives in a normal home atmosphere, but which permits a more rigid control over the defective than is possible under statutory supervision,

was becoming increasingly difficult to implement. *Until guardianship conditions are made more attractive to offset the additional care which a defective requires and the statutory requirements entailed in the guardianship, and until the guardian feels free to resign office if such a step becomes necessary, I can see no alternative but that this valuable provision must fall gradually into disuse. No scheme of guardianship can be successful until institutional accommodation is freely available, so that a defective becoming unsuitable for guardianship at any time can speedily be admitted to custodial care in hospital.*

(iii) *Occupation and Training.*

There is a duty imposed by the Mental Deficiency Acts upon local health authorities " to provide suitable training or ccupation for defectives who are under supervision or guardianship " unless they satisfy the Board of Control that there are adequate reasons for not so doing. Generally speaking, this duty is most efficiently carried out by the provision of suitable centres to which the defectives are brought for training purposes. The purpose of an occupation centre may be summarised thus:—

1 To develop the patients' minds and bodies within the limitation imposed by their defect, so that both at the centre and in their own homes they may lead happier and more interesting lives.

2 With this end in view, to help those attending to form good habits, to acquire self control and to develop a social sense as they learn to work and play with others.

3 To relieve the strain caused by the presence of an untrained defective in the family and to help the the parents or other relatives by demonstrating methods of care and training.

In an occupation centre little emphasis is placed on purely academic subjects, and the teaching of even the rudiments of reading and writing is not attempted unless a child is considered capable of assimilating such instruction. The time table therefore includes habit training, sense training, physical training, speech training, handwork, music and movement, training in simple domestic tasks, table manners, etc. Where older

patients are received, lessons in more advanced handicrafts, carpentry, knitting, laundering, etc., can be taught, but the methods throughout must of necessity be on the practical rather than the academic side. Whilst the law imposes a duty to provide proper training and occupation for defectives of all ages, such training is largely confined in Cumberland to children under the age of 16, who have been excluded from participating in the normal educational system because of their inability to profit by the curriculum which is available at the ordinary or special schools. The reasons for confining attention to the younger end is largely that the scheme of training as a whole is yet only in its infancy, and with limited accommodation at the existing centres, it is thought desirable to offer training to children, who have been excluded from the scholastic system, in the hope that they will profit by occupation centre training and discipline, so that they are more likely to be stabilised during adolescence and adult life. If this policy of restricting the use of the present centres to juveniles was not followed, the buildings would quickly be filled with a semi-permanent population which would preclude the admission of newly ascertained defective children.

Whilst the true function of occupation centres is to provide the training and occupation demanded by the law, there is growing concern throughout the country that by the admission of low grade defectives who ought properly to be admitted to institutional care, the character of these centres is changing and the target for the occupation centres is deteriorating. In this connection it is interesting to note a comment which was made by an inspector of the Board of Control following an inspection of the Wigton Occupation Centre, who reported: "I do feel that the essential purpose of the centre must not be lost sight of, and only those able to benefit from its training should be admitted." I do not think we should be at all disturbed by our policy of introducing children to occupation centre care and training who are not strictly regarded as trainable in such a centre, but who should be subject to the more rigid control which is available only at suitable institutions. Our first duty must lie in providing relief to distressed parents from the care of low grade, anti-social or physically handicapped defectives, as, until institu-

tional accommodation is available in sufficient quantity, the fact of providing care for such a child even for a few hours a day serves a greater social need than the training or occupation of defectives of higher grade. In the case, and again to quote the Board's comments through its inspector, reference was made to a girl, aged seven, about whom it was said "It is very doubtful whether she is suitable (to attend). She did not appreciate what was said to her and during the mid-day meal she was heard to use obscene language continually." Such children should, in my opinion, at least be given an opportunity of attendance at an occupation centre in an attempt to make them more manageable at home. Although this girl is an only child, her mother was a nervous wreck in trying to cope with her daughter, who was virtually inarticulate, had to be fed, slept very little, was rarely still even for a few moments, and who had lengthy spasms of screaming. After four months' attendance on a five-day week basis, that same child will now sit and actually play with toys; she is making determined and not unsuccessful efforts to speak, she can feed herself, is able to join in very simple games and now sleeps regularly for twelve hours each night. The reaction of the parents can be imagined, and this case is merely an example of the general, almost overwhelming, gratitude of parents for such service as we can offer in this direction.

The Whitehaven and Maryport Centres continue to function as reported last year, namely at Whitehaven on three days each week and at Maryport on the other two week days, the same staff being used at both centres. After a long and sorry chapter of delays and frustrations, the Wigton Occupation Centre was opened in July. These rented premises, though small, provide the necessary essentials for a full-time centre (that is on five days a week). The centre nominally will cater for about sixteen children, dependent on the ages and types admitted, and by the end of the year fourteen children were in attendance. The Carlisle City authority opened an occupation centre at Kingstown during the year and the County Council were offered two vacancies at that centre, which we gratefully accepted. This enabled two defectives living in the county area to attend the centre provided by Carlisle.

A small handicrafts class for adult female defectives continued at Workington on two afternoons a week.

No home teaching is at present being undertaken in the county. This form of training, whilst serving a useful purpose, is a most expensive proposition in a scattered county such as Cumberland. It was, therefore, decided to utilise the days on which a home teacher was visiting a small number of defectives in their own homes, to greater advantage by employing the same officer as an assistant supervisor at the Whitehaven Centre which enabled more children to have a larger degree of training. By the end of the year 38 children were in regular attendance at the occupation centres (by comparison with 18 last year). It is interesting to note that, of the 38 children attending occupation centres, 18 are on the waiting list for institutional accommodation.

In looking to future requirements with reference to the training of mental defectives, it should be noted that at the end of the year under review, 61 children were regarded as able to profit by occupation centre training, 37 adult defectives by such forms of training as are available in the industrial type of centre and 23 from home teaching. In the foreseeable future, therefore, I suggest that the demands within the county can best be served by the closing down of the existing centre at Maryport, which is open only on two days a week in most unsatisfactory premises, and by the extension of the Whitehaven Centre from a three-day week basis to full-time in more commodious premises. It will be necessary if this suggestion comes to fruition to provide proper transport for those children from north of Whitehaven as far as Maryport to enable them to attend what I hope will be a more commodious and whole-time centre based on Whitehaven.

Finally, there is a growing need for at least some form of training provision in the Millom area, and every effort must be made to provide at least part-time training for those children in that area who have been excluded from school, and it must not be overlooked that even when a training scheme is developed to the stage envisaged above, there still remain an appreciable number of defectives for whom no training facilities are available merely because of their location in isolated areas in the county.

(iv) *Institutional Treatment*

On the 31st December, 1952, the County Council was responsible for 567 mental defectives. Of these, 293 were in institutions or on licence therefrom, as follows:—

In the area of the Newcastle Regional Hospital Board

	1952	1951
Dovenby Hall Hospital, Cockermouth ...	202	198
Durran Hill House, Carlisle	7	7
Aycliff Hospital, Heighington, Darlington	4	3
Leamington Hall, Alnwick	2	3
General Hospital, West Hartlepool ...	2	2
Prudhoe and Monkton Hospital, Prudhoe	1	2
Bishop Auckland Institution, Durham ...	1	1
Morpeth & Northgate District Hospital ...	1	1

In other Regions.

Milnthorpe Hospital, Kendal	33	35
Royal Albert Hospital, Lancaster	19	17
Lisieux Hall, Chorley	4	4
St. Mary's Home, Alton, Hants.	3	3
Coleshill Hill, Birmingham	1	—
Monyhull Hall, Birmingham	1	—
Totterdown Hall, Walton-on-Thames ...	1	1
St. Raphael's, Barwin Park, Hants. ...	1	1
Hortham Colony, Almondsbury, Bristol ...	1	1
House of Help, Bath	1	1
Calderstones, Whalley, near Blackburn ...	—	1

Under the jurisdiction of the Board of Control.

Rampton Hospital, Retford, Notts. ...	6	5
Moss Side Hospital, Maghull, Liverpool ...	2	4
	293	290

The duties of a local health authority under the Mental Deficiency Act are perfectly plain, and it is specified that it shall be their duty to provide suitable supervision for mental defectives or "if such supervision affords insufficient protection, to take steps for securing that they should be dealt with by being sent to institutions or places under guardianship in accordance with this Act." As I pointed out in my last annual report, the local health authority cannot carry out this statutory duty because hospital accommodation for defectives is simply not available to anything like the extent required.

Nine new cases were admitted under order to institutions during the year in comparison with four in 1951 and six in 1950. Even so, the waiting list of persons requiring hospital accommodation because

domiciliary supervision is considered inadequate shows an increase of 24 during the year under review.

The following table analyses the list of defectives awaiting admission to institutions at the end of 1952 in the form submitted to the Minister in the annual statistical return. Comparative figures for the end of the preceding year are shown in brackets.

	Under 16	16 years and over	Total
1. In urgent need of institutional care.			
(a) Cot and chair cases ...	7 (6)	1 (1)	8 (7)
(b) Ambulant low grade cases	13 (14)	5 (3)	18 (17)
(c) Medium grade cases ...	15 (11)	7 (3)	22 (14)
(d) High grade cases ..	1 (2)	2 (1)	3 (3)
	36 (33)	15 (8)	57 (41)
2. Not in urgent need of institutional care.			
(a) Cot and chair cases ...	2 (3)	1 (1)	3 (4)
(b) Ambulant low grade cases	8 (5)	6 (—)	14 (5)
(c) Medium grade cases ...	8 (8)	12 (9)	20 (17)
(d) High grade cases ...	3 (3)	5 (2)	8 (5)
	57 (52)	39 (20)	96 (72)

The table is divided into two main groups according to degrees of urgency. In the first half are included only those cases which were considered to be really urgent at the end of the year. The second half analyses those cases where present care and supervision is thought to be of doubtful adequacy and where admission to institutional care is considered desirable, but not for the moment an urgent necessity. In differentiating between these two broad and arbitrary groups, it must be remembered that relative urgency can change quite quickly. For example, a case which is not considered urgent can become, more or less overnight, one of extreme urgency because of the sudden illness or death of the person mainly responsible for the defective's care.

A number of gloomy facts emerge when the table is considered. The total list has increased in number during the year by twenty-four. The "urgent" list shows on increase of ten, practically the whole of whom are defectives of medium grade. The "non-urgent"

list shows an even greater increase of fourteen, nine of whom are ambulant low grade defectives.

I would like to comment at this stage on the reasons why the list continues to lengthen. Firstly, there is a greater degree of ascertainment. The present scholastic system makes ample provision for providing training for children in accordance with their capabilities and requirements, and it is therefore obvious that the number found to be ineducable within the educational system is increased because of the continual survey of the position as applied to school children generally. Secondly, the housing situation of the community at large, which deteriorated as a result of wartime conditions, invariably adds to the list of defectives requiring the greater care which is available only in institutions. A number of people at present on waiting lists for mental deficiency hospitals could be adequately supervised in their own homes if the homes themselves were satisfactory. Thirdly, as was mentioned in my last report, the legal provision for the guardianship of defectives under order in their own homes is falling into disuse. No scheme of guardianship can be entered into unless there is ample provision for the defective's removal to a suitable institution if the guardianship proves unsatisfactory. Under this circumstance, the waiting list for hospital accommodation now includes a small number of defectives who could under normal circumstances at least be given a trial under the conditions of control which a statutory form of guardianship affords in these cases. Lastly, I regret to record that there seems to be developing in some cases what I can only describe as a lack of social consciousness. The welfare state, supported as it is by social legislation, has, in my opinion, engendered an increased demand for the taking over by statutory bodies of responsibilities in connection with various classes of persons who are considered to need extra help or protection. Whilst this is a difficult subject in which to bring specific examples, there is a growing feeling among social workers that there is a trend in some cases to force the hand of the statutory authority to exercise its functions in which, if the degree of family effort were of the standard reasonably to be expected, demands for formal action in accordance with the law should not arise.

The present position, therefore, with reference to

hospital accommodation for mental defectives continues to be most unsatisfactory. We cannot overlook the fact that at the end of 1952 the number of our defectives in mental deficiency hospitals was seven fewer than at the end of 1949, while at the same date the waiting list for this type of accommodation was 25% larger than ever before. There is, of course, the encouraging prospect of more beds becoming available at the Dovenby Hall Hospital as a result of new building during 1953. This building is progressing favourably and will provide 80 additional beds, and although those allocated to the use of the county of Cumberland will be most welcome, they will by no means solve this distressing problem, and these extra beds must only be regarded as a temporary amelioration of a most difficult position. In theory, the National Health Service Act, with its scheme of regionalisation of hospital beds under the Minister's jurisdiction, made available beds in any part of the country to any local health authority. There were to be no boundaries between regions, but our experience is that this policy has just not worked out. Cumberland has suffered by the scheme of regionalisation particularly in the field of mental deficiency, in that it has virtually lost the facilities which were formerly available at Milnthorpe Hospital. I have repeatedly tried to give a fair picture of the effect of the tremendous shortage of institutional accommodation for defectives on the mental deficiency service as a whole, and, in particular, drawing attention to the misery which is caused by the enforced retention of low grade, anti-social or physically sick defectives in their own homes. Coupled with this, of course, we have the disastrous position of the local health authorities being unable to carry out their duties, and even—as occurred in a case at the Cumberland Quarter Sessions towards the end of 1952—a court of law being unable to carry out its wishes in accordance with the law because a bed was not available in a suitable institution.

As a final suggestion, therefore, I must emphasise that no effort should be spared to draw up and bring to fruition a long term policy to overcome this nation wide appalling dearth of mental deficiency accommodation. The problem is growing in magnitude. The distress which is caused increases daily, so that a vigorous building policy must be devised as a scheme of the

very highest priority and, parallel with this, the recruitment and training of adequate nursing staff to man the new hospitals or institutions or the extensions of existing hospitals must be treated as a matter of great urgency and importance.

This tremendous problem, as I have said, is by no means local in character. According to the most recent statistics which are available on a national scale there was during the years 1950 and 1951 a *decrease* throughout the country of 419 beds for mental defectives in institutions. This, to quote the official report, " was mainly due to the re-assessment of bed space on a basis of authorised standards," and at the end of 1951 the deficiency of accommodation was 4,778 as against 3,444 at the end of the preceding year. Whilst the provision of adequate institutional accommodation for mental defectives since the implementation of the National Health Service Act is no longer the responsibility of local health authorities, we know that the Newcastle Regional Hosptial Board are fully aware of the desperate position and are prepared, as far as financial and supply difficulties permit, to give the highest priority to this provision.

PART II.

REPORTS AND NOTES ON INDIVIDUAL SERVICES AND OTHER MATTERS.

Orthopaedics.

Venereal disease.

Cancer.

Infectious disease.

Food and milk.

Housing.

Water and sewerage.

Laboratory services.

Orthopaedic Services

The statistics which follow, for the year 1952, do not vary materially from those for the previous year. The trend is for the more important orthopaedic defects to go direct to the hospitals, in contrast to what used to be the case when our county orthopaedic clinics were recognised as clearing houses for all orthopaedic conditions up to the age of adolescence.

More attention is now being paid to the remedial treatment of early postural defects and in the case of school children a start has been made, following upon a very large and successful conference held in West Cumberland early in 1953, with the remedial treatment of these early postural defects in school by selected teachers under the general direction of the County Chief Organisers of Physical Training, in co-operation with our Orthopaedic Physiotherapists.

This will relieve the strain on our intermediate clinics and will also save a good deal of educational time in that the children—we hope in increasing numbers—will be treated on the spot instead of having to travel considerable distances to our intermediate clinics.

Orthorpaedic conditions affecting children under five years of age.

Bow leg and knock knee	242
Flat foot	77
Congenital deformities of feet	3
Postural defects of feet	39
Hallux valgus and deformed toes	6
Injuries (including fractures)	34
Poliomyelitis	18
Torticollis	8
Cerebral palsy	7
Congenital dislocation of the hip	8
Birth palsy	4
Scoliosis, lordosis and kyphosis	3
Other conditions	36
	485

Tuberculosis of Bones and Joints.

	Adults.	School Children.	Under 5 years.
Totals	93 ...	34 ...	3

Adult Non-Tubercular Cases.

Poliomyelitis	24
Arthritis	17
Scoliosis, lordosis and kyphosis	17
Congenital dislocation of the hip	9
Slipped epiphysis	2
Flat foot	12
Osteomyelitis	10
Vertebral disc protrusion	13
Hallux valgus, and deformed toes	6
Injuries (including fractures)	5
Celebral palsy	6
Congenital defects	8
Other conditions	20
	149

General Statistics.

Number on Aftercare register, 1-1-52	629
New cases during 1952	221
Cases renotified after previous discharge	1
Number of cases removed from register	133
Number remaining on register at 31-12-52	718
Number attending surgeons' clinics	821
Attendance at aftercare clinics	1487
X-ray examinations during 1952	58
Waiting for X-ray	54
Home visits	287
Plasters applied	67
Surgical boots and appliances supplied	216
Appliances supplied from stock	33

Hospital Admissions.

Name of Hospital.	In Hospital at 1/1/52.	Admitted during year.	Discharged.	In at 31/12/52.
Ethel Hedley Hospital Windermere	16	34	29	21
Shropshire Orthopaedic Hospital Oswestry. In addition to above figures **33** patients were admitted and discharged after short stay review.	6	7	9	4
Cumberland Infirmary, Carlisle	—	17	17	—

Patients Awaiting Hospital Admission

(Including School Children).

	Adults.	School Children.	Under 5 years.
Ethel Hedley Hospital, Windermere	—	9	1
Cumberland Infirmary, Carlisle	2	6	6
	2	15	7

Venereal Diseases

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

"Last year I reported on the remarkable decrease in patients suffering from early syphilis. This phenomenon, experienced in my own clinic, was shown to have occurred throughout this country and in America. Correspondence with foreign colleagues, as in Austria, revealed the same state of affairs occurring in other European countries also.

"In 1952 only three cases of early syphilis reported for investigation at Cumberland Infirmary, and none at Whitehaven. All three had been infected outside Cumberland: in one case the source of infection was London, in another it was Korea, and in the third it was Spain. It has come to my knowledge, however, that one patient who sought advice in Manchester had been infected in Carlisle.

"In order to provide a background against which to interpret the situation in Cumberland, I again wrote to colleagues in various parts of the country and studied their figures for early syphilis in recent years. I used the figure for 1946 as 100% in each case, and tabulated results for succeeding years as a percentage of the 1946 figure. A graph was constructed for each clinic. It was remarkable how close was the correspondence between one graph and another.

"Gonorrhoea is likewise even less common at the clinics in Carlisle and Whitehaven. By contrast the bigger city clinics report an increase in cases of gonorrhoea coming for treatment in 1952. Such a development was totally unexpected and very unwelcome. As far as Cumberland is concerned the only reasonable inference is that general practitioners

treat their own cases, whereas in busy cities they send their patients to the V.D. Clinics. The upward trend in gonorrhoea cases for 1952 is revealed in the consolidated figures for Scotland, and for England and Wales.

If we assume that it is the use of antibiotics which has influenced the downward trend in syphilis, we are faced with the paradox—that gonorrhoea increases while syphilis decreases. At the Broomielaw Clinic in Glasgow the weekly returns for gonorrhoea have not changed very much since 1938—in spite of sulphonamides, penicillin, and all the other antibiotics to which gonorrhoea is more susceptible than syphilis. Some have tried to explain the difficulty by pointing out that the incubation period of gonorrhoea is much shorter than that of syphilis, so that, in a population where antibiotics are used day in and day out by every medical practitioner in the country, the chances of aborting a developing gonorrhoeal infection are less than in the case of syphilis. I had an idea myself that the fact that women infected with gonorrhoea were mostly asymptomatic offered an alternative explanation; it seemed to me that women so infected would be less likely to come under the influence of attack by drugs such as the antibiotics, and would provide a continuing reservoir of infection. But explanations like this, and other suggestions of a similar kind, cannot explain the divergent trends as between these two diseases. Another factor to be fitted into the picture is the modern simplicity of gonorrhoea. Complications are very rarely seen. What is the cause of all this? Obviously the influences which have produced such a welcome change in the morbidity of syphilis are still not accurately known. Until these influences can be discovered it would be unjustifiable to hazard predictions regarding future trends in syphilitic infection. Nevertheless, one is left with a feeling of insecurity and doubt: past optimism and complacency has been somewhat shaken.

Late Syphilis.

More cases of later syphilis are being dealt with as the months go by. Recently I had occasion to make an analysis for the World Health Organisation of the records of patients treated for early syphilis in Cumberland during the years 1946 and 1947. I was

appalled by the numbers who defaulted during treatment. This factor of default characterised to an even greater extent the years of the war when patients lived in a world of constant change, were here to-day and gone to-morrow, and where continuation of treatment was often difficult or impossible. These patients, only partially treated or not treated at all, represent the cases of late syphilis which are applying for advice in ever increasing numbers at the moment. It is a strange illustration of the changes that have taken place in this speciality during the post-war years that, whereas I saw only three cases of early syphilis in the year 1952, I examined three new cases of G.P.I. within the course of one week recently.

Congenital Syphilis.

I am happy to report that only one new case of congenital syphilis was seen last year, and this was not a child but an adult. Last year the County Council (on the advice of the Medical Officer of Health, Dr. Kenneth Fraser) decided it would be justifiable to offer a fee to general practitioners in the county in return for sending samples of blood from pregnant women under their care. The serum is examined for Wassermann, Rhesus Factor and blood grouping. Their foresight is a practical illustration of their determination to use every method in an attempt to eliminate congenital syphilis in Cumberland. The response was excellent and nearly 600 sera were sent for examination: three samples showed a positive Wassermann test and no babies were lost from syphilitic infection. I feel that this is an excellent start and an achievement to be proud of. I know of no other county in this country that has had the foresight to develop such an organisation. Dr. W. V. Macfarlane, who is Consultant Venereologist in the Newcastle Area, quotes figures for Ante-Natal work carried out by general practitioners there (from payments made by Local Executive Councils) thus:—

Total pregnancies	...	15,178
Blood specimens taken	...	probably not exceeding 10%

These figures speak for themselves.

The following table lists the total numbers of fresh infections (acute gonorrhoea and early syphilis) and the total attendances at the two Clinics at Cumberland Infirmary and Whitehaven Hospital:—

Year.	Early V.D. Infections. Carlisle.	Whitehaven.	Total Attendances. 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
1951	43	9	2436	1141
1952	29	8	2081	870

The table showing 'Early V.D. Infections' is less significant as the years go by. The majority of patients in this category have always been suffering from gonorrhoea. As has been pointed out elsewhere, general practitioners now treat the majority of their own patients. The table 'Total Attendances' must be interpreted likewise, in the light of the increasing interest shown by general practitioners. Patients no longer require to attend hospital for routine courses of daily penicillin: some patients, indeed, receive weekly injections from their own doctors. These developments are, on the whole, to be welcomed. The main result is that the hospital clinic has lost its function as a treatment centre and has become, more and more, a diagnostic centre. This tendency brings the V.D. clinic in line with the consultant clinics of the other specialities.

The following table illustrates the localities from which new patients were collected:—

Town or Area.	To Carlisle Clinic.	To Whitehaven Clinic.	Total.
From: Carlisle and suburbs	163	—	163
Alston	1	—	1
Aspatria	4	—	4
Brampton	10	—	10
Cleator Moor	—	5	5
Cockermouth	3	2	5
Dumfriesshire	17	—	17
Egremont	—	1	1
Frizington	—	2	2
Holmrook	—	2	2
Longtown	5	—	5
Maryport and area	8	22	30
Millom	—	4	4
Netherton and Sellafield Camps	—	1	1
Penrith and area	19	—	19
Shap and Westmorland	5	—	5
Whitehaven	3	32	35
Wigton	6	—	6
Workington and area	9	20	29
Others—outside Cumberland	21	4	25
TOTALS	274	95	369

One outstanding development of last year was the evolution of a new test for syphilis. It is referred to as the T.P.I. test (Nelson) and depends upon the ability of serum from a syphilitic patient to immobilise treponema pallida in culture. Unlike the Wassermann, Kahn and other blood tests hitherto in use, the treponema pallida immobilisation test is proving itself a specific test for syphilis. Much work requires to be carried out before its specificity can be established, but already it has proved of great value in the differentiation of patients who show false positive Wassermann results from cases of true syphilis. By the kindness of Dr. Orpwood Price, this test is now available to patients in this area."

CANCER

Deaths from cancer during the year amounted to 361 which shows a slight decrease on the figures for the previous year. Details of these deaths by age groups and sanitary districts are given below.

Cancer Deaths during 1952—By Sanitary Districts

	Males	Females	Total
Urban Districts :			
Cockermouth	6	9	15
Keswick	3	5	8
Maryport	10	7	17
Penrith	13	12	25
Whitehaven	21	22	43
Workington	39	18	57
Aggregate of Urban Districts	92	73	165
Rural Districts :			
Alston	3	1	4
Border	19	23	42
Cockermouth	12	19	31
Ennerdale	19	22	41
Millom	14	15	29
Penrith	7	8	15
Wigton	23	11	34
Aggregate of Rural Districts	97	99	196
Whole County	189	172	361

Cancer Deaths during 1952—By Age Groups

	0-45		45-65		65+		All Ages Totals	
	M.	F.	M.	F.	M.	F.	M.	F.
Urban Districts ...	3	6	38	25	51	42	92	73
Rural Districts ...	5	12	41	31	51	56	97	99
Whole County ...	8	18	79	56	102	98	189	172
	26		135		200		361	

The hospital side of this matter is entirely one for the Special Area Committee. Our part as a health authority is confined to the provision of domiciliary nursing, domestic help, and after care, under section 28 of the Act. We are, of course, also responsible for transport.

A general picture of the work undertaken during the year at the Cumberland Infirmary, which includes of course patients from areas outside the administrative county, follows. For these figures I am indebted to the secretary of the East Cumberland Hospital Management Committee.

Patients Attending Out-Patient Clinics

	First Attendance	Other Attendances	Totals
County	176	1025	1201
City	79	492	571
Other Districts ...	41	214	255
Totals	296	1731	2027

Patients Attending Radiotherapy Department

	New Patients	Recurrences	Attendances	Treatments
Deep ...	168	35	1994	5043
Superficial	140	1	243	
	308	36	2237	
Total Attendances		2581		

Patients Admitted to Hospital

	In Patients
County	126
City	74
Other Districts	39
	239

A radiotherapy diagnostic and follow-up clinic was opened at Workington Infirmary on March 6th, 1952. Its main purpose is to save patients travelling to Carlisle

for routine visits and for such treatment as can be provided at the Workington clinic.

From March to December 1952, 51 new patients and 674 old patients attended. It may be possible in future years to divide these into malignant and non-malignant.

New equipment for superficial X-ray has been installed at Workington Infirmary, replacing that formerly used which had become out of date. Superficial X-ray treatment started in the spring of 1953 and therefore no figures are relevant to the current report.

The opening of the Workington diagnostic and follow-up clinic will obviously affect in future years the figures for the Cumberland Infirmary, but it may be expected that the aggregate figures of the two clinics will continue to show increased attendances, especially in the follow-up section.

PREVALENCE OF, AND CONTROL OVER, INFECTIOUS AND OTHER DISEASES

No epidemic of infectious disease of any significance occurred during the year, with the exception of a small outbreak of Sonné dysentery in the Ennerdale rural district.

Compared with the figures for the previous year, as will be shown by a glance at the attached table, the notifications of infectious disease were remarkably small.

The odd case of suspected smallpox came up for investigation, but fortunately the diagnosis was not confirmed in any case.

The small table which follows shows the records of deaths from the commoner infectious diseases in respect of the past few years.

1945/1951 inclusive	Scarlet Fever	nil
1952		nil
1945/1951 inclusive	Diphtheria	5
1952		nil
1945/1951 inclusive	Enteric Fever	1
1952		nil
1945/1951 inclusive	Measles	20
1952		nil
1945/1951 inclusive	Whooping Cough	27
1952		nil
1945/1951 inclusive	Infantile diarrhoea	80
1952	(including gastritis and enteritis)	10

The longer table which now follows shows the incidence of the infectious diseases in the County during 1952.

NOTIFICATION OF CASES OF INFECTIOUS DISEASES IN THE COUNTY OF CUMBERLAND DURING THE YEAR, 1952.

District.	Scarlet Fever.	Whooping Cough.	Dip.	Measles.	Pneumonia.	Meningococcal Infection.	Acute poliomyelitis Paralytic.	Acute poliomyelitis Non-paralytic.	Acute encephalitis Infective.	Acute encephalitis Post. infectious.	Dysentry.	Food Poisoning.	Erysipelas.	Chicken Pox.	Enteric Fever.
Urban Districts															
Workington ...	51	74	—	63	15	1	1	—	—	—	—	—	10	44	—
Whitehaven ..	53	2	—	11	12	—	—	—	—	—	—	—	5	—	—
Cockermouth	1	—	—	—	—	1	—	—	—	—	—	—	—	—	—
Keswick	4	—	—	1	—	—	—	—	—	—	—	—	—	—	—
Maryport ...	19	21	—	20	4	—	—	—	—	—	—	—	1	—	—
Penrith	16	68	—	76	5	—	—	—	—	—	—	1	3	—	—
Rural Districts															
Alston	1	2	—	156	—	1	—	—	—	—	—	—	1	69	—
Border	20	32	—	81	8	1	2	3	—	—	3	5	—	2	—
Cockermouth	32	8	—	19	3	—	3	—	—	—	—	1	3	—	—
Ennerdale ...	28	2	—	8	4	2	2	—	—	—	41	—	1	—	—
Millom	10	32	—	138	13	—	—	—	—	—	1	—	9	—	—
Penrith	21	52	—	18	8	3	1	—	—	—	—	—	1	—	—
Wigton	22	95	—	71	7	—	—	—	—	—	—	—	5	—	—
TOTALS ...	278	388	—	662	79	9	9	3	—	—	45	7	39	115	—
1951 ...	240	679	2	4616	139	17	24	10	2	—	89	10	44	348	—
1950 ...	280	497	—	619	129	—	22	6	—	—	121	—	25	104	—
1949 ...	182	447	13	657	158	—	31	—	2	—	—	—	48	—	—

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.

The most important event in recent months has been the decision of the Ministry of Agriculture and Fisheries to declare Cumberland and Westmorland and certain parts of Lancashire and the North and West Ridings of Yorkshire a free testing area. After the area has been a free testing area for two years from March 1st, 1953, the area will then be declared an eradication area and about six months thereafter will be declared an attested area. That is the target. This is very welcome news and it is interesting to note that this is the first large area in England which has been so dealt with. It is, if my information is correct, not only the first large area in England to be so dealt with, but with the exception of the Scilly Isles, the first area, irrespective of size, to come under this procedure.

The number of cattle in the area is about 390,000. I understand that in Cumberland, approximately 64% of the cattle are in attested herds. In the adjoining county of Westmorland, the percentage is, I believe, roughly 80% and there is no doubt that it is these high percentages of cattle in attested herds which, compared with certain other areas where the percentage is less, indeed much less, than 25%, which have led the Ministry to take the steps indicated leading up to the target of the classification of the area as attested. The County Councils, the Divisional Inspectors of the Ministry and the farmers in the area are all entitled to be congratulated on the results of their labours over many years. So far as this county is concerned, we can feel well paid for the strenuous efforts undertaken by the Council towards the eradication of tuberculous cattle from the herds of the county which have involved the examination during the past ten years of not less than 10,000 milk samples submitted for biological testing.

When one remembers the former death rate from tubercular infection of bovine origin and perhaps even more the incidence of ill-health and suffering from the same cause, we can look back with some pride to past efforts and forward with hope and confidence to the time when, the area being declared attested, no reacting animal will be allowed within its boundaries. The Health Committee have decided that we continue up to the date when the area is declared attested, our sampling of those milk supplies which are consumed within the county area and are not pasteurised.

The sampling figures for the past few years, including 1952, which are still of interest, are as follows:—

Year	Number submitted to the Biological Test	Percentage Positive for Tubercle
1943	1323	2.04%
1944	1273	1.6 %
1945	1112	0.99%
1946	1245	1.3 %
1947	1125	0.7 %
1948	1171	0.77%
1949	867	0.81%
At this point, sampling for tubercle was transferred from graded and ungraded to ungraded herds only.		
1950	No worth-while figures available.	
1951	506	0.79%
1952	641	0.78%

The figures for 1952 mean that only five samples out of the 641, which came almost entirely from ungraded herds, were found positive for tubercle. As I pointed out in previous reports, this is really an astonishing position, because it has always been anticipated nationally that reacting animals thrown out of attested and tuberculin tested herds would inevitably gravitate into ungraded herds with a consequent rise in risk to the consumer, unless the milk were pasteurised. Our figures for 1951 and 1952 just do not support this assumption. Perhaps one should add that the Divisional Inspector of the Ministry of Agriculture and Fisheries in addition to four cows found as a result of the tuberculous samples mentioned above, found at routine herd inspections or as a result of having been notified by the owners of the animals, thirteen further tubercular cows which had not been discovered by routine sampling. These seventeen cows were all in ungraded herds.

The districts from which the 641 samples were taken during 1952 were as follows:—

Sanitary District.	Number taken for biological examniation for tubercle. 1952.	1951.	1/7/50—31/12/50.
Rural			
Alston	1	—	1
Border	1	—	66
Cockermou'h	171	86	31
Ennerdale	93	93	68
Millom	130	37	9
Penrith	45	34	1
Wigton	153	207	119
	594	457	295
Urban			
Cockermouth	—	—	6
Keswick	4	21	8
Maryport	22	5	28
Penrith	—	1	—
Boroughs			
Whitehaven	12	11	26
Workington	9	21	25
	641	516*	388

*Investigation of 10 of these samples had to be abandoned as the guinea pigs died before a definite result could be obtained.

For comparison, the figures for 1951 and for the second half of 1950 are given, showing how much the figures vary in the same district from year to year. Various factors account for this, such as staff difficulties, and obviously during 1952, restrictions due to foot and mouth disease curtailed for a time sampling activities. It is again satisfactory to note that no tubercular infection of school milk supplies was discovered either through biological sampling or through veterinary inspection.

With regard to the bacteriological cleanliness of our school milk supplies other than tubercle, as stated in last year's report, I have no information.

I continue to be greatly indebted to the Divisional Inspector of the Minister of Agriculture for his close co-operation with this department. He gives me the following figures dealing with cattle slaughtered during the year and with certain other matters. The figures for 1951 are shown in brackets:—

Number of confirmed cases of Tuberculosis—17 (28).

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	1,076 (1,015)	52,835 (51,949)	Nil
Accredited ...	71 (20)	1,901 (583)	Nil
Non-designated ...	2,523 (2,736)	44,731 (47,490)	17

Tuberculin Testing of Tuberculin Tested Herds.

No. of cattle tested	71,940 (73,870)
No. of reactors	145 (244)

Tuberculosis (Attested Herds) Scheme (as at 31-12-52).

No of attested herds	3,314 (2,802)
No. of supervised herds	41 (115)

Pasteurised Milks.

There continue to be only three pasteurising plants in the administrative county, one in Egremont and two in Millom. Sampling is carried out through the co-operation of the sanitary inspectors of the respective district councils, for which co-operation we are grateful. Fifty-one samples were taken during the year and submitted to the phosphatase and methylene blue tests. Of these, forty-three were satisfactory and eight unsatisfactory (four to methylene blue only, three to phosphatase only and one to both tests).

HOUSING

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

"At the time of the preparation of these notes the cost of erection of houses is still rising. The County Council are at a particular disadvantage in respect of costs compared with housing authorities because they invariably build single or at the best, semi-detached dwellings on separate sites, a factor which adds at the very least 10% to the cost of a similar house built as part of a housing scheme.

It was so disturbing to find steady increase in prices every time that tenders were invited for a standard type of dwelling, that it became necessary to reconsider the standard plans of all types of County Council houses, and effect reductions in the design. It is noteworthy that, at a time when the Ministry of Housing were allowing more freedom, it was imperative in view of rising costs to reduce floor areas below the then existing standards in order to effect economies.

Every effort has been made to secure economy in construction of County Council properties, but there

is a level in capital cost below which it is not advisable to go and the cost of maintenance can soon outweigh an initial saving in capital.

Another factor which seems to militate against low tenders is the standard of building required on County Council contracts—it is not an unreasonably high standard, it is simply "good, honest workmanship." Unfortunately, and I regret having to say this—too often do I hear from firms—"We have to put our best tradesmen on to your (County Council) jobs and that puts up our tender." This shows, I think, how the average standard of building has dropped. I am not one to decry modern workmen and workmanship. I contend that there are as good tradesmen to be found to-day as there ever were; as good workmanship can be done to-day as has ever been done. Unquestionably, however, both in quality and output, the normal quality of building workmanship has dropped, but this can be explained. There are thousands of one generation of building tradesmen who from the first days of their apprenticeship have never seen a better standard, nor have worked on anything but housing schemes, nor have they had freely at their disposal materials to carry out their work. Moreover, the incentive scheme, admirable in many ways, is based solely on the output of the building tradesman, and takes no account of the quality of workmanship.

Police :

Last year's negotiations with the Home Office resulted in their acceptance of a new and smaller plan but delayed the placing of new contracts for over six months. The programme based on the new drawings and specifications is now well under way again.

Six houses have been completed during the past year; twenty are now under construction, and tenders are being considered for a further twenty-two.

To achieve the requirement of a good house for each policeman ninety-six more houses are to be built, but the speed of building will be governed by financial considerations and the ease or otherwise of obtaining sites.

Fire Service :

Thirteen new houses have been completed adjacent to the Workington Fire Station, converting an area of derelict backland into a pleasant estate on two sides of a "square", the pairs of houses being linked with outbuildings to form a continuous facade and to screen the back gardens.

A project for a new fire station and firemen's houses at Hensingham has reached an advanced stage of planning.

Nurses :

The district nurse's house with surgery at Bewcastle has been completed and occupied, but the rise in building costs made it necessary for the plan to be reduced, and a smaller edition of the house with garden but without surgery has been built at Penrith for less than £2,000.

Similar houses, but with surgery and waiting space added are being built at Irthington, Burgh-by-Sands and High Hesket, but Frizington, Parton and Bothel are the next districts to be provided with these standard nurses' houses.

Education :

No new houses have been built, but a caretaker's flat has been incorporated in the Irthing Valley Secondary Modern School, opened recently, and there is every prospect that new houses will be built at certain of the new schools.

Existing houses are being improved and modernised as circumstances permit, particularly where waterborne sanitation is being installed in a country school. in which case a bathroom is formed and the house connected to the new drain.

Another recently completed job was the formation of a convenient self-contained flat on the first floor of the over-large eight bedroomed Headmaster's house at the Nelson Grammar School, Wigton, thus releasing the ground floor for teaching purposes.

Smallholdings :

The programme for improvements to the county's smallholdings has been put into operation during the last year, and apart from the construction of farm buildings, many of the houses are being improved, and one new house at Nether Welton is under construction.

Staff :

No new staff houses have been built recently, but four houses have been acquired from the Whitehaven Corporation for the use of staff in that area."

The attached schedule has been compiled from returns received from the district councils in the administrative county.

DISTRICT COUNCIL HOUSING RETURNS

For

YEAR ENDED 31st DECEMBER. 1952

	Alston R.D.C.	Border R.D.C.	Cockermouth R.D.C.	Ennerdale R.D.C.	Millom R.D.C.	Penrith R.D.C.	Wigton R.D.C.	Whitehaven Borough	Workington Borough	Cockermouth U.D.C.	Keswick U.D.C.	Maryport U.D.C.	Penrith U.D.C.
Population 1931	2678	26049	18792	28235	12582	12016	22058	—	24691	4784	4635	12382	9065
1951	2300	29848	20436	29631	13424	11500	23733	24624	28882	5234	4660	12237	10490
A. 1—Total number of occupied dwelling houses in the district	861	7792	5816	8339	4150	3410	6871	—	—	1822	1563	3743	3050
2—Total number of occupied dwelling houses subject to Demolition Orders, Closing Orders or Undertakings	5	85	38	72	—	—	32	—	—	47	1	187	14
3—Estimated number of houses (exclusive of above) which are unfit for habitation and cannot be made fit at a reasonable cost	170	620	476	2026	130	390	383	--	300	—	20	402	396
4—Estimated number of sub-standard houses (exclusive of above) which could be repaired and made fit	330	950	1879	3325	929	1000	1573	—	200	—	100	153	90
5—Number of houses found to be overcrowded	30	67	65	29	18	240	20	—	30	—	—	—	110
B. WAITING LISTS. Total number of valid applicants on Council's waiting list exclusive of those living in houses under A2 and 3 above	12	920	247	364	244	No Wtg. List	729	—	1500	120	114	537	100
C. NEW HOUSES COMPLETED DURING THE YEAR— 1—By or for the Council— For aged persons	—	—	—	10	—	—	—	16	—	4	—	—	—
For agricultural workers	—	6	10	6	4	9	13	—	—	—	—	—	8
Flats	—	—	—	—	—	—	—	—	—	—	—	—	32
General purposes houses	2	56	54	164	63	23	55	266	30	34	6	156	54
2—Private building	3	19	20	8	4	6	13	9	49	10	8	3	10
Total	5	81	84	188	71	38	81	291	79	48	14	159	104
D. 1—Number of houses for which application was made by private persons for Improvement Grants under the Housing Act, 1949	—	9	11	1	—	2	8	—	—	2	—	—	1
2—Number of houses for which grants were approved	—	8	11	—	—	1	8	—	—	—	—	—	1
3—Number of houses where improvements were carried out and grants paid	—	8	8	—	—	—	2	—	—	—	—	—	—
4—Number of houses purchased or taken over by the Council with a view to improvement or conversion	—	—	22	—	—	—	—	—	—	—	—	—	—
5—Number of houses improved by the Council— (i) With grant	—	—	—	—	—	—	—	—	—	—	—	—	—
(ii) Without grant	—	—	—	—	—	—	—	—	—	—	—	—	—
E. TEMPORARY ACCOMMODATION Number of families occupying camps and temporary buildings	—	81	2	—	—	—	56	—	—	—	—	—	76
F. HOUSING PROGRAMME— Estimated number of houses to be built during the ensuing year— (i) Private	4	39	20	12	10	6	13	20	—	—	10	4	10
(ii) Council	24	102	85	200	90	50	170	270	250	78	20	201	52

WATER AND SEWERAGE SCHEMES

(a) Water

At the commencement of the year under review (April, 1952 to March, 1953), the Council were at a disadvantage in considering water supply schemes submitted for grant aid because of the delay in the publication of the report of the water supply survey undertaken in July 1951, by Mr. C. H. Spens and Mr. R. A. Elliott, two of the Ministry's Engineering Inspectors. It was not possible to give unqualified approval to schemes in the absence of the report and without knowledge of its effect on the County's water supply schemes and particularly with regard to the area of the North Cumberland Water Board.

Following the Chancellor of the Exchequer's Budget Speech of 1952, the Ministry of Housing and Local Government issued a Circular (No. 54/53) on economies in Local Government Services drawing attention to the need for economy in further expenditure under present conditions and stressing the necessity of concentrating on the most vital needs among the services for which Local Authorities require loan sanction or grant from the Ministry. The Minister set out the order of priority to be given to schemes of water supply, which, briefly, were as follows:—

(a) URBBAN AREAS.

(i) *New Housing.*—A scheme must represent the most economical method of providing new houses with water or drainage and of avoiding delay in occupation of the houses.

(ii) *Public Health.*—It must be established that the scheme is not merely desirable, but is essential on public health grounds.

(b) RURAL AREAS.

Rural Water Supply Schemes.—Those schemes which, in view of existing conditions, are considered to be most urgent. Schemes for supplying areas where there is no piped water at all, will be given a higher priority than those for improvement of existing piped supplies.

The Minister also stated that the Inland Water Survey, including new work on the gauging of streams

and the collection of statistics, had been suspended for a period of three years.

Cumberland and Westmorland Water Supply Survey—Summary" (" Spens Report ")

This summary on the Survey of Water Resources in Cumberland and Westmorland carried out by Mr. C. H. Spens and Mr. R. A. Elliott in July, 1951, was received from the Ministry of Housing and Local Government on the 16th September, 1952. The Minister, in forwarding the summary, said he was not committed to any of the proposals it contained, but suggested that the authorities should consider, in consultation with other authorities concerned, the practicability of preparing schemes for the improvement of supplies and for ultimate development on the lines indicated in the report or on similar lines. The report recommended the development of individual sources of supply and the formation of water areas, rather than the Caldewhead Scheme, which it was said would involve heavy capital expenditure.

The North Cumberland Water Board were left with no alternative but to give general consent to the participating Authorities to enable them to proceed with alternative sources of supply.

Conferences between certain of the water undertakers in the two Counties have taken place, from which it appears that the majority of the Authorities are anxious to retain their separate functions as water undertakers, and in some instances are not prepared to join together as suggested in the report.

In consequence of the " Spens " report, it is likely that in the future a large number of comparatively small schemes of water supply will be submitted to the council for grant aid, and the County Engineer is trying to obtain the maximum co-ordination between authorities, to secure the most efficient and economic schemes, bearing in mind the development likely to be undertaken in the county in accordance with the county development plan.

It will be seen, however, that bearing in mind the directions from the Ministry previously referred to and the recommendations of the " Spens " report, that only the most urgent of the schemes submitted are likely to be permitted to proceed and that the proposals are,

indeed, long term, and unlikely to materialize for some considerable time.

The schedule set out in Appendix A shows the schemes dealt with during the year, the estimated capital cost, and, where the grant stage has been reached, the amount of grant which has been provisionally allocated.

Two orders affecting water supplies in the county have been made by the Minister under Sections 23 and/or 26 of the Water Act, 1945, viz.: — "The Border Rural District Water Order, 1952," and "The Wigton Water Order, 1952." The first mentioned order empowers the Border R.D.C. to take all the water flowing from the adit of a disused mine at Roughton Gill and the Wigton order enables the Wigton R.D.C. to construct an intake and other works on Hall's Beck and at Aughertree Spring subject to certain provisions regarding compensation water on Hall's Beck.

APPENDIX "A"

WATER SUPPLY SCHEMES CONSIDERED BY THE COUNTY COUNCIL DURING 1952-53.

Scheme submitted by 1.	Name of Scheme. 2.	General Outline. 3.	Estimated Cost. 4.	Grants. Ministry. 5.	Grants. County 6.	Remarks. 7.	Stage at 31/3/53. 8.
Alston with Garrigill. R.D.C.	Comprehensive Water Scheme.	——	£109,000	Provisionally £50,000. (Notified 4/53 and includes £1,600 towards scheme (a).	Under consideration	——	Approved by C.C.
	(a) The Raise Portion.	(a) Improved supply to Alston Town.	£4,500		(a) £1,450.	——	(a) Grant approved.
Border R.D.C.	Banks Water Mains Ext. Scheme.	Extension to High House, Burthinghurst, Low Dovecote & Clockey Mill areas.	£15,750	——	——	Border R.D.C. may apply for grant to Min. of Ag. & Fish.	Approved by C.C. on Eng. grounds.
Cockermouth R.D.C.	Hause Gill Water Scheme.	(a) Improvements at Hause Gill Intake. (b) New 5in. Main Tallantire—Br. Moor and to supply Seaton	£14,290	——	——	——	(a) Approved by C.C. as necessary and sound in principle. (b) Observations deferred pending Ministry guidance.

Scheme submitted by 1.	Name of Scheme. 2.	General Outline. 3.	Estimated Cost. 4.	Grants. Ministry. 5.	Grants. County. 6.	Remarks. 7.	Stage at 31/3/53. 8.
Cockermouth R.D.C.	Holmebeck.	Extension to High Nook Beck, Loweswater.	£8,640	—	—	In 1947 this Scheme was recommended by C.C. for inclusion in Holme Beck Scheme, but Min. approved Scheme as then submitted by R.D.C.	Approved by C.C.
Ennerdale R.D.C.	Ivy Hill, St. Bees.	4in Main to augment St. Bees Supply and serve Small Holdings.	£5,400	—	—	—	Approved by C.C.
Do.	Central and S.W. Areas.	Improved distribution in Central and S. Western Areas of R.D.	£118,278	—	—	Scheme implements proposals already approved by C.C.	Approved by C.C. on Eng. grounds.
Do.	Birks Road, Cleator Moor.	Improvement of Supply.	£2,500	Nil on grounds that no deficiency is likely owing to additional revenue likely to accrue from Brewery & Eng. Works.	No liability.	—	Approved by C.C.

Scheme submitted by 1.	Name of Scheme. 2.	General Outline. 3.	Estimated Cost. 4.	Grants.		Remarks. 7.	Stage at 31/3/53. 8.
				Ministry. 5.	County. 6.		
Millom R.D.C.	Eskdale Water Supply.	Supply from Willan Beck.	£12,165	£5,500	£3,332	——	Work commenced 1/53.
Penrith U.D.C.	Hayeswater Improvement.	Increased supply from Boredale Head to Penrith.	——	——	——	Min. decision that area was not Rural locality for purposes of Acts. No grant offered.	——
Workington B.C.	High Duty Alloys, Distington.	8in. main, Winscales, Distington.	£6,150	——	——	Min. decision that apart from whether area is a Rural locality no deficiency is likely to arise, therefore, no grant offered.	——
			£292,173	£55,500	£4,782		

(b) Sewerage

Circular No. 54/53 already referred to in regard to water supplies, also gave the order of priority for sewerage schemes and stressed the following points:—

(a) URBAN AREAS.

(i) *New Housing.*—As well as representing the most economical method of providing new houses with drainage, where a scheme would serve existing as well as new houses, it may be necessary, for the time being, to restrict the expenditure to the work required for the new houses alone.

(ii) *Public Health.*—Unsatisfactory conditions in some respects may not mean necessarily danger to health, and the replacement of works and machinery in danger of breakdown; work for obviating pollution of water supplies that may give rise to disease; sewerage schemes designed to relieve flooding inside dwelling houses; and the improvement or replacement of sewage works overloaded or obsolescent to an extent that may give rise to conditions affecting the health of the people in the areas concerned, would receive consideration on public health grounds. Works of this nature, must, however, be supported by a report from the Medical Officer of Health on the nature and extent of the danger.

(b) RURAL AREAS.

(a) *Rural Sewerage.*

Authorisation of new schemes must be limited to those necessary for new housing or on grounds of public health, as in urban areas.

Grants under Section 3 of the Distribution of Industry Act, 1945, will not be made in future.

(b) *Schemes not yet approved in principle.*

Schemes that have not yet reached the stage of being investigated in detail and approved in principle, will be dealt with up

to the point where approval in principle can be considered. New schemes should be submitted in broad outline only, and contract drawings, specifications and bills of quantities should not be prepared. After approval in principle has been given, the Minister will inform the Authority that these documents should be made ready and materials ordered with a view to a start being made.

The change in policy, whereby grants under the Distribution of Industry Act, 1945, have been withdrawn has affected particularly the Wigton Town sewerage scheme in respect of which a provisional grant had already been indicated, and the consequent delay by the re-submission of the scheme to the Ministry, and the rising costs of both labour and materials which have in the meantime taken place, have increased the capital cost of this scheme from £62,560 in 1947 to approximately £133,700 in 1952.

A summary of the schemes dealt with during the year, appears as Appendix B hereto.

APPENDIX "B"

SEWERAGE AND SEWERAGE SCHEMES CONSIDERED BY THE COUNTY COUNCIL DURING 1952/53.

Scheme submitted by 1.	Name of Scheme. 2.	General Outline. 3.	Estimated Cost. 4.	Grants.		Remarks. 7.	Stage at 31/3/53. 8.
				Ministry. 5.	County. 6.		
Border R.D.C.	Houghton Sewerage Scheme.	Houghton Village with provision for housing development in the area.	£9,200	——	——	——	Approved by C.C.
Do.	Crosby-on-Eden	——	£9,500	£1,250	£1,250	——	Approved for grant purposes.
Cockermouth R.D.C.	Winscales and Furnace Row.	Small scheme for 11 reconditioned houses.	——	——	——	R.D.C. applying for grant under Housing Act, 1949.	No further action by C.C.
Ennerdale R.D.C.	Egremont-Braystones Hall Sewer.	——	£27,000	——	——	——	Engineering observations sent to R.D.C.

Scheme submitted by 1.	Name of Scheme. 2.	General Outline. 3.	Estimated Cost. 4.	Grants.		Remarks. 7.	Stage at 31/3/53. 8.
				Ministry. 5.	County. 6.		
Penrith R.D.C.	High Hesket Sewerage Scheme.	High Hesket Village.	£9,200	——	——	Protracted negotiations re siting of disposal works, etc.	General approval by C.C., but engineering improvements suggested.
Wigton R.D.C.	Wigton Town Sewerage Scheme.	Extensive new works and replacement of existing sewer.	£133,700	——	——	Scheme originally submitted under Public Health Act, 1936. Grant offered under Distribution of Industry Act, 1945, but since withdrawn.	Awaiting report of Ministry inspection.
			£188,600	£1,250	£1,250		

LABORATORY SERVICES

We are fortunate in having at the Cumberland Infirmary a dual purpose laboratory undertaking public health work for the local authorities, clinical pathology for hospitals and general practitioners, and examining and reporting on water and milk samples sent in for bacteriological or chemical investigation.

From the public health side, the work undertaken at the laboratory is mainly concerned with the examination of milks (chiefly for tubercle), water supplies, various blood tests of expectant mothers, and bacteriological and other investigations in connection with epidemics including epidemics of food poisoning.

The figures which follow show the very large amount of work undertaken by the laboratory. These figures of course include a very large amount of work which has no connection with public health, and from the public health point of view refers to work done on behalf of many other authorities than the County Council. Nevertheless the figures are of great interest. Dr. Faulds, the pathologist in charge of the laboratory, has sent these notes on the year's work from the public health aspect.: —

" There have been no major epidemics in the period under review, apart from small localised outbreaks of streptococcal throats resembling scarlet fever in several small schools. There was no increase in poliomyelitis or gastro-enteritis and there has been no case of diphtheria during the last twelve months.

The number of milks examined is the same as the previous year, but the amount of work done in the laboratory shows an increase of 8%, most of which is clinical work associated with the hospitals.

236 samples of ice-cream were submitted to the laboratory for examination and of these the grading was as follows: —

Grade 1 (Good)	Grade 2 (Fair)	Grade 3 (Poor)	Grade 4 (Bad)
107	50	36	43

The response of the practitioners to the free service offered by the County Council to examine the blood of expectant mothers has been disappointing. In an investigation carried out by Sir James Spence in Newcastle on the expected and actual numbers of cases of haemolytic disease of the newborn, Cumberland does

not come out very well. The expected incidence of this condition is five per one thousand births in Cumberland and Westmorland and we only discovered 2·15. The expected annual stillbirths in this area due to haemolytic disease of the newborn should be three, but the total number returned in 1952 is one, therefore we are only discovering less than 50% of the cases who should have benefited by earlier diagnosis and hospital treatment.

The new laboratory in Workington is finished and will be in use as from the beginning of July, 1953. This we hope will increase facilities for the practitioners in West Cumberland, especially when a pathologist, resident in the West, has been appointed. The Public Health work will, however, still come to Carlisle as no facilities for public health bacteriology will exist in West Cumberland."

PATHOLOGICAL DEPARTMENT, CUMBERLAND INFIRMARY, CARLISLE.

Number of Specimens received during 1951 and 1952

Year	Milks	Post-Mortems	Pathological Specimens	Total
1951	810	455	27,515	28,780
1952	765	457	29,987	31,209

Units of Work done during 1952.

	Pathological Specimens		Waters			
	Public Health	Hospitals & General Practition's	Bacterio-logical Examinat'ns	Chemical Analyses	Milks	Post-Mortems
Jan./Mar.	6,624	51,120	498	368	3,354	2,908
Apr./June	7,337	50,519	761	544	5,838	3,637
Jul./Sept.	5,925	53,312	870	516	3,641	3,427
Oct./Dec.	6,429	53,366	672	180	5,738	4,535
	26,315	208,317	2,801	1,608	18,571	14,517

Total Number of Units 272,129

PART III.

REPORTS BY THE CONSULTANT CHEST PHYSICIANS ON PULMONARY TUBERCULOSIS AND DISEASES OF THE CHEST.

East Cumberland	—	Dr. W. H. Morton
West Cumberland	—	Dr. R. Hambridge

TUBERCULOSIS

As a preamble to the reports from the consultant chest physicians which follow, it will be useful to give certain figures for the whole county.

Notifications.

The following table shows the notifications in Cumberland for 1952 and the preceding years: —

Year	Pulmonary	Non-Pulmonary
1946	197	48
1947	162	58
1948	195	45
1949	222	32
1950	231	48
1951	267	46
1952	259	45

Deaths.

Deaths from pulmonary tuberculosis for 1952 amount to 43, which is much the lowest figure so far recorded. Deaths from non-pulmonary tuberculosis amount to 9.

The following table shows the deaths from pulmonary and non-pulmonary tuberculosis in Cumberland for 1952 and preceding years: —

Year	Pulmonary	Non-Pulmonary
1946	97	28
1947	101	32
1948	116	15
1949	107	25
1950	101	15
1951	80	11
1952	43	9

Distribution.

The distribution of deaths from pulmonary tuberculosis by areas has been received from the Registrar General as follows: —

Urban Districts	Deaths	Death rate
Cockermouth	—	—
Keswick	—	—
Maryport	5	.40
Penrith	—	—
Whitehaven	9	.37
Workington	10	.35
Aggregate of Urban Districts	24	.28
Rural Districts	**Deaths**	**Death rate**
Alston	1	.44
Border	2	.07
Cockermouth	2	.10
Ennerdale	7	.24
Millom	3	.22
Penrith	2	.17
Wigton	2	.09
Aggregate of Rural Districts	19	.15
Total for the administrative county	43	.20

It may be of interest to compare the deaths from pulmonary tuberculosis in East Cumberland and West Cumberland for the past few years, and these figures are set out in the table which follows:—

		East Cumberland		West Cumberland	
Year	Total	Total	Percentage	Total	Percentage
1946	97	25	25.8%	72	74.2%
1947	101	21	20.8%	80	79.2%
1948	116	31	26.7%	85	73.3%
1949	107	36	33.6%	71	66.4%
1950	101	22	21.8%	79	78.2%
1951	80	18	22.5%	62	77.5%
1952	43	7	16.3%	36	83.7%

The percentages given in the above table, represent the percentage proportion of the total deaths occurring in the county during these years allocated between East and West Cumberland. The table shows clearly where the chief incidence lies, and it is striking that whereas the deaths in East Cumberland at 7, represent only 16% of the total deaths for 1952, the 36 deaths in West Cumberland represent approximately 84% of the total. *The actual figures of deaths, apart from the percentages, have of course to be read in conjunction with the population figures for the two areas of the county, which are as follows:—*

East Cumberland ...	82,490
West Cumberland ...	132,560
	215,050

These population figures are the Registrar General's estimated mid-1952 figures.

Expressed as a rate per 1,000 *population, the deaths from pulmonary tuberculosis during* 1952 *worked out as follows:—*

East Cumberland	.08
West Cumberland	.27

EAST CUMBERLAND

Chest Service—East Cumberland

Introduction.

"The Chest Centre at the City General Hospital, Carlisle, continues to serve the whole of the Area covered by the East Cumberland Hospital Management Committee; this takes in the Eastern half of the County of Cumberland.

The Mass Radiography Unit allotted to the Special Area has been fully employed throughout this area during 1952 and in spite of the long distances involved in reaching the comparatively sparsely populated areas actually carried out more examinations during the year than either of the other four units in the Newcastle Region.

TUBERCULOSIS

Notifications.

Whilst the notification rates throughout Great Britain generally show a decline for 1952 the notification rate has again risen in Cumberland. As far as East Cumberland is concerned, our experience during the first few months of 1953 suggests that in the normal course of events the peak has now probably been reached, and that the rates for the present and succeeding years will fall into line with the rates generally throughout Great Britain.

There is, however, no room for complacency, as undoubtedly there must still be many patients in this area suffering from active pulmonary tuberculosis not known to us and who are infecting others. A provisional survey of new cases coming to our notice in 1952 showed that in only 22% was there a family history of tuberculosis. Many such cases have come to our notice through the operation of the mass radiography unit—the greatest single measure of attacking tuberculosis outside the household.

The value of supervising family contacts is now well established. Apart from this supervision, however, and the mass radiography surveys, there is a large gap in our ability to prevent and control tuberculous disease. It would seem that because of the relatively great advances in treatment of the disease — both therapeutic and surgical—the epidemiology of the disease has been to some extent neglected. A recent

survey elsewhere has shown that the type of case mainly responsible for infecting others is the well established one which had probably been recognised elsewhere, but had not remained under supervision.

The ideal of a six monthly routine x-ray check of every single person in the community is a Utopia which for economic and manpower reasons is impracticable. There is, however, considerable scope for improvement with our present resources and equipment. Several recent mass radiography unit public sessions have been poorly attended and our unit can, and will, cope with considerably increased numbers at these sessions if the members of the public would only realise the gain to both themselves and the community in general. This also applies to factory surveys. Whilst our response in factories in the East Cumberland area is excellent, I do not see why we cannot get a 100% response; it is just as easy for the unit to examine all the workers in a factory instead of only 75%.

Our supervision of family contacts is carried out as far as possible in its broadest sense. We are prepared to examine and test not only immediate contacts in the household, but contacts, for example in neighbouring households. The same policy is applied when a case of tuberculosis is discovered in a child; contact examination facilities are immediately made available not only to the contacts at home, butto contacts in school.

Once again co-operation between the general medical practitioners and ourselves has been of an exceedingly high standard. In the vast majority of cases which come to our notice the patient suspected of having tuberculous disease is first referred for an opinion, and notification results when the diagnosis has been confirmed in consultation. This is a most happy state of affairs and ensures that no patient is notified in error.

Deaths.

The figures published by the Registrar General every year give the mortality rate from tuberculosis by age groups in both sexes; there is a marked fall in the deaths in all age groups, but the overall picture as it affects the two sexes is altered. In females the death rate is highest in early adult life whilst in males the rate is highest at the end of the working span. This is

interesting as it confirms our experience in Cumberland, and is just what one would expect, particularly in males, as active disease in the older age groups is difficult to treat satisfactorily.

Statistics.

Table 1 gives the total number of notified cases of tuberculosis, both pulmonary and non-pulmonary on the clinic register for the Eastern Division of the County of Cumberland.

I would particularly comment on the number of known cases within this area who have had a positive sputum during the latter six months of 1952—viz. 74. Many of these are, unfortunately, in the older age groups, but in spite of the increased number of notified cases on the register the number with a positive sputum is less than it was for the previous year.

Table 1.

CLINIC REGISTER AS AT THE END OF 1952—COUNTY OF CUMBERLAND—EASTERN DIVISION

	Respiratory.			Non-Respiratory.			Totals.			Grand Total
	M.	W.	Ch.	M.	W.	Ch.	M.	W.	Ch.	
Cases on Clinic Register on 1st January, 1952 ...	155	125	10	7	8	17	162	133	27	322
Additions to Register during 1952	45	50	3	5	7	9	50	57	12	119
	200	175	13	12	15	26	212	190	39	441
Removals from Register during 1952	19	17	3	5	1	3	24	18	6	48
Number on Register on 31st December, 1952 ...	181	158	10	7	17	20	188	175	30	393
Number known to have had a positive sputum within the preceding 6 months	41	33	—	—	—	—	41	33	—	74

Table 2 shows the number of examinations, etc. carried out at the chest centre in Carlisle; the figures for the county area being in the first two columns.

STATEMENT OF ATTENDANCES AT CHEST CENTRE, CARLISLE, DURING 1952

	East Cumberland.		Carlisle City		North Westmorland		Total	
	R.	N.R.	R.	N.R.	R.	N.R.	R.	N.R.
1—No. of New Cases seen:—								
Adult Male ... ...)								
„ Female ... ...)	733	16	702	10	149	1	1584	27
Male child ... ...)								
Female child ... ...)							1611	
2—No. of Old Cases seen:—								
Adult Male ... ...)								
„ Female ... ...)	1535	53	1948	97	235	20	3716	170
Male child ... ...)								
Female child ... ...)							3886	
3—No. of New Contacts seen:—								
Adult Male ... ...)								
„ Female ... ...)	540	—	498	—	144	—	1182	—
Male child ... ...)								
Female child ... ...)								
4—No. of Old Contacts seen:—								
Adult Male ... ...)								
„ Female ... ...)	425	—	705	—	158	—	1288	—
Male child ... ...)								
Female child ... ...)								
5—No of cases seen by physiotherapist:—								
Adult Male ... ...)	May to June, 1952—118							
„ Female ... ...)	December total — 65						183	
Male child ... ...)	July/November attendances were in-							
Female child ... ...)	cluded in "old cases" and totalled 365.							
6—No. of A.P. refills given	1031	—	1499	—	104	—)		
7—No. of P.P. refills given	724	—	1253	—	76	—)	4731	—
8—No. of E.P. refills given	43	—	1	—	—	—)		
9—Aspirations 2							114	
10—Screen examinations only ...							249	
11—TOTAL ATTENDANCES ...							13,244	

Contact Examinations.

Contact examinations remain a most important part of the war against tuberculosis and the table gives the relevant details including the number of vaccinations with B.C.G. vaccine at Carlisle. The figures in the first three columns again refer to the County area.

As before all contacts with negative Mantoux Tests are offered B.C.G. vaccination. The protective power of B.C.G. vaccination is now well established and there is no question but that the incidence of tuberculous disease in those vaccinated is but a fraction of that in those who are not vaccinated. In Carlisle we first commenced to use this vaccine in late 1950 and so far no case vaccinated has developed an active tuberculous lesion.

In countries where vaccination has been carried out over a period of 15 years the mortality from the disease likewise shows a striking reduction in those vaccinated. I would again point out the very real difficulty in assessing the true degree of protection obtained. As I stated last year the Mantoux Test is not a true indication. The test is usually described as positive or negative; in actual practice the skin reactions are however measured and the level of tuberculin sensitivity expressed in the terms of distribution and the mean size of the reaction in the group examined as a whole. The actual measurement of the diameter of the indurated area requires skill and practice and even with an experienced observer the error is by no means small. Again, the Mantoux reaction is much influenced by many factors in the preparation and administration of the vaccine.

Table 3.
SUMMARY OF CONTACT EXAMINATIONS DURING 1952.

	East Cumberland.			Carlisle City			Westmorland.			
	M.	W.	Ch.	M.	W.	Ch.	M.	W.	C.	Total
(a) Total number of new contacts examined in 1952 either at Chest Centre or M.M.R.	132	264	266	144	359	289	18	27	99	1598
(b) Total No. of new contacts attending Chest Centre only		540			498			144		1182
(c) No. of old contacts examined during 1952		425			705			158		1288
(d) No. of contacts examined through the Mass Radiography Unit.										1307
(e) Total No. diagnosed as tuberculous	—	2	—	1	2	3	—	—	—	8
(f) No. of Mantoux Tests carried out during 1952		799			619			185		1603
(g) No. of contacts vaccinated with B.C.G. during 1952		74			109			32		215

Institutional treatment.

The number of beds available for the treatment of pulmonary tuberculosis in the area covered by the East Cumberland Hospital Management Committee is given in Table 4:—

Table 4.

Institution	No. of beds
Meathop	10
Blencathra	40
City General Hospital	14
Longtown	23
Cumberland Infirmary	10
Ormside	20

Table 5 gives a summary of the hospital return for the year 1952 in respect of the beds under the East Cumberland Hospital Management Committee.

Table 5
SUMMARY OF HOSPITAL RETURN FOR EAST CUMBERLAND
For the Year 1952

	Blencathra	Ormside.	City General Hospital.	Cumberland Infirmary.	Longtown.
No. of patients given:—					
(a) Streptomycin	—	1	2	—	—
(b) Streptomycin & Paramisan ...	—	53	36	19	38
(c) Isonyazide	—	—	2	—	2
(d) Isonyazide & Streptomycin ...	—	7	5	3	7
(e) Paramisan	—	—	4	—	8
(f) Adhesion Section	—	—	31	—	—
(g) Phrenic Crush	—	—	73	4	3
(h) P.P. inductions	34	—	50	—	1
(i) A.P. inductions	26	—	14	—	—
(j) Aspirations	—	—	5	1	—
No. of patients discharged during 1952—					
R.A. Cases	27	57	37	8	32=161
R.B. Cases	110	6	93	43	43=295
	137	63	130	51	75=456

Table 6 gives the number of *county* patients from the Eastern Division occupying sanatorium beds on the 1st January 1953 and excludes patients from Carlisle and North Westmorland.

Table 6.

Sanatorium	Beds
Blencathra	15
Meathop	4
Stannington	—
Longtown	5
City General Hospital	1
Cumberland Infirmary	5
Ormside	7

Table 7 gives the total number of cases from the Eastern Division of the county admitted to institutions for treatment during 1952:—

Table 7.

Sanatorium	Adults	Children
Blencathra	25	—
Meathop	4	—
Stannington	—	1
Longtown	21	—
City General Hospital ...	24	2
Cumberland Infirmary ...	15	—
Ormside	19	—

Table 8 shows the waiting list for admission for sanatorium treatment in Section (a) and the list for admission for major surgical treatment in Section (b), and relates to patients from the whole of the area covered by the East Cumberland Hospital Management Committee.

Table 8.

Waiting lists for the whole of the area covered by The East Cumberland Hospital Management Committee:—

Section (a) **Sanatorium Waiting List** as on the 1st January, 1953:—

Males	Females	Children
10	5	1

Section (b) **Major Surgical Waiting List** as on the 1st January, 1953:—

Males	Females
13	21

The very full use made of the beds available to East Cumberland patients during the year is largely responsible for the comparatively small list of those awaiting sanatorium treatment. There is still a shortage of beds for the treatment of tuberculosis and there are no beds for the investigation and treatment of non-tuberculous

pulmonary conditions, such as bronchiectasis and neoplasm. It has been decided to allot two beds for bronchoscopy cases in the new geriatric wing at the City General Hospital.

Chemotherapy continues to play a vital role in the treatment of patients; the use of streptomycin combined with paramisan is now well established. The hopes we entertained a year ago from the use of the new drug—isoniazide—have unfortunately not materialised, and one can say now after having 12 months' experience of the new drug that there is no evidence that isoniazide and streptomycin is in any way superior to paramisan and streptomycin. Isoniazide is no longer given by itself as persistent evidence of resistant strains emerge rapidly in such patients. We have tended more and more to use isoniazide and streptomycin in patients who have not responded, or have reacted badly, to paramisan and streptomycin. An emergence of strains of the tubercle bacillus highly resistant either to streptomycin, and or isoniazide worsens the prognosis.

As I pointed out last year one form of treatment of tuberculosis is often complementary to the other; chemotherapy and collapse therapy are now well established. There is no waiting list for minor surgery and the facilities available at the Cumberland Infirmary are adequate so far as minor surgery is concerned. Our biggest handicap is the waiting list of cases for major surgery. During practically the whole of 1952 major surgery in tuberculosis has been at a stand-still. Whilst I have been fortunate to secure admission of an odd case not only in the Newcastle Region but outside it I look forward to the day when we shall have no waiting list for major surgery at all.

As facilities for major surgery become available to us considerably larger numbers of patients will qualify for admission; the present waiting list being largely composed of patients whose only chance of life is major surgery. The operation of thoracoplasty is now a well tried operation of proved and accepted value. Resection is a procedure of more recent date but with the advance in chemotherapy an ever increasing number of patients will be recommended for this operation in future. I would emphasise that major surgery is a supplementary and not a complementary form of treatment. Rest and

graduated exercise remain the basis of all treatment in pulmonary tuberculosis. Chemotherapy and surgical treatment, both minor and major, result in a considerable shortening of this period of rest and graduated exercise. Effective chemotherapy not only has increased the number of patients with lesions treatable by resection but has also led, partly because of certain dissatisfaction about the value of pneumothorax, to considerable widening of the indications for excision of the lung or portions of the lung. I still feel there is a very definite place for artificial pneumothorax and consider that the results of a good pneumothorax free from adhesions are in many ways superior to a thoracoplasty. The difficulty has been in the past that many pneumothoraces have been unsatisfactory from the beginning and have been continued for the simple reason that no major surgical alternatives were available. Artificial pneumothorax therefore came into some disrepute. We never now continue with an unsatisfactory pneumothorax when not only may the disease not be controlled, but when also it may be frankly dangerous to continue this form of treatment.

We now recognise the case for resection of the large caseous focus so often met with and usually containing a liquified area in the centre with viable tubercle bacilli. These caseous masses, often surrounded by fibrous tissue, remain in continuity with the bronchus and may cause violent pneumonic spread and tuberculous endo-bronchitis, a common cause of relapse in patients who have made a good clinical recovery. Such caseous foci situated in areas such as the apical and posterior segments of the upper lobes and in the dorsal segments of the lower lobes are particularly liable to cavitation and should probably be dealt with by resection. After pre-operative treatment of bed rest and chemotherapy a patient may have returned several negative sputum results, but this is not an indication that the patient is out of danger. Removal of such major foci improves the general resistant powers of the patient and eliminates the very considerable threat to the well-being of such an individual. Each case requires very careful assessment, as obviously removal of large masses of functioning lung tissue will have to be avoided.

Ambulance Service.

In Table 5 you will note that the number of collapse therapy refills given at the Chest Centre has again shown a considerable increase and this factor is largely responsible for our continued demands on the Ambulance Service. We continue to discharge patients home before their full period of graduated bed rest and exercise has been completed. Were it not possible to make use of the ambulance service in this way our sanatorium waiting list would be considerably higher.

Bronchiectasis.

Table B1 shows the number of cases of bronchiectasis on our register at the end of 1952.

Table B.1.

Males	Females	Children	Total
21	13	22	56

Table B.2.

Number of attendances at the Physiotherapy Clinic during 1952 :—

Males	Females	Children	Total
13	58	49	120

The results of treatment by physiotherapy have been excellent and several cases presenting evidence of mild bronchiectasis have become entirely symptomless on this treatment alone; in the remainder the results have been remarkable, not only locally in the chest but in the patient's general condition. One indeed feels that in many early cases at least the bronchiectatic condition is reversible in that the bronchial tree returns to normal. Such a result has even been confirmed by bronchograms.

At present we have a waiting list of patients for bronchoscopy and bronchograms with a view to possible major surgery, but as I pointed out last year, during this waiting period the patient's condition generally improves with physiotherapy and no harm results.

Asthma and Bronchitis.

An increasing number of children suffering from asthma and bronchitis have been investigated and a serious effort has been made to train the patients in remedial breathing exercises under the supervision of the physiotherapist, and to combine this with advice on freeing the rooms at the patient's home, particularly

the bedroom of dust. Inhalent allergens and paliative measures during the attacks of asthma are left with the general practitioners concerned in each case.

Pulmonary Neoplasm.

The number of cases of pulmonary neoplasm has again been small, but cases have again been fully investigated and admissions to Shotley Bridge for major surgery have taken place almost immediately. Cases considered to be unsuitable for surgery are referred to the radiotherapy department.

Pneumoconiosis.

Few cases of pneumoconiosis come directly to our notice in the East Cumberland area as most such cases arise in West Cumberland. Odd cases crop up in the Alston area of the county and around Aspatria. During 1952 new pneumoconiosis panels were constituted and a panel sits at Carlisle, on an average, every month. 24 such cases were examined during the latter part of 1952.

Mass Radiography.

(Note :—figures given in brackets throughout the report relate to the corresponding figures for 1951.)

1952 saw the completion of the first full year's work by the mass radiography unit alloted to the Special Area.

The unit was fully occupied throughout the year. The base at No. 1 Brunswick Street, Carlisle continued to be used for public surveys within the City of Carlisle, and made possible the periodic overhaul of the mass radiography unit vehicles without any interruption in the continuity of the work. During the year, two members of the clerical staff left, one on being promoted to another appointment and the other on account of marriage. These members were replaced by two others.

In July Dr. Hambridge, the new Consultant Physician for the West Cumberland area, took up his duties and has since been responsible for the interpretation of films and the full investigation of all cases in the West Cumberland area.

Groups examined.

During 1952 the unit operated continuously throughout the Special Area and in addition to carrying

out surveys at works and factories, surveys of the general public were carried out on 24 (11) occasions. 2,033 (1,502) contact cases were x-rayed, 1,307 from the East Cumberland area and 726 from West Cumberland. 938 (303) national service recruits were examined; 5 were found to be suffering from active tuberculosis, 6 from bronchiectasis and 1 from heart disease.

Facilities for chest x-ray examination continued to be made available in our public surveys to school children of 14 years and over. The school medical officers of the authorities concerned were contacted and full advantage was taken of the service as 4,642 (3,212) children of these age groups passed through the unit. It is to be noted that examination of school children is only carried out after receiving the consent of the parents.

The full co-operation of the general practitioners in the areas visited was invited during each survey and the number examined 355 (262) shows a small but welcome increase in the numbers referred by the doctors themselves. When one bears in mind that the Special Area is so widely scattered and that medical practitioners refer the vast majority of their cases to the established chest centres, I feel that this figure is satisfactory.

Sessions were held for members of the general public in 20 (8) towns in the Special Area. Preliminary propaganda was carried out including advertisements in the press, in local cinemas and by posters and handbills. These public surveys necessitated no prior appointment and were well attended, no less than 23,281 (15,486) persons having passed through the unit.

Results.

During the period 44,849 (32,387) persons were examined by the unit. These include 1,079 (849) inmates of Dovenby Hall and Garlands Hospital. Excluding the mental patients 43,770 (31,538) civilians were examined, of whom 22,816 (16,022) were males and 20,954 (15,516) were females. These examinations are set out in the Ministry of Health age groups in Table M.R. 1.

TABLE M.R. 1.

Age	14 & Under	15-24	25-34	35-44	45 49	60 & Over.	Total all ages.
Male	1,834 (1,305)	5,289 (3,441)	5,156 (3,554)	4,407 (3,158)	4,860 (3,652)	1,270 (912)	22,816 (16,022)
Female ...	1,893 (1,339)	6,867 (5,362)	4,180 (3,129)	3,545 (2,543)	3,617 (2,673)	852 (470)	20,954 (15,516)
Totals	3,727 (2,644)	12,156 (8,803)	9,336 (6,683)	7,952 (5,701)	8,477 (6,385)	2,122 (1,382)	43,770 (31,538)

Number recalled for full sized X-ray film—1,665—3.71% of total examined. (1,512)—(4.67%)

Number referred for clinical examination—600—1.34% of total examined. (423)—(1.30%)

Number failing to attend for full sized film—93—5.58% of those recalled. (69)—(4.56%).

The detailed results of the x-ray examinations are shown in Table 2.

TABLE M.R. 2.

	Male.	Female.	Total.	Percentage of total examined.
Abnormalities revealed.				
(i) Non-tuberculous conditions:				
1. Abnormalities of ribs, etc.	201	221	422 (395)	.94 (1.22)
2. Bronchitis & Emphysema	365	348	713 (15)	1.59 (.05)
3. Bronchiectasis	64	30	94 (102)	.21 (.31)
4. Pneumoconiosis	130	—	130 (126)	.29 (.39)
5. Pleural thickening	245	113	358 (202)	.8 (.62)
6. Intrathoracoc neoplasms	6	5	11 (12)	.02 (.04)
7. Cardiovascular lesions—				
(a) Congenital	—	2	2 (10)	.004(.03)
(b) Acquired	161	229	390 (249)	.87 (.77)
8. Miscellaneous	109	54	163 (152)	.36 (.47)
(ii) Suspected Pulmonary Tuberculosis.				
Previously known—				
1. Active	12	8	20 (17)	04 (.05)
2. Inactive	8	11	19 (14)	.04 (.04)
Newly discovered—				
1. Active	56	75	131 (114)	.29 (.35)
2. Inactive primary	240	218	458 (403)	1.02 (1.24)
3. Inactive post-primary ..	394	264	658 (715)	1.47 (2.21)

The number recalled for clinical examination included all persons presenting radiological evidence of possible active pulmonary tuberculosis, cases of bronchiectasis, particularly those in the under 35 age groups, all neoplasms, and many of the persons presenting iron-ore and pneumoconiotic changes in the x-ray pictures. Clinical examinations were carried out at the Chest Centres.

Table M.R.3 gives a detailed analysis of the work of the Unit in East Cumberland.

Table M.R.3—EAST CUMBERLAND

Source of Examination.	Miniature films.	Large films.	Clinical Exams.	Active T.B.	Inactive T.B.	Bronchiectasis.	Neoplasms.	Pneumoconiosis.	Cardiac Conds.
Doctors' Cases	214	19	11	1	5	2	2	1	1
Ante-natal Cases	8	1	1	1	—	—	—	—	—
Contact Cases	1307	45	15	4	30	—	—	—	16
National Service Recruits	938	11	14	5	6	6	—	—	1
Scholars	3069	53	12	1	27	4	—	—	11
School Staff	277	6	2	—	4	—	—	—	2
General Public	14893	607	214	43	368	39	6	12	130
Surveys	7815	274	75	13	222	16	—	—	48
Mentally defective patients	700	29	16	3	45	1	1	—	36
TOTAL	29221	1045	360	71	707	68	9	13	245

Comments.

Because of advances in chemotherapy and thoracic surgery, the main emphasis on chest disease tends to centre on the treatment of the new case. Mass radiography examination of individuals however is a sure indication that the epidemiology of disease is not being over-looked, and that prevention is as vitally important as treatment. I would again emphasise that the results of the mass radiography service cannot be assessed on the number of abnormalities found, and especially on the number of new cases of active tuberculosis discovered. Important though these figures are, it is not less important to be able to give an assurance that so large a proportion of the general public have normal chest x-rays. Once again I would emphasise that even in spite of a normal x-ray report, should chest symptoms develop later, the person concerned should seek further medical advice, preferably from his own doctor.

In 1951, the statistical data suggested that there was a larger incidence of tuberculous disease in the Workington and Maryport areas, than elsewhere in the Special Area. The figures for 1952 tend to emphasise this, and it is logical to suggest that as soon as full chest centre facilities are available in the West Cumberland area, more time should be spent by the unit in this area than hitherto. Unfortunately, the response of both the general public and the personnel of many factories to mass radiography examination is not as good as it is in East Cumberland.

Acknowledgments.

Once again it is a pleasure to acknowledge the valuable help received in the chest centre work as a whole from the staff of the Public Health Department, and particularly I would express my sincere thanks to Dr. Kenneth Fraser, the County Medical Officer for his continued valuable co-operation."

W. H. MORTON.
Consultant Chest Physician,
East Cumberland.

Chest Centre,
City General Hospital,
CARLISLE.

WEST CUMBERLAND

TUBERCULOSIS.

Chest Clinic Organisation.

"During 1952, a Consultant Chest Physician was appointed, with responsibility for the Chest Service in this area. Following this appointment, several changes in the organisation of certain chest clinics in the area were made.

The small peripheral clinics at Cockermouth, Cleator Moor and Frizington were closed and patients asked to attend Workington and Egremont clinics respectively. The Workington clinic was moved from the Park Lane premises to the out-patient department at Workington Infirmary.

In September, full clinical responsibility was vested in the Consultant Physician, replacing the former system of sessional responsibility of several different Medical Officers.

There are now four regional chest clinics in West Cumberland, viz.:—Workington, Whitehaven, Egremont, Millom; each clinic is able to serve as an out-patient department only. All out-patient collapse therapy is conducted in the X-ray department at Workington Infirmary.

Office accommodation has been provided in the out-patient department at Workington Infirmary for clerical work and the storage of records and X-rays, which have now been centralised there.

Tuberculous Notifications.

Notifications made during the year under review total 236, of which 27 were non-respiratory and 209 respiratory. Compared with the figures for 1951—39 non-respiratory and 204 respiratory—there does not appear to have been any significant change.

The clinic tuberculosis register, however, shows a marked increase in fresh cases diagnosed, amounting to a further 98 above the 1951 total. It is not clear whether this increase has come about by a change in clinical interpretation of what constitutes a notifiable case, or by a real increase in notifiable disease, or by both these factors.

From a study of the trend of fresh cases since 1948, shown in Graph 1, it appears likely that a further real increase in notifiable disease has occurred despite the figures for annual notifications stated above, which suggest otherwise.

Posthumous Notifications.

These numbered 6 for the area during the year. The number is small and the proportion of the total of new notifications negligible (2.08%) suggesting a high order of co-operation from the general practitioners, upon whom responsibility for notification usually rests.

Case Rate.

The case rate per 1,000 population for 1952 was 1.78. This figure is high. The following table sets out the observed case rates and mortality rates on a similar basis for the five year period proceeding 1952.

TABLE I.

Year.	1948	1949	1950	1951	1952
Population	129,670	131,350	134,140	133,043	132,560
New Notifications	203	187	218	243	236
Case rate per 1,000 population ...	1.56	1.42	1.62	1.80	1.78
Number of Deaths	96	86	90	73	40
Death rate per 1,000 population ...	0.74	0.65	0.67	0.54	0.30

Death Rates.

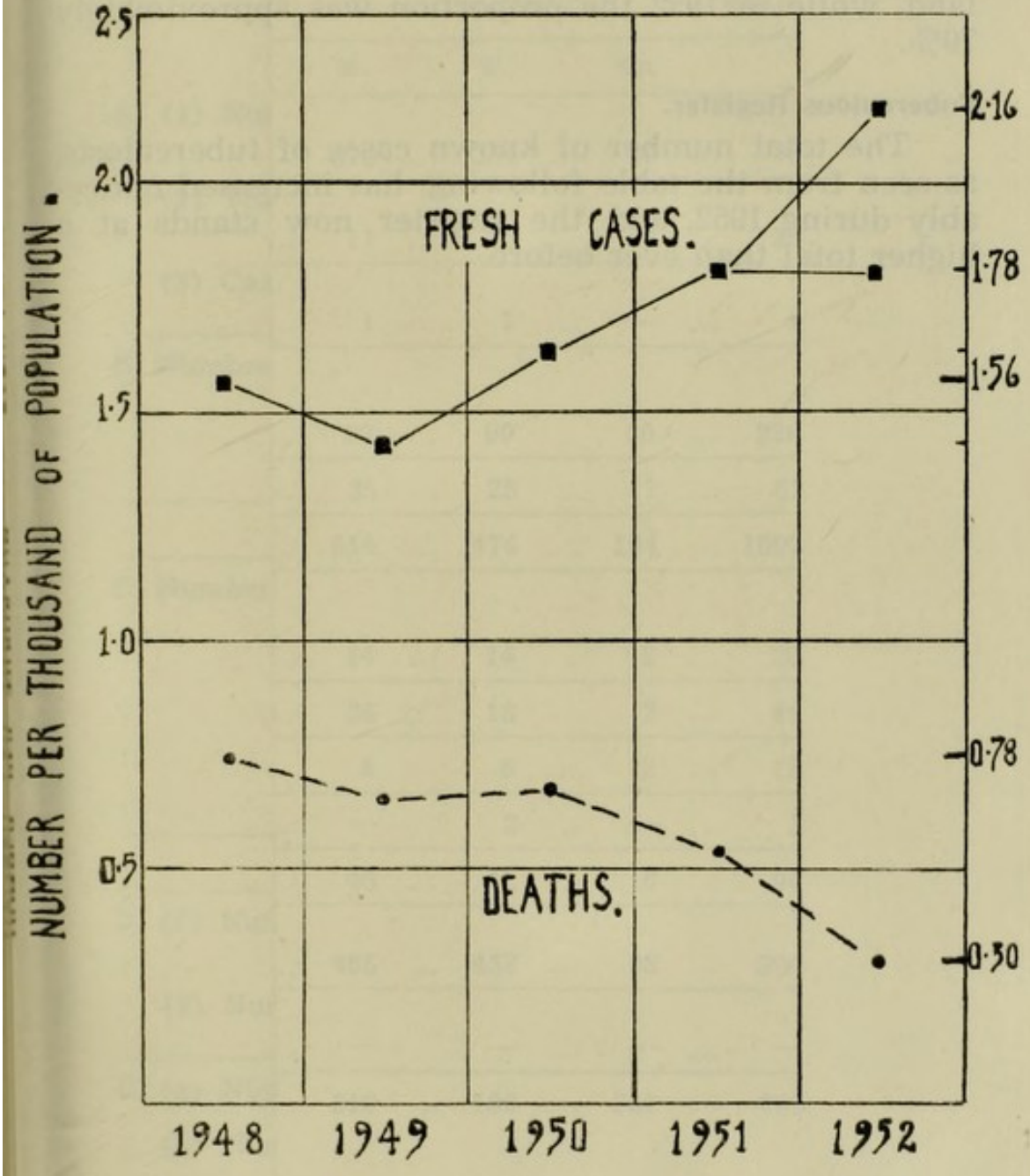
The known death rate for 1952 per 1,000 population was 0.30 compared with 0.54 for 1951 and 0.67 for 1950.

Total deaths from all forms of tuberculosis in West Cumberland in each of the past 10 years are as follows:

Table 2.

1943	1944	1945	1946	1947	1948	1949	1950	1951	1952
93	94	118	88	102	96	86	90	73	40

From the following graph, which sets out the case rate and death rate for each of the past five years, it can be seen that there has been an appreciable improvement in the death rate since 1948 with a marked increase in the number of cases coming under supervision and treatment.


NUMBER PER THOUSAND OF POPULATION.
2·5
2·0
1·5
1·0
0·5
FRESH CASES.
DEATHS.
2·16
1·78
1·56
0·78
0·30
1948
1949
1950
1951
1952

It is of further interest to note that the number of deaths from tuberculosis in West Cumberland in 1952 constitutes an appreciably smaller proportion of such deaths occurring in the Special Area.

Thus, in 1950 and 1951, approximately 80% of all deaths in the Special Area occurred in West Cumberland, while in 1952 the proportion was approximately 70%.

Tuberculous Register.

The total number of known cases of tuberculosis, as seen from the table following, has increased noticeably during 1952, and the register now stands at a higher total than ever before.

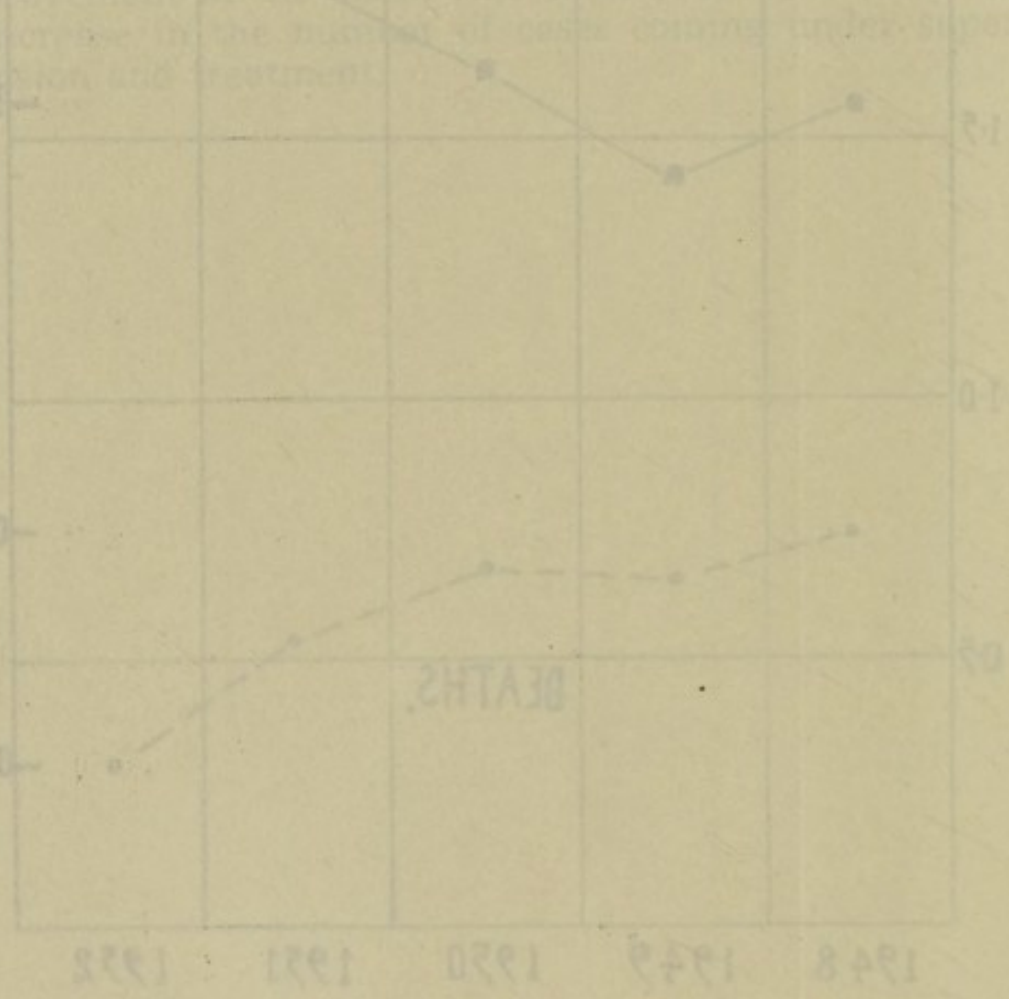


Table III.

CLINIC WORK, 1952—WEST CUMBERLAND.

	Respiratory.			Non-Respiratory.			Totals.			Grand Totals.
	M.	W.	Ch.	M.	W.	Ch	M.	W.	Ch.	
A. (1) Number of notified cases of Tb. on clinic registers on 1st January, 1952	348	308	35	22	26	34	370	334	69	773
(2) Transfers from clinics under other H.M.C's. or B.G's during the year.	11	14	3	—	1	1	11	15	4	30
(3) Cases lost sight of which returned to clinic during the year	1	1	—	—	—	—	1	1	—	2
B. Number of New Cases diagnosed as tuberculous during the year—										
TB. Minus	95	85	20	2	14	10	97	99	30	226
TB. Plus	35	25	1	—	—	—	35	25	1	61
TOTALS OF A. & B.	490	433	59	24	41	45	514	474	104	1092
C. Number of cases in A. & B. written off clinic registers during the year:—										
(1) Recovered	13	12	—	1	2	2	14	14	2	30
(2) Died (all causes)	25	15	1	1	3	1	26	18	2	46
(3) Removed to other HMC of BG. clinics	8	6	—	—	2	2	8	8	2	18
(4) Other reasons	—	2	—	—	—	—	—	2	—	2
TOTALS OF C.	46	35	1	2	7	5	48	42	6	96
D. (1) Number of notified cases of Tb. on clinic registers on 31st December, 1952	444	398	58	22	34	40	466	432	98	996
(2) Number of above known to have had positive sputum within preceding six months	32	15	1	—	—	—	—	—	—	—
E. (a) Number of persons first examined during the year	208	172	246	2	14	11	210	186	257	653
(b) Number of those in (a) who attended as Contacts and who were—										
(1) Diagnosed as tuberculous	—	2	2	—	—	1	—	2	3	5
(2) Not Tuberculous	9	30	196	—	—	—	9	30	196	235
(3) Not determined (as at 31/12/52)	7	2	—	—	—	—	7	2	—	9

It should be remarked that in 1951, the register total remained fairly constant despite 243 new notifications; these were offset by a large number of cases written off the register for all causes, viz: 195. Less than half this number have been written off during 1952, and it is unlikely that such a number of cases, as in 1951, will again be written off in any one year.

At the 31st December, 1952, there were 7.53 cases of tuberculosis per 1,000 population in this area.

B.C.G. Vaccination.

The scheme introduced by the Minister of Health to provide for B.C.G. vaccination of contacts and others amongst the general public, whom Chest Physicians consider it desirable to vaccinate, has been continued during the year. The number so far vaccinated monthly is small, but is likely to increase.

Number of patients vaccinated during 1950 and 1951	60
Number of patients vaccinated during 1952 ...	87
Total	147

Although no reliable statistical data are available for West Cumberland, the incidence of contacts already infected when first examined, appears high, and while vaccination remains limited to this group, this procedure is unlikely to contribute materially to any reduction in morbidity.

Chest Clinic Attendances, etc.

The average number of attendances per session has increased by 50% during the year; owing to the merger of the Cockermouth, Cleator Moor and Frizington clinics, comparative totals for the individual clinics are of little significance. The figures for West Cumberland are:—

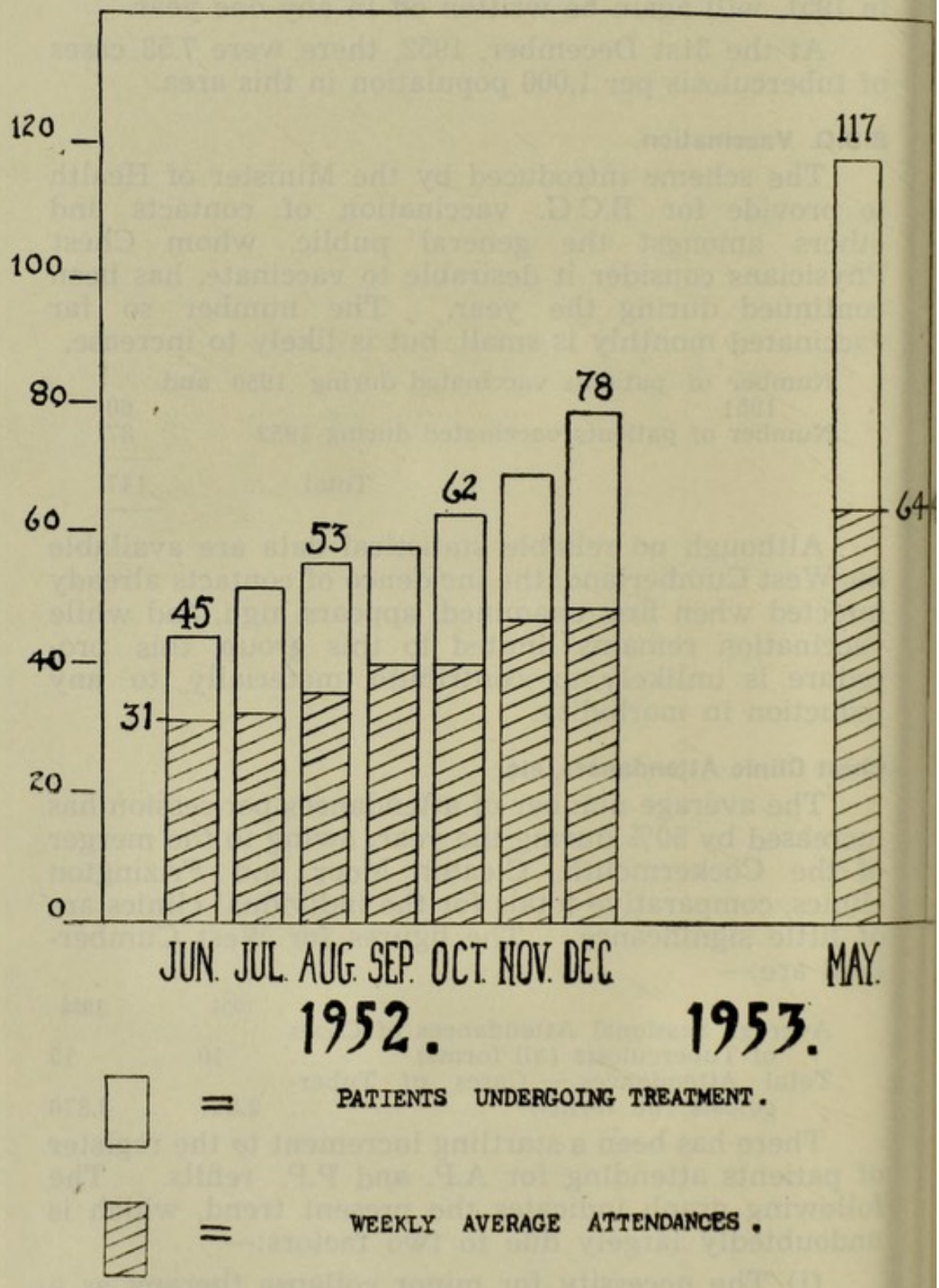
	1951	1952
Average Sessional Attendances of Cases of Tuberculosis (all forms) ...	10 ...	15
Total Attendances — Cases of Tuberculosis (all forms)	2,847 ...	3,876

There has been a startling increment to the register of patients attending for A.P. and P.P. refills. The following graph indicates the present trend, which is undoubtedly largely due to two factors:—

(i) The necessity for minor collapse therapy as a less desirable but more practical measure, in

the absence of an adequate major surgical service.

(ii) The ability to treat, in this way, disease which before streptomycin and chemotherapy were available, was unsuitable for collapse therapy.



Non-Tuberculous Conditions.

These have made up a small proportion of clinic attendances and have been dealt with according to existing facilities and practice.

Mass X-ray.

The one unit shared with East Cumberland has operated periodically in the West during 1952.

A summary of its findings is set out below. It is worthy of note that the incidence of new active cases of tuberculosis in West Cumberland was 5.1 per thousand examined—a figure higher than the national average and more than twice as high as in East Cumberland."

R. HAMBRIDGE,
Consultant Chest Physician
(West Cumberland).

Table IV.
M.M.R.—WEST CUMBERLAND

Source of Examination.	Miniature films.	Large films.	Clinical Exams	Active T.B.	Inactive T.B.	Bronchiectasis.	Neoplasms.	Pneumoconiosis.	Cardiac Conds.
Doctors' Cases	141	21	6	2	6	1	1	7	1
Ante-natal Cases	6	—	—	—	—	—	—	—	—
Contact Cases	726	38	17	5	34	—	—	2	6
National Service Recruits	—	—	—	—	—	—	—	—	—
Scholars	1573	24	7	1	16	1	—	—	1
School Staff	—	—	—	—	—	—	—	—	—
General Public	8388	372	143	47	231	12	1	95	109
Surveys	4479	157	62	22	126	8	—	13	26
Mentally defective patients	315	8	5	3	10	4	—	—	5
TOTAL	15628	620	240	80	423	26	2	117	148

PART IV.

The Welfare Services

I am indebted to the County Welfare Officer (Mr. Walker) for the following 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.

Care of the aged.

The most important phase in the advance of welfare services in the administrative county has been the opening of the Council's first residential home or hostel at Grange Bank, Wigton, situated within about ten minutes walk from the centre of the town, and providing accommodation for 19 elderly females.

Grange Bank is a home within the true meaning of the word, and whilst several other such homes will be necessary to meet the full needs of the county under a long term policy if the avowed intention of the final break-up of Poor Law is to be achieved, the opening of Grange Bank does mark the first step in the realisation of a policy of small homes advocated long before the passing of the Act of 1948, but, of necessity, held up due to economic and other difficult conditions and considerations which faced the County Council during the long period of depression. Another factor bearing on the apparent slow progress in the establishment of new homes, and as mentioned in previous reports, has been, and still is, the difficulty of finding properties (situated in town areas) which could be purchased and suitably adapted.

Some of the residents now in Grange Bank were previously maintained in the former Public Assistance Institutions (erected about 100 years ago) which, although considerably up-graded in internal structure and equipment since 1930, and more especially so since 1948, could not be placed in the category of homes or hostels as envisaged by the Act. By this it is not meant that the institutions can play no part in the long term policy of providing residential accommodation. From a close investigation of the problem, it is quite apparent that not all the aged people now maintained in the former institutions would fit into the modern type of home or hostel, and that at least two of the institutions could play an important part in the over-all policy of residential and temporary accommodation.

In the report for 1951/52, an estimate was given of the number of small homes which would be required on a long term policy, with an intimation that the provision should be made now whilst the country could cope with the problem, and whilst the disproportion of old to young was not too great. It was pointed out that

as the numbers of old people grow, all the problems grow too, and the people who provide the money and goods to keep the old people in comfort grow fewer in proportion, thus accentuating the burden which would be laid on the young people.

I am reminded of these observations by (a) a recent statement by the Chancellor of the Exchequer, and (b) the interest being shown by the medical profession in the care of the aged. In a statement on the Government's attitude to the problems presented by the prospective increase in the number of old people, the Chancellor of the Exchequer is reported as having said that the number of men and women over the present minimum pension ages of 65 and 60 was expected to rise from nearly 7 million in 1952 to nearly 10 million in 1977, a rise of more than 40 per cent. During the same period the number of the population between 15 and these pension ages was expected to decline. Against this background the Government had already announced their policy of encouraging an extension of the span of working life, and last year the Minister of Labour had appointed a National Advisory Committee on the Employment of Older Workers to advise and assist him in promoting the employment of older men and women. Their first report is expected shortly. The Government recognised that the long term implications of the increase in the numbers of old people were of the highest social and economic importance and, at the same time, of great complexity. They had, therefore, decided to set up an independent committee to advise them with the following terms of reference: "To review the economic and financial problems involved in providing for old age, having regard to the prospective increase in the number of the aged, and to make recommendations."

That the British Medical Association should apparently go out of its way to bring to the notice of the Minister of Health the widespread feeling amongst doctors in the country that something more should be done for the aged, is another indication of the growing interest in the welfare of the aged. In support of a recommendation to the Minister of Health to consider the establishment of units to co-ordinate the work of the various authorities caring for the aged, one doctor said that the care of the aged and the difficulties

presented by our ageing population were the biggest problems in social medicine for one hundred years. The proportion of elderly persons was growing so quickly that unless ways were found of keeping them in productive employment the economy of Britain would be over-balanced by them. In about 25 years time, if the present trend continues, and there is no reason why it should not, every working person will have to work about twelve hours of each week in order to support in goods and services an aged person.

The setting up by the Government of an independent committee to review the economic and financial problems involved in providing for old age and to make recommendations, will be generally welcomed.

Whilst under the present social system the provision of financial assistance is left to the State and is completely divorced from that of accommodation and general welfare of the aged, it seems to me that local authorities should be given statutory powers to (a) meet the essential needs of old people; (b) co-ordinate the work of the various voluntary bodies and others engaged in welfare work; and (c) reforge that " missing link " as exemplified by the Relieving Officer, the local official known to all and regarded as a real friend of those in need of help and advice. Under the present system aged persons are visited by numerous officials (local authority and otherwise) seeking information on this, that and the other. Whilst very frequently a matter of annoyance to the old folks, this duplication of visits, enquiries and form filling could be avoided and the position simplified if there were made available to them an all-in-purpose local authority official 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 or other incidental services as may be required, but be under a statutory obligation to see that they are provided.

(1) Additional homes or hostels.

(2) Hostel provision for short term cases and as a holiday centre.

(3) Half-way homes.

Additional to Grange Bank, Wigton, 2 further properties have been purchased to provide residential accommodation for the aged. One is in Cockermouth

and the other in Whitehaven, and when adapted will provide accommodation for 19 males and 31 males and females respectively.

At a very early date the County Welfare Committee will be asked to consider the issues heading this paragraph, and referred to in considerable detail in last year's report, so that policy decisions thereon may be taken before the preparation of Estimates for 1954/55.

Whilst (1) and (2) are straightforward issues for the County Council as the responsible local authority, the issues under (3)—Half-way Homes catering for borderline cases, responsibility for which lies somewhat indefinitely between the local authority and the Regional Hospital Board—call for the serious consideration of both bodies if a solution is to be found which will ensure that old people do not suffer from any fears of insecurity and the deficiency of attention which would result from a wrangle between the two bodies over financial or other responsibilities.

The problem of accommodation for aged persons is engaging the close attention of the County Councils Association and the Association of Municipal Corporations who have decided that a working party consisting of officers from each Association and from the London County Council should consider the problem and submit a full report.

The Local Joint Health Consultative Committee for Cumberland and North Westmorland have also appointed a working party to enquire into the problems of the chronic sick and aged infirm, in the hope that the result may produce suggestions and solve some of the local problems without waiting for the views of any central committee, and the County Welfare Committee will be asked to consider joining issue with the Consultative Committee in the consideration of the matter.

Present Part III. 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) and one modern hostel. The establishments are:—

No.	Establishment	Number of Beds. Part III. Accommodation Males	Females	Total	Hospital Males	Females	Total
1	Station View House, Penrith	27	15	42	16	16	32
2	Highfield House, Wigton	50	19	69	17	18	35
3	Meadow View House, Whitehaven	147	67	214	42	50*	92*
4	Grange Bank, Wigton	—	19	19	—	—	—
		224	120	344	75	84	159

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

As the predominant user of the first 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 first three establishments, to the total number of 159 (see details above) are reserved to the Board for the maintenance and treatment of persons for whom the Board became responsible as from 5th July, 1948.

The Council's (Provision of Accommodation) Scheme, 1949, provides that the Council shall keep under constant review the accommodation and services provided in accordance with the scheme and so far as circumstances permit continue to improve existing accommodation and provide, on a long term policy so far as may be requisite, homes and hostels giving residential accommodation of various types to meet the different needs of the categories of persons concerned and referred to in detail in the scheme. It also provides that the Council shall use their best endeavours to complete any necessary improvements of existing accommodation and services by the 31st March, 1954. The modernisation and improvement of Part III. Accommodation existing in July, 1948, and the amenities therein provided, have proceeded on normal lines during the

past year, and it is hoped that all necessary improvements and upgradings will have been completed by the date mentioned.

The following table shows the number of admissions and discharges during the twelve months to the 31st March, 1953:—

	Station View House, Penrith.			Highfield House, Wigton.			Meadow View House Whitehaven.			Grange Bank, Wigton.	
	Part III.	Hosp.	Total.	Part III.	Hosp.	Total.	Part III.	Hosp.	Total.	Part III.	Total.
Admissions	22	34	56	58	73	131	118	190*	308	15	15
Discharges	20	15	35	65	49	114	116	96	212	—	—
Deaths	1	20	21	—	28	28	2	96	98	—	—
Residents and Patients maintained on 31/3/53	35	29	64	61	26	87	123	79	202	15	15

*Included in this figure are 25 births.

Due to lack of nursing staff it has been necessary to restrict, to a small extent, the admission of sick patients to the reserved accommodation at Penrith. Twelve months ago it was suggested that a solution to this most difficult of staffing problems might well be the taking over by the Regional Hospital Board of responsibility for the recruitment and engagement of nursing staff. Negotiations with this end in view have been completed, and whilst the management and administrative control of the hospital sections of the former Public Assistance Institutions will remain with the County Council, the Hospital Board's Management Committees in Cumberland will in future be responsible for maintaing the full complement of nursing staff, including the payment of their salaries and other allowances, provision of holiday reliefs and reliefs on account of sickness. This is a very satisfactory arrangement and will relieve the County Council of an almost insoluble nursing recruitment problem.

Charges for accommodation.

In accordance with the provisions of Section 22(2) of the Act, the County Council increased the standard charge from 58/4d. per week to 63s. per week as from 1st October, 1952. The latter rate will remain in force until reviewed by the Committee after considering the costing statement for the financial year ended 31st March, 1953. During the year ended 31st March, 1953,

and with the exception of 137 residents who have paid for their accommodation etc. at rates between the minimum of 21/- per week and the standard charge, the remainder have made payments at the minimum charge, the total payments by residents during the year amounting to £13,258. In a few cases only did the respective Area House Committees find it necessary to write off small outstanding amounts as irrecoverable.

Under the National Assistance (Charges for Accommodation) (Amendment) Regulations, 1953 the minimum charge will be increased from 21s. to 26s. p.w. as from the 3rd August, 1953, which it is estimated will increase the income to the Council by something like £1,000 in a full year.

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, continue to have their accommodation charges waived up to a maximum of 10/6d. per week for such period as the House Committee may decide. The anomalous position that payments cannot be waived under Section 23(3) of the Act in respect of services rendered in the hospital section, 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 accordance with the provisions of the National Assistance Act, and must remain so pending amending legislation.

At the end of March, 1953, there were 37 males and 18 females receiving remissions of 2/6d. or 5/- per week, having regard to the measure of regular assistance given. The total remissions or reduction in collections amounted to £10 per week, or at the rate of approximately £520 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.

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 to select their own Doctor, 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. Chiropody services have been provided free of cost to the residents, who derive much benefit therefrom.

Holidays.

Under the amenity provisions of the Act the County Council have, over the past three years, authorised a week's holiday at the seaside, or other approved place, for aged residents in Part III. accommodation. This holiday is arranged in the early part of the season, advantage being taken of specially reduced boarding rates offered to local authorities arranging holidays for old people. The holiday, whilst being of great benefit from a health point of view, is greatly appreciated by the old people, and is the subject of animated discussion and anticipation weeks before it takes place.

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 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, and is of considerable value to the County Council. Appropriate grants are made to the Diocesan Council and the arrangement is reviewed each year on the basis of records of county cases received into Coledale Hall.

Temporary Accommodation.

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

Although at the moment this type of accommodation can be provided only in the former Public Assistance Institutions, not as yet adapted in whole or in part for families to live together as units, no serious difficulties have been experienced in providing the accommodation, although the loose and " couldn't care less " attitude of mothers in the matter of parental responsibilities to their children is still very much in evidence.

During the year ended 31st March, 1953, 28 cases (representing 20 men, 11 women and 16 children) were provided with temporary accommodation due to eviction from houses or rooms, or inability to find suitable lodgings, the highest number maintained in any one week being 33 persons (16 men, 6 women and 11 children). The 28 cases consisted of 8 family units. On the 31st March, 1953, temporary accommodation was being provided for 9 men, 2 women and 4 children.

Under a long term policy two of the former Public Assistance Institutions could be adapted in part to provide temporary accommodation on a family unit basis, whilst retaining sectional accommodation for (a) the category of aged persons who would not fit into life in a modern type of home or hostel; and (b) chronic sick persons. This is an issue which will be included in the general report to the County Welfare Committee on (a) additional Homes or Hostels; (b) Hostel provision for short term cases; and (c) Half-way Houses (See page hereof).

Old People's Welfare Committees—Voluntary Effort.

The National Assistance Act envisaged 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. As a means to that end, County Committees consisting of representatives of statutory authorities and voluntary organisations have been set up in various

parts of the country. The primary object of these committees is to establish, in the larger towns, local committees whose members would themselves be responsible for (a) providing a visiting service to old people in their own homes; (b) the establishment of clubs; (c) the provision of hot -mid-day meals; (d) laundry work; (e) holiday arrangements and other services of a personal nature. It is understood that on the 31st March, 1953, the number of local committees in the country was 996.

The Cumberland Old People's Welfare Committee has been in existence for over three years, during which time only three local committees have been set up. This cannot be considered a satisfactory achievement, and in the Committee's third annual report, the Secretary, in expressing regret that more progress could not be reported, goes on to say that this does not mean that the Committee has done nothing, or that it accepts the implication that there is nothing more that can be done. He states that the Committee is fully aware that there are fields of work where, if people could be found, the work is both necessary and desirable.

There are in the County something like 21,000 persons over 65 years of age, many being over 70 and not a few over 90, and whilst they may be receiving all the statutory benefits (financial and otherwise) made available for them, there must be many old people, some living alone, who would greatly welcome helpful advice and assistance in those services of a more personal and intimate character such as have been mentioned in this section.

What then is the reason for this apparent lack of interest in the formation of local committees. Covering the larger towns and areas in Cumberland are local Old Age Pensioners' Associations and other organisations who for years have arranged socials, outings, etc., to bring occasional pleasures and comforts to old people, and in view of these activities it would seem that efforts to co-ordinate and expand the service through an "all-in-purpose local Welfare Committee" have not so far been favourably received. In my opinion this is all the more reason why the county committee should make more determined efforts to establish local committees, by calling together in conference the organisations in question, because quite apart from the occasional tea party or annual outing, there are many

services of a day to day or week to week nature which, if made available under a concerted effort, would bring added pleasures to old people and especially those who through infirm and other conditions are unable to do much for themselves, let alone leave their homes to participate in the occasional party, outing, etc.

In the rural areas the position of old people is perhaps not so difficult. In many villages the old folk are known to everybody, and if any need arose or was likely to arise, help and assistance would be there on the spot. Even so, an approach was made to the Cumland Federation of Women's Institutes with a suggestion that affiliated Institutes be informed of the county committee's concern for the welfare of old people in rural areas, and with a request that they might consider the appointment of an "old people's friend" for the locality, the primary objects being (a) periodical visits; (b) assistance with shopping; and (c) the many other services of a personal nature which have been referred to.

The County Federation readily acquiesced in the proposal, and whilst 15 Institutes have replied that there was no need to appoint anyone, it is very encouraging to note that up to date 67 out of 150 Institutes have appointed an "old people's friend," to whom has been sent helpful literature and suggestions for the home care of old people in need of services they are unable to provide themselves. One is hopeful that in the course of time the remaining Institutes will see their way to co-operate in this worthy object and thereby forge another link between the old people in the rural areas and the County Committee.

Meantime, the County Committee is being urged to make determined efforts to secure the establishment of local committees in about a further dozen of the more urbanised areas in the county.

In regard to the three local committees established in Penrith, Cockermouth and Keswick, and whilst it is pleasing to report continued progress by the first two committees (including in the case of Penrith the introduction of a service of hot mid-day meals), it is a matter of regret that the Keswick Committee, having tried the experiment of running an Old People's Club, are of opinion that the work of the Old Age Pensioners Association meets all needs.

One of the major problems which have beset Old People's Welfare Committees for some time has been the question of providing a chiropody service for old people. There are a large number of people to whom domiciliary treatment would be of real preventative value, in that resulting greater mobility would mean that such matters of cooking, shopping and so on would be easier and the general health of the old people would be maintained. Whilst such a service has been provided for residents in the County Council's Part III. accommodation, it is not a free service which could be made available to old persons living in their own homes. The need for chiropody as part of the Health Services has been stressed on several occasions at meetings of the Cumberland Old People's Welfare Committee, and whilst it is understood the issue is being dealt with at high level through the National Committee, it is clear that for the time being home treatment could only be provided through schemes organised and operated by the local voluntary committees. Some local committees in the country have proceeded on these lines and made arrangements with chiropodists who, for an agreed composite fee for a session of so many hours, deal with as many cases as possible. The old people themselves contribute a small sum towards the service, the balance of the cost being provided from the funds of the voluntary committee. The Penrith Commitee is considering the inauguration of such a scheme, and on its success, or otherwise, may depend the establishment of similar schemes in other parts of the county through the agency of such local voluntary committees as are in existence at the time.

Welfare Services for the Blind, Deaf and Dumb, Etc.

During the year the agency arrangements with

(a) the Cumberland and Westmorland Home and Workshops for the Blind;

(b) the Barrow, Furness and Westmorland Society for the Blind; and

(c) the Carlisle Diocesan Association for the Deaf and Dumb;

have been continued without any major issue arising which would call for detailed comment in supplementation of the comprehensive details given in the report for 1951/52.

Cumberland's Register

(a) Blind

Taking into account new admissions to the register, de-certifications, removal and deaths, the number of registered blind persons in the Administrative County shows an increase of 19 during the year under review. Actually the number of new admissions to the register was 78. The number and classification of blind persons on the 31st March, 1953, was as follows:—

Age Group	Males	Females	Total
0- 1	—	—	—
1- 5	—	—	—
5-16	3	—	3
16-21	2	3	5
21-40	21	13	34
40-50	17	15	32
50-65	49	53	102
65-70	17	30	47
70+	108	121	229
	217	235	452

In addition to the above, there are 43 persons registered as partially sighted.

Day to day administration by the Council's agents proceeds on well defined lines and much help and advice continues to be given to the voluntary committees on matters of general administration and individual problems.

A contract has been let for the erection of new workshops and it is hoped that this part of the composite scheme of workshop and hostel facilities at Petteril Bank, Carlisle, will be completed within the next twelve months.

Meantime, the question of adaptations to the hostel originally estimated to cost £6,476 but recently increased to £13,345, has been deferred pending further consideration being given to the need, or otherwise, for several of the adaptations recommended.

The Cumberland and Westmorland Home and Workshops for the Blind also acts as agents to the Carlisle County Borough Council and, as will be seen from the attached report, which gives a picture of the organisation and service as a whole for that part of the geographical County covered by the agency arrangements, the welfare service provided for the blind is very comprehensive.

(b) **Deaf and Dumb.**

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 those areas 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, 1953, there were 250 deaf and dumb persons on the register distributed and classified as follows:—

Category	Cumb. C.C.	West. C.C.	Lancs. C.C.	Barrow C.B.C.	Carlisle C.B.C.	Total
School age or under ...	15	6	2	7	11	41
In Institutions	2	3	1	1	1	8
In Mental Hospitals ...	5	—	1	—	1	7
In Full-time Emplyt. ...	61	11	9	12	22	115
Married Women at Home	16	3	2	5	11	37
Single Women at Home	8	3	2	3	—	16
Unemployed—Age ...	5	1	1	2	4	13
Unemployed — Infirmity	2	—	1	2	1	6
Unemployed	1	—	—	1	1	3
Private Means	—	—	—	1	3	4
TOTAL ...	115	27	19	34	55	250

The Association continues to develop and expand its services and one feels well satisfied with the continued progress, and the present trend to remould the service more in keeping with local authority practice whilst in no way destroying or interfering with the purely voluntary side of the Association's work.

During the twelve months under review, 954 visits have been made by members of the Association staff to deaf and dumb persons in the area. These figures include routine visits to country folk to relieve their loneliness, visits to check details in the register, and visits for special purposes such as, for example, to interview parents in connection with the placement of young boys and girls in employment, to assist the officers of the National Assistance Board by interpretation on initial visits. Sick people at home and in hospital have also been visited.

Since the Trainee Missioner left in 1952 it has not been possible to pay as many visits as in previous quarters, but this part of the Association's work has not been neglected, and the Superintendent has endeavoured to fill the gap by increasing his own visiting by some forty per cent.. Supervision at the Social Centres also has been more difficult. The situation will be remedied as soon as a new appointment is made. The Committee of the Association has decided to employ another experienced Missioner, if a suitable one can be found, and steps have been taken in this direction.

From the viewpoint of individual welfare it is most important that deaf and dumb people should be usefully occupied in suitable employment, and it has always been the policy of the Association to help its people to find and keep the kind of work for which they seem best fitted. With this end in view the co-operation of the Juvenile Employment Officer of the Ministry of Labour is sought whenever a deaf child reaches school-leaving age, and the Missioners assist with advice and interpretation in the placing of the youth in employment.

The percentage of employment amongst deaf adults in this part of the country is at present as high as it ever has been, and there are practically no unemployed.

The Social Centres in Carlisle, Barrow and Workington have been in constant use, and all the usual activities have been continued.

The Association is fully alive to all problems which beset deaf and dumb people and, notwithstanding a staff shortage (there being at present only the Secretary Superintendent and a Missioner at Barrow) which is a handicap to a continuous service, let alone development and expansion, the Association can be complimented on the high standard of its existing services.

(c) **General.**

In welfare services for the blind and the deaf and dumb, the guiding principle is to ensure that each person shall have the maximum opportunity of sharing in, and contributing to, the life of the community, and this is the aim of the County Council and its agents.

RECEPTION CENTRES

PERSONS WITHOUT A SETTLED WAY OF LIVING

According to a report from the National Assistance Board, the term "persons without a settled way of living" was a fresh attempt to describe a group of people whom it has never been found possible to define briefly. They are sometimes referred to as "vagrants," though in so far as that term suggests that they are constantly wandering about the country, it is too narrow. The English Poor Law described them as "casual poor persons," a term which merely distinguished the fleeting use they might make of a particular institution from the use made of it by more permanent residents, but which, nevertheless, in its abbreviated form "casuals" is still convenient. The term "reception centre" replaced the term "casual ward."

The Act imposed a duty on the National Assistance Board to make provision whereby persons without a settled way of living may be influenced to lead a more settled life, and so provide and maintain centres to be known as "reception centres" for the provision of temporary board and lodging for such persons. The Act also empowered the Board to require County and County Borough Councils to exercise on behalf of and in accordance with directions given by the Board, the functions of the Board of providing and maintaining reception centres, subject to reimbursment by the Board of approved expenditure by local authorities in carrying out this agency duty.

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 functions of the Board in this matter have been carried out by the County Council since 5th July, 1948, and 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
30/6/51	626	27	2	655	5	—	—	5
30/9/51	695	31	2	728	—	2	—	2
31/12/51	687	43	—	730	1	—	—	1
31/3/52	686	43	2	731	—	—	—	—
30/6/52	850	28	—	878	2	2	—	4
30/9/52	866	26	1	893	—	1	—	1
31/12/52	748	50	—	798	—	—	—	—
31/3/53	873	31	—	904	—	—	—	—

In a special report issued by the Board last year, on the work and administration of reception centres, a warning was given that the present agency arrangements and in certain cases, the close connection between reception centres and institutions, and sometimes hospital accommodation, must continue.

The general conclusions reached by the Board were as follows :—

(1) The question of agency administration resolves itself largely into one of economy.

(2) Restrictions on capital expenditure must rule out for the present any possibility of transferring reception centres to other premises where new buildings would be required, or where the acquisition and adaptation of other premises would lead to heavy capital outlay.

(3) Even if the problem of capital expenditure did not exist, centres dealing with small numbers of casuals are too expensive to run as self-contained units.

(4) For these reasons it will be difficult for the present to make much further change in the existing arrangements.

(5) Subject to what has just been said, in those cases where the centre is not sufficiently distinct from the main institution for the association to cause no embarrassment, the Board will continue to do what is possible either to remove the centre or to see that it is effectively detached from the main institution in such a way as to prevent any contact between casuals and persons, such as hospital patients, who ought not to be brought into contact with them.

The policy of the Board in so far as it relates to the continuance of reception centres within the curtilage of hospitals and Part III. establishments is greatly to be deplored. The presence of casuals is not a good thing either for the atmosphere of hospitals or welfare establishments, and a continuance of the system can only have a detrimental effect on the standard and service of these establishments.

With this in mind and having regard to certain difficulties in the way of reception centre accommodation in the City of Carlisle, and the capital expenditure which might have to be incurred by the Board in extensions to the centre at Penrith and the provision of a new centre in Carlisle, a suggestion was made to the Board that consideration might be given to the use of certain buildings (Crown property)—the Merrythought Hostel, used as a Prisoners-of-War Camp and later as an Agricultural Hostel—on the main Penrith-Carlisle road, and which might well solve the problem of both the City and County Authorities.

The suggestion has been favourably received by the Board, the Carlisle City Council, and the Special Area Committee of the Regional Hospital Board, and if the cost of adaptations to the Merrythought Hostel is not unreasonably high, there is a prospect that the scheme might proceed and thereby not only negative the need for further expensive schemes both at Penrith and Carlisle, but effectively deal with the objection to the presence of casuals at Station View House, Penrith.

Investigations are proceeding and should a reception centre be ultimately established in the Merrythought Hostel, the County Welfare Committee have already agreed to the suggestion of the Board that the County Council should be responsible for the supervision and running of the centre subject to full reimbursement of expenditure.

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, and its various agents. This report merely touches upon some of those main features of the administration which it is thought would be a useful supplement to the very comprehensive report attached to the County Medical Officer's Report for 1951.

W. C. WALKER,

County Welfare Officer.

APPENDIX

CUMBERLAND AND WESTMORLAND HOME AND WORKSHOPS 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 the 31st March, 1952. was as follows:

Age Group.	Males. City.	Males. County.	Females. City.	Females. County.	Total. City.	Total. County.
0— 1 ...	—	—	—	—	—	—
1— 5 ...	—	—	—	—	—	—
5—16 ...	1	3	1	—	2	3
16—21 ...	2	2	1	3	3	5
21—40 ...	6	20	10	13	16	33
40—50 ...	1	17	5	12	6	29
50—65 ...	7	49	13	49	20	98
65—70 ...	8	16	8	29	16	45
70+ ...	21	99	18	116	39	215
Total ...	46	206	56	222	102	428

2 CARLISLE WORKSHOPS.

(a) **Types of Employment and numbers employed on the 31st March, 1953 (excluding Trainees).**

Trade	Males City	Males Cnty	Females City	Females Cnty	Total City	Total Cnty
Agents and Collectors	—	—	—	—	—	—
Firewood Department	2	3	—	—	2	3
Bed and Mattress Making	1	3	1	—	2	3
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 ...	—	—	3	3	3	3
Re-seating Chairs (in cane)	—	—	—	1	—	1
Total	6	14	4	4	10	18

General Observations on Employment.

There are no changes in the personnel of the Workshops since the last report. All workers have been afforded full time employment and at the close of the year there was a plentiful supply of orders booked to ensure full-time work for some time. A part contract of 400 hair mattresses for hospitals was in hand at the end

of March, when 289 had been delivered, leaving a balance of 111 for production during April and May. Further contracts for firewood (City Schools), stockings and brushes (County Welfare Department) and scavenger brooms (Whitehaven Borough) have been obtained for the year commencing 1st April, 1953.

(b) **Training.**

Blind Persons at 31st March, 1953, receiving training with the approval and recognition of the Ministry of Labour:—

Training in	Males		Females		Total	
	City	Cnty	City	Cnty	City	Cnty
Upholstery	—	1	—	—	—	1

General Observations on Training.

This trainee refuses to continue his training until accommodation for his wife and family is available in or near Carlisle.

There are two further out-county trainees, viz.: Robert Iveson (brushmaker—Barrow), who continues to show good progress, whilst Janet Addison, the trainee in chair-caning from Gretna, has had her training period extended for a further 6 months.

(c) **State of Workshops—adequacy of Facilities.**

The Workshops in Lonsdale Street, Carlisle, and at Harraby remain as before, but on 12th March the Architects were informed by the Ministry of Works, that an immediate starting date had been given for the proposed new workshops at Harraby and arrangements are in hand to implement this decision.

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

Centre.	Training in	Males.		Females.		Total.	
		City	Cnty.	City	Cnty.	City	Cnty.
Yorkshire ... School for Blind.	Basketry ...	—	1	—	—	—	1
	Machine Knitting. ...	—	—	—	1	—	1
Chorley Wood. ...	Shorthand and Typing	—	—	—	1	—	1
Newcastle. ...	Machine Knitting and Cane Seating. ...	—	—	1	—	1	—
	Total ...	—	1	1	3	1	4

Observations.

With one exception the trainees at centres other than Carlisle remain as before—the only change being the removal from the Register of a boy training in basketry who died during the quarter.

In addition to the foregoing a City case has been sent by the Ministry of Labour and National Service for a refresher course in shorthand and typing and a short course of training in telephony.

(e) **Blind Children in Special Schools.**

School.	Males		Females		Total	
	City	Cnty	City	Cnty	City	Cnty
Newcastle	—	1	—	—	—	1
Manchester	—	—	1	—	1	—
Chorley Wood ...	—	—	—	1	—	1
Ellen Terry Home ...	1	—	—	—	1	—
Fulwood, Preston ...	—	1	—	—	—	1
Royal Normal College	—	1	—	—	—	1
Council Schools:						
Silloth	—	—	—	1	—	—
Total	1	3	1	2	2	5

3 OPEN INDUSTRY.

(a) **Types of employment and numbers employed at 31st March, 1953.**

Trade	Males		Females		Total	
	City	Cnty	City	Cnty	City	Cnty
Factory Operatives ...	—	2	—	—	—	2
Labourers	1	6	—	—	1	6
Telephone Operators ...	1	2	—	—	1	2
School Teachers ...	—	—	1	—	1	—
Shop Assistants ...	—	—	1	—	1	—
Agricultural Workers ...	—	3	—	—	—	3
Physiotherapists ...	—	—	1	—	1	—
Poultry Farmers ...	—	5	—	—	—	5
Other open employment and St. Dunstaners not included above.	—	5	—	—	—	5
Total	2	23	3	—	5	23

(b) **General Observations.**

The table of those engaged in open industry shows the same numbers employed as in previous reports, but the composition of the categories is changed following the return to work of one City female, the employment of a County male previously classified not available for

work, the retirement of a County female and the disablement of a County male following an industrial accident.

4 HOSTEL—PETTERIL BANK.

(a) **Number of residents in Hostel on the 31st March, 1953.**

Males.		Females.		Total.		Total engaged in W/shops.		
City	Cnty.	City	Cnty.	City	Cnty.	City	Cnty.	Others.
—	7	—	1	—	8	—	8	2 (Barrow and Gretna)

(b) **General Observations on maintenance, social activities and other matters of interest.**

It should be noted that the brush trainee (Barrow) referred to in para. 2 (b), resides in the hostel in addition to those enumerated above.

The Social Club continues to meet each week and an all-electric record player has been purchased by the Committee of the Workshops to enable those attending the social evenings to enjoy music and dancing.

5 HOME EMPLOYMENT (not pastime workers).

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

	Males.		Females		Total		Visits in
	City	Cnty	City	Cnty	City	Cnty	Quart'r
Braille Copyist ...	—	—	—	1	—	1	10
Piano Tuner ...	—	1	—	—	—	1	1
Farmer	—	1	—	—	—	1	2
Boot Repairing ...	—	1	—	—	—	1	7

Additional to the above an application has been received for admission to the scheme from a blind poultry farmer residing in Brampton.

6 HOSPITALS, INSTITUTIONS AND HOSTELS (Other than Petteril Bank).

The number of Blind Persons in Hospitals, Institutions, Homes and Hostels on the 31st March, 1953, was as follows:—

Hospital, Institution or Hostel	Males		Females		Total	
	City	Cnty	City	Cnty	City	Cnty
Part III Accommodation ...	2	10	2	4	4	14
Other Residential Homes ...	2	—	3	—	5	—
Mental Hospitals	2	3	2	2	4	5
Other Hospitals	—	—	1	1	1	1
Total	6	13	8	7	14	20

A total of 76 visits has been paid to the blind in the several hospitals and institutions, and in one case members of the Social Club visited their fellow member in hospital. In addition to the regular visits to the hospital, etc., the Home Teachers have visited the homes and families of blind patients where necessary or desirable after visiting the hospital.

7 HOME TEACHERS.

No. of Home Teachers in County area ... 4 (one vacancy)
„ „ „ „ „ City area ... 1 Total 5

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
City—				
Miss Speight	Cert.	102	163	34
Cumberland Rural Areas—				
Miss Fairhurst	„	99	205	30
Maryport and District				
Miss Hetherington ...	„	83	258	21
Workington, Whitehaven and District—				
Mr. Hilland (Males) ...	„	80	204	3
Miss Hogarth (Females)	„	79	138	—
Mrs. E. Todd (very old folk)	Uncert.	87	443	64

During the quarter ended 31st March, 1953, the Home Teachers paid over 1,500 visits to the Blind living in their own homes or in lodgings, and approximately 1,000 additional contacts have been maintained with those who attend the several functions and classes. A further 150 calls were made on behalf of blind people or in their interests and over 100 visits paid to partially sighted cases now formally registered and everything possible done to ensure that all on the Registers are adequately provided for and properly cared for.

Miss Hogarth, formerly Home Teacher in Whitehaven and district, obtained a post in Northumberland and left Cumberland on 28th February. The vacancy has been advertised and will be filled as soon as possible. In the meantime all cases in the district are being duly visited.

8 HANDICRAFT CLASSES.

Location	No. of Class's held during quarter	Avge. Attendance	No. of lessons	Instruction given in	Instructor
Penrith ...	7	8	55	Basketry Pulp Cane Work Chair Caning	Miss Fairhurst
Cockermouth	9	6	50	Knitting Raffia work Weaving	Miss Hetherington
Maryport ...	11	14	88	Rugs Stool seating Embroidery	do.
Whitehaven	11	10	120	Tea cosies Straw bags Netting	Mr. Hilland & Miss Hogarth
Carlisle ...	11	9	113	Leathercraft Beadwork Crotchet work	Miss Speight

General Observations.

Attendance at the classes shows a slight average increase but the number of individual lessons given at the classes increased to 426 in March, 1953, as compared with 359 in the December, 1952, quarter. In preparation for the Coronation Exhibition supplementary lessons have been given at home where needed and a good display of goods is assured. Lady Lowther has consented to open the Exhibition, which will be augmented by a display of goods manufactured in the workshops.

9 CLUBS.

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

Location of Club.	Open, i.e. Daily, Weekly, Monthly, etc.	M/ship. (B.P.)	Av. Attend. (B.P.)
Penrith ...	... Monthly ...	16	... 12
Cockermouth (including Maryport)	... „ ...	22	... 17
Whitehaven	... Fortnightly ...	19	... 15
Workington	... Weekly ...	43	... 37
Cleator Moor	... Fortnightly ...	25	... 20
Carlisle ...	... Monthly ...	28	... 18

General Observations and Report.

The varied programmes of social and other activities, including entertainments, talks on matters of interest, bus excursions, etc., have been greatly appreciated.

10 BRAILLE & MOON—READERS AND INSTRUCTIONAL ACTIVITIES

	City		County	
	Brl.	Moon	Brl.	Moon
(a) No of readers registered with the National Library (Northern Branch) ...	19	3	23	10
(b) No. of other readers ...	4	—	—	2
(c) No. of Blind Persons receiving lessons in Braille and/or Moon	1	1	3	3
(d) No. of lessons given during the quarter	7	7	14	14

General Observations.

There has been little change in the number of readers of Braille or Moon during the quarter and whilst a limited number of new pupils have begun lessons following registration, some of the older folks have given up for various reasons after passing the elementary stages.

A partially sighted young lady in Workington, whose sight is deteriorating, has mastered Grade I Braille very quickly and is now having more advanced tuition against the day when she may become certified blind.

In the City a new case of 79 years of age has shown remarkable aptitude as a Moon pupil and been made a member of the Library for the Blind.

Of the more advanced pupils, and particularly among the regular readers, much may be said for their concentration at this time in preparation for the local Braille Reading Competition, which is open to all readers on the registers in the City and County. The competition has this year drawn quite a large entry of local competitors, some of whom will qualify for entry in the North of England competition to be held in Manchester in May. For the local competition, also held in May, a cup, presented by Major Richard Lamb, is awarded to the competitor gaining the highest marks in any class.

11 GENERAL SOCIAL ACTIVITIES, ENTERTAINMENTS, OUTINGS, ETC.

In addition to the Social work undertaken at the several social clubs and centres in the City and County, the blind have had the privilege of

attending concerts, entertainments and other functions not specifically organised for them.

The Penrith blind were invited to a concert held in aid of the Flood Disaster Fund and a most enjoyable evening was spent by those able to attend. In February, the Rotary Club of Whitehaven invited the blind from Whitehaven and district to an Annual Tea and Party specially arranged for them. The concert, which followed an excellent meal, was much appreciated.

A recently formed blind concert party, drawn from the Maryport, Cockermouth and district members of the social clubs and handicraft classes, were invited to entertain the members of the Maryport Rotary Club and later entertained the members of the Penrith Blind Social Club.

Forty elderly blind people in the City were invited to a tea and concert organised by the City Y.M.C.A. for old folks. Transport was provided and the function was a helpful addition to the social activities in the City.

Similarly, booked seats were made available for City blind people and their guides at concerts arranged and given by the Currock Choral Society and the Carlisle Harmonic Choir. At both events the guest artistes were vocalists and instrumentalists of national repute and the concerts proved entertaining and enjoyable.

12 WIRELESS, TALKING BOOKS, ETC.

The demand for wireless sets is almost fully met, including newly registered cases, with the result that two new sets only were issued during the quarter. Three sets have been repaired and reissued and two sets repaired and returned to the original users. The 1953 allocation of new sets is due, so there should be no difficulty in meeting the future need.

As previously stated, there are twelve Talking Book machines in the City and County, but with the machines distributed over such a wide area the books (records) are now sent direct to the users and whilst we have no complete record of the books read, all machines are in full use all the time.

13 HOME HELP SERVICE AND GENERAL MATTERS OF INTEREST.

There are ten registered blind people and one partially sighted case enjoying the benefits of the County Home Help Service. In several cases the blind person could not possibly carry on without the assistance of the Home Help, in others the home conditions are so much improved and the blind individuals themselves so much better cared for that the service can quite safely be classified as indispensable.

Grants and assistance have been obtained for the blind or given out of the voluntary funds of the Workshops to all in need and have included clothing, boots, shoes, delicacies to invalids, sweets and tobacco to hospital cases and others, and in one case an electric blanket was purchased for a chronic invalid.

The Musical Festival among the Blind Social Clubs proved so successful last year that arrangements are proceeding for a much bigger event this year and details of travelling, catering, adjudicators, etc., are in the process of being organised, whilst the club members are rehearsing most assiduously for both individual and concerted classes.