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COUNTY COUNCIL OF CUMBERLAND

ANNUAL REPORT

ON THE

HEALTH OF THE COUNTY

FOR THE YEAR 1960

JOHN LEIPER, M.B.E., T.D., M.B., Ch.B.,
M.R.C.S., L.R.C.P., D.P.H.,
County Medical Officer.

INDEX

HEALTH COMMITTEE, 31st DECEMBER, 1960

Chairman: Mr. R. F. Dickinson.

Vice-Chairman: Mrs. E. G. Cain, O.B.E.

Askew, J.
Banham, G.
Barton, Dr. E. B.
Batey, Rev. H. T.
Bland, T. P.
Bryan, D.
Curwen, Mrs. J. N. St. G.
Douglas, J.
Herdman, J. F.
Kilbride, J.
McCann, Rev. F. K.
McKeating, Mrs. B. O.
McPoland, Mrs. F.
Nixon, W. G.
Powers, J. E.
Smith, Mrs. M.
Stephenson, W.
Townsley, R.
Wilson, D. G.
Wilson, Mrs. M. A.
Young, T.

Ex-Officio Members:

Chairman of County Council—Westoll, J.

Vice-Chairman of County Council—Edmonds, C.

Chairman of Finance Committee—Highton, L.

External Members:

Collins, R. G.
Faulds, Dr. J. S.
Ferguson, Dr. T. T.
Fletcher, Dr. A. F.
Fletcher-Vane, Mrs. M.
Graham, Miss E. R.
Grant, Dr. R. N. R.
Hasell, Mrs. G., OB.E.
Hodgson, Mrs. H. L.
James, Mrs. E. L.
Laycock, Miss G. G.
Long, R.
McCowan, R. D.
Ritson, C.
Rolland, Dr. C.

PREFACE

To the Chairman and Members of the Cumberland County Council.

Mr. Chairman, Ladies and Gentlemen,

I have the honour to present the Annual Report for the year ended 31st December, 1960, which is prepared in accordance with Ministry of Health Circular 1/61.

The vital statistics show that there was a slight increase in the birth rate, 18 as compared with 17.8 per thousand population in 1959, and the crude death rate of 12 per thousand shows little change over the last decade.

The infant mortality rate is again quite satisfactory at a figure of 23.1 per thousand live births, but the perinatal mortality rate which is a more sensitive indication of the efficiency of the maternity service, is increased from 34.5 to 42.2 per thousand live and still births due to an increase in the number of still births.

The most important event during the year was the coming into general operation on 1st November of the Mental Health Act, 1959, and the notable change in outlook shown in that Act is being met by increases in community care carried out by the authority's mental welfare officers.

There has been an increasing amount of co-operation with consultant psychiatrists and family doctors on this subject, and although much obviously remains to be done, there is no doubt that a good start has been made and that barriers that have existed in this County for many years have now started to be broken down.

Great store is set by maintaining the excellent co-operation which exists with general medical practitioners, and to this end a six monthly bulletin is planned to be issued to general practitioners giving a concise indication of the activities of the Health Department.

There has also been further implementation of the recommendations and conclusions of the County Council Working Party on the Needs of the Aged. There is an increase in the provision of accommodation in small homes, and I am glad to see that there

is an increasing number of district councils considering schemes for group dwelling for elderly persons with warden oversight and communal facilities, sited right in the centre of the community so that the senior citizens have, as it were, a window on the high street.

A chiropody scheme came into being late in the year, and although there were some minor difficulties at the start I consider the scheme to have run exceedingly smoothly, and in a great measure this has been due to the help of the chiropodists themselves and the administrative help that has been given me in various areas by voluntary bodies.

Here I would like in general to stress the importance of Old People's Welfare Committees and the continuing necessity now of an easy link up on information with regard to old people who are in need of either nursing care or social support in the community.

The difficulties associated with the running of an ambulance service, which is on a contractual basis, continue to increase and lead one to wonder whether it is time to consider the establishment of a direct service.

It is realised that Health Education represents an increasing amount of the work of the doctors and nurses of the local health authority. Much general health education has been started this year in schools. It is worrying for doctors to realise that the national figures indicate that an increasing number of children commence the smoking habit while still at school.

The reports of the two Consultant Chest Physicians both indicate that the conquest of tuberculosis is by no means accomplished as yet.

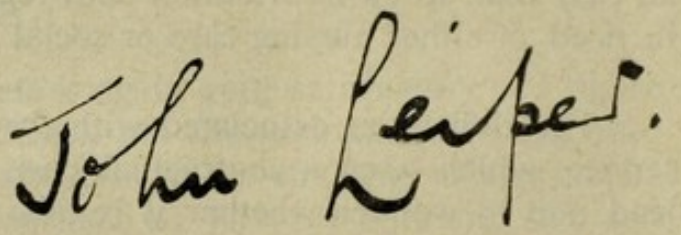
During the year a bi-monthly meeting of Assistant County Medical Officers together with the Nursing Officer and Administrative Officers and medical officers of this headquarters, has been held, and the matters under discussion have included changes brought about by the Mental Health Act, the secondment of health visitors to work with groups of general practitioners, services for old people, the attendance of medical officers at hospital clinics, carrying out a mantoux survey of school entrants and the use of triple antigen.

During the year Dr. W. H. P. Minto resigned to take up an appointment with the Ministry of Health, and the Report includes the last report of Mr. A. C. S. Martin, Chief Dental Officer, who has brought forward the authority's dental service to a state of efficiency of which he can be most proud.

My thanks are due to the members of the Council, especially the Chairman of the Health Committee, and to the Officers of other departments and voluntary organisations. The high standard of work of the members of the Health Department has continued to be invaluable.

I am, Ladies and Gentlemen,

Your Obedient Servant,



County Medical Officer.

County Health Department,
11 Portland Square,
Carlisle.

September, 1961.

Telephone No.: Carlisle 23456.

ADMINISTRATION

The County Council, which is the local health authority, administers the county health service through its Health and Housing Committee which, in turn, has four standing sub- committees—General Purposes, Nursing, Mental Health and Welfare. In addition, there is a Joint Health and Education Sub-Committee, which has representatives of both the health and education committees and deals with matters pertaining to the health of the school children.

In addition to its 26 representatives of the County Council, the Health and Housing Committee also has 15 "external" members who represent the medical, dental, pharmaceutical and nursing professions, the hospital management committees, or are co-opted for their special interest in some branch of the service. In this way a wide variety of interests, and lines of thought all with the welfare of the health services in general as the prime objective are brought to bear on the making of policy decisions.

From there onwards problems are handled administratively by me and my staff, by the County Welfare Officer and his staff, and where appropriate, by other departments. So far as the health department is concerned, the administration is through the central office in Carlisle and, for certain day to day matters mostly affecting the school health service in West and South Cumberland, from the area office at Whitehaven. Dr. J. L. Hunter, the senior assistant county medical officer, is in charge of the area office. There is no divisional administration in the county.

At the end of the year the administrative and clerical staff numbered 40, of whom 9 were in the area office at Whitehaven. This was three below the establishment, two being posts which had been made redundant during the year by re-organising duties, and are likely to be deleted when the review of establishment and gradings is completed. In addition the Assistant Medical Officers who are also Medical Officers of Health have the assistance of clerks on the staffs of the district councils for their county work. Part of the salaries of these clerks are paid by the County Council and in aggregate they amount to the equivalent of two full-time clerks. The clerical staff are organised into four main sections, Ambulance, Mental Health, Nursing and School Health, each with an administrative assistant in charge. There is also an administrative assistant in charge of the clerical work at Whitehaven and there is some clerical assistance in the Dental Section.

It is most helpful that I or my deputy can attend the meetings of a number of committees outside the County Council, either as representatives of the authority, as co-opted members, or as observers. The main committees coming within this category are the Special Area Committee, the West Cumberland Hospital Management Committee, Garlands Hospital Medical Advisory Committee, and the Local Medical Committee, and I find it most useful to be able to tell these bodies what the view of the authority is likely to be, or what my personal views are, before they take any policy decisions that may later affect the county health service. In the case of the Local Medical Committee, it gives me an opportunity of explaining new county policies or services to the general practitioners, and seeking their co-operation in carrying them out. To further this co-operation, which is so vital to the smooth running and efficiency of the service, I am contemplating the issue of an information bulletin at about six monthly intervals to keep all doctors in touch with the activities of the department.

Another way in which the administration of the service is helped by " outside " connections is the joint appointment of assistant medical officers. Most of them work for the county on about a half-time basis and are for the remainder of their time medical officers of health to district councils. There are undoubted advantages in such an arrangement.

During the course of the year an internal working party was established to review the administration of the home help service and while the results of this seem promising it is not possible to say precisely what effect it had on the efficiency and cost of the service by the end of the year under review. I hope to comment again on this in my next report. It is intended to develop these working parties so that all aspects of the administration can be reviewed, and I have in mind for attention early in 1961 the ambulance service and the boundaries of nursing districts.

Two-monthly meetings of all Assistant County Medical Officers are held so that I might discuss with my colleagues all aspects and implications of problems before any policy decisions are taken. I think that these conferences serve a very useful purpose. The medical officers are also assisting me in the review of all forms and circulars which are used in the department to cut out as many as possible and to simplify the remainder. The con-

ference is being widened to include Dr. J. W. Platt, the Consultant Paediatrician, and arrangements are also being made for others such as consultant chest physicians to come to meetings to discuss their work with the medical officers.

This authority was probably more fortunate than others with staffing during the year, although we, too, had our difficulties. We were one full-time Assistant Medical Officer short during the latter half of the year, a speech therapist below establishment for the whole year and there were usually about six vacancies for nurses and health visitors throughout the year. The most seriously affected section of the service was orthoptics, where there was only one orthoptist for the first seven months of the year and we were completely without staff for the remainder.

MEDICAL, DENTAL AND ANCILLARY STAFF

County Medical Officer and Principal School Medical Officer—

W. H. P. Minto, M.D., D.P.H. (resigned 30.4.60).

J. Leiper, M.B.E., T.D., M.B., Ch.B., M.R.C.S., L.R.C.P., D.P.H. (commenced 4.7.60).

Deputy County Medical Officer and Deputy Principal School Medical Officer—

J. D. Terrell, M.B., Ch.B., D.P.H., D.C.H.

Assistant County and School Medical Officers, and District Medical Officers of Health—

J. L. Hunter, M.B., Ch.B., D.P.H., Senior Assistant County Medical Officer and Medical Officer of Health, Workington Borough.

J. N. Dobson, M.B., Ch.B., D.P.H., Medical Officer of Health, Whitehaven Borough and Ennerdale Rural District.

J. R Hassan, M.B., Ch.B., D.R.C.O.G., Medical Officer of Health, Alston Rural District (also general practitioner).

I. S. Jones, M.R.C.S., L.R.C.P., D.P.H., Medical Officer of Health, Wigton Rural District and Penrith Urban District.

J. Patterson, M.B., B.Ch., B.A.O., D.P.H., Medical Officer of Health, Cockermouth Rural and Urban Districts and Keswick Urban District.

E. A. Perrott, M.D., B.S., D.P.H., Medical Officer of Health, Millom Rural District (resigned 30.6.60).

T. F. M. Jackson, L.R.C.P., L.R.C.S., L.R.F.P.S., D.P.H. (commenced 1.7.60).

K. J. Thomson, M.B., Ch.B., D.P.H., Medical Officer of Health, Border Rural District and Penrith Rural District.

Assistant County and School Medical Officers—

A. M. Anderson, M.B., Ch.B., D.P.H. (resigned 25.8.60).

G. G. W. Bennet, M.B., Ch.B., D.P.H.

E. M. O. Campbell, M.B., Ch.B., D.P.H., D.T.M. & H.

C. H. Mair, L.R.C.P., L.R.S.C.(Ed.), D.P.H.

Chief Dental Officer—

A. C. S. Martin, L.D.S.

Dental Officers—

I. R. C. Crabb, L.D.S.
D. H. Hayes, L.D.S.
M. Hayes, B.D.S.
F. H. Jacobs, L.D.S.
D. C. Lamond, L.D.S. (resigned 20.4.60 .
A. MacDonald, L.D.S. (commenced 1.5.60).
R. B. Neal, M.B.E., L.D.S.
A. R. Peck, L.D.S.
J. G. Potter, L.D.S.
A. M. Scott, L.D.S.
J. Watson, B.D.S., L.D.S.

Mental Health—

Consultant Psychiatrists (Part-time) seconded from Newcastle-upon-Tyne Regional Hospital Board.

J. R. Stuart, M.B., Ch.B., D.P.M.
T. T. Ferguson, L.R.C.P., L.R.C.S., L.R.F.P.S,

Mental Health Officer—

N. Froggatt.

Mental Health Workers—

Miss E. F. Hall.
Mr. M. H. Payne.
Miss E. Welch.

Social Worker—

Mrs. M. M. Coles (part-time).

Psychiatric Social Workers—

Miss M. Lamb (Part-time).
Mr. R. Milne.

Nursing Staff—

Superintendent Nursing Officer—

Miss I. Mansbridge, S.R.N., S.C.M., Q.N., H.V.Cert.

Deputy Superintendent Nursing Officer—

Miss I. John, S.R.N., S.C.M., Q.N., H.V.Cert.
(resigned 10.7.60).

Miss M. Blockey, S.R.N., S.C.M., Q.N., H.V.Cert.
(commenced 1.9.60).

Assistant Superintendent Nursing Officers—

Mrs. A. Steele, S.R.N., S.C.M., Q.N., H.V.Cert.
Miss P. G. O'Sullivan, S.R.N., S.C.M., Q.N., H.V.Cert.
Miss D. D. James, S.R.N., S.C.M., Q.N., H.V.Cert. (temporary from September, 1960).

Health Visitor for Health Education—

Miss G. L. Benfield, S.R.N., S.C.M., H.V.Cert., PH.Admin. Cert.

Health Visitors	...	20	whole time		1	part-time	
District Nurse Midwives/ Health Visitors	...	45	,,	,,	1	,,	,
District Nurse/Midwives	...	19	,,	,,	3	,,	,,
Midwives	...	9	,,	,,			
District Nurses	...	9	,,	,,	1	,,	,,
School and Clinic Nurses	...	4	,,	,,	2	,,	,

Orthopaedic Physiotherapists—

Miss J. M. Morris, M.C.S.P., M.E.
Miss J. A. Fraser, M.C.S.P., O.N.C.

Orthoptists—

Miss H. Melvill, D.B.O. (resigned 31.8.60).
Miss A. Murray, D.B.O. (resigned 9.3.60).

Speech Therapists—

Mrs. S. E. Latimer, L.C.S.T. (Part-time from September, 1960).
Miss E. B. Moon, L.C.S.T.
Miss M. E. Rawle, L.C.S.T. (commenced 12.9.60).
Mrs. A. Taylor, L.C.S.T. (Part-time from September, 1960).
Mrs. E. O. S. Todd, L.C.S.T. (resigned 12.3.60).

Chief Clerk—

T. Ryder (resigned 3.4.60.).
J. J. Pattinson (commenced 4.4.60.).

STATISTICAL AND SOCIAL CONDITIONS OF THE AREA

Area in Acres of Administrative County—967,054 acres.

Rateable Value (April 1st, 1960)—£2,277,699.

Estimated product of 1d. rate (1960-61)—£8,902.

Population (Census, 1951)—217,540.

Population (1960 Mid-year estimate)—219,160.

Live Births—Number	3,940
Rate per 1,000 population	18.0
Illegitimate live births per cent. of total live births	4.1%
Still Births—Number	111
Rate per 1,000 total live and still births	27.4
Total live and still births	4,051
Infant deaths (deaths under 1 year)	91
Infant mortality rates—	
Total infant deaths per 1,000 total live births	23.1
Legitimate infant deaths per 1,000 total legitimate births	22.5
Illegitimate infant deaths per 1,000 total illegitimate births	37.5
Neo-natal mortality rate (deaths under 4 weeks per 1,000 total live births)	17.8
Early neo-natal mortality rate (deaths under 1 week per 1,000 total live births)	15.2
Perinatal mortality rate (Still births and deaths under 1 week combined per 1,000 total live still births)	42.2
Maternal mortality (including abortion)	2
Rate per 1,000 total live and still births	0.5

A more detailed analysis of the above figures is given overleaf:-

	Male.	Female.	Total.	Urban Districts.	Rural Districts.	Admin. County.	Eng'd and Wales.
LIVE BIRTHS—							
Legitimate ...	1974	1806	3780				
Illegitimate ...	84	76	160				
	2058	1882	3940				
Birth rate per 1,000 population ...				18.5	17.6	18.0	17.1
STILL BIRTHS—							
Legitimate ...	52	56	108				
Illegitimate ...	3	—	3				
	55	56	111				
Still birth rate per 1,000 total births ...				28.3	26.8	27.4	19.7
DEATHS							
All causes ...	1367	1262	2629				
Death rate per 1,000 population ...				12.1	12.0	12.0	11.5
INFANT DEATHS—							
All infants under 1 year of age—							
Legitimate ...	51	34	85				
Illegitimate ...	3	3	6				
	54	37	91				
Total infant deaths per 1,000 total live births				29.7	18.3	23.1	21.7

COMPARATIVE VITAL STATISTICS

Year	Estimated Mid-Year Population	Births		Deaths			
				Under 1 year		All ages	
		No.	Rate	No.	Rate	No.	Rate
1921 ...	216691	5325	24.5	437	82	2703	12.5
1931 ...	205270	3589	17.4	261	72	2813	13.7
1938 ...	194900	3092	15.9	184	59.5	2638	13.0
1951 ...	214700	3681	17.1	124	34	2827	13.2
1952 ...	215050	3714	17.3	119	32	2603	12.1
1953 ...	216100	3608	16.7	97	27	2571	11.9
1954 ...	216600	3533	16.4	98	27.6	2567	11.9
1955 ...	216700	3556	16.4	101	28.4	2653	12.2
1956 ...	217450	3679	16.9	112	30.4	2653	12.2
1957 ...	217600	3901	17.9	103	26.4	2640	12.1
1958 ...	217700	3834	17.6	108	28.2	2643	12.1
1959 ...	218900	3888	17.8	82	21.1	2611	11.9
1960 ...	219160	3940	18.0	91	23.1	2629	12.0

Year	Population	MALES								
		0—	1—	5—	15—	25—	45—	65—	75+	All Ages
1921	216691	255	72	39	58	139	273	260	234	1330
1931	205270	154	53	44	65	140	369	316	312	1453
1938	194900	105	31	25	44	97	360	372	348	1382
1951	214700	78	18	8	20	79	373	378	514	1468
1958	217700	64	12	4	14	66	374	364	518	1416
1959	218900	51	6	8	21	46	362	393	507	1394
1960	219160	54	9	11	16	58	347	383	489	1367
% deaths in age groups 1921		19.17	5.41	2.93	4.36	10.45	20.53	19.55	17.60	100
% deaths in age groups 1958		4.52	0.85	0.28	0.99	4.66	26.41	25.71	36.58	100
% deaths in age groups 1959		3.66	0.43	0.57	1.51	3.30	25.97	28.19	36.37	100
% deaths in age groups 1960		3.9	.7	.8	1.2	4.2	25.4	28.0	35.8	100

— CUMBERLAND

FEMALES										
0—	1—	5—	15—	25—	45—	65—	75+	All Ages	Total Deaths	Crude Death Rate
182	82	42	74	151	296	235	311	1373	2703	12.4
107	50	44	60	102	191	301	404	1360	2813	13.7
79	31	27	35	117	278	308	381	1256	2638	13.0
46	25	4	23	70	264	353	572	1359	2827	13.2
44	6	5	10	47	233	313	569	1227	2643	12.1
31	2	8	6	35	213	319	603	1217	2611	11.9
37	4	8	5	47	207	294	660	1262	2629	12.0
13.26	5.97	3.05	5.39	11.00	21.56	17.12	22.65	100		
3.59	0.49	0.41	0.81	3.83	18.99	25.51	46.37	100		
2.55	0.16	0.66	0.49	2.87	17.50	26.22	49.55	100		
2.9	.3	.6	.4	3.7	16.5	23.3	52.3	100		

District	BIRTHS				
	Legitimate	Illegitimate	Total	Births per 1,000 of population (crude)	Comparability factor
URBAN DISTRICTS—					
Cockermouth ...	92	6	98	17.6	1.01
Keswick ...	58	—	58	12.6	1.00
Maryport ...	194	9	203	16.2	0.95
Penrith ...	190	7	197	18.5	1.01
Whitehaven ...	543	25	568	21.5	0.96
Workington ...	506	19	525	17.9	0.97
Aggregate ...	1583	66	1649	18.5	0.98
RURAL DISTRICTS—					
Alston ...	22	4	26	11.6	1.09
Border ...	514	24	538	18.1	1.15
Cockermouth ...	291	11	302	15.1	0.99
Ennerdale ...	578	24	602	20.3	1.01
Millom ...	267	13	280	19.4	1.04
Penrith ...	185	5	190	16.5	1.03
Wigton ...	340	13	353	15.7	1.02
Aggregate ...	2197	94	2291	17.6	1.04
Administrative County ...	3780	160	3940	18.0	1.02

AND POPULATION IN THE YEAR 1960

DEATHS			INFANT MORTALITY				
Total Deaths	Deaths per 1,000 of population (crude)	Comparability factor	Legitimate	Illegitimate	Total	Deaths of Infants under 1 year per 1,000 live births	Estimated mid-year population
78	14.0	1.00	4	—	4	40.8	5560
65	14.1	0.86	1	—	1	17.2	4600
136	10.8	1.16	4	—	4	19.7	12540
138	13.0	0.86	1	—	1	5.1	10630
283	10.7	1.14	19	—	19	33.5	26450
375	12.8	1.19	18	2	20	38.1	29350
1075	12.1	1.10	47	2	49	29.7	89130
30	13.3	0.94	—	—	—	—	2250
385	13.0	0.96	11	1	12	22.3	29650
245	12.2	1.08	4	—	4	13.2	20040
348	11.7	1.21	13	3	16	26.6	29640
130	9.0	1.11	2	—	2	7.1	14420
129	11.2	1.00	6	—	6	31.6	11510
287	12.7	1.02	2	—	2	5.7	22520
1554	12.0	1.06	38	4	42	18.3	130030
2629	12.0	1.08	85	6	91	23.1	219160

Rates Per 1,000 Population

MORTALITY RATES PER 1,000 LIVE BIRTHS

	Cause of Death	Administrative County	Cockermouth U.D.	Keswick U.D.	Maryport U.D.	Penrith U.D.
	All Causes	2629	78	65	136	138
1.	Tuberculosis, Respiratory	15	—	—	2	—
2.	Tuberculosis, other	1	—	—	—	—
3.	Syphilitic disease	5	—	—	—	—
4.	Diphtheria	—	—	—	—	—
5.	Whooping cough	—	—	—	—	—
6.	Meningococcal infections	—	—	—	—	—
7.	Acute Poliomyelitis	—	—	—	—	—
8.	Measles	—	—	—	—	—
9.	Other infective and Parasitic diseases ...	3	—	—	—	—
10.	Malignant neoplasm, stomach	81	3	1	4	—
11.	Malignant neoplasm, lung bronchus ...	67	—	1	2	2
12.	Malignant neoplasm, breast	25	—	1	3	1
13.	Malignant neoplasm, uterus	21	1	1	1	1
14.	Other malignant and lymphatic neoplasms	199	7	2	15	10
15.	Leukaemia, Aleukaemia	9	1	—	—	—
16.	Diabetes	15	1	—	1	—
17.	Vascular Lesions of Nervous System ...	439	14	20	11	37
18.	Coronary Disease, Angina	533	15	15	35	27
19.	Hypertension with Heart Disease ...	37	—	2	1	—
20.	Other Heart Disease	394	9	12	17	30
21.	Other Circulatory Disease	130	4	—	11	9
22.	Influenza	4	—	—	1	—
23.	Pneumonia	63	1	3	5	1
24.	Bronchitis	66	5	—	8	2
25.	Other Disease of the Respiratory System	35	3	1	1	2
26.	Ulcer of Stomach and Duodenum ...	21	—	1	2	—
27.	Gastritis, Enteritis and Diarrhoea ...	13	—	—	1	1
28.	Nephritis and Nephrosis	20	—	1	—	—
29.	Hyperplasia of Prostate	17	—	—	1	1
30.	Pregnancy, Childbirth and Abortion ...	2	—	—	—	—
31.	Congenital Malformations	34	2	—	—	2
32.	Other Defined and Ill defined diseases ...	252	11	2	8	8
33.	Motor vehicle accidents	37	—	1	1	—
34.	All other accidents	73	1	1	5	1
35.	Suicide	18	—	—	—	4
36.	Homicide and Operations of War ...	—	—	—	—	—

ADMINISTRATIVE AREAS (1960)

Whitehaven M.B.	Workington M.B.	Aggregate of U.D.'s	Alston R.D.	Border R.D.	Cockermouth R.D.	Ennerdale R.D.	Millom R.D.	Penrith R.D.	Wigton R.D.	Aggregate of R.D.'s
283	375	1075	30	385	245	348	130	129	287	1554
4	4	10	1	1	2	—	1	—	—	5
—	1	1	—	—	—	—	—	—	—	—
—	—	—	—	—	1	2	2	—	—	5
—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—
1	—	1	—	—	1	1	—	—	—	2
11	14	33	—	15	6	10	3	3	11	48
6	17	28	2	5	5	11	6	2	8	39
2	3	10	—	1	1	7	3	1	2	15
1	5	10	—	2	2	1	—	1	5	11
21	28	83	—	24	21	34	9	8	20	116
1	1	3	—	—	2	—	1	1	2	6
—	1	3	—	5	1	4	—	1	1	12
45	57	184	8	55	37	59	22	21	53	255
42	72	206	8	85	48	72	30	30	54	327
6	5	14	1	4	3	6	1	2	6	23
26	45	139	—	81	31	33	16	19	75	255
9	12	45	5	23	21	15	5	6	10	85
—	1	2	—	1	—	—	—	—	1	2
9	8	27	1	3	11	15	1	2	3	36
5	13	33	—	9	8	4	5	2	5	33
3	1	11	—	6	4	8	1	4	1	24
1	4	8	1	1	2	4	1	1	3	13
3	1	5	—	1	—	3	3	1	—	8
2	2	5	—	6	2	3	2	1	1	15
3	4	9	1	4	1	1	—	1	—	8
—	—	—	—	—	2	—	—	—	—	2
6	6	16	—	5	3	6	1	1	2	18
57	46	132	2	27	18	31	15	10	17	120
6	6	14	—	7	3	4	1	4	4	23
13	12	33	—	12	6	13	1	6	2	40
—	6	10	—	2	3	1	—	1	1	8
—	—	—	—	—	—	—	—	—	—	—

SECTION 22

CARE OF MOTHERS AND YOUNG CHILDREN

The Population (Statistics) Act, 1960

The Population (Statistics) Act, 1960, became law on 1st October, 1960, and introduced certain changes in the law relating to the certification of stillbirths. A registered medical practitioner who is present at a stillbirth or examines the body of a stillborn child must, at the request of a qualified informant, give a certificate stating that the child was not born alive and, where possible, stating to the best of his knowledge and belief the cause of death and the estimated duration of the pregnancy. Where no medical practitioner was present at the stillbith or has examined the body, the certificate must be given by the certified midwife who was present or who examined the body. Such a certificate is to be given only in respect of a stillborn child as defined in the Births and Deaths Registration Act, 1953, i.e. a child which has issued forth from its mother after the 28th week of pregnancy and which did not at any time after being completely expelled from its mother breathe or show any other signs of life. If the child was born alive and died subsequently then, whatever the duration of pregnancy and however short the duration of life, the birth and death have to be registered separately and the ordinary rules apply for the certification of the death by any doctor in attendance.

Perinatal Mortality

The perinatal death rate is defined as the number of stillbirths and infant deaths under the age of seven days per 1,000 total births. Table I below shows the number of stillbirths and stillbirth rates over the past ten years compared with the national rates, and Table II shows similar figures for perinatal deaths.

TABLE I

Year	No. of Stillbirths	No. of Stillbirths per 1,000 total births	Rate— E'land & Wales
1951	101	26.7	23.0
1952	94	25.0	22.7
1953	99	27.0	22.4
1954	106	29.8	23.5
1955	79	21.7	23.2
1956	111	29.3	23.0
1957	102	25.5	22.4
1958	80	20.4	21.6
1959	83	20.9	20.7
1960	111	27.4	19.7

TABLE II

Year	No. of perinatal deaths	No. of perinatal deaths per 1,000 total births	Rate—E'land & Wales
1951	157	41.5	38.1
1952	149	39.1	37.5
1953	153	41.3	37.0
1954	159	43.7	38.1
1955	140	38.5	37.6
1956	175	46.2	36.8
1957	166	41.5	36.2
1958	149	38.1	35.1
1959	137	34.5	34.2
1960	171	42.2	32.9

It must be remembered that the perinatal death-rate is influenced by a number of factors; the health of the mother during pregnancy, the type of labour, the weight of the infant, the age of the mother and the number of her previous confinements. It is unfortunate that the downward trend in the perinatal death rate since 1956 has not been maintained, and this is mainly due to the increase in stillbirths during 1960 to 111, the figure in 1959 being 83. Most of the increase in stillbirths will be seen to be in full-time babies, and the causes showing the steepest rise from last year are complications of the Rh. factor, antepartum haemorrhage, and asphyxia associated with umbilical cord difficulties.

In the following table an analysis has been made of the causes of the 171 perinatal deaths during the year.

Analysis of Causes of 171 Perinatal Deaths during 1960

Cause of Death	Stillbirths		Deaths during	Total
	Premature	Full-time	1st week	
Toxaemia ...	8	3	—	11
Antepartum Haemorrhage ...	7	11	—	18
Placental Insufficiency (infarct.) ...	2	5	—	7
Placenta Praevia ...	1	—	1	2
Rh. with Antibodies ...	2	6	2	10
Immaturity ...	2	—	15	17
Congenital Malformation ...	15	8	8	31
Maceration of foetus ...	3	—	—	3
Postmaturity ...	—	2	—	2
Asphyxia				
(1) Not known ...	1	3	—	4
(2) Prolapse of cord ...	—	1	1	2
(3) Compression of cord ...	1	3	—	4
(4) Cord round neck ...	2	5	—	7
Difficult labour with breech delivery ...	2	—	—	2
Difficult labour with impacted shoulders ...	—	1	—	1
Difficult labour with deep transverse arrest ...	1	2	—	3
Birth injury (Sub-tentorial haemorrhage) ...	—	1	5	6
No known cause ...	8	5	—	13
Intestinal obstruction and infection ...	—	—	2	2
Atalectasis ...	—	—	21	21
Pneumonia ...	—	—	3	3
Congenital heart disease ...	—	—	2	2
	55	56	60	171

Infant Mortality

The following table shows the causes of deaths of infants under one year at different age periods. A high incidence of deaths in the first week due to atalectasis is noticeable:—

Cause of Death		Age in weeks 1	2-4	5-52	Total
Placenta praevia	...	1	—	—	1
Rh. with antibodies	...	2	—	—	2
Immaturity	...	15	—	—	15
Congenital Malformation	...	8	5	3	16
Asphyxia due to					
(a) prolapse of cord	...	1	—	—	1
(b) inhalation of vomit	...	—	—	5	5
Birth injury	...	5	—	—	5
Intestinal obstruction and infection	...	2	1	2	5
Atalectasis	...	21	—	—	21
Pneumonia	...	3	3	8	14
Congenital heart disease	...	2	1	3	6
		60	10	21	91

Prematurity

The survival rate of premature infants according to weight and to place of birth and nursing is set out in the table on page 30.

It is interesting to note that, of the 39 premature infants born at home and nursed entirely at home, all survived 28 days, and this year would appear to be the first time that this has happened since this particular return was introduced some years ago.

Arrangements for the admission of premature infants to hospital continue as previously. Sorrento premature baby cots were provided at Workington Infirmary and at the City Maternity Hospital, Carlisle. Any practitioner requiring the use of the premature unit contacts the appropriate hospital in the first instance. The hospital authorities are then responsible for contacting the ambulance service either at Workington or Carlisle who proceed to the hospital to collect the unit. This is always accompanied by a midwife from the hospital who is experienced in the use of the equipment.

Premature Live Births

Weight at Birth.	Born in Hospital.*			Born at home and nursed entirely at home.			Born at home and transferred to hospital on or before 28th day.			Born in nursing home and nursed entirely there.			Born in nursing home and transferred to hospital on or before 28th day.			PREMATURE STILL-BIRTHS.		
	Total.	Died within 24 hours of birth.	Survived 28 days.	Total.	Died within 24 hours of birth.	Survived 28 days.	Total.	Died within 24 hours of birth.	Survived 28 days.	Total.	Died within 24 hours of birth.	Survived 28 days.	Total.	Died within 24 hours of birth.	Survived 28 days.	Born in hospital.	Born at home.	Born in nursing home.
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)
(a) 3 lb. 4 oz. or less (1500 gms. or less) ...	32	15	8	—	—	—	1	—	—	—	—	—	—	—	—	23	3	—
(b) Over 3 lb. 4 oz. up to and including 4 lb. 6 oz. (1500-2000 gms.) ...	35	2	30	3	—	3	6	—	5	—	—	—	—	—	—	14	1	—
(c) Over 4 lb. 6 ozs. up 4 lb. 15 oz. (2000-2250 gms.) ...	38	2	36	4	—	4	2	—	1	—	—	—	—	—	—	8	—	—
(d) Over 4 lb. 15 oz. up to and including 5 lb. 8 oz. (2250-2500 gms.) ...	32	—	32	1	—	1	—	—	—	—	—	—	3	3	—	48	7	—
TOTALS ...	84	—	83	189	19	157	39	—	39	10	—	7	—	—	—	—	—	—

* The group under this heading includes cases in one hospital and transferred to another.

Ante Natal Care

During the year efforts have been made towards the establishment of local maternity liaison committees, as envisaged in the Cranbrook Report, to discuss future liaison between hospital and domiciliary care. I sincerely hope that it will be possible to report next year that these committees are functioning in both East and West Cumberland. Meetings took place with the consultant obstetricians in West Cumberland at which it was suggested that an investigation be made of all " at risk " births with the object of compiling a register of children who might require special medical care in the future. It was also felt that the consultant paediatrician would play an important part in the compilation of such a register.

The ante-natal relaxation and mothercraft classes have continued successfully. There were 158 classes held during the year in the County Council clinics at Whitehaven, Workington, Frizington, Seascale, Millom, Cleator Moor and Egremont. In the more rural areas where attendances at clinics is impossible owing to transport difficulties some midwives have taught relaxation exercises and mothercraft in the patients' own homes. There has been a great increase in the use of filmstrip projectors, flannelgraphs and other visual aids to make these classes more interesting. Since the midwives have had special training in teaching relaxation exercises to groups of mothers there has been a greater increase in attendances. The mothers are becoming increasingly interested and are enquiring if their friends who attend hospital ante-natal clinics can attend the classes with them. There is still room for further expansion in this aspect of ante-natal work as there are some areas not covered, for instance, Brampton and Penrith, and in the rural areas there are many patients booked for hospital who are not able to attend any classes.

During the year a further three haemoglobinometers have been provided and this makes a total of twelve that are in use in the county. The midwives use these in co-operation with the family doctors to carry out blood testing for anaemia.

Unmarried Mothers

The arrangements for the care of unmarried mothers made with the Carlisle Diocesan Council for Social and Moral Welfare and the Lancaster Diocesan Protection and Rescue Society, continued to operate. These mothers are admitted to Coledale Hall, Carlisle; St. Monica's and Brettargh Holt at Kendal; and the Salvation Army Home, "Hopedene", Newcastle, for six weeks before and after confinement.

During the year 1960, maintenance at the above homes was approved for 44 cases—this was an increase of 7 over the figure for 1959.

The age groups of these 44 cases are shown in the following table and comparable figures for the previous years are also shown:—

Age	1960	1959	1958	1957
13	1	—	—	—
14	—	—	—	1
15	1	1	—	—
16	3	3	1	1
17	3	4	2	3
18	3	6	5	5
19	10	3	2	4
20	3	4	3	3
21	4	5	4	1
22	—	3	2	3
23	1	1	2	3
24	2	—	2	1
25	1	1	2	1
26	1	—	2	1
27	1	1	1	—
28	4	1	—	3
29	—	1	—	—
30	3	1	—	4
31	—	—	—	—
32	—	1	—	1
33	—	—	—	—
34	—	—	—	2
35	—	1	—	1
36	—	—	—	—
37	1	—	—	—
38	—	—	—	—
39	2	—	—	—
TOTALS	44	37	28	38

Dental Services

The Chief Dental Officer makes the following comments on the dental service for 1960:—

In the report for 1959 reference was made to the fact that the members of the county nursing services had been asked to co-operate in relation to the dental care of maternity and child welfare cases by impressing mothers with the need of dental treatment for both themselves and their children. For the first part of the year this did not seem to be securing results, but a marked increase became apparent in the last quarter. The actual numbers were as follows:—1st quarter 76, 2nd quarter 78, 3rd quarter 73, 4th quarter 139, so that it is evident something is happening and it may be assumed that the nursing services have a large share in it. There is also a marked increase in the under fives, though it is not easy to allocate this to any definite period of the year, but it demonstrates that parents are beginning to realise where treatment can be obtained for these cases, though unfortunately in most cases it is for relief of pain.

This again raises the question of health education and doubtless there is a definite need in this direction. While it is admitted that Health Week demonstrations and lectures create an interest, it must be remembered that " Rome was not built in a day " and within limits the quicker a building is erected the sooner it will come down. It is not intense activity for a week that produces results, though it may be spectacular, but the continual reiteration of facts over long periods by those who are in personal touch with the parents that finally produces lasting results, and this is what is being aimed at through the nursing services. In the same way talks to Women's Institutes and other suitable organisations have their place in building up a right dental outlook and there is gradually growing demand for these. This is ideal, as it is always easier to educate a person who wishes to learn, so it is better for the request to come from the public and thus provide a receptive audience. In short, have the Dental Health week to draw attention to the matter, but maintain the persistent unobtrusive propaganda behind the scenes. Escaping steam makes a lot of noise and draws a lot of attention, but it is the steam that goes quietly into the cylinder that pulls the train out of the station. It would seem that this is happening with the maternity and child welfare service in the county and, though acceleration may be poor, it is evident and is likely to continue.

There is still a full staff in the county with provision for increase up to four more as the need arises, so that the prospects are good, especially as the whole staff are marked by an excellent team spirit and in this, my last annual report as Chief Dental Officer, I wish to say how much I have valued this as well as the excellent relationships which have existed between us all and which have made my work a real pleasure. I would also like to thank the members of the committees concerned for their unfailing helpfulness and sympathetic attitude over the years, which has made the development of the service an easy matter.

Numbers provided with Dental Care

	Examined	Needing treatment	Treated	Made Dentally fit
Expectant and Nursing Mothers ...	366	364	336	203
Children under 5 ...	435	400	400	227

Forms of Dental Treatment Provided

	Scalings and gum treatment.	Fillings	Silver Nitrate treatment.	Crowns or Inlays.	Extractions.	General Anaesthetics.	Dentures Provided. Full Upper or Lower.	Partial Upper or Lower.	Radiographs.
Expectant and Nursing Mothers ...	38	239	—	3	1835	139	231	64	21
Children under 5 ...	—	118	60	—	827	233	—	—	7

Distribution of Welfare Foods

This service continued through 1960 with very little change. The steady fall in demand continues, though this is only happening in the towns. Issues remain at much the same level in the distribution points operated by the W.V.S. in the rural areas, although four small distribution points were closed during the year. Three of these were at Laversdale, Newton Arlosh and Ainstable where agents resigned because there was little or no demand for the foods, and a fourth point was closed at Keswick. No new distribution points were opened during the year, but when Hadrian's Camp was taken over by an Army Apprentice School the clinic and welfare foods distribution was transferred to the village hall at Houghton.

Total issues to beneficiaries and hospitals

	National Dried Milk	Cod Liver Oil	Vitamin Tablets	Orange Juice
1955	... 145696	25082	6413	113548
1956	... 151101	23669	7274	124212
1957	... 128219	22517	6920	137336
1958	... 115685	15198	6338	89366
1959	... 105984	15350	7076	93684
1960	... 92676	14961	7450	90343

Attendances at Child Welfare Centres

During the year the total number of children attending county clinics decreased slightly, but the attendances showed a slight increase.

The following table shows the number of centres provided and details of attendances:—

Year.	No. of centres provided at end of year.	No. of child welfare sessions held per month at centre.	No. of children who first attended the centre during the year and who at their first attendance were under 1 year of age.	No. of children attending during the year and who were aged:			Total No. of children who attended during the year.	Total attendances during the year.
				Under 1 year.	1—2 years.	2—5 years.		
1960 ...	22	95	2011	1548	1408	1368	4299	22089
1959 ...	22	92	2093	1596	1455	1389	4440	21947
1958 ...	19	88	1757	1326	1192	1225	3743	18061
1957 ...	18	69	1754	1310	1051	1056	3417	14452
1956 ...	15	59	1458	1053	922	964	2939	11912
1955 ...	15	58	1382	975	896	1103	1947	11734
1954 ...	15	65	1347	933	1027	1181	3141	12794

County Council Clinics

On 17th May, 1960, the new clinic at Flatt Walks, Whitehaven, was officially opened by Lord St. Oswald. The clinic was built at a cost of £37,000 and its opening marks an important stage in the provision of adequate up to date clinic accommodation in one of the most populous areas in the county. For many years Whitehaven had been served by two separate and old premises for clinical and administrative purposes respectively, with yet a third being used for child guidance clinics. All of this accommodation left much to be desired in terms of space, general convenience and all the facilities which should accompany efficient clinic working. The inadequacy was being gradually underlined by a steady increase in consultant and dental clinics.

The new building therefore replaced old, inconvenient and ill equipped premises by a modern unit housing both clinical and administrative accommodation and catering for child welfare, school health, dental and child guidance departments, besides various consultant facilities such as orthopaedic and ophthalmic clinics. Notable and welcome provisions are the adequate waiting hall with children's playroom, the lecture and demonstration hall for health education and other purposes, and a specially equipped room for the early ascertainment of deafness. The well appointed dental unit promises well for an extended service to mothers and young children, and we look forward to strengthening and extending the local authority clinic services with staff and patients meeting in congenial and attractive surroundings.

An interesting feature of our clinics during the past year has been the increasing use made of them for purposes other than maternity and child welfare. The following table shows the clinics in the county and the types of sessions held there.

County Council Clinics

Centre	County Council or Rented premises	Clinics
Alston	R ...	Ante-natal, Child Welfare, Dental, School Clinic
Aspatria	C.C. ...	Ante-natal, Child Welfare, Dental, School Clinic, Speech Therapy, Welfare Foods, Orthopaedic
Brampton	C.C. ...	Child Welfare, Chiropody, Dental, School Clinic
Carlisle	C.C. ...	Child Welfare, Child Guidance, Dental, Immunisation and Vaccination, Orthoptic, School Clinic, Speech Therapy, E.N.T., Ophthalmic, Orthopaedic
Cleator Moor	C.C. ...	Ante-natal, Child Welfare, Dental, School Clinic, Orthopaedic
Cockermouth	C.C. ...	Ante-natal, Child Welfare, Chiropody, Dental, Immunisation and Vaccination, School Clinic
Egremont	C.C. ...	Ante-natal, Child Welfare, Chiropody, Dental, Hearing Therapy, School Clinic, Chest, Orthopaedic
Frizington	C.C. ...	Ante-natal, Child Welfare, Dental, School Clinic
Houghton	R ...	Child Welfare
Keswick	R ...	Child Welfare, Dental, Immunisation and Vaccination, Speech Therapy, Ophthalmic, Orthopaedic
Maryport	C.C. ...	Ante-natal, Child Welfare, Child Guidance, Dental, Immunisation and Vaccination, School Clinic, Speech Therapy, Orthopaedic
Millom	C.C. ..	Ante-natal, Child Welfare, Child Guidance, Dental, Immunisation and Vaccination, School Clinic, Speech Therapy, Surgical, Chest, Gynaecological, Medical, Minor Ailments (G.P's.), Ophthalmic, Orthopaedic

County Council Clinics

Centre	County Council or Rented premises		Clinics
Nenthead	C.C.	...	Child Welfare, School Clinic
Penrith	C.C.	...	Ante-natal, Child Welfare, Dental, Orthoptic, School Clinic, Speech Therapy, Family Planning, Orthopaedic Psychiatric
Seascale	R	...	Ante-natal, Child Welfare, Immunisation and Vaccination
Whitehaven Flatts Walks	C.C.	...	Ante-natal, Child Welfare, Child Guidance, Chiropody, Dental, Hearing Therapy, Immunisation and Vaccination, Orthoptic, School Clinic, Speech Therapy, Chest, E.N.T., Ophthalmic, Orthopaedic
Mirehouse	C.C.	...	Ante-natal, Child Welfare, Dental, School Clinic
Woodhouse	C.C.	...	Ante-natal, Child Welfare, Immunisation and Vaccination, School Clinic
Wigton	C.C.	...	Child Welfare, Chiropody, Dental, Hearing Therapy, Immunisation and Vaccination, School Clinic, Speech, Therapy, Orthopaedic
Workington Park Lane	C.C.	...	Ante-natal, Child Welfare, Child Guidance, Chiropody, Dental, Hearing Therapy, Immunisation and Vaccination, Orthoptic, School Clinic, Speech Therapy, Family Planning, Orthopaedic Note — Spastic Therapy Clinics held about three times a year
Harrington	R	...	Ante-natal, Child Welfare
Seaton	R	...	Child Welfare
Westfield	R	...	Child Welfare

Family Planning

The arrangements for advice on this subject have continued as in previous years. The Family Planning Association hold their own clinics in County Council premises at Park Lane, Workington, and Brunswick Square, Penrith. County patients who live in the Carlisle area can be seen at Victoria Place, Carlisle, by appointment.

Nurseries and Child Minders Regulation Act, 1948

The above Act makes it the duty of the Local Health Authority to keep registers of:—

(a) Premises in their area other than premises wholly or mainly used as private dwellings, where children are received to be looked after for the day or a substantial part thereof or for any longer period not exceeding six days.

(b) Persons in their area who, for reward, received into their homes children under the age of five to be looked after for the day or a substantial part thereof or for any longer period not exceeding six days.

During the year an application to be registered as a Child Minder was received from a lady at Seascale, and this was granted. This is the second registration in the County under this Act.

SECTION 23

MIDWIFERY SERVICE

During the year 145 midwives notified their intention to practice. These included 9 whole-time district midwives, 58 midwives working in the maternity department of hospitals in the administrative county, and 68 district nurse midwives.

There are 3 pupil midwives obtaining 3 months district experience with the Council's midwives at Whitehaven and Cleator Moor.

The number of domiciliary confinements undertaken during the year was 1,151. A doctor was present at 294 of these confinements and in 36 cases no doctor was booked.

The total number of home visits paid by midwives and immediately concerned with the confinement was 21,651 and in addition they paid 4,495 visits to 979 cases who had been delivered in hospital, but discharged home before the 14th day.

A further 10,589 home visits were paid by midwives in connection with ante-natal and post-natal examinations as distinct from the above mentioned nursing visits. For the same purpose mothers made 4,855 attendances at nurses' clinics, of which 2,639 were at sessions at which a general practitioner was present.

Midwives sent for medical help in domiciliary cases on 234 occasions.

The following table has been compiled to show the age and parity of those mothers delivered at home in 1960 whose parity was over four. The total of 237 suggests to me that some further attention should be given to ensure by all available means that as many such " poor risk " cases as possible should be delivered in hospital.

Age Group	Parity of the mother							
	4	5	6	7	8	9	10 +	Total
Under 20 ...	—	—	—	—	—	—	—	—
20 — ...	3	—	—	—	—	—	—	3
25 — ...	40	9	9	1	4	—	—	63
30 — ...	33	21	15	6	3	3	2	83
35 — ..	21	17	15	4	3	2	5	67
40 — ...	6	5	—	5	1	1	—	18
45 + ...	—	—	—	2	—	—	1	3
Totals :	103	52	39	18	11	6	8	237

Analgesia

During the year gas and air analgesia was employed by midwives to the extent of 811 cases. This is again a slight decrease on the previous year's figure. Oxygen infant resuscitators were used in 48 cases in 1960. There were 57 outfits for use in the county during the year.

A further four Trilene inhalers were purchased in 1960, making a total of 12, and these have been used on 233 occasions.

Post Graduate Courses

As required by the rules of the Central Midwives Board 18 midwives attended refresher courses during the year at Hull, Bangor, Sheffield and Birmingham. One of the Assistant Superintendent Nursing Officers attended a postgraduate course at London in April.

SECTION 24

HEALTH VISITING

At the end of 1960 there were 20 whole-time health visitors employed out of an establishment of 24. In the rural areas of the county much of the health visiting work is undertaken by 45 district nurses, 17 of whom hold the health visitor's certificate. The remainder are employed under a temporary arrangement by dispensation from the Ministry of Health.

It was only possible to fill one of the vacancies in West Cumberland during the year despite repeated advertisements. The health visitors made 27,775 visits to children under one year of age and 34,511 visits to children aged 1 to 5 years. This is a decrease on the figures for the previous year, but it is inevitable owing to the more selective visiting being undertaken by the health visitors.

Each year provision is made in the estimates for four health visitor scholarships, each to the value of about £525, and advertisements inviting applications for these scholarships are inserted in the Nursing Journals. The four most suitable applicants are chosen and we have in the past been fortunate in securing places at Bolton Technical College for the year's course starting in September. Before being accepted for the course the students sit an entrance test and are interviewed. Sometimes the four students are all " outside " nurses and sometimes some of our own nursing staff apply and are accepted for the course. Since 1958 when the scholarship scheme was reviewed, it has been our practice to grant " outside " nurses a scholarship of £500, plus tuition fees, travelling expenses while on the course, and £5 towards the cost of books. In the case of nurses already being employed by the County Council, their salary continues on the same scale as they were receiving prior to the course, and they receive the additional items mentioned above. Before the course begins all students sign agreements to the effect that they will work in Cumberland for at least two years after completing the course.

Over recent years these arrangements have worked well, and during 1960 three of our own nurses commenced the health visitors' course at Bolton in September.

Two health visitors attended a course in Glasgow in May and two in London at the end of the year. Arrangements have been made for two more health visitors to attend a course on " Mental Disorders " at Oxford in March, 1961. The health visitors in Cumberland have not so far taken an active part in Mental Health work but the importance of a clear insight into this work is realised and by arranging for them to attend suitable courses they are able to become more familiar with this aspect of the work of the department.

During the year we have been pleased to welcome students from Australia, British Honduras and South Africa, all of whom spent a week with us studying aspects of work in a rural county. Twelve health visitor students from Bolton Technical College came to the county for a week in April. These students live with the nurses who enjoy having them as it gives them an opportunity of keeping up to date with the newest trends in public health work.

A circular on Phenylketonuria was issued to all health visitors and nurses undertaking health visiting, and " Phenistix " were distributed throughout the county. Every child is now being tested once at about six months, and up to the end of the year there have been two suspected cases which on further investigation have proved negative. As the incidence of this condition is approximately one in 35,000, we hope it may be many years before a positive case is found.

Secondment of Health Visitors to Groups of General Practitioners

Towards the end of the year it was decided to try an experimental scheme in the Workington and Penrith areas of the county in which health visitors were seconded to work with groups of general practitioners. Reports have been received both from the general practitioners and the health visitors concerned and their reactions are favourable. There were minor difficulties to overcome but in an experimental scheme of this nature these were perhaps inevitable.

The health visitors report that from their point of view the scheme has everything to commend it, and that their relationship with the families in their area is now perhaps even closer than it was previously. The impression they get is that their visits are

more welcomed by the family when they family doctor has already mentioned that they will be calling. In addition, more old people were being brought to their attention and the health visitor was able to keep a friendly eye on their progress and be able to report any deterioration in health immediately. All the health visitors have mentioned the advantage of working with the doctors and thus learning more of their methods of work.

From the family doctors' point of view, most have stressed the advantages of the scheme, particularly in relation to the visiting of the chronic sick and aged. They all admit that, in the field of health education, and because of differing opinions between general practitioners, the health visitor and family doctor may in the past have been giving conflicting advice to patients. Under this new scheme the possibility of this happening can be disregarded because all will work as part of a team. One of the practices involved has felt that the amount of use which they could make of a health visitor hardly justifies a secondment in their particular area and practice, though so far as the outworking of the scheme has gone it has been in the main helpful. The health visitors taking part in the secondment still, of course, retain their school and child welfare clinic duties. One of the doctors in Workington states that under the scheme it has been possible for the health visitor to avoid much useless visiting of patients who are known to the general practitioner to be doing well and to direct her to those patients where she can give valuable help and advice. I regard this as of the utmost importance because I have no doubt that, in the future, the health visitor must of necessity undertake more and more selective visiting. This same practitioner goes on to say that this scheme has proved, beyond all reasonable doubt, that this is the only way in which health visitors should be employed.

It seems that the pilot scheme has demonstrated that a more satisfactory health visitor/doctor relationship can be established on this basis while the qualified opinion of the doctors in one practice would seem to show that in the early stages of such a scheme careful selection with regard to personnel and type of district is important. All of this considered, I feel that the scheme might well be extended to include another one or two carefully selected areas, selected from the points of view mentioned above. Further implementation of this scheme will be carried out during 1961 and it is hoped that we will be able to report still further progress at the end of that year.

Liaison Arrangements

There has been continued liaison with the hospitals but owing to shortage of staff visits by health visitors have not been so frequent as in the past. At the end of the year plans were being formed for the attendance of health visitors at paediatric clinics and for a closer liaison with the maternity units.

This is Dr. Platt's first full year in Cumberland as the County's first consultant paediatrician, and the regular contact with him which the nursing staff are being able to establish and maintain is proving most helpful in the home care and nursing of sick children. Dr. Platt is able to guide the health visitor or district nurse when one attends his out-patient clinics on the whole management of such conditions as hiatus hernia with vomiting in small babies, so reducing the need for hospitalisation with its attendant risks. It is also felt that the secondment of health visitors to general practices is complementary to this in linking with the family doctor on the home rather than hospital care of both the young and chronic sick.

SECTION 25

HOME NURSING

1. At 31st December, 1960, there were employed 65 Queen's or State Registered Nurses and 12 State Enrolled Assistant Nurses who are also State Certified Midwives.

	No. of cases nursed
Medical	4982
Surgical	1806
Tuberculosis	114
Infectious Diseases	8
Maternal Complications	59
Others	103
	7072
Number of nursing visits paid	121026
Number of casual visits paid	6570
	127596

It is of interest to compare the home nursing figures for 1960 with those of the previous five years:—

No. of Cases Nursed

	1955	1956	1957	1958	1959	1960
Medical ...	5371	5178	5444	4946	5297	4982
Surgical ...	2575	2316	1935	1897	2002	1806
Infectious Diseases ...	28	13	16	12	16	8
Tuberculosis ...	316	189	250	250	171	114
Maternal Complications	71	94	112	85	69	59
Others ...	30	35	24	88	219	103
	8391	7825	7781	7278	7774	7072

Analysis of Cases Nursed

		Percentage of total cases nursed
No. of cases nursed over 65 years of age ...	2489	35%
No. of cases of cancer	210	3%
No. of children nursed under 5 years of age ...	513	7%
Remaining cases	3860	55%
	7072	

No. of Nursing Visits to above Cases

	1955	1956	1957	1958	1959	1960
Medical ...	87983	86372	99007	97337	94437	91855
Surgical ...	35962	29907	29265	30073	28724	23639
Infectious Diseases ...	581	84	67	81	52	81
Tuberculosis ...	8859	5289	6171	5886	4149	4132
Maternal Complications	161	570	845	629	642	504
Others ...	212	715	131	237	609	815
Casual visits ...	4782	5771	6493	3656	7151	6570
	138540	128708	141979	137899	135764	127596

Analysis of Nursing Visits

		Percentage of total nursing visits paid
Total number of nursing visits to persons over 65 years of age	71125	56%
Total number of nursing visits to children under 5 years of age	3161	2.5%

There has been a decrease in both the patients nursed and the visits paid. The only increase of any significance is the visits to people over 65 years of age. The nurses are finding that there is a change in their work due apparently to the early ambulation of patients in hospital and also to the oral administration of penicillin and anti-diabetic drugs. The nurses are encouraged to pay more social visits to the elderly. This is of great value to a person living alone under stress or housebound, as is the giving of nursing attention, but it is a little difficult for some of the nurses to adjust themselves to this changing pattern as their training has been essentially of a practical nature and the results of their work are not now so apparent.

Throughout the year students from the Cumberland Infirmary, Whitehaven Hospital and Workington Infirmary have spent a morning on the district with the nurses. The time is very short, but it does enable them to get some idea of the domiciliary services provided. We have also had student district nurses from Gateshead and Sunderland who spent three days in a rural area.

Lectures are given to students in training on the social aspects of diseases and to the district nursing students at Gateshead on the work in a rural area.

In January two district nurses attended a refresher course at Bedford College, London, and a further six nurses will be attending a refresher course at the same college early in 1961. Miss P. G. O'Sullivan, Assistant Superintendent Nursing Officer, was seconded to take the Public Health Administration Course at the Royal College of Nursing from September, 1960, to July, 1961, and Miss I. Mansbridge, Superintendent Nursing Officer, attended the Royal Society of Health Congress at Torquay in April.

We continue to hold meetings and lectures at regular intervals and the group discussions held are found to be of value to the nursing staff as a means of keeping up-to-date.

Housing of Nurses

During the year houses were completed at Longtown, Seascale, Brampton and Hayton, bringing the total number of houses built by the County Council to 22. The Council therefore now own 36 nurses houses, 14 having been bought from District Nursing Associations or the North-Eastern Housing Association. In addition, 12 houses are rented by the Council and sublet to nurses.

The erection of a house at Bootle was begun and two flats are to be incorporated in the new County Council building which is being built at St. George's Road, Millom.

SECTION 26

Immunisation and Vaccination

Facilities are available throughout the county for the protection of all in the appropriate age groups against diphtheria, whooping cough, tetanus, poliomyelitis and smallpox. Arrangements can be made for the immunisation or vaccination to be given either by the medical officers in the county council clinics or schools, or by most general practitioners. There is complete freedom for the individual or parent to decide by whom the protection shall be given.

A total of over 37,000 immunisation procedures (i.e., primary course or later reinforcement) were given during the year and of this total 35 per cent. were carried out by general practitioners.

(a) **Diphtheria Immunisation**

During the past two years as a result of the prolonged and intensive campaigns of vaccination against poliomyelitis, diphtheria immunisation amongst school children unavoidably fell into arrears. Fortunately during the current year it was possible to recover some of the ground which had been lost, and the following table indicates the total immunisation procedures carried out during 1960 with comparative figures for the preceding decade.

1960	8245
1959	5077
1958	4024
1957	7127
1956	5221
1955	9463
1954	6880
1953	6658
1952	8915
1951	6489

Of the total of primary courses which were given, slightly over 22 per cent. were in fact given to school children.

Although the total number of immunisations which was given shows a welcome increase, it will be seen from the following table, which gives details of the immunity index, that the position as far as school children are concerned indicates the need for renewed efforts to achieve a high level of both the entrant and more especially the later reinforcement injections during school life. The immunity index is expressed as a percentage showing those children known to have been protected within the previous five years.

Year	Age of Children			
	Under 1	1—4 years	5—14 years	Total
	per cent.	per cent.	per cent.	per cent.
1960 ...	20.58	58.16	48.38	49.13
1959 ...	15.09	55.51	51.43	49.91
1958 ...	9.69	53.35	59.27	54.72
1957 ...	7.80	56.92	65.84	59.46
1956 ...	4.33	57.09	71.5	63.15
1955 ...	5	59	74	65
1954 ...	6	63	68	62

For the twelfth successive year no case of diphtheria was notified in the county. Elsewhere in the country there have been local outbreaks which give cause for alarm, and which emphasise that there must be an increase in the number of children in Cumberland protected if we are to remain free from diphtheria.

(b) **Whooping Cough Vaccination**

Protection against whooping cough by the use of plain pertussis vaccine is on a relatively small scale and only 593 children were so protected. There were, however, 2,664 children who were protected by combined diphtheria pertussis antigens.

(c) **Tetanus Immunisation**

At the end of the year plans had been made for introducing tetanus vaccination for children in the county clinics and schools. From 1st January, 1961, this scheme has been in operation.

There are two main arms of the scheme. Firstly pre-school children can be given tetanus vaccination in the clinics, either as a single antigen or more frequently combined with diphtheria and whooping cough. Secondly school children, entrants or older, who may have previously received diphtheria but not tetanus immunisation are offered protection against tetanus.

The medical officers working in the clinics have been recommended, as general policy, to follow Schedule B of the Wellcome Symposium on Immunisation in Childhood (see separate sheet), and health visitors are making mothers of young children aware that this comprehensive and long term scheme of injections is available at the clinics. The mothers retain complete freedom of choice between the services of the medical officers in the clinics and those of the family doctor. I hope that by offering the complete range of injections at the clinics some of those mothers who seem slow to visit their family doctor for this purpose will be willing to have the necessary injections given at a clinic. The urgent issue is that the children be immunised somewhere.

I know that the casualty surgeons in both East and West Cumberland are anxious to establish a register of children protected against tetanus so that they may increasingly dispense with the use of anti-tetanus serum in cases of injury. I hope to work out in detail with them during 1961 an arrangement whereby this register can be established from the records of tetanus protection accumulated by the local health authority.

(d) **Smallpox Vaccination**

Vaccination against smallpox continued to be available either at the clinics or in the surgeries of general practitioners, and during the year 1,643 persons had a successful primary vaccination, together with 238 who were revaccinated. Included in the total figure are 1,402 infants under 1 year; this figure is down by over 300 on the previous year.

The schedule of vaccination and immunisation procedures mentioned above in connection with tetanus protection, allows of vaccination against smallpox being carried out any time within the first five years, but many doctors feel that it should still be done very early if only to ensure that it is not missed completely. It will be necessary to watch carefully the tendency shown in this year's figures for the number of infant vaccinations to drop, to see whether there are any signs of these children receiving their protection later in pre-school life.

(e) **Poliomyelitis Vaccination**

At the beginning of February the Ministry of Health extended arrangements for vaccination against poliomyelitis by offering it to all persons who had not reached the age of forty, and also to certain additional small groups.

SCHEDULE B

ge	Visit	Vaccine	Injection	Interval
6	1	Triple (diphtheria, tetanus & pertussis)	1	4weeks or more
ns	2	Triple (diphtheria, tetanus & pertussis)	2	4weeks or more
	3	Triple (diphtheria, tetanus & pertussis)	3	
10	4	Poliomyelitis	4	4weeks or more
ns	5	Poliomyelitis	5	
18	6	(Triple (diphtheria, tetanus & pertussis)	6	
ns		(Poliomyelitis[x]	7	
	Smallpox some time during the first 5 years			
pol	7	Diphtheria & tetanus	8	
ntry	8	(Diphtheria & tetanus		
9yrs		(Smallpox (re-vaccination)	9	
15yrs	9	B.C.G.	10	

ere is no doubt that a fourth dose of poliomyelitis ccine will be necessary, but the exact timing of this se has not yet been decided.

As a result, additional sessions for vaccinations were established in the clinics and these, together with the already established sessions, were publicised throughout the county by means of notices in the local press and by handbills which were distributed throughout the areas. The response was very disappointing and it was decided after the summer holiday period was over to arrange a more intensive campaign in the county, and at the same time to approach the management of the various factories and industrial establishments and to suggest to them that where the numbers justified it, the assistant county medical officers might visit the factories, etc., and offer vaccination to all employees who wished it. This campaign resulted in a slightly better response, but even so the number vaccinated was disappointing and during the year the total number of persons aged 18 or over who were protected increased by slightly less than 6,000.

Based on the Registrar-General's estimated mid-1960 population, slightly over 74 per cent. of children in the age range 1 to 4 years had received two or three injections by the end of the year, and in the age range 5 to 14 years (i.e., children born in the years 1955 to 1946) this figure was 88 per cent. A total of 21,233 persons between 15 and 27 years have also received two or three injections, and based on an estimated population this represents over 48 per cent. who have had some protection. During 1960 over 35,000 individual injections were given throughout the county.

The following table illustrates the known state of vaccination against poliomyelitis at the end of the year and shows comparative totals for the years 1958 and 1959.

Poliomyelitis Vaccination

Age Group	Total number of persons vaccinated		
	Received three injections	Received two injections	Total
Children and young persons born in years 1943—60 ...	43762	7202	50964
Young persons born in years 1933—42 ...	9513	3937	13450
Persons born before 1933 who have not passed their 40th birthday ...	2641	3278	5919
Others ...	967	395	1362
Total as at 31.12.60 ...	56883	14812	71695
Total as at 31.12.59 ...	39297	23225	62522
Total as at 31.12.58 ...	2294	44010	46304

SECTION 27

AMBULANCE SERVICE

This authority must now be one of the very few, if not the only one, still running the ambulance service wholly on a contractual basis.

When the National Health Service Act of 1946 placed upon all local health authorities the duty to run ambulance services, this authority decided to meet its obligations by asking the voluntary committees and agencies which had previously been running ambulances to continue to do so, but as agents for the County Council. To meet the need for transport for sitting cases arrangements were made with garages and taxi proprietors for cars to be available at an agreed cost per mile.

There must have been some doubt then as to how long such a system could survive, as it was stated that these arrangements were of an interim nature and that if experience later proved it necessary two ambulance stations, one in East Cumberland and one in West Cumberland, would be opened to run a centralised and directly controlled service.

The expansion of the service was fairly rapid, especially the sitting case car service. It had not been in operation long before it was felt necessary to set up transport bureaux at the Cumberland Infirmary, Carlisle, and at Whitehaven Hospital to co-ordinate all requests for transport and in general effect economies wherever possible in the running of the service, both ambulance and sitting case cars. There had been no sitting case service prior to 1948, but by 1950 the cars were covering about 492,000 miles a year in the county, and were costing almost £20,000. After the transport bureaux were set up all requests for transport passed through the hands of the clerks there, except in emergencies when doctors were allowed to call out either an ambulance or a sitting case car. It was a tribute to the efficiency of the bureaux that, although the number of patients carried increased from 24,000 in 1950 to 50,000 in 1960, the mileage was actually cut by 35,000.

Apart from this introduction of bureaux clerks to control the calling out of ambulances and sitting case cars, the service has continued in basically the same form as was set up as an interim arrangement. The contractors have in most cases changed, and now consist of nine private individuals or firms, one urban district council, one voluntary committee, and the two Hospital Management Committees. This has meant some redistribution of the ambulances as contractors have not necessarily been in the same towns or villages as their predecessors.

At the present time the authority has 24 ambulances, of which 7 are of the dual purpose type and are able to carry either sitting cases or stretcher cases.

The following table shows that during the year under review there has been a fairly sharp rise in the number of journeys, the number of patients carried, and in the mileage. Most of these increases are in sitting case work and seem to be due in the main to increased demands caused by the opening of the new West Cumberland Hospital at Hensingham.

	Ambulances			Sitting-case Cars			Hospital Car Service			Summary of all Services		
	Total No. of Journeys	Total No. of patients carried	Total mileage	Total No. of Journeys	Total No. of patients carried	Total mileage	Total No. of Journeys	Total No. of patients carried	Total mileage	Total No. of Journeys	Total No. of patients carried	Total mileage
1959 ...	12951	22099	256174	15246	48701	416094	766	1902	41353	28963	72702	713621
1960 ...	13241	23098	259533	17834	58791	472578	688	1787	36428	31763	83676	768539
Increase or decrease compared with previous year ...	+290	+999	+3359	+2588	+10090	+56484	—78	—115	—4925	+2800 (9.7%)	+10974 (15.1%)	+54918 (7.7%)

The cost of the service has been showing a fairly rapid and steady increase over the years—from about £30,000 ten years ago, to over £65,000 in the financial year ended 31st March, 1960, and while I do not think there is any lack of effort or efficiency by the contractors I consider that the day is not far distant when the authority must look carefully into the possibility of providing a centralised and directly run service in the county.

Civil Defence Ambulance Section

At the end of the year the total strength of the section was 490, an increase of 30 volunteers over the previous year. During the year four volunteers attended Home Office courses at central schools.

The ambulance section took part in exercises and in an elminating competition which was held to select the team which was to represent the county in the regional tourney, Cockermouth was again successful. In the Tourney the Cockermouth team was placed second in competition with the representatives of 11 other divisions.

SECTION 28

PREVENTION OF ILLNESS, CARE AND AFTER CARE

Tuberculosis

Work in connection with the control of tuberculosis continues to be an important part of the local health authority's duties under this heading. The comprehensive reports of Dr. Morton and Dr. Hambridge on the Chest Services in East and West Cumberland respectively (which are printed as Appendices) once again bring the picture of tuberculosis control in the county up to date. To both of them I am much indebted not only for their excellent reports, but for their unfailing helpfulness and co-operation in all the aspects of tuberculosis control in which we have a joint responsibility.

The notifications of pulmonary tuberculosis in Cumberland have fallen from 267 in 1951 to 123 in 1960. The steepest decline has been since 1957. Again, as far as deaths from pulmonary tuberculosis are concerned, there were only 15 in 1960 compared with 80 in 1951, though the year 1952 saw the most dramatic fall (from 80 to 43) in this period. The following table shows the notifications of pulmonary tuberculosis by sex and age. I think this is still a significant table to show because it emphasises the age groups in both sexes which are contributing the largest number of notifications.

Notifications of Pulmonary Tuberculosis by Sex and Age

	0-4	5-9	10-14	15-19	20-24	25-34	35-44	45-54	55-64	65 & over
Males	1	—	—	4	3	5	15	14	12	17
Females	—	3	2	4	9	16	7	8	3	—

B.C.G. vaccination was given at the Chest Clinics to 698 contacts of tuberculosis cases and to 25 nurses. The scheme for B.C.G. vaccination for 13 year old school children continues and 2,384 children received a skin test in 1960. Of these 1,963, i.e., 82 per cent. were negative, and it was possible to vaccinate all but 10 of these children.

There is a suggestion that we are now getting down to a " hard core " of tuberculosis sufferers who are difficult to ascertain by the methods which have proved so effective in recent years in reducing both morbidity and mortality rates. Females in the third decade and men over 50 are the groups most productive of cases now. It is to be hoped that the protective effects of B.C.G. vaccination at 13 years will carry over into the third decade and so ultimately reduce the incidence in the former group. Time enough has not yet elapsed since the B.C.G. vaccination scheme started to answer this. One small group of the older men, namely, those in Part III Accommodation, are being offered a chest X-ray and some success has already been achieved in surveying many of them. I trust that as the general unobtrusive care of elderly people becomes increasingly a responsibility of the health visitor in conjunction with the voluntary workers in this field, it will be possible to gain the confidence of the elderly in such important matters as the use of the mass radiography unit on its regular circuits.

After Care of other Illness

The demand for various articles of loan equipment has continued throughout the year and the following table gives some idea of the main items of equipment on loan :

Equipment	1958	1959	1960
Commodes	38	15	34
Crutches	5	8	11
Dunlopillo Mattress	25	28	28
Invalid Chairs—			
Adult	67	69	71
Junior	6	10	11
P.C.P. Air Mattresses	—	—	3
Tripod Walking Sticks	15	35	53
Hospital Beds	6	10	12

In addition, such items as hydraulic hoists, adult cots, Dunlopillo pillows, adjustable walking sticks, lazy tongs, combined knife and fork, stocking putters-on, and many other aids to the elderly and disabled, have been requested and supplied. The larger items of equipment are issued from Carlisle, but the district nurses hold a small stock of Dunlopillo rings, cushions, bedpans, urinals, bed cradles and plastic sheeting to meet immediate needs.

Some difficulty has been experienced concerning the type of invalid chair required. In many of the smaller houses in the

county, space is a problem and doorways are narrow, consequently the demand for a self propelling type of chair that folds up has increased considerably during the year. The junior chairs are still required, however, not only for children, but also for the frail old lady who finds the adult type somewhat unwieldy.

Convalescence

During the year arrangements were made for 38 persons each to have two weeks recuperative holiday at convalescent homes. 36 went to Silloth Convalescent Home, and two to homes outside the county. All were assessed according to their incomes, and contributed towards their stay in accordance with the County Council's scale of charges.

Orthopaedic Treatment

The following figures do not need any explanation, although it is worth while drawing attention to the fact that there have been no known cases of tuberculosis of bones and joints in children under five years of age since 1954. The steady decline in the numbers both of school children and adults so affected continues.

Number on aftercare register 1.1.60.	1803
New cases during 1960	198
New cases notified for physiotherapist only	162
Cases re-notified after previous discharge	17
Number of cases removed from register	497
Number remaining on register 31.12.60.	1683
Number of attendances at Surgeon's Clinics	1121
Number of attendances at aftercare clinics	3656
X-ray examinations during 1960	152
Home visits	1150
Plasters applied	86
Surgical boots and appliances supplied (including insoles)	733

Conditions affecting children under five years of age

Flat feet	108
Bow legs and knock knees	150
Poliomyelitis	1
Scoliosis, lordosis and kyphosis	2
Congenital defects of feet and otherwise	19
Congenital dislocation of the hip	7
Torticollis	3
Cerebral palsy	16
Postural defects	7
Hallux valgus and deformed toes	18
Birth palsy	2
Perthes and coxa vara	1
Arthritis	1
Other conditions	33
	368

Conditions affecting school children

Flat feet	321
Bone and joint T.B.	8
Injuries (including fracture)	7
Poliomyelitis	55
Knock knees and bow legs	246
Cerebral palsy	70
Other birth injuries	9
Torticollis	7
Spina bifida	6
Paraplegia	2
Perthes disease and coxa vara	15
Congenital dislocation of the hip	30
Congenital defects (including talipes and pes cavus)	93
Hallux valgus and deformed toes	47
Postural defects	74
Scoliosis, lordosis and kyphosis	13
Muscular dystrophy	2
Schlatter's disease	2
Arthritis, synovitis, rheumatism	4
Slipped epiphysis	1
Other conditions	55
	1067

Conditions affecting adults

Flat feet	15
Bone and joint T.B.	63
Poliomyelitis	19
Scoliosis, lordosis and kyphosis	12
Congenital defects of feet and otherwise	11
Congenital dislocation of the hip	12
Injuries and fractures	19
Cerebral palsy	16
Postural defects	1
Vertebral disc protrusion	33
Hallux valgus and deformed toes	7
Birth palsy	2
Osteomyelitis	2
Perthes and coxa vara	2
Arthritis	15
Spina bifida	6
Synovitis — rheumatism	1
Slipped epiphysis	1
Dystrophies	3
Achondroplasia	1
Paraplegia	2
Other conditions	5
	248

Prevention of Blindness, and Care and After-care of Blind or Partially Sighted Persons

A. Follow-up of Registered Blind and Partially Sighted Persons.

	Cause of Disability			
	Cataract	Glaucoma	Retrolental Fibroplasia	Others
(i) Number of cases registered during the year in respect of which Section F of Form B.D.8 recommended :—				
(a) No treatment	8	1	—	30
(b) Treatment (Medical. surgical or optical)	16	6	—	21
(ii) Number of cases at (i) (b) above which on follow-up action have received treatment	7	6	—	12

B. Ophthalmia Neonatorum.

There were no cases notified during the year.

Health Education

The following talks were given during the year :

Child Welfare Centres	21
Ante-Natal Clinics	158
Schools	111
Voluntary Organisations	148
County Constabulary	6
Cunmberland Infirmary Student Nurses	6
Whitehaven Hospital Student Nurses	2
Wigton Secondary School Pre-nursing Course	9
Further Education Centres and Colleges	10
Gateshead District Nurse Students	1
Total	472

The development of Health Education in 1960 has shown that there is an ever growing awareness of matters pertaining to health within the county. Because of the greater demand for talks it was found necessary to obtain more filmstrip projectors and filmstrips; also other visual aids such as flannelgraphs, leaflets and posters, to meet this growing situation. The number of filmstrip projectors has been increased to four, and it is considered necessary to increase this still further by purchasing another five projectors and more filmstrips and to site them at easily accessible centres in the county. This will enable the nursing staff to use this type of visual aid more constantly and avoid the difficulties of transit of projectors, screens and filmstrips from one end of the county to another.

In seven Child Welfare Centres small discussion groups have been formed by mothers. These groups are encouraged to choose their own health topics, which the health visitor presents as a short talk using filmstrips, pictures, flannelgraphs, posters and leaflets, and other demonstration material to give emphasis to the special points for discussion. These friendly groups provide greater social contact for those mothers who need it and help in dispelling many of the doubts and out-of-date ideas which are found in some of our small and rather isolated communities. The number of these groups is increasing.

In eight ante-natal clinics relaxation exercises with mothercraft are taught by the midwives. In Whitehaven centre the mothers who are booked for hospital confinements join the classes and this splendid and happy arrangement enables the groups to

see a lively active bundle of humanity called "a new baby" being bathed in hospital instead of an inanimate doll. Filmstrips, flannelgraphs, the gas and air machine, and other articles of nursery equipment all help to give interest in the knowledge which is imparted to these mothers-in-waiting; they themselves have often expressed their thanks to the midwives who are giving this valuable service.

In 1960 a more organised approach to talks in schools has proved of interest to the children and teachers alike. Twenty-two schools in thirteen areas have accepted the offer of health talks by the health visitor/school nurse. As the demand grows it becomes more apparent that the nurses must be constantly in search of new ideas and demonstration material to make the talks attractive; this is most important especially for the younger children. Preparation of flannelgraphs, mounted pictures and models, all take time and there is little opportunity for this among the many increasing duties the staff are called upon to do. The talks are planned to interest three different age groups—the seven year olds, the nine to ten year olds, and the thirteen to fourteen age group. Some of the essays and attractive booklets made by the middle age group have shown that the talks have made the children aware of matters of personal hygiene, the value of well balanced meals, the importance of health and the measures we can take to avoid infection and the prevention of home accidents.

The demands for talks to voluntary organisations have again been many and a variety of health subjects were requested. It is a pleasure to talk to these diverse groups and it is hoped they will continue to ask for more and more talks on all aspects of health maintenance, particularly mental health, cancer with especial reference to "smoking and lung cancer" and the preparation for retirement and the uses of leisure.

Every effort is being made to keep the morbid connection between cigarette smoking and lung cancer in the forefront of all ventures in health education whether in group talks and discussions or at the individual level. It is proving rather dismaying, however, that to apparently convince of this relationship is not sufficient to dissuade many cigarette smokers from the habit. Shock tactics have not been resorted to in any great measure in stressing this subject, but I am giving much thought to the best approach to school children based on some sort of estimate of the actual smoking habits of school children.

In some areas in Cumberland the district nurses have been requested to help with Home Nursing Courses arranged by the British Red Cross Society for Civil Defence groups. These courses were well attended and greatly enjoyed by the participants, many commenting on the usefulness of the knowledge they had gained.

Mention must be made of the continued series of talks given to student nurses at the Cumberland Infirmary and Whitehaven Hospital on the "Social Aspects of Diseases". These lectures are also given to the girls attending the pre-nursing course at Wigton Secondary School. The talks enable the students to develop a wider understanding of the cause and effect of illness on family life and that patients are members of a family group and not just interesting diseases.

The County Constabulary have again had instruction on "Emergency Midwifery". Although this demand of their service must indeed be very rare, it is knowledge which is considered important for them to hold.

The series of Health Talks given in Further Education Centres in 1959 were completed in the early months of 1960 at Whitehaven and Workington Colleges of Further Education. Attendances at the five talks were small at both these centres, but much lively discussion took place among the audiences, particularly in topics such as Smoking and Lung Cancer, Prevention of Road and Home Accidents, Slimming and Food requirements, and Mental Health care.

The progress of Health Education in Cumberland is no easy matter to organise, for much of the county consists of rural areas and scattered communities, but district nurses, midwives and health visitors continue to visit the homes and give individual advice. As the secondment of health visitors to groups of general practitioners develops, so will health education be inculcated to as wide a public as possible, especially to those who are unable or unwilling to attend group meetings; these are the homebound aged persons, the problem families and others who find it difficult to attend welfare centres and the many social organisations which meet up and down the county. An approach is being made by district nurses and health visitors in health talks in Old People's Clubs. This it is hoped will become a regular part of the health education activities of the county.

Nursing staff group meetings have enabled the public health nurses to meet and discuss the planning and organisation of health education and the use of visual aids. Many ideas and techniques have arisen from these meetings.

A Health Education Display was presented to the public at the opening of Flatt Walks Clinic, Whitehaven. This small type of display is attractive, but such occasions are few and all centres are not equipped to make frequent displays possible.

There has been an increase in the volume of Health Education undertaken throughout the county in the year. The groups have been small and the subject matter has been simple in design, but possibly more effective than the larger campaigns which have been produced from time to time. Such publicity is costly and time consuming in its preparation and the results appear less satisfactory in the long term view.

Prevention of Break-up of Families

Regular meetings continue to be held in all parts of the county where all of the workers concerned in the family care of the less satisfactory households meet to discuss their problems. Time does not lessen the conviction that these meetings are highly valuable.

An important advance during 1960 by the Welfare Department in the matter of preventing family disruption was the building of temporary accommodation at Highfield House, Wigton, for evicted or otherwise homeless families. There are three units, one for eight persons and two each accommodating four. The building was well advanced at the end of the year. This offers an opportunity of keeping together some families who would otherwise be separated by domestic upheaval, and of giving them special supervision and advice while there. The families will pay a rental for the accommodation and be responsible for their own domestic arrangements such as cleaning and cooking. There will be many difficulties in maintaining a flow of families needing this type of assistance, but it is a provision which should prove very helpful so long as it is carefully controlled.

Chiropody Service

After considering an announcement by the Minister of Health that he was prepared to approve proposals by local health authorities who wished to establish chiropody services as part of the arrangements for the prevention of illness, the County Council decided to begin such a service on 1st November, 1960.

At the outset it was decided that the service should be provided free and that it should be for three priority groups — the elderly (men of 65 years of age and women of 60), expectant mothers and the physically handicapped. Voluntary schemes for the elderly were already being run by Old People's Welfare Committees in some areas of the county and arrangements were made for their responsibilities to be taken over by the authority, although in four areas the committees were asked to continue to arrange for the treatment to be given, but as agents of the authority and covering all cases in their areas, not merely their members. This was necessary for a technical reason, but it did not affect a person's chance of getting treatment and the full cost was borne by the authority. All applications for treatment had to be on grounds of need, supported by a certificate from a doctor or a nurse and those requiring treatment were expected to make their own way to the treatment centre, except where a home visit was specifically recommended by a doctor.

To begin the scheme, arrangements were made with 13 chiropodists who were in private practice for them to treat patients referred under the county scheme. This led to the establishment of, in effect, 20 "treatment centres", 8 of them being in County Council clinics, where chiropodists worked sessions for the authority, and 12 of them in surgeries where the chiropodists treated the county patients alongside their private patients.

The service began on 1st November and by the middle of the month it was obvious that the sessions reserved with local chiropodists were insufficient to meet the demand. A full-time chiropodist was therefore appointed, in addition to those working sessions on a part-time basis, but he did not actually take up duty until early in 1961. By the end of the year — only two months after the service had begun—624 people had been recommended for treatment. Of these 602 were classified as elderly, 5 were expectant mothers and 17 were handicapped persons. These figures include a total of 187 who were unable, on medical grounds, to travel to a clinic or surgery and had to be treated at home. This was a higher proportion than had been expected and led to difficulties in some areas because of the time taken to deal with each case.

The rapid initial "build-up" of the service confirmed the need for it, especially among the elderly, and first impressions are that it is much appreciated and serving a very useful purpose.

Venereal Diseases

I am indebted to Dr. H. J. Bell, Consultant Venereologist, for his permission to publish the following extracts from his annual report to the Special Area Committee of the Newcastle Regional Hospital Board:—

For some years the following table has had a place in my Report:—

TABLE I

Year	Early V.D. Infections		Total Attendances	
	Carlisle	Whitehaven	Carlisle	Whitehaven
1951	65	20	2436	1141
1952	51	13	2081	870
1953	43	17	1924	976
1954	48	18	1461	619
1955	48	26	1202	641
1956	60	23	909	450
1957	45	17	741	362
1958	45	22	806	301
1959	69	20	893	398
1960	74	20	920	471

The expression "Early V.D. Infections" includes patients attending for the first time with gonorrhoea, non-specific urethritis, and syphilis (of less than one year's duration). No cases of early syphilis were encountered during the year. The figure of 20 early V.D. infections dealt with at Whitehaven Hospital included only three cases of acute gonorrhoea; this figure cannot bear any real relationship to the incidence of the disease in West Cumberland, but must be regarded rather as an indication of the numbers who are treated by their own doctors. Of much greater concern to myself is the fact that not one single female applied for treatment of gonorrhoea at Whitehaven. The volume of work carried out at that Clinic continues to show a marked increase, however, as judged by the figure for total attendances. At Cumberland Infirmary, Carlisle, the early V.D. infections are the highest in the Table, being made up of 42 cases of gonorrhoea, and 32 cases of non-specific urethritis. This continues the trend of a slowly rising graph in gonorrhoea which has been noted since 1953.

The totals of new cases, venereal and non-venereal, are included together in the following Table:—

TABLE II

Year	New Cases seen for the First Time	
	Carlisle	Whitehaven
1951 ...	293 ...	154
1952 ...	274 ...	95
1953 ...	250 ...	92
1954 ...	219 ...	87
1955 ...	168 ..	74
1956 ...	136 ...	78
1957 ...	173 ...	61
1958 ...	191 ...	45
1959 ...	213 ...	63
1960 ...	248 ..	72

The very obvious increase in new cases attending at Carlisle does not derive from any one specific condition—but all categories of disease, venereal and non-venereal, showed a similar increase.

In my recent Reports, very little mention has been made of syphilis, except the comment that the early infectious disease is hardly ever seen in Cumberland. There were no such cases in 1960. It is to be noted, however, that a recrudescence has been reported from both the U.S.A. and Italy in the last three years. A minor rise in the English figures—especially in London—may be the result of the difficulty in differentiating syphilis and yaws among immigrants, and its significance must still remain speculative.

In one type of this disease the trend in Cumberland differs from that of the rest of the country. Since 1956, late syphilis—especially neurosyphilis—has been seen in the Cumberland Clinics in increasing numbers. The most common diagnosis is " General Paralysis of the Insane ". The British Medical Journal has contained two reports by psychiatrists in the last twelve months, drawing attention to the apparent increase in this condition. These reports refer to the obviously deranged type of patient. In this area, there has been encountered a series of patients showing so little evidence of mental deterioration that the diagnosis was made almost, as it were, by instinct. Characteristic physical signs were absent in most. These very mild examples of G.P.I. lead to the

suspicion that there may be many more sufferers at large who have escaped diagnosis. By contrast, tabes dorsalis is a rare condition. During the past year, two serious cases of congenital neurosyphilis were diagnosed in school children at Whitehaven. It is in the diagnosis and treatment of later syphilis, of course, that the experience of a venereologist is most rewardingly employed.

In my Reports for 1958 and 1959 I commented on the distressing increase in V.D. reported by the Minister of Health's statistics referring to England and Wales as a whole. Apparently there are more patients attending the V.D. clinics now than there were just before the war. Comparatively rural areas, like Cumberland, do not share in this continuing trend, nor in the new features which are being held as responsible—at least partially—for the new situation. Truthfully, no one knows precisely what the underlying cause must be, just as no one knows why early syphilis should tend to disappear while other forms of Venereal Disease become more common. But certain new features have been given prominence in reports by Venerologists in the bigger City Clinics and by the Minister himself. They are such as the high incidence of disease among coloured immigrants, the resistance of the gonococcus to penicillin, the part played by homosexuals (especially in London) in the dissemination of syphilis, and teenage promiscuity and infection. To these I should personally want to stress again the by-passing of the official clinics, especially in semi-rural areas like our own, and the prevalence of treatment by the family doctor : my comment on the Whitehaven Clinic (above) serves to underline my plea, and illustrate why the practice makes nonsense of any hope of controlling the disease.

I have dealt with the question of coloured immigrants and penicillin resistance in a previous report. The question of increasing promiscuity among teenagers is a difficult one to analyse realistically, because, although social workers, venereologists and others involved are quite certain in their own minds that this promiscuity is a factor, among others, in the social sickness of the community, statistics to illustrate their day-to-day experience are hard to come by. The promiscuous person only contributes to a statistic if he or she comes to grief. (Anyone especially interested in this problem should read "Symposium on V.D. and the Teenager" in the Royal Society of Health Journal of September-October, 1960). For instance, in one London Clinic, nearly 20 per cent. of V.D. infections treated among women were from the

teenage groups, and most of these girls were suffering from gonorrhoea. A report from the Medical Officer of Holloway Prison stated that, in the examination of prostitutes under detention, the majority were in the 15-20 years group, and added, that since 1957, this age group has shown an absolute and relative increase. Other figures of V.D. teenage infections in this country analysed by the British Co-operative Clinic Group showed that increases of this kind were in the 18-19 age group. Of the 42 cases of gonorrhoea seen in Carlisle in 1960 there were 8 females and one male in the age group 15-19 years. All 8 females had been sent for examination from the local Remand Home at Mill House. Apart from patients from this institution, however, there were no female teenage patients seen at the Clinic.

It is important to understand clearly what is meant by the terms "promiscuity" and "teenager". Sexual intercourse with a constant partner may be immoral, but does not produce much V.D. This kind of thing has always been fairly common among the 18 and 19's in the population I serve. The truly promiscuous are those who associate with a variety of partners and they are the people who spread the disease. Boys and girls mature much earlier than they used to, they earn good wages earlier, and they marry earlier. For these, and other reasons, I find it difficult to consider a young man of 18 years as a teenager. The public Press gave a good deal of publicity to that part of the Minister of Health's Report (1959) which dealt with promiscuity and V.D. among teenagers. Interpretation of this kind of comment must be guarded for the reasons given. The Central Council of Health Education, with the co-operation of other interested organisations, is leading an investigation on this problem of promiscuity among young people, and the result is anticipated with interest and some anxiety.

It is encouraging to report, however, that in this area the factors suggested for the increased incidence in V.D. elsewhere—

coloured immigration, teenage promiscuity, and homosexual infection—do not have to be reckoned with. Penicillin resistance to the gonococcus has been noted, but only occasionally. The trend for cases of gonorrhoea to rise has probably nearly reached its peak — as in Scotland — since the early months of 1961 have already shown a decline in numbers of cases. Table III, herewith, illustrates the situation—

TABLE III

Fresh Cases of Gonorrhoea

Year	England and Wales	Scotland	Carlisle
1952	19095 ...	2863 ...	26
1953	19263 ...	3251 ...	16
1954	17536 ...	2798 ...	22
1955	17845 ...	2545 ...	21
1956	20388 ...	2708 ...	38
1957	24381 ...	2831 ...	25
1958	27915 ...	3324 ...	28
1959	31320 ...	3382 ...	34
1960	33640 ...	2937 ...	42

The figures given, nevertheless, only suggest a trend and the true epidemiological incidence of gonorrhoea remains unknown. to add 20—30 per cent. of these figures would probably produce a figure somewhere near the true incidence.

MENTAL HEALTH SERVICE

On 1st November the Mental Health Act, 1959, replaced complicated and out-dated legislation. The theme of the new Act can be summarised as follows:—

(a) the treatment of mental disorders should be available with as little formality as applies in the case of any other form of illness;

(b) the care of the patient should be undertaken within the community whenever possible, and hospital admission (for treatment rather than custodianship) reserved for patients requiring medical or nursing treatment which cannot be given outside hospital.

Circuiar 9/59 from the Ministry of Health laid out a framework for the planning and development of Mental Health Services provided under Section 28 of the National Health Service Act, 1946, soon to be amplified by the Mental Health Act, 1959, which later became operative in full on 1st November, 1960. The County Council's suitably modified proposals on the Mental Health Service were approved by the Minister in July, 1960, and the Ministry of Health now asks that an account be given of progress in implementing the recommendations contained in Circular 9/59. The coming into operation of the Mental Health Act 1959, in the year 1960 provides undoubtedly the most outstanding event in the work of the department in the year, and I set out below in some detail the progress made, using the same main headings as used in Circular 9/59.

(a) Junior Training Centres

Whilst not wishing to suggest a precise order of priority for meeting various needs within the mental health services, the Minister advised local health authorities to keep to the forefront the need for adequate provision for the training of subnormal children. In Cumberland it had previously been decided that the child found unsuitable for education in school should, as a first priority in the mental health service, be given the opportunity of full-time training in a suitable centre. Even before Circular 9/59 was issued the authority was in the fortunate position of being able to offer full-time training in a day junior training centre to any mentally subnormal child in the county, this being an achievement of a high order when one realises the difficult geography of the administrative area.

The present junior training centres at Whitehaven and Wigton provide places for 65 and 25 children respectively, and an arrangement exists with the City of Carlisle for the training of two or three County children, who live within easy reach of the City, to be admitted to the City's Training Centre on a patient-day-cost basis.

The existing centres are expected to meet the training demand for all suitable juniors for the next few years. The Wigton Centre is purpose designed and the plan permits of easy extension. The Whitehaven Centre is a temporary war-time building of limited structural life and was adapted to its present use at the beginning of 1954. A permanent extension was added in 1957. It is thought that it may be necessary as time passes for a purpose designed junior training centre to be built in the area to replace the present building. More important than the building, however, are the new thoughts that are now freely in play regarding the training of subnormal children who attend. No longer do we think in terms of occupation for these mentally handicapped children. We now think of them as normal children with a handicap, and with this in mind the entire concept of their training is changed.

During 1960 the supervisor of Wigton Training Centre, Miss MacPherson, commenced a full academic year's training at Manchester for supervisors of junior training centres. When she returns in the summer of 1961 the supervisors of both training centres will have completed this training and will be able to guide their assistants in the most modern and up-to-date methods. It is hoped that the National Association for Mental Health will soon be able to establish in the North of England a part-time course for the staff of junior training centres which will be sufficiently near for them to attend.

Training centre staff meetings, including the staff of the residential hostel, are being held approximately six monthly, when there is an opportunity for full discussion of all problems affecting the administration and training at the centres. These meetings afford an opportunity to discuss policy trends in the training of the subnormal and such other matters as the place of speech therapy and physiotherapy for the children. I know that the staff appreciate these meetings and the sense of team consolidation which they bring.

One aspect of the training of the children in the centres which has interested me considerably is their physical education,

Following discussions with the Director of Education, and with the enthusiastic co-operation of the chief organisers of physical education, I and some of the staff have been given an insight into the modern approach to the physical education of normal children. The keynote seems to be guidance towards self expression in the field of physical activity involving a more complete range of body movements and producing more acute awareness of the position and usefulness of all parts of the body. As far as normal children are concerned this approach, with the elimination of much of the formal in physical education, suggests immediately many advantages in the realm of character formation as well as purely physical improvement, and the application of this to the subnormal child presents to my mind a challenging field of activity. So long as one is not over-ambitious about their achievements I think that there is a real field for developing this new look in physical education in the training centres and at the residential hostel described later. I am selecting, with the help of the physical education organisers, the most suitable equipment to purchase for the centres, and I expect that there will be further arrangements made for the demonstration and discussion of these methods with the training centre staff.

I have also considered the provision of speech therapy for the children at the training centres, and in the hopeful anticipation of a period of more stable staffing in this work I mean to arrange for more time than hitherto to be given to many of these children. I feel sure that the improvement of the communication of many subnormal children by this means is probably the most important gateway to fuller activities and ultimately a fuller life for them. Speech therapy for the severely subnormal is undoubtedly, however, a time consuming business, and the distribution of time and effort to the centres will have to be worked out step by step as the problem is more closely studied.

In association with the larger junior training centre at Whitehaven, a Parents' Association was commenced at the end of the year under the chairmanship of Mr. Froggatt, Mental Health Officer, and its activities have been greatly appreciated. Mr. Froggatt will guide the Association as chairman in the first year, and it is expected thereafter that it will be run entirely by the parents themselves who will no doubt look to the teachers and social workers for advice. From the commencement the Secretary/Treasurer of the Asociation has been a parent. The parents

are invited to meet once per month on a Thursday evening at the Centre, and a suitable series of helpful talks by such members of the staff as a speech therapist, the road safety officer, and others, will be interspersed with occasional social evenings and the showing of appropriate films.

I also feel that reference must be made here to special care units provided as part of a junior training centre. These are small units to cater for grossly handicapped children whose mental and physical condition has made it impracticable for them to participate in the training which is normally available in the centre. Though the demand may be very small, experience has, however, shown the great benefit of these units not only in providing care and the elements of training for these few children who would otherwise have to remain at home, but for the relief to the parents and for demonstrating to them the methods of training which can be continued at home. Most of these children can only attend the special care unit on a part-time basis, and I would recommend that the authority give consideration to the inclusion of a small unit of this type when future building of a purpose-built junior training centre is contemplated.

(b) **Adult Training Centres**

There is no separate provision for the training of adults, but spare accommodation in the junior training centres has been made available for the continuation of the training of subnormal patients beyond the age of 16 years. The scope of this form of training has been handicapped by the lack of suitable facilities and to some extent of male staff. It is not considered expedient to detract from their main purpose by making adaptations in the junior training centres since the presence of some adults in these centres is only regarded as a temporary measure.

Three main adult groups have to be considered :

(1) Those requiring training or retraining in work habits or who require some stabilisation to fit them for entry or re-entry to employment.

(2) Those who can be usefully employed in a local authority workshop but who cannot be trained for ordinary or sheltered employment elsewhere.

(3) Those needing considerable supervision to perform the simplest operation.

The achievement of the happy position of being able to offer training to all junior subnormals in the county brings closer the realisation of a separate centre for adult subnormals. Similar difficulties will be met here in achieving comprehensive training throughout the county as were encountered in the case of the subnormal children, but again the provision of residential accommodation promises that in a long term view an increasing number of adult subnormals will be catered for. This being so, the county has approved the establishment of an adult training centre in the most densely populated part of the county (West Cumberland) during the financial year 1961-62. Negotiations are in hand for the acquisition of a most desirable site which is ideally situated geographically, and which is capable of further development for this and other purposes in the light of future experience. Preliminary plans have been provisionally approved by the Ministry and these provide for the training of 50 adults (both sexes) at the outset, but make it possible to increase the number of places to 80 at a later stage with relatively little further expenditure.

(c) **Residential Accommodation for the Mentally disordered**

Beside the obvious need in our type of area for hostels in association with both junior and adult training centres, there must also be considered the duty of the local health authority to cater for the need for hostels and residential homes for a broad range of patients who " are or have been suffering from mental disorder ". This wide range is covered in our approved proposals by simple yet comprehensive terms to the effect that in addition to the existing provision " the authority proposes to provide when necessary either directly or otherwise residential accommodation for persons who are mentally dsordered, but who are not in need of hospital treatment or care and for persons recovering from mental illness ".

The hostel for juvenile subnormal patients at Orton Park opened as one of the first in the country, on 1st April, 1959. Its primary function is to provide hostel facilities for those children whose homes are beyond the catchment areas of the junior training centres to enable them to participate in full training at a day centre. Generally speaking, the residents return to their own homes at week-ends and during school holidays. A secondary but nevertheless valuable function is to provide facilities for the short term care of young subnormals without interruption of training, to cover periods of temporary domestic difficulties in the home.

Without such a hostel I should find it impossible to offer the necessary training to those of our subnormal children who live in the more isolated parts of Cumberland. That this venture has been eminently successful is evidenced by the fact that not a single refusal of the facilities offered has been received. Patient days for 1960 totalled 4,029 and 16 children (11 boys and 5 girls) who otherwise would have had no opportunity of receiving training, were in residence at the end of the Christmas term, together with three children (two boys and one girl) whose homes were within the catchment area of the Whitehaven training centre, but who for domestic reasons were in residence at Orton Park. All of these children in residence at the hostel were receiving daily training at the Wigton Centre, about six miles away. Short term care at Orton Park was given in 11 cases (seven boys and four girls), some of these children being admitted on more than one occasion during the year.

The establishment of this hostel for subnormal children presents an interesting field for the study of the needs of these children in various respects, and also of certain administrative problems in connection with the inevitably high unit cost when the training centres are closed for school holidays and the children are at home.

In the first place, with regard to the children themselves, the activities in which they should engage out of training centre hours have been discussed fully with the staff. Every effort is being made to place the emphasis on active play and games which involve the maximal exercise of the child's thinking capacity without overtaxing him, rather than the passive watching of television which, nevertheless, undoubtedly has an important role if suitably controlled, in both the amusement and the instruction of the subnormal.

I am glad to be able to note that the Women's Voluntary Service has shown a very helpful interest in the children at the hostel, not only in the matter of providing equipment for their activities, but in such other matters as arranging occasional outings and picnics for the children in new surroundings.

I am giving some thought at the moment to the ideal ratio of time at the hostel and at home for some of the older residents. I feel that as the pattern of life at a hostel develops on the lines mentioned above as an integral part of the training of these children, it may be well for some of them to return home only at fortnightly or perhaps occasionally even longer intervals so that

greater continuity of training from the educational and social points of view can be maintained.

Also, in this connection I am sure that the pattern of day to day care whereby housemothers have the care of small groups of children, is a correct one. I regard highly the importance of each child, in the circumstances of the hostel, being the object of the attentions of as limited as possible a number of adults so that something in the nature of a mother substitute can be recognised by the child. The attentions of the staff must be child centred. This pattern of care has been well established in some children's homes and seems clearly to come nearest to meeting the basic emotional needs of the children.

A study, known as the Brooklands Experiment, administered by the Mental Health Research Fund and carried out by the Fountain Hospital Research Group, compared the development of a small group of mentally subnormal children in a small residential unit with that of a similar control group living under institutional conditions. At the end of two years the Brooklands children showed marked improvement in verbal behaviour and in intelligence as compared with matched controls living in the main hospital. In social and emotional behaviour striking changes were recorded in the Brooklands group who had been subject to new patterns of education and management on lines similar to those used in residential nurseries and nursery schools for ordinary children of about the same mental age. The revealing lessons learned in this experiment have been discussed with the staff and it is very gratifying how readily they are becoming orientated to the most advanced thinking on this matter.

To achieve the comprehensive type of training which the advantages of a residential hostel offer for subnormal children requires that the staff of the hostel must receive every help towards a clearer understanding of the needs of the children. Since there are no courses yet specifically run for the training of the staffs of residential hostels of this kind, I planned at the end of the year a short inservice training course for the hostel staff, in which short talks will be given on child development and various aspects of the care of subnormal children by various members of the staff and also introducing contributions from the Superintendent of the Mental Deficiency Hospital and the teaching staff of Infants' Schools. Free discussion is planned and the staff themselves are keen for this project to go ahead. The proposed syllabus for this inservice course is shown below:

Session		Subject and Speaker
1	...	The physical, mental and social development of the child (Part 1). Dr. C. H. Mair, Assistant County Medical Officer.
2	...	The physical, mental and social development of the child (Part 2). Dr. C. H. Mair, Assistant County Medical Officer.
3	...	The needs of the child in care. Miss M. Silva-Jones, County Children's Officer.
4	...	The mentally subnormal child. Dr. T. T. Ferguson, Medical Superintendent, Dovenby Hall Hospital.
5	...	The local health authority's mental health service. Mr. N. Froggatt, Mental Health Officer.
6	...	Behaviour disorders in children and their management in the home. Mr. R. Milne, Psychiatric Social Worker.
7	...	The educational approach to child teaching. Miss A. S. Tickle, Headmistress of Wigton Infants' School.
8	...	Spasticity and other physical disabilities most commonly associated with mental subnormality. Dr. J. D. Terrell, Deputy County Medical Officer.
9	...	Summary. Dr. J. Leiper, County Medical Officer.

In addition, the Matron of the hostel attended a refresher course for the staff of children's homes where the growth and needs of children separated for any reason from their homes were studied. Although run for those caring for normal children, there was much which she found of value as applicable to the subnormal children at Orton Park. She also attended, along with the Supervisor of the Whitehaven Training Centre, a course for supervisors and assistant supervisors of training centres held near Ripon, Yorkshire. This two-day course dealt most helpfully with various activities such as physical education, art, speech training, and the place of the three Rs in the training of subnormal children.

As was to be expected, the unit cost of maintaining this residential hostel is high, and this was one of the factors which suggested the idea that subnormal children from other authorities, particularly highly industrialised towns and cities, might benefit from spending a holiday at Orton Park during the times when our own residents were at home for training centre holidays. I am

making this plan, which has been approved by the Health Committee, known to the Medical Officers of Health in the North of England, and I am confident that the advantages of this scheme will appeal to some of them. Not only will subnormal children from other areas who rarely or never get a holiday benefit from such a scheme, but the economics of the hostel itself will be assisted.

It was thought that our next venture in providing residential accommodation might take the form of a hostel for post psychotics, and a provisional capital sum for such a hostel for 25 patients was included in the 1962-63 programme. Because of some uncertainty about the project in the light of the experience of other authorities it was later decided to leave the scheme in the 1962-63 programme, but to reduce it in size to accommodate 17 patients. More detailed consideration is being given to the function of such a hostel in relation to the social and clinical needs of the patient (short stay or long stay or some combination of both). The position at the time of writing is that the matter stands referred to a small sub-committee of members of the Mental Health Sub-Committee which will have the advice of consultant psychiatrists representing the Garlands and West Cumberland Hospitals and a representative of the Ministry of Health in addition to the authority's own officers.

(d) **Home Visiting Services**

The shift of emphasis towards the care of the mentally disordered in the community inevitably demands considerable expansion of the authority's mental health staff, on whom falls the main burden of domiciliary support to those living in the community. Three types of officer are at present involved in Cumberland—psychiatric social workers, full-time mental welfare officers, and a number of officers whose limited mental welfare duties are part-time and minimal in extent. The now infrequent duties of these duly authorised officers in connection with compulsory admission of patients to hospital will, I anticipate, ultimately be assumed by the mental welfare officers.

As long ago as 1958 the Council adopted schemes for the inservice training of both psychiatric social workers and mental welfare officers. This far-sighted policy has paid handsome dividends in the light of subsequent events. My present policy is to man the local health authority's mental health staff by adequately

trained officers who will undertake, to varying degrees according to skill and the extent of their training, whole-time duties in all fields of domiciliary mental health social work. Some measure of the increase in our commitments is given when it is pointed out that the establishment of full-time officers has changed in two years as follows:—

		At 1.1.59	At 1.4.61
Mental Health Officer	...	1	1
Psychiatric Social Workers	...	1	2
Metal Welfare Officers	...	2	5

All these posts are filled at the time of writing with the single exception of one psychiatric social worker. This vacancy is being reserved for a male student who is at present undergoing further training at Manchester University under the Council's scholarship scheme and who is expected to take up his duties in September, 1961.

(e) **Social Centres**

The provision of social centres is recommended as being a successful form of support for mentally disordered adults, particularly after hospital treatment. Whilst this is an experimental field which has proved to be of therapeutic value in the larger centres of population, the practical difficulties which we face in Cumberland (wide hospital catchment areas, low density of population, and the cost and difficulty of transport) present almost insuperable obstacles to the success of ventures of this kind. Our proposals indicate the willingness of the Council to provide " day centres, social clubs and other activities either directly or in association with other authorities or agencies for the mentally disordered living in the community and for persons recovering from mental illness ". If it is deemed desirable and practicable these services will be shared with those provided for other classes of handicapped persons.

Some progress is recorded in that facilities have been made available for the use of the Whitehaven Training Centre by the psychiatric unit of the West Cumberland Hospital on one evening each week as a social club for former patients of the unit. Although the club is run by its members, local health authority's social workers join those attached to the hospital in giving active support. A happy and social atmosphere prevails at meetings, which is undoubtedly beneficial to those attending, but experience

shows that the total membership can only remain relatively small in number for the reasons enumerated above. A limited membership is a restricting influence on the range of club activities which are possible, and this in turn makes it much more difficult to maintain active participation by the members.

(f) **Priorities**

The Minister expressed the wish in Circular 9/59 that the first priority be given to the provision of adequate training facilities for children up to 16 years. This having already been achieved in Cumberland, the assessment of future needs, particularly as regards residential accommodation, will require careful planning in consultation with the hospital authorities. The immediate way ahead seems quite clearly to be the secure establishment of a comprehensive visiting service by mental welfare officers for all of the mentally disordered who require this, while pressing on with the building of the first adult training centre and, as soon as possible thereafter, of residential accommodation to serve this centre. Hostel accommodation for post psychotic patients will be provided whenever the way is reasonably clear as to the extent of the need for this.

(g) **Co-operation with other Local Authorities, the Hospital Service, General Practitioners and Others**

Development of the mental health services provides an obvious opportunity for strengthening the links between the local authority's community services, the hospital service and the general practitioner in the best interests of the patient. Much has already been achieved in this direction and a good deal more can yet be brought about. To Dr. Braithwaite, who retires this year as Medical Superintendent at Garlands Hospital, I am grateful for his helpful co-operation, especially in the formulation of the early plans for implementing the new Act.

Certain of the points of contact with the consultant psychiatrists and general practitioners which have already been established should be mentioned. Dr. Ferguson, Medical Superintendent of Dovenby Hall Hospital, and Dr. Braithwaite, Medical Superintendent of Garlands Hospital, are members of the Mental Health Sub-Committee of the Health Committee, and I am recommending to the Health Committee that the membership is strengthened by increasing the representation of psychiatrists and general practitioners.

Both I and my Deputy attend the meetings of the Medical Advisory Committee at Garlands Hospital, where all of the consultant psychiatrists in the county, together with other hospital representatives and representatives of the general practitioners meet over the problems of the mental hospital. This has provided a useful opportunity to discuss aspects of mental health services which affect us all, and much useful discussion has taken place on the field of work of the mental welfare officers employed by the local authority. These latter will necessarily work closely with the psychiatrists in the help and support of patients who have been under their care and are being discharged again to their own homes, and particularly in West Cumberland they have been attending and participating in the discharge cases conference on patients from the psychiatric unit at West Cumberland Hospital. I do hope that increasing use will be made of the mental welfare officers by all of the psychiatrists in the county, and that a full case load will be built up with those working in East Cumberland from the increasingly numerous cases being discharged from Garlands Hospital.

I feel sure that these conferences are an ideal meeting place for all those who share responsibility in the care and aftercare of the mentally sick, including the family doctor. His rôle must surely be a key one in the aftercare of discharged patients as well as in the management of the many psychologically disturbed people who may never or seldom require the services of a psychiatrist but to whom I am sure the mental welfare officer may often be able to be of some help. I have given instructions that all the mental welfare officers should meet all the general practitioners in their area, for I am convinced that much valuable work by the general practitioner in the field of mental health both with regard to prevention and treatment can be assisted materially by the mental welfare officer. A most valuable link already exists with a large majority of the general practitioners in the county through the Mental Health Officer of the County Council, Mr. Froggatt, who has for a long time worked in close collaboration with them over the legal and administrative aspects of this work.

One other very useful link in East Cumberland has been the commencement of a psychiatric out-patients clinic in Penrith, held at the County Council Clinic there. This is to my mind an ideal arrangement for peripheral psychiatric out-patient consultation, and offers obvious advantages for continuing contact between psychiatrists and local authority social workers. It is, moreover, a convenient meeting place with general practitioners who may very

usefully come into the clinic for discussion as a most important part of the team dealing with patients' difficulties.

It is my intention in 1961 to commence the issue of a bulletin for general practitioners of information on local authority services, and this development of the mental health services will figure largely in this. The implications and general re-orientation of mental health services under the new Act is a complicated subject for the busy general practitioner to study, and I hope by these means to very briefly convey information on the local authority's responsibilities and aspirations in the mental health services.

General Observations

From the account given above it will be seen that some real progress has been made in Cumberland towards implementing the new and forward looking legislation of the Mental Health Act. Very significant therapeutic advances in the treatment of mental illness have been made in recent years and there seems no doubt that more and more cases of mental illness will be treated and cared for without admission to hospital. There must be a progressive build-up of community care if this desirable pattern of the future is to be realised. It is to be hoped that suitable courses will soon be available in all parts of the country to meet the urgent need for training of social workers in the mental health service, and also of the staffs of junior and adult training centres.

This is the first year in which it can be said that community care has been extended from the mentally subnormal to the mentally ill. Much careful and repeated evaluation of the meaning and content of community care for this class will be necessary as the months and years pass. The case loads provided by both G.P.s and psychiatrists for the mental welfare officers and psychiatric social workers have to be matched against an ultimate establishment of social workers. This entirely new field of work amongst the mentally sick in their own homes and places of employment must be explored and cultivated so that the work gradually becomes as definitely orientated to prevention as in the case of infectious diseases.

The demand for hospital accommodation for the severely subnormal is not, however, likely to decline since many severely mentally handicapped people are surviving into adult life as a result of therapeutic advances in the treatment of infections and other diseases. The problem in many of these cases is one of long continuing care, often for the entire lifetime of the individual.

The overall picture of the future of the mental health services under the Mental Health Act, 1959, is clearly one presenting an important challenge to each of the three branches of the health service, and particularly in the matter of the closest possible integration of the various responsibilities into a single efficient service.

Approval of Medical Practitioners

Eleven practitioners have been specially approved by the local health authority for the purposes of Section 28 of the Mental Health Act as having special experience in the diagnosis or treatment of mental disorder. Of these, seven are employed in the hospital (psychiatric) service, three are medical officers of the local health authority, and one is in general practice.

Statistics

Hospital Admissions and Discharges

The Mental Health Act was in operation for only the last two months of the year, but throughout the whole of 1960 it had been possible to admit patients informally both to mental hospitals and to hospitals for the subnormal. It is pleasing to record that on only five occasions throughout 1960 was it necessary to admit subnormal patients to hospital under procedures involving detention and that of these, four of the Orders were made by Courts following criminal charges. During the same period 21 patients (nine male and 12 female) were admitted informally.

The discharge of Orders authorising detention of subnormal patients in hospital and their transference to informal status continues where appropriate. During 1960, 62 Orders of detention (in respect of 21 males and 41 females) were cancelled, the patients remaining in hospital under informal conditions. There has been no evidence locally, as has been the experience in some areas, of a mass exodus of patients from hospital following discharge of their Orders for detention.

As regards the mentally ill, the pattern which has emerged as a result of the new legislation is very much as was expected, and informal admission continues to be the usual procedure. During November and December, 1960, only 18 patients (nine of each sex) were admitted to a mental health hospital under Sections 25

and 29 of the Mental Health Act, 1959, for observation which included a power of detention for a short period. In only three of these cases was it found necessary to make application for treatment Orders under Section 26 authorising detention for a longer period.

Hospital Waiting Lists

Once more it is pleasing to record that our list of subnormal patients awaiting admission to hospital care seems to be relatively lighter than that of most authorities. At the end of the year only two patients (both male) are recorded as urgently requiring admission to hospital and one of these has since been admitted to Dovenby Hall Hospital. The list of subnormal and severely subnormal patients whose names appear on waiting lists seems fairly formidable as follows:—

	Male	Female	Total
Subnormal: Under 16 ...	—	—	—
16 and over ...	2	—	2
Severely subnormal:			
Under 16 ...	2	3	5
16 and over ...	14	19	33
	18	22	40

We must, however, bear in mind that these patients are, for the time being at least, adequately cared for in the community, but their names must be included as ultimately requiring hospital care for a variety of social reasons, none of which at present constitutes a really urgent problem. It is usually possible to relieve temporary difficulties within a household by arranging a period of " short term " care for such patients either at Dovenby Hall Hospital or our hostel at Orton Park.

Short Term Care (Circular 5/52)

In having our own hostel for subnormal children to which stable ambulant juveniles can usually be admitted to tide over a critical period in the home, we are more fortunate than most local health authorities. When this is coupled with the facilities which exist at Dovenby Hall Hospital for those patients requiring active

medical or nursing care, we are indeed in an enviable position. The following figures show the use of this scheme during 1960 :

	Patients admitted	Patient days
Dovenby Hall Hospital ...	23	2775
Orton Park ...	11	860
	34	3635

The fact that it is relatively easy to arrange for the short term care in hospital or hostel of a subnormal patient ha. a pronounced effect on the waiting lists for long term hospital care. When relief can be given from the strain of providing continuous attention to a subnormal patient and if parents know that in an emergency they can usually be helped by this form of service, the domestic situation (of giving the additional care which is frequently necessary) is much more easily tolerated.

Ascertainment and Supervision of Subnormality

To use the terminology of the old Mental Deficiency Acts, whilst the process of ascertainment of deficiency of mind is no longer statutorily necessary, it is obviously the first duty of the local health authority to decide which members of the community are subnormal within the meaning of the Mental Health Act and to offer community care or other services.

So far as subnormality is concerned, the Mental Health Act amends the Education Act, 1944, and children between the ages of 2 and 16 years are referred by the local education authority to the local health authority when they are thought to be " unsuitable for education at school ". Under the old legislation and during that part of 1960 prior to the commencement of the Mental Health Act (1st January to 31st October, 1960) new cases were reported as follows:—

	Under 16		16 and over	
	M	F	M	F
Reported by local education authority :				
(a) While at school or unable to attend school ...	7	3	—	—
(b) On leaving special schools ...	—	—	5	5
(c) On leaving ordinary schools ...	3	2	—	—
By Police or Courts ...	1	—	1	—
From other sources ...	—	—	3	3
	11	5	9	8

SECTION 29

HOME HELP SERVICE

No. of home helps accepted and enrolled on the register at 1st January, 1960	227
No. of home helps accepted during year	39
	266
No. of home helps resigned during year	37
	229

District in which the home helps reside:—

	1956	1957	1958	1959	1960
Alston	8	10	11	12	12
Aspatria	17	18	15	13	16
Border Rual	37	44	45	44	41
Cockermouth	3	3	2	3	4
Ennerdale	20	24	31	31	31
Keswick and Threlkeld	5	6	7	6	5
Maryport, Dearham and Broughton	16	16	12	10	9
Millom	10	16	15	19	19
Penrith and Penrith Rural ...	12	17	16	25	25
Silloth and Mawbray	11	13	13	10	12
Whitehaven, Distington and St. Bees	14	14	13	19	17
Workington	20	19	22	25	24
Wigton and Mealsgate	14	16	17	10	14
	187	216	219	227	229

Householders—

No. of applications received for home helps	479	469	455	447	504
No. cancelled or not supplied ...	169	187	175	152	175
No. of new cases helped	296	264	268	270	313
No. of cases on books, 1st January, 1960	317	342	414	454	509
Cases pending	14	18	17	18	21

Analysis of cases helped—

Confinements	73	56	45	45	60
Tubercular cases	19	11	10	12	13
Old age and infirmity	304	329	391	421	492
Mental health	2	1	3	1	—
Cardiac	49	48	56	53	62
Blind	30	28	22	29	28
Cancer	2	1	5	7	4
Illness of long duration (cerebral haemorrhage, rheumaroid arthritis, etc.)	48	51	91	91	98
Illness of short duration (post operative, influenza, etc.) ...	48	51	59	65	65
	613	606	682	724	822

In each area meetings of home helps are held at which problems are discussed. In addition, visits have been paid as follows:

To householders	1527
To home helps	971
	2498

With the demand on the Home Help Service ever increasing, it was decided that the nurses and health visitors should take a larger part in the supervision of the home helps and should call periodically to see the householders concerned in their areas. Owing to the steady increase of cases the administrative staff find it extremely difficult to keep the visiting up-to-date and welcome the assistance of the nursing staff in the field to keep a closer contact with these households. More and more elderly people will depend on domestic help as an important support in enabling them to stay in their own homes when no longer fit to cope with the daily chores. Often therefore the health visitor or district nurse will be able to combine supervision of the home help's duties with helpful visits to the old people themselves. The number of home helps has not increased and they are working harder, particularly in the urban areas in West Cumberland where the travelling distances between cases is not so great. The problem of recruiting sufficient home helps is always with us, particularly in Keswick and some villages in the rural areas.

Mrs. Steele, Assistant Superintendent Nursing Officer, attended the Annual School and Conference of Home Help Organisers at Cirencester in September.

GENERAL PUBLIC HEALTH

Infectious Diseases

Inspection and Supervision of Food

Water and Sewerage

Housing

Swimming Pools

Windscale Liaison Committee

Welfare Services

Notification of Cases of Infectious and Other Notifiable Diseases, 1960

	Scarlet Fever.	Whooping Cough.	Ac. Poliomyelitis Paralytic.	Non-Paralytic.	Measles.	Diphtheria.	Dysentery.	Meningococcal Infection.	Acute Pneumonia.	Smallpox.	Acute Encaphalitis Infective.	Post Infectious.	Enteric or Typhoid Fever.	Paratyphoid Fever.	Erysipelas.	Food Poisoning.	Tuberculosis Respiratory.	Meninges and C.N.S.	Other.	Puerperal Pyrexia.	Ophthalmia Neonatorum.
URBAN DISTRICTS —																					
Cockermouth ...	—	11	—	—	—	—	2	—	—	—	—	—	—	—	—	—	3	—	—	—	—
Keswick ...	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	3	—	—	—	—
Maryport ...	10	49	—	—	8	—	—	—	9	—	—	—	—	—	3	8	10	—	3	—	—
Penrith ...	4	12	—	—	86	—	1	—	7	—	—	—	—	—	1	1	2	—	1	—	—
Whitehaven ...	10	39	—	—	675	—	—	—	—	—	—	1	—	—	—	59	19	—	1	2	—
Workington ...	6	51	—	—	19	—	2	2	36	—	—	—	—	—	—	—	23	—	2	4	—
RURAL DISTRICTS—																					
Alston ...	2	—	—	—	4	—	—	—	5	—	—	—	—	—	—	—	5	—	—	—	—
Border ...	9	54	—	—	40	—	1	—	7	—	—	—	—	—	1	1	8	—	2	1	—
Cockermouth ...	11	20	—	—	25	—	28	—	7	—	—	—	—	—	—	2	7	—	—	—	—
Ennerdale ...	10	31	—	—	937	—	—	—	2	—	—	—	—	—	—	5	30	1	4	1	—
Millom ...	40	89	—	—	14	—	1	—	1	—	—	—	—	—	—	18	9	—	1	—	—
Penrith ...	6	4	—	—	59	—	—	—	4	—	—	—	—	—	1	—	2	—	1	—	—
Wigton ...	6	32	—	—	132	—	—	—	5	—	—	—	—	—	—	1	5	—	1	1	—
TOTAL FOR YEAR ...	114	392	—	—	1999	—	35	2	83	—	—	1	—	—	6	95	126	1	16	9	—
1959 ...	254	153	—	—	3363	—	21	1	90	—	1	—	2	1	13	56	127	2	16	47	3
1958 ...	115	28	4	1	349	—	187	5	60	—	—	—	—	—	12	11	155	4	23	30	2
1957 ...	25	661	11	4	3557	—	20	5	182	—	2	1	—	—	19	28	186	2	32	44	2
1956 ...	40	625	46	11	2256	—	47	5	135	—	—	2	1	2	25	16	260	2	27	16	2

INSPECTION AND SUPERVISION OF FOOD

I am indebted to the Chief Inspector of Weights and Measures for the following report:—

Food and Drugs Act, 1955

Summary of work done under the above Act during the year ended 31st December, 1960

	Total Samples Obtained		Genuine		Unsatisfactory	
	Milk	Other Foods	Milk	Other Foods	Milk	Other Foods
Submitted to Public Analyst ...	66	214	46	206	20	8
Tested by Sampling Officers ...	317	—	301	—	16	—
	383	214	347	206	36	8
	597		553		44	

Milk

When formal samples of milk are obtained, informal samples are also taken from the same supplies which enables the sampling officers to initially test the milk by means of Gerber apparatus. If any unsatisfactory sample is obtained, or there is any doubt about the quality of the milk, the corresponding formal sample is immediately forwarded to the Public Analyst. In instances where only informal samples are obtained and which are found to be unsatistfactory, formal samples are taken as soon as possible from the same source.

Sixty-six samples of milk, including 15 "appeal to cow" samples, were submitted to the Public Analyst during the year. Adverse reports were received on 20 samples, 6 producers being involved.

Of the 317 samples of milk tested by the sampling officers and not submitted to the Public Analyst, 16 were found to be slightly below standard, but further samples taken shortly afterwards from the same sources of supply were found to be of satisfactory quality.

The presumptive standard for milk, other than Channel Islands or South Devon, laid down in the Sale of Milk Regulations 1939, is 3.0 per cent. fat and 8.5 per cent. solids-not-fat. The average quality of the samples tested by the sampling officers was 3.54 per cent. fat and 8.66 per cent. solids-not-fat. These figures show a decrease of 0.12 per cent. in the fat content with no change in the percentage of non-fatty solids, when compared with last year's figures. These averages do not include the results of analyses by the Public Analyst.

Of the total number of milk samples taken, the percentage of unsatisfactory samples is 9.4, which shows an increase when compared with 7.96 per cent. for previous year.

The 20 milk samples certified by the Public Analyst to be unsatisfactory were dealt with as follows :—

Four samples, from the same source of supply, were below standard in fat and non-fatty solids and 3 of the "appeal to cow" samples taken in this case were of genuine quality although slightly below standard in solids-not-fat. When the Public Analyst received the original samples the milk was sour and he was unable to apply a freezing point test to prove the presence of extraneous water. However, on one sample the extent of deficiences in fat and solids-not-fat were so great as to be conclusive of the presence of added water. The farmer concerned was prosecuted and fined £50.

Two other samples containing added water were from one producer. The facts in this case did not warrant legal proceedings and the producer was cautioned.

Eleven samples were found to be deficient in fat content and the deficiencies were due to the milk produced being of poor quality. The four producers concerned were cautioned and advised to obtain help in improving the quality of the milk. Further samples taken from the same sources have shown the standard to be improved.

Fifty-six samples of milk were taken at schools and canteens and all were found to be satisfactory.

As the result of a complaint from a member of the public, not in connection with any of the above samples, a firm of dairymen was prosecuted for selling a bottle of milk containing a dead insect and a fine of £20 plus £3 3s. 0d. costs was imposed.

Foodstuffs Other Than Milk

A total of 214 samples of various foodstuffs and drugs were taken during the year and 206 were found to be genuine and 8 unsatisfactory, a percentage of 3.25.

The 8 unsatisfactory samples consisted of biscuits (2), yoghurt, salmon spread, ground rice, a proprietory medicine for sore throats, an orange drink and rum butter.

With regard to one of the samples of biscuits, the sample was taken as a result of the purchaser complaining that the biscuits were discoloured. The Analyst stated that the discolouration was due to carbonised starch and was harmless.

The other biscuits were shortcake biscuits and although of satisfactory quality, a display card claiming that fresh butter was used in the manufacture of the biscuits was rather misleading as only a portion of the fats used was fresh butter. The manufacturers willingly called in all the display cards and issued new ones which complied with the ingredients of the biscuits.

An informal sample of yoghurt was found to be made from skimmed milk, the Analyst stating that this article should be from cow's milk. The manufacturers disagreed with this view and were of the opinion that the article was of satisfactory quality. As there is no standard for this article no further action was taken.

The salmon spread was an informal sample which was found to be 8.6 per cent. deficient in fish content. A formal sample taken from the same consignment proved to be of genuine quality.

The ground rice turned out to be a sample of semolina, the packets having been incorrectly labelled. The stock was returned to the manufacturers for re-labelling.

The throat medicine was incorrectly labelled as the declaration of ingredients did not include the percentage of acid sulphuric B.P.C. This omission was not in conformity with the requirements of the Pharmacy and Medicines Act and was due to a badly printed label. The manufacturers immediately took steps to amend the printing.

The result of an analysis of a sample of orange fruit drink showed that when compared with the label the amount of fruit

claimed to be present was not justified. Another unsatisfactory point was that part of the statement on the label was in too small print. The claim by the manufacturers in respect of the amount of fruit was based on a recommedation by the Food Standards Committee but which was not at the time law. When this was pointed out to the manufacturers they agreed to have new labels printed containing the correct statement with regard to the fruit content and also to increase the size of print.

With regard to the sample of rum butter the ingredients were not listed on the carton, but this omission has now been rectified.

Various complaints from members of the public regarding food have been investigated. One was that some tinned salmon appeared to contain particles of glass. These particles were found to be crystals of magnesium ammonium phosphate, a natural component of salmon which frequently crystallises after tins have been standing some time, the crystal being harmless.

Another complaint was that a sweet contained a piece of metal. This complaint was justified and resulted in the manufacturers being prosecuted and fined £5 plus £3 3s. 0d. costs.

Milk (Special Designation) Regulations 1960

These regulations came into operation on the 1st October, 1960, but did not become effective until 1st January, 1961, so far as dealers' licences were concerned. The principal changes made were :—

(a) dealers' licences, except for a few kinds which will be granted by the Minister of Agriculture, Fisheries and Food, will be granted by the County Council and will permit sales outside as well as inside the area of the licensing authority.

(b) a dealer's pre-packed milk licence is introduced to permit the sale of all three kinds of specially designated milk — tuberculin tested, pasteurised and sterilised — where the milk is obtained by the dealer in the container in which it is to be supplied to the consumer, or is pasteurised or sterilised by the dealer.

(c) the period for which a dealer's licence will be granted is extended from one year to five years.

As the Council does not have a Public Health Inspector, arrangements were made with the District Councils for their staff to carry out the necessary visits to those who wished to be licensed and to take samples. It was agreed that these inspections were to be carried out twice a year and that the County Council would pay £1 per visit.

The County Council's responsibility for licensing and supervising milk pasteurising establishments continues, this duty being incorporated in the 1960 regulations.

At the end of the year a visit was being arranged to the Milk Laboratory at the Ministry of Agriculture, Fisheries and Food establishment at Bitts Park, Carlisle, for all the medical officers and the public health inspectors of the district councils in the county. At the time of writing this report this visit has taken place, and it proved most successful in giving a better understanding to both sides of the aims and responsibilities of the other in the production of safe and clean milk for the public.

WATER AND SEWERAGE

The preparaton and submission of schemes to the Ministry for approval has proceeded at much the same rate as in the previous year, this year there being four new water schemes and six new sewerage schemes.

Two of the water schemes were submitted by the Wigton R.D.C. and make up stage IV of their Water Development Scheme which has been proceeding over the past number of years. At the time of writing information has been received that work on part I of stage IV is hoped to commence in September, 1961.

Of the remaining two schemes one was a small extension in the Border Rural District and the other was part of the Ennerdale R.D.C.'s Southern Area Water Scheme—this is a scheme to supply Gosforth from Winscales Reservoir.

Three of the sewerage schemes (Thornthwaite, Skirwith and Armathwaite) were previously submitted and considered a number of years ago but not proceeded with, and they are now to be re-submitted to the Ministry by their respective district councils with various amendments and greatly increased costs.

One of the remaining three is a scheme prepared by the County Engineer for Ennerdale R.D.C. and provides for the Distington, Lowca, Moresby and Parton areas. The other two are small schemes, one at Houghton and the other at Old Town, High Hesket.

Notification was received from the Ministry that the grant for the Skelton sewerage scheme would be increased by £30 per half year for 30 years, and that a grant of £290 per half year for 30 years would be made to Wigton R.D.C. for their Glasson and Drumburgh scheme. The County Council agreed to pay an equivalent grant in both cases.

As reported last year the Council are assisting district councils by preparing water and sewerage schemes and the additional engineering staff have prepared schemes for the Millom, Ennerdale and Keswick District Councils.

Water Boards

The Order providing for the constitution of the West Cumberland Water Board was made on 30th August, 1960, and the Board was constituted on 1st November, 1960, the date of transfer of the undertakings being 1st April, 1961.

With regard to South Cumberland, the Draft Order has not yet been made.

The Carlisle Water Order providing for the transfer of the water undertaking of the Border R.D.C. to the Carlisle Corporation was made by the Minister of Housing and Local Government on 12th September, 1960, and no objections were put forward by the County Council.

Scheme submitted by	Name of Scheme	General Outline	Estimated or Final Cost	Grants		Stage at 31st March, 1961
				Ministry	County	
Border R.D.C.	Crew Fell Extension (Penton)	To extend the existing Crew Fell Scheme to Old Hall Lane End	£4330	No grant	No grant	Approved as sound and adequate. Work in progress
Ennerdale R.D.C.	Southern Area Water Supply. Stage V Phase I	Outline Scheme to supply water obtained in bulk from Whitehaven Corporation's Ennerdale Water Scheme to the southern area of the Ennerdale R.D. Phase I—to supply water to Gosforth via a 6 in. main from Winscales Reservoir	£31000	—	—	Approved as sound and adequate on engineering grounds to meet a proven need
Millom R.D.C.	Water Supply to Northern Parishes	To supply the northern parishes (Prepared by County Engineer)	£161300	—	—	Approved in principle by Ministry
Wigton R.D.C.	Water Development Scheme Stage IV Part I	To lay trunk main from Fletchertown to reservoir at Low Aketon, and 12 in. main to Balladoyle	£237827	—	—	Approved as sound and adequate
Wigton R.D.C.	Water Development Scheme Stage IV Part II	Submitted in two parts—		—	—	Proposals approved as generally sound and adequate
		(a) to supply the parish of Caldbeck	£130512			
		(b) to supply Ireby and District	£46900			

Sewerage Schemes

Scheme submitted by	Name of Scheme	General Outline	Estimated or Final Cost	Grants		Stage at 31st March, 1961
				Ministry	County	
Border R.D.C.	Houghton Sewage Disposal Works Extension	Scheme to enlarge the works to accommodate increased flow	£5280	No grant	No grant	Approved as sound and adequate. Work nearing completion
Cockermouth R.D.C.	Thornthwaite Sewerage and Sewage Disposal Scheme	To serve farms and houses, etc. in the Thornthwaite District	£11223 (1951 price)	—	—	Scheme approved as sound and adequate in 1951 but not proceeded with. District Council now wish to proceed. Ministry Inquiry held on 1st March, 1961, result awaited
Ennerdale R.D.C.	Egremont and Braystones Outfall Sewer	Storm relief and sewerage	£46960	No grant	No grant	Ministry Inquiry held in March, 1960 and scheme approved by Ministry of Housing and Local Government. Tenders being obtained
Ennerdale R.D.C.	Distington, Lowca Moresby and Parton Sewerage Scheme	Scheme to serve the four areas. (Prepared by County Engineer on behalf of District Council	£60000	—	—	Following marine survey, the provision of storage tanks would be necessary and detailed designs being prepared

HOUSING RETURNS FOR THE COUNTY OF CUMBERLAND

For year ended 31st December, 1960

(N.B.—Corresponding figures for 1959 are shown in brackets.)

	Alston R.D.C.	Border R.D.C.	Cocker-mouth R.D.C.	Ennerdale R.D.C.	Millom R.D.C.	Penrith R.D.C.	Wigton R.D.C.	Whitehaven Borough	Workington Borough	Cocker-mouth U.D.C.	Keswick U.D.C.	Maryport U.D.C.	Penrith U.D.C.
Population ... 1951	2327	29848	20455	29676	13428	11720	23733	24624	28620	5300	4660	12180	10490
1960 (Est.)	2250	29650	20040	29640	14420	11510	22520	26450	29350	5560	4600	12540	10630
A 1 Total number of occupied dwelling houses in the district	865 (886)	8276 (8071)	6345 (6235)	9260 (8896)	4495 (4465)	3651 (3633)	7168 (7110)	7745 (7810)	8860 (8836)	2030 (1998)	1667 (1660)	4010 (4011)	3385 (3423)
2 Total number of occupied dwelling houses subject to Demolition Orders, Closing Orders or Undertakings	— (—)	10 (13)	11 (15)	154 (100)	27 (27)	25 (29)	20 (18)	75 (59)	55 (37)	31 (25)	4 (4)	85 (100)	5 (7)
3 Estimated number of houses (exclusive of above) which are unfit for habitation and cannot be made fit at a reasonable cost ...	60 (74)	420 (471)	32 (52)	660 (800)	43 (49)	123 (130)	256 (272)	200 (310)	50 (50)	246 (277)	7 (20)	161 (191)	101 (112)
4 Estimated number of sub-standard houses (exclusive of above) which could be repaired and made fit	90 (98)	760 (810)	N.A. (N.A.)	1780 (1900)	108 (116)	500 (523)	1303 (1348)	150 (N.A.)	70 (120)	28 (28)	95 (100)	113 (133)	48 (70)
5 Number of houses found to be overcrowed	6 (10)	27 (34)	3 (4)	6 (15)	13 (5)	52 (56)	4 (7)	— (4)	— (—)	— (N.K.)	— (—)	— (2)	1 (15)
B WAITING LISTS													
Total number of valid applicants on Council's waiting list exclusive of those living in houses under A 2 and 3 above	14 (16)	210 (179)	437 (480)	427 (535)	212 (140)	— (—)	334 (290)	880 (850)	915 (1149)	97 (150)	no list kept	332 (309)	258 (260)
C NEW HOUSES COMPLETED DURING THE YEAR													
1 By or for the Council													
For aged persons	— (—)	18 (5)	15 (2)	12 (3)	— (—)	— (—)	— (—)	12 (—)	— (—)	— (—)	— (—)	— (—)	9 (29)
Flats	— (—)	14 (8)	— (—)	— (—)	— (—)	— (—)	— (—)	14 (30)	— (—)	— (—)	— (—)	— (—)	— (—)
General Purpose Houses	— (—)	10 (43)	6 (41)	120 (80)	— (—)	5 (9)	30 (—)	39 (100)	14 (—)	5 (—)	— (—)	72 (—)	— (—)
2 Private building	2 (2)	206 (206)	102 (122)	62 (40)	30 (5)	17 (13)	22 (16)	80 (28)	50 (63)	28 (35)	7 (5)	1 (1)	54 (26)
Total ...	2 (2)	248 (262)	123 (165)	194 (123)	30 (5)	22 (22)	52 (16)	145 (158)	64 (63)	33 (35)	7 (5)	73 (1)	63 (55)
D 1 Number of houses for which application was made by private persons for Improvement Grants	8 (8)	101 (49)	63 (55)	59 (26)	84 (46)	53 (28)	67 (139)	17 (15)	47 (22)	13 (5)	11 (14)	21 (2)	16 (16)
2 Number of houses for which grants were approved	8 (8)	99 (49)	62 (54)	55 (22)	81 (1)	49 (27)	68 (139)	17 (15)	55 (16)	12 (4)	11 (13)	21 (2)	13 (16)
3 Number of houses where improvements were carried out and grants paid	9 (5)	49 (26)	75 (42)	27 (20)	66 (46)	46 (37)	141 (26)	15 (6)	42 (none)	7 (3)	6 (3)	13 (2)	12 (9)
4 Number of houses purchased or taken over by the Council with a view to improvement or conversion	— (—)	4 (—)	— (—)	— (—)	2 (1)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)
5 Number of houses improved by the Council													
(i) with grant	— (—)	— (—)	— (—)	— (—)	— (3)	— (—)	23 (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (8)
(ii) without grant	— (—)	6 (—)	— (—)	— (—)	1 (—)	— (—)	2 (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)
E TEMPORARY ACCOMMODATION													
Number of families occupying camps and temporary buildings ...	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	23 (34)	— (—)	— (—)	— (6)	— (—)	— (—)	— (1)
F HOUSING PROGRAMME													
Estimated number of houses to be built during the ensuing year ...													
(i) Private	— (2)	N.K. (N.K.)	200 (100)	120 (100)	56 (40)	20 (20)	27 (35)	80 (100)	50 (60)	50 (30)	6 (5)	— (6)	40 (50)
(ii) Council	18 (16)	60/70 (50)	50 (41)	666 (658)	68 (24)	20 (10)	62 (30)	174 (198)	340 (58)	42 (90)	14 (24)	50 (80)	36 (24)

Millom R.D.C.	*Drigg and Holmrook Sewerage and Sewage Disposal Scheme*	Scheme to serve the two villages. (Prepared by County Engineer on behalf of District Council)		—	—	Outline scheme in preparation
Penrith R.D.C.	Sewage Disposal Scheme, Old Town, High Hesket	Two outline proposals submitted to serve hamlet of Old Town, High Hesket	Scheme A £8800 Scheme B £6700	—	—	District Council informed that either scheme will prove capable of development to provide a sound scheme
Penrith R.D.C.	Skirwith Sewerage Scheme	To serve village. Amendment of scheme submitted in 1950	£17300	—	—	Approved as sound and adequate
Penrith R.D.C.	Armathwaite Sewage Disposal Scheme	To provide sewer and disposal works at Armathwaite	£17600	—	—	Approved as sound and adequate. Ministry Inquiry held on 14th December, 1960. Result awaited
Keswick U.D.C.	Sewage Disposal Works	Modification and additions to sewerage works. Prepared by County Engineer on behalf of the District Council	£56000	—	—	Approved as sound and adequate. Awaiting Ministry Local Inquiry
Penrith R.D.C.	Skelton Sewerage Scheme	To serve Skelton village	£16650	Half yearly payments increased from £130 to £160 for 30 years		Work in progress

SWIMMING POOLS

One aspect of public health which has not materially affected Cumberland up to now arises because of the tendency for schools to provide their own swimming pools. I do not refer here to the indoor public baths with their adequate chlorination and filtration plants, but to the small out-door pools which are provided mainly to teach children how to swim. They are provided from school funds and, as cost is therefore of great importance, there is a temptation to put in an inadequate filtration/sterilisation plant, if indeed one is installed at all. It is pleasing to note that we are getting away from the old idea of constantly filling and emptying a pool to avoid having filtration/sterilisation plant, but until the claims of the manfacturers of these plants have been proved in in the county I think we must keep a close watch on the health hazards. In doing this one must strike a balance between those hazards, themselves difficult to define and prove, and the value of the pools in reducing the risks of drowning among school children. It is worth noting at this point that over 20 per cent. of the deaths from drowning in this country occur among school children.

I hope that by next year there will be more experience on which to report.

WINDSCALE LIAISON COMMITTEE

Following the incident which occurred at one of the atomic reactors at Windscale Works in October, 1957, a Liaison Committee was set up to bring more closely together the U.K.A.E.A. establishment management and those with a local interest and responsibility in the protection of the public in the event of any further accident involving a radiation hazard outside the confines of the factory. The membership of the Committee was widely spread to embrace elected representatives and officials of the local authorities, including the county medical officer and the medical officers of health of the district authorities most closely concerned.

The main aims of the Committee were the establishment of an effective administrative machinery for handling any further emergency; to give maximum protection and reassurance to the public; to make clear to the local authority representatives the significance of any hazards involved at the works, and the alteration and progress in the type of scientific equipment used.

One of the first problems tackled by the Committee was the drawing up of an emergency scheme through a special sub-committee, and this has been brought up to date from time to time. At the latest meeting of the Committee an account was given by the general manager of the works on the operation of the new advanced gas cooled reactor which was nearing completion, and there was an opportunity to discuss the type of hazard which may conceivably arise from this reactor.

The appearance of the atomic energy establishment in recent years has introduced a new potential hazard to the public health which has occasioned the medical officers of health concerned considerable thought as to their own statutory responsibility in the matter. It is the duty of the medical officer of health, whether of a county or a district, to 'inform himself as far as is practicable respecting all matters affecting or likely to affect the public health in the county/district, and be prepared to advise the county/district council on any such matter.' On the other hand, the monitoring tasks involved in checking radiation hazards in connection with atomic energy establisments is such a highly technical and skilled matter that there are considerable difficulties in the way of any local authority establishing its own monitoring system. The chief responsibility for this work has been placed by the Government upon the Ministry of Housing and Local Government.

WELFARE SERVICES

This report on the work of the Welfare Department in 1960 for which I am indebted to Mr. S. Hodgson, the Deputy County Welfare Officer, refers to a year during the whole of which Mr. W. C. Walker was County Welfare Officer.

Housing and Part III Residential Accommodation

The effects of an increasing ageing population are now becoming more evident and there is a growing need for more residential accommodation. The following comparative statement clearly shows a marked increase in the numbers of persons being accommodated in County Homes since 1948. It will be noted that the increase in residents coincides with the opening of the small modern type homes.

Year	No. of Beds provided			No. of Residents		
	Joint User Establishments	Modern Type Homes	Total	Joint User Establishments	Modern Type Homes	Total
31.12.1949 ...	375	—	375	235	—	235
31.12.1950 ...	375	—	375	238	—	238
31.12.1951 ...	325	—	325	243	—	243
31.12.1952 ...	325	—	325	217	—	217
31.12.1953 ...	325	19	344	201	18	219
31.12.1954 ...	325	19	344	219	19	238
31.12.1955 ...	263	69	332	188	57	245
31.12.1956 ...	263	69	332	189	70	259
31.12.1957 ...	242	69	311	188	65	253
31.12.1958 ...	242	87	329	193	88	281
31.12.1959 ...	252	108	360	199	99	298
31.12.1960 ...	215	146	361	174	132	306

To meet the situation and arising out of the report and recommendations of the Working Party set up in 1959, two new homes of 38 beds each are to be built in Workington and Egremont respectively during the financial year 1961-62 and it is hoped a third and similar one in North Cumberland in 1962-63. It is now an undoubted fact that more people are living to old age and there is not the same hesitation about entering the modern type home that was encountered earlier when joint user establishments provided the only accommodation. In the modern type home the

residents respond sufficiently to the care and attention given to enable them to resume a fairly active life in their new surroundings and this speaks well for the staff and others concerned.

On the 16th May, 1960, the first purpose-built home was opened in Maryport with accommmodation for 38 residents. This home provides 9 two-bedded and 20 single bed-rooms and has proved very successful, giving more flexibility in the matter of admission as between males and females. Since opening two married couples have been admitted, and the fact that they were enabled to continue to live together was very much appreciated.

The Towers, Skinburness, is proving to be a very useful and important addition to the welfare facilities available to elderly and infirm people. During the year 175 persons from other establishments and from their own homes were admitted for varying holiday periods. Also in this home are a smaller number of permanent residents who formerly resided in the Silloth area.

Table of age groups in the modern type Homes

Home	No. of Beds					AGE GROUPS OF RESIDENTS												
						MALES						FEMALES						
	4 bedded rooms	3 bedded rooms	2 bedded rooms	Single rooms	TOTAL	Under 60	60—70	71—80	81—90	Over 90	TOTAL	Under 60	60—70	71—80	81—90	Over 90	TOTAL	Total No. of Residents
Grange Bank, Wigton— Opened 1.4.53.	12	6	—	1	19	—	—	—	—	—	—	2	3	4	9	1	19	19
Derwent Lodge, Papcastle— Opened 1.1.55.	8	6	4	—	18	—	2	10	4	2	18	—	—	—	—	—	—	18
Garlieston, Whitehaven— Opened 1.11.55.	12	18	—	2	32	—	—	7	8	2	17	—	2	3	10	—	15	32
The Croft, Kirksanton— Opened 1.3.58.	—	6	10	2	18	1	2	4	—	—	7	—	2	2	7	—	11	18
Parkside, Maryport— Opened 16.5.60.	—	—	18	20	38	—	2	12	3	—	17	3	2	6	10	—	21	38
The Towers, Skinburness— Opened 1.8.58.	12	—	8	1	21	(—	—	2	—	—	2	1	—	1	2	—	4	6)
						(1	1	2	5	1	10	—	—	2	—	—	2	*12)
Totals ...	44	36	40	26	146	2	7	37	20	5	71	6	9	18	38	1	72	143

Discussions with district councils have taken place on the group building of bungalows or flats suitable for old people with special reference to the services of a warden and a useful and close co-operation has been established. Schemes have been submitted by the Border and Wigton Rural District Councils and Keswick Urban District Council which when completed will to some degree offset the need for providing Part III residential accommodation.

Much publicity, through the medium of the Press and by contact with voluntary organisations, has been given in connection with the "Homefinding" scheme. Investigation into responding householders has shown that the weekly payments required for accommodation offered are in excess of the resources available by individual applicants for Part III accommodation despite the additional grant available from the National Assistance Board.

Temporary Accommodation

Additional to the provision of residential accommodation, there is also a duty on the County Council to provide "Temporary Accommodation" for persons who are in urgent need thereof, being need arising in circumstances which could not reasonably have been foreseen. The erection of a building on a site within the grounds of Highfield House, Wigton, and giving accommodation for three family units will be ready for use during 1961.

Calthwaite Reception Centre

Persons without a settled way of living

The responsibility for running this centre, on behalf of the National Assistance Board, rests with the County Council, the day to day management being vested in the Northern Area House Committee.

The following statistics are given for the twelve months to 31st December, 1960:—

Admissions and Discharges

	Males	Females	Chn.	Total
In Centre, night of 31.12.59 ...	7	—	—	7
Admissions ...	2313	39	—	2352
Discharges ...	2312	39	—	2351
In Centre, night of 31.12.60 ...	8	—	—	8

Breakdown of Discharges

	Males	Females	Chn.	Total
Transfer to Part III Accommodation ...	4	—	—	4
Transfer to Hospital ...	—	—	—	—
Returned to families (as far as known) ...	5	—	—	5
Placed in employment by Warden, Ministry of Labour, and National Assistance Board ...	86	1	—	87
Wanted persons apprehended in Centre ...	6	—	—	6
Other discharges ...	2211	38	—	2249
Totals ...	2312	39	—	2351

I think that one pleasing feature of the work at Calthwaite during the past year is the placing in employment of 87 persons as compared with 52 for the previous year. It is a difficult business and it can only be hoped that a percentage of the casuals, however small, will, through making themselves independent by their own work, learn that there is a better way of life than roaming the roads.

Set out below is a statement showing admissions to the Centre during the years 1958-60, with a note in the latter two years as to how (– or +) the figures compare with those of the previous year:—

Four weeks ended	ADMISSIONS Corresponding periods with comparison (— or +) with previous year's figures		
	1958	1959	1960
25th January ...	222	199 (— 23)	160 (— 39)
22nd February ...	267	198 (— 69)	157 (— 41)
22nd March ...	259	271 (+ 12)	184 (— 87)
19th April ...	245	286 (+ 41)	176 (—110)
17th May ...	287	315 (+ 28)	186 (—129)
14th June ...	333	271 (— 62)	171 (—100)
12th July ...	332	227 (—105)	192 (— 35)
9th August ...	294	221 (— 73)	176 (— 45)
6th September ...	326	256 (— 70)	200 (— 56)
4th October ...	319	219 (—100)	232 (+ 13)
1st November ...	271	184 (— 87)	188 (+ 4)
29th November ...	241	158 (— 83)	175 (+ 17)
27th December ...	168	154 (— 14)	141 (— 13)
Totals ...	3564	2959 (—605)	2338 (—621)

The decline in admissions during 1959 has been steadily maintained during 1960, although it will be noted that from early September to the end of the year, overall admissions increased by 21 over those for the corresponding period in 1959. The Board's annual report for 1959 stated that the average nightly number of casuals accommodated in Reception Centres was, during each month of that year, below the corresponding figure for 1958. It may be that this trend is continuing on a national level; on the other hand the closure of other Centres may have resulted in itinerants taking other routes.

Registration of Disabled Persons in Old People's Homes

A further private home at Rothersyke, Egremont, has been registered under the provisions of the National Assistance Act, 1948, as a residential home for 10 disabled or old persons, thereby making three privately run homes in the administrative county.

Handicapped or Disabled Persons

The Council have approved three welfare service schemes for the following groups viz.:—

1. Blind and Partially sighted persons.
2. Deaf and Dumb persons.
3. Handicapped persons other than those covered by 1 and 2.

The Cumberland and Westmorland Home and Workshops for the Blind and the Barrow, Furness and South Cumberland Society for the Blind have continued to act as the committee's agents in the administration of welfare services for the Blind in three respective areas and the Carlisle Diocesan Association for the Deaf act as agents for social services for the Deaf and Dumb.

Reports on the various aspects of the services are presented half yearly to the Welfare Committee. The total number of blind and partially sighted persons registered on the 31st December, 1960, was 669, classified as follows:—

	MALES		FEMALES	
Age Group	**Blind**	**Partially Sighted**	**Blind**	**Partially Sighted**
0—5 ...	1	—	—	—
5—10 ...	3	3	2	—
11—15 ...	3	5	1	3
16—20 ...	2	5	—	4
21—30 ...	7	—	2	1
31—39 ...	15	2	7	2
40—49 ...	12	2	15	3
50—59 ...	25	7	19	7
60—64 ...	16	6	29	4
65—69 ...	18	4	40	12
70+ ...	115	24	201	42
Total ...	217	58	316	78

The erection of a social/handicraft centre in Workington is proceeding and will be available for use by all the above mentioned groups in 1961, as will also the club room which has been provided in the new health, welfare and registration office at Millom.

Voluntary Services

Continued support and financial aid has been given to the Cumberland Old People's Welfare Committee, whose achievements in the formation of more local Old People's Welfare Committees and establishment of clubs and social centres for old people have been very helpful and beneficial to elderly persons continuing to reside in their own homes.

With financial assistance from the Welfare Committee the W.V.S. has continued to run efficiently a "meals on wheels" service in Workington and this service has now been extended to Whitehaven and Millom.

Management of the Property of Mental Patients

The management and administration of the estates of persons, normally resident in the County who are mentally incapable of managing their affairs is a duty undertaken by the Welfare Department.

An official handbook is issued to receivers by the Court of Protection and it may be of interest to quote the following extract :

> " In addition to managing the patient's estate in accordance with the powers expressly conferred upon him, it is expected that the receiver should take a personal interest in the welfare of the patient and submit to the Chief Clerk of the Court any proposals likely to ameliorate the patient's condition or add to his comfort. Any such proposals should be made after consultation with the patient's medical attendant or with the medical superintendent of the institution in which the patient may be residing. In this connection, consideration should be given to the patient's holiday, motor drives, supply of gramophone or wireless sets, etc., for the patient's enjoyment."

It will be seen therefore that the duties of the receiver are not confined to the routine of managing the patient's financial affairs, but also extend to providing for the patient's welfare and for those amenities he is able to enjoy within his means.

Care of Property of Persons admitted to Hospital, &c.

Section 48 of the National Assistance Act, 1948, makes it a duty of the Council where a person is admitted to a hospital or to Part III accommodation, or removed to any other place under a Court Order made under Section 47 of the Act, to " take reasonable steps to prevent or mitigate the loss or damage " to the moveable property of that person.

This duty is carried out by officers of the department.

Civil Defence

Civil Defence issues, particularly those relating to the Welfare Section continue to receive considerable attention.

In May, 1960, Circular 16/60 was issued by the Home Office after consultation with the Ministry of Housing and Local Government and the Ministry of Agriculure, Fisheries and Food giving guidance on the new arrangements for the organisation of the Welfare Section and for the appointment of Welfare Section Officers to take charge of the Section at the various levels of the Civil Defence organisation.

The excellent relationship with the Women's Voluntary Service continues and the training of volunteers has progressed most satisfactorily throughout the year.

A further course for the training of local instructors was held when the six candidates were successful in passing the examination, thereby making a total of 25 trained local instructors, of whom 18 are actively engaged in the training of volunteers.

APPENDICES

I. Annual Report on Tuberculosis and Other Chest Diseases in East Cumberland.

II. Annual Report on Tuberculosis and Other Chest Diseases in West Cumberland.

III. Mass Radiography.

APPENDIX I

Annual Report on Tuberculosis and other Chest Diseases in East Cumberland in 1960

Introduction

Once again the volume of out-patient work continues at the chest centre at a high level. Although the total number of attendances shows a slight drop as compared with last year, this is due almost entirely to a decrease in the number of cases seen by the physiotherapist. Greater use has been made of the physiotherapists both at Penrith and Kirkby Stephen, particularly for patients coming from North Westmorland and the south-east Cumberland areas.

The number of new cases of tuberculosis discovered during the year shows a very substantial decrease as compared with 1959 —the decrease amounting to no less than 38 per cent. This is extremely satisfactory in itself, but a study of the figures later on in this report, particularly those referring to new cases discovered with a positive sputum, suggests that there is still a long way to go before the problem is entirely solved.

Non-tuberculous chest diseases account for most of the work at the chest centre. The number of new cases of pulmonary cancer discovered during the year emphasises the continued need for adequate therapy.

Tuberculosis

Notifications

In the East Cumberland Division of the East Cumberland Hospital Management Committee area notifications of pulmonary tuberculosis showed a decrease of 21 whilst the new cases of non-pulmonary tuberculosis decreased by 5.

Table 1 gives the number of notifications throughout England and Wales for 1960 and the preceding five years:—

Table 1

Year	Pulmonary	Non-pulmonary
1955	34209	4554
1956	31642	4173
1957	29310	3807
1958	26595	3503
1959	21063	3855
1960	21129	2861

Table 2 shows the number of notifications for the same period in East Cumberland:—

Table 2

Year	Pulmonary	Non-pulmonary
1955	56	20
1956	54	10
1957	54	12
1958	47	15
1959	50	11
1960	19	6

For the first time, in the area served by the East Cumberland Hospital Management Committee which covers Carlisle and North Westmorland in addition to the eastern area of the county, the number of new cases of active pulmonary tuberculosis has fallen below the hundred mark and we hope this fall will continue. At the same time the number of new cases of pulmonary cancer as seen in Table 12 remains at a steady level. Whilst both diseases involve all age groups, men of 45 years of age and upwards are much more frequently involved per thousand in both diseases and it is considered that these present the population group most likely to benefit from routine chest radiographic examination. Of the cases of pulmonary tuberculosis discovered in 1960, the sexes involved were roughly equal, but two-thirds of the males were over 45. In pulmonary cancer males are involved in a ratio of about 6 to 1 female, and also again 75 per cent. of the males are over 45. It is most important therefore that any male patients in the age group of 45 and upwards attending a doctor, no matter how trivial or vague his symptoms may be, should be referred for chest X-ray examination. Apparently healthy individuals of this age group should undoubtedly have an annual X-ray examination.

The mass radiography unit alloted to the Special Area continued in operation throughout the year, whilst a static unit has also operated locally at the base in Brunswick Street, Carlisle, since early 1960. The mobile unit continues to play its part in discovering new cases of both pulmonary tuberculosis and pulmonary cancer. The static unit is largely concerned with the examination of patients referred by their own doctors because of symptoms and, as a result, the work of this unit is proportionately more valuable as a case-finding measure.

Table 3 illustrates the usefulness of the static unit as a diagnostic measure as compared with the work of the mobile unit, both in East and West Cumberland.

Table 3

	Mobile Unit		
	East Cumberland	West Cumberland	Static Unit
Miniature Films ...	20014	16314	2418
Large Films ...	1209	624	497
Referred for clinical examination ...	179	104	132
Active Tuberculosis ...	12	18	9
Inactive Tuberculosis (under supervision) ...	4	21	7
Bronchiectasis ...	12	9	7
Neoplasm ...	5	7	14
Pneumoconiosis ...	2	52	—
Cardiac Disease ...	108	23	12
Sarcoidosis ...	3	—	2
Other Conditions ...	20	8	4
Not Yet Diagnosed ...	—	—	—

The sex and age distribution of the new cases in East Cumberland in 1960 are set out in Table 4.

Table 4

	Under 5	5-15	15-25	25-35	35-45	45-55	55-65	65+	Total
RESPIRATORY									
Males ...	—	—	1	—	2	1	3	3	10
Females ...	—	—	1	2	1	3	2	—	9
NON-RESPIRATORY									
Males ...	—	2	—	1	—	—	—	—	3
Females ...	1	—	1	1	—	—	—	—	3

Table 5 gives the pulmonary notifications, again for 1960, and classified into those who are infectious and those who are non-infectious at the time of their initial examination; the extent of the disease is also shown.

Table 5

	R.A.1	R.A.2	R.A.3	R.B.1	R.B.2	R.B.3
RESPIRATORY						
Males ...	1	6	—	2	—	1
Females ...	4	2	1	1	1	1
No. of above respiratory cases referred from M.M.R. Units						
Males ...	—	—	—	—	—	—
Females ...	1	—	—	—	—	—

The marked decline in the number of new cases of pulmonary tuberculosis in the county area is probably fortuitous and one expects some variation in this figure from year to year. It is true also that the number of new cases of non-pulmonary tuberculosis still show a decline as with pulmonary tuberculosis, but the low figure for the year together with our experience at the chest centre definitely suggests that not all cases of non-pulmonary tuberculosis are notified. This is particularly applicable to adults with comparatively minor lesions such as tuberculous cervical glands. We feel it is important that notification of such cases should be continued as without this we cannot make any efforts to discover the source of the infection.

Deaths

The number of patients dying from pulmonary tuberculosis in the Hospital Management Committee area during 1960 constitutes a new low record; although 35 patients whose names were on the Tuberculosis Register died during the year, only four patients died from tuberculosis itself; no less than 15 of these cases died as a result of cardio-vascular incidents, whilst carcinoma at various sites was responsible for the death of another six patients.

As death as a result of pulmonary tuberculosis is nowadays unusual the tables formerly incorporated in the report and relating to deaths are now omitted.

TABLE 6
CLINIC REGISTER AS AT THE END OF 1960 — EAST CUMBERLAND

	RESPIRATORY			NON - RESPIRATORY			TOTALS			Grand Total	
	M	W	Ch	M	W	Ch	M	W	Ch		
A (1) No. of notified cases of TB on Register 1.1.1960 ...	267	244	19	22	63	10	289	307	29	625	(649)
(2) Transfers in from other areas during the year ...	13	8	1	—	—	1	13	8	2	23	(18)
(3) Cases lost sight of which returned during the year ...	1	2	—	—	—	—	1	2	—	3	(—)
B No. of NEW cases diagnosed as TB during the year TB minus ...	7	6	—	1	1	3	8	7	3	18	(41)
TB Plus ...	3	3	—	—	1	—	3	4	—	7	(20)
Totals of A and B ...	291	263	20	23	65	14	314	328	34	676	(728)
C No. of cases in A and B written off Register during year—											
(1) Recovered ...	—	13	4	3	6	2	3	19	6	28	(60)
(2) Died (all causes) ...	8	1	—	1	2	—	9	3	—	12	(14)
(3) Removed to other areas ...	8	12	1	2	2	—	10	14	1	25	(22)
(4) Other reasons ...	2	—	—	—	—	1	2	—	1	3	(7)
Totals of C ...	18	26	5	6	10	3	24	36	8	68	(103)
D No. of notified cases of TB on Clinic Register on 31.12.60 ...	273	237	15	17	55	11	290	292	26	608	(625)

The figures in parenthesis are the corresponding figures for 1959

Table 6 gives the number of pulmonary and non-pulmonary cases on the chest centre register at the end of 1960.

Table 7 relates to pulmonary tuberculosis only and gives respectively the number of new cases, quiescent cases, and the number of resistant cases on the registers at the chest centre at the end of 1960. The figures refer to the whole area of the East Cumberland Hospital Management Committee.

Table 7

	In Hospital			AT HOME								Total
				Still positive			Formerly pos. neg. at end of 1960			Negative		
	M	F	Ch	M	F	Ch	M	F	Ch	M	F	Ch	
No. of active cases ...	14	14	1	2	1	—	17	6	—	31	17	5	108
No. of quiescent cases ...	—	—	—	—	—	—	—	—	—	547	532	53	1132
No. of resistant cases ...	1	—	—	2	1	—	—	—	—	—	—	—	4

The regimen of treatment remains unaltered. Bed rest initially with intensive combined chemotherapy results in cure in the vast majority of new cases. Resection is reserved for persistent foci which fail to resolve with chemotherapy alone but the numbers referred for surgery show a progressive decline.

Tubercle bacilli are mainly spread by patients with chronic cavitating disease and resection of any such cavities preceded and followed by adequate chemotherapy not only results usually in complete cure of the patient but is very valuable as a public health measure. The small number of cases still positive and resistant to the main antibiotic armamentarium remains a difficult problem. Of the four cases noted in Table 7, three have already had major thoracic surgery and all have had intensive combined chemotherapy. All four are in such a state that further surgery cannot be contemplated and one is forced to persist with a combination of antibiotics which we know are not so potent as Streptomycin with Isoniazid and Paramisan.

One accepts it as a fact to-day that all strains isolated are of the human type. The whole of England has been an attested area with all herds free from tuberculosis since 1st October, 1960, and our local area of Cumberland has been free for a considerably longer period of time. The completion of the eradication plan has undoubtedly been a considerable achievement on the part of the veterinary services.

Chronic cavitating pulmonary disease is either the result of an overwhelming infection or a particularly virulent strain of bacilli. In the East Cumberland area the risk of infection is falling, the population in general is a well-nourished population and it appears that strains of tubercle bacilli of attenuated virulence are unable to establish sufficient chronic cavitating disease to survive.

There is no question but that, clinically, bed rest is of proved value initially in the treatment of pulmonary tuberculosis. It remains a difficult matter to decide on the length of the period of bed rest in each individual case. In very active tubercle with cavitation it is beneficial and cavities tend to close, just as bed rest tends to promote the rate of healing in cases of peptic ulcer. No hard and fast rule, however, can be given. Venous thrombosis and pulmonary emboli can make lying in bed a hazardous occupation. Each case has therefore to be judged on its own merits.

We continue to use combined chemotherapy, i.e., two or more drugs at the same time because of the risk of developing resistant strains of tubercle bacilli. Recently there has been in the international field considerable advocacy for using Isoniazid alone to control pulmonary tuberculosis; such pressure has been particularly acute in both America and India. There is some evidence to suggest that the use of Isoniazid and Paramisan together in pulmonary lesions of doubtful activity makes the likelihood of a relapse less likely than with similar cases who do not receive any therapy. Isoniazid has been used itself in various areas for the treatment of patients whose only evidence of tubercle is a positive Mantoux test, but there is no valid evidence that this procedure is worth while. An impressive series of control studies carried out by the Medical Research Council leaves no doubt as to the value of combined therapy.

As indicated, the need for surgical resection is diminishing in tubercle. This is not surprising; many of the cases submitted to the surgeon during the past five years were patients who first came under treatment prior to 1950-51 when our drug regimen was much less effective than it is to-day. As a result, many of these patients who also had collapse therapy, had residual foci which failed to resolve, hence the need for resection. Many of these cases too had residual cavitating disease occupying the greater part of a lobe. To-day it is unusual, after a reasonable period of satisfactory and intensive combined chemotherapy, for a patient to have a residual active focus occupying more than a small segment of a lobe. The vast majority of cases referred to the surgeon to-day only require segmental resection. It is essential to continue with chemotherapy for some time after the completion of hospital treatment, and this specialised aftercare, which may last 15 months to two years, is most important in order to prevent any probability of a relapse.

Although the number of new cases of non-pulmonary tuberculosis coming to our notice is small, I should like to draw attention to the fact that of the 20 new cases no less han 6 are cases of genito-urinary tubercle; indeed this figure has not shown any decrease over the past five years. Until intensive combined chemotherapy was introduced the standard of treatment for renal tubercle was nephrectomy, and, as in other major operations in tuberculous patients in pre-chemotherapy days, the operation carried a high mortality. Now, with intensive combined chemotherapy the tendency, in the vast majority of these patients, is towards

complete cure just as in the treatment of pulmonary tuberculosis. Surgery is resorted to less and less, and is only indicated when there is persistence of tubercle bacilli. The full regimen of combined chemotherapy is therefore carried out for renal tubercle as it is carried out for pulmonary tuberculosis.

Contacts

Contact work has been continued as in previous years, and Table 8 shows the number of new contact examinations at the chest centre, and the number of these contacts who have been diagnosed as suffering from active tuberculous disease for the past five years.

Table 8

	No. of NEW contacts seen	No. of contacts diagnosed as tubercle
1955	1126	5
1956	920	4
1957	1126	5
1958	986	3
1959	1152	6
1960	906	—

Table 9 shows the number of contacts and hospital staff who have been vaccinated with B.C.G. vaccine over the same period. Our contacts continue to be routinely examined either at the chest centre or at the mass radiography units, and this is particularly important where the intial Mantoux test has been positive.

Table 9

	Contacts		Hospital Staff	
	M	F	M	F
1955 ...	54	31	2	24
1956 ...	38	46	—	27
1957 ...	74	69	—	34
1958 ...	79	76	3	45
1959 ...	77	79	1	49
1960 ...	43	57	14	25

Although at the chest centre we are concerned chiefly with the examination and B.C.G. vaccination of contacts and hospital staff, very close liaison is maintained with the local authority scheme whereby all school-leavers, having a negative Mantoux test, are vaccinated with B.C.G. vaccine; some of these vaccinated children fail to convert and they are referred to the chest centre for retesting and if necessary re-vaccination.

Hospital Facilities, Waiting-List, and Rehabilitation

There is no waiting-list for the admission of cases of tuberculosis to hospital or to the thoracic unit. Table 10 shows the number of beds available to the chest service during 1960, the unit at Ormside Hospital was allowed to run down until it finally closed on the 31st March, 1960.

Table 11

	1960					1959			
	Beds		Patients			Beds		Patients	
	No. of beds available	Average daily No. occupied	Total discharges	Discharges of cases of tubercle	Average length of stay in days	No. of beds available	Average daily No. occupied	Total discharges	Average length of stay in days
Cumberland Infirmary	13	12.3	217	11	21.5	—	—	—	—
City General Hospital	—	—	—	—	—	21	20.01	261	34.7
Blencathra Hospital	31	33.56	106	86	129.2	48	42.67	92	175.8
Longtown Hospital	24	24.76	128	61	67.9	24	23.97	87	110.5
Ormside Hospital	*	5.5	13	12	115.8	22	19.01	62	132.5

* Unit allowed to run down in January and finally closed in March, 1960.

Rehabilitation panels continue to be held at monthly intervals.

Other Chest Diseases

Neoplasm

Table 12 shows the number of new cases of lung cancer seen at the chest centre in 1960. The small decrease in this figure compared to 1959 gives no reason for optimism as the survival rate from the disease remains poor and treatment remains inadequate.

Table 12

	Males	Females
No. of new cases in 1960	15	5
No. of 1960 cases unfit for surgery	13	5
No. of new cases—		
1959	22	9
1958	23	4
1957	7	4
1956	11	
1955	12	

Advanced local disease with or without spread to other areas, or a poor cardio-respiratory reserve excludes surgery for the vast majority of new cases. In those accepted for surgery there is no delay in their admission to the thoracic unit.

The therapy of those not submitted for surgery is largely palliative and symptomatic. Deep X-ray therapy is valuable in that it relieves pain and arrests haemoptysis in approximately 75 per cent. of patients. The three-year survival rate of such cases is under 10 per cent. and upper lobe lesions seem to do rather better than those situated on lower lobes. The chances of longer survival are also much greater with squamous-celled carcinoma than with anaplastic-celled carcinoma. Some cases submitted to deep X-ray therapy show a very considerable regression of the tumour mass with improvement in the patient's general condition, and particularly by clearing the bronchi, in the function of the affected lung. On the other hand, some patients do not respond at all, partly because the tumour is insensitive and probably more likely because there has been earlier dissemination of the malignant cells to other areas of the body.

Although more effective oral nitrogen-mustard drugs are becoming available for use in bronchial carcinoma, the fact that newer preparations are always being introduced bears out our view that chemotherapy so far in pulmonary cancer has little or no effect on the survival rate. No one is satisfied with our present drugs. One of the chief difficulties with drugs of the nitrogen-mustard group is that these drugs dissociate with release of the active components as soon as the drug is dissolved in water. The problem would be to prepare a compound that would be activated only at the site of the tumour and could be suspended in stable solution if given parentally, and could also be given orally.

Bronchiectasis

Table 13 shows the number of cases of bronchiectasis in Cumberland on the active register at the chest centre and attending for physiotherapy. This table also shows the number of new cases of bronchiectasis seen over the past five years.

Table 13

No. of cases of bronchiectasis on Register at 1.1.61.	132
New cases diagnosed in—	
1960	16
1959	16
1958	19
1957	18
1956	19
1955	12

The results of physiotherapy in bronchiectasis are good providing one has the fullest co-operation from the patient or from the patient's parents. The tendency is for fewer cases to be submitted to the surgeon. Minor unilateral cases do well with physiotherapy alone, and if the latter is adequately carried out patients can become almost symptom free and not require surgery. Bilateral cases on the other hand, if not responding adequately to physiotherapy, would require bilateral surgery with the inevitable risk of respiratory crippling. Indications for surgery, therefore, in bronchiectasis have become narrower and rather more clear cut than they were ten years ago.

Bronchitis, Asthma, etc.

Other conditions such as bronchitis, asthma and emphysema require the help of the physiotherapist. In this country chronic bronchitis still causes more unemployment and sickness than any other single condition. In addition, many men continue at work even in spite of considerable disablement, particularly those employed in light sedentary occupations. The problem for the chronic bronchitis over the age of 50 is an acute one. Physiotherapy is of undoubted value; patients feel that something active is being done for them, and if at the same time appropriate medical treatment is given to combat the frequent intercurrent infections which they get, most are able to continue satisfactorily at work.

APPENDIX II

Annual Report on Tuberculosis and Other Chest Diseases in West Cumberland in 1960

In reviewing the work of the Chest service during 1960, certain points immediately emerge which may well be significant. In the ensuing pages these points are gone into in more detail, but to summarise them at the onset they are briefly as follows:—

The morbidity rate for all forms of tuberculosis, which in recent years had been progressively declining, has remained constant in 1960. There was undoubtedly a large pool of undisclosed cases in the community in 1952-53 and, following the improved diagnostic facilities established then, most of these had been identified and treated in the ensuing three years. Thereafter the annual case rate declined and it was hoped that this would continue. It is as yet too early to forecast with certainty that this may not indeed be the case in subsequent years: but if the experience of 1960 recurs it appears that something in the order of 100 new cases of tuberculosis may be expected annually.

The proportion of new cases who were infectious at diagnosis in 1960 shows little change from previous years: without earlier diagnosis it is most improbable that any marked reduction in the morbidity rate will be seen.

Attendances at the Mass X-Ray Unit's sessions are the second lowest since the Unit began operating in West Cumberland: whilst the young adult population show no marked reluctance to attend, the comparative indifference of the older age groups, in which the incidence of infectious disease is now highest, is a matter of concern which demands special consideration.

The mortality rate, which showed a marked improvement during the years 1953-1959 has not continued to fall; and as the age groups primarily concerned here are the more mature ones, which combine some indifference to health with the impact of accumulated years on their health generally, little improvement in the present figure of 10/100,000 may be anticipated.

Offsetting these somewhat sobering facts is, however, the very obvious improvement in health of the juvenile and young adult populations. Each year now brings evidence of the value of pre-

ventive measures established in 1953. Thus, in 1958 there were 35 cases below the age of 19; only 13 cases occurred in 1960. The same age group produced 90 cases in 1953. Also on the credit side, fewer cases now require surgical treatment — a corollary to the improvement in therapy generally with rapidly established control in 90 per cent. of cases.

New Cases of Tuberculosis

There has been no reduction in the number of new cases of tuberculosis in West Cumberland this year. The trend, to which attention was drawn in 1959, of a continued decline in diagnosed cases has halted—possibly only temporarily—but it may be significant, and any forecast of a further marked and continuous decline, though hoped for, can be anticipated only if this year's experience is not repeated in 1961. The following table shows the annual incidence of notified disease since 1954.

Table I

Year	Respiratory	Non-respiratory	Total
1954	245	32	277
1955	193	21	214
1956	169	35	204
1957	120	31	151
1958	110	15	125
1959	89	8	97
1960	99	12	111

Age and sex incidence has not varied greatly from previous years' findings: the majority of women patients arose in the 20—35 years of age group whilst men above the age of 50 years formed the largest single group of either sex. Regrettably, this year further cases of childhood disease arose, there being six notified cases below the age of 14 years. There is now, however, a tendency to notify a case of tuberculosis in childhood which some years ago would not have been deemed notifiable, and this change of criterion tends to invalidate true comparison. Howbeit, the ideal state of children growing up free of recognisable tuberculous diesase is by no means accomplished in West Cumberland and is not likely to be achieved so long as the adult population continues to be satisfied with infectious ignorance.

Case Rate

Based on the Registrar-General's estimated mid-year population of 138,000, the Annual case rate for 1960 was 78/100,000. This figure is higher than in recent years, but much lower than West Cumberland's case rate in the 1953-7 period. There is no doubt that a considerable improvement has been effected in the previously lamentable epidemiological state of West Cumberland. But, as in most things, concepts are relative; and to see this community's current tuberculous state in relation to the wider world of the English Counties and County Boroughs will undoubtedly give a more balanced view. The latest figures from the Annual report of the Ministry of Health show that of the County Boroughs only South Shields, Gateshead, Newcastle-upon-Tyne and Sunderland have case rates higher than this area: whilst the average rate for England and Wales is 63.9/100,000, with West Cumberland's figure next in doubtful pride of place to the County of London which rates 95/100,000. Compared with such communities as West Suffolk and the North Riding of Yorkshire (rates of 26/100,000 and 36,/100,000 respectively) there would, on these figures alone, seem to be a case for extending rather than curtailing measures for tuberculous case finding and control.

Tuberculosis Register

The number of cases remaining on the Tuberculosis Register at 31st December, 1960, was 1,138 (1,529 for 1959, 1,658 for 1958 and 1,689 in 1957). Once again the decline in this figure has been mainly due to removal from the Register of 239 cases classified as recovered. This figure contrasts with the total number of cases removed from the register through death from tuberculosis — 14.

An analysis of the state of health of patients on the Tuberculosis Register, which is a rough index of the efficacy of treatment, shows a continuation of the trends in 1959 and earlier. Of patients diagnosed prior to 1960, 91 per cent. had disease quiescent or rendered so during this year. As in previous years, new cases coming on to the Register showed a non-quiescent proportion of 81 per cent.

Infectious at Diagnosis

Despite all efforts to encourage early diagnosis—Mass X-ray techniques, routine ante-natal chest X-rays, contact examinations, freely available general practitioner X-ray facilities at the major hospitals and Chest Clinics, lectures and seminars on health education and so on, and the awareness of clinicians and practi-

tioners of the special hazard of this community, there has been no appreciable reduction over several years in the proportion of cases found infectious at diagnosis—27 per cent. in 1960 compared with 30 per cent. for 1959. Of newly diagnosed cases, in Maryport 30 per cent. were sputum positive when found; 30 per cent. in Ennerdale were infectious; 30 per cent. of Whitehaven cases and 27 per cent. of Workington's new cases similarly had progressed to infectiousness by the time of diagnosis. So long as this rate of infectiousness obtains, there can be little hope of avoiding childhood tuberculosis in these cases' contacts.

Mortality Rate

The only notable change in the pattern of deaths from tuberculosis in West Cumberland during 1960 was the complete absence, for the first time, of any deaths from this disease in the Ennerdale Rural District. However, Workington and Whitehaven made up for this and the total for the area was 14—one death less than 1959; giving a death rate of 0.10/1,000. As in previous years, the majority of deaths occurred in the male age groups above 60 years, mostly in ex-miners with silico-tuberculosis.

Treatment

During 1960, the only centre for medical inpatient treatment has been Homewood, or as it has now become Ward E of the West Cumberland Hospital, Hensingham. Surgical cases have been dealt with at Seaham Hall, as in previous years. The number of the latter has again fallen and, as long-term drug therapy becomes more effectively practised, is likely to fall still further. The number of cases requiring surgical treatment for tuberculosis this year was 19; 31 in 1959; 35 in 1958 and 40 in 1957.

At Homewood there were 123 discharges or deaths during the year, the average bed occupancy being 86 per cent. and the average duration of stay approximately 83.68 days again, as in 1959.

Drug Resistant Organisms

Despite efforts to prevent this most undesirable end product of drug treatment, the number of patients harbouring organisms resistant to the standard anti-tuberculous drugs has remained constant during the year, and at the end of 1960 there were 32 patients with partly or completely resistant organisms identified in sputum. In addition, 5 of the 14 deaths previously reported were of patients

whose organisms were known to be resistant prior to 1960. The control of this aspect of investigation has been entirely in the hands of the Public Health Laboratory, Carlisle, whose assistance and invaluable advice has been very much appreciated. The increase in requests for laboratory work has been very considerable indeed.

Summary of Chest Clinic Statistics

Table II

Clinic	No. of Sessions		New Patients		Total Attendances	
	1960	**1959**	**1960**	**1959**	**1960**	**1959**
Workington ...	173	175	869	918	3038	3491
Egremont ...	152	146	862	725	2973	2967
Millom ...	13	14	61	56	204	224
Total ...	338	335	1792	1699	6215	6682

From the foregoing table the pressure of outpatient work can be seen to have remained constant. Despite a fall in re-attendances of old patients as their greater security and less likelihood of relapse with modern treatment has become an established fact, some increase in the number of new patients attending has resulted in much the same total figures as for 1959. The changing emphasis of hospital outpatient needs is recorded in the ensuing analysis of clinic sessions and attendances which compares the peak years of 1955-56 with 1960. During 1955-56, collapse therapy was being widely practised in this area, but with the establishment of greater control by major surgery and long-term drug therapy, collapse therapy was gradually abandoned. Thus in 1955, whilst total attendances rose to 11,350, of these, collapse therapy attendances accounted for 4,603: attendances at consultative sessions were 6,747, an average of 22 persons per session at Workington, 23 at Egremont and 20 at Millom. The corresponding attendances per consultative session in 1960 were 21 at Workington, 21 at Egremont and 15.5 at Millom.

Of the 6,215 total attendances in 1960, 1,792 attended for complete examination, 1,416 for routine radiography only, and 949 were seen as contacts for the first time.

Contact Examination

There has been no change in contact procedures during the year, apart from variations in X-ray procedures for certain age

groups of children consequent upon the recommendations of the Adrian Committee's report on Radiological Hazards.

New contacts seen for the first time totalled 949. The number of contacts skin tested was 467, of which 20 were reactors to 1/1000 O.T. The 447 non-reactors, along with neonatal contacts and some non-reactors tuberculin tested in late 1951 were vaccinated with B.C.G., the total number vaccinated being 598, a smaller number than in 1959 (668) and 1958 (695).

The number of contacts found tuberculous during 1960 was 8, giving a case rate amongst contacts of approximately 9/1,000.

The following table sets out the total number of juvenile contacts skin tested and shows the percentage of reactor rates at different ages.

Table III

Age	Number of reactors	Number tested		Reactor Rate %	
0 — 4 ...	4	... 274	(335)	1.4	(4.4)
5 — 9 ...	3	.. 110	(170)	2.7	(4.7)
10 — 14 ...	13	... 83	(114)	15.6	(15.7)

(Figures in brackets refer to 1959 values)

From the foregoing it can be seen how very sharply the reactor rate rises above the age of 9 years. In fact, the reactor rate below 9 is falling appreciably each year, whilst the value of 15.6 per cent. for the 10—14 years of age group has not shown any marked decline up to the present: however, it is almost certain that this age group will within the next few years show a noticeable decrease in reactor rates as the measures of tuberculosis control established 10 years ago begin to be reflected in young people turning 13 and 14 for instance in 1963 and 1964.

Case Finding Procedures

Apart from the regular visits of the Mass X-Ray Unit to West Cumberland and the continuing, and valuable, ante-natal routine chest radiography at the main maternity centres in the area, no specific case finding measures have been practised in 1960. In view of the marked decline in attendance at the Mass X-Ray Unit and the continued high morbidity rate in the area, some serious consideration needs to be given to other possible measures

to bring tuberculosis into a state of control comparable to that which now obtains over the greater part of the United Kingdom.

At Workington, the Maternity Unit referred 638 ante-natal patients for routine radiography, whereas Whitehaven, on a much smaller scale, referred 248 patients. From these 886 ante-natal patients, 4 cases of minimal active tuberculosis were found and B.C.G. vaccination was extended to 27 neonatals by virtue of tuberculous stigmata on the maternal X-ray.

Mass X-Ray Statistics

During 1960 the Unit made its usual peripatetic intrusions into West Cumberland with a somewhat indifferent response from the community here and correspondingly lower yield of cases than in previous years in all but the general public section of its work. From the ensuing analysis of its work, it can be seen that the Unit contributed 18 cases of active tuberculous disease—16 per cent. of the total of 111 new cases as mentioned in the earlier part of this report. In 1954 the Unit's contribution to the total of 277 new cases was 100 (35 per cent.). Thus it is plain how limited now this method of case finding has become. It is by no means certain that had the total attendances this year been better than the 16,314, appreciably more cases would have been found. It is of the utmost significance that in East Cumberland where a static unit operates as well as the mobile unit, general practitioners needed to refer to the static unit only 1,567 patients for X-ray to provide 9 fresh active cases of tubercle. In considering the case finding procedures for this area for future years, this highly significant figure which underlines similar findings in other areas and has been widely reported in Ministry of Health publications, should certainly not be ignored.

A summary of the Unit's findings in West Cumberland follows:—

Table IV

Source of Examination	Mini. films	Large films	Clinical exams.	Active T.B.	Inactive T.B.	Br'sis.	Neo-plasams	Pn'sis	Cardiac Con-ditions
Doctors' Cases	42	11	1	1	—	1	—	—	—
Contact Cases	768	74	7	3	1	1	1	9	3
Scholars	994	13	2	—	—	—	—	—	—
School Staff	31	2	—	—	—	—	—	—	—
General Public	7262	326	65	11	12	3	3	40	13
Surveys	6941	191	28	2	7	3	3	3	7
M.D. Patients	276	7	1	1	1	1	—	—	—
Totals	16314	624	104	18	21	9	7	52	23

Non-Tuberculous Conditions

The main non-tuberculous conditions of significance amongst Chest Clinic patients continue to be pneumoconiosis, bronchial carcinoma, the respiratory allergies, a declining number of cases of bronchiectasis and other miscellaneous entities which constitute no public health problem. However, increasing attention is now being paid to the chronic bronchitic with emphysema and its cardiac sequelae: whilst treatment for this condition is by no means definitive, much can be done by appropriate supportive measures at times of epidemic infection. Provision for inpatient treatment has already been made and is likely to continue.

APPENDIX III

MASS RADIOGRAPHY

Report on the Work of the Mass Radiography Unit during the year 1960

(NOTE—Figures given in brackets throughout the report relate to the corresponding figures for 1959.)

The Mobile Unit was fully operational throughout the twelve months. The Unit vehicles were overhauled by the Ministry of Supply during the month of June and during this period we arranged for the Unit to operate at 1 Brunswick Street, Carlisle. The Static Unit at the M.M.R. Base began operating on the 18th January, 1960, and continued throughout the year with two half day sessions weekly. The figures given in the report relate to the work of both units.

Groups Examined

In addition to carrying out surveys at works and factories, surveys of the general public were carried out on 57 occasions. 1,627 (2,104) contact cases were X-rayed, 859 from the East Cumberland area and 768 from West Cumberland.

Results

38,746 (44,554) persons were examined by the Units during the year. These included 276 inmates of Dovenby Hall Hospital. Patients at Garlands Hospital are no longer examined by the Unit. Excluding the mental patients 38,470 (43,482) persons were examined.

Number recalled for full sized X-ray film	2330	...	6.01% of total
	(2348	...	5.27%) examined
Number referred for clinical examination	415	...	1.07% of total
	(499	...	1.12%) examined
Number failing to attend for full sized film	96	...	4.12% of those
	(141	...	6.00%) recalled

Table 1 shows the number of abnormalities revealed during 1960 throughout the whole of the Special Area. I would point out that all the figures in the tables which follow refer to abnormalities found on large film examination. Many abnormalities are noted on miniature film which either require no further investigation or are consistent with the patient's age and do not require therapy. Many cases of inactive tubercle come within this category. These miniature film abnormalities are not included in the tables.

Table 1

	No. of Cases Found		Percentage of Total	Examined
ABNORMALITIES REVEALED				
(1) Non-tuberculous conditions:				
(a) Bronchiectasis ...	28	(52)	.07	(.12)
(b) Pneumoconiosis ...	54	(74)	.14	(.17)
(c) Neoplasm ...	26	(17)	.07	(.04)
(d) Cardiovascular conditions ...	140	(280)	.36	(.63)
(e) Miscellaneous requiring investigation ...	37	(39)	.10	(.09)
(2) Pulmonary Tuberculosis:				
(a) Active ...	39	(45)	.10	(.10)
(b) Inactive requiring supervision ...	32	(64)	.08	(.14)
(c) Active (Previously known)	—	(2)	—	(.005)

Table 2 gives a detailed analysis of the work of the Units, with the work of the Mobile Unit divided into the East and West Cumberland areas.

Table 2

Source of examination	STATIC UNIT CARLISLE					MOBILE UNIT EAST CUMBERLAND							MOBILE UNIT WEST CUMBERLAND							
	Doctors' cases	Contact cases	Students 15 years and over	General Public	TOTALS	Doctors' cases	Contact cases	Students 15 years and over	School staff	General Public	Surveys	TOTALS	Doctors' cases	Contact cases	Students 15 years and over	School staff	General Public	Surveys	Mentally defective patients	TOTALS
Miniature Films ...	1567	196	10	645	2418	24	663	1376	200	9924	7827	20014	42	768	994	31	7262	6941	276	16314
Large Films ...	368	16	—	113	497	5	45	59	5	639	456	1209	11	74	13	2	326	191	7	624
Clinical Examinations ...	109	4	—	19	132	4	11	5	1	106	52	179	1	7	2	—	65	28	1	104
Active Tuberculosis ...	9	—	—	—	9	—	—	1	—	8	3	12	1	3	—	—	11	2	1	18
Inactive Tuberculosis requiring supervision ...	5	1	—	1	7	—	—	—	—	2	2	4	—	1	—	—	12	7	1	21
Bronchiectasis ...	6	—	—	1	7	—	1	—	—	4	7	12	1	1	—	—	3	3	1	9
Neoplasms ...	13	—	—	1	14	1	—	—	—	2	2	5	—	1	—	—	3	3	—	7
Pneumoconiosis ...	—	—	—	—	—	—	—	—	—	1	1	2	—	9	—	—	40	3	—	52
Cardiac Conditions ...	8	1	—	3	12	—	1	—	1	84	22	108	—	3	—	—	13	7	—	23

Table 3 gives the relative figures as between East and Wes
Cumberland for the past eight years.

Table 3

Year	EAST CUMBERLAND							WEST CUMBERLAND						
	Active Tuberculosis	Inactive Tuberculosis	Neoplasms	Cardiac Conditions	Bronchiectasis	Pneumoconiosis	Active Tuberculosis	Inactive Tuberculosis	Neoplasms	Cardiac Conditions	Bronchiectasis	Pneumoconiosis
1953 ...	56	506	5	243	64	6	78	341	4	95	29	84
1954 ...	49	438	6	217	39	1	100	381	6	101	22	133
1955 ...	51	455	10	363	38	3	60	302	1	70	25	80
1956 ...	46	338	8	360	37	3	56	258	2	53	15	61
1957 ...	37	312	7	368	18	2	24	226	4	72	24	92
1958 ...	40	153	10	321	27	2	16	81	4	90	16	125
1959 ...	33	40*	13	241	37	3	14	24*	4	39	15	71
1960 ...	21	11*	19	120	19	2	18	21*	7	23	9	52

* Requiring Supervision

Table 4 refers solely to new cases of pulmonary tuberculosis seen in East Cumberland.

Table 4

Year	Number of new cases	Number with positive sputum	Percentage of new cases with positive sputum	Number of new cases referred by M.M.R.	Percentage of new cases referred by M.M.R.	Percentage positive sputum cases found by M.M.R.
1953 ...	140	45	32	52	37	20
1954 ...	170	56	33	36	21	13
1955 ...	139	42	30	43	31	21
1956 ...	125	39	31	39	31	18
1957 ...	125	42	34	33	26	29
1958 ...	117	32	27	29	25	9
1959 ...	116	31	27	28	24	6
1960 ...	72	28	39	21	29	18

The number of new cases of pulmonary neoplasm coming to our notice during 1960 is shown in the following table which again refers to East Cumberland.

Table 5

	1954	1955	1956	1957	1958	1959	1960
No. of cases of neoplasm seen at Chest Centre ...	16	21	29	38	59	59	54
No. discovered by M.M.R.	6	10	8	7	10	13	19

Comments

Mass Radiography continues to be an important facet in our case finding measures both in pulmonary tuberculosis and lung cancer. The static unit is largely concerned with the examination of patients with symptoms referred by their own doctors and as a result the work of this unit is proportionately more valuable.

Both units have operated continuously throughout the year and with its wide coverage one would have expected a much higher response in the communities surveyed than we do actually get. One is indeed lucky to carry out a survey and secure a 75 per cent. response.

Even with such a figure, however, there is strong evidence suggesting that the prevalence of both tuberculosis and lung cancer is higher in the 25 per cent. who do not accept mass radiography examination. An annual X-ray examination for every adult is surely not unreasonable and would be of invaluable benefit not only to the patient but to his relatives and friends. Unfortunately persistent efforts to get this hard core of non-attenders through the Unit bears little fruit and the final result is not commensurate with the effort and the cost involved. Apathy is difficult to combat and the decline in the reservoir of tuberculous infection in the community probably accentuates the feeling of security in people who consequently do not pass through the Unit.

For the first time in the area served by the East Cumberland Hospital Management Committee the number of new cases of active tuberculosis has fallen below the 100 mark. At the same time the number of new cases of lung cancer has remained at a

steady level. While both diseases involve all age groups, men over the age of 45 are much more frequently involved and this is the population group most likely to benefit from routine radiography examination. In 1960, of the new cases of pulmonary tuberculosis in the East Cumberland area discovered, the sexes involved were roughly equal, but 2/3 of the male patients were over 45. In the case of lung cancer the males are involved in the ratio of 6 to 1, male to female, and here again 60 per cent. of the males were aged over 45.

The high pick-up rate of both tuberculosis and lung cancer in the static unit is to be noted. The majority of the examinees are patients with pulmonary symptoms referred by their own doctors. In view of the marked preponderance of both diseases in males over the age of 45 it is strongly suggested that doctors in the Carlisle area should refer all such persons for at least annual examination no matter how trivial or vague their symptoms may be.

Both units were operated during the latter 6 months of the year with unqualified technical staff and technical standards have been maintained at the usual level. The mobile unit is being converted to a 100 m.m. unit this year and considerable alteration to the van is also anticipated in order to make the mobile unit more fully mobile. We had anticipated carrying out further street surveys during 1960 but as such surveys are very difficult with the van as it is built at present we have delayed carrying out the street surveys until after modification of the van. Present figures show a larger pick-up rate in the City of Carlisle than elsewhere in the Special Area and it is anticipated that the first of these street surveys will be arranged for a section of the City.

Acknowledgements

It is a pleasure to acknowledge once more the valuable help received in arranging these surveys from the Medical Officers of Health concerned in the area and from the Managements and Workers' Organisations in the factories visited.

The interpretation of films and disposal of abnormalities is no easy task and would be impossible without the friendly co-operation of my colleagues on the hospital staff, and to all I tender my sincere thanks.

I would also like to thank the numerous organisations who have in any way helped us, including the Police who continue to advise with regard to the traffic problems inherent in our surveys.