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CUMBERLAND COUNTY COUNCIL

THE HEALTH OF CUMBERLAND 1965

REPORT OF THE COUNTY MEDICAL OFFICER

COUNTY COUNCIL OF CUMBERLAND

ANNUAL REPORT

ON THE

HEALTH OF THE COUNTY

FOR THE YEAR 1965

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.

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HEALTH, HOUSING AND WELFARE COMMITTEE, 1965

Chairman: Alderman Mrs. E. G. Cain, O.B.E., J.P.

Vice-Chairman: Lady Inglewood, J.P.

Aldermen:

Curwen, Mrs. J. N. St. G., J.P.
McCann, Rev. F. K.
Stephenson, W., J.P.

Councillors:

Bainbridge, J. J.
Blair, J.
Cross, P. J.
Dickinson, D. L.
Forsyth, Rev. W.
Gaffney, C.
Johnston, T. W.
Kilbride, J.
Lovell, J.
MacInnes. Miss J. E.
McKeating, Mrs. B. O.
McPoland, Mrs. F.
Nixon, W. G., J.P.
Smith, Mrs. M., J.P.
Thomas, H.
Wilson, Mrs. M. A., J.P.

Ex-officio Members:

Chairman of County Council: Westoll, J., J.P.

Vice-Chairman of County Council: Dickinson, R. F., J.P.

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Chairman of Education Committee: Jackson, W.

External Members:

Carr, R.
Collins, R. G.
Douglas, Mrs. M. B.
Duff, Mrs. M. B.
Ferguson, Dr. T. T., J.P.
Grant, Dr. R. N. R.
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Richardson, G. S.
Perrott, Dr. E. A.
Stout, Mrs. K. N. L.
Todd, Dr. K.
Young, A., M.B.E.

NORTHERN AREA (HEALTH) SUB-COMMITTEE

Chairman: MacInnes, Miss J. E.

Vice-Chairman: Wilson, Mrs. M. A., J.P.

Councillors:

Blair, J.
Dickinson, D. L.
Johnston, T. W.
Smith, Mrs. M., J.P.

Ex-officio Members:

Chairman of County Council: Westoll, J., J.P.

Chairman of Health Committee: Cain, Mrs. E. G., O.B.E., J.P.

Vice-Chairman of Health Committee: Lady Inglewood, J.P.

Chairman of Education Committee: Jackson, W.

External Members:

Barton, Dr. E. B.
Bell, S. A.
Carr, R.
Cross, W. D.
Douglas, Mrs. M. B.
Duff, Mrs. H.
Glaister, N. A.
Herbert, H. H.
Raven, M.
Slee, E. J.
Todd, Dr. K.
Windle, Miss S.
Wright, T.

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Barton, Dr. E. B.
Duff, Mrs. H.
Johnston, T. W.
MacInnes, Miss J. E.
Smith, Mrs. M., J.P.
Wilson, Mrs. M. A., J.P.

Ex-officio Members:

Chairman of County Council: Westoll, J., J.P.

Chairman of Health Committee: Cain, Mrs. E. G., O.B.E., J.P.

Vice-Chairman of Health Committee: Lady Inglewood, J.P.

SOUTHERN AREA (HEALTH) SUB-COMMITTEE

Chairman: McPoland, Mrs. F.

Aldermen:

McCann, Rev. F. K.
Stephenson, W., J.P.

Councillors:

Cross, P. J.
Forsyth, Rev. W.
Gaffney, C.
Kilbride, J.

Ex-officio Members:

Chairman of County Council: Westoll, J., J.P.

Chairman of Health Committee: Cain, Mrs. E. G., O.B.E , J.P.

Vice-Chairman of Health Committee: Lady Inglewood, J.P.

Chairman of Education Committee: Jackson, W.

External Members:

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Dunne, D.
Grice, R. G.
Kessell, Mrs. D. R.
Perrott, Dr. E. A.
Reed, Mrs. F. M
Richardson, G. S.
Roe, W.
Roebuck, C. M.
Simpson, K. H.
Stout, Mrs. K. N. L.
Walsh, J., M.B.E., J.P.
Wandless, Miss M. I.
Wilson, K.

HOUSE SUB-COMMITTEE

Cross, P. J.
Hanna, W.
Kilbride, J.
McPoland, Mrs. F.
Walsh, J.

Ex-officio Members:

Chairman of County Council: Westoll, J., J.P.

Chairman of Health Committee: Cain, Mrs. E. G., O.B.E., J.P.

Vice-Chairman of Health Committee: Lady Inglewood, J.P.

WESTERN AREA (HEALTH) SUB-COMMITTEE

Chairman: McKeating, Mrs. B. O.

Vice-Chairman: Nixon, W. G., J.P.

Alderman: Curwen, Mrs. J. N. St. G., J.P.

Councillors:

Bainbridge, J. J.
Lovell, J.
Thomas, H.

Ex-officio Members:

Chairman of County Council: Westoll, J., J.P.

Chairman of Health Committee: Cain, Mrs. E. G., O.B.E., J.P.

Vice-Chairman of Health Committee: Lady Inglewood, J.P.

Chairman of Education Committee: Jackson, W.

External Members:

Collins, R. G.
Fawcett, J. W.
Ferguson, Dr. T. T.
Graham, Miss E.
Grant, Dr. R. N. R.
Hogarth, S. T.
Holding, W. D.
Potts, C. R.
Smith, Miss D.
Smith, Mrs. M.
Smith, Mrs. M. A.
Thomas, Mrs. A. B., J.P.
Young, A.

HOUSE SUB-COMMITTEE

Bainbridge, J. J.
Fawcett, J. W.
McKeating, Mrs. B. O.
Nixon, W. G., J.P.
Young, A.

Ex-officio Members:

Chairman of County Council: Westoll, J., J.P.

Chairman of Health Committee: Cain, Mrs. E. G., O.B.E., J.P.

Vice-Chairman of Health Committee: Lady Inglewood, J.P.

PREFACE

To the Chairman and Members of the Cumberland County Council

Mr. Chairman, Ladies and Gentlemen,

I have the honour to present my Annual Report on the Health of the County of Cumberland in the year 1965.

Medical services exist to meet basic needs of society, and as society changes, so does medicine, including Public Health. The main change has been the realisation that team work between the three main branches of the health service has taken over from the isolation of individual effort.

Many of the tasks hitherto carried out by doctors and nurses in the Public Health Service are tasks that originated at a time when gaps existed in the medical service. I feel that the time has arrived for an objective re-appraisal of the need of these services to be continued in their present form, and for the total community health picture to be re-examined to see if there exists new gaps which should be filled by those whose role is that of preventive medicine.

It appears that the most deficient part of the community health picture is that associated with the ascertainment of significant ill-health in the early and presymptomatic stage when it is amenable to treatment. It is heartening to be able to record an excellent start in the scheme for early detection of cancer of the neck of the womb in a susceptible age group of women in this County. I hope and expect that further schemes for early detection of disease will shortly be inaugurated for other groups.

Public health today also has a major role in providing community care for four main groups of persons—mothers and young children, the physically handicapped, the mentally disordered and the elderly. Community care has never been defined, but the phrase undoubtedly expresses an important and developing aspect of social policy, namely, that it is better, wherever possible, to provide help and support for people living in their own homes, with their own families, in their own neighbourhoods, rather than in institutions. Should this become impracticable then care should be in residential settings which will estrange them from their natural and normal surroundings as little as possible. In a rural and remote county such as Cumberland I feel that we are in a privileged position in respect of community care, in that the sociological pattern is that of the extended family; that the family doctor care and support team including nurses and social workers is so far advanced and so complementary to hospital care; and lastly that such an amount of help and support is so willingly and so ungrudgingly given by voluntary bodies.

Community care must be viewed as a type of provision which is actively and positively required by the patient or client, and not as a second best which is erroneously thought to be greatly cheaper than hospital or institutional care.

One of the developments in the year has been the renewed emphasis on comprehensive joint planning of services, particularly for cases of mental disorder and geriatric cases. Out of this is emerging a pattern of joint meeting of officers concerned in the planning and operation of these specialities, akin to that of the successful local maternity liaison committees.

I consider that in this County, which is one of the first to have a new district general hospital, there is urgent need for oper-

ational research to be carried out, by those best able to do it, on the effect of a district general hospital on the community services. I feel that the impact of such a hospital is becoming more marked especially in relation to the domiciliary midwifery service and to home nursing.

As Cumberland, and the Lake District generally, become more accessible to people in these islands environmental health services continue to pose some difficulties. There is an increasing need for constant review of the adequacy of sanitary facilities in general.

Attempts are being made to present to the individual patient in need a unified health service. Various possibilities of administrative linkage suggest themselves, one of them being the setting up of a department of social medicine in a hospital.

The statistics are again better than previous years and seem to indicate to me that great progress continues to be made. Comparisons should not, however, continue to be made with the past. Other thoughts must be in our minds—thoughts for the future.

My thanks go out to the Chairman of the Health Committee for her support and guidance, and to the staff for their consistently fine work in a year of such progress.

I am, Ladies and Gentlemen,

Your Obedient Servant,

John Leiper.

County Medical Officer.

County Health Department,
11, Portland Square,
Carlisle.
Telephone No.: Carlisle 23456.

MEDICAL, DENTAL AND ANCILLARY STAFF

County Medical Officer and County Welfare Officer—

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

Deputy County Medical Officer and Deputy County Welfare Officer—

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

Area Medical Officers and District Medical Officers of Health—

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

J. L. Hunter, M.B., Ch.B., D.P.H., Western Area Medical Officer and Medical Officer of Health Workington Borough.

J. D. Terrell, M.B., Ch.B., D.P.H., D.C.H., Acting Northern Area Medical Officer.

A. Crowley, M.B., B.Ch., D.Obst.R.C.O.G., D.P.H., Deputy Southern Area Medical Officer, Medical Officer of Health Millom Rural District (resigned 14.11.65).

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

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

Assistant County Medical Officers and District Medical Officers of Health—

E. M. O. Campbell, M.B., Ch.B., D.P.H., D.T.M. and H., Medical Officer of Health Maryport Urban District.

D. H. Chowdhury, M.B., B.S., D.P.H., Medical Officer of Health Wigton Rural District and Penrith Urban District (commenced 22.2.65).

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

H. C. T. Smith, M.B., Ch.B., D.P.H., D.P.A., Medical Officer of Health Wigton Rural District and Penrith Urban District (resigned 10.1.65).

Assistant County Medical Officers—

J. E. Ainsworth, M.B., Ch.B.

H. M. Marks, M.B., Ch.B., D.C.H. (commenced 1.5.65).

E. M. Spencer, M.B., Ch.B., (resigned 30.6.65),

M. Timperley, M.B., Ch.B.

K. R. Walker, M.B., Ch.B. (commenced 1.11.65).

DENTAL

Chief Dental Officer—

R. B. Neal, M.B.E., T.D., L.D.S.R.C.S.

Area Dental Officer—

I. R. C. Crabb, L.D.S.R.F.P.S.

Dental Officers—

J. A. G. Baxter, L.D.S.R.C.S.

A. B. Gibson, B.D.S. (commenced 1.1.65).

M. Green, L.D.S.R.C.S.

F. H. Jacobs, L.D.S.

I. H. Parsons, L.D.S.

A. R. Peck, L.D.S.

A. M. Scott, L.D.S.

WELFARE SERVICES

Welfare Services Officer—

S. Hodgson, M.B.E., F.C.C.S.

Deputy Welfare Services Officer —

N. Froggatt.

Social Welfare Officers—

Northern Area

Miss E. A. Welch, A.A.P.S.W., Senior Welfare Officer.
A. Hill (commenced 1.1.65).
G. A. H. Miller.
I. H. Moffet.
M. H. Payne.
W. H. Robinson (part-time).

Western Area

Miss E. M. Hall, Senior Welfare Officer.
G. Cowham, R.M.N.
A. Davidson, R.M.N.
A. Irving.
F. Lewthwaite (resigned 31.10.65).

Southern Area

A. F. Barlee, B.Sc., Econ., Senior Welfare Officer.
J. Allison.
R. Daley (commenced 1.10.65).
J. Gibson (part-time).
J. C. Tanti.

Trainee Welfare Officer—

Miss L. O'Hare (commenced 1.9.65).

Manager/Matron of Residential Accommodation—

H. C. Allen, Station View House, Penrith (resigned 30.4.65).

Mrs. M. Beresford, Grisedale Croft, Alston.

Mrs. M. Campbell, Castle Mount, Egremont.

Mrs. M. Cowham, Post Psychotic Hostel, Fairview, Bransty, Whitehaven (commenced 5.12.65).

Mrs. F. Davies, Derwent Lodge, Papcastle (resigned 16.4.65).

Mrs. H. Day, S.E.N., Richmond Park, Workington (commenced 18.12.65).

Miss E. T. Durkan, The Croft, Kirksanton (commenced 1.9.65).

Miss B. Edgar, Grange Bank, Wigton.

Mrs. A. Hill, Station View House, Penrith (commenced 1.9.65).

P. A. Howe, Highfield House, Wigton.

Miss E. Knox, The Croft, Kirksanton (resigned 12.6.65).

Mrs. K. Lewthwaite, S.R.N., S.C.M., Richmond Park, Workington (resigned 31.10.65).

Mrs. H. S. Milnes, Derwent Lodge, Papcastle (commenced 25.5.65).

Miss A. G. Ross, S.R.N., Parkside, Maryport.

Mrs. D. Smitham, S.R.N., Garlieston, Whitehaven.

Miss E. Vallock, Moot Lodge, Brampton (resigned 14.12.65).

Miss V. Woodman, S.R.N., The Towers, Skinburness.

Warden of Calthwaite Reception Centre—

F. C. Murdoch (closed 1.5.65).

Social Worker/Craft Instructor—

G. S. Toms.

Home Teachers for the Blind—

Miss J. Burgess.

Miss L. D. Fraser.

Mrs. G. Hawthorn (part-time—commenced 22.2.65).

Mrs. G. Mossop.

Miss M. Shuttleworth.

Training Centre Supervisors—

J. J. Lace, Distington.

Miss A. Love, Whitehaven.

Miss G. L. Lister, Wigton.

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.

NURSING STAFF

Superintendent Nursing Officer--

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

Deputy Superintendent Nursing Officer—

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

Nurses' Qualifications Code:

1. State Registered Nurse (or Registered General Nurse).
2. State Certified Midwife.
3. Queen's Nurse.
4. Health Visitor's Certificate.
5. Registered Fever Nurse.
6. State Enrolled Nurse.
7. Registered Sick Children's Nurse.
8. Orthopaedic Nursing Certificate.
9. Diploma in Tropical Nursing.

NORTHERN AREA

Northern Area Nursing Officer—

Miss M. G. M. Watson, S.R.N., S.C.M., Q.N., H.V.Cert., R.F.N. (resigned 8.9.65).

Health Visitors—

Miss M. M. Butler, 1, 2, 3, 4.	Longtown.
Miss E. M. Chalkley, 1, 2, 3, 4.	Penrith.
Miss A. Dixon, 1, 2, 3, 4.	Penrith.
Mrs. E. J. Edwards, 1, 2, 4 (part-time).	Hesket.
Miss E. Henderson, 1, 2, 3, 4.	Penrith.
Miss B. W. Knibbs, 1, 2, 3, 4	Brampton.
Miss E. A. Lockhart, 1, 2, 3, 4.	Brampton.
Mrs. A. W. E. Maughan, 1, 2, 4.	Penrith.
Miss E. Mercer, 1, 2, 4, 5.	Wigton.
Mrs. M. McCredie, 1, 2, 4 (part-time).	Lazonby.
Mrs. M. C. Roberts, 1, 2, 4.	Aspatria.

All the above are seconded to General Practitioners.

Health Visitor/Midwife—

*Mrs. M. Dobson, 1, 2, 3, 4.	Houghton/Scotby/ Wetheral.

District Midwife—part hospital appointment—

Mrs. F. M. Hurst, 1, 2, 3.	Brampton.

District Nurse/Midwives—

*Miss J. R. N. Byres, 1, 2, 3, 5.	Hesket.
*Miss E. M. Dixon, 1, 2, 3.	Longtown.

Miss V. Dodgson, 1, 2.	Abbeytown.
Miss L. R. Douglass, 2, 6.	Skelton.
*Miss J. Gibbs, 1, 2, 3.	Longtown.
*Miss A. M. Holliday, 1, 2, 3.	Aspatria.
*Miss G. Jobson, 1, 2, 3.	Silloth.
*Mrs. I. Penn, 1, 2, 3.	Penrith.
Mrs. M. E. Wilde, 1, 2, 3.	Relief.
*Miss K. Winter, 1, 2, 3.	Penrith.

District Nurse/Midwife/Health Visitors—

*Miss A. Bowler, 1, 2, 3, 4.	Caldbeck.
*Miss A. A. Cockton, 1, 2, 3, 5.	Burgh-by-Sands.
Mrs. D. M. Lancaster, 1, 2, 3, 4.	Wigton.
*Mrs. M. J. Mathews, 1, 2, 3, 4.	Watermillock
*Miss F. McGrath, 1, 2, 3.	Dalston.
*Mrs. E. E. Rome, 2, 6.	Kirkbride.
Miss P. B. Simpson, 1, 2, 3, 4.	Wigton.

District Nurses—

Miss M. A. Barclay, 1, 2, 3, 5.	Greystoke.
*Mrs. J. A. Branthwaite, 1, 3.	Houghton.
*Mrs. F. A. Gaskin, 1, 2, 3.	Irthington and part Brampton.
Mrs. M. Hope, 1, 2, 3.	Relief.
Mrs. V. M. Lamb, 1, 2.	Langwathby.
Mrs. G. Nixon, 1, 2.	Relief.
Mrs. D. J. Patterson, 1.	Relief.
*Mrs. E. J. Relph, 1, 3.	Penrith.
Mrs. D. M. Scoon, 6.	Relief.
*Mrs. S. Staley, 1.	Alston (part-time).
Mrs. M. M. Walker, 1.	Longtown (part-time).

Mrs. E. M. Walton, 1, 2, 9.	Alston (part-time).
*Miss M. Weightman, 1, 2, 3.	Scotby/Wetheral.
*Miss B. M. Wesson, 1, 2, 3.	Hayton and part Brampton.

Clinic Nurse—

Mrs. E. M. Stafford, 1.	Part-time.

*Nurses seconded to General Practitioners.

WESTERN AREA

Area Nursing Officer—

Mrs. A. Steele, S.R.N., S.C.M., Q.N., H.V.Cert.

Health Visitors—

*Miss G. Davies, 1, 3, 4.	Workington.
*Mrs. B. L. Goodson, 1, 2, 4.	Workington.
*Mrs. M. Hewitson, 1, 2, 4.	Workington.
Miss M. Horn, 1, 2, 4, 5.	Cockermouth.
*Miss A. Jackson, 1, 2, 4.	Workington.
*Miss F. Kendall, 1, 2, 4.	Maryport.
*Mrs. M. Lythgoe, 1, 2, 4.	Workington.
*Miss J. E. Surtees, 1, 2, 4.	Workington.
*Miss S. Twigg, 1, 2, 3, 4.	Maryport.

District Nurse/Health Visitor—

Miss M. P. Reynolds, 1, 2, 4. 50% D.N. 50% H.V.	Lorton.

District Nurse/Midwives—

Miss A. Chadwick, 1, 2, 3.	Maryport.
Mrs. C. M. Gate, 1, 2, 3.	Maryport.
Miss S. J. Graham, 2, 6.	Brigham.

Mrs. N. N. Hodgson, 2, 6.	(Full-time relief).
*Miss S. M. J. Iliffe, 1, 2, 3.	Borrowdale.
Miss A. I. Kirk, 1, 2, 3.	Cockermouth.
Mrs. H. M. McCallam, 2, 6.	(Full-time relief).
Miss M. Musgrave, 1, 2, 3.	Cockermouth.
Miss O. Pickering, 1, 2, 3.	Maryport.

Midwives—

Mrs. M. M. Hind, 2, 6.	Workington.
Mrs. A. Maguire, 2.	Workington.
Mrs. M. K. Tunstall, 1, 2.	Workington.

District Nurse/Midwife/Health Visitors—

*Miss M. Casey, 1, 2, 3, 4.	Keswick.
Mrs. A. Donald, 1, 2, 3, 4, 7.	Oughterside.
*Miss A. M. Greggain, 1, 2, 3, 4.	Bassenthwaite.

District Nurses—

Mrs. J. E. Barnes, 1, 2, 3.	(Part-time relief).
*Mrs. A. M. Edgar, 1, 2.	Threlkeld.
*Mrs. M. Hamilton, 1, 3.	Workington.
Mr. T. D. Holmes, 1, 3.	Workington.
*Mrs. M. I. Lowis, 1, 3.	Workington.
*Mrs. L. Messenger, 1, 2, 3.	Workington.
*Mrs. J. Palin, 1.	Workington.
Mrs. V. Sherwood, 1, 3, 8.	Brougnton.
*Mrs. R. Stephenson, 1, 2, 3.	Workington.
Mrs. M. M. Swinburne, 1, 2.	(Part-time relief).
*Mrs. M. Young, 1, 2, 3, 7.	Workington.

School/Clinic Nurses—

Mrs. M. E. Sanson, 1, 2, 5.	(Part-time relief).
Miss D. Wise, 1, 2, 3, 5, 9.	Workington.

*Nurses seconded to General Practitioners.

SOUTHERN AREA

Area Nursing Officer—

Miss J. Reid, S.R.N., S.C.M., Q.N., H.V.Cert.

Health Visitors—

Mrs. E. A. Aderinola, 1, 2, 4.	Millom.
Miss I. M. Alcock, 1, 2, 4.	Whitehaven.
Miss I. E. Bowe, 1, 2, 3, 4.	Millom.
Mrs. S. Crellin, 1, 2, 4.	Whitehaven.
Miss E. Crosby, 1, 2, 4.	Ennerdale.
Miss M. E. Gibson, 1, 2, 4.	Ennerdale.
Miss A. M. Little, 1, 2, 4.	Millom.
Miss R. A. Lodge, 1, 2, 4.	Whitehaven.
Mrs. A. Petch, 1, 2, 3, 4.	Whitehaven.
Miss R. Sheppard, 1, 2, 3, 4.	Ennerdale.
Miss P. Walsh, 1, 2, 4.	Ennerdale.

All the above are seconded to General Practitioners.

District Nurse/Midwives—

Miss A. Armstrong, 1, 2, 3.	Egremont.
*Miss M. G. Beattie, 1, 2, 3.	Millom.
*Mrs. I. Booth, 1, 2.	Millom.
Mrs. C. E. Hall, 1, 2, 3.	Egremont.
*Miss J. Leadbetter, 1, 2, 3.	Cleator Moor/ Whitehaven.
Miss F. Lonsdale, 1, 2.	Seascale.

Miss M. Proctor, 1, 2, 3.	Frizington.
Miss H. Spencer, 1, 2, 3.	Frizington.

Midwives—

Mrs. M. Ainsworth, 1, 2.	Whitehaven.
Miss A. Singleton, 1, 2.	Whitehaven.
Miss E. M. Miller, 1, 2.	Cleator Moor.

District Nurse/Midwife/Health Visitors—

Mrs. J. A. Graham, 1, 2, 3, 4.	Distington.
Miss J. A. G. Hardie, 1, 2, 3, 4.	Parton.
Miss D. D. James, 1, 2, 3, 4.	Seascale/Gosforth.
Mrs. M. Marshall, 1, 2, 3.	Muncaster/Bootle.

District Nurse/Health Visitor—

*Miss I. J. Hoult, 1, 2, 4. 50% H.V. 50% D.N.	Frizington.

District Nurses—

*Mrs. E. Brannon, 1, 3.	Whitehaven.
*Miss O. G. Coates, 1, 3.	Whitehaven.
Mrs. F. Corkhill, 1, 3.	Egremont.
*Mrs. H. Egan, 1, 5.	Whitehaven.
Mrs. D. Jolly, 1, 2, 5.	Millom (relief).
*Mrs. I. Routledge, 1, 2, 3.	Whitehaven.
Mrs. M. T. Toole, 1, 3.	Cleator Moor.
Mrs. S. E. Troll, 6.	Millom (part-time relief).
Miss M. K. Wilson, 1.	Millom Rural.
*Miss J. Woodend, 1, 3.	Whitehaven.

School/Clinic Nurses—

Mrs. E. M. Maguire, 1, 2, 8.	Whitehaven/ Cleator Moor.
Mrs. B. F. Wilson, 1.	Whitehaven.

*Nurses seconded to General Practitioners.

Audiometricians—

Mrs. M. Cross.
Mrs. M. G. Hicks.

Chiropodists—

G. H. Thomas, M.Ch.S.
W. W. Gordon.
Mrs. H. Coulson (commenced 21.9.65).

Orthopaedic Physiotherapists—

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

Orthoptists—

Mrs. G. Richardson, D.B.O. (part-time).
Mrs. J. Scott, D.B.O. (part-time).
Mrs. L. Tongue, D.B.O. (part-time).

Speech Therapists—

Mrs. E. M. Blacklock, L.C.S.T.
Miss E. B. Moon, L.C.S.T. (part-time).
Mrs. S. Latimer, L.C.S.T. (part-time).
Mrs. M. V. Aitchison, L.C.S.T. (part-time—resigned 31.8.65).

County Ambulance Officer—

M. F. Smith.

Senior Administrative Assistant—

J. J. Pattinson, D.F.C.

ADMINISTRATION

The end of 1965 marked the completion of the first full year of area administration and, in general, this major re-organisation seems to have settled down and be working well. Much hidden need for services has been uncovered and the problem now is meeting those needs.

The point about the new administration which seemed to cause most concern is the revised committee arrangements. The Health, Housing and Welfare Committee is primarily concerned with receiving the reports of the Area Health Sub-Committees, the Joint Health and Education Sub-Committee and the Petteril Bank Joint Sub-Committee (for the administration of the Workshops for the Blind), and considering itself matters relating to the ambulance service and general policy and finance. The Area Sub-Committees are responsible for the general supervision and day-to-day administrative functions arising from the statutory provisions referred to the Health, Housing and Welfare Committee by the County Council in its capacity as local health authority, except the ambulance service and a few minor items. When the reorganisation was being planned it was thought that such an arrangement would give a reasonably equitable distribution of committee work between the parent committee and its sub-committees, but after twelve months experience members generally seemed to be of the opinion that the Area Sub-Committees were not getting the volume of items for consideration which had been expected, while the Health, Housing and Welfare Committee was, at each of its quarterly meetings, having too many problems referred to it.

The Health Committee considered that these points can be overcome by two means: a more flexible interpretation of "policy" so that items previously considered by the parent committee can be referred to or emanate from sub-committees, and the establishment of a General Purposes Sub-Committee to deal with administrative matters not related to the functions of the existing standing sub-committees, matters connected with the ambulance service and such matters of policy as may be referred to it for detailed study.

One of the major problems which has been before the committees is nursing reorganisation (which will be reported on fully elsewhere in this report) and it is in a situation such as this, when local knowledge is so important, that the value of the wide representation of the Area Sub-Committees has been proved. Each of these sub-committees has twenty-four members, of which

4 are ex-officio (Chairman and Vice-Chairman of the Health, Housing and Welfare Committee, Chairman of the County Council and the Chairman of the Education Committee),

7 are County Councillors and must include at least one member of the Education Committee,

7 are nominated by the District Councils in the area, representation being on a population basis,

1 is nominated by the Cumberland Executive Council,

1 is nominated by the Special Area Committee of the Regional Hospital Board,

2 are nominated by the teachers in the area, and

2 are persons appointed by the Health Committee as having special experience of the functions of the committee.

Although some of the information is repeated elsewhere in the report, I believe that the consolidated facts given in the tables printed on pages 28 and 29 will present an interesting, overall picture of area administration.

Any steps towards the closer integration or unification of the three branches of the health service are, I think, of the greatest importance. Present legislation keeps us separate but much can be achieved by keeping each other informed of our proposals and being able to discuss from another angle possible solutions to our problems. This is facilitated by the fact that I or my deputy can attend meetings of such important committees as the Special Area Committee of the Regional Hospital Board, West Cumberland Hospital Management Committee, Garlands Medical Advisory Committee, the Local Medical Committee, Local Maternity Liaison Committees, Cumberland Old People's Welfare Com-

mittee and the Cumberland Council of Social Service. The Superintendent Nursing Officer is a member of the East Cumberland Hospital Management Committee. These contacts are invaluable, but it is the meetings of the Health and Medical Services Liaison Group which holds special promise in this respect. The group has representatives of the Special Area Committee of the Regional Hospital Board, Cumberland Executive Council, Carlisle Executive Council, Cumberland Local Medical Committee, Carlisle Local Medical Committee, Carlisle Borough Council and the County Council. It meets at six monthly intervals and its special purpose is to enable the proposals of any of the constituent bodies which may affect the others to be discussed by all at the earliest formative stage, so enabling any points of possible friction or overlapping to be given careful thought and investigation before any detailed planning takes place, and enabling joint action to be taken where thought to be desirable. Some of the matters which have been considered by the group are the location of consultants' clinics for school children—local authority clinic or hospital; the need for a consultant child psychiatrist in the area; the joint use of local authority and hospital medical staff; hospital reorganisation; multiphasic screening of population groups; the siting of ambulance stations in conjunction with hospital developments, and the development of health centres. These steps keep the branches of the service in close contact with each other, while contact is maintained with other authorities in the North and North East, officers of the Regional Hospital Board and the Ministry's Officers through the regular two-monthly meetings of Medical Officers of Health of the Local Health Authorities in the Newcastle Region and the Local Health Authorities and Regional Hospital Board Liaison Committee.

In addition to expressing the local authority's point of view at meetings of the Local Medical Committee, and getting the views of general practitioners on the local authority services, individual general practitioners are kept in touch with the work of the department through a bulletin which is issued three times per year. Recent editions have covered such subjects as the establishment of cervical cytology clinics; the attachment of local authority staff to general practice; arrangements for the transport to hospital of

prematurely born infants; the opening of the hostel for post-psychotics, the adult training centre and two Old People's Homes; information about the ambulance service; the reorganisation of the health visiting service for tuberculosis patients, and information about the establishment of luncheon clubs and day centres for the elderly. I believe that the bulletin serves a useful purpose although the doctors, despite frequent requests, have not commented or made any suggestions as to how it might be improved.

The table printed on page 29 indicates the staff establishment of the department but, unfortunately, not all the posts are filled. Even so, the situation is not as difficult as in many authorities and is no worse than is becoming customary in Cumberland. Nevertheless, it is not accepted as an inevitable situation and every effort has been made to fill the vacancies. Those for dental officers, an area nursing officer, a speech therapist and orthoptists are proving the most difficult to fill, although there are now signs that medical officers—both full-time assistants and assistants with district medical officer of health duties—are more difficult to recruit than in the past.

To try to ensure the availability of orthoptists in the future two courses of action were taken. An arrangement was made with the East and West Cumberland Hospital Management Committees that one of them would try to recruit an orthoptist who would, for part of her time, be seconded to local authority work. It was felt that such an arrangement might attract an orthoptist who preferred the variety of work available in a hospital to full-time work amongst school children, and it did in fact prove successful. The second course of action was for the County Council to award a scholarship of £450 a year, plus tuition and examination fees and travelling expenses connected with the work of the course, to a pupil at a Cumberland grammar school who wished to undergo training. The young lady is now a student at the Orthoptic Department of Glasgow Eye Infirmary. She has agreed, in return, to work for this authority for at least two years after completing her training.

The lack of a speech therapist in the West and South of the county for a third year resulted in the authority deciding to award to any would-be speech therapist a scholarship similar to that for the orthoptist. It is hoped that it will be similarly successful.

Broadly, 1965, while producing its problems was, from the administrative point of view, one of getting a completely new organisation settled down.

AREA ADMINISTRATION

Area	*Area Medical Officer*	*Districts covered*	*Total acreage*	*Total population*	*School population*	*Births in 1965*	*Child Welfare Clinics*		*Training Centres*		*Part III Accomm.*	
							Premises	*Attendances*	*Centres*	*Places*	*Homes*	*Places*
Northern	Dr. F. S. Rogers, 13 Portland Square, Carlisle.	Alston R.D. Border R.D. Penrith R.D. Penrith U.D. Wigton R.D.	612,000	77,490	12,367	1288	14	10,046	1	45	6	198
Western	Dr. J. L. Hunter, Stoneleigh, Park End Road, Workington.	Cockermouth R.D. Cockermouth U.D. Keswick U.D. Maryport U.D. Workington M.B.	173,000	73,680	12,475	1328	8	9,366	1	50	3	95
Southern	Dr. J. N. Dobson, Area Health Office, Flatt Walks, Whitehaven.	Ennerdale R.D. Millom R.D. Whitehaven M.B.	182,000	74,400	13,901	1395	9	17,440	1	45	3	88

AREA ADMINISTRATION — STAFF ESTABLISHMENT

Post	*Establishment*			
	Northern	*Western*	*Southern*	*Total*
Area Medical Officer (also District Medical Officer of Health) ...	1	1	1	3
Assistant County Medical Officers (full-time equivalent)	2½	2½	2½	7½
Area Dental Officer	—	1	—	1
Dental Officers	3	3	3	9
Dental Surgery Assistants	3	4	3	10
Senior Welfare Officers	1	1	1	3
Social Welfare Officers	4	4	4	12
Home Teachers of the Blind ...	2	2	2	6
Speech Therapists	1	1	1	3
Orthoptists	1	1	—	2
Chiropodists (full-time only) ...	1	—	2	3
Physiotherapists	1	—	1	2
Audiometricians	1	—	1	2
Social Worker/Craft Instructor ...	—	1	—	1
Administrative and Clerical staff ...	11	10	10	31
Area Nursing Officers ...	1	1	1	3
Full-time Health Visitors	10	9	11	30
Full-time Midwives	—	3	3	6
D.N., D.N/M., D.N/H.V., D.N/M/H.V.	27	23	22	72
Full-time School Nurses	—	1	2	3

STATISTICAL AND SOCIAL CONDITIONS OF THE AREA

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

Rateable Value (April 1st, 1965) — £7,108,186.

Estimated product of 1d. rate (1965-66) — £28,332.

Population (Census, 1951) — 217,540.

Population (Census, 1961) — 223,202.

Population (1965 Mid-year estimate) — 225,570.

Live Births — Number	3,916
Rate per 1,000 population	17.4
Illegitimate live births per cent of total births	5.6
Still Births — Number	80
Rate per 1,000 total live and still births	20.0
Total live and still births	3,996
Infant deaths (deaths under 1 year)	66
Infant mortality rates —	
Total infant deaths per 1,000 total live births ...	16.9
Legitimate infant deaths per 1,000 total legitimate births	~~17~~ 16·5
Illegitimate infant deaths per 1,000 total illegitimate births	~~23~~ 22·6
Neo-natal mortality rate (deaths under 4 weeks per 1,000 total live births)	10.7
Early neo-natal mortality rate (deaths under 1 week per 1,000 total live births)	9.5
Perinatal mortality rate (stillbirths and deaths under 1 week combined per 1,000 total live and stillbirths)	29.3
Maternal Mortality (including abortion)	—
Rate per 1,000 total live and stillbirths	—

A more detailed analysis of the above figures is given overleaf.

	Male	Female	Total	Urban Districts	Rural Districts	Admin. County	Eng'd & Wales (Prov.)
LIVE BIRTHS—							
Legitimate ...	1882	1906	3695				
Illegitimate ..	113	108	221				
	1995	1921	3916				
Birth rate per 1,000 population ...				18.2	16.8	17.4	18.0
STILL BIRTHS—							
Legitimate ...	36	39	75				
Illegitimate ...	2	3	5				
	38	42	80				
Still birth rate per 1,000 total births				16.7	22.5	20.0	15.7
DEATHS—							
All causes ...	1449	1257	2706				
Death rate per 1,000 population ..				12.3	11.8	12.0	11.5
INFANT DEATHS—							
All infants under 1 year of age—							
Legitimate ...	40	21	61				
Illegitimate ...	1	4	5				
	41	25	66				
Total infant deaths per 1,000 total live births				11.5	20.8	16.9	19.0

MORTALITY TRENDS IN CUMBERLAND

Year		*Under 1*	*1—*	*5—*	*15—*	*25—*	*45—*	*65—*	*75+*	*Total*
1925	...	357	181	93	141	286	623	621	659	2961
		12.1%	6.1%	3.1%	4.8%	9.7%	20.9%	21.0%	22.3%	Rate 13.4
1935	...	202	64	68	91	231	636	630	749	2671
										Rate 13.3
1955	...	101	7	15	22	79	607	737	1075	2648
										Rate 12.2
1956	...	112	12	18	24	112	571	719	1085	2653
										Rate 12.2
1957	...	103	21	19	33	120	553	734	1057	2640
										Rate 12.1
1958	...	108	18	9	24	113	607	677	1087	2643
										Rate 12.1
1959	...	82	8	16	27	81	575	712	1110	2611
										Rate 11.9
1960	...	91	13	19	21	105	554	677	1149	2629
										Rate 12.0
1961	...	88	7	19	19	86	570	747	1189	2725
										Rate 12.3
1962	...	108	15	13	15	114	574	759	1125	2723
										Rate 12.2
1963	...	87	8	11	33	97	648	721	1208	2813
		3.1%	0.3%	0.4%	1.2%	3.5%	23.0%	25.6%	42.9%	Rate 12.5
1964	...	76	19	14	24	88	626	705	1118	2670
		2.8%	0.7%	0.5%	0.9%	3.3%	23.5%	26.4%	41.9%	Rate 11.8
1965	...	66	11	13	29	89	618	750	1130	2706
		2.4%	0.4%	0.5%	1.1%	3.3%	22.8%	27.7%	41.8%	Rate 12.0

MORTALITY TRENDS IN CUMBERLAND 1915-65 Percentage of Total Deaths

District	BIRTHS					
	Legitimate	Illegitimate	Total	Births per 1,000 of population (crude)	Comparability factor	Stillbirths
URBAN DISTRICTS—						
Cockermouth	87	11	98	16.1	1.00	4
Keswick	46	6	52	12 0	1.12	—
Maryport	194	16	210	17.2	0.96	5
Penrith	189	12	201	18.5	1.00	2
Whitehaven	490	25	515	18.9	0.93	7
Workington	551	24	575	19.2	1.00	10
Aggregate	1557	94	1651	18.2	0.98	28
RURAL DISTRICTS—						
Alston	32	1	33	16.0	1.25	—
Border	462	28	490	15.7	1.12	15
Cockermouth ...	304	15	319	15.1	1.02	7
Ennerdale	610	34	644	20.2	0.99	10
Millom	228	16	244	16.1	1.08	6
Penrith	168	7	175	15.2	1.07	1
Wigton	334	26	360	16.5	1.05	1
Aggregate	2138	127	2265	16.8	1.05	5
Administrative County	3695	221	3916	17.4	1.02	8

ND POPULATION IN THE YEAR, 1965

DEATHS			INFANT MORTALITY										
Total Deaths	Deaths per 1,000 of population (crude)	Comparability factor	Total Infant Deaths	Legitimate	Illegitimate	Neonatal Deaths	Early Neonatal Deaths	Infant Death Rate	Neonatal Rate	Early Neonatal Rate	Perinatal Deaths	Perinatal Death Rate	Estimated mid-year population
90	14.8	1.08	—	—	—	—	—	—	—	—	4	39.2	6080
89	20.5	0.83	—	—	—	—	—	—	—	—	—	—	4350
149	11.6	1.15	3	3	—	2	1	14.3	9.5	4.8	6	27.9	12190
147	13.5	0.88	—	—	—	—	—	—	—	—	2	9.9	10870
298	10.9	1.31	8	8	—	6	5	15.5	11.7	9.7	12	23.0	27290
339	11.3	1.14	8	7	1	5	5	13.9	8.7	8.7	15	25.6	29910
812	12.3	1.13	19	18	1	13	11	11.5	7.9	6.7	39	23.2	90690
34	16.5	0.87	1	1	—	1	1	30.3	30.3	30.3	1	30.3	2060
322	13.5	0.86	10	8	2	5	5	20.4	10.2	10.2	20	39.6	31240
222	10.5	1.10	4	4	—	3	2	12.5	9.4	6.3	9	27.6	21150
376	11.8	1.21	16	15	1	10	9	24.8	15.5	14.0	19	29.1	31940
165	10.9	1.28	2	2	—	1	—	8.2	4.1	—	6	24.0	15170
125	10.9	1.02	4	4	—	2	2	22.9	11.4	11.4	9	49.4	11510
250	11.5	0.94	10	9	1	7	7	27.8	19.4	19.4	14	38.2	21810
1 4	11.8	1.03	47	43	4	29	26	20.8	12.8	11.5	78	33.7	134880
2 5	12.0	1.07	66	61	5	42	37	16.9	10.7	9.4	117	29.3	225570

	Cause of Death	Administrative County	Cockermouth U.D.	Keswick U.D.	Maryport U.D.
	All Causes	2706	90	89	149
1.	Tuberculosis, Respiratory	4	—	—	1
2.	Tuberculosis, Other	1	—	—	—
3.	Syphilitic disease	2	1	1	—
4.	Measles	1	—	—	—
5.	Other infective and Parastic diseases	6	—	—	—
6.	Malignant neoplasm, stomach	95	6	2	5
7.	Malignant neoplasm, lung bronchus	92	4	5	4
8.	Malignant neoplasm, breast	32	2	1	2
9.	Malignant neoplasm, uterus	22	—	—	1
10.	Other malignant and lymphatic neoplasms	218	4	5	8
11.	Leukaemia, Aleukaemia	18	—	—	1
12.	Diabetes	34	1	—	4
13.	Vascular Lesions of Nervous System	480	14	21	26
14.	Coronary Disease, Angina	623	20	15	41
15.	Hypertension with Heart Disease	48	2	3	5
16.	Other Heart Disease	300	9	19	10
17.	Other Circulatory Disease	120	4	1	5
18.	Influenza	7	—	—	—
19.	Pneumonia	89	4	3	6
20.	Bronchitis	92	3	2	9
21.	Other Disease of the Respiratory System	32	4	—	2
22.	Ulcer of Stomach and Duodenum	19	—	—	1
23.	Gastritis, Enteritis and Diarrhoea	15	—	1	—
24.	Nephritis and Nephrosis	17	—	1	1
25.	Hyperplasia of Prostate	6	—	—	—
26.	Congenital Malformations	24	—	—	2
27.	Other Defined and Ill defined diseases	200	9	5	1
28.	Motor Vehicle accidents	35	1	2	2
29.	All other accidents	57	2	1	2
30.	Suicide	15	—	1	
31.	Homicide and Operations of War	2	—	—	—

TRATIVE AREAS (1965)

	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.
	298	339	1112	34	422	222	376	165	125	250	1594
	—	—	1	—	1	—	1	—	—	1	3
	1	—	1	—	—	—	—	—	—	—	—
	—	—	2	—	—	—	—	—	—	—	—
	—	—	—	—	—	—	—	—	—	1	1
	—	2	3	—	1	1	1	—	—	—	3
	15	8	39	1	11	11	19	3	3	8	56
	12	15	41	—	9	4	19	7	5	7	51
	4	3	18	—	1	1	3	5	3	1	14
	2	2	5	1	6	—	4	1	—	5	17
	23	37	89	3	29	13	27	15	13	29	129
	5	1	8	—	1	—	3	—	3	3	10
	5	2	14	—	3	3	5	5	2	2	20
	51	60	201	5	76	43	60	30	20	45	279
	55	78	250	7	109	64	88	40	28	37	373
	4	5	22	—	11	6	3	1	2	3	26
	19	36	113	6	56	21	30	16	22	36	187
	16	16	47	1	22	8	23	12	1	6	73
	3	—	3	—	—	1	2	—	7	1	4
	3	9	37	—	11	12	10	5	—	7	52
	1	15	43	5	13	4	14	5	—	8	49
	3	2	11	—	4	2	9	2	1	3	21
	2	4	7	—	2	3	1	—	—	6	12
	2	2	8	—	3	—	2	—	1	1	7
	2	1	7	—	2	2	2	3	1	—	10
	1	1	2	—	1	1	1	—	—	1	4
	4	1	7	—	3	2	9	1	1	1	17
	3	25	86	3	29	11	27	8	7	29	114
	3	3	15	1	3	7	1	2	2	4	20
	8	8	26	1	13	2	8	3	3	1	31
	1	3	6	—	2	—	2	1	—	4	9
	—	—	—	—	—	—	2	—	—	—	2

BIRTH AND DEATH STATISTICS

Year	Estimated mid-year population	Births: Number	Births: Rate	Deaths: Number	Deaths: Rate	Excess of births over deaths
1915 ...	204,939	4,910	22 7	3 537	17.6	1,373
1925 ...	220,030	4,177	18.9	2,961	13.4	1,216
1935 ...	201 000	3,318	16.5	2,671	13.3	647
1947 ...	202.460	4,446	22.0	2 788	13.8	1,658
1951 ...	214,700	3,681	17.1	2,827	13.2	854
1952 ...	215,050	3.714	17.3	2,603	12.1	1,111
1953 ...	216,100	3,608	16 7	2,571	11.9	1,037
1954 ...	216,600	3.533	16.4	2 567	11.9	996
1955 ...	216 700	3,556	16.4	2,653	12.2	903
1956 ...	217.450	3,679	16.9	2,653	12.2	1,026
1957 ...	217,600	3.901	17.9	2 640	12.1	1,261
1958 ...	217,700	3,834	17.6	2 613	12.1	1,191
1959 ...	218.900	3.888	17.8	2,611	11.9	1,277
1960 ...	219,160	3,940	18.0	2,629	12.0	1,311
1961 ...	221,460	3,900	17.6	2,725	12.3	1,175
1962 ...	223 330	4.085	18 3	2,723	12 2	1,362
1963 ...	224,630	3,964	17.7	2 813	12.5	1,151
1964 ...	225,690	4.147	18.4	2 670	11.8	1,477
1965 ...	225,570	3,916	17.4	2,706	12.0	1,210

NURSING SERVICES

Sections 23, 24 and 25 of the National Health Service Act 1946

"It shall be the duty of every local health authority to secure, whether by making arrangements with the Board of Governors of teaching hospitals, Hospital Management Committees or voluntary organisations for the employment by those Boards, Committees or organisations of certified midwives or by themselves employing such midwives, that the number of certified midwives so employed who are available in the authority's area for attendance on women in their homes as midwives, or as maternity nurses during childbirth and from time to time thereafter during a period of not less than the lying-in period, is adequate for the needs of the area.

It shall be the duty of every local health authority to make provision in their area for the visiting of persons in their homes by visitors to be called "health visitors", for the purpose of giving advice as to the care of young children, persons suffering from illness and expectant or nursing mothers, and as to the measures necessary to prevent the spread of infection.

It shall be the duty of every local health authority to make provision in their area, whether by making arrangements with voluntary organisations for the meployment by those organisations of nurses or by themselves employing nurses, for securing the attendance of nurses on persons who require nursing in their own home."

The Changing Pattern of Nursing Services in the Home

The year 1965 is one which has seen many operational changes in the nursing services in the home in Cumberland and these will be outlined later in this report. What seems of more fundamental importance is the recognition and careful objective analysis of the fundamental issues underlying these changes and the further evolution of the service.

In recent years many, if not all professional disciplines have undergone closer definition than ever before, largely because of the need to relate them more accurately to near neighbours in the professional world (e.g. health visitors and social workers) or to 'auxiliary' skills, combining in team work, (e.g. auxiliary nurses and state registered nurses). Nursing, and certainly the home nursing services administered by local health authorities, have called for such definition, as indeed has the field of work of the family doctor, in terms of the ancillary helps to which he should have access in order to allow of his practising his proper professional task. It would be idle to ignore the fact that this whole emphasis on defining. and more judiciously using, professional skills is associated with a very real and alarming shortage of highly trained professional people.

What then is the proper content of 'nursing' in the context of community care?—assuming the latter term with all its limitations and over-simplification to refer to care outside of hospitals. Has the task of the district general hospital affected this, remembering of course, that Cumberland has one of the first of these in the country; and how is 'community nursing' going to dovetail with general practice—present, and even more importantly, future.

Some of these factors are imponderables, (notably the future pattern of general practice)—but not all. We are already in a position in this county to weigh the factors associated with a district general hospital, only fully functional, it is true, for one year. Even before this is considered, however, we must look at the base-line of nursing work in the home at present being done, and in this connection something should be said about a two stage survey recently conducted in the county of the working day and

week of all the nurses themselves. This, it should be remembered, relates to a situation where already all but one of the health visitors and 78 per cent of the home nurses have been seconded to general practitioners.

The content of the work of the nursing staff has been changing in the past few years, and it has been difficult to assess what constituted the normal working day of the average nurse, midwife or health visitor. The Ministry, in the Circular 12/65, 'The Use of Ancillary Help in Local Authority Nursing Services' stated how valuable such a survey would be not only in calculating the hours of work, but in defining what duties might be allocated to less qualified or lay staff. Such a survey had, in fact, already started using a form which was applicable to all categories of nursing staff covering all aspects of the work, district nursing, midwifery, health visiting, school health work and including travelling, clerical work, attendances at general practitioners' surgeries and miscellaneous items.

Three periods of two weeks each at a different time in the year were considered. The first was in July when the schools were on holiday, the second in November and the third will take place in the spring of 1966.

The results of the survey to date are surprising in some respects. It has shown that health visitors, whether in rural or urban areas, are fully occupied. Indeed it seems the health visitor is a member of the team who has been the least disturbed by the changing pattern. Her activities are well defined, interesting, varied and she may be in danger of being overwhelmed by the constant addition to her programme of work.

The midwifery situation, as noted elsewhere, is for various reasons unique, and from the surveys it is apparent that there is a considerable degree of under-employment and consequent staff dissatisfaction.

Home nursing shows under-employment in some areas, both urban and rural, and steps are already being taken to remedy this, either by enlarging the area or by introducing other aspects of

work such as attendance at a doctor's surgery for certain sessions each week, or by taking part in home nursing for the taking of cervical smears.

This then shows broadly that the health visitors are fully occupied and I have no doubt that some of the factors in their work for the future, which I mention below, will mean only a constant need for more domiciliary qualified nurses in this specialty for a long time to come. In domiciliary midwifery there is serious and very disturbing under-employment, despite radical pruning of the numbers of staff undertaking this work which has already taken place—a reduction from 69 to 49 in the course of 1965 alone—again, further comments below. In the field of home nursing there is shown to be something less than full employment in a good number of cases and so far the evidence is not forthcoming that attachment to general practice, as far as it has gone for home nurses and as long as it has so far lasted, has significantly affected the volume of work of the nurse. It was my reasonably confident expectation that this expansion would happen and I am deeply interested in the thoughts of my colleagues in general practice as to the extent and ways in which they feel they can more fully use the services of the district nurse.

To pursue, for a moment, the emergent pattern of work of the home nurse, it will be seen that it is the clarification of her future role in partnership with the family doctor which contributes one of the major elements in the field of public health nursing. If the district general hospital indeed fulfills its originally allotted function of diagnosis and treatment with the return of all possible patients to their own home as speedily as can be, then the home nurse can look forward to little serious acute illness to nurse at home, and an increasing volume of chronic geriatric work which has not yet reached the stage of requiring hospital care. What is more, the further development of such services as home helps, and day and night nursing and sitter services for certain terminal or other 'intermediate term' illnesses may well tell in favour of keeping such cases in their own homes. It is interesting, however, to wonder even at this early stage, whether the district general hospital is in fact moving already towards the position of assuming a greater volume of responsibility for termnial illness.

Here, as in the field of midwifery, as I shall shortly indicate, it is a little disappointing to realise that hospital planning has gone ahead largely independent of the services to be provided in the home by the general practitioner and the local authority staff. It is sincerely to be hoped that a prominent feature of future integration of the health services will be care in joint planning in such intersecting spheres of service.

Having said this, however, I cannot speak too highly of some of the elements of direct co-operation which the hospital personnel, medical, nursing and administrative, have given in recent years, both from the district general hospital in West Cumberland and from the East Cumberland hospitals alike. The welcoming of the area nursing officers into the wards, particularly the geriatric, and of the health visitor in obstetric and paediatric departments, has been a great step forward. The current refresher training of home nurses in the most up-to-date surgical nursing techniques for application in the home, is a further move in the right direction; the direction towards an integrated hospital/home nursing service with direct person to person communication between nurses inside and out of hospital, within the over-all policy of the doctors responsible for patient care.

The association of the home nurse with family doctors has, however, I am glad to say indicated various guide-lines of development, notably in connection with the constitution of the "home medical-care team" and in the realm of what might be called 'out-patient' nursing in the general practitioner's surgery. It was noticeable, when an element of this surgery-nurse work was agreed upon for a few general practitioner attached nurses, that the need became immediate for help in the shape of the State Enrolled Nurse, though the developing need for the latter in the home has been clear for some time. This has led to a more determined effort to visualise the team of the future as it will function in relation to presumably enlarged group practices on the one hand, and the still relatively isolated smaller rural practice on the other. Of the latter we shall obviously in Cumberland still have a large proportion compared with many parts of the country. Is this pattern one of an agreed number of health visitors, home nurses and State Enrolled nurses (full or part-time in varying proportion)

—even family home helps—attached to a group practice and working as a team or 'firm'; possibly a designated senior member of the nursing team with responsibility in co-ordinating the work of the others—a 'senior sister' in the practice? The latter function may well of course, be carried out by the area nursing officer, as indeed it is at present in the main, though from a purely administrative angle. Clearly more secretarial help will be associated with general practice in the near future and the need for such assistance is becoming daily more apparent for the nurses also. Should joint appointments of secretaries in practices be made, or at least the cost of shared secretarial help be met in part by the local authority? It seems to me that only within a pattern developing along such lines as the above will the field of work of the home nurse be clarified and her new image become clearer to the nurse herself with satisfying conviction. That the nurses are unsettled at present is an understatment of the position as some of their own comments indicate clearly, and since their future unquestionably lies in closer working with family doctor groups, the re-organisation and greater professional satisfaction of the latter is at the heart of the nurses' future.

Of course there are pros and cons in all of the elements of such a picture. The inevitable, and probably highly desirable, use of more part time nurses places the nurse/doctor attachment at some hazard—how many part-time nurses can be 'attached' effectively to a practice and maintain close and regular contact? On the other hand, the very multiplicity of persons involved allows of wider residential scatter of the nurses living in the community and preserves in some cases the confidence especially of the smaller rural communities, in the presence of a nurse in the village, a service of great historic value to many, though its limitations in the modern context of home medical care, are also becoming better understood.

The concept of the 'surgery nurse' touched on above, plunges at once, of course, into the whole question of planning, finance and administration as between executive councils and local health authorities. If surgery nurses are to be provided in future for general practitioners, let it be prayed fervently that somehow this is done in conjunction with the local authority nursing service;

and not introduced on a different administrative basis with all the attendant risks of friction and competition involved. Perhaps however the whole administrative future of the family doctor, and what is now the local authority personal health service, will converge more purposefully in the future.

Much of what has been said above in connection with home nursing applies equally to **health visiting** in terms of relationships with family doctors and with hospitals. In some of the more rural situations the functions will continue to be combined but with full qualification in health visiting a 'sine qua non'.

The main anxiety which many health visitors must feel, centres on her twin-disciplinary approach in nursing and social work. The latter's meteoric emergence in recent years as a major professional discipline comes very understandably to be construed from the health visitor's point of view as something of a threat. I am sure however, that the health visitor's sound base in the practice of family doctoring makes her position secure. If she gets into clear focus her major role in the maintenance of good health in risk groups, (including the elderly, of course); the parallel detection of early evidence of disease (by personal visitation and observation, or by vigorous and pioneering participation in the approaching avalanche of health screening work); and her spearhead role in health education (via home, surgery, school, community associations, etc.) she will demonstrate her complete indispensability in the medical services of the country. This will, however, be to a large extent dependant on her willingness to relinquish what are often long cherished but out-dated concepts, notably that of the 'clinic' as her 'castle'. Her main task is in the home, alongside the family doctor, or in the wider community situations as mentioned above.

In the domiciliary midwifery service the basic problem, now most acute, is the steady decline in domiciliary midwifery in the county over the past 10 years. With the very generous provision of maternity beds in the district general hospital in West Cumberland a position was reached where, as far as two-thirds of the county's population is concerned, it is quite feasible to reach 100% hospital confinement should this be desired by the hospitals

and by mothers. Already at the end of 1965 the proportion of hospital confinements in West Cumberland has reached 84%. The burning question before a local authority in these circumstances is how to fulfil a statutory requirement of Section 23 of the National Health Service Act to provide a domiciliary midwifery service "adequate for the needs of the area". Despite prior reductions in the number of practising domiciliary midwives, in 1965 as many as 45 midwives conducted 15 cases or less, and 20 midwives actually conducted 5 or fewer in the year. Is this a service "adequate" in terms of training and practice of the midwives? Is it just and fair to midwives to ask them to work in such a pattern with progressive loss of skills and job-satisfaction? So far the measures taken to ameliorate this position have consisted in the quite drastic reduction of the numbers of local authority midwives undertaking domiciliary midwifery (with all the attendant uncertainties and unhappiness for the staff); the wide extension of the geographical area of many midwives; the introduction of new methods of communication via the ambulance service where scarce midwifery 'cover' was an anxiety; the further planning of communications with midwives cars by short wave radio. At the time of writing this Report I am discussing the whole problem in great detail with my Committee, including possibilities such as the complete integration of hospital and domiciliary midwifery in one area of the county as a pilot scheme (where already the hospital confinement rate is almost 90%); the inevitability of discontinuing the district part of Part II Midwifery Training; and even the advisability—indeed the inevitability—of thinking of a positive policy of 100% hospital confinement.

It must be recognised, however, that this situation has been developing for 10 years and an all-round failure to appreciate the implication of the impending situation should prove salutary in terms of future trends in other areas of nursing and indeed of all services.

REORGANISATION OF THE NURSING SERVICES

The following account is given by Miss Mansbridge, Superintendent Nursing Officer, on the major moves in reorganisation during 1965 including the main issues as they appear to the nursing staff:—

"It is said 'The mind likes a strange idea as little as the body likes a strange protein and resists it with similar energy. If we watch ourselves honestly we shall often find that we have begun to argue against a new idea even before it has been completely stated.'

Not unexpectedly, there was some evidence of this when nursing reorganisation started with the introduction of area administration in the Autumn of 1964. Fortunately, however, the nursing staff on the whole were of broader vision and accepted the changes — if not with enthusiasm at least as a challenge.

Much thought and time has been given, by both the committees responsible and the officers concerned, to the reorganisation of the nursing services — home nursing, midwifery and health visiting — to keep them abreast of modern trends and able to meet new requirements.

The need for reorganisation was brought about by the following changes:—

1. The old district nursing association boundaries were determined by the locality's ability or willingness to raise the necessary funds to employ a nurse, and by her ability to cover the area on foot, or bicycle. Of necessity she had to be "all-purpose", that is undertaking the general duties of nursing, midwifery and health visiting, although not always fully qualified to do so. Before the advent of the National Health Service her services were inclined to be called on instead of those of a doctor.

2. Rural de-population, coupled with the use of telephones and cars, has meant serious under-employment in some districts.

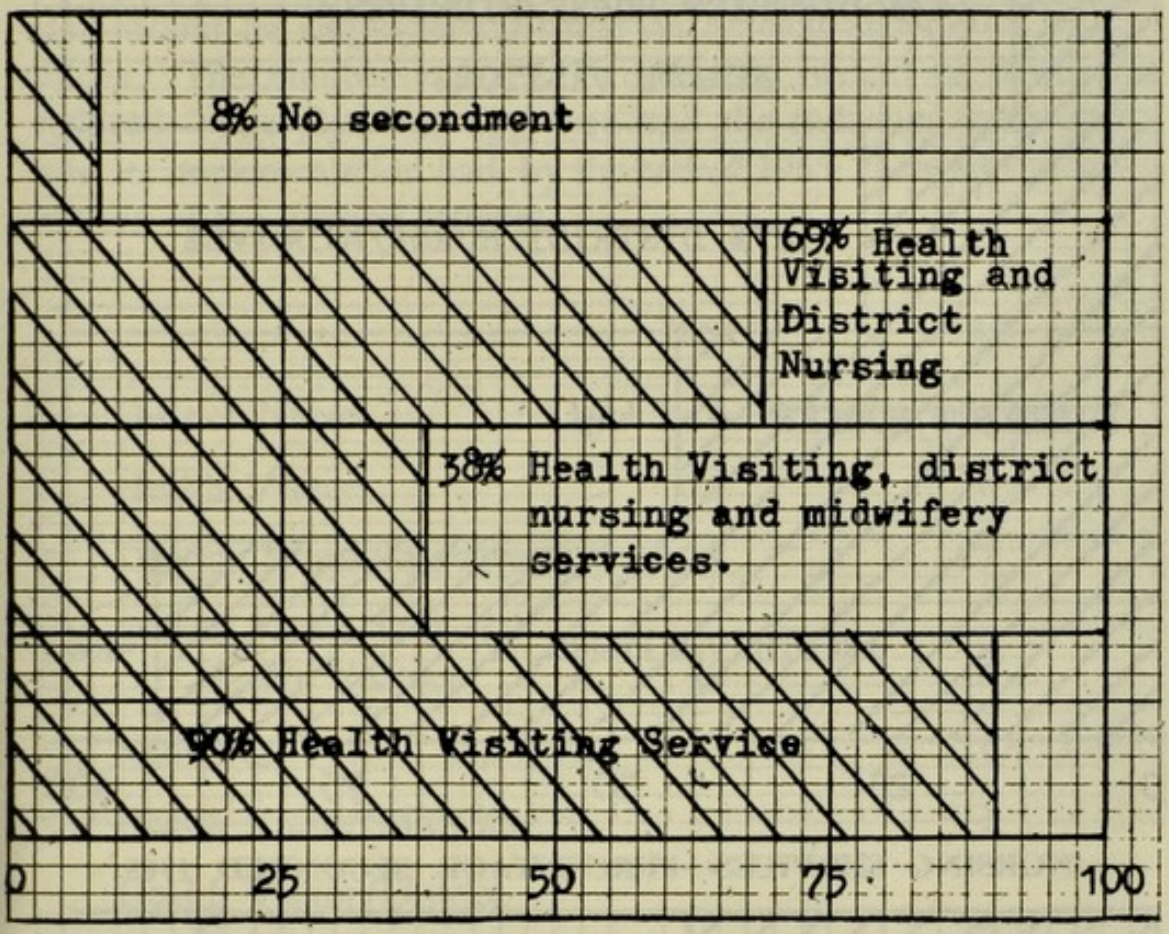
Over the years there has been piecemeal amalgamation of districts to overcome this difficulty, but this has not been to any comprehensive plan

3. The diminution in the number of home confinements, coupled with the increased complement of hospital beds requiring only a minimum number of 48 hour discharges of patients has, of necessity, altered radically the work of the district nurse/ midwife. Whereas formerly she attended 15 to 25 confinements each year, the number has latterly reduced in many instances to under 10, or even under 5, per year.

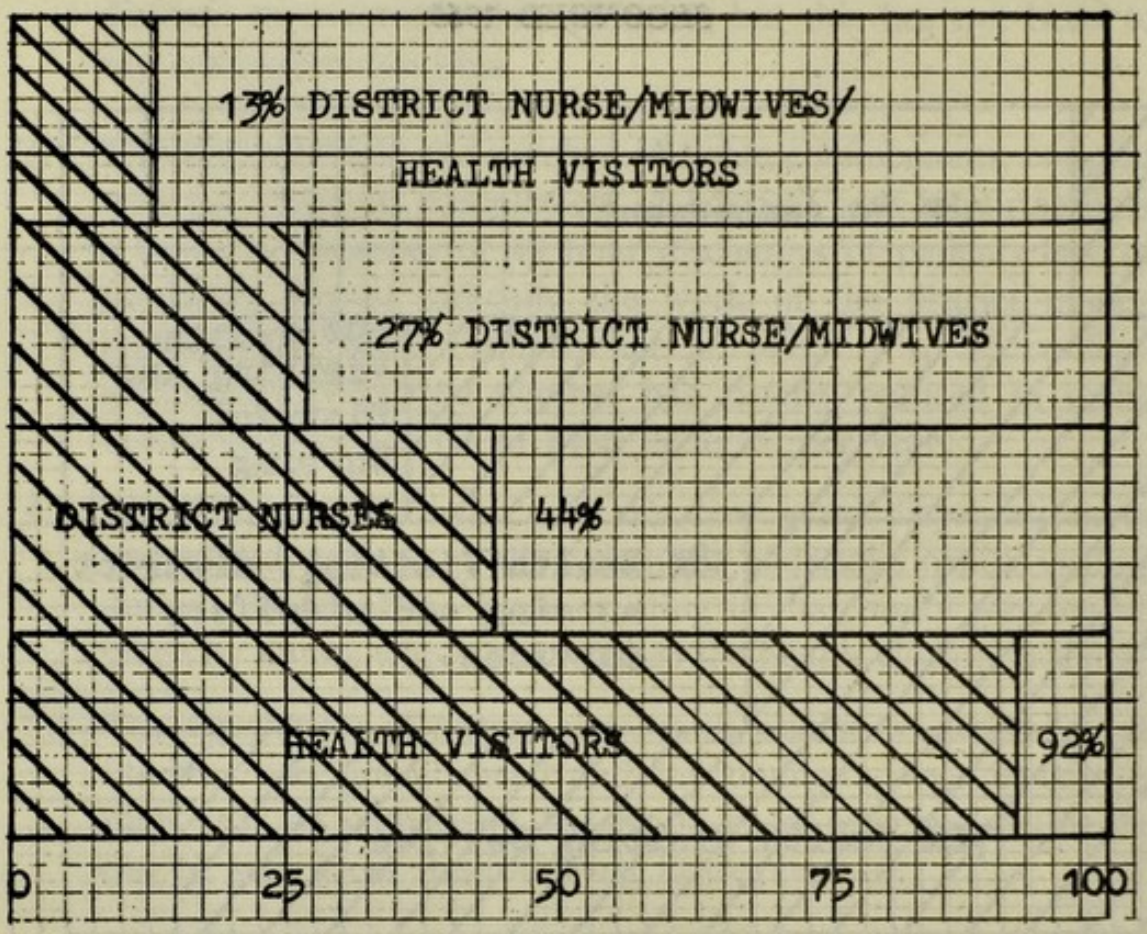
4. The Ministry of Health does not now grant dispensations to unqualified persons to allow them to undertake health visiting duties. Much of the health visiting in the county was undertaken by nurses who had not taken the health visitors' training.

5. The attachment of nurses and health visitors to general practitioners was going ahead and the numbers were increasing each year. Cumberland has made good progress in this, as can be seen from the following histograms:—

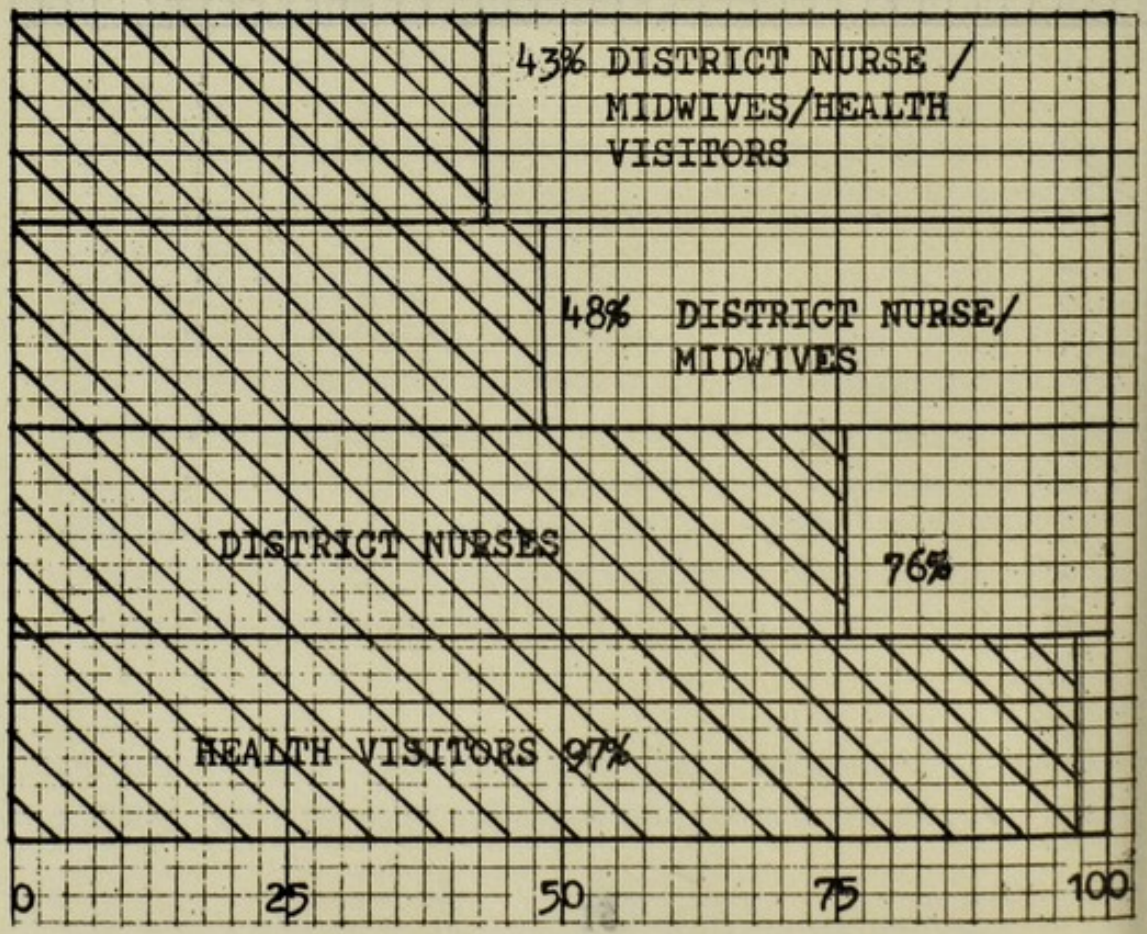
GENERAL PRACTITIONERS—PERCENTAGE WITH SERVICES SECONDED 1965



NURSING SERVICES—PERCENTAGE SECONDED 1964



NURSING SERVICES—PERCENTAGE SECONDED 1965



A detailed plan was submitted to the County Council, the aim being to meet and overcome these difficulties by specialisation. The number of triple appointments would be reduced and more staff would be employed full time on nursing and health visiting duties. The number engaged in midwifery would be drastically reduced. The plan was approved and the following table shows how its implementation had, by the end of 1965, changed the whole pattern of the nursing services.

	1964	*1965*
District Nurses	16+8 P/T	29+11 P/T
Health Visitors	25	30+ 2 P/T
District Nurse/Midwives ...	23	27
District Nurse/Midwife/ Health Visitors ...	39	14
Midwives	7	6+ 1 P/T
Health Visitor/Midwife ...	—	1
Health Visitor/District Nurse	—	2

It was, of course, essential to explain the situation to the staff and meetings were held in each area when full discussion took place. Later, each nurse was invited to state the category of nursing in which she would prefer to work and for which she was qualified, should the reorganisation affect her. In spite of these meetings and discussions on the impending changes, the nurses have felt somewhat frustrated. Their previousy defined areas and responsibilities appeared to have been taken from under their feet and this has left a feeling of insecurity which no doubt accounts for some resistance to the changes.

In retrospect, it was obvious that more steps should have been taken to inform the village communities of the pending changes in the nursing reorganisation, as the plan spelled the end of the village nurse and aroused objections in some village com-

munities. The residents of the village of Lorton and surrounding area took exception to the transfer of the nurse from the village, and a meeting was held in the village hall to explain the scheme. The final decision was that a nurse should continue to reside in the village but as there was insufficient work in the area to keep her fully occupied, she should assist with school work and at clinics in Cockermouth.

It was evident that the aims of the plan would have to be explained fully in all areas affected and it was, therefore, arranged that in all those districts, the parish Councils would be invited to convene meetings, to which they would invite representatives of voluntary organisations such as the Women's Institute. Changes would only be made after they had been agreed at such meetings and the implementation of the reorganisation plan would therefore be in step with local opinion. First indications are that the communities involved are reacting favourably towards the plan when it is explained to them.

At the time of writing, meetings have been held at Wetheral, Thursby, Dalston, Greystoke, Mungrisdale and requests are being received from other areas.

The Ministry Circular 12/65 on "The use of ancillary help in the local authority nursing services" stresses the importance of ensuring that the best use is made of the skills of the qualified nurse and advocates the employment, where appropriate, of less qualified nursing staff, nursing auxiliaries or lay personnel to assist in the work. It is anticipated that this will result in an improved service, provided the ancillary staff are properly prepared for their work. The qualified staff will be released for duties commensurate with their qualifications and skills. It is intended to recruit these less qualified members of staff as need and opportunity permits.

After a year of area administration, the Area Nursing Officers in the Western and Southern areas, Mrs. Steele and Miss Reid, both report that they appreciate the benefit of meeting personally the members of their Area Health Sub-Committees and working closely with the Area Medical Officers, Senior Welfare Officers, Social Workers and other members of the area teams.

Mrs. Steele writes, 'The nursing staff in my area now know they have a centre within easy reach where they can call in for discussion with me and collect equipment etc. The new organisation of the service at a local level is, I think, an advance. The appointment of nursing staff at area level gives the Area Medical Officer the opportunity of selecting his own team of workers. Liaison with the hospitals and general practitioners has improved with secondment, and the availability of a local office is a valuable link with all concerned'.

Miss Reid writes, 'I appreciate the value of local administration particularly as the Southern Area is such a distance from Carlisle. I find it much quicker to be able to deal completely with things locally, and it is easier to maintain direct contact with all staff'.

The situation in the Northern Area, where the greater part of the reorganisation has taken place, has been rather disrupted owing to the resignation of Miss M. Watson, the Area Nursing Officer, who left in August to take up the appointment of Superintendent Nursing Officer in Banffshire. This left a big gap which up to the present time has not been filled, and the work is covered temporarily by Miss Blockey, Deputy Superintendent Nursing Officer.

As Superintendent Nursing Officer, I am now able to give my time to policy and planning, which in these times of change demand much thought. More selective contact with the services on the ground in areas of special difficulty has to be practised, with more time being given to training and the organisation of courses. The variety and exchange of ideas with Area Nursing Officers, each responsible for injecting imagination and drive into the local development of services in their areas, proves mutually stimulating.

The reorganisation programme has been woven into the work throughout the year and in retrospect it appears a co-ordinated pattern is emerging which shows hopeful signs of a good, unified service for the future."

MIDWIFERY

The steady trend towards hospital confinements has continued throughout the year producing a progressively more serious effect on the domiciliary midwifery service. The National Health Service Act 1946, Section 23, laid upon local authorities the responsibility for the provision of a domiciliary midwifery service adequate for the needs of the area, either by direct employment of midwives or on an agency basis. The diminution in the number of domiciliary cases makes it increasingly difficult to cater for the changing needs and wishes of the population. The table below shows how the trend has developed and pinpoints the marked decrease in domiciliary births:—

TABLE 1

Live and Still Births

Year	Total Births	Domiciliary	Institutional	Domiciliary Percentage
1953 ...	3,722	1,587	2,135	42.7
1954 ...	3,594	1,482	2,112	41.2
1955 ...	3,655	1.488	2,167	40.7
1956 ...	3,841	1,584	2,257	41.3
1957 ...	4,029	1,473	2,556	36.6
1958 ...	3,886	1,413	2,473	36.4
1959 ...	3,997	1,324	2,674	33.1
1960 ...	4,046	1,225	2,821	30.3
1961 ...	3,937	1,128	2,809	28.6
1962 ...	4,136	1,148	2,988	27.7
1963 ...	3,996	982	3,014	24.6
1964 ...	4,215	888	3,327	21.1
1965 ...	3,968	711	3,257	17.9

During the year the midwives paid 13,567 visits to patients confined at home and in addition paid 2,340 visits to patients discharged from hospital before the tenth day. The number of early discharge patients is not large as there are sufficient hospital beds to allow patients to stay for eight to ten days. Early discharge is not encouraged and is usually by the request of the mother herself for specific reasons.

The overall substantial reduction in the number of practising domiciliary midwives is shown in Table II. The marked difference in full time equivalent between 1963 and 1964 reflects re-allocation of midwives' time, and the substantial drop in the total number of domiciliary midwives at the end of 1965 is associated with the implementation of current nursing re-organisation plans.

TABLE II

	1957	1958	1959	1960	1961	1962	1963	1964	1965
Domiciliary Midwives	77	78	76	74	66	73	74	69	49
Full-Time Equivalent	47	46	46	44	39	44	43	22	19
Institutional Midwives	34	37	42	42	44	53	55	60	59

The reduction of the domiciliary midwives' cases and the wider areas to be covered necessitated a review of the methods of communication. The most difficult areas are in the northern part of the County and here it was decided to use the ambulance service in a 'call out' arrangement when a midwife could not be located and this is most helpful as it is available 24 hours a day. The ambulance depot has the list of midwives and telephone numbers and makes the necessary contact when requested. A longer term approach is under consideration by means of short wave radio control in midwives' cars and negotiations are in hand to try this as a pilot scheme with a group of six midwives in the Northern area as soon as this can be arranged.

Midwives who notified their intention to practice in the County during the year numbered 144. These included 7 whole-time domiciliary midwives working in urban areas, 65 district nurse/midwives working in semi-urban and rural areas and 70 midwives working in the maternity hospitals or maternity units of small hospitals. Two midwives working from a private agency attended patients in the County and notified their intention to practice. It will be readily appreciated that many of those notifying intention to practice overlap one another in post so that these figures cannot be immediately related to those in Table II.

The West Cumberland Hospital Maternity Unit now includes an active General Practitioners' Unit comprising approximately 20% of the maternity beds and is continuing to have a profound effect on the domiciliary confinement rate in West Cumberland, so much so that the Part II Midwifery Training Scheme is in jeopardy and it is doubtful whether it can continue. This scheme requires a certain number of domiciliary confinements for pupils under the supervision of selected training midwives. During the year six pupil midwives took their district training and passed the examination. As there were only 127 confinements in the training midwives' areas, had there been the full complement of 12 pupil midwives it would have been impossible to give effect to the Part II Training requirements on the district. The task of the training midwife is fraught with anxiety when there are insufficient cases. How can she give her pupil midwives adequate experience when there are not enough available cases either for herself or the pupils? Decisions will be necessary in 1966 on the whole future of this scheme as far as the Local Health Auhority is concerned.

TABLE III

Confinements attended by individual midwives

No. of Midwives	0-5	6-10	11-15	16-20	21-25	26-30	30+
In 1965	20	15	10	5	6	2	9

This is a disturbing pattern even though the number of midwives has been drastically reduced during the year. How can the midwives keep their skills and have job satisfaction in such a situation? Varying fundamental solutions to this problem will be explored in the coming year including a possible agency arrangement with the Hospitals for domiciliary midwifery.

During the year 84 mothers were booked for home confinement who were in the main high risk groups, i.e. aged 35 years or over, having their fifth or later pregnancy, or others over 30 having first babies. There were 55 mothers booked for home confinement in respect of their fifth or subsequent pregnancy.

These figures show a marked improvement over 1964 figures, a decrease of 42.8% of high risk group mothers being confined at home. This is a most satisfactory change and must reflect an increasingly enlightened attitude to the place of confinement of these mothers. The reasons given by some mothers for refusing hospital admission were not always easy to assess, the majority stating they "did not wish to go to hospital" or they were "anxious about the other children".

Medical help was sought by the midwives according to the rules of the Central Midwives Board on 35 occasions—a decrease of 58 on the previous year—as set out in the following table:—

Ante-natal Period —

Antepartum haemorrhage	2
Early rupture of membranes	2
Placenta Praevia	1
Threatened miscarriage	1
Toxaemia	2

During Labour —

Retained placenta and P.P.H.	3
Ruptured perineum	5
Still Birth	1
Mal presentation	1

During Puerperium —

Mother —

Pyrexia	4
Engorged breasts	1
Phlebitis	1
Sore throat	1
Fainting attacks	1

Baby —

(a) Spots	2
(b) Sticky eyes	7

It is interesting to note that of the 84 'At Risk' booked cases, 69 were delivered at home and 15 were delivered in hospital. Of those transferred to hospital, 8 were transferred during the ante-natal period, 9 during labour and 2 during the puerperium.

The results of the confinements were:—

Stillbirths	5 (2 at home; 3 in hospital)
Miscarriages	Nil
Live Births	78
First week death ...	1

When the perinatal mortality rate for these 84 cases is compared with that for all births in the County during the year, they are seen to be approximately three times more productive of perinatal deaths.

Ante-natal clinics are variously held in the local authority clinics, and in the doctors' and midwives' surgeries, 650 expectant mothers, booked for either domiciliary or hospital confinements, attended these clinics during the year.

It is essential to achieve a better attendance at mothercraft and relaxation classes. These are available through the hospital service and at clinics throughout the County. A small survey which took place in the County showed that less than one-third of all expectant mothers received group health education, although half received some instruction when discussion in patients' own homes and general practitioners' and nurses' surgeries were taken into account. There has been some increase in the year in the classes in clinics held, to a total of 291, and there were 1,564 attendances. The health visitors take part in these classes, some giving only one talk and others taking the series. They also take part in the hospital courses. It requires constant pressure to impress on some mothers the importance of these classes. Three midwives attended a special weekend course in Newcastle for Psychoprophylaxis in Childbirth. It was both a stimulating and interesting weekend and very helpful to all who took part.

As envisaged in last year's report, the dual appointment of a midwife to the local authority and hospital service was started in April as a pilot scheme with Brampton Cottage Hospital General Practitioners' Obstetric Unit. It has not been as successful as was hoped. The unit of five beds appears too small to allow midwifery work only being undertaken when on duty in the hospital and the domiciliary commitment is also insufficient as there have been only ten domiciliary cases to the end of December. It seems, therefore, that further consideration must be given to this form of appointment, which to be successful must ensure full employment and satisfaction in the work.

Mrs. Steele, Western Area Nursing Officer, attended a refresher course for supervisors of midwives in Cardiff, in April. The lectures and discussions covered a very wide field including amongst others such subjects as "New Trends in Ante-Natal Care", "Tests of Placental Function", "Problem of Low Birth Weight Babies", "The Problems of Cervical Carcinoma" ,and a forum on "Can the Midwifery Service be Unified."

Six domiciliary midwives attended statutory courses arranged by the Royal College of Midwives at Bangor, Nottingham and Cheltenham, and four attended courses arranged by the local authority of Kingston upon Hull. The midwives appreciate these courses and the opportunity of meeting midwives working in other areas but they feel that if some practical hospital work could be included in the course it would be most beneficial.

The local branches of the Royal College of Midwives in East and West Cumberland each arrange a study day or weekend when all midwives both hospital and domiciliary have the opportunity of attending lectures given by both visiting and local consultants. These study days are much appreciated and usually well attended and a good meeting place for hospital and domiciliary midwives.

Miss Blockey, Deputy Superintendent Nursing Officer, has continued to give lectures on emergency midwifery to groups of Police Officers attending refresher courses at Carleton Hall Police Headquarters and when required to groups of full time ambulance staff. The importance of this will be appreciated when it is realised that four confinements took place in ambulances during the year; these are cases into each of which I am looking in some detail.

Co-operation with the hospital service in both East and West Cumberland has continued on most satisfactory lines. Three meetings were held during the year of both East and West Cumberland Maternity Liaison Committees. There has been good general discussion on all aspects of the Midwifery Service and in particular the following subjects were specially considered:— a study of all perinatal deaths in East Cumberland; a scheme for free domestic help in approved cases or obstetric need, started in April, and beneficial in three cases where it was difficult for the mother to

rest in bed without domestic help; the planning of early discharge schemes for maternity patients, as suggested by the Ministry of Health—no action was necessary in this area; the results of a small survey on health education for expectant mothers. West Cumberland gave special consideration to Part II Training and the reduction in the domiciliary bookings in the area.

I have no doubt at all that the coming together in these Committees of all the authorities with responsibility in the maternity services has had a far reaching effect on the attitudes of all concerned and has had its own beneficial influence on the now very gratifying statistics for Cumberland of maternal and perinatal deaths. The general awareness is keen I am sure of the numerous factors contributing to an improved Maternity Service—this notwithstanding the very serious problems facing the local authority in maintaining a domiciliary midwifery service, a matter which I have already dealt with.

HEALTH VISITING

The health visitor had probably been least affected by the re-organisation of the nursing services. There is a danger, however, of work which does not require her skill being allocated to her. The Ministry Circular 12/65 defines a health visitor's work as follows:—

"The functions of a health visitor should primarily be health education and social advice; she may usefully undertake other functions but these should arise from or be incidental to her primary functions. In carrying out all her functions a health visitor should have full regard to the needs of the family and the part played by other workers."

During the year the number of full time health visitors has increased from 25 to 30 and at the same time the number of district nurse/midwife/health visitors has been reduced from 39 to 14 and a post of health visitor/midwife and two of health visitor/district nurse have been created. This reduction in triple appointments has taken place mainly in the Northern Area, a rural part of the county where previously district nurse/midwife/health visitors were rather more widely employed.

Only 4 of those now carrying out health visiting duties do not hold the Health Visitor's Certificate.

The full-time health visitor, attached to the general practitioner, finds her time fully occupied and is able to use it to the best advantage both for home visiting and for promoting health education in the schools and clinics. She is not, as when previously employed as district nurse/midwife/health visitor, concerned with the nursing of patients or with midwifery and so is able to plan her day's work and knows she can fulfill her commitments.

There is now 97% attachment of full-time health visitors to general practitioner groups, including two part-time health visitors each attached to general practitioners working in a very rural area. The results are very satisfactory for the general practitioners, who each now deal with only one health visitor, and also for

the health visitors who can keep actively engaged in the work yet be able to manage their domestic commitments.

The amalgamation of tuberculosis visiting into general health visiting has worked reasonably satisfactorily, each health visitor now being responsible for the tuberculous patients in her general practitioner's practice. Two health visitors who previously undertook full-time tuberculosis visiting have been attached to general practitioners for general health visiting duties, each previously having attended a refresher course in Birmingham.

The pattern is also changing in the health visitor's work at the clinic, where there is more scope for ancillary help—the less qualified nurse and the voluntary helper. The former, take over duties which do not require her specialist training; the latter, have assisted in the clinics for some years with excellent results, but still there is need to extend this, the requirements ranging from clinic to clinic. For example, the older school children can assist in looking after toddlers at clinics during holiday periods as has been started at Cleator Moor. The child welfare centre of today has to fulfill not only a medical function but an important social and educative function. It must be a place where young mothers can be helped to gain confidence in themselves and in the care and development of their children and the health visitor must have time to help and advise.

The following table shows the number of home visits to children under five years of age:—

Year	No. of children under 5 years of age visited during the year	Fist visits to children under 1 year of age	Total visits to children under 5 years
1963 ...	18737	4034	58847
1964 ...	17473	4039	61866
1965 ...	16949	3899	57367

The value of selective health visiting becomes more pronounced through the attachment of the health visitor to the group practice. It is here that she comes in contact with mothers who particularly need help, meeting them at an earlier stage in their problems than she might otherwise have done. There may be fewer actual home visits but the results are better since the attention is focused on those who really need help.

In addition, 10,239 visits have been made to persons over 65 years of age. The visits to the elderly are expanding yearly and the health visitors find this contact a very useful and rewarding one as so much can be done by ascertainment of their needs and consequent referral to the right source of help.

A big step forward in preventive medicine was taken in April with the establishment of clinics for the taking of cervical smears for women between the ages of 35-50 years. This simple test undertaken by health visitors specially trained for the work offers early diagnosis of one of the most common forms of cancer in women. It was felt that there was a lot to be said for health visitors taking the smears in the clinic; if a doctor did this, over much significance might be implied to the patient as to medical screening of other conditions. The response was at first slow, but after increased advertising, the numbers attending rose and, by the end of the year, 1,751 women had been tested with a positive result in 6 cases. Further reference is made to this elsewhere in the Report.

The number of other workers approached by the health visitor in the course of her work is remarkable and the following contribution by Miss Davies, a health visitor, illustrates the wide contacts associated with the work:—

"Over the last 12 months I have had liaison with the hospital ward sisters, casualty sister, hospital dietitian, pathology staff, probation officer, youth employment officer, hospital almoner, appliance officer, public health inspectors, housing department, moral welfare officer, Children's department, home teacher for the blind and other welfare officers. Through the school nurse I have obtained the teacher's assessment of a child and the par-

ents' views for the information of the family doctor. Health visiting is very interesting, often there is not enough time to do all one would like. Working for the family doctor has become so routine that it is sometimes difficult to describe, but you may be interested to know that the weekly immunisation session I started has now become a child welfare session where children are not just immunised but examined and referred where necessary for a consultant's opinion."

It was decided to organise within the county, for the first time, an in-service, residential refresher course for health visitors and it was held at Dalston Hall from April 4th to 9th. Sixteen health visitors from our own staff and four from outside the County attended.

The programme included 'The health visitor's work and training', 'The health visitor and the elderly', 'Health Education', 'The subnormal in the community' and 'Hospital development and the health visitor'. Alderman Mrs. E. G. Cain, O.B.E., Chairman of the Health Committee, opened the Course, and among the speakers were Dr. J. H. Walker, Lecturer in Public Health, The University, Newcastle-on-Tyne, on 'Comprehensive Community Care', and Miss E. E. Wilkie, Chief Professional Adviser, Council for Training of Health Visitors, on 'Training the future health visitor'. Dr. A. J. Dalzell-Ward, Medical Director, Central Council for Health Education, spoke the third day on 'The Borderline between health and sociology' and was followed by Miss D. S. Elliot, Health Education Officer, Croydon, on the 'Use of Visual Aids'. Dr. R. H. M. Stewart, Senior Administrative Medical Officer, Regional Hospital Board, Newcastle-on-Tyne, brought the Course to an end with a very enlightening and interesting talk on 'The Hospital Services in the Region'.

Visits were paid during the week to the West Cumberland Hospital, Flatlets for the Elderly at Keswick, and the Junior Training Centre at Wigton.

Everyone enjoyed the freedom of studying in such pleasant surroundings and expressed their appreciation of having had the opportunity of attending such an interesting Course.

The usual arrangements with Bolton Technical College Health Visitors' Course for 12 students to spend a week in the County for experience in rural health visiting were repeated in April. This is of benefit both to the student and health visitor. The interchange of ideas is interesting, helpful and of undoubted benefit to both student and health visitor.

Two students from the Community Health Course at the William Rathbone College, Liverpool, spent a week each in the County studying nursing administration in a rural area.

Miss Reid, Area Nursing Officer, attended a refresher course for Superintendent Health Visitors, in London, the theme being 'A Philosophy for the Future and a Challenge'.

Health visiting, as a specialist professional discipline within nursing, has been facing serious threats for some years. The opportunity now is clearly before the health visitor to establish herself as the central figure alongside the family doctor, in the community medical care team. I believe that in Cumberland the health visitor is securely on the road to just such a position.

HOME NURSING

The home nursing service has undergone considerable change during the last year, both in the type of work undertaken and the personnel involved.

Through the re-organisation plan already referred to, there were at the end of the year, 29 nurses engaged in home nursing full-time and 11 part-time, whereas twelve months ago there were only 16 full-time and 8 part-time. Overall, there are however only 72 full-time members of staff whose duties include a home nursing component compared with 78 at the end of 1964. To meet the changing conditions the move has had to be towards fewer people with more specialisation. Many of the nurses now have a much wider area to cover and often more than one colleague to contact for relief purposes, but a scheme to notify doctor and the public where staff can be contacted has been arranged as far as practicable.

With the increasing attachment of home nurses to the general practitioner it is considered that, where practicable, nurses might give in the surgeries some of the treatment they would otherwise have to give in patients' homes. This will relieve nurses of a certain amount of time consuming home visiting and, at the same time, the link between doctor, nurse and patient will be improved and strengthened.

A pilot scheme started in July in Workington with one practice and has proved very successful as evidenced by a report received from Miss Young, the Queen's Nursing Sister. To allow her to give more time to surgery work a State Enrolled Nurse has been appointed part-time to assist with general care and bathing of patients in the practice. Miss Young writes, "The secondment of district nurses to general practitioners continues satisfactorily. The scope has been enlarged since July by the work carried out in the surgery, in a room equipped for nursing procedures, such as injections, dressings, ear syringing, collection of blood specimens. swabs etc. Over 500 cases have already been treated. This has proved interesting and allows many patients previously visited at home to attend at the surgery for attention and social contact.

Several minor operations, such as removal of sebaceous cysts and warts, have been carried out by the doctors under local anaesthetic and with my help."

A general practitioner writes, "In our practice we have found 'our' District Nurse to be of much more help to us than 'a' District Nurse as under the old scheme. This is not just due to the closer liaison between us and the nurse but the fact that the system encourages all to act as a team, and this feeling seems to percolate through to the patient."

During the year, meetings were held with the surgical consultants in both East and West Cumberland to discuss the part to be played by nurses in providing home nursing for those who had undergone surgical treatment for such operations as appendicitis and herniotomy. The first requisite was to bring the nurses up to date with modern surgical nursing and techniques and it was therefore arranged that each should spend a week in a surgical ward and have an opportunity of seeing procedures for the preparation of the patient, the operation and post-operative treatment. A start was made in East Cumberland at the City General Hospital in July and by the end of the year 12 nurses had had this "refresher course". Mrs. Relph, from Penrith, comments:—

"May I say how much I enjoyed my week at the Carlisle Hospital. All the staff were most pleasant, and helped me to see all that has to be seen of modern methods used in surgery today.

I found the changes quite astonishing and how good it is that we should be allowed back into hospital from our 'outside nursing world' to observe these changes and meet our fellow workers."

For various reasons the scheme could not start in West Cumberland until January 1966, but at the time of writing 26 nurses have spent a week at either the West Cumberland Hospital or Workington Infirmary. All have appreciated the help given by the staff and the opportunity to observe up to date surgical work. I would like to record my appreciation to both East and West Cumberland Hospital Management Committees for the co-operation and help given.

Future plans for district training for state enrolled nurses have been discussed with the West Cumberland Hospital Management Committee in connection with State Enrolled Nurse training already given at Workington Infirmary. It is envisaged that the pupil nurses will take an eight weeks' course in district work during the last three months of training. A similar course will also be available for State Enrolled Nurses who are appointed to the county staff.

In the statistical table on Home Nursing, it will be seen that there is a reduction of 62 in the total number of patients nursed during the year. There were 93 patients more over 65 years of age, but this was more than counterbalanced by a reduction of 155 in the remaining cases. Of the 279 patients suffering from cancer 29 had cancer of the lung, and in all, 7,026 visits were paid to patients suffering from this disease. There is an increase of 16,351 in the visits paid to all patients and in view of the reorganisation and staff changes I think this is a very creditable situation.

Home nurses have joined in the group meetings which are held in each Area at regular intervals, when all matters of local interest are discussed. Three nurses attended a special course on 'The Care of the Elderly' in Birmingham, and three attended a Refresher Course at Tetley Hall, Leeds, when lectures were given on 'Chronic Bronchitis', 'Recent Advances in Paediatric Surgery', 'The Varieties of Mental Disorder', 'Thoracic Surgery' and other subjects. Three more of the staff attended a Mental Health Course at Beaumont Hall, Leicester. This Course was particularly appreciated as it covered so many of the problems connected with mental ill health and deterioration which are met with during the course of the nurse's work. Mrs. Lowis reports, "The Course was most interesting and very stimulating. I now feel I have a better understanding of mental health."

Towards the end of the year a meeting was held with Group Captain M. G. Philpott of the Marie Curie Memorial Foundation, with a view to establishing a branch of the Day and Night Nursing Service in Cumberland for the home nursing care of cancer pat-

ients from 1st January, 1966. It is primarily to relieve the relatives of some of the intensive nursing responsibilities and so enable patients to stay at home instead of being admitted to hospital.

Advertisements inserted in the local papers by the Marie Curie Memorial Foundation invited applications for this work and the outcome was the selection and registration of fifteen persons as being suitable for and available to help. Four live in the Northern Area, six are in the Western Area and five in the Southern Area. Of these, 9 were trained nurses, either State Registered or State Enrolled.

Home Nursing

		Total number of persons nursed during the year.	Aged under five at first visit.	% of total cases nursed.	Aged 65 or over at first visit.	% of total cases nursed.	Malignant Disease.	% of total cases nursed.	Remaining cases.	% of total cases nursed.	Total Number Nursing Visits.
1961	...	6375	390	6%	2495	39%	213	4%	3277	51%	127,610
1962	...	5696	381	7%	2893	51%	237	4%	2185	38%	117,648
1963	...	6083	455	7%	2933	48%	248	4%	2447	41%	125,266
1964	...	6167	448	7%	2966	48%	285	4%	2468	41%	134,305
1965	...	6105	433	7%	3059	50%	279	5%	2334	38%	150,656

A circular explaining the facilities available was sent to all doctors, nurses and hospital secretaries. It is hoped that as many as possible will take advantage of the help available.

The Welfare Fund of the Marie Curie Memorial Foundation for patients suffering from cancer has been operating for many years and patients have been provided with such items as bedding, clothing, laundry and toilet necessities, extra fuel and nourishment. The demand has never been excessive but it is a very useful fund to draw on when required and the need can be met immediately. This year there have been nine applications, all of which have been granted.

The British Red Cross Society continues to run successfully the three loan equipment depots and the only problem seems to be the occasional urgent demand when all the normally adequate stock of an item of equipment is already on loan. These problems are, however, overcome and I am indeed grateful to the British Red Cross Society for their unfailing help and co-operation.

The nurses still keep loan equipment for some small items and there has been no significant change during the year. Disposable equipment—which includes sterilised syringes and needles, masks caps and polythene sheeting—is in continual use and much appreciated. The laundry service continues to operate in Whitehaven and has been used by 86 families during the year. The co-operation and help of the West Cumberland Hospital laundry service is invaluable. Incontinence pads are in great demand; around 40,000 have been used in the year. Their disposal, as mentioned last year, is by burning and no difficulties have arisen in regard to this method. They are much appreciated for the comfort of the patients and as a hygienic aid to the relatives caring for incontinent patients.

HOME HELP SERVICE

Section 29 of the National Health Service Act, 1946

"A local health authority may make such arrangements as the Minister may approve for providing domestic help for households where such help is required owing to the presence of any person who is ill, lying-in, an expectant mother ....., aged, or a child not over compulsory school age, within the meaning of the Education Act, 1944".

MOBILE HOME HELPS

HOME HELP SERVICE

The Home Help Service though still permissive as defined in the National Health Service Act 1946 has become a recognised and most important service available to all and used more particularly by the elderly. It is significant that each year there is a national expansion in the number of home helps employed and the householders helped. The cause for this is in the inevitable annual increase in the number of elderly in the population. There are many more persons over 80 years of age requiring help or needing more help than they may at present receive. An important feature of the Home Help Service is the regularity of the help available; it gives the greatest comfort and security to an elderly person, particularly to one living alone, to know someone will be coming to the house on definite days of the week who will be able to do things which have had to be omitted because of incapacity.

The households helped during the year increased by 41 to the highest total yet, namely 1,174, of which no less than 81% were elderly persons (the histogram on page 82, shows the distribution of classes helped). The following table shows a breakdown into areas:—

Area	No. of Home Helps	No. of Housekeeps assisted
Southern	69	414
Western	53	391
Northern	126	369

This again demonstrates the need for an increased number of home helps in the Northern Area owing to the much wider geographical area to be covered, and it is here that the mobile Home Help Service will be of great value.

Information regarding the service is available to all the elderly not only from the doctors and nurses but also through the Old Peoples' Clubs throughout the County. Talks on all local authority services, illustrated with coloured slides, are frequently

given and a special write-up on the Home Help Service has appeared in the Clubs Bulletin which has a wide circulation. There should by now be very few of the over 60 age group who do not know of the service, though many will not require help, they should know how to obtain it when necessary.

The referral of a household for a home help is usually from one of the following sources; the doctor, nurse, hospital, relative or friend, or the application may come directly from the household. The home is visited to assess the need; this is done by one of the nursing staff who can make the necessary decision at the visit. There is no need for a medical certificate.

A most successfuul innovation during the year was the provision in July of a Morris Mini van equipped with cleaning materials and utensils. It was made available for use by two home helps, Mrs. M. Garrett and Miss D. Hewitt in the Cockermouth area. "Home Helps join the Flying Squad" was the press announcement which created great interest. Through this development the Service has been expanded to communities which hitherto could not be reached by public services. It has also been possible to increase the caseload of the home helps as less time is now spent in travelling. The area covered is one in which it is particularly difficult to enrol home helps owing to the hotel work and other factors. Mrs. Garrett and Miss Hewitt report as follows:—

"Before we had the van we relied entirely on the local 'bus service, where there was any, and quite often it was very difficult or impossible to help people in the more remote areas. This problem has now been solved and economies made in time. Another inconvenience which has been overcome has been arriving soaking wet at houses in very bad weather.

We would like in particular to mention one case which it would have been impossible to help without the van. This was a confinement case who lived near Dunmail Raise on the borders of Westmorland, and because of the mobility of the Home Help Service she was able to have her baby at home and still receive the necessary care and rest because of our help."

The success of this scheme is already apparent and further financial provision for vans is under consideration. The second van will be allocated for use in the Northern area of the County.

There is fortunately a considerable amount of voluntary neighbourly help still available, particularly in the rural areas and this can be of great value both to the householder and the service. The friendly neighbour visits when it would be impossbile for the home help to attend and the home help can give practical assistance with the housework at stated times, both co-operating to keep the home running smoothly.

Circumstances may occur in a family where a relative on whom the household is depending for support has to give up her work to stay at home with an elderly person and the question arises, should such a relative be paid as a home help? This should only be considered if every other means of help has been explored and no satisfactory solution found. The relative if accepted should be willing to help other households if required and as circumstances permit; this helps her to be a full member of the service and to have a wider knowledge of the work.

A free service to certain categories of patients has been under discussion from time to time. The most important group who may require help in emergency are those obstetric cases with complications such as toxaemia of pregnancy arising during the antenatal period. Immediate rest in bed may be required and while there may be adequate help available without the assistance of a home help there are certain households where difficulties arise and a home help is essential, but may be refused on account of the expense. The provision of a certain amount of free home help could offer a definite contribution to the well-being of the mother and baby and ultimately have a beneficial effect on the perinatal and infant mortality rate.

After full discussion with the consultant obstetricians and members of the local Maternity Liaison Committees in both East and West Cumberland, the Health Committee agreed that on medical or obstetric grounds, where hardship would occur, it

would be possible to waive the charge in appropriate cases. This has resulted in three households being helped in this way with beneficial results, the mothers having developed toxaemia during pregnancy.

In December the Ministry issued Circular 25/65 on the Home Help Service. The Minister stated that he regards "the provision of home helps as a service which is an important element of community care and one on which the domiciliary health and welfare services as a whole increasingly depend for their proper functioning." The Circular covers assessment of need, recruitment and training, good neighbour and neighbourly help schemes. Suggestions for the training of home help organisers are included and are useful to local authorities in giving a wider scope for initiating training schemes. The final paragraph relates to the abolition of the minimum charge which at present may be reimbursed by negotiations with the National Assistance Board. Initial consideration of this matter by the Health Committee resulted in no action at the present. The standard charge for the services of a home help has remained at 4s. 7d. per hour, though an increase is expected should there be a further pay award.

Recruitment remains at a steady level and except in a very few situations the applications of the householders are fulfilled even to the provision of residential help for midwifery cases in outlying rural houses.

The Family Help Service, commenced in 1964 to help families with special problems, has continued to function in a limited way during the year. A great deal of time is sometimes spent both by ourselves and the Children's Department in arranging help for a "problem family" only to find that the help is rejected after a short period. One family has had continuous help for six months and is now managing alone but will have further help if the need reappears. Another of these families left the district and one moved to other accommodation where they hoped to manage without help. During the year two new families were helped making a total of six since the scheme started. These two families had special problems each of a very different nature but requiring intensive supervision, which unfortunately ended w

an eviction order in one case and the children taken into care. The second family remains under supervision.

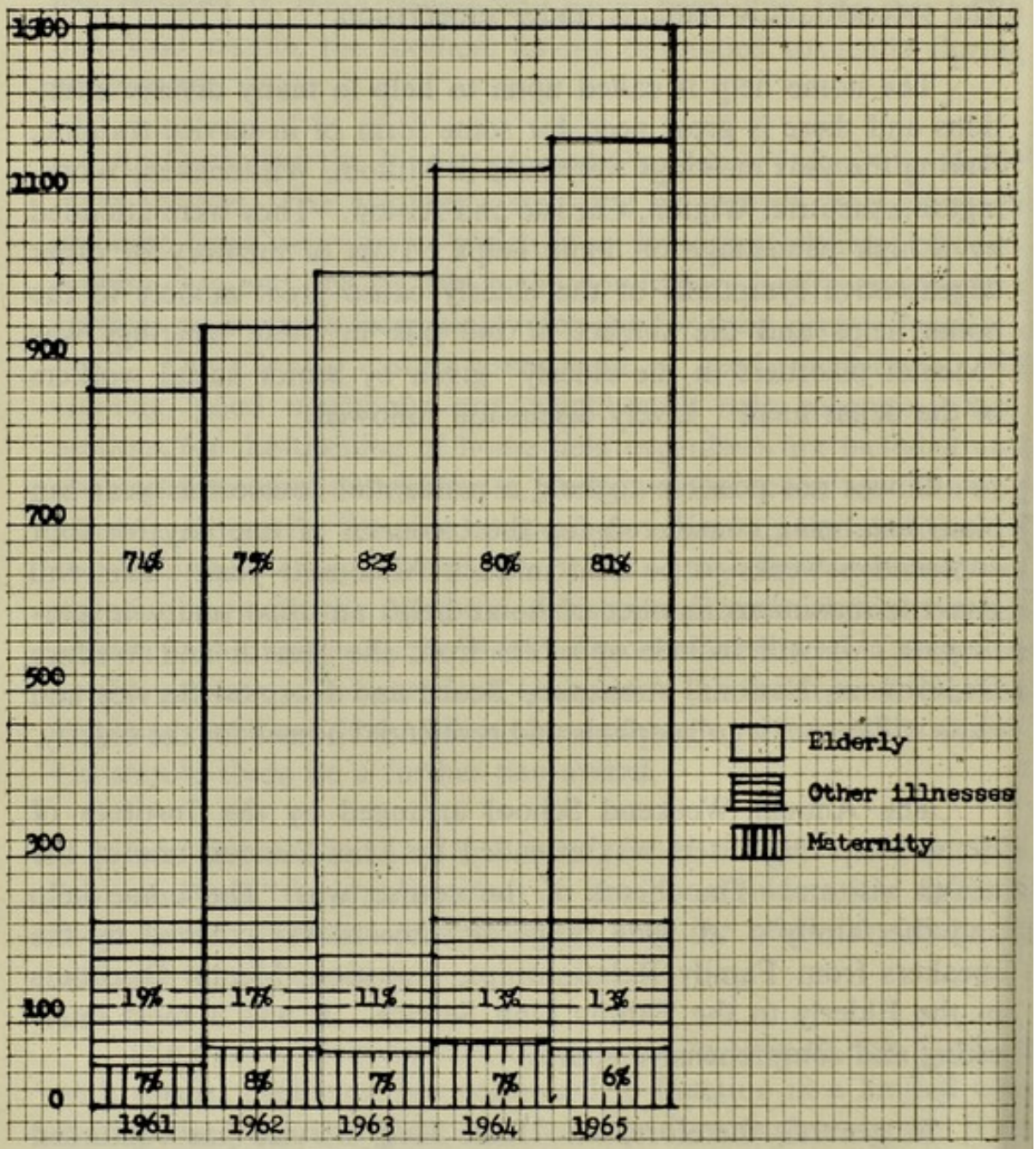
The home help is called upon to help in many diverse situations and there is great need for some form of in-service training. During the year meetings were held in Millom, Whitehaven, Workington, Aspatria, Wigton, Carlisle and Alston. They were attended by a high percentage of home helps. Loss of memory or other degenerative symptoms of the elderly cause great anxiety to the home helps and the subject of the talk at these meetings was "Mental disorders in the elderly" given by senior social workers of the department. Lively discussion followed.

It was not possible to hold a residential course this year but plans are being considered for short courses of one day for four consecutive weeks to be held in each Area next year. This will give the maximum number of home helps an opportunity to participate. It will include speakers from the Health and Welfare Department, National Assistance Board and Hospital Service and visits will be made to hospitals and residential homes for the elderly.

The Annual Weekend School arranged by the Institute of Home Help Organisers was attended by Miss Surtees, one of the health visitors. The theme of the course was "The home help and the family". A wide range of subjects was covered by the speakers from Family Relationships, Nutrition, Mental Disorders in the Elderly to the Family Unit Service. It was a most interesting and comprehensive course.

In general, therefore, the Home Help Service has continued to expand as anticipated and the costs are rising annually. Nevertheless, the service is one which gives great satisfaction both to those who receive benefits and to those who work in it.

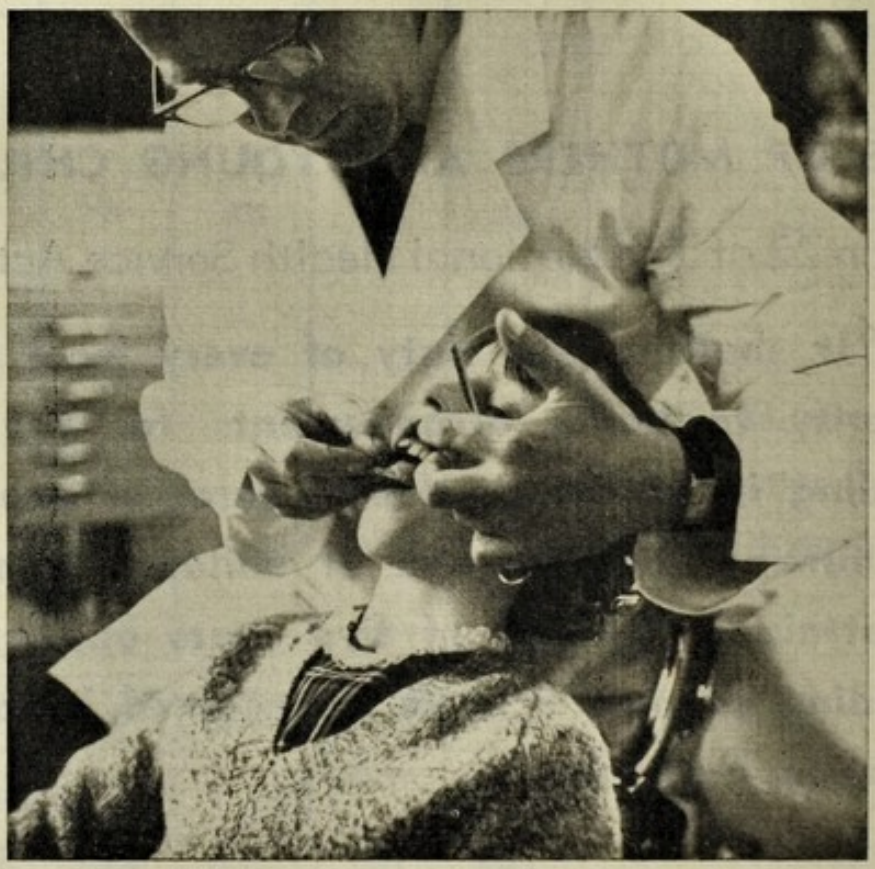
HOME HELP CASES



CARE OF MOTHERS AND YOUNG CHILDREN

Section 22 of The National Health Service Act, 1946

"It shall be the duty of every local health authority to make arrangements for the care, including in particular dental care, of expectant and nursing mothers and of children who have not attained the age of five years and are not attending primary schools maintained by a local education authority".



ORTHODONTIC TREATMENT

CARE OF MOTHERS AND YOUNG CHILDREN

Other parts of this annual Report, notably those on Midwifery Health Visiting, Health Education and Vaccination and Immunisation demonstrate how widely the responsibilities of the authority under this heading ramify; and also how intimately they are now bound up with the work of the family doctor and the obstetrician and paediatrician. The specific comments given below on certain facets of the service, such as 'Welfare Food', 'Unmarried Mothers', draws conveniently together some activities of the department with an important bearing on the wider field of care of Mothers and Young Children. They should be viewed against this background and particular importance is to be attached to the Dental Service and Mr. Neal's anxieties about the inadequate cover of expectant mothers' dental care. The tremendously important advance with regard to fluoridation of water supplies is associated with Mr. Neal's report since it will, in due course, make such a substantial contribution to child dental health.

Statistics

It is also convenient and appropriate at this point in the report to comment on the most important statistics touching mothers and young children, and themselves providing an inescapable commentary on the effectiveness of the total of health services for this group in particular.

In 1964 the perinatal mortality rate—the number of stillbirths and first-week deaths per 1,000 live and still births—fell below the 30 mark for the first time in Cumberland to 29.4. This year, there has been a further decrease in the rate to 29.3 and credit for this continuing improvement must go to the consultants, general practitioners, hospital and local authority midwives and to the East and West Cumberland Local Maternity Liaison Committees for their efforts in this field.

Once again the improvement has been in the early neonatal or first week deaths. In actual numbers, there were 37 deaths in 1965 compared with 47 in 1964; the rates being 9.4 and 11.3 per 1,000 live births respectively. The number of stillbirths has actually

increased by 3 which, in view of the decrease in the number of births, has raised the stillbirth rate to 20.0 from 18.2 per 1,000 live and still births.

The overall reduction in the number of perinatal deaths is therefore 7. The perinatal mortality rate remains pre-eminent as the most significant single index of maternal and early neonatal services and the figures achieved in Cumberland are, in my opinion, very creditable. They have been achieved only by a integrated effort of all concerned, whether Local Authority or Hospital staffs or family doctors. Each quarter's statistics are considered without fail at both East and West Cumberland Local Maternity Liaison Committees, about which more is said in the part of the report dealing with midwifery.

It will be seen that it is stillbirths which are now forming the hard core of perinatal deaths and considerable research is going into this problem over the country. Inevitably the rate of progress must slow down as the hardest problems remain to be solved, yet it is still true, I am sure, that consistent and concentrated attention to all the already established danger-spots, notably the arrangements for the confinement of 'high risk' expectant mothers, will press down still further the satisfying figures we have achieved in Cumberland.

A glance at the table on page 88 of the Analysis of Perinatal Deaths and at the figures shown on page 92 on Premature Births, will serve to demonstrate the prominance of this 'diagnosis'. In 1965 there were 86 premature stillbirths with 15 where prematurity was accounted the primary cause; and 10 attributed to the closely related cause of 'placental insufficiency'. The significance of this is more difficult to assess and clearly the whole of 'prematurity' and 'immaturity' is an intensely complex one and one in which I know my paediatrician colleagues are closely interested. This is but an example of one of the remaining problems in maternal and infant health where more fundamental questions are being asked and probed behind a term which will no doubt in time become unacceptable in itself as a major cause of stillbirth or neonatal death.

Year	Stillbirths	Early Neonatal Deaths	Perinatal Deaths	Stillbirths per 1,000 total births		Perinatal Deaths per 1,000 total births	
				Cumberland	E'land & Wales	Cumberland	E'land & Wales
1955 ...	79	61	140	21.7	23.2	38.5	37.4
1956 ...	111	64	175	29.3	22.9	46.2	36.7
1957 ...	102	64	166	25.5	22.5	41.5	36.2
1958 ...	80	69	149	20.4	21.5	38.1	35.0
1959 ...	83	54	137	20.9	20.8	34.5	34.1
1960 ...	111	60	171	27.4	19.8	42.2	32.8
1961 ...	76	53	129	19.1	19.0	32.4	32.0
1962 ...	78	71	149	18.7	18.1	35.8	30.8
1963 ...	76	60	136	18.8	17.2	33.7	29.3
1964 ...	77	47	124	18.2	16.3	29.4	28.2
1965 ...	80	37	117	20.0	15.7	29.3	26.9

Analysis of Causes of 117 Perinatal Deaths during 1965

Cause of Death	*Stillbirths*		*Deaths during*	
	Premature	*Full-time*	*1st Week*	*Total*
Toxaemia	9	1	--	10
Antepartum Haemorrhage	3	1	—	4
Placental Insufficiency	10	5	—	15
Rh. with Antibodies	2	—	—	2
Prematurity	15	—	13	28
Congenital Malformation	9	5	6	20
Asphyxia—	—	—	1	1
(1) Prolapse of Cord	1	1	—	2
(2) Cord around neck	1	3	—	4
(3) Intra Uterine	—	—	—	—
(4) Pneumonia (Inhalation) ...	—	—	—	—
(5) Anoxia	—	—	—	—
Atalectasis	—	1	7	8
Congenital heart disease ...	—	--	4	4
Cerebral Haemorrhage	—	3	1	4
No known cause	6	3	4	13
Pneumonia	—	—	1	1
Mal Presentation	—	1	—	1
	56	24	37	117

Infant Mortality

Cause of Death	*Age in Weeks* Under 1	1 to 4	4 to 52	*Total*
Prematurity	13	—	—	13
Congenital Malformations ...	6	2	4	12
Asphyxia	1	—	2	3
Atalectasis	7	—	—	7
Pneumonia and Bronchitis ...	1	1	11	13
Congenital heart disease	4	2	1	7
Cerebral haemorrhage	1	—	—	1
Meningitis	—	—	—	—
Gastro Enteritis	—	—	3	3
Other Causes	4	—	3	7
	37	5	24	66

The comparative rates of infant deaths per 1,000 total live births for Cumberland together with England and Wales are as follows for the period 1955 to 1965:—

Year	*Rates per 1,000 total live births* Cumberland	England and Wales
1955 ...	28.4	24.9
1956 ...	30.4	23.8
1957 ...	26.4	23.1
1958 ...	28.2	22.5
1959 ...	21.1	22.2
1960 ...	23.1	21.8
1961 ...	22.6	21.4
1962 ...	26.4	21.7
1963 ...	22.0	21.1
1964 ...	18 3	19.9
1965 ...	16.9	19.0

Notification of Congenital Abnormalities

At the beginning of 1964 the Ministry introduced a scheme for the recording of all instances of malformations apparent at birth and for classified information on each child, either live or still-birth, to be forwarded to the Registrar-General.

Doctors and midwives were accordingly asked to complete a simple form describing as accurately as possible the malformation observed. Most of these are completed by the hospital midwives, although in some instances agreement on the description of the abnormality is reached in conjunction with the doctor in charge of the birth.

This scheme has worked satisfactorily and during the year 66 notifications were received bringing the total to 131 for the two years. The malformations were classified as follows:—

	Males		Females		Total	
	Live Births	Still Births	Live Births	Still Births	Live Births	Still Births
Total cases notified	55	7	52	17	107	24
Classification:—						
Central nervous system ...	6	6	7	17	13	23
Eye, Ear	1	—	1	—	2	—
Alimentary system ...	7	—	6	—	13	—
Heart and great vessels ...	3	—	2	—	5	—
Respiratory system ...	1	—	1	—	2	—
Uro-genital system ...	8	—	—	—	8	—
Limbs	24	—	26	—	50+	—
Other skeletal	2	—	1	—	3	—
Other systems	1	—	—	—	1	—
Mongolism	1	1	6	—	7	1
Other malformations ...	1	—	2	—	3	—

+ includes 27 notifications of talipes.

The most relevant figures available for comparison are those for the study carried out in Birmingham some three years ago and which are quoted in the Ministry of Health publication on Congenital Malformations. This showed that of 57,000 live and stillbirths, 23 per thousand had macroscopic abnormalities of structure attributable to faulty development and present at birth. The corresponding rates for Cumberland for the years 1964 and 1965 were 16.3 and 16.6 per thousand births respectively.

Of the total of 131 known cases notified during the two years approximately 18% were stillborn, and of the 24 stillbirths all but one were from malformation connected with the Central Nervous System. By comparison the Ministry publication quoted a national stillbirth figure of 20%.

The incidence of the commonest malformations were anencephalus (2.2 per 1,000), spina (1.0), hydrocephalus (0.6), cleft lip or palate (1.5), mongalism (1.0), cardiaic malformations (0.6), and talipes (3.3).

The number of female stillbirths during the two years from malformations of the central nervous system was 17 from a total of 24 cases notified, (70.8%), and there were 6 male stillbirths from similar causes from 12 notified (50%).

Hospital confinements during the year under review accounted for 83% of the total births and all children born in the major Maternity hospitals are seen by a consultant paediatrician.

The system of recording for the Registrar-General would seem to be mainly of long-term statistical value, though perhaps of limited immediate value in the local content and this at risk of not being assiduously followed up.

Prematurity

A premature infant is a live born infant with a birth weight of 5 lbs. 8 ozs. or less, or with a period of gestation of less than 37 weeks.

The percentage of premature live births of total live births decreased from 6.1% in 1964 to 5.2% in 1965.

Premature births notified during 1965 are set out below with the 1964 figures for comparison.

	1964	1965
1. Number of premature live births notified:—		
(a) in hospital	224	196
(b) at home	22	17
(c) in private nursing homes	—	—
Total ...	246	207
2. Number of premature stillbirths notified:—		
(a) in hospital	42	51
(b) at home	4	3
(c) in private nursing homes	—	—
Total ...	46	54

There was a total of 11 premature babies born at home during 1965 compared with 16 during 1964; of these 11 all survived.

There have been 39 fewer premature live births than in 1964; this may well be associated with better selection of high risk cases for hospital and a high level of ante-natal care.

Premature Live Births

Weight at Birth	Born in Hospital				Born at home or in a Nursing Home: Nursed entirely at home or in a nursing home				Born at home or in a Nursing Home: Transferred to Hospital on or before 28th day				Premature Stillbirth Born	
	Total Births	Died: Within 24 hours of Birth	Died: In 1 day and under 7 days	Died: In 7 days and under 28 days	Total Births	Died: Within 24 hours of Birth	Died: In 1 day and under 7 days	Died: In 7 days and under 28 days	Total Births	Died: Within 24 hours of Birth	Died: In 1 day and under 7 days	Died: In 7 days and under 28 days	In Hospital	At home or in a Nursing Home
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)
1. 2 lbs. 3 ozs. or less ...	3	1	1	1	—	—	—	—	—	—	—	—	15	2
2. Over 2 lbs. 3 ozs. up to and including 3 lbs. 4 ozs.	17	9	1	—	—	—	—	—	—	—	—	—	13	1
3. Over 3 lbs. 4 ozs. up to and including 4 lbs. 6 ozs.	46	3	4	—	—	—	—	—	4	1	1	—	10	—
4. Over 4 lbs. 6 ozs. up to and including 4 lbs. 15 ozs.	41	—	1	1	1	—	—	—	—	—	—	—	7	—
5. Over 4 lbs. 15 ozs. up to and including 5 lbs. 8 ozs.	89	—	1	1	10	—	—	—	2	—	—	—	6	—
6 Total	196	13	8	3	11	—	—	—	6	1	1	—	51	3

Care of Unmarried Mothers

The County Council do not administer any Mother and Baby Homes; those in use for the resdential care of the unmarried mother and her child are outwith the administrative County.

The arrangements between the County Council and the Carlisle Diocesan Council for Social and Moral Welfare and the Lancaster Diocesan Protection and Rescue Society have continued under which the Moral Welfare Case-Workers give valuable help in making suitable arrangements for the confinement of these girls. The County Council continued its financial support to the Diocesan Councils by making direct annual grants and also accepts financial responsibility on agreed scales towards the cost of maintenance fees.

The usual period for which the Council accepts financial responsibility is six weeks before and a similar period after confinement, although extensions may be granted on account of unsatisfactory home conditions, immaturity etc.

The Case Workers of the three Social and Moral Welfare Associations in the area make all arrangements, financial and otherwise, for the admission of mothers to the homes, first referring the cases to the Department for acceptance of financial responsibility.

During the year 60 cases were approved for maintenance in the undermentioned homes; the average length of stay of each patient after confinement is also shown:—

Coledale Hall, Carlisle	31 (32 days)
St. Monica, Kendal	17 (45 days)
Brettargh Holt, Kendal	6 (52 days)
Salvation Army Home, Newcastle-on-Tyne	3 (54 days)
Other Homes	3 (37 days)
	60

The age groups of the 60 cases are shown in the following table with comparative figures for the previous five years; from the table it will be seen that the number of admissions during the year were considerably more than in the preceding years:—

Age	1965	1964	1963	1962	1961	1960
13	—	—	1	—	—	1
14	—	—	1	2	—	—
15	1	4	3	3	1	1
16	6	3	—	5	3	3
17	6	4	2	4	5	3
18	13	5	3	7	2	3
19 — 24	31	21	12	12	22	20
25 — 30	2	1	7	4	1	10
31 and over	1	3	2	1	1	3
	60	41	31	38	35	44

I am indebted to Miss J. C. Pochin, Welfare Worker with the West Cumberland Welfare Association, for the following comments on her work with unmarried mothers during the year:—

"It is not simply a matter for help in "getting it adopted" that leads expectant unmarried mothers to approach a Worker. Many have no intention of parting with their child, but may want to go away from home during the last weeks of pregnancy and until they are used to handling their baby; others desire help in applying for statutory benefits and obtaining affiliation orders, and yet others may come simply for support and friendship in the uncertainty and strain of their new situation. It also remains true that many girls who are determined on adoption before the baby is born, change their minds rapidly and completely as soon as they see the new arrival—and this applies to grandparents, too!

There is much to be done to help the unmarried mother who decides to keep her baby, especially in the first weeks when she is in process of settling down to a very different sort of life at home.

Our foster mothers have again been of the greatest possible help in caring for babies born in hospital locally, who were to be placed for adoption at the age of six or eight weeks. We are exceptionally fortunate in having their help, and I am full of admiration for the generosity with which they take on this additional responsibility as well as their already large family commitments.

When I look back upon the year's work I am impressed by the wide range of individual needs and circumstances that come our way. Every grade of mentality from the definitely 'backward' to the superlatively intelligent and highly strung, every sort of social circumstance from professional occupations to poverty in a condemned house, every age-group from school girls to mature matrons, has been represented in the year's case-load.

There have been other problems, too: girls at odds with their parents, who, it is encouraging to find, have been greatly helped by free and frank discussion with an 'outsider' who is able to see both sides of the situation impartially."

Distribution of Welfare Foods

Each Area Medical Officer is responsible for the distribution of welfare foods in his area. New supplies are delivered to the distribution points at intervals of approximately one month.

Welfare foods are available at 95 distribution points in the County and foods are easily available even in the more remote areas. Twelve of the points are child welfare clinics and there is a large number of private houses and shops used. Private houses play a particularly important part in the country districts.

Members of the W.V.S. have continued to play an invaluable part in the efficient running of this service and it is owing to their sterling work that the costs of this service have been kept so low.

Sixty-six of the points are manned wholly or partly by members of the W.V.S. and, in the northern area of the County, the foods are distributed by a W.V.S. van and driver, accompanied by a member of the Health Department staff. In some parts of the County foods are distributed by hired transport.

During the year, two distribution points in the Wigton area, at West Newton and Crofton, were closed owing to slackening of demand and no new points have been opened in the County.

The year has seen an increase in the demand for National Dried Milk—a reversal of the trend of previous years and, although the increase is not large enough to be significant, it is hoped that the trend of recent years has been halted and that more mothers are buying National Dried Milk in preference to the many proprietary brands available.

Sales of orange juice have continued to rise gradually after the sharp drop experienced when the price was increased from 5d. to 1s. 6d. in 1961. However, sales of cod liver oil, which experienced an even sharper drop, still continue to decrease as do sales of vitamin tablets. The demand for these vitamins has dropped partly, perhaps, because of the increased number of proprietary brands of vitamins now available and partly because of some

awareness that the higher standard of living enjoyed by most people has resulted in an improved health of both mothers and young children with a diet deficient in vitamins a rarity.

There is some question of the desirability of using child welfare clinics as distribution points because, although it is most convenient for the mothers to buy welfare foods when they are attending the clinic, there is some danger that mothers will come to the clinic only to buy foods and the clinic may be regarded as a "shop", its primary purpose being obscured.

On the whole, the scheme run by the County for the distribution of welfare foods seems to be most efficient and comprehensive and the service provided it quite adequate. It is only unfortunate that more mothers do not avail themselves of the services provided.

The table below shows total issues of welfare foods for the last ten years:—

Total Issues

Year	*National Dried Milk (in tins)*	*Cod Liver Oil (bottles)*	*Vitamin Tablets (packets)*	*Orange Juice (bottles)*
1956	151,101	23,669	7,274	124,212
1957	128,219	22,157	6,920	137,336
1958	115,685	15,198	6,338	89,366
1959	105,984	15,350	7,076	93,684
1960	92,676	14,961	7,475	90,343
1961	78,155	9,067	5,017	50,653
1962	79,446	4,712	2,669	31,964
1963	78,858	5,162	2,630	34,973
1964	74,886	4,909	2,236	36,389
1965	78,047	4,636	1,881	39,053

Dental Service

The Chief Dental Officer, Mr. R. B. Neal, makes the following comments on the dental services for 1965:—

"It is with regret that one has to admit that Cumberland is still two dental officers under strength and that these two vacancies are in the west, especially when one realises that the private practitioner dental services are so limited in that area—there being one private dentist doing only two sessions per week in Millom, one whole time at Egremont and one at Cleator Moor. The rest of the County is reasonably well served and, in many areas the demand for maternity and child welfare dental treatment is negligible. This is due partly to the fact that the patients receive private treatment or else they are apathetic and do not seek treatment. If only one could impress sufficiently strongly upon doctors and midwives the importance of removing oral sepsis and improving the masticatory efficiency of all expectant mothers, it would be a step in the right direction. A patient would certainly take more notice if told by the obstetrician to have her teeth put in order. Some hospitals will not admit patients for confinement unless their teeth have been attended to except in cases of emergency.

"At this time, the importance of water fluoridation cannot be over-tsressed, because it is the only hope of future generations in avoiding multiple extractions and dentures at an early age. The efficiency of fluoridation as a prophylactic against decay has been proved, as, too, has its complete safety. If only all children could have the benefits of fluoridation from birth, one could confidently expect a 50 per cent to 60 per cent reduction in dental caries in the years to come. Despite popular belief it is not only the children whose teeth become more caries resistant, but adults too, though to a lesser degree. Oral hygiene and a correct diet are essentials to both dental and general health, but these measures are inadequate in themselves to stop the ravages of tooth decay and everyone should really do their utmost to bring about fluoridation in the very near future.

"Mr. J. A. G. Baxter is still continuing his research work and some very interesting results are being obtained, which one sincerely hopes will be of great value to the profession as a whole, because, as yet, there is no certainty as to the causative organisms involved in dental caries. If the true nature and type of organism can be found, it is possible that the method of treating carious teeth would need to be modified.

"Tremendous progress has been made with regard to the building of new clinics and redecorating and re-equipping the older ones. It is hoped that all clinics will be brought up to standard within the next 18 months, and this should help towards attracting new dental officers to West Cumberland."

Fluoridation of Water Supplies

In my Annual Report for 1964 I gave details of some research into the cause of dental caries which is being carried out in this County. I am now pleased to be able to report a year of considerable progress in a major preventative of caries—the adjustment of the fluoride content of public water supplies in Cumberland.

The Health Committee first considered the matter in January 1963 and, on its recommendation, the County Council approved, in principle, the fluoridation of the water supplies where they are deficient in fluoride naturally, subject to the consideration of further reports on detail to be submitted after discussions with the water undertakers in the county.

These discussions were held up pending the outcome of High Court actions. When objections against schemes were lost in New Zealand and Dublin, and withdrawn at Watford, negotiations were re-opened, initially with the West Cumberland Water Board. This authority agreed to the adjustment of the fluoride content in their supplies as did the South Cumberland Water Board later in the year, but the Keswick, Carlisle and Eden Water Boards have declined to co-operate at the present time.

In the West Cumberland Water Board's area the supplies in which it is proposed to adjust the fluoride level are those drawn from Crummock Water, Quarry Hill and Hause Gill sources, while in the South Cumberland Water Board's area, the supplies to be adjusted are those from Ennerdale Water and Baystone Bank. These five sources supply the domestic water for a population of about 130,000, more than half the population of the County.

The basic reason for seeking to ensure that all water supplies contain fluoride to the level of one p.p.m. is the well established fact that this measure is effective in reducing, by approximately half, the dental decay in children who have drunk such water from an early age. Various other methods of administering the required level of fluoride have been suggested, and many of them tried. These include the taking of tablets, and the application directly to teeth of fluoride solutions or toothpastes. Not

only has the effectiveness of these measures not been clearly demonstrated but the improbability of their being applied consistently over long periods to large numbers of children must be obvious. In Cumberland in 1965, over 15.000 fillings were inserted into the permanent teeth of school children and a further 5,000 permanent teeth were extracted in a school population of about 39,000. To quote Lord Cohen of Birkenhead, the fluoridation of water supplies is "adjusting the level of the natural content of a natural constituent of water in the interests of children".

The fluoridation of water supplies is an exercise in preventive health, and is not an alternative but complementary to other methods of preventing dental decay. The discouraging of excessive consumption of sweets by children and the teaching of good dental hygiene remain of the highest importance and will continue to receive increasing attention. Education by the health visitors and school nurses in the schools and by the dentists themselves in the clinic is actively encouraging children to take a greater interest in their dental health.

The West Cumberland Water Board has recently accepted a tender for the construction of a new treatment works at Crummock Water and the County Council, at its meeting in February, 1966, endorsed its earlier decision by agreeing to meet the cost of the fluoridation equipment. At the same meeting a request of the Newcastle and Gateshead Water Company, which supplies a very small area in Cumberland on the Northumberland border, for the Council's approval to the addition of fluoride to the water supplies in this area was agreed to.

It will, of course, be a year or two before water with an adjusted fluoride level flows from any taps in this County and a longer period of time still before we may expect any significant drop in the number of carious teeth needing filling and extraction. However, the foundation has now been laid to an era of improved dental health for the population of Cumberland.

Child Welfare Centres

These centres have been the subject of unending criticism and counter criticism for many years, especially since the central place of the general practitioner in the health services has been more actively projected. I gave an account in the last two years of the survey carried out in Cumberland of Local Authority Child Welfare Clinics and it was clear that a pretty constant demand exists on the part of mothers for the services offered. There today should be:—

(1) the selective screening of young children for developmental and other abnormalites, physical and emotional, to ensure early complete assessment and necessary treatment and follow-up;

(2) planned and positive individual and group health education;

(3) general health advisory services by nurses trained for this;

(4) immunisation and vaccination services.

It will be quite apparent that such services provided by general practitioners with attached Local Authority Nursing Staffs have certain advantages to offer mothers and children but nothing like comprehensive provision can be envisaged in this direction for a long time, if ever, and meanwhile the necessary service is to be provided leading to another compromise situation in an evolving and developing health service—perhaps but another example of a stop gap service by local authorities when seen in the long term in due course to go over to the family clinician. The real skill in planning such a service at present lies, in my view, in exploiting to the maximum every element of flexibility in the situation. This in practice means the planning and deployment of personnel and premises.

Considering the latter first of all it will be realised that Local Authority "clinics" as heretofore planned and built, have had the needs of the historic Child Welfare Clinics mainly in mind. This does indeed serve a very useful basis for many activities other than Child Welfare clinics but increasing attention has now to be given to the specific needs of other groups who may well

come to use the building more frequently than mothers and young children e.g., the handicapped and elderly for day centre and club activities; selected population groups for health screening procedures, and indeed family doctor surgery purposes remembering how these might change and expand with nursing team attachment. Before this report is published there will undoubtedly be far reaching developments affecting general practitioners' surgery premises and I do hope these lead in the direction of greater joint use of premises by the local authority or general practitioner groups—not necessarily entirely in the direction of general practitioners using local authority "clinic" premises but probably also of the reverse order. More judiciously grouped doctors in general practice might well be in a position to discuss this more fully in the rural areas where many of the other advantages of grouping will be less obvious. Child Welfare clinic activities could, in some situations, prove the spearhead of a movement nearer to the health centre concept.

When thinking of the personnel of the service the close association of local authority nursing staff with general practitioners is already seen in operation in the case of some of those general practitioners who conduct their own child welfare sessions—this is further mentioned below.

The role of the health visitor requires continuing thought in this context including the extent to which she should "preside" at Child Welfare Sessions either in "clinic" or "surgery" with a heavy weighting of her increasingly skilled social work in the home. The exact elements of Child Welfare Clinic work which demand her presence will need to be thoughtfully defined.

Also, might not the remaining Local Authority medical staff engaged in clinical work in clinics and schools in future link with one or more group practice where the latter move forward in the development of health screening procedures, of which procedures much Child Welfare activity mentioned above is but one example.

Perhaps it is not practical to envisage developmental screening and follow-up, general advisory work, health education and vaccination and immunisation all proceeding at the same session

and a variety of experimental patterns of "clinic" sessions could usefully be tried, including of course an appointments system as at present applied by some.

While these thoughts develop the following factual account of the service in 1965 includes the comments of some of the nurses working with general practitioners in "clinics" and their surgeries.

At the end of 1965 the County Council were providing services at 31 centres. Two new village centres were opened during the year—at Thursby and Hunsonby—and the clinic held at Netherton Trailer Park was closed. The year saw a further increase in attendances at child welfare clinics from 35,162 in 1964 to 36,852.

No new clinic buildings were completed during the year but the Cleator Moor clinic including a nurse's flat which is the first to be built under the 10-year Plan, was nearing completion at the end of the year and is expected to be taken over early in 1966 when the old and unsatisfactory premises at present in use, will be closed.

Subject to the approval of building plans by the Ministry it is hoped to begin work on two new purpose-built clinics at Longtown and Maryport during the next financial year.

Voluntary helpers continue to play an important part in the running of child welfare clinics, relieving the health visitors of such tasks as distributing welfare foods, weighing babies and looking after records. Members of the W.V.S. are at present helping at 24 clinics and their valuable assistance contributes greatly towards the efficient running of the clinics leaving the health visitor free to carry out the specialised work for which she has been trained. Ministry of Health Circular 12/65 emphasized the part to be played by ancillary staff in the running of child welfare clinics and recommended that the scope of their duties might be further widened.

The scheme whereby health visitors attend at child welfare clinics held in the surgeries of certain general practitioners has continued to expand and 318 sessions were held resulting in 4,487

attendances compared with 239 sessions and 3,371 attendances in 1964. Several health visitors in the Western Area of the County comment on the scheme as follows:—

"From the start of being seconded as a health visitor to general practitioners, I tried hard to get a special session going for babies at their surgery, but there were several difficulties. 'My practice' has three partners; they have a morning and evening main surgery and a daily afternoon surgery just outside the town.

At first the special sessions were purely for immunisation, but gradually they merged into "child welfare" combining immunisations with consultations, follow up work, and referrals to consultants.

The mothers, especially the ones with more than one child appreciate this session very much. It has proved that it is better to have babies coming to a special surgery rather than to the normal ones which are always heavy, and I feel sure it must have cut down the risk of cross infection.

Since 1.4.65 to the present date I have seen 707 children with the family doctor at these special weekly sessions. Of this number 50% were for immunisations, 25% consultations, 15% follow-up work, 10% referrals to consultants."

"Doctors ———————— and ———————— hold 'maternity and child welfare' surgeries every Thursday afternoon from 2.0—3.0 p.m. The doctors alternate in attending these surgeries.

I attend one surgery on the 1st and 2nd Thursday in the month. I usually inform the mothers in their homes when I first visit them so that they are able to contact me there and we can discuss any feeding or other problems. In both surgeries I usually remain in the consulting room with the doctor and so we are able together to discuss any problems with the mother. In other cases the doctor though present leaves me to advise the mother."

Over the past five years I have found the Child Welfare sessions held with general practitioners to be of great value. It is

here the ante-natal mother meets the health visitor and the doctor working as a team. During that period the health visitor answers many of her questions and is already a friend before her baby arrives.

The mother seeing the doctor and health visitor working together helps tremendously in the weeks when the baby is small; the young mother has many queries and instead of 'bothering' the doctor unnessesarily she often contacts the health visitor who can deal with her problem. This helps the doctor who quite often will say to a mother or father "Ask Miss ———————— she is the expert on that."

"The child welfare clinic commenced four and a half years ago. It is held each Tuesday afternoon 3.0—4.0 p.m. with the general practitioner and myself in attendance. We now have assistance from one of the clerical staff.

The clinic was initiated chiefly as an immunisation and vaccination clinic but with time has increased considerably both in attendances and the volume of the work being done.

Many opportunities occur for advice on personal problems. The parents may also have other types of health education which is individual rather than group, because of the numbers which attend—usually 30—40 per session—and the fact the time available is short.

Books are provided at the clinic for toddlers and a happy and relaxed atmosphere is present.

The advantages are that the doctor and the health visitor know the families and the family doctor has an opportunity to see the children when they are well."

In the Local Authority clinic premises the 'at risk' notifications of children so classified because of ante natal or post natal factors, come to rest for reference by Medical Officers when the child attends the clinic. Special efforts are made by the health visitor to secure the attendance of these children whose need of developmental screening is clear. The Local Authority medical officers

in the clinics have all been furnished with easy reference guides to simple developmental observation and one in each area has undertaken the Ruth Griffiths training in more detailed developmental examination. The latter can then be applied to selected children referred by other medical officers, by general practitioners or by the paediatricians. The role of the latter in child welfare clinics, whether practice or Local Authority based, is one which I hoped to see increase in day to day importance, with his visiting these centres and advising on procedures, techniques and in appropriate circumstances of individual cases.

CHILD WELFARE CENTRES, 1965

The following table gives particulars of the sessions and attendances at Child Welfare Centres throughout the County:—

Centre	Address	Day	No. of Sessions	Total Att.	Average Att.
Northern Area					
Alston	Cottage Hospital, Alston	Wednesday	50	495	10
Anthorn	W.V.S. Welfare Office, Anthorn	2nd and 4th Thursday	23	453	20
Aspatria	North Road, Aspatria	Wednesday	51	1196	23
Brampton	Union Lane, Brampton	Friday	50	1539	31
Dalston	Village Hall, Dalston	Monday	47	1126	24
Houghton	Village Hall, Houghton	2nd and 4th Wednesday	24	446	19
Hunsonby	The Institute, Hunsonby	1st and 3rd Thursday	6	88	15
Longtown	T.A. Centre, Longtown	Tuesday	50	1106	22
Longtown C.A.D.		Alternate Monday	12	95	8
Penrith	Brunswick Square, Penrith	Tuesday	49	1507	31
Scotby	Village Hall, Scotby	1st and 3rd Thursday	22	263	12
Thursby	Church Hall, Thursby	1st and 3rd Tuesday	17	168	9
Wetheral	Village Hall, Wetheral	2nd and 4th Thursday	24	347	14
Wigton	Birdcage Walk, Wigton	Monday	47	1217	26
			472	10,046	21
Western Area					
Cockermouth	Harford House, Cockermouth	Monday	48	1182	25
Crosby, Maryport	Nurse's House, Parkside, Crosby	2nd and 4th Wednesday	19	107	5
Dearham	Nurse's Hse., Central Rd., Dearham	Wednesday	43	563	13

Centre	Address	Day	No. of Sessions	Total Att.	Average Att.
Keswick	13—15 Bank Street, Keswick	Thursday	52	568	11
Maryport	24 Selby Terrace, Maryport	Tuesday	49	1330	27
Seaton	Miners' Welfare Hall, Seaton	2nd and 4th Thursday	23	547	24
WORKINGTON—					
Park Lane	Park Lane, Workington	Wednesday and Thursday	125	3606	29
Salterbeck	Holden Rd., Salterbeck, Workington	Friday	51	1463	29
			410	9,366	23
Southern Area					
Cleator Moor	Ennerdale Road, Cleator Moor	Thursday	52	2420	47
Egremont	St. Bridget's Lane, Egremont	Thursday	66	2812	43
Frizington	Council Chambers, Frizington	Monday	49	1088	22
Millom	18 St. George's Road, Millom	Tuesday	50	2027	40
Seascale	Gosforth Road, Seascale	Thursday	52	2149	41
Thornhill	Community Centre, Thornhill	1st and 3rd Wednesday	24	558	23
WHITEHAVEN—					
Flatt Walks	Flatt Walks, Whitehaven	Tuesday	49	2550	52
Mirehouse	Dent Rd., Mirehouse, Whitehaven	Monday	48	2044	43
Woodhouse	Woodhouse, Whitehaven	Wednesday	52	1792	34
			442	17,440	39
		GRAND TOTALS	1,324	36,852	28

ATTENDANCES AT CHILD WELFARE CLINICS 1956-1965

Year	No. of centres provided at end of year	No. of child welfare sessions held per month at centre	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		
1956 ...	15	59	1053	922	964	2939	11912
1957 ...	18	69	1310	1051	1056	3417	14452
1958 ...	19	88	1326	1192	1225	3743	18061
1959 ...	22	92	1596	1455	1389	4440	21947
1960 ...	22	95	1548	1408	1368	4324	22089
1961 ...	23	95	1603	1667	1704	4974	23004
1962 ...	27	96	1894	1625	2080	5599	27299
1963 ...	29	98	1901	1892	2007	5800	31948
1964 ...	30	106	2231	1865	2145	6241	35162
1965 ...	31	110	2322	2385	2285	6992	36852

Family Planning Clinics

The County Council provide facilities for the Family Planning Association to hold sessions at the following clinics:—

Park Lane Clinic, Workington	first, third and fifth Wednesdays.
Flatt Walks Clinic, Whitehaven	second and fourth Wednesdays.
Brunswick Square, Penrith	second and fourth Thursdays.

One hundred and ninety-three new patients sought advice at the three clinics, an increase of 25 over the previous year. Of these cases, most were referred by other clinic patients or friends or by their general practitioner. A small number were referred from other sources such as local authority or hospital and some came in response to progaganda by the press or radio. Consideration has been given to the opening of a further clinic in the southern area of the County but this has not been possible owing to difficulties in obtaining staff. However, enquiries are continuing and it is expected that a clinic will be opened during 1966.

One of the doctors has been kind enough to let me have the following observations on her work in two of the clinics:—

"During the year 1965 there has been an increase in the number of new patients attending both clinics, most of them asking for advice about 'conventional' methods of birth control. The small number of patients on oral contraceptives can be accounted for largely by the fact that only patients unwilling or unable to obtain oral contraceptives from their general practitioners attend the clinics for this purpose.

"All patients taking oral contraceptives have a cervical smear test taken annually and all other patients over the age of 30 years have a cervical smear test every three years. In fact, this involves few patients as many of our patients have had the test at their post natal examination at the hospital or now an increasing number are found to have attended voluntarily at the local authority clinics set up for this purpose".

Nurseries and Child Minders

The provisions of the Nurseries and Child Minders Regulation Act 1948 require that every local health authority shall keep registers (a) of 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 period not exceeding six days; (b) of persons in their area who, for reward, receive into their homes children under the age of five to be looked after as aforesaid.

Applications for registration are made to the local health authority and the premises must be maintained subject to the conditions laid down by the authority on registration. Premises are regularly inspected by medical officers authorised by the authority and health visitors carry out monthly child welfare visits.

At the end of the year there were 13 registrations in force in the County and the table below shows the localities and numbers of places provided:—

North Cumberland	*West Cumberland*	*South Cumberland*
Brampton — 15	Cockermouth — 50	Whitehaven — 10
Brampton — 12	Workington — 15	Millom — 20
Brampton — 25	Workington — 35	Millom — 10
Houghton — 18	Seaton — 20	
Penrith — 25		
Dalston — 20		

During the year two registrations ceased and six new premises were opened; one application to take an increased number of children was granted. The increase in the number of premises is marked over previous years and it is interesting to note that in 1959 only one registration was in force in the County.

Early in 1965 the Ministry issued a Circular entitled "The Day Care of Children" in which the recommendations originally made in 1948 were modified and a schedule was attached setting out

standards of accommodation and care in day nurseries. This included type of diet, health measures such as medical examination of the children, measures to be taken in cases of infectious diseases, the ratio of staff to children and the basic essentials for the care and supervision of the children.

At the time when this circular was issued this authority had just completed a review of its requirements for day nurseries and child minders which had proceeded broadly along the lines which were indicated in the circular.

With regard to child minders it was decided that in view of the limitations of this work in any one home the requirements should continue to be limited to satisfaction with regard to premises, minders being fit persons, regular supervision by the health visitor, and the specification of the number of children allowable in any child minder's group. A schedule was also prepared with regard to day nurseries, although this authority does not itself run any day nurseries as a direct service.

In 1965 there was some question of closing one of the nurseries in the western area of the county owing to an outbreak of measles in the district but as no cases occurred in the nursery it was decided that this measure was not necessary.

The facilities provided by day nurseries and daily minders are without doubt of great value to both the mothers and the young children who attend them; particularly in the case of only children learning to mix socially with other children is of great importance and the companionship gained is invaluable. Attending a nursery or play group also helps considerably when the transition to full-time school takes place.

For many mothers it is a great boon to have their children looked after for a few hours each day while they are doing house work or shopping, secure in the knowledge that their children are happily occupied and well looked after. Both mothers and children are likely to benefit appreciably from this service.

Marriage Guidance Councils

The County Council makes an annual grant to the two Marriage Guidance Councils operating in Cumberland. The Carlisle, Cumberland and Eden Valley Marriage Guidance Council has a service based in Carlisle but also has sessions at Workington on two nights a week for which the County Council allows free use of accommodation at Park Lane Clinic. The Catholic Marriage Advisory Council, to which the Council also makes a grant, has a centre in Carlisle. The main aims of the Marriage Guidance Councils are to promote the right relationships vital to successful marriage and to offer counsel to those who encounter difficulties in the way of married happiness if possible before those difficulties become serious.

Below is a table of new cases dealt with by the two local organisations since their establishment:—

	Carlisle, Cumberland & Eden Valley Council		*Catholic Advisory Council*	
Year	*Carlisle*	*Workington*	*Carlisle*	*Total*
1961	49*	—	—	49
1962	57	—	—	57
1963	55	19*	18	92
1964	15	36	15	66
1965	39	39	3	81

* Part year only.

The Secretary of the Carlisle, Cumberland and Eden Valley Marriage Guidance Council has commented on the work of her Council during 1965 as follows:—

"The Carlisle and Cumberland Marriage Guidance Council has made slow but steady progress during 1965. Seventy-eight new cases were opened; of these 39 couples resided in the County of

Cumberland and 39 in the City of Carlisle. One hundred and eighty four interviews were given (Cumberland 109, Carlisle 71); 97 of these interviews were with wives, 73 with husbands and there were 14 joint interviews. These families between them shared 103 children under the age of 16.

"Our education counsellors are worked to capacity and we urgently need more men and women to train for this work. They have held 167 sessions with 1,445 young people attending. These sessions were held in schools, youth clubs, hospitals and factories. They work through group discussion and find a very lively audience, willing to take a full part in the discussions wherever they go".

The Secretary of the Catholic Marriage Advisory Council comments:—

"I must regretfully report that last year we have not felt our work to be progressing as satisfactorily as we had hoped.

"There have been only three counselling cases during the year, one of which has been carried over from the previous year. I understand that, throughout the country, the Council generally is finding its remedial work remaining fairly static compared with the growth of its educational activities.

"In the spring of 1965 we held an afternoon's course for engaged couples on preparation for marriage but this was very poorly attended (I may say, in parenthesis that we have just concluded a similar afternoon which was quite lively and modestly successful). These courses contain talks followed by general discussion on marriage as a vocation, understanding each other and bringing up children, by lay counsellors; on the physiology of marriage by doctors and on bringing God into their marriage, by a Priest.

"Two of our counsellors, a man and a woman, have visited the Catholic Youth Centre at Keswick run by Father O'Dec and have spoken there to groups of boy and girl school leavers on entry into adult life and its responsibilities and on marriage.

"We have also been assisted by Catholic doctors attached to our centre in the instruction of married people on the temperature method of birth regulation".

HEALTH EDUCATION

Rapid and far reaching developments in the field of education generally have served to blur the edges of health education as a special subject. The movement seems to be very much in the direction of a strong unification of education in all it's aspects and, naturally what has always been regarded as health education comes to be seen as an integral part of the wider field. Clearly, however, specialisation within education will remain in an up to date form and the doctor and nurse must obviously adapt themselves to making their specialist contribution in the new context. This includes the rapidly expanding field of adult education where, however, the "captive" nature of the audiences available is less marked than in the schools. It remains true, of course, that a great deal of the most valuable health education to be effected through the Local Authority Health and Welfare Department, concerns the community as a whole and groups who may not be directly affected by the many modern and imaginative attractions of the Education and Further Education activities of a Local Authority.

I believe that another major movement affecting all our thinking on health education for the future is the rapidly advancing thought on the subject of health screening procedures. As these are brought increasingly before the public either as a whole or in special groups, in themselves they constitute an important element of health education and provide opportunities for increasing awareness in this field far beyond the bounds of the immediate procedures being carried out. The first arrival in this train of events as far as Cumberland is concerned has been the establishment of clinics for the taking of cervical smears from women most at risk of developing cancer of the neck of the womb. Both national and local publicity on this subject have stimulated wide interest in the whole question of cancer prevention and have given further evidence of the changing attitude to the previous taboo on this group of diseases. Coming to a clinic or surgery for a procedure such as a cervical smear must surely entail an attitude of mind receptive of future health teaching. As screening clinics develop for elderly people and for younger groups in due course, a vastly widened field of opportunity must open up. Obviously, of course,

one is face to face with the inevitable fact that one is dealing in these circumstances with people who are sufficiently interested in their own health anyway to take advantage of such procedures. However, it has already been demonstrated in certain areas of this country that this screening movement must, in some cases, be pressed into the home if those in greatest need are to be served. I refer to the domiciliary schemes for the taking of cervical smears in order to embrace the lower socio economic groups who are known to be at greatest hazard. Associated with such activities there is the obvious opportunity for the necessary health education at the individual or family level. In this general context of screening schemes I feel it is appropriate to quote the very interesting account given by Miss Surtees, the health visitor attached to a group practice in West Cumberland where an obesity clinic is held in the surgery. Miss Surtees writes:—

"The obesity clinic held every two weeks at the family doctor's surgery continues to progress on the whole satisfactorily. As previously stated this includes taking blood pressure, testing urine, taking into account age and height.

"Instruction is given in diet with the use in some instances of appetite suppressors.

"Weight reduction successes have varied between slightly under 14 lbs. to 47 lbs. The most recent member of the clinic is a middle-aged lady weighing 250 lbs., who has already made a promising start and a five months old baby with obese tendencies. One 47 year old lady suffering from hypertension lost 48 lbs. in eight months. To quote herself she found that "the self brain washing" needed in order to achieve this was well worth the effort not to mention the improvement in health, looks and morale. Furthermore, she could now wear a much smaller size in clothing. Members of her family are following and enjoying her pattern of balanced eating.

"Another patient with hypertension found that treatment from her doctor and dieting had helped her tremendously, apart from a considerable loss in weight and drop in blood pressure. This lady also brought her married daughter who had become a worrier and

a compulsive eater since her husband was at sea and she had the responsibility of a shop. A change of mental attitude and balanced meals soon brought about a substantial reduction in weight in this girl who was a most co-operative patient.

"Patients who complain that dieting is too expensive, and they cannot afford to go on a diet require help with budgeting. In many cases it is simply bad eating habits started early in life which are very hard to change. This requires constant discipline and determined effort, tempered with encouragement."

Progressive changes in the world of education and it's techniques on the one hand, and in the field of the early detection of disease on the other are, then, perhaps the two major contemporary developments against whose background the activities in health education of a Public Health Department must be seen.

There is, however, a further point very fundamental in my view to rethinking on this subject, which, although not new, has been rather strikingly emphasized in the past few years. This is the rather frightening emergence of a balance being struck in many people's minds between hazards to health in any particular activity, and the enjoyment which this same activity may be seen to provide. I refer mainly, of course, to cigarette smoking and its health hazards. It is true that other hazards than lung cancer, notably the affect on chronic bronchitis and heart disease, have been long known with regard to cigarette smoking just as the health hazards of excessive alcohol consumption go almost as far back into antiquity as medicine itself. The stark evidence, however, concerning lung cancer and smoking has given sharp focus to this problem which has perplexed health educators, namely the breaking of the psychological barrier which is set up against a very serious situation and in defence of what is claimed to be a real enjoyment, though involving, in many cases, the element of an addiction. Some have suggested that the current popularity of the cigarette will wane in due course apart altogether from conciousness of its health hazards. Even if this is so it is obvious that many a thousand lives will be lost in the meantime. How to convey to people who smoke cigarettes that everything considered, including

the enjoyment they claim from their habit, they will be better to give it up?

Before delving into the profound psychology of such a difficult human situation it surely must be acknowledged that there has never been any massive attempt to dissuade people from smoking while there has been just such a contrary effort consistently applied by tobacco manufacturers for decades. At the risk of sounding tiresome on the matter is seems questionable whether any necessarily small local efforts at dissuading people from smoking can be expected to be effective in the absence of a really hard hitting and sustained national campaign using every known technique of advertising. The almost paltry results achieved by anti-smoking clinics was underlined again in Cumberland during 1965, when one Area Medical Officer made a determined effort by wide advertising to establish such a group. In fact a total number of 36 people attended for a course of six meetings and there was sustained interest by some 15 of these. Some months after the meetings had been held a questionnaire to those attending revealed the claim by 4 that they had stopped smoking and by 2 more that they had been helped to cut down their cigarette smoking. Again this is preaching to the more than half converted it may be said, and certainly one is very conscious of such efforts by-passing completely the vast number of cigarette smokers, a pretty accurately known number of whom are heading for serious trouble soon.

While on this subject, however, I am certain that sustained efforts in schools by the staff of the School Health Service and the teaching staffs themselves, are not to be despised by any means in influencing young people not to smoke. It is very gratifying to speak with heads of schools who obviously take a great pride in dissuading their pupils from the cigarette habit.

Nothing that I have said detracts in the slightest from the continuing value of the consistent day to day activities in particular of the nursing staff in the department, in the many opportunities for health education which they make and take. This is often, of course, for special groups, notably ante-natal mothers, mothers

with young children, in the schools, and increasingly with elderly people. I think the table shown below indicates that a great deal is being done in Cumberland.

It is encouraging to find how much health education is given to these groups either individually or by means of group discussion or talks at larger meetings. The table below shows the number of talks and attendances given in 1965. These figures show a 41 per cent increase in the number of meetings held and a 54 per cent increase in the number of attendances compared with the figures for 1964:—

Number of Meetings: 855. Total Attendances: 11,859.

Talks		*Attendances*
Maternity and Child Welfare	452	3,165
Accident Prevention and First Aid	62	1,182
Health of the Child and Adolescent	29	372
General Health Topics	257	6,260
Prevention of Disease	55	880
Number of Talks at clinics	288	2,980
Number of Talks at schools	150	5,034
Number of Talks at Mothercraft and relaxation classes	291	1,564
Number of Talks to other meetings — (Mothers' Clubs, etc.)	126	2,281

There is a wide variety of subjects included under these headings. Weekly talks are given to the ante-natal and post-natal mothers at the Maternity Units in the West Cumberland Hospital and Workington Infirmary. These are very receptive audiences and

there is usually good discussion. It is an opportunity for the mother to get to know the health visitors and to know of the services available to her when she returns home.

Miss Jackson and Miss Surtees have co-operated at Workington Maternity Unit and report:—

"The Maternity Ward staff have been most co-operative and helpful and have arranged for the ante-natal patients who are able and the post-natal patients to attend each Thursday morning for one hour — ten to twenty mothers attend. We cover a wide variety of subjects, from the needs of the baby, neo-natal cold injury, feeding, hygiene of breasts and care of teats and bottles, immunisation and safety measures in prams, cots and baths. Educational films have also been shown. The mothers have said how much they enjoy this time and would like more.

"Many talks are given to ante-natal patients in the doctors' surgeries, at the clinics and in the homes."

Mothers' Clubs have continued most successfully at Brampton and Egremont in addition to the monthly meeting which has an educational value. The Club at Egremont, under the direction of Miss Crosby, held a very successful sale of work raising money for various charities which were selected by the members. This gave them opportunity to work together for a good cause and the whole project was much enjoyed by all. Brampton Club members started a Play Group Association for pre-school children. The committee arranged a rota of two mothers who would be responsible for the children each week. The play group meets in the Church Hall twice weekly, and the aim is to help the children adapt themselves to meeting other children and joining in group play.

It is a very successful venture which is helping both the mothers and children. It is something started on their own initiative and results of such a community effort are very rewarding.

Opportunities for health teaching in the schools are increasing and senior girls are very interested in talks on such subjects as 'Home making as a career', 'The Family in need of help and the

services available', 'Prevention of disease', 'The importance of routine in a child's life' and 'Accident Prevention' to mention but a few, and in some areas the school children help to look after the toddlers in the clinic sessions when the health visitor talks to the mothers.

Several of the staff have taken a course of lectures for the Duke of Edinburgh Award, or the British Red Cross Society or St. John Ambulance Brigade, in 'Child Care' and 'Home Nursing' or have examined the candidates for the award of these certificates

The administrative nursing staff are frequently invited to speak to members of Women's Institute Branches, Old People's Clubs, Rotary and Inner Wheel and other organisations; each talk gives the opportunity of some form of health education.

The Central Council for Health Education is the organisation which offers most advice on methods, materials and techniques. This has been invaluable in the supply of filmstrips of many subjects such as cervical cytology, palpation of the breast, to mention two of the latest. Posters, leaflets, literature and filmstrips are available for use of the nursing staff and we have now built up a supply which is held in each area office, in addition to those available at headquarters.

Each of the main clinics has a projector and screen and the newest clinic at Cleator Moor has a special back projector daylight screen. A sound film unit is now in frequent use and similar units used in schools can be made available for the showing of educational films.

The report of the Committee on Health Education set up by Lord Cohen and published in 1964 recommended intensification of the health education effort. To do this to any great extent requires more staff, more equpiment, more financial help. Meanwhile, we continue to sow the seeds of preventive health.

It has still, unfortunately, not been possible to make an appointment of a Health Education Officer for the County. Obviously such an appointment is of tremendous importance in the development of this responsibility which permiates the entire work of the department. I continue to hope that this appointment will be made in the not too distant future.

VACCINATION AND IMMUNISATION

Section 26 of the National Health Service Act, 1946

"Every local health authority shall make arrangements with medical practitioners for the vaccination of persons in the area of the authority against smallpox and the immunisation of such persons against diphtheria".

VACCINATION AND IMMUNISATION

Under the County Council scheme, facilities are provided for protection against diphtheria, whooping cough and tetanus; immunisation may be given against diphtheria or whooping cough either separately or together or in further combination with protection against tetanus.

Immunisation in childhood in the County is based on Schedule P of the Ministry of Health publication on "Active Immunisation Against Infectious Disease" which is set out below; the ages given are a general guide and may be varied as necessary:—

About age	Protection against
3 months	Diphtheria—whooping cough—tenanus.
4 months	Diphtheria—whooping cough—tetanus.
5 months	Diphtheria—whooping cough—tetanus.
6 months	Poliomyelitis (oral).
7 months	Poliomyelitis (oral).
8 months	Poliomyelitis (oral).
17 months	Diphtheria—whooping cough—tetanus.
18 months	Smallpox.
5 years	Diphtheria—tetanus—poliomyelitis (oral).
9 years	Smallpox—re-vaccination.
10 years	Diphtheria—tetanus.
12 years	B.C.G. vaccination.

A communication from the Ministry of Health to local authorities at the beginning of September advised that the Sub-Committee on Poliomyelitis Vaccination had agreed that simultaneous administration of oral poliomyelitis vaccine with triple antigen for preliminary immunisation or with diphtheria and tetanus vaccine at school entry could be recommended at the discretion of the doctor concerned. It is likely that this method

of administration will be extended in the near future to children under school age. Alternatively a single dose of vaccine incorporating potent inactivated poliovirus antigen, diphtheria toxoid and tetanus toxoid would provide adequate reinforcement at school entry to children who had received primary immunisation against these diseases in infancy. The Sub-Committee also recommended that there was no need to delay tonsillectomy when this operation was indicated, because of the season of the year or because of recent administration of oral vaccine. This procedure has been adopted in this County and will, no doubt, prove considerably time-saving in carrying out the immunisation programmes in schools.

Apart from B.C.G. vaccination, immunisations may be given either by the Council's medical staff at child welfare clinics or by periodic school visits, or under the Council's arrangements with general practitioners. The health visiting staff continue to play an important part by their efforts to encourage mothers to bring infants forward for primary protection early in life and for reinforcing injections until attaining school age. The policy of the attachment of health visitors to work with general practitioners is proving of increasing value as evidenced in the numbers of pre-school children receiving primary courses or reinforcing injections either at the child welfare clinics or at general practitioners' surgeries.

A record card is sent to all parents of children soon after birth giving a guide to the recommended ages for all vaccination and immunisation requirements throughout pre-school and school life. A birthday card is also given by the health visitor to the parents of each child reaching the age of one year as a reminder of the importance of protection being given to the child as early as possible. Publicity matter supplied by the Central Council for Health Education and by the Ministry of Health is displayed in County Council clinics, drawing the attention of parents to the facilities available; the showing of film strips in the clinics serves a similar purpose.

The statistics relating to the vaccination of persons under the age of 16 completed during the year are set out on page 137.

Fifty-eight per cent of all injections and immunisations were carried out by the Council's medical staff and the remainder by general practitioners.

Concern has been expressed in certain quarters that children might be immunised twice within the short space of time but, to avoid this possibility, every effort is being made to keep as short a period as possible between the receipt of the parental consents and carrying out the immunisations. In those cases where difficulty is experienced in obtaining completed records from general practitioners, the attached health visitors are able to help.

(a) **Diphtheria Immunisation**

The numbers of children immunised during the year were as follows:—

Primary courses—pre-school children	3,286
Primary courses—school children	1,016
Reinforcing injections—pre-school children ...	1,432
Reinforcing injections—school children ...	4,024
Total ...	9,758

The immunity indices for the above groups calculated on the numbers of children who have received a complete course of injections within the last five years are:—

Pre-school children	66%
Children of school age	63%
Children aged 0—15 years	64%

A comparison with the previous year shows increases in the indices of two per cent in each of the above groups.

The continued rise in the precentage of children considered adequately protected is most encouraging and reflects the successful combined efforts of the doctors and health visitors and the

regularity of the school visits which are either combined with school medical inspections or by special school visits for the purpose.

(b) **Whooping Cough Immunisation**

The number of children of all ages completing a primary course of immunisation during the year was 3,329 whilst 1,703 received reinforcing injections. Most of the primary courses were given in early infancy, usually in the first year of life, with reinforcing injections between the ages of 18 months and 2 years.

(c) **Tetanus Immunisation**

The number of children receiving protection during the year was 9,603 and grouped as follows:—

Primary courses—pre-school children	3,275
Primary courses—school children	1,974
Reinforcing injections—pre-school children ...	1,432
Reinforcing injections—school children ...	2,922

In the majority of pre-school cases, protection against tetanus is by means of triple antigen which also provides protection against diphtheria and whooping cough.

Hospitals continue to be notified of tetanus injections given to children and 9,523 such notifications were sent to the Casualty Departments during the year. General practitioners were also informed of injections given in schools and clinics.

The Ministry of Health booklet on "Active Immunisation Against Infectious Diseases" and a further communication in September, 1965, advised that persons who had commenced tetanus immunisation in hospitals should be encouraged to complete the course of active immunisation by two further injections of tetanus toxoid. At the time of writing, discussions are being held as to whether general practitioners should be invited to give these injections, or special evening sessions be held in County clinics by the Council's medical staff. Of the two, it would seem that the more practical way would be for the completed course to be given by

general practitioners: the health visitors, who are all seconded to general practitioner groups, are in a position to follow up, where necessary, the persons requiring these injections, both adults and children, where appointments have been made to attend general practitioners' surgeries. Tetanus toxoid would be made available to general practitioners through the local authority and one fee of 5s. would be payable by the County Council for a record of the two injections if given before the sixteenth birthday.

(d) **Smallpox Vaccination**

The County Council, as the local health authority, are responsible for making adequate arrangements for the vaccination of infants against smallpox; vaccination may be carried out either at the child welfare centres or through the services of medical practitioners.

No notifications of cases of smallpox were received during the year, nor were there any cases or deaths from complications of vaccination. The following table shows the numbers of children vaccinated during the year with comparative figures for the previous five years. The increases for 1964 and 1965 in the numbers of children receiving primary vaccination between the ages of one and two years were in accordance with the Ministry's advice that vaccination of young children should preferably be carried out in the second year of life.

Year	Age under one year	Age one year	Age 2—4 years	Total
1965	464	893	210	1,567
1964	594	742	119	1,455
1963	786	208	80	1,074
1962	2,150	322	428	2,900
1961	1,816	154	119	2,089
1960	1,402	62	64	1,528

The extremely low rates of vaccination continue to be most disturbing and the fact that the last case of smallpox was notified in the administrative county almost 40 years ago is probably a contributory cause of the apathy of parents in seeking vaccination for their children; of the total of 1,671 children and young persons vaccinated or re-vaccinated, 1,385 were given by general practitioners and the remaining 286 by the Council's medical staff.

(e) **Poliomyelitis Vaccination**

The general arrangements for vaccination against poliomyelitis remain unchanged and continue satisfactorily.

The number of children in the different age groups receiving either primary courses or reinforcing doses of oral vaccine during the year are shown below with the corresponding figures for the previous year:—

Primary courses—pre-school age ...	3,405	(2,724)
Primary courses—school age	1,089	(422)
Reinforcing doses—pre-school age ...	107	(240)
Reinforcing doses—school age ...	4,697	(1,592)
Total ...	9,298	(4,978)

These figures show satisfactory increases both in the numbers of pre-school children receiving primary courses and in the reinforcing doses administered to children on school entry.

Seventy-two per cent of the vaccinations of pre-school children were carried out by general practitioners and 28 per cent by the Council's medical staff in child welfare clinics whilst, of the children of school age, eight per cent were vaccinated by general practitioners and the remainder in schools.

The immunity indices at the end of the year show 58 per cent of pre-school children and 91 per cent of school children as being adequately protected against poliomyelitis. The overall figure for

children age 0 to 15 years is 80 per cent. The figure of 58 per cent for pre-school children is disappointing. Parents must constantly be reminded of the great importance of protection of the young child and of the need to bestir themselves to see that their children are so protected. It is an interesting and disturbing feature of these figures that the better results are only obtained in the school situation, where children only go by default in their protection at the specific wish of the parents.

The outbreak of poliomyelitis in Lancashire in the summer months resulted in a large number of adults coming forward, either for primary protection or for reinforcing doses, and it was necessary to hold special clinic sessions for this purpose. In all 1,846 primary courses and 826 reinforcing doses were administered by the Council's medical staff at these sessions. These included persons considered to be at special risk, e.g., ambulance and hospital and nursing staffs, etc.

(f) **Vaccination against Anthrax**

Ministry of Health Circular 19/65 recommended that all persons exposed to special risks of contracting the disease should be offered active immunisation. This would consist of three injections as the primary course and annual reinforcing doses each consisting of one injection. The workers mainly concerned are those in establishments such as tanneries, glue, gelatin, soap and bone-meal factories and woollen mills who are regularly handling certain raw materials specified in the Ministry's Circular. There are four such firms in the County which handle raw materials with anthrax risk, but the numbers of persons requiring protection is not expected to be large.

Arrangements are in hand for these vaccinations to be carried out by the appointed factory doctors, and the scheme should be in operation early next year; vaccine will be available free of charge to factory doctors and obtainable from the Area Health Offices. Records of vaccinations carried out will not be required by the authority.

(g) **Vaccination against Measles**

By Circular 6/66 the Ministry of Health advised local authorities that controlled trials of measles vaccine have been carried out in children aged 10 months to two years, and the Joint Committee on Vaccination and Immunisation had accepted that the vaccination schedules used in the trials are effective and acceptable procedures. The Joint Committee regarded it as premature to embark on any programme of general measles vaccination but agreed that the vaccines, which will shortly be put generally on sale, should be available to doctors wishing to use them for any of their patients.

Although it is not suggested that local authorities generally should seek to make arrangements at this time, the Minister is prepared to consider giving approval to authorities wishing to make arrangements for this purpose under Section 26 of the National Health Service Act, 1946.

As a preliminary step and before any decision is made as to the submission of proposals under Section 26, the matter is to be discussed with the local Medical Committee.

VACCINATION OF PERSONS UNDER AGE 16 COMPLETED DURING 1965

Table 1 — Completed Primary Courses—Number of persons under age 16.

Type of vaccine or dose	*Year of Birth* 1965	1964	1963	1962	1958-61	*Others under Age 16*	*Total*
1. Quadruple DTPP.	4	37	13	1	1	—	56
2. Triple DTP.	1147	1662	271	122	61	8	3271
3. Diphtheria/Pertussis	—	—	—	—	1	1	2
4. Diphtheria/Tetanus	3	4	5	4	483	385	884
5. Diphtheria	—	8	3	2	39	37	89
6. Pertussis	—	—	—	—	—	—	—
7. Tetanus	1	—	1	—	235	801	1038
8. Salk	—	1	6	5	17	3	32
9. Sabin	524	2131	450	233	645	423	4406
10. Lines 1+2+3+4+5 (Diphtheria)	1154	1711	292	129	585	431	4302
11. Lines 1+2+3+6 (Whooping Cough)	1151	1699	284	123	63	9	3329
12. Lines 1+2+4+7 (Tetanus)	1155	1704	289	127	780	1194	5249
13. Lines 1+8+9 (Polio)	528	2169	469	239	663	426	4494

Table 2 — REINFORCING DOSES — Number of persons under age 16.

Type of vaccine or dose	*Year of Birth* 1965	1964	1963	1962	1958-61	*Others under Age 16*	*Total*
1. Quadruple DTPP.	—	—	—	—	—	—	—
2. Triple DTP.	—	429	790	196	258	30	1703
3. Diphtheria/Pertussis	—	—	—	—	—	—	—
4. Diphtheria/Tetanus	—	4	7	6	1782	816	2615
5. Diphtheria	—	—	—	—	282	856	1138
6. Pertussis	—	—	—	—	—	—	—
7. Tetanus	—	—	—	—	26	10	36
8. Salk	—	1	1	—	1	9	12
9. Sabin	—	17	53	35	3140	1547	4792
10. Lines 1+2+3+4+5 (Diphtheria)	—	433	797	202	2322	1702	5456
11. Lines 1+2+3+6 (Whooping Cough)	—	429	790	196	258	30	1703
12. Lines 1+2+4+7 (Tetanus)	—	433	797	202	2066	856	4354
13. Lines 1+8+9 (Polio)	—	18	54	35	3141	1556	4804

PREVENTION OF ILLNESS, CARE AND AFTER-CARE

Section 28 of the National Health Service Act, 1946

"A local health authority may, with the approval of the Minister, and to such extent as the Minister may direct shall, make arrangements for the purpose of the prevention of illness, the care of such persons suffering from illness . . . . . ., or the after-care of such persons, but no such arrangements shall provide for the payment of money to such persons, except in so far as they may provide for the remuneration of such persons engaged in suitable work in accordance with the managements".

PREVENTION OF ILLNESS, CARE AND AFTER-CARE

The "Section 28" responsibilities of Local Health Authorities have always embraced certain important aspects of the department's work including its part in the tuberculosis services, in providing convalescence for appropriate cases, etc., and on these subjects I comment again below.

At one stage a few years ago early action on advances in Mental Health Services were based on Section 28 until special legislation emerged to deal more comprehensively with this wide field of service.

This section of the Act has, however, become more significant again both nationally and in our local Cumbrian context because of recent moves towards activities of far reaching importance, which find their statutory basis here. I refer to the development of health screening procedures. In 1965 the Authority's first major amendment to Section 28 proposals since 1948 was approved by the Minister in the following form:—"In co-operation with Hospital Authorities the authority will make available to all women at risk, a service for the collection of cervial smears for cytological diagnostic investigation".

This development of which I give a little more detail below, opens, in my view, an era of increasingly intensive interest and activity in health screening procedures. In some cases these will be pilot ventures such as surveys of focal points of health hazard to elderly people, eyes, ears, teeth, etc., which I hope to pursue soon; others will develop from the beginning as more long range population group ventures—much indeed as cervical cytology has already started. Which of these ventures will be mainly a Local Authority organisational responsibility is, however, an open question. It is clear that none can run satisfactorily apart from a large measure of co-operation between family doctor, local authority staff and hospital consultant staff in the specialities most concerned. Correspondence with the Ministry of Health during the year on the subject of screening for glaucoma clearly indicated that at present this is one condition not primarily associated in their mind with a Local Authority based initiative. No doubt some

clearer guidance will soon be forthcoming as to the areas of this work thought most suitable for Local Authority based planning and execution.

The recent decision of the County Council to support the fluoridation of water supplies is also immediately relevant to "prevention of illness, care and after-care" though fuller comments on this subject appear in association with the Principal Dental Officer's report on the dental care of mothers and young children.

Thus it will be seen that the topics which have tended to dominate this part of my report in the past, now take their place alongside newer concepts in preventive health.

Cervical Cytology

On 1st April, 1965, the first cervical smears were taken in Local Authority clinics in Cumberland by specially trained health visitors. For some time previously this service, as a preventative measure against cancer of the cervix, had been available to a limited extent through Family Planning Association clinics and Hospital post-natal clinics. Now it was being offered to all women between the ages of 35 and 50 with special emphasis on those who had borne children—that is, the main "risk" group. Since then, and until the end of 1965, 1,597 women have been so examined in Local Authority clinics and from this number six cases have been found requiring follow-up; six women whose lives can be said, without sentiment, to have been saved. The numbers coming forward in 1966 so far promise a much higher total for that year. It should not be thought, however, that the response of the "target" population to the initial provision of this service was spontaneous or brisk. Not unexpectedly sustained and studied publicity had to be employed, geared also to the gradually developing capacity of the Hospital Laboratory to deal with specimens. To the unfailing helpfulness and co-operation in this of Dr. Faulds and Dr. Inglis, Consultant Pathologists, Cumberland Infirmary, I would like to pay tribute. Gradually limited publicity by Local Authority Nursing staff in their normal professional circles of influence gave way to general press advertisements and posters in clinics and, in some cases, in general practitioners' surgeries. Attendance has

been by appointment throughout and so far no serious waiting lists have been accumulated. In 4 situations evening sessions are now in operation or planned and obviously meet a real need.

At meetings with representatives of the general practitioners, appointed by the Local Medical Committee, and gynaecologists it was agreed that it would be preferable for all records to be maintained centrally in the pathology department at Cumberland Infirmary and that if necessary the County Council and Carlisle Borough Council would contribute to the cost of any additional clerical expenditure incurred by the hospital in this centralisation. It was also thought that the best way of letting women know the results of smears taken in local authority clinics would be through their own doctors and it was therefore arranged that the laboratory would send the results to general practitioners, at whose surgeries the women would call.

Unfortunately, as the numbers of women attending the clinics increased this arrangement began to impose a burden on the surgery arrangements of some general practitioners and at the end of the year further meetings were held to review the procedure. It seems that the general practitioners do not now wish to have to convey the result to those women with negative smears and it is likely that in future they will receive a simple notification direct from the pathological laboratory, a pre-addressed envelope being sent from each clinic with every smear. In the case of a positive smear or a smear which suggests a need for further investigation or even treatment for some other condition the notification will be sent to the general practitioner and it will be his responsibility to contact the patient and explain the situation.

This new arrangement will pose an additional clerical burden on the pathology department but if necessary the cost will be shared by the local authorities. The benefits from keeping the lines of communication as simple and short as possible are thought to outweigh the relatively small cost.

Gratifying though the results so far are, it is but a beginning and study of the group which came forward in 1965 has led to a close analysis of the socio-economic grouping of these women. It

is well established that as well as a certain age range of married women and particularly those who have borne children, an important factor is the so-called socio-economic group to which a woman belongs, more positive cases are found amongst classes 4 and 5, generally speaking the wives of the less skilled working man in the community. Now this is not the group which tends to take first advantage of a scheme such as has started in the clinics; and I have found that in Cumberland so far 68% of those attending are from social classes 1, 2 and 3 and only 6.7% from social class 5. This is undoubtedly a major factor in leading to a detection rate of only 2 per thousand to date, while experience elsewhere has shown that as high a "yield" of positives as 20 per thousand may be obtained if a high proportion of social clases 4 and 5 are involved. One way of achieving this is through a domiciliary service in which the general practitioner would co-operate in arranging visits to the homes by duly trained nurses. Such a scheme is before me now as a pilot venture and probably constitutes the next main step forward in this service. Another factor which may well signficantly affect the pattern of Local Authority clinic services in this field is the extent to which a re-organised general practitioner service may elect to carry out these examinations in group practice surgeries.

Tuberculosis and Diseases of the Chest

To Dr. Morton and Dr. Hambridge, Consultant Chest Physicians in East and West Cumberland respectively, I am again indebted both for their reports which are published as Appendices to this annual report and for their unfailing help and co-operation throughout the year. While continuing vigilance is obviously still necessary in the matter of tuberculosis detection, control and contact tracing much of the emphasis in this group of diseases has passed to the urgent issues in the prevention of chronic bronchitis and lung cancer. Although Dr. Morton shows that in 1965 the number of new cases of lung cancer coming to light is down compared with the previous year, the overall picture of this disease holds no reassurance — least of all to the cigarette smoker who persists in ignoring the thoroughly established connection between the two. Dr. Morton also strongly emphasises the importance of eliminating cigarette smoking in the prevention of chronic

bronchitis. Certainly we are face to face here with a very fundamental challenge to the changing of a community health attitude and no really effective solution is in sight.

That the historic after-care services for the tuberculosis sufferer—the special equipment, even to garden shelters for open air sleeping, etc.—are a feature of the past we must be truly thankful. The clinician has brought this infection under control by drugs so that even the contribution of surgery is now small. The support of his wonderful therapeutic work by Local Authority staff in the community and working as a team with the patient's family doctor, will continue undiminished till this scourge is finally eliminated.

After-Care of Other Illnesses

Section 28 of the National Health Service Act provides that local authorities "may make arrangements for the care of persons suffering from illness or the after-care of such patients" and these include the provision by the local authority of equipment necessary to the nursing of patients in their own homes.

Under this scheme requests for equipment to be provided on loan are generally made by hospitals, general practitioners or through district nurses and issues are made by the British Red Cross Society, acting as agents for the County Council. They operate from the following depots which conform to the areas of administration:—

Carlisle, 28 Victoria Place.

Monday—Friday, 10 a.m.—12 noon.

Workington, 59 Station Road.

Tuesday and Thursday, 10 a.m.—12 noon.

Whitehaven, Whitehaven Hospital.

Tuesday and Thursday, 10 a.m.—12 noon.

These arrangements for distribution have been in operation since the beginning of 1964 and thanks are due to the Society for the expeditious manner with which requests for equipment have been met; there is no doubt that the service is both successful and economical for the County Council. Occasional difficulties in meeting requirements are inevitable due to fluctuating demands for certain items of equipment (particularly wheelchairs and commodes) arising from distribution and transport problems; and in the collection from patients' homes of equipment no longer required. These are, however, less general now that distribution is made through local stores instead of from a single depot as was the case a few years ago.

Each of the "loan" depots carries a certain amount of "basic" equipment such as wheelchairs, hospital-type beds, mattresses, bed pans, etc., and the district nurses hold small stocks of such items as urinals, bed pans, bed cradles, waterproof sheeting, etc., to meet immediate needs; articles of equipment of a specialised nature and therefore of limited use, for example lifting hoists and postural beds may also be provided as necessary.

Loan equipment is, as a general rule, returned in a satisfactory and clean condition and this is attributable in part to the district nurses visiting the homes of the patients during the normal course of their duties.

In 1964 agreement was reached by the County Council and the Hospital Management Committee on their respective responsibilities, and this has established a formula to enable a decision on responsibility to be taken where appliances or articles of equipment are required for a patient's home use. This has worked extremely well, with a measure of flexibility and co-operation in local arrangements between hospitals and the local authority.

Generally speaking, it is the responsibility of the local authority to provide wheelchairs on a temporary basis but after the patient has been in possession of one for a period of three months the case is referred to a hospital consultant with a view to a request for a Ministry of Health chair. Pending delivery of this, however, the period of loan by the County Council can be

extended. In those cases where the need is obviously long-term, the hospital consultant concerned considers the advisability of requesting a Ministry wheelchair at the onset.

With regard to the loan of the many types of walking aids, if there is need at the time of discharge from hospital, or if the person is an out-patient, it is the responsibility of the hospital to provide these. Similarly, such aids required on permanent or semi-permanent loans are also provided by the hospital authority on a consultant's recommendation. If the need for a walking aid arises after discharge from hospital or is recommended by the family doctor in association with out-patient treatment, the responsibility for supplying this rests with the local authority. If on the other hand it is required for more than six months the hospital consultant is asked to review the case to ascertain whether the appliance should be supplied by the hospital.

The following table shows the number of major items of equipment issued during the past five years; no charge to the patient is made for any article supplied on loan.

Equipment	Items issued during 1965	1964	1963	1962	1961
Commodes	145	105	98	76	49
Crutches	62	65	34	17	9
Hospital Beds	10	22	9	11	6
Invalid Chairs—					
Adult type	176	134	141	105	83
Junior type	22	8	7	10	11
Mattresses—					
Rubber	15	21	20	31	16
Inflatable	3	8	3	3	7
Tripod Walking Sticks ...	150	130	127	91	46

Domiciliary Physiotherapy Care

Miss Morris and Miss Fraser, the two domiciliary physiotherapists in Cumberland, have contributed the following notes on their regular work:—

"Last year we gave an account of the varied work expected from an orthopaedic physiotherapist, both in home visiting and clinic work, and there has been little change during the last twelve months.

"On the whole, the number of adults and particularly older people visited has increased, often not for regular visits but to check on types of walking aid or other items of equipment needed to facilitate independence. Items such as these do so much to enable old people living on their own to be mobile and to manage.

"Regular domiciliary visiting of 24 adult stroke patients who cannot attend the hospital departments continues, either weekly, fortnightly or monthly according to the stage that the patient has reached or the accessibility of their home. There comes a time with some cases when little more physical improvement can be expected, particularly in the hand and arm, where active movements have never returned and the limb is virtually useless. When the patient reaches this stage it is better to discontinue physiotherapy as such and for the patient and his relatives to be encouraged to accept the disability and lead as normal a life as possible. It is still, however, very important that they understand the necessity of

continuing to mobilise the affected shoulder, to prevent the stiffness which would make dressing difficult; and, even though it may take much more time, to continue carrying out many daily living activities, simple domestic jobs, dressing, toilet, etc., with the sound arm.

"The craft classes which many of our stroke cases are attending throughout the County are making a very obvious difference in the patient's attitude to activities both through the meeting of others, better and worse than themselves, and

by their discovering that it is possible to knit or make a rug with one hand. There are many problems which crop up when visiting a stroke patient which can really only be coped with in co-operation with a trained occupational therapist and we shall welcome the day when this is possible."

Convalescence

The arrangements by the Authority for the provision of convalescent treatment for adults not requiring extensive medical or nursing care, were continued during the year and the number of persons admitted under the scheme was 144, a considerable increase compared with previous years as will be seen from the following table. This was due to the larger number of persons referred through the domiciliary nursing service by general practitioners particularly in the western area of the County, and interest is being displayed as to the reason for the increase in the numbers from one area compared with the remaining two areas of the County.

Convalescent Home	1961	1962	1963	1964	1965
Silloth	35	55	51	83	141
Boarbank, Grange-over-Sands	1	1	—	—	1
Other Homes	—	5	1	—	2
Totals:	36	61	52	83	144

Patients, as a general rule, are admitted for a two-week period which may be extended by a further week if necessary. A financial assesment is made in accordance with the County Council's scale to determine the amount each patient may be asked to contribute towards the cost of maintenance although in actual fact, very few persons are asked to contribute.

Whenever possible places are sought at Silloth which is pleasantly situated on the Solway and has the advantage of being open during the winter months and is easily accessible by road

from all areas of the County. Although convalescent facilities are available to persons from 14 years of age upwards, the majority of persons admitted under the arrangement with the County Council are elderly.

Ambulance transport may be provided when this is considered necessary by the general practitioners referring the patient. It is occasionally necessary to find alternative accommodation at Homes other than Silloth for patients requiring more extensive care, for example diabetes or those with severe heart conditions.

The Home is registered as a Nursing Home under the Nursing Home Act, 1963, and is run on a non-profit basis with a fully qualified nursing staff, including a night nurse.

I am grateful to Mrs. A. McCracken, S.R.N., the Matron of Silloth Convalescent Home, for the following comments:—

"Today when hospital beds are in demand, many patients are nursed in their homes through acute illnesses which leave them weak and debilitated. These patients may apply to the appropriate Health Authority for two weeks' convalescence. After consideration the request may be granted and through the Health Authority the patient may be sent to Silloth Convalescent Home.

"The Home provides complete rest, nursing care, good food, and freedom from worry. The air at Silloth possesses splendid qualities, and all these factors help to restore the patient to full health.

"Other patients though not acutely ill have suffered for years from illnesses which have incapacitated them greatly. These patients may also apply to the Health Authority and, again, if the request is granted they are sent to the Home for two weeks' recuperation. Many of these patients live alone and become very depressed through the long, lonely winter. For these people two weeks' convalescence with proper nourishment, nursing care, and contact with other people are

of immense benefit and they return to their homes, improved in body and mind and able to cope again with their infirmities."

The meetings of the Convalescent Home Committee continue to be attended by myself or my Deputy.

CHIROPODY SERVICE

The authority's free chiropody service for the elderly, expectant mothers and physically handicapped has been operating from 1st November, 1960, and the rate of expansion has been fairly steady at around 1,000 cases per year. By the end of 1965 the total number being treated had risen to 5,948, an increase of 774 or 15% on the previous year. In fact over 1,100 new cases were referred to the chiropodists during the course of the year, but a review of the register to remove the names of those who had not needed treatment for 12 months reduced the net increase to 774.

The 5,948 patients received a total of 25,314 treatments and it is rather worrying to note that the very high proportion of 25% have been recommended for domiciliary treatment by general practitioners and, of even greater concern, that 30% of all treatment given was in the patients' own homes. This adds enormously to the cost of the service and is one of the reasons why the authority's chiropody service is, on the most recent statistics available, costing considerably more per thousand of population than in any other county. Although the service is available to the three priority groups of patients, in practice its benefits are enjoyed almost entirely by the elderly, as the handicapped and expectant mothers form a negligible proportion—less than 1%—of those treated. About 18% of all the elderly in the administrative county are receiving this free treatment, taking the term elderly to mean men of 65 and over and women of 60 years of age and over.

Another point of interest is the disproportionate way in which the patients are spread throughout the county. Although the three areas have almost equal population, southern area has about 1,400 patients, northern area has about 2,000 and 2,500 live in the western area.

One feature of the service over which I have expressed anxiety in previous reports—the number of broken appointments—has, I am pleased to say, shown considerable improvement in 1965. In those parts of the southern area covered by the full-time chiropodists the absentee rate was about 8% in 1961, increasing to 14% by 1964, but now showing a very welcome drop to 6%. This probably

reflects the efforts made to impress on patients and their relatives the importance of cancelling in good time appointments which cannot be kept. The worst months for absenteeism were January and November.

Another problem on which further thought may be focussed is the period between treatments. Up to now chiropodists have been authorised to treat all those referred to them under the county scheme up to a maximum of eight times in a twelve month period, i.e., about six weeks between each treatment. Where they felt more frequent treatment to be necssary they could make a suitable recommendation. However, with the growing demand for treatment it may be necessary to extend the period between visits to ensure that more patients may get some benefit.

During the course of the year the authority was fortunate to recruit the services of another full-time chiropodist, Mrs. H. Coulson, who joined Mr. G. H. Thomas to work mainly in the southern part of the county. Mr. W. W. Gordon moved from there to Penrith to meet a need arising from the sickness and impending retirement of part-time staff. In addition to the three full-time members of staff there are 15 chiropodists in private practice who also give treatment under the county scheme, their case loads varying from only 32 to over 600. Those in the latter category are, in fact, devoting almost all their time to local authority work but theoretically continue to be classed as part-time officers because they are paid on a sessional or case basis.

Free treatment is available in the following 16 towns and villages, no new centres having been opened in 1965:—

Alston	Maryport
Aspatria	Millom
Brampton	Penrith
Carlisle	Seascale
Cockermouth	Silloth
Egremont	Whitehaven
Keswick	Wigton
Longtown	Workington

It is intended to open a further treatment centre—at Cleator Moor—when the new clinic which was completed there at the end of the year is brought into use in January, 1966.

This county does not seem to suffer from the shortage of chiropodists which restricts the local authority services in some other areas and, indeed, applications have been received from three more persons seeking full-time appointments.

I believe that future planning will be more towards a full-time service. It will not be easy to phase this to keep to a minimum the disturbance it must inevitably cause to the private practice chiropodists who may have lessened their interest in the private side of their practices to take on patients under the county scheme; but with goodwill all round it should be possible to reach an amicable solution. This is a problem which the authority will be starting to tackle early in the new year.

In general the chiropody service is working well. Voluntary societies are co-operating in the provision of transport in some areas, without which a number of patients would have difficulty in getting to treatment centres, but an extension of this service would be a boon and could perhaps go some way towards resolving the most disquieting feature of the whole service. I refer to the proportion of patients receiving domiciliary treatment. Apart from being costly and time consuming, it cannot be to the advantage of the patients or the professional satisfaction of the chiropodists that they should sometimes be giving treatment without proper lighting, equipment or hygienic facilities. If voluntary sources could help further by transporting those who are fit to receive surgery or clinic treatment provided they can be given transport, I am sure this would go a long way towards easing a disturbing problem.

I believe that the chiropody service offered to the elderly in Cumberland is second to none in its comprehensiveness and in the quality of the treatment offered. The service has developed

rapidly in this county largely because of the availability both of a number of full-time chiropodists and because of the willingness of private chiropodists to undertake sessional work under the County Council's scheme. Although there may have to be some deceleration in the development of the service it will be some time before many other areas have reached the standard of service offered in Cumberland.

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 now, the following table has had a place in this Report:—

Year	Early V.D. Infections		Total Attendances	
	Carlisle	Whitehaven	Carlisle	Whitehaven
1955	48	26	1,202	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	472
1961	67	20	755	454
1962	70	52	640	473
1963	86	41	715	266
1964	84	56	635	284
1965	99	68	730	388

" The table above illustrates the continuing increase in ' Early V.D. Infections ' which came for treatment to the two clinics in Cumberland. In this category were included only two examples of early syphilis, one at each Clinic, and in both cases the origin of infection was outside the county itself. The total numbers of non-gonococcal urethritis (N.G.U.) remained much the same as in 1964; it is gonorrhoea which is responsible for the increase in these V.D. infections. At the Carlisle Clinic the figures for 1964 and 1965 respectively were 55 and 71; at the Whitehaven Clinic they were 41 and 55. Of these Whitehaven patients 28 derived from Workington itself. I had a good deal to say about these Workington

cases last year and expressed concern that so many infections originated in public houses. This feature has been very much less noticeable since then, and there is indisputable evidence that the licensees of these public houses have been sympathetic to my personal pleas, and have made a real effort to help me. Moreover, Dr. Hunter and his staff have worked harder than ever to help in contact-tracing, and the like activities. The efforts of these dedicated Health Visitors have been something of a deterrent to the 'ladies' in the area, and a source of satisfaction to myself. One extraordinary testimonial to their efficiency is that more women than men were treated for gonorrhoea at the Whitehaven Clinic. The usual ratio of men to women treated for this infection is about four to one, according to the Ministry's statistics for England and Wales.

"In my Report for 1964 I spent considerable space discussing the advertising of local V.D. Clinics. I mentioned the Circular C.M.O./2/65, sent to Medical Officers of Health in England and Wales by the Ministry which suggested the Local Health Authorities might consider displaying notices giving information about V.D. treatment in places where young people congregate, and also in places where the Local Authority already displays posters on other subjects, e.g., in the entrance to Town Halls, or Public Health Departments or Public Libraries, where people could look at the poster and find from it the address of the V.D. Clinic WITHOUT DRAWING ATTENTION TO THEMSELVES. The Post Offices were also asked to authorise the inclusion of the address of the local V.D. Clinic in the list of the local Addresses of Departments and Organisations which is displayed in all Post Offices.

"The implementation of such a novel project can develop only slowly. Already notices are appearing in some Post Offices and Youth Clubs in Cumberland; all my colleagues in the Health Departments have assured me that they will keep this problem under constant review during 1966.

"Under 'Early V.D. Infections' I list cases of early syphilis, of gonorrhoea, and of non-specific urethritis (N.S.U.). This does not equate with the Ministry's definition of V.D., which covers syphilis, gonorrhoea and chancroid. This last condition is so rare

that it must be years since I have seen an example of the disease. By contrast, the total numbers of N.S.U. patients treated at clinics in England and Wales last year was greater than the total number of male gonorrhoea patients.

" It must be admitted that it is difficult to categorise N.S.U. Most cases follow a known sexual exposure : but there are a number of men who develop the same signs and symptoms as features, or complications which are secondary to (non-sexual) conditions elsewhere in the genito-urinary tract. Finally the doctor's dilemma is the more troublesome if coitus with a marital partner is the only possible source of the condition. So, although Venereologists regard most examples of N.S.U. as a sexually acquired (venereal) disease, they realise, at the same time, that many are not venereal.

" It is a very odd condition, too, since it manifests itself only in the male. If there is a parasite shared between the male and female partners, this agent has, so far, defied discovery. Most Venereologists, like myself, have examined hundreds and hundreds of women who were the sexual partners of men treated for N.S.U. without finding any constant clinical picture. Moreover, the female partner complains of nothing. Does she share a parasite (bacterium, virus, mycoplasma or some other infecting agent) with her partner, or does she merely irritate or sensitise him in some way ? For myself, I begin to believe that she is a mere source of irritation : her discharges cause sensitation and inflammation of the male urethra which results in infection by his own commensal bacterial flora.

" This same vague conception of the cause (aetiology) of N.S.U. is beginning to crystallize in the minds of my colleagues, and was summarised very succinctly in a recent article in the ' Medical News ' of February 18th, 1966, by Dr. T. E. T. Weston from the Department of St. Thomas' Hospital, London. The title of the paper is ' An allergic basis for non-specific urethritis.' He points out that it remains a condition of unknown aetiology, in spite of intensive study and extensive investigations. Most of the research into its causation has, so far, proceeded on the assumption that it is an infective condition and has been primarily directed towards the identification of the responsible organism.

" Dr. Weston continues to develop his thesis along the lines which would match the experience and inductive reasoning of his colleagues. He reminds us that some few cases are due to physical or chemical trauma (e.g., foreign bodies shoved into the urethra, syringing with soap, panic applications of lysol and other caustic antiseptics—these are well-known in V.D. Clinics). He notes, too, that occasionally a common parasite is to be found in both male and female. Examples are such as trichomonas vaginalis, thrush, and the virus of trachoma, but that the occasional discovery of a common parasite may have tended to distort the trend of the real investigation. They are casual, but not causal, factors. In short, Dr. Weston suspects that the cause of N.S.U. is not an infective one at all.

" He goes on to suggest that sometimes the male urethra may become sensitive to something that is normally present in, and non-pathogenic to the genital tract of the female consort, rather than as the result of exposure to some yet unidentified infective agent harboured by his consort. He summarises his thesis by saying:

> ' It would seem possible, therefore, that not only may N.S.U. be a manifestation of the sensitivity of a particular male to one particular female, but that he may have a much more general tendency to sensitivity to vaginal secretions as such."

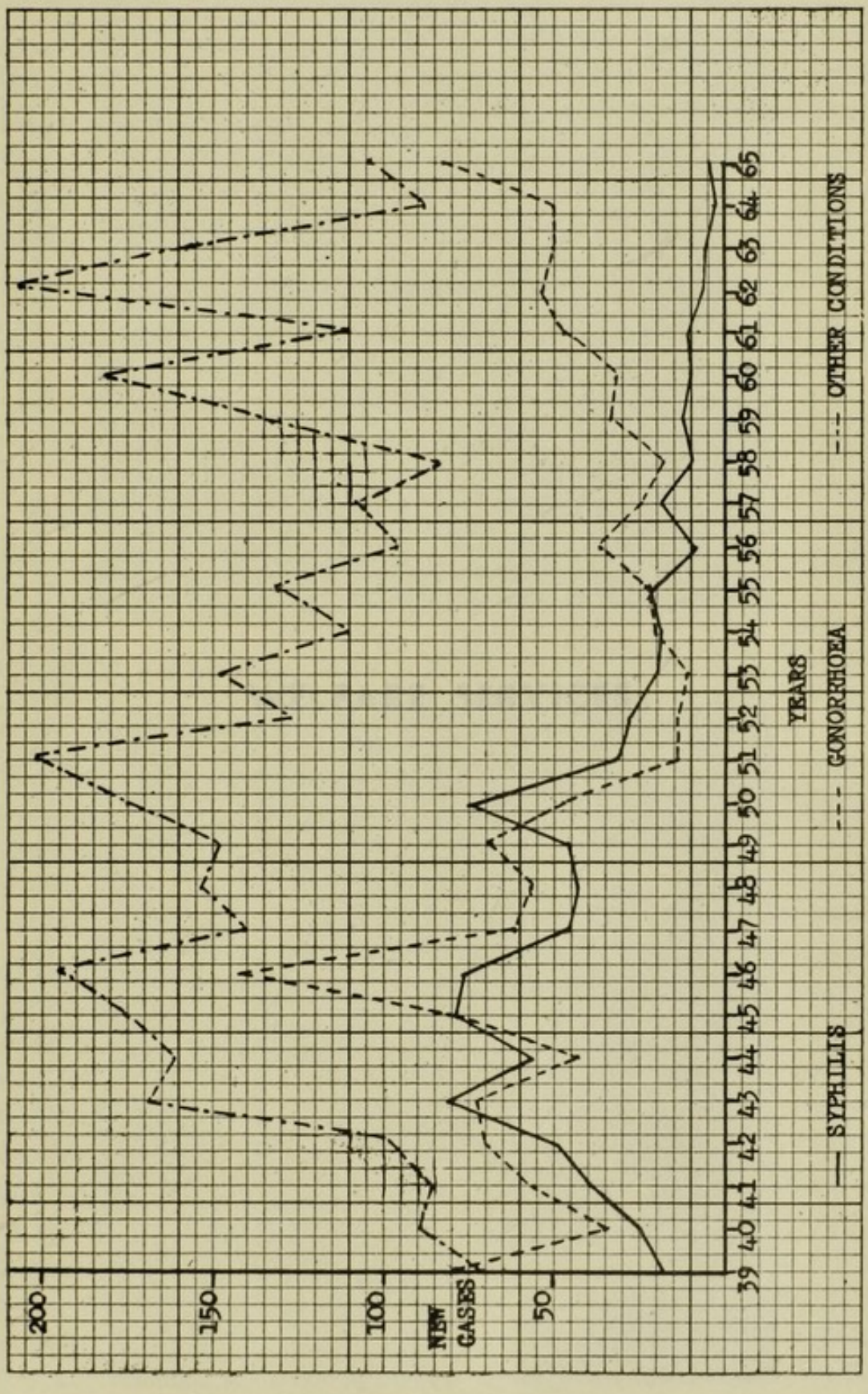
" With all this I agree.

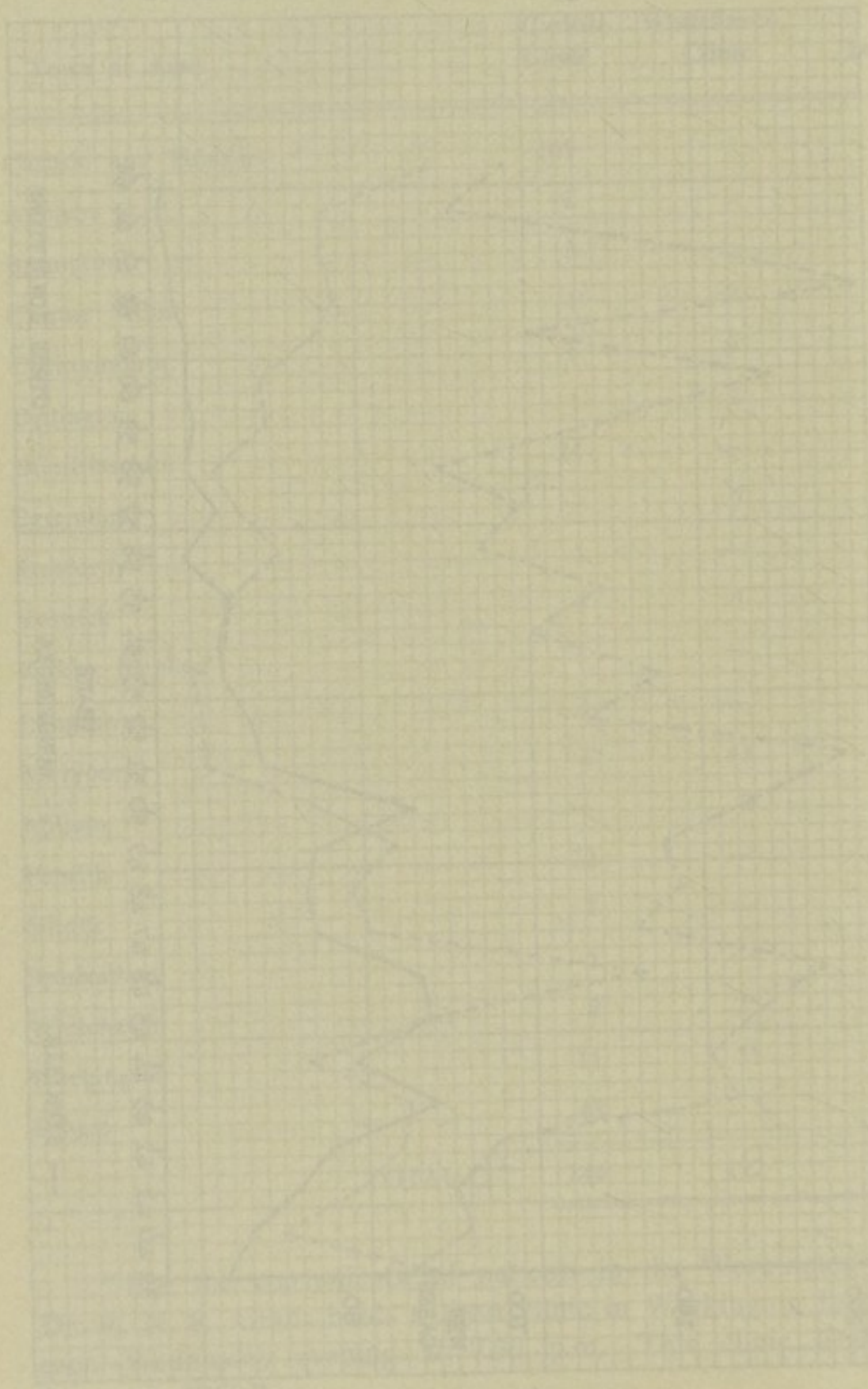
" I append a table showing the place of origin of the new cases attending the two Clinics in Cumberland in 1965:—

Town or Area	To Carlisle Clinic	To Whitehaven Clinic	Total
Carlisle and Suburbs	105	—	105
Appleby	2	—	2
Brampton	3	—	3
Cleator Moor	1	7	8
Cockermouth	1	9	10
Distington	1	2	3
Dumfriesshire	24	—	24
Egremont	—	7	7
Gosforth	1	—	1
Keswick	3	1	4
Kirkby Stephen	1	—	1
Longtown	4	—	4
Maryport	6	13	19
Millom	—	2	2
Penrith	22	—	22
Silloth	7	—	7
Spadeadam	1	—	1
Whitehaven	8	25	33
Workington	11	51	62
Others	43	5	48
TOTAL	244	122	366

"For the convenience of patients in the Workington area, Dr. R. N. R. Grant holds a short clinic in Workington Infirmary each Wednesday evening at 7.30 p.m. This clinic began in February, 1966."

VENEREAL DISEASES — NEW CASES PER YEAR 1939 TO 1965
ADMINISTRATIVE COUNTY OF CUMBERLAND





WELFARE SERVICES

MOOT LODGE — BRAMPTON

VOLUNTARY WORKERS — MEALS ON WHEELS

WELFARE SERVICES

The Welfare Services of the Local Authority are directed towards the elderly and physically handicapped in the main. Although the partly neglected needs of the latter are rightly asserting themselves and receiving due attention, it is the former, the elderly, whose complex physical and psychological needs provide an undiminished challenge. The basic needs of the retired elderly person are by now well defined. They can be summarised as follows:—

(1) Basic domestic provision—adequate home comfort, food, medical and nursing services.

(2) Companionship—acceptable and sincere.

(3) Activity—congenial and purposeful.

(4) Usefulness — real, however small and apparently insignificant.

(5) Status—dependent on the above; in the end vital; and not provided by labels such as " senior citizen."

The needs are known and the methods and means of meeting them must evolve against a background of unending thought, operational research, and reappraisal of services.

The services of a local authority in Welfare have long tended to be thought and spoken of as (a) Domiciliary; and (b) Residential. Whether this division is any longer really meaningful may be challenged in the light of the aim of today, to ensure that wherever an elderly person is (with the possible exception of hospital), he or she is " at home." In what we speak of as residential accommodation—the old persons' Home with a traditional capital " H "—anxiety no longer remains about basic physical care, comfort and nutrition. Thereafter, however, the meeting of the individual's further needs as summarised above can in many ways present more difficulties than in those " own home " situations where contacts and companionship can be reasonably preserved and progressive isolation avoided. The " bridge," as we have realised for some time now, is the invaluable " supported independency "

situation; and the relationship between all forms of "home" provision or preservation for the elderly, demands constant fresh and progressive thought.

These matters, and a full range of others mentioned further in this report, are being gone into in considerable depth in the course of 1966, by the County Council's second Working Party on the Needs of the Aged; a review of the first Working Party report published in 1959. The work of this party will be of inestimable value to me as County Welfare Officer in establishing guide lines for the future development of services. That certain very distinguished national figures have indicated a willingness to come to speak to the Working Party is most gratifying, and will give the benefit of the best informed views supported by outstanding research work.

Having referred to the very incomplete distinction between "home" and "residential" welfare services, it must be recognised nevertheless that there will continue to be approximately 95% of elderly people living in their own homes and not in either Old People's Homes or special housing of the "supported independency" type with warden help. This 95% will be divided broadly into those living with children or other close relatives, and those living on their own, usually small and often very old, houses; and of the latter some will be alone, others with spouse or "living" companion. Remembering that a great deal of what must be said about meeting the needs of these elderly people in their own homes, applies similarly to those in special housing or even in welfare Homes, it is apparent, I think, that only a true sense of community responsibility will ever achieve the full provision necessary. I believe a local authority welfare service is in a special position of responsibility to lead in this direction and to shape the community's attitude aright. To this end I and members of my staff have spent, and will continue to spend, a great deal of time in bringing to key groups in the community a picture of the pressing needs of the growing number of elderly people in our midst. What I say further below about the specific services provided by the department should be thought of always in this

wider context; should be seen as a secure framework on which help and support from family, voluntary sources, and the wider community can be built effectively and comprehensively.

It will be readily appreciated that the local authority welfare service is the agency which is embracing the largest single body of trained social workers in the local community. Their training is geared to the understanding of social forces at work in our communtiy and to the special techniques of grappling with the problems which these bring. The mystique of "case-work" may be regarded somewhat suspiciously by some, but I have no doubt that there will be a real harvest of benefit from the application of young, able minds to the understanding of the very complex social pressures and forces at work today. While, as I have already said, the elderly, the physically handicapped and, closely related, the mentally disordered, are the special concerns of the health and welfare department, social work develops in parallel in other fields, notably with children; with youth; with the delinquent and criminal; in the field of education, etc., and inevitably much discussion has arisen as to the intersections of these spheres of social work. Should the main "unit" for the attention of trained social workers be the family; and if so how is this to be defined? A joint committee of the Ministry of Housing and Local Government; the Ministry of Health; the Home Office and the Department of Education and Science is at present taking evidence on this point from many bodies, including local authorities.

I feel sure, however, that the services at present offered to the groups indicated above as the special responsibility of "health and welfare," will continue to be necessary substantially as of now, for a good time to come, even in the presence of a Family Social Service, should this come about.

What then do these mainly consist of and what are the achievements and difficulties of the social welfare officers of the department? That they work very closely with the family doctor/nurse team must be underlined again and the more direct linkage of social welfare officer and the medical team has been much before me. In those areas where conditions favour a degree of attachment, some progress has been made and in general every encourage-

ment has been given to the frequent personal contact between doctor, nurse and social welfare officer. The doctors tend very understandably to rely on the attached health visitor for the social work element of their patients' problems, and there is no doubt that the practical problems of adjusting to the regular consultation between a larger team are relevant in general practice. It does seem clear, however, that the family doctor of the future will find himself the leader of just such a team and requiring quite a deep understanding of the role each member has to fill. Only time and progressive education and understanding of these disciplines will gradually bring this about and while the process advances, not entirely painlessly at all points, much tolerance and patience will be needed. Obviously relevant to all of this is the future shape of general medical practice about which developments are awaited at the time of writing this report. It will also be apparent that much of this links closely with developments in public health nursing, discussed at some length in another part of this report.

In day to day work the social welfare officers find a substantial part of their time occupied by their mental health duties, both for the subnormal and the mentally disordered, as is reported in more detail under the heading 'Mental Health'. This is far from distinct, however, from their work amongst the physically handicapped and those selected elderly people whom they visit. Both these groups are peculiarly 'at risk' with regard to mental illness and this fact I regard as one of the cardinal justifications for unifying the duties of the social welfare officers as in Cumberland. Too much time tends to be required also in assessing, both regarding needs and finance, those elderly people who apply for a place in an old people's home.

This is not unimportant work by any means but is one factor leading to an early careful appraisal of the need for 'welfare assistants' to be appointed in due course. These are the less trained social worker assistants who would be able to free more highly trained workers for more skilled 'case-work' duties. Writing on the work in the Western area and expressing anxieties as well as satisfactions, Miss Hall, Senior Social Welfare Officer comments:--

"The Community Welfare Officer of the Western Area are covered at present by a Senior Welfare Officer, four Social Welfare Officers and two Home Teachers of the Blind. There is a vacancy at present for Social Welfare Officer/Craft Instructor.

"The Area is divided into four with a fairly comparable case load, but this of course can be upset by demolition in town centres and housing development on the outskirts, and by the growth of an ageing population in town centres.

"The greatest handicap experienced by all the workers is TIME. Time to work; time to listen; time to plan; time to stand back and assess; time to compile adequate reports etc.

"With the present case loads **time** has to be shared amongst the aged, the physically handicapped, the mentally handicapped, and the mentally ill.

"Winter is still with us and many aged suffered severely during the recent 'flu epidemic and have not recovered completely. Time must be given to their welfare *now* when they need it, with the result that other duties may be neglected.

Latterly many handicapped persons have been receiving visits from social welfare officers and it is surprising the number of extra registrations this has brought forward. Another contributing factor to this has been the success of the meetings at the social centre at Workington (Monday afternoons — social; and Wednesday afternoons—craft classes). It is very much a case of 'come and bring your friend to be amongst friends.' The same applies to the social club at Keswick which meets once a month.

"The increase in cases coming to notice has naturally drawn attention to their needs and the issue or loan of suitable aids is steadily rising. Thanks for co-operation are due to the staff of the Red Cross Depot in meeting needs for aids. The fact that a handicapped person can get about and be independent is a very big factor in morale.

"There is close liaison with local housing authorities to meet the needs for ramps or other structural adaptations and these have

proved a boon in many, many cases. One cannot but be impressed by the cheerfulness of those handicapped and their willingness to help themselves and others".

It will be remembered that the ten year plan for social welfare officer staffing provides for 6 in each area (4 at present) plus a senior Social Welfare Officer trained to a higher professional standard. The appointment of Miss Hall as Senior Social Welfare Officer in the Western area completed the 'top tier' in 1966, and future development now also involves, as I have said, the question of the place of the welfare assistant. It will be readily appreciated that this thought is in parallel with the increasing use of assistant nurses in the field of home nursing.

The question of the regular visitation of elderly people is a perennial one beset with many practical and human difficulties, notable amongst which are the problems of compiling a comprehensive register and keeping this up-to-date; and the question as to the right person or persons to undertake regular visitation. I have long felt that the family doctor was the best person to focus services on the elderly and the close attachment of local authority staff to him has been pursued very much with this in mind. Nevertheless other methods which seem practicable, for keeping a more comprehensive review of the elderly 'at risk', merit close investigation and perhaps a new look at this subject will be taken by the new legislative and administrative approach to social services promised by the present Government.

Elsewhere in this report on the Welfare Services, more is said about the wonderful work being done by voluntary workers and organisations, for the elderly and the disabled, and perhaps it is opportune here to say a word about the role of the family. It was clear from the survey undertaken in the county of the "over 75's" that by far the largest part of the visiting of the elderly was carried out by the family and close relatives. This reflects the 'extended' family situation which prevails in much of a rural county like our own, in contrast to the so-called 'nuclear' family in other, notably new urban areas. The latter consisting of parents and dependent children only, necessarily involves separation from the previous generation, grandfather and grandmother, to a greater

or lesser degree; certainly as far as living together in the same house in concerned. Reference is often made to some civilisations, such as the Chinese, in which parents and grandparents have been traditionally revered to a very high degree; and contrasts have been seen in many Western civilisations where a sense of responsibility towards increasingly dependent parental relatives has seemed much less developed. This but indicates that complex and very anciently rooted social factors are at work in this matter and the moulding of attitudes is a long-term and deep human problem. The needs of the ageing and those of younger generations must somehow be balanced so that neither feels unduly sacrificed for the sake of the other, though this service is not possible without sacrifice to some extent. There does seem to be at least a risk in this country of the younger generations inclining towards a less responsible attitude to their dependent elderly than often seems right and to the duty — and satisfaction — of taking trouble to give time and care to even unappreciative older relatives. It is to a great extent the 'extended family' situation we have in Cumberland with elderly relatives living with, or close to, their children though this situation is threatened to some extent by the outward migration of younger adults which has been apparent for some years. Thus many elderly Cumbrians are well care for by their children as we have reason to know in the health and welfare department and great effort must be directed towards maintaining conditions in which this can be continued and extended without undue stress and strain; conditions outstandingly of housing as we shall see.

The major responsibility for 'housing' the elderly is, of course, that of the housing authorities, the District Councils. Of the elderly, only the small proportion of approximately 16 per thousand will be accommodated in local authority Welfare Homes. Attention has inevitably varied over the country on the part of housing authorities to the question of housing for families on the one hand, and of special housing for the elderly and handicapped on the other. The greatest single advance for the latter has been the provision of grouped dwellings or supported independency schemes with resident warden help. Eight such schemes have now been completed in the county providing for 179 people and further schemes now in progress will provide a further 106 places. The

value of these schemes is well established and it seems as though the level of provision planned in Cumberland and mentioned above, is meeting and likely to meet, the need in this direction reasonably for the immediate future. No doubt more will in the long term be called for and this demand relates in a very interesting way to family housing plans on the one hand and to local authority Welfare Home provision on the other. Should housing authorities be more concerned with providing a proportion of houses large enough, and suitably planned, for the accommodation of grandparents where desirable and necessary? This is no doubt an important point which the County Council's Working Party will wish to discuss with representatives of the housing authorities at an appropriate stage. If such a development comes about to a greater extent how will this affect the need for supported independency dwellings and for places in old people's Homes? These are imponderables at present but a challenge to both acute observation of a changing situation, and to planned research. Meantime what appear reasonable levels of provision are being aimed at in residential Home accommodation while an important feature of the latter remains the upgrading of accommodation which is still not satisfactory in quality. One thing is clear and that is that neat categories of elderly people in terms of degree of disability for each type of 'housing' is not realistic or possible. Many will inevitably continue to deteriorate in health and die in their own homes, in special housing provision, or in old people's Homes without any question of 'progression' from one to the other. Perhaps the element of choice will play a greater part in the future in settling the 'home' of an old person, along with the general quality of community care services allowing of the staying in his or her own home, whatever precise form this takes.

I am grateful to Dr. Patterson, Medical Officer of Health to Keswick Urban District Council, Cockermouth Rural District and Urban District Councils and Deputy Western Area Medical Officer for the following comments on the supported independency units functioning in his area. One of these was the first scheme to be opened in the County and I have always regarded the role of the Medical Officer of Health to a housing authority who is also on the staff of the County Health and Welfare Department as a key

one in the co-ordination of the welfare services needed by the residents of these units. Dr. Patterson writes as follows:—

Supported Independency Units

For me, this idea began as a means of providing compact housing units for single people approaching the elderly state, either without relatives or whose relatives were indifferent to their needs. At first housing authorities were reluctant to use their limited finances other than for families, but happily this situation has changed and both single persons and families are now catered for.

The first supported independency units had, of necessity, to take those persons who were available, and several of them should have been catered for elsewhere. As welfare home places were in short supply and many of the old people refused to go there anyhow, it would have been wrong to leave them where they were and leave partial dependency places vacant. Their admission to such places put a heavy strain on the welfare services which was added to by the attitude of some medical practitioners who assumed they were a cross between a welfare home and a geriatric unit with a night and day nursing service provided. It is very satisfying to be able to say that the welfare services coped adequately.

Since then, two other units have been set up and the lessons learned from the first scheme applied, successfully.

One essential to the efficient running of a unit is the warden. She must have intelligence, and a sense of compassion, but she must not want to nurse the tenants, coddle them or organise them. She must observe them but not become anxious and start to do things for them. She must keep them independent, and she must be in sole charge, that is, she asks for what services she finds are needed rather than others telling her what she should do.

The selection of tenants is important. The age range can be from 60 upwards but depends upon the physical and mental health of the person. If the prospective tenant is likely to want a welfare home or geriatric unit in two years or less, then they will not be suitable but may have to be accommodated temporarily. To have

a welfare home near so that transfer to and fro would be easy, is the ideal situation and would make persuasion of the elderly tenant to transfer more easy.

The education of the practitioner as to what a supported independency unit is, is important because co-operation in the hospitalisation of people where necessary can make the warden's task much easier.

The provision of supported independency units in rural areas is particularly difficult because of siting and transport troubles, but a joint scheme between a rural and urban area is the answer to this.

There is no doubt in my mind that this is the future answer to the problem of the aged, from a housing and welfare angle and efforts should be made to provide more of them.

Mrs. Hope, resident warden at Barras House, Dalston, has kindly contributed the following comments on her impressions and experience since the opening of the flatlets there in 1963:—

> "Our field is so wide, it is difficult to summarise the many aspects of life at Barras House. School girls shop for the less able tenants during their Homecraft lessons. The girls have also completed a bedspread from knitted nylon squares made by our blind lady. A hairdresser pays a weekly visit for those who wish a shampoo and set at 2/6d. Carlisle Toc. H. gave us our Christmas tree again and entertain us from time to time. We have entertained overseas students to tea in the sitting room. The Caldew School girls were also our guests. This was a very enjoyable afternoon, with the girls teaching the elderly to jive and the elderly teaching the girls to waltz. Our Harvest Festival Service was particularly worthwhile; the display of produce and flowers going to Strathclyde House. The Christmas Party was again the highlight of the year, the funds being raised from a Coffee Evening in the sitting room. We have continued to add to our Indian Tree crockery and have also been able to buy a tea trolly. The guest bedroom still proves a useful asset to the tenants, being let approximately fifty nights a year.

The health of the tenants continues to improve. One elderly lady who came to us three years ago leaning heavily on a stick and, who eighteen months ago had a life expectancy of about one month, has now discarded her stick and dances to the music of Jimmy Shand! Here I should like to note the unfailing interest and attention which Dr. Hayne and Dr. Bradley give to us. We like the tenants to think of Barras House as a good class hotel. At the word "Home" which the press and others have used, morale drops to zero. It is often a great strain trying to maintain a happy atmosphere especially as these elderly people are rent payers. It is, however, a proved fact that happy tenants are healthy tenants. Perhaps the greatest help we can have is in educating the relatives. So many tenants have in the past been brought amidst a great flourish of attention and then left by their relatives to the warden's care. Thanks to our cleaner Barras House continues to be kept clinically clean. The high standard we try to maintain needs constant vigilance but is paying its dividends in great pleasure and an increased life span. We thank Mr. Hill our housing manager for the new decoration which has now been completed and for entering Barras Close in the best kept villages (Council house estates) competition, which is to be judged in July.

So we look to the future with a sense of achievement in the past."

Residential Accommodation

In turning to think more specifically about the authority's so-called "Part III accommodation" reference should be made to a recently issued memorandum by the Ministry of Health to Hospitals and Local Authorities on joint planning of residential accommodation; indicating the aims which local authorities should have before them in providing homes; suggesting criteria for selection of residents; advising on staffing. This important memorandum—again a subject for close study by the Working Party—codifies developing thought over a few years and I am glad to think that the widest and most fundamental principles which it enunciates have been appreciated and accepted by the Cumber-

land County Council for some years and our services have developed in accordance with these. One of the largest single problems touched on in the memorandum concerns the provision for the aged with varying degrees of mental confusion or infirmity, a problem very much in the foreground of my mind. The aim commended by the Ministry of Health as "endeavouring as far as is reasonable and practicable to accommodate in these (unspecialised) homes people with physical handicaps, difficult personalities or confusion of mind, (and) to provide separate small homes, normally of not more than 35 places, for people with special needs, including elderly mentally infirm people who are found to be so disturbed that they cannot suitably live with other residents".

The number of beds in Part III accommodation is now 381 provided as follows:—

Ex-public assistance institutions	117
Homes in adapted premises	114
Purpose-built Homes	150
	381

An additional 40 beds will become available in mid-1966 by the completion of a new Home in Whitehaven. By the end of the ten year building programme it is hoped to provide 659 beds in modern premises.

At the 31st December, 1965, the total number of persons accommodated was 370. The following table of beds and occupancy illustrates the increased number of persons being cared for in Homes with the closing of ex-Public Assistance Institutions. It has been found that when a new Home is built and brought into use, there is an undiscovered demand for admission. There is a waiting list which remains around the 90 mark although by no means all of these are in immediate or urgent need of a place in a home.

The Home nearing completion in Whitehaven has been planned as for the more infirm. Since infirmity in old age will increasingly centre on the mental rather than the physical disabilities, the developing use of the new Home will be observed closely; it should provide an opportunity to study the advisability of thinking in terms of one floor or one wing of such a home for the more disabled residents. This approach, very much in keeping with the Ministry's latest recommendations, would preserve the 'neighbourhood care' principle to a large extent, one which I am sure must be jealously guarded in a rural community.

	No. of beds provided			*No of Residents*		
At 31st December	*Joint-User Establishments*	*Modern type Homes*	*Total*	*Joint-User Establishments*	*Modern type Homes*	*Total*
1949	375	—	375	235	—	235
1950	375	—	375	238	—	238
1951	325	—	325	243	—	243
1952	325	—	325	217	—	217
1953	325	19	344	201	18	219
1954	325	19	344	219	19	238
1955	263	69	332	188	57	245
1956	263	69	332	189	70	259
1957	242	69	332	188	65	253
1958	242	87	329	193	88	281
1959	252	108	360	199	99	298
1960	215	146	361	174	132	310
1961	215	146	361	178	132	310
1962	117	230	347	93	208	301
1963	117	230	347	112	222	334
1964	117	229	346	114	218	332
1965	117	264	381	116	254	370

The health and welfare services ten year plan now provides for the early closure of the two remaining ex-public assistance institutions and ultimately for the replacement of Homes in adapted premises by purpose-built Homes. It is only in the latter that an efficient service can be provided, not only for the residents themselves but in housing the resident staff in satisfactory quarters. Fortunately in Cumberland, the admission of mentally disordered elderly people into the mental hospital, presents no difficulties. The percentage of elderly patients who are admitted to the Garlands Hospital has risen only from 19 to 21 during the past 4 years, whereas in many parts of the country the increase has been about 60/70.

Two new Homes have been completed — Moot Lodge, Brampton for 25 residents which became occupied in March and Grisedale Croft, Alston for 10 residents a month later. The latter Home is in association with a District Council's Supported Independency Scheme, the general oversight of which is carried out by the Matron of the Home. The Matron of Grisedale Croft reports:

"Grisedale Croft opened at the beginning of April, 1965. We have progressed very quietly since then with very few crises, the home and flatlet scheme working very well. Most of the tenants of the flats fit in with the everyday working of the home and try to help with the little extra jobs in the home as well as looking after themselves in their own flats.

"The Open Day was held on the 16th of July, luckily we were favoured with a very fine day which helped to show the Home and grounds to better advantage, particularly as the roses presented to us by the Alston Women's Institute to commemorate their Golden Jubilee year were then blooming well.

"On the 15th September we had a very important visitor, Sir Arnold France, the Permanent Parliamentary Secretary to the Minister of Health.

"On the 14th September we started to cook lunches for Meals on Wheels, at first having difficulty in persuading people to have them, but now we find we have a waiting list. We also supply

lunches on three days a week for the Luncheon Club in the Home.

"Weekly Whist Drives were started in October in aid of the Comforts Fund and have proved so popular that they are likely to go on all during the year, the main attraction being the warmth of the building, whilst players in Alston usually have to play in Arctic conditions.

"Over Christmas we had many parties of Carol Singers, and the residents joined in the singing with great enjoyment. The local Brownies and Girl Guides gave a concert which was greatly enjoyed by everyone and they also presented the Home with a beautiful bible in large print, from which a lady from the flatlets reads a portion every Sunday to the residents. Every Wednesday two ladies from the W.V.S. visit us, talking to the ladies and playing dominoes with the men. This is greatly appreciated by the residents, although they tend to require encouragment to be sociable with anyone from outside the home itself.

I do find, on the whole, that the residents, when they enter the Home, are most grateful for everything—though sometimes some of the benefits lose a little in appreciation through familiarity! We find that understanding and tolerance are the keys to a happy relationship."

Mrs. Campbell, the Matron of Castle Mount, Egremont, writes as follows:—

"Each morning coffee is given out by members of the Mothers' Unions. The Church of England Mothers' Union do it for one month and the Union of Catholic Mothers for two months. The same applies with 3 p.m. tea. Every Sunday there is a service by either the Methodist or Church of England minister — they and the Catholic priest have a monthly communion service.

"Meals on Wheels have risen from thirty-four to seventy-two; day centre attenders have increased from one to fifteen.

"On the 27th March a group of Rangers will be visiting the Home each Sunday afternoon for the next three months to see in what way they can be of some service to the residents.

"From October until the end of March, Inner Wheel members come each Wednesday afternoon and give a prize to the winner of the whist and domino competition. Two more prizes are given to the winners of the special draw for those who are handicapped and cannot join in the games. In January the members provided a tea for the residents.

"Every Friday afternoon members of the W.V.S. go round with the trolley shop and any profit from this is towards giving the residents a trip out in the summer. I would like to mention here that when we had four staff and twelve residents down with 'flu, Mrs. Todhunter, who is in charge of the meals on wheels, worked in the kitchen one morning from 8 a.m. until 11-30 a.m. when she then took out the dinners.

"We have one male resident who makes himself responsible for the care of the budgerigars and plants in the first floor lounge. Another (legless) wheels himself into the kitchen after every meal and helps dry the dishes; two others do the errands and another repairs his own shoes. Three registered blind ladies knit dish-cloths and another lady does most of the sewing repairs for the men.

Throughout the year the residents have been entertained by various organisations; we have also received gifts of fruit and flowers and several of the residents have been invited to local events. Eleven residents went to see the Blackpool Illuminations."

Activities in the Homes

A further word might usefully be added here about some of the activities in the Homes.

Day Centre and Luncheon Club facilities are now available at many of the Homes namely:—

Home	*No. of weekly attendances*
Richmond Park	32
Parkside	21
Castle Mount	15
The Croft	10
Moot Lodge	17
Garlieston	12
Grisedale Croft	11

Meals for the meals on wheels service are being produced in the kitchens of Richmond Park, Highfield House, Station View House, The Towers, Castle Mount, Garlieston, Parkside and Grisedale Croft, but a certain restriction must be placed on the number of meals being produced from this source. This involves problems which will be dealt with later in the Report.

As last year, a week's holiday was arranged — this time at a holiday camp in Morecambe — for as many residents of Homes as wished to go. Fifty-seven residents took advantage of these arrangements. The following comments have been received from Mr. Clark, who escorted the party:—

"Unfortunately the weather was not too good, but all enjoyed themselves as much as possible under the circumstances. The staff at the holiday camp were very kind and attentive, the meals were excellent and without any doubt were enjoyed by all, and a good number attended the free concert show every night.

"The general opinion was that a hotel or guest house, where residents could sit in a comfortable lounge in the event of inclement weather, was much preferable to a holiday camp."

For the first time a holiday exchange scheme was arranged with the County Borough of South Shields; 9 of our residents going

to homes in South Shields for a holiday and a similar number of South Shields residents coming to Cumberland.

The youth of the County is now showing a growing interest in the elderly and our Homes are being visited regularly by children from the upper forms of the Grammar and Secondary Schools. This has brought about an added interest in the Homes and is proving to be well worth while. Assistance is given to the residents by writing letters, shopping, playing cards, chess, dominoes etc.

By arrangement with the Hon. Director of the Community Service Volunteers a Mr. J. Trustram who was waiting admission to King's College, Cambridge spent six months in several of our Homes.

The following is a synopsis of a report received from him:—

"My stay in Cumberland was most valuable to myself as I found close contact with old people easy and therefore rewarding, it was much more difficult to try and involve other young people.

Old people in Homes tend to be isolated and need to be reintroduced into the community by long established friendships. Interest in the elderly can best be promoted by changes in the uses of education in ideas of service giving encouragement and making ideas into reality. Girls were more willing to help, but they think more in terms of jobs than friendship. It is often thought that old people in Homes have no problems as they are fully cared for, but this factor and their immediate environment make them part of an unnatural community and so the friendship of younger people who are a part of the real social community outside the Home is needed."

Miss Woodman, Matron of The Towers, has given an account as follows of the establishment of an Over Sixty Club in an Old People's Home:—

"This Home has approximately 20 permanent residents and 7 holiday beds. With the help of the County Organiser of the Old People's Welfare Council, a Committee of 7 local

people was elected and an Over Sixties Club was formed in June, 1965.

"The membership is now 26 outside members, drawn from a radius of two miles and 20 residents of the Home; the holiday people take part in all activities. The membership fee is 2s. 6d. and each member has an Over Sixty Forget-Me-Not badge; afternoon socials are held every fortnight on a Wednesday from 2-15 p.m. to 4-30 p.m.; entertainment may be bingo for which small prizes are given or a film show, slides or talks. Tea is served at the close and outside members pay 6d.; the money goes towards future catering. The Committee all bring home-made cakes. At each social there is a raffle with a good prize; proceeds go towards club funds. An outing to the Lakes was taken in September with a free raffle on the 'bus, community singing and high tea was taken at Keswick—this was a great success.

"A bonfire and fireworks display was given by helpers; local children kept the bonfire going and afterwards all came into the Home for snacks. A very successful Christmas party was given on 8th December with a meal of cold turkey, ham, tongue and home made trifle. Music was provided and each member gave a present. There have been two outings to rallies at Carlisle and Cockermouth.

"Advantages — outside members, residents and holiday guests all gain from these meetings and look forward to them.

"Each member is given a birthday present.

" 'Get well' cards are sent to all members who are ill and this is greatly appreciated.

"Pensioners tea is available at reduced prices and it is hoped to extend this service—and, the bank balance is healthy!"

Staffing

The quality of the staff, more than the siting, buildings, furniture and other amenities, determines the richness of life in the Home. The prospect of having to care for increasingly frail residents is likely to aggravate staffing difficulties. Staff training may well prove the key to recruitment and status; it is certainly essential if a secure and efficient service is to be maintained.

The Homes are staffed by efficient and devoted officers but when vacancies do occur it is difficult to obtain replacements especially so in the case of assistant matrons. In January Mrs. Campbell Matron of Catle Mount, Egremont, returned from a fourteen-week course organized by the National Old People's Welfare Council. The Matrons of the Alston and Brampton Homes attended a week's refresher course in October.

In consultation with Dr. Begg, arrangements are in hand for selected matrons to spend a period of time at Garlands Hospital, Carlisle, to gain experience about problems associated with the integration of the confused and disturbed elderly in Old People's Homes.

The Health, Welfare and Housing Committee in June approved a scheme for trainees who would ultimately be appointed as Assistant Matrons in Welfare Homes. The scheme provides that after an initial period of three months during which suitability for further training could be assessed, an induction course of four weeks would be arranged. This would cover a wide spectrum of work involving not only the running of Part III accommodation but other aspects of the Health and Welfare Services and embracing the duties of the social welfare and nursing services, the home teachers, craft instructors and the voluntary services. The trainees would then widen their experience by attachment to the various residential Homes within the County on a rota basis. At an appropriate time they would be seconded to one of the fourteen-week courses for Matrons and Assistant Matrons of Old People's Homes which are run by the National Old People's Welfare Council at an approximate cost of £200 per student. This trainee scheme which is now successfully launched, should in two/three years ease the present shortage of senior staff in the Homes.

Mrs. Campbell has sent in the following contribution regarding the trainee at the Egremont Home:—

"In October, 1965, a sixteen year old girl commenced work in the Home as part of her training to become an assistant Matron, she appears to be interested in the work—is willing to learn, reliable and punctual. With the exception of cooking she has done all other jobs in the Home. She has relieved each member of staff on their rest day and has assisted the person doing the cooking on the cook's rest day. Under the supervision of the assistant matron or myself she has prepared medicines and tablets and given them out. She knows how to keep the accommodation, receipt and saving books. This week she has tried to make out the menu and do the necessary ordering from it; considering it was her first attempt she did quite well."

I believe that any disadvantages associated with the youth of these trainees will be greatly outweighed by the positive contribution which trained and keen young people with responsibility can make to the residents' care.

Private Disabled Persons or Old Persons Homes

The only changes occurring during the year were the cancellation of the registration of Seaton Villa, Seaton, the proprietress having retired, and the registration of a Home at Braithwaite, subject to satisfactory fire precautions keing carried out.

There are in the County four registered voluntary Homes as follows:—

Stoneleigh, Gosforth	11 persons
Rothersyke House, Egremont	20 persons
Scalesceugh, Near Carleton	25 persons
Spring Bank, Braithwaite	10 persons

The Homes are regularly visited and inspected. These places make a small but not insignificant contribution to the overall needs of places in Homes.

Temporary Accommodation

By agreement with the Children's Officer the key role in the rehabilitative efforts directed at the families in the Wigton units is deemed by the child care officers. Supported by the field staff of this department and by the National Society of Prevention of Cruelty to Children officers and others, a very exacting and challenging task has been energetically tackled; and what success has been achieved co-operatively owes much to painstaking effort and a constructive approach by, amongst others, certain of the housing authorities. Unless families in serious difficulties have a prospect in terms of employment and housing the fundamental incentive to self-help is missing. Three housing authorities in particular have given great help in the past year to these families at Wigton and I am grateful to the Clerks and Housing officers of these authorities who have taken such a valued interest in the problem. Two families in particular moved out to a fresh start in housing provided by their 'original' authorities, one after almost three years despairing effort.

In addition to the accommodation provided for three family units at Highfield House, Wigton, a house was bought at Harriston, Aspatria and was occupied on 10th November, 1965. The unit at Highfield House, Wigton continues to be fully occupied and there is usually quite a time lapse before re-housing can take place. Families so accommodated continue to receive support and help from social workers, health visitors, district nurses and child care officers.

The northern area of the County has had the greatest difficulties in 1965 in the matter of families requiring temporary accommodation. Several of these situations have arisen, occupying a great deal of the social welfare officers' time and causing everyone much anxiety with efforts to avoid family break-up and yet prevent 'squatting' situations in the temporary accommodation which does exist. Housing authorities in the area have not been unhelpful in re-housing some of these families, often from 'tied' housing in the agricultural community. In a situation where over-provision of temporary accommodation could defeat its own purpose the correct level is hard to determine; and a more comprehensive responsibility

on housing authorities would not seem out of place to provide 'emergency' probably sub-standard housing after the truly temporary accommodation of the welfare authority has played its part. Otherwise the welfare authority tends to become a 'de facto' housing authority for a few selected unsatisfactory 'tenants'.

Thus a complex problem of providing a very necessary type of accommodation, yet one requiring careful control, is being met in Cumberland at present apart from any central 'hostel' type of provision — a solution more applicable to larger urban areas and not without its own serious built-in problems as one large authority in England is currently proving. With so many other elements of the old Poor Law being systematically eliminated from the scene, it is to be hoped that the growing numbers of trained social workers will yet further reduce the need for this type of accommodation for certain families.

Persons without a Settled way of Living

Calthwaite Reception Centre

Notwithstanding local representations by the County and Carlisle City Councils, a visit by a deputation to the Chairman of the National Assistance Board, the Calthwaite Reception Centre was officially closed on 1st May 1965. Should there be the need to accommodate a person without a settled way of living due to there being insufficient time to direct him to an appropriate centre, the National Assistance Board have arranged lodgings in Carlisle for an over-night stay. At the time of closure members felt there was some anxiety as to what would happen in the future; up to the present no difficulties have arisen but a keen watch is being kept on the situation.

Voluntary Work for the Elderly

I cannot speak too highly of the large amount of work done by the various voluntary organisations with whom we have the friendliest co-operation.

The Meals on Wheels Service continues to meet an existing demand which is consistently and rapidly increasing and this upward trend will bring its own problems to the forefront, particularly in the matter of transport. Whilst the W.V.S. are dealing with the Meals on Wheels Service in a most praiseworthy manner, they are finding some difficulty in recruiting an adequate number of drivers this relates especially to the scattered rural areas. The graph at the end of this section illustrates the geometrical expansion of the Meals on Wheels Service. During the year 36,199 meals were supplied and this is estimated to increase to 44,000 next year. Luncheon clubs arranged by Old People's Welfare Committees and the W.V.S. are now well established at Brampton, Maryport, Workington (two) and Cockermouth.

A further expansion of these services is under constant review in conjunction with the voluntary organisations. The need is ascertained from various sources, namely doctors, health visitors, district nurses, etc. and immediate action is taken to meet all demands. With the continuing expansion in the Meals on Wheels Service, difficulties regarding the provision of the meal and of transport are becoming only too evident and these are being investigated and discussed by the Second Working Party on the Needs of the Aged in Cumberland.

The County W.V.S. have sent me the following report for the year —

"Requests for Meals on Wheels to be started, or increased, continue to be received. New services have been started in Longtown, Alston, Maryport, Aikton, Caldbeck and numbers have been increased in Egremont and Ennerdale Rural District. Further expansion seems inevitable, but the provision of the meals will become increasingly difficult as those old people's Homes which can supply meals are being used to capacity, except for Brampton which will probably be so used in the coming year. Apart from old people's Homes, meals are purchased from restaurants, canteens, school meals kitchens, hospital kitchens and the Ministry of Works establishment at Eskmeals.

"Meals on Wheels started in Cumberland at Workington in October 1959. During 1960 1,524 meals were delivered. In 1965, 36,199 meals were delivered and, generally speaking, each recipient received two meals per week. 'Good neighbour' schemes are beginning to develop where there are only one or two old people in a village who are recommended as being in need."

"The Hotlock containers continue to be satisfactory and they are of good strong construction. Where the number of pensioners is slightly over the capacity of the Hotlocks, we have found that plastic insulated picnic bags fitted with Hotlock dishes, can be used to transport up to five additional meals; and these can also be used where a round is very small. These bags will have a short life but are useful in certain circumstances and the capital outlay is small compared with Hotlocks.

"Very few complaints have been received on the quality of the meals and, generally speaking, the old people are most appreciative of both the service and the visit. The drivers and helpers have done a first-class job and have never failed to deliver the meals, even when it meant the local policeman borrowing a tractor and driving it himself when cars could not get through the snow.

"Two new luncheon clubs were started in Workington. Premises were loaned free of charge, but a certain amount of equipment and crockery had to be purchased. W.V.S. members cook and serve the lunches at both clubs and the old people who are recommended in the same way as for meals on wheels, pay 1s. a meal. They seem to enjoy their outing and at both clubs there has been a noticeable improvement in their turnout and general appearance. They have all made luncheon club friends and, at one club, two senior girls from the Victoria School help to serve the meals.

"Generally speaking, 1965 was a satisfactory year but if the services increase at a similar rate in the future, much thought will have to be given to both provision and transporting of meals."

Mrs. Ellwood, Welfare Organiser of the Cumberland Old People's Welfare Committee continues to energetically co-ordinate much of the voluntary work for the elderly and there is a very close liaison with your officers. Her appreciation of this is expressed in the following report:

"That the County Council should repeatedly show its awareness of the volume and quality of voluntary service which has been forthcoming all over the County during the last year has given great pleasure to those of us engaged in furthering voluntary effort. Our scattered rural community has provided a very creditable amount of voluntary service in many different fields and that this should be recognised and appreciated by the health and welfare department is a source of satisfaction to all organisations and individuals engaged in this work. By showing confidence in the voluntary bodies by giving them the opportunities to work closely with the statutory authorities, by keeping them informed on major issues—all this has been of the utmost value in ensuring a working partnership. There are some services which can be better performed by a voluntary organisation. Others where the statutory body can be the only real source of help; but together much can be achieved. We do not have unlimited voluntary resources but these can and do accept responsibility and the challenge of new work and fresh ideas".

Mr. Mulelly, Secretary of the Cumberland Council of Social Service, has also sent in this contribution:—

"Thanks to the enlightened policy of the County Council and the goodwill of those who lead the voluntary organisations, Cumberland is rapidly acquiring a reputation as a place where statutory and voluntary bodies work together harmoniously and productively for the common good. The Council of Social Service has been particularly grateful for the opportunity to play a modest part in the extension of services for the elderly and the disabled and for enabling young people to give voluntary service to the community. The readiness of large numbers of young people to undertake community service projects is a heartening feature of our present time and it is to be hoped that those engaged in social and welfare work, whether as members of statutory or voluntary

bodies or as professional social workers, will do their best to encourage and to make constructive use of it.

"Further evidence that Cumberland must be counted amongst the progressive Counties was provided this year when the County Councils' Association and the National Old People's Welfare Council each appealed to local authorities to promote and support the provision of training meetings and courses for voluntary workers. For several years now such facilities have been provided in the County by the Council of Social Service and other bodies in co-operation with and fully supported by the Health and Welfare and Education Departments of the County Council".

In each area, group meetings were held between the nursing staff and the Women's Institute Welfare Secretaries to ensure a person-to-person liaison. Subjects which came under discussion included 'good neighbour' meals, visiting, village clubs, transport and particular local problems.

Handicapped and Disabled Persons

The number of handicapped persons has increased by 76 during the year and the number registered on 31st December were classified as follows:—

HANDICAPPED PERSONS

	Persons aged 16—64		*Persons aged 65 and over*		*Total*	
	M.	*F.*	*M.*	*F.*	*M.*	*F.*
Amputation	18	3	4	5	22	8
Arthritis and rheumatism	14	16	8	12	22	28
Congenital malformation and Deformities	33	22	2	—	35	22
Diseases of the digestive and genito-urinary systems; of the heart; of the circulatory system; of respiratory system (other than tuberculosis) and of the skin	28	9	10	7	38	16
Injuries of the head, face, neck, thorax, abdomen, pelvis or trunk. Injuries or diseases (other than tuberculosis of the upper and lower limbs and of the spine)	41	5	15	2	56	7
Organic nervous diseases; epilepsy, disseminated sclerosis, poliomyelitis, hemiplegia, sciatica etc.	55	41	12	3	67	44
Neuroses, psychoses and other nervous and mental disorders not included above	9	8	1	1	10	9
Tuberculosis (respiratory)	5	1	—	—	5	1
Tuberculosis (non-respiratory)	8	2	—	—	8	2
Diseases and injuries not specified above	9	4	—	2	9	6
TOTALS:—	220	111	52	32	272	143

There were 16 disabled persons accommodated on behalf of the Council by voluntary organisations and for whom the authority is financially responsible for maintenance charges.

Home	Men	Women
Langho Colony, Blackburn	—	1
Maghull Epileptic Colony, Liverpool ...	4	—
Enham-Alamein Village Centre, Enham-Alamein	1	—
Percy Hedley Centre, Newcastle upon Tyne	2	1
Scalesceugh Home for Spastics, Carlisle ...	4	1
Ernest Ayliffe Home for the Aged & Infirm, Deaf and Dumb, Leeds	1	—
British Legion Lister House, Sharow, Ripon	1	—

The Cumberland, Westmorland and Furness Spastics Society administer the Scalesceugh Home for Young Spastics; this is a beautiful old house set in its own parklands near Carlisle. It opened in March 1965 and at first took only five residents as the staff were fully occupied in cleaning and decorating the rooms. The building has been without an inhabitant for several years. The number of residents has built up as rooms have become available to use and there are now 20 young people. Two of these are sponsored by the County Council; one is a girl who moved in right from the opening date and the other a boy, was transferred from Percy Hedley Centre for Spastics at Newcastle to be nearer to his home at Cummersdale.

It is intended to build a special workshop near to the house but separate from it so that the task of obtaining work from local factories can be extended and the residents can earn some money while being usefully occupied. At present those who can, help with gardening and the day-to-day running of the Home. They hold whist drives and have organised outings to Carlisle for shopping and the cinema as well as going to special events such as the local production of the Gondoliers. They also have their own 'Sixty-two Club' in which they can discuss plans for the future and suggest ways in which the daily running of the Home can be made easier.

It is hoped that eventually there will be a total of 25 residents. This will not be possible, however, until the old part of the building has been converted into two flats—this work is now in hand.

The Home has always had a happy and light-hearted atmosphere since its opening. It is now settling down and becoming a real home for unfortunate young people who may previously have felt outcasts from society.

The Home for 20 younger handicapped persons will be built at Ewanrigg Road, Maryport and the Ministry of Health has approved the cost limit for this project.

At Wigton clinic a club for the physically handicapped started about eighteen months ago as a half-day club, catering for the handicapped in the areas covered by Wigton, Aspatria and Silloth. Initially about a dozen people attended and their activities were mainly cane-work and seagrass stool making. After the first few months it was decided to expand the club to a full day starting at 10 a.m. and to do this we needed voluntary helpers and also a prepared meal. Voluntary helpers were recruited from wives of local school teachers and they have stuck faithfully to the club since then and been of invaluable help. Meals were provided by the School Meals Service which, of course, were not available during school holidays though the club continued to meet without a break. We therefore had to improvise with food from the local shops such as fish and chips or meat pies during school holidays.

The activities of the club expanded to social pursuits such as dominoes and cards and handicrafts were extended to include rug making and embroidery. The social welfare officer concerned organised outings during the summer months and also a Christmas party. There have been occasional film shows and there is now the prospect that quite a few of the members will be going on the holiday organised by the Council of Social Service to Prestatyn in September. The club is becoming welded into a fairly tight unit of about 20 people but because we have used the club facilities for a few adult subnormals due to lack of a suitable training centre for our adults, we have found a few members reluctant to continue with the club activities. The subnormal element is noisy and un-

able to settle to anything for any length of time and this disturbs the group for whom the club was intended so that we now have to think of excluding the subnormals. Because the voluntary helpers were interested in the local schools, we had the offer of two older girls each time from the Friends' School at Wigton on a rota system to help with setting out the meal, making tea, getting suitable materials for those who were confined to chairs etc. This led on to the idea of a sale of work to be held in the Friends' School on the Open Day to raise funds for another outing or similar treat and this is to be held some time in July.

Two further classes for handicapped persons are now being held at Further Education Centres—one at Ullswater School, Penrith and the other at Irthing Valley School, Brampton, and the children take an interest in the class and its members. Further classes have commenced in rented premises at Keswick and Whitehaven. A wide selection of craft work including pottery and woodwork will be available when the Training Centre at Flatt Walks is adapted for use as a Centre for the Handicapped. Mr. Toms, the handicraft instructor, has resigned and it is proposed that he be replaced by an occupational therapist.

In the following comments Miss Welch, Senior Social Welfare Officer, Northern Area, who has played a large part in starting the clubs in that area, indicates some respects in which progress is still needed:

"Social Clubs for Handicapped People: We now have four of these in the Northern Area, each in charge of a teacher or occupational therapist whose aim has been to help physical manipulation and to give mental satisfaction by helping the patient to make something. What is now needed, in my opinion, is a professional person who can organise clubs and go on to stimulate thought and activity. There is still a lot of apathy in the out-look of the people who attend these clubs. Some of these could be helped by regular home visiting, which has not yet been possible because of other commitments. Someone who had experience of running clubs could also stimulate discussion and thought, and although not fully occupied inside the clubs could spend any spare

time visiting the local factories to see whether suitable work could be obtained for these people to do, for which they could be paid".

In this area, the facilities for the rehabilitation and for sheltered employment of the handicapped fall very short of what is needed and there seems to be no prospect within the foreseeable future of an industrial rehabilitation unit being provided by the Ministry of Labour within easy reach of Cumberland. In some of the larger centres of population, industrialists have joined together to form a voluntary association for the specific purpose of rehabilitation by industrial therapy of long term institutionalised residents of mental hospitals. This concept, possibly with a broader base to include a wider range of handicap or disability, might well have a local application and is in my view worth further investigation.

Blind and Partially Sighted Persons

The number of registered blind persons decreased by 24 during the year and the number of registered partially sighted persons decreased by one.

During the year, 49 persons were certified to be blind and 22 partially sighted. Of these, 36 blind and 15 partially sighted persons were 65 years of age or over.

The following table shows the age groups of blind and partially sighted persons registered on 31st December, 1965:—

Age Group	Blind M.	Blind F.	Blind Total	Partially Sighted M.	Partially Sighted F.	Partially Sighted Total
0—1 ...	—	—	—	—	—	—
2—4 ...	—	—	—	1	1	2
5—15 ...	4	4	8	5	4	9
16—20 ...	3	1	4	7	4	11
21—49 ...	34	18	52	13	11	24
50—64 ...	37	34	71	12	9	21
65 and over ...	128	242	370	29	60	89
TOTALS:—	206	299	505	67	89	156

The Home Teachers continued to distribute the large-print books provided by the County Library to partially sighted persons.

A partly disabled lady from Caldbeck makes tape recordings of "Cumberland Tales" and extracts from specialist publications for playing back to blind persons.

The North Region Association for the Blind arranged a holiday at Bridlington during the first week in May—this was thoroughly enjoyed by a group of blind persons from the Workington area. Once again two people attended a two-day course for blind farmers organised by the North Regional Association. This was held on an experimental farm at Barlby, near Selby, and was designed more for rehabilitation than as a general course in animal husbandry. Mr. Eric Toole, secretary of the North Regional Association, explained: "The majority of these men have suffered from bad sight for many years and a number have been totally blind from birth. Their farming enterprises are mainly pigs and poultry, for here they are completely in control. They would find it extremely difficult to manage cattle and sheep."

Miss Fraser, Home Teacher for the Blind in the Northern Area writes as follows:—

"There are five Home Teachers for the Blind employed by the County Council.

"Any person who would like to benefit from the services provided for the blind and partially sighted must first be registered. An examination is carried out by an Ophthalmic Surgeon and arrangements made by the Area Medical Officer. Following registration, the persons concerned are visited regularly by the Home Teachers. The services available cover all age groups—young children and their schooling, adults who require help with training and subsequent employment, and the elderly blind and those unable to take paid employment.

"The Home Teacher sees that the blind receive any financial assistance to which they may be entitled, radios are supplied by the British Wireless for the Blind Fund and free wireless licences are available. She also teaches Braille and Moon Type—some blind people enjoy reading through membership of the Talking Book Library while large print books are available for the partially sighted.

"Handicraft classes and social centres are organised. Previously there was only one class for the blind in the Northern Area at Penrith. Now there are classes in Wigton and Brampton attended by the blind along with other handicapped persons. Lunch is provided for the members by the school meals service."

Follow-up of Registered Blind and Partially Sighted Persons 1963-1965

A.

	Cause of Disability			
	Cataract	*Glaucoma*	*Retrolental Fibroplasia*	*Others*
December, 1963—				
(i) Treatment (Medical, surgical or optical)	23	7	4	20
(ii) Numbers of cases at (i) above which on follow-up action have received treatment ...	10	5	4	15
December, 1964—				
(i) Treatment (Medical, surgical or optical)	26	2	1	12
(ii) Numbers of cases at (i) above which on follow-up action have received treatment ...	13	2	—	7
December, 1965—				
(i) Treatment (Medical, surgical or optical)	17	2	—	11
(ii) Numbers of cases at (i) above which on follow-up action have received treatment ...	8	2	—	8

B. Ophthalmia Neonatorum; and there were no cases notified during the year.

Workshops for the Blind

The reorganisation of the Workshops for the Blind and the Sighted Disabled and the implementation of the first report and recommendation of the Ministry of Labour were completed during the year.

A decision to close the hostel was taken and this was done on the 31st July, 1965.

This enabled the transfer of the Administrative Offices from the Workshops into the Hostel building releasing valuable floor space in the Workshops for the development and expansion of the bedding and upholstery departments.

Efforts to improve sales continue. It is of some interest to note that when the control of the Workshops was transferred from the voluntary organisation to local authority administration (Cumberland County and Carlisle City Councils') the annual sales amounted to about £13,000, this figure is expected to reach £30,000 during the financial year ending 31st March, 1966.

By arrangement with the Carlisle City Council, a showcase for the display of goods manufactured in the Workshops has been installed in the foyer of the Civic Centre which will give a good display of the work being done by blind and sighted disabled persons from City and County areas.

The making and selling of firewood is to cease on 31st March, 1966, and arrangements have been made for the training and employment of the men concerned in other branches of the Workshops.

Major Holt, Manager of the Workshops, has kindly contributed the following:—

> " During 1965 the Workshops have steadily expanded their activities; the accent has been on increasing production and sales. In order to achieve more production space the main offices were removed to the hostel building thus providing a

larger area for the Upholstery Department and making space for a Divan Frame Making Department. Power operated tools have been introduced to increase production in the divan frame section and the use of such tools in this department has helped in producing a better quality article in a shorter time.

" New racking has been erected to accommodate new materials and finished goods, providing better facilities for the selection and storage of goods.

" There has been a steady increase in sales over the year, due to the support given us by local authorities, retailers and the general public. We have concentrated on advertising the actual products made in these Workshops and this has produced more work for our employees.

" We have had visits from leading personalities in the local industrial field and the wholesale outlets for our products have increased due to the interest shown by local retailers in the quality and competitiveness of our goods.

" Local organisations have visited us and parties of up to 30 have shown great interest in our work.

" In place of the sales centre in the Carlisle Covered Market, a new Showcase has been provided in the foyer of the Civic Centre and goods made by the blind are displayed for the public to view.

" We have decreased the number of men employed on the chopping and bundling of firewood and the re-training of individuals in more congenial work has proceeded. The Firewood Department will close on 31st March, 1966.

" Very few new blind entrants for employment are available and more sighted disabled to help the existing blind have been introduced into the Workshops, e.g., an epileptic has been trained as a machinest to help the blind in finishing processes in the mattress making department.

"The Manager has attended a course on advanced management at the Birmingham College of Technology.

"The workers previously accommodated in the hostel have been found congenial lodgings near the Workshops and have been integrated into home life. The hostel has been closed and midday meals are provided through an industrial firm's canteen. Expenditure on hostel facilities has been drastically reduced without loss of benefits to the workers.

"The coke burning central heating system has been converted to oil fired heating greatly reducing the manpower commitment.

"A phased programme for re-painting and decorating the buildings has been introduced and the re-painting is producing a brighter and more congenial working atmosphere.

"We are concentrating on the production and sales of brushes, baskets, divan beds, mattresses, cushions, pillows and upholstery.

"We continue to believe that full employment is the best type of welfare for both the blind and disabled."

Deaf and Hard of Hearing

I am grateful to Mr. Hayhurst, Secretary of the Carlisle Diocesan Association for the Deaf, for his contribution to this Report:—

"The Carlisle Diocesan Association for the Deaf has continued to act as agent for Cumberland County by providing welfare services for the profoundly deaf in accordance with the Council's approved scheme. This agency arrangement with the Association which was first agreed in 1950, was reaffirmed at a meeting in the Courts in June when representatives of the five constituent local authorities met the Association's representatives. The numbers of profoundly deaf in the County do not vary much from year to year. On 31st December there was a total of 123, including 22 children, attending special schools for the deaf and partially deaf.

"Social centres in Workington and Carlisle have been in constant use as meeting places and programmes have included outings during the summer months and indoor socials at all other times. Inter-club visits have been organised within the Association's area and members have attended rallies further afield. The special needs of young people have been remembered and every encouragement has been given to them to take part in further education projects arranged by the British Deaf and Dumb Association, especially the 'Mountain Venture' courses based on Denton House, Keswick, with the help of Cumberland Education Committee. All these activities have continued to help the deaf people widen their social horizons and are an important part of any deaf welfare service. A regular service of home visiting, especially for the house-bound, has been maintained and interpreters have always been available to help facilitate communication between deaf people and others. The handicap of profound deafness to a large extent precludes participation in ordinary Church worship. Simple Church services in a manner understood by the deaf, have been held regularly in the Association's Centres."

Recent discussion with the Association confirmed that the Council would leave the work with the profoundly deaf in the hands of the voluntary body. It was agreed that necessary improvements to be carried out in the service provided for the hard of hearing would be better made available by the local authority with the Association co-operating in the work where necessary, including the limited training of those social welfare officers who would be undertaking the work. With the assistance of Mr. Mellor, of the Development Committee of the British Association of the Hard of Hearing, the names of potential members of a hard of hearing club in the Wigton area have been listed and an inaugural meeting is being arranged at Wigton. In an attempt to strengthen the Association's staff, efforts are being made to recruit a trainee welfare officer and the Council has offered to help in securing a candidate for this appointment.

In conclusion, the previous pages give some indication of the changing pattern of the local authority welfare services which exist now and have existed in the past, to meet the varied and basic needs of society. As society has changed, so have these needs, and I am satisfied that those of the present day are being reasonably met.

Experience has now shown that the decision of the Cumberland County Council in 1962 to unite the Health and Welfare Departments was a wise one. The great knowledge and vast and continuous experience of Mr. S. Hodgson, Welfare Services Officer, has paved the way for the constantly improving level of service now provided. The Council are lucky in having an officer of Mr. Hodgson's breadth of vision, humanity and compassion for the less fortunate members of the society, and this Report would not be complete if mention of Mr. Hodgson's well deserved award of the M.B.E. in the New Year's Honours List were not made.

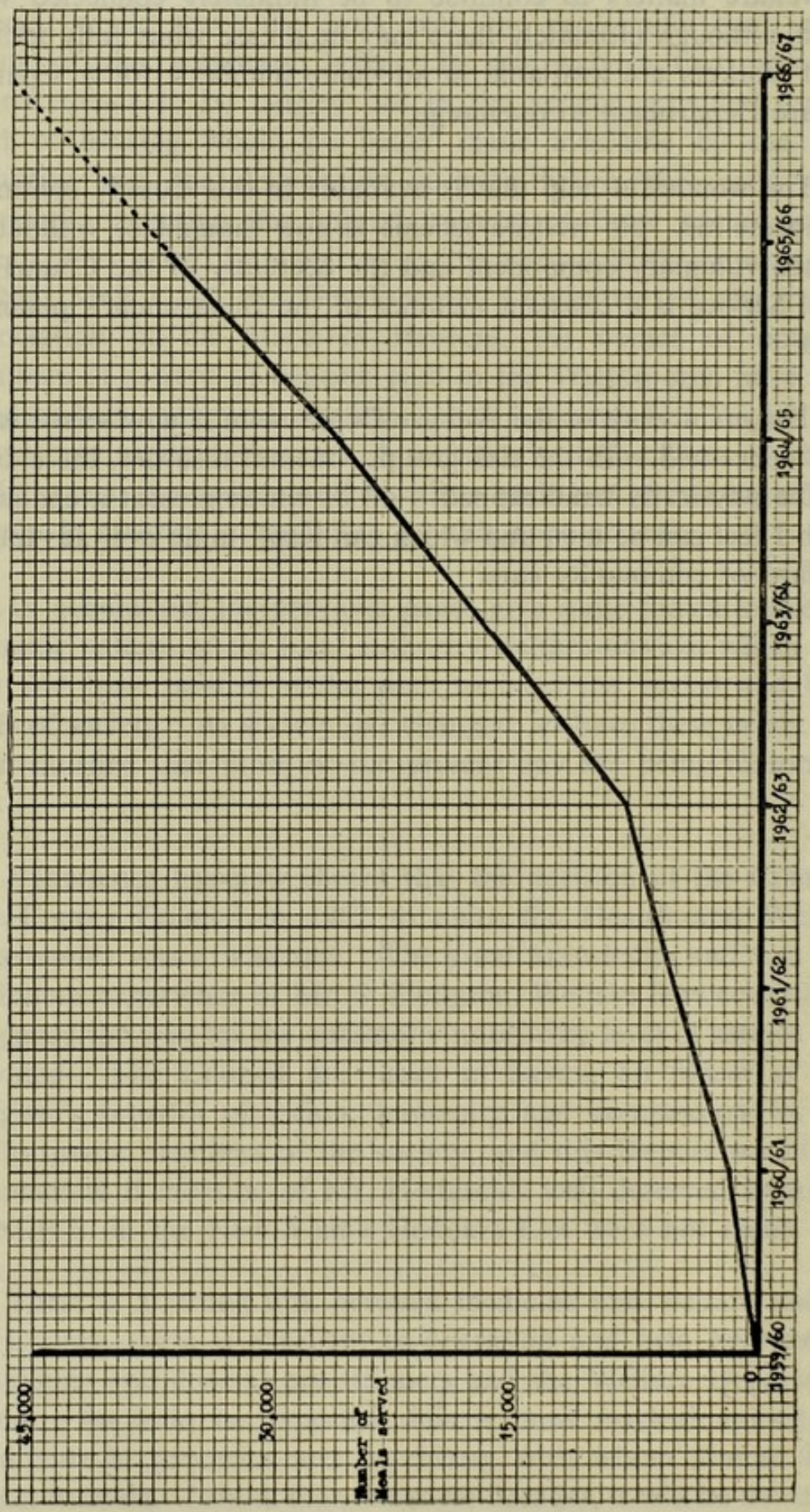
There is a strong link between medicine and welfare and, in this County, there is excellent co-operation and help between all consultants and general practitioners and the Welfare Department officers. As is to be expected, this is most marked among the consultants in geriatrics and psychiatry with whom almost daily contact is made. I think that, for some decades, it will be necessary

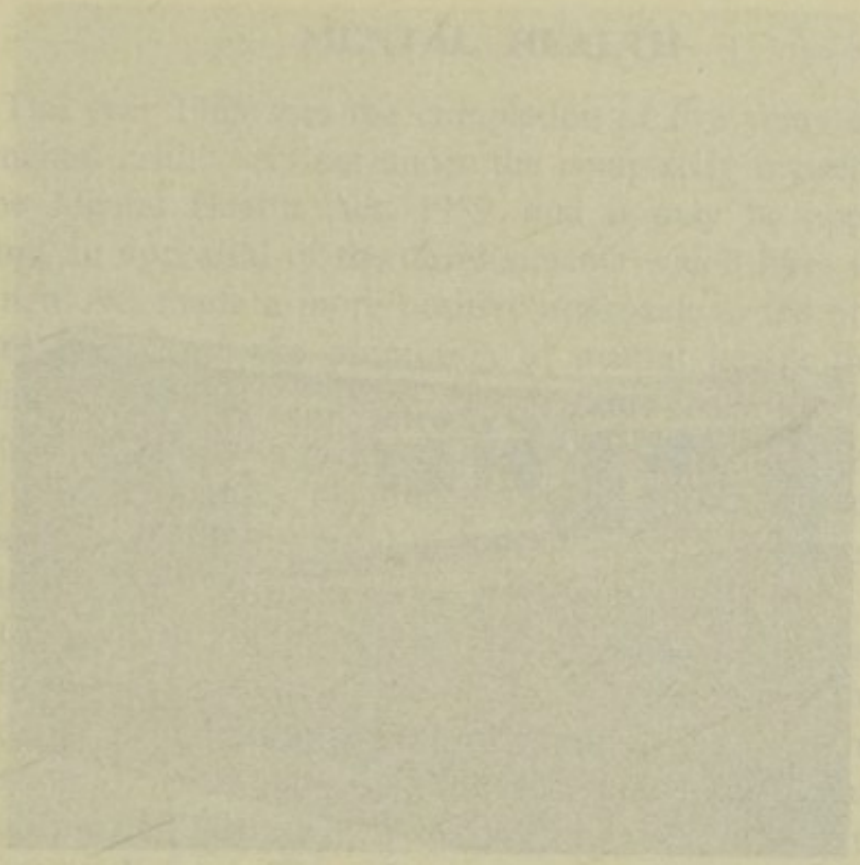
for welfare matters to continue to be intimately connected with health, although ultimately there may be a case when fully trained social workers are available in adequate numbers, for a separate Welfare Department to re-emerge.

The wonderful help that is available in this County continues to impress me. No welfare scheme is now thought of without its planned voluntary component and the Secretary of the Council of Social Service is a constant member of the Department's planning group.

The main work of the Welfare Department is now seen clearly to be concerned with the risk groups—mental disorder, the elderly and the physically handicapped— all of which present a challenge which I feel can be met, and which can result in an ever advancing standard of community care.

CUMBERLAND — MEALS ON WHEELS SERVICE





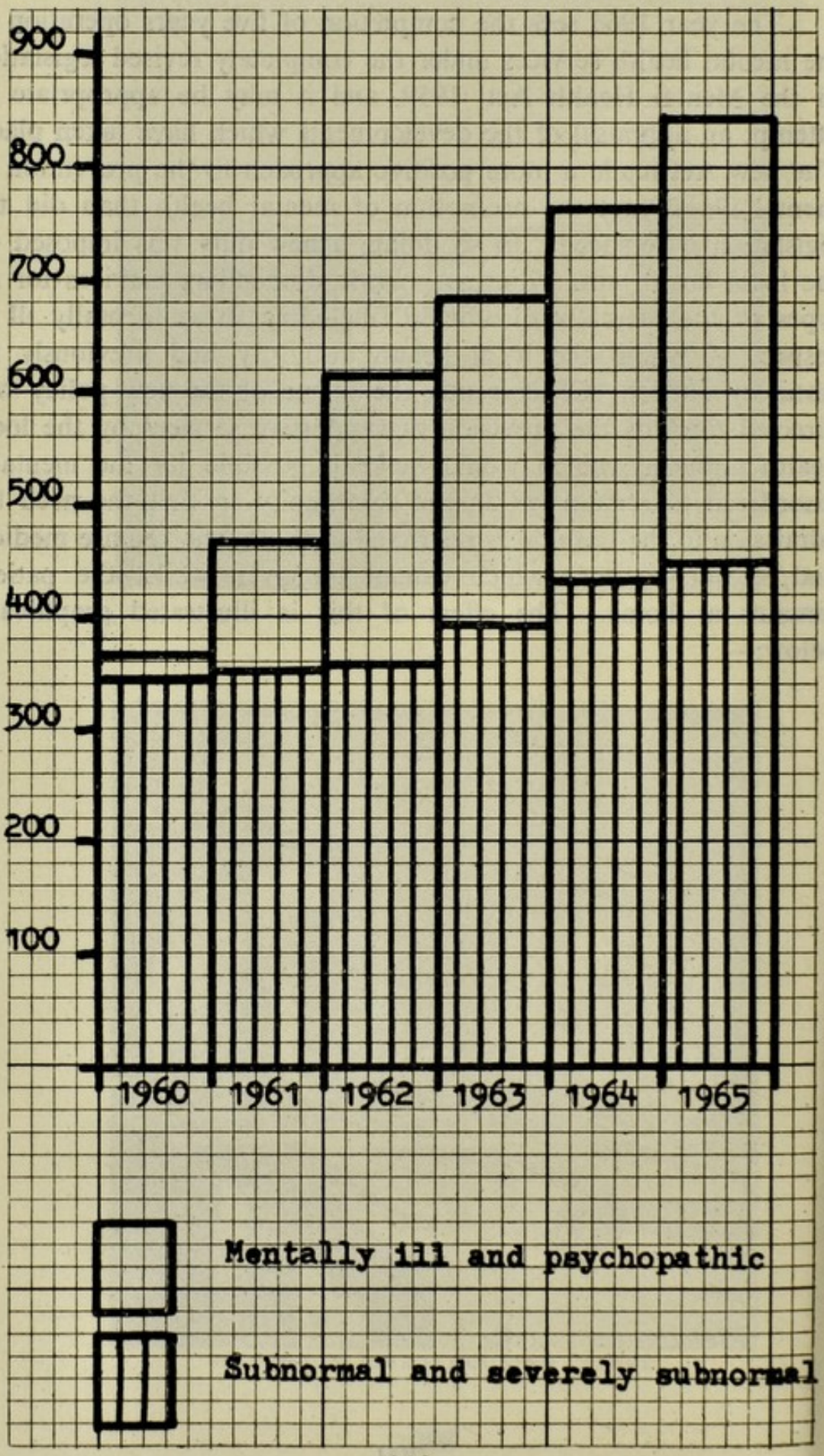
MENTAL HEALTH

DISTINGTON ADULT TRAINING CENTRE

MENTAL HEALTH

The year 1965 sees the completion of five years operation of the mental health services under the completely revised legislation of the Mental Health Act, 1959, and it may be appropriate to attempt an appraisal of the developments which have taken place. The new Act made a more positive approach to the prevention of mental illness and the promotion of mental health than did the legislation it replaced. In so doing, a new duty was imposed on the local health authorities to provide domiciliary services for all types of the mentally disordered (including those mentally ill in respect of whom the local health authority had previously no statutory duties). Concurrently the theme of the new policy was directed towards the provision of supportive services by the local health authority which would make it possible for the mentally disordered to remain within the community so that the need for admission to the hospital is restricted to those who require medical and/or nursing care which cannot be given whilst the patient remains at home. The effect of this is illustrated graphically below:—

SOCIAL WELFARE OFFICERS — DOMICILIARY CASE LOAD



The total number of patients under local health authority care in their own homes has more than doubled since 1960. When these are broken down into the two main groups, it will be seen that whilst there has been a gradual increase in the number of subnormal patients receiving some form of domiciliary support, corresponding figures for the mentally sick have climbed sharply from 17 in 1960 to 396 by the end of 1965. Referrals of new cases of mental illness to the local health authority have remained fairly constant at an annual average of 215 since 1960—the lowest number being 193 in 1961 and the highest 229 in 1964.

Two major policy changes whose introduction was, in part, stimulated by the experience of changing and ever-increasing demands in the field of domiciliary social work, have, I feel, been more than justified. I refer firstly to the scheme of area administration which made closer liaison possible between the various local authority services concerned with medical/social problems at a local level and, secondly, to the Council's decision to amalgamate the mental health and welfare sections of the Department. This latter arrangement came into being for a number of reasons, not the least of which was the generic nature of modern training for social work but the local effect has, undoubtedly, been to confirm that the social problems of the handicapped have very much in common whether the handicap be mental or physical or merely resultant from the aging process; that handicaps are frequently found in combination and that all the indications are that the problem of confused elderly is one which will continue to exert increasing demands on the services.

The inherent difficulties which surround a tripartite National Health Service can, at present, only be tackled by joint planning and consultation towards a comprehensive mental health service in which the local health autrority, the psychiatric hospitals and the family doctor services each play their respective roles in a spirit of active co-operation and co-ordination of effort for the benefit of the patient. The relationships between the psychiatric hospitals and associated outpatient clinics (through the consultant psychiatrists) and the local health authority services for the mentally disordered are excellent and the easy access to the hospital consultants and social workers which is afforded to my staff is

greatly appreciated. Similarly the attachment of local authority social workers to general practitioner groups has proved to be mutually helpful and fruitful on behalf of the patient. I look forward to the formation of both regional and local Mental Health Liaison Committees as envisaged in a Circular issued by the Minister of Health in December to foster even closer links between the hospital, local authority, family doctor and voluntary services to cover all the needs of the mentally disordered.

To summarise these observations the following table quotes figures submitted to the Minister at the end of each of the past five years—some of which are the subject of further comment later.

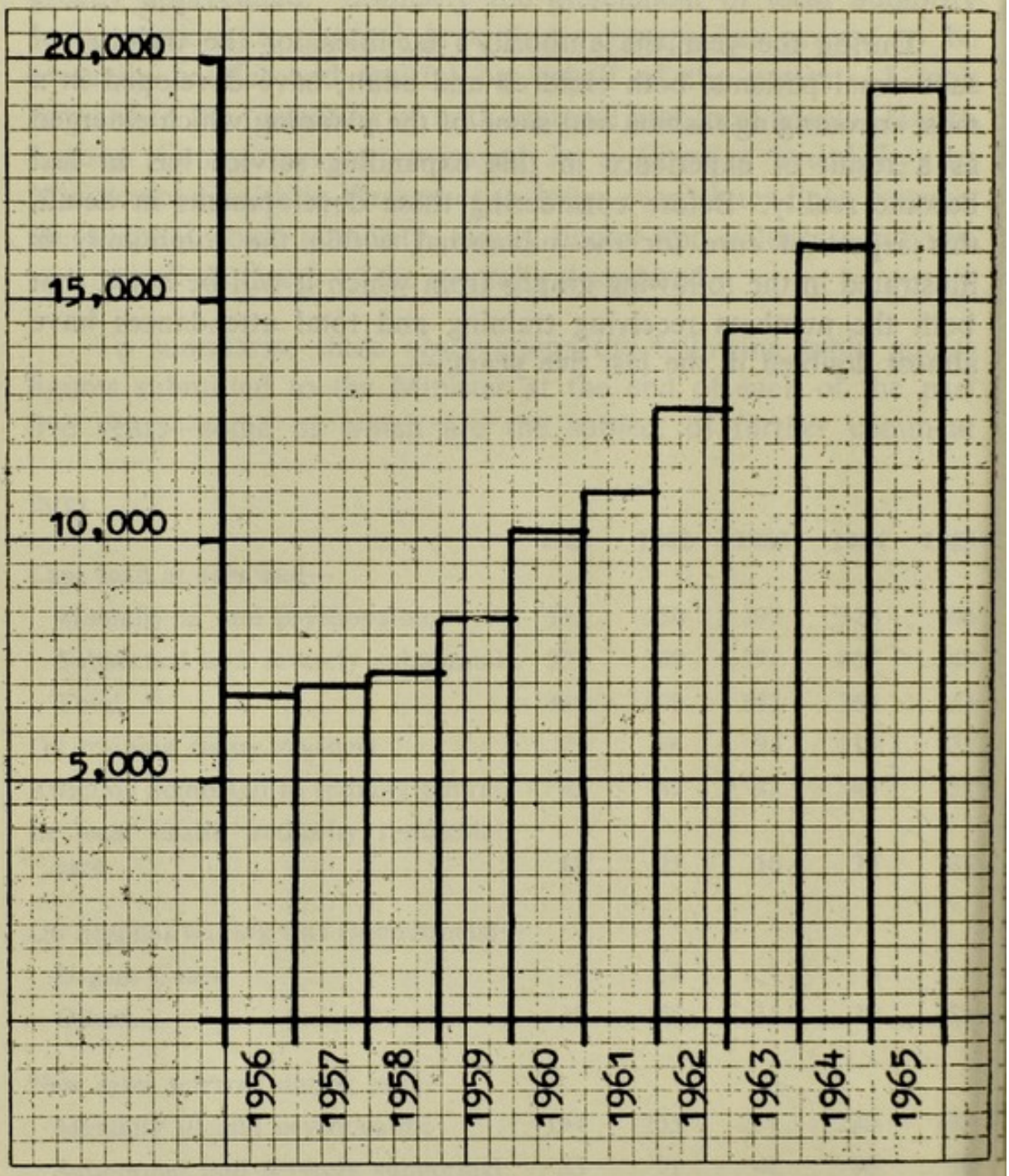
	1961	1962	1963	1964	1965
Case load at year end—					
Mentally ill and psychopathic ...	115	250	292	328	396
Subnormal and severely subnormal	351	359	391	437	449
Total	446	609	683	765	845
On training centre registers	71	86	95	119	135
Awaiting admission to training centres	42	46	42	45	39
In local health authority residential care	18	21	16	33	25
On hospital waiting lists (subnormals)—					
Urgent Cases	—	1	1	4	1
Others	39	46	31	20	13
New cases referred during year—					
Mentally ill and psychopathic ...	194	235	211	230	223
Subnormal and severely subnormal	35	71	42	86	62
Total	229	306	253	316	285
*Staff—					
Senior social welfare officers ...	1	1	1	2	3
Social welfare officers	6	6	6	10	11
Trainees	—	—	1	2	2

* It should be noted that from 1964, mental health and welfare functions were merged within one section and all the field staff undertook combined duties.

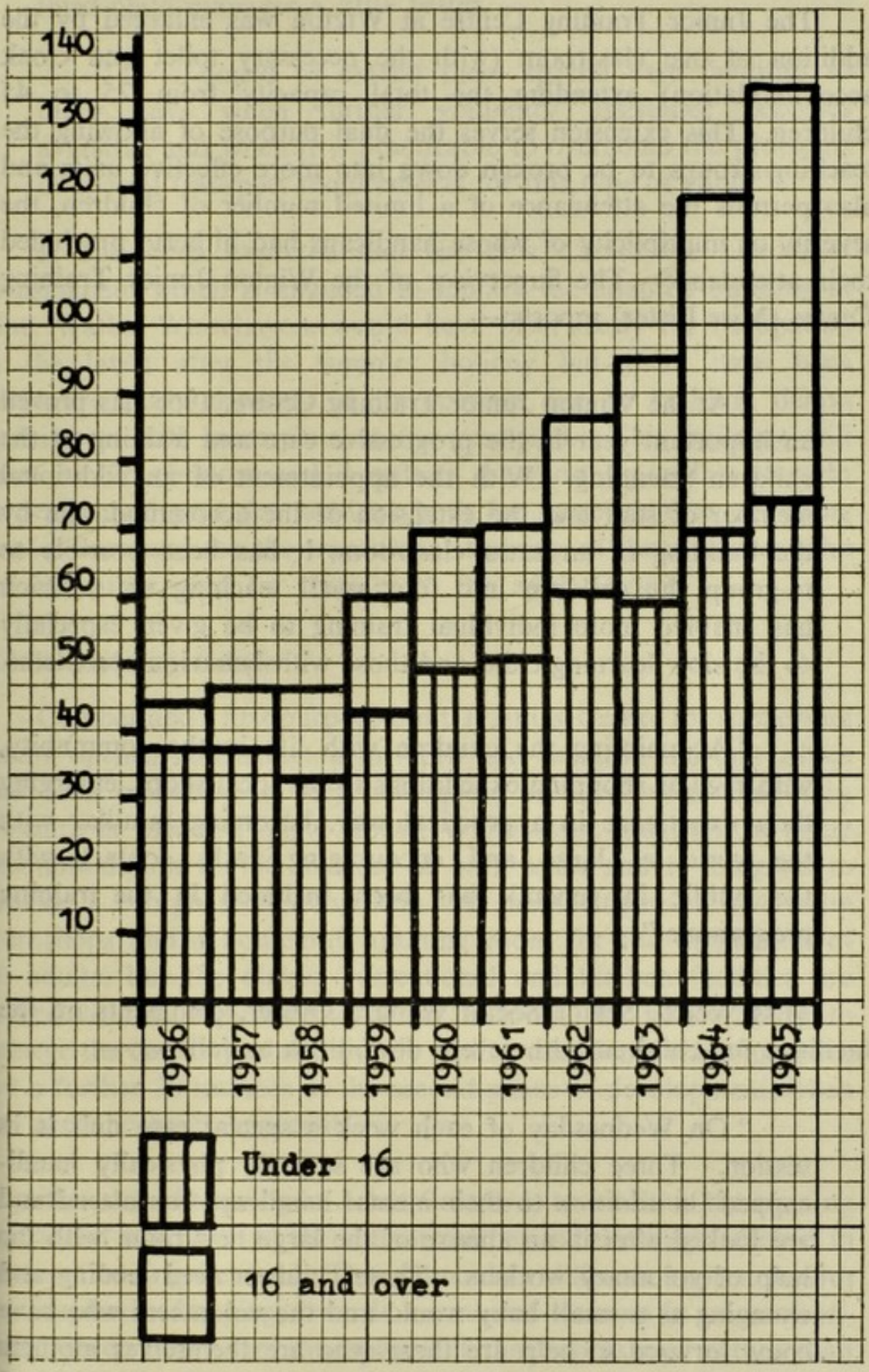
Training Centres

During the year the authority's facilities for the training of subnormal patients, both children and adult, have developed in a most encouraging fashion and some of the planning which emerged as a result of experience in this expanding service has at last become reality. Before considering these developments in detail, this aspect of care for the subnormal within the community is illustrated in the following graphs from which it will be noted that both the numbers receiving training and total attendances have almost doubled in the last five years:—

TRAINING CENTRE ATTENDANCES



TRAINING CENTRES — NUMBERS ON REGISTERS



Junior Training Centres

The Junior Training Centre at Wigton was enlarged by the addition of one classroom (with the necessary toilet and cloak accommodation) extending the total capacity from 25 to 45 children. This extension serves the dual purpose of allowing the teaching groups to be broken down into more effective units and also permits the attendance of a limited number of children, the severity or multiplicity of whose handicaps had hitherto precluded their attendance. The Supervisor of the Wigton Junior Training Centre (Miss Lister) reports:—

> " At the Wigton Junior Training Centre, 1965 has proved an important year in the progressive care and training of the children attending. With the appointment of an additional member of staff and the extension of the accommodation by the building of an extra classroom, it has been possible to re-group the children into four small teaching units which has enabled more individual training to be given especially to the slow learning child and those with behaviour problems.
>
> " Acquainting the children with life in the community, with regular shopping expeditions to the local shops, enlarging their experience in a practical way, becoming familiar with the world at large and encouraging early contact with the public in general, has been included in the training programme."

Miss Welch, Senior Social Welfare Officer, comments on the facilities for children with severe disabilities as follows:—

> " On Wednesday of each week a special care unit is in session. Three children who are severely physically handicapped (in addition to their mental handicap) can attend and are looked after in an annexe of the large new room with the help of voluntary workers. These children need feeding and changing as a small baby would and the volunteers who have come forward to help are those who are themselves mothers of families. One lady in particular takes great trouble and

endless patience to feed the two slow eating children. The third child manages a little better.

"It is hoped to extend these special care facilities to other days when further voluntary assistance becomes available and when it is practicable to overcome the problems of special transport requirements for this type of child."

It had been expected that the new Centre for juniors at Hensingham which is intended to replace the adapted building at Flatt Walks, Whitehaven, would have been ready for occupation at the latest after the summer holiday but there have been successive postponements of its opening due to building delays and it was still incomplete at the year end. This building will cater for 75 children and it reflects the most up-to-date thought in design and provides facilities both for those children requiring special care and for the transitional training of those juniors who are being prepared for transfer to the adult Centre.

Adult Training Centre

Cumberland's first purpose-built Training Centre for subnormal adults opened at Distington in April and replaced the unit which had been operating in very inadequate premises as a temporary measure at Meadow View House, Whitehaven. Basically it offers accommodation for 50 trainees of both sexes and is designed to provide a two-phase development. At present there are two main workshops and a housecraft training room for the instruction of 50 adults, but the dining, recreational and kitchen facilities are geared to the requirements of 80 trainees, the policy being to enlarge the capacity of the unit by adding additional teaching space for a further 30 trainees as the second phase of development, when the need becomes apparent.

The aim of training in Adult Centres is to continue the training and social education of the subnormal beyond the stage reached in Junior Training Centres. This demands a different approach with the emphasis changing towards vocational training in an environment which offers the atmosphere of the "workshop" rather than the "school". This transition can most successfully be achieved

in a functional building designed for the purpose where the programme of training can be presented in an adult manner. To help this training of the adolescent and adult towards social maturation and independence, the holiday periods at Distington have been reduced from the school holidays which operate at the Centres for juniors, to something more nearly approaching those in industry and the working day has been extended to one of seven hours. The midday meal is supplied under a cafeteria system, each trainee being given the daily exercise of paying for his or her meal in cash and there is a weekly payment of "wages" which can be graduated for application, diligence and general conduct. Although it will probably continue to be necessary to provide some special transport to this Centre, because of its wide catchment area and the paucity of public transport in the rural areas, wherever services permit, the trainees are being taught to make their own way to and from the Centre by the ordinary service buses.

This training centre has filled the obvious remaining gap in the community care of the subnormal, at least in West Cumberland where the need was most apparent and pressing. Invaluable experience has been gained at Distington since its opening which, together with the earlier lessons learned at the temporary centre at Meadow View House, will enable future planning to be formulated with greater assurance.

It may be of interest to record parental reactions to this first venture in the training of subnormal adults. I thought it desirable to meet the parents to explain to them the aims of the new centre and to enlist their co-operation. To my surprise there were strong vocal objections to the proposal to a gradual transfer to the use of public transport systems, to extending the length of the working day, to reducing the holiday periods to less than school holidays and to a number of minor proposals directed towards the achievement of a greater degree of independence in the trainees. By persuasion and patient effort through demonstration these parental attitudes of over protection are being changed and there is being built up a family and community support of the centre's efforts in training towards social maturity and acceptance.

Future Developments

For some years now Cumberland has had no waiting list for admission to the Junior Training Centres, the number of places exceeding total requirements. The Ministry advises that authorities should aim at providing at least 0.46 places in Junior Training Centres for the subnormal per 1,000 of the population and when the new Hensingham Centre opens shortly, Cumberland will then have 0.51 places per 1,000 population. With the development of units within the Training Centres for those who have until fairly recently been regarded as unsuitable for training because of gross disabilities, the number of potential candidates for admission will increase but I am satisfied that the two modern purpose-built Centres, supplemented by the boarding provision which is essential in so rural an area, will entirely satisfy the demand for some years to come.

The position regarding the training of adult subnormals is more complex and less easily defined. When the present pattern of mental health services emerged in 1959, local health authorities were instructed to give first priority to the development of Training Centres for children who had been excluded from school attendance because of their disability, with the result that the provision of Training Centres for adults (about which there was considerably less experience) took second place. Locally, it was felt that the separate development of adult training could not be undertaken until the needs of juveniles had been reasonably well met, although a stage was reached when there was some continuation of training byond the junior stage by making use of spare places in the Junior Centres. As a purely temporary measure and to tide over the period of final planning and building, a Centre for adults only was opened in February, 1963, which was closed in April, 1965, when the Distington Centre became operative. Even when the Distington Centre is enlarged to accommodate 80 trainees, this will only provide places for adults at the rate of 0.34 per 1,000 population as against the Ministry's recommendation of 0.65 per 1,000 of the population. To overcome this deficit and to achieve the standard suggested by the Ministry, the Council proposes to build further Training Centres, each for 50 adults, in East Cumberland in 1968/69 at a location not yet

decided and at Maryport in 1970/71. It has been found in this field (as in other health and welfare services) that the provision of facilities uncovers the need but, even with this consideration in mind, the total of those receiving training and those awaiting training facilities (90) represents a need as at present ascertained of only 0.41 places per 1,000 population.

It becomes increasingly difficult to forecast the number of adult subnormals who are likely to require training in the years ahead. The ascertainment of subnormality up to school leaving age presents no real problem. "At risk" children are noted in early life and the routine assessment of special educational needs during the school years reveals those whose mental retardation indicates the need for training in Junior Centres. Nevertheless there has been, and presumably will continue to be, a variable number whose social inadequacy does not become apparent until some time after they have left school. These failures of adjustment to a work situation become candidates, previously unknown to the department, for training in an Adult Centre.

In the present state of knowledge, therefore, I feel that in a sparsely populated rural County such as Cumberland the primary aim should be to provide a Centre in each of the three areas into which the County is divided for day to day administration and which all have populations of about 75,000. The location of an Adult Centre to serve the northern area poses a problem because, besides being three times larger in area than either of the others, there exists no single conurbation which provides a big enough population to justify its selection as a focal point for this development. Public transport in this scattered area naturally tends to concentrate towards the city of Carlisle and the ultimate solution may be to build in or near the city as offering the most convenient location and/or to seek an arrangement for at least some proportion of the candidates to attend that authority's Centre.

The Senior Social Welfare Officer for the Northern Area (Miss Welch) makes the following observations about the difficulties surrounding training provision for adult subnormals in that part of the County:—

"There are about ten adult subnormals living in the northern area who could and would take advantage of the facilities provided by an Adult Training Centre. In view of the scattered area in which they live it has not been found possible to use any existing building for this purpose and this has become more of a problem as the year progressed. Several retarded school leavers would benefit from a period of training in an Adult Centre and some of those in the Junior Centre are reaching the age when they should be transferred. Two adult subnormals from the northern area are able to travel to the Distington Training Centre and seem to be thoroughly enjoying their training. It is hoped to increase the numbers attending the Distington Centre from the northern area and we have particularly in mind one or two girls who could benefit from training in domestic subjects which would ultimately enable them to secure domestic work in hostels or private houses."

The work potential of various types of handicapped persons—the mentally subnormal, the blind, those with physical disabilities—has undoubtedly been under-estimated in past years and various agencies, including the training and rehabilitative services of the Ministry of Labour, local Health and Welfare Authorities and Regional Hospital Boards, are all attempting to develop facilities to meet the need which exists in their own particular sphere of interest. Coupled with this has been the greater realisation of the value of work as a therapy which is being amply demonstrated in the psychiatric hospitals where the tendency is now away from simple diversionary occupation and towards rehabilitation through active industrialised work therapy. With so much activity and experiment proceeding along similar lines, I feel that the time is rapidly approaching when experiences should be shared and over-lapping eliminated by considering amalgamation of functions to produce more efficient and viable units for the training, rehabilitation or sheltered employment of the handicapped in general.

I cannot close this part of my report without reference to the abnormal strain which is placed on the resources for training and for sheltered employment of the mentally disordered by reason of

the paucity of "job-opportunity" in the county area as a whole and in the more rural parts in particular. The logical and desirable progression through training to open or sheltered employment is very much more difficult to achieve because of the limited range of employment which is available and because of the relatively high rate of unemployment in the area. The placing of the mentally disordered in open employment (particularly high grade sub-normals and more especially females) would obviously be very much easier if the opportunities for light industrial employment were greater both in number and variety and if the mentally disordered faced less severe competition for employment from their fully able fellows.

A recent Commons debate occupied the House for nearly five hours on the motion—"that responsibility for the education and training of all mentally handicapped children should be transferred from the Ministry of Health to the Department of Education and Science; that improved educational opportunities are the key to the proper development of these children; that their subsequent training and employment under sheltered conditions, or where possible in open industry, should be the responsibility of the Ministry of Labour . . . ." The time devoted and the support which was given to the motion clearly indicated that there is a general and increasing awareness of the potential of children who are at present classed as unsuitable for education at school to learn by educational techniques and of their potenial for useful work later in life. So far as children are concerned, both the British Medical Association and the teaching profession have expressed the belief that this is a teaching problem and not simply a matter of care and welfare and those contributing to the debate gave much support for transferring responsibilities for the education and training of subnormal children to education authorities to improve their educational opportunities. At the same time, it was agreed that local education authorities have no experience relative to those children in the very low ranges of ability. The House was reminded that for mentally handicapped adults, as for other adults, the Ministry of Labour has responsibilities for vocational training, industrial rehabilitation and employment (including sheltered employment) for those who are capable of remunerative work.

Hostel Accommodation

(a) **For Subnormals.**

The hostel at Orton Park which provides accommodation for 22 children was never fully occupied during 1965. The maximum number of children in residence at any time was 15 and the average daily occupancy was 13.3. Only on rare occasions has it been fully occupied since 1959 when the hostel was opened to enable children from the more isolated parts of the County to participate in training at a Junior Centre. If whole-time training is to be available to all the children who are unsuitable to attend school because of a mental disability, this can only be achieved by affording hostel facilities to those who live in the more remote areas which are too far away for daily travel to a Centre but the measure of this need can now be more accurately assessed in the light of experience. The trend adopted by Children's Committees is away from hostels and towards small "family unit" homes. This policy has been accepted as a long-term measure by the Committee and the Council has included three family unit type homes (each to accommodate six children) in its 1971/76 programme to replace the present hostel.

I am satisfied that the present system of operating the hostel on a part-time basis (closing each weekend and during the Training Centre holidays) has been justified and that the children suffer no detriment when compared with the original scheme by which the hostel remained open on a full-time basis. Commenting on this Mrs. Kelly, the resident house-mother in charge of the hostel, makes the following observations:—

> " This scheme has proved in most ways to be beneficial to the children and to have solved the recruitment and retention of staff. The children now have a greater sense of security in the knowledge that they return to their parents and home environment every weekend and for the whole of the Training Centre holidays. This makes our task easier in that there was often distress and bewilderment among some of the children who remained at the hostel for two or three weeks at a time under the old system.

" We have strived to make the hostel exactly like a normal home. The children are given complete freedom in play and in using the house and every room. We believe that the children are subject to discipline during their day at the training centre and in the evenings it is felt that they should have much greater freedom and feel free to do as they wish and go where they want."

(b) **For the Mentally Ill.**

Once more delays in building have postponed the opening of Cumberland's first hostel for the support of the mentally ill within the community. The first residents will now be admitted early in 1966. Not many local health authorities have yet ventured into this field and those which are providing hostels for the mentally ill are experimenting along widely different lines. Having been assured by my colleagues in psychiatric medicine that the need for this type of "halfway house" provision exists, I look forward to its successful operation. Its opening presents a new challenge to demonstrate teamwork between the tripartite National Health Service—to the hospital and consultant service, to the general practitioners and the local health authorities medical and social work services. The present hostel has been sited in the most densely populated part of the County where job opportunity and transport are at their best. Accommodating a total number of 17 residents of both sexes in single bedrooms the hostel has been designed so that it can readily be extended to accommodate 30 residents without further extension of dining room, kitchen and lounge facilities. For the time being it will serve the whole of the County area but provision has been made in the ten year plan for a second unit of similar size to be located in East Cumberland during 1970/71.

Hospital Accommodation

By comparison with most other local health authorities, Cumberland is fortunate to be spared the anxiety which accompanies the need for the admission of mentally disordered patients to hospital care.

So far as the mentally ill are concerned, there is rarely any delay in securing the admission of a patient who is in need of treatment or care which can only be given under hospital conditions. The consultant psychiatrists are readily available at the hospitals or their associated peripheral outpatients clinics, to the general practitioners and to my own social workers.

This is greatly appreciated and the smooth interplay of the hospital, general practitioner and local authority services for the benefit of the patient does much to prevent the development of critical situations and ensures speedy action if in-patient treatment should become necessary. There is growing apprehension as to the cost of the concept of community care in terms of social reactions to the presence within a household of a member suffering from a mental illness. These considerations must always be borne in mind by the social worker, but their anxieties in this direction are lessened and the attitudes of the family are more easily manipulated in the knowledge that hospital care will be available for the patient if care at home fails for any reason. During 1965, the number of beds available at the acute psychiatric department at the West Cumberland Hospital was increased from 16 to 30 and the extended department is now large enough to accommodate a reasonable number of day patients in addition to the in-patients.

At the end of the year, there was only one subnormal patient whose need for admission to hospital was regarded as within the urgent category whilst another 14 were included on a list of those who, as a result of domestic circumstances, age or physical condition, or a combination of these factors, will, at some later stage, require hospital care. Cumberland's position is very much better than that of most other authorities in that only in one year since 1961 has the urgent waiting list of subnormals contained more than a single name. During the same period of five years, the number of subnormals who were considered as probable candidates for admission because of anticipated physical or social changes has decreased from 47 to 14.

This, I feel, is due in no small part to the implementation of those policies extending the domiciliary care services for the

mentally disordered to enable them to remain within the community and to restrict hospital admissions to those who need specific medical treatment or nursing care which cannot be made available to them in the home situation.

Dovenby Hall Hospital is to be enlarged in the near future. Building is expected to begin about the middle of 1966 and will take about a year and, although new accommodation for 60 patients will be provided, one of the existing wards of 40 beds is to be converted to use (temporarily) as a school. The net increase will, therefore, be of 20 beds making the total nominal accommodation 405 beds. It is not expected that it will be possible to admit new patients as a result of this development because the new accommodation will mainly be used to alleviate the degree of over-crowding which has existed for some years at Dovenby.

Recruitment and Training

(a) **Social Workers.**

There can no longer be any doubt that the policy of community care for the mentally disordered depends more on staffing than in material provisions, and that the effectiveness of this policy, to the extent that the local authority is involved, is directly proportionate to the numerical adequacy and quality of its field workers. In 1960, only four full-time social workers were employed for mental health duties in Cumberland. During 1964 the mental health functions were merged with those of general welfare as a result of which those officers formerly engaged on general welfare duties joined with the former mental health staffs to form a single team, each member of which now undertakes both functions. By the end of 1965 the social workers, for combined mental health and welfare duties, numbered 14 with a further two in training.

Mr. Cowham was the second officer in the Department to be awarded the Certificate of the Council for Training in Social Work following a two years' generic course of training and returned to duty in the western area of the County in July. His former post as

a trainee welfare officer was offered to Miss O'Hare, who has been accepted for a similar course of study commencing in September, 1966, by which time she will have completed a year's local "in-service" training. It is confidently expected that Mr. Ruddick, now in his second year of training, will be successful in his examinations and return to join the southern area staff in 1966.

This policy of progression through local "in-service" training to the full-time two-years course which leads to the Certificate of the Council for Training in Social Work is at present the only way of ensuring that adequately trained staff are available in the numbers required for an effective field work service. The number of students qualifying for the certificate in social work on the successful completion of an approved generic course of training, whilst improving the quality of service available, by no means make a sufficient numerical contribution to the strength which is likely to be necessary in the light of commitments and policies imposed upon local health authorities by the Mental Health Act. The shorter (one-year) courses which are considered adequate to complete the training to certificate standard of older but unqualified officers with some experience, are not materialising as was hoped and those officers who have been the mainstay of the service in an unqualified capacity for many years are feeling some sense of dissatisfaction and frustration that so little appears to be being done to enable them to attain the same status and standards as their relatively newly recruited colleagues.

It has been interesting to note the reactions of newly trained officers on their return to duty. During training, students are given responsibilities for a very small caseload in the handling of which they are carefully supervised so that their theoretical training can be related to practical casework. On returning to field work in the department, they are quickly faced with a much greater personal responsibility for a mounting caseload and their senior welfare officer, whilst available for overall supervision and guidance, cannot provide the degree of close supervision and support which had been given during the training period. This difficulty, I suppose, is fairly common to many on their first acceptance of professional responsibilities. Coupled with this, however, and of greater personal difficulty, is the process of

orientation between their theoretical training in social casework practice and the limitations which are imposed by legislation and the administrative structure of the service. This "marrying" of training to possible and practical applications in their work can be very worrying to enthusiastic, conscientious officers whose principal concern must always be for the welfare of the client.

A week's refresher course for the social welfare officers, which was also attended by representatives of other authorities in the north of England and the south of Scotland, was held at Keswick in October. We were delighted to welcome Miss Sheridan, Chief Welfare Officer of the Ministry of Health, and other distinguished speakers in the field of sociology, psychiatry, rehabilitation and social casework. The course aimed to show the social welfare officers the setting of their work today and to help them towards an orientation of their work in terms of modern sociology but focusing some of their attention on mental health and physical handicap as large problems in this field.

(b) **Training Centres.**

Four additional assistants were engaged during 1965 to meet the increasing provision, two being employed at the centre for adults and one at each of the junior training centres so that children requiring special care could be admitted. Not a single application for any of these posts was received from a candidate having experience in teaching the mentally subnormal and the posts were offered to the applicants who seemed to offer the best potential for this work. The are, however, both unqualified and inexperienced so that, for the time being, they can only be taught their job by local "in-service" methods. To this extent, therefore, the quality of the training offered at the centres is diluted and for this very reason I urge the introduction of the trainee scheme for the recruitment of suitable young people who could enter the service with sound career prospects by offering secondment to approved full-time training. This is the only way open at present of ensuring a flow of adequately trained personnel into the centres. I am pleased to report that one trainee (Miss Armstrong) began the two-year course leading to the Diploma of the Training Council for Teachers of the Mentally Handicapped in September and I expect

that the other (Miss Carruthers) who was below the minimum age for entry during 1965, will start a similar course in September, 1966.

It is encouraging to note that the pioneer work of the National Association for Mental Health in arranging training courses for this type of staff is now being considerably supplemented from other sources following the formation of the Training Council for Teachers of the Mentally Handicapped which was set up by the Ministry of Health in February, 1964. There are now eleven courses available for teachers of children, five of which are two-year courses designed for the younger, less experienced students and six of one year's duration for more mature students with some experience. These are all full-time courses and there are, as yet, no courses available to this area which provide part-time study facilities for those members of the staff who have domestic commitments which prevent their prolonged absence from home.

Less encouraging is the fact that only three courses provide the full year's training for instructors of subnormal adults. Training centres for adults are being developed at a much quicker rate than are the junior centres where the provision already measures up more adequately with the ascertained need.

Local policy has always been to try to keep the training centre staffs abreast of modern developments in teaching methods and techniques and, to this end, the three supervisors (all themselves qualified) attended a week's refresher course organised by the National Association for Mental Health at Sheffield in July and three unqualified assistants took part in a regional study day which was held at the Prudhoe and Monkton Hospital in June. The training centre staffs meet, in conference, three times each year to discuss progress and developments.

Social Activities

Social Clubs

The evening social clubs for psychiatric patients which are held weekly at Whitehaven and Workington continue to flourish,

both membership and average attendance showing steady increases. The development of this form of indirect therapy has been encouraging. The first club opened at Whitehaven in 1960 and the second club was started at Workington in 1963 to ease the pressure of increasing membership and, simultaneously, to reduce the catchment area. Another similar fragmentation for the same reasons seems likely in the near future and a third club will probably be opened at Maryport shortly. Whilst the policy has been to encourage the members to run these clubs, I am grateful for the continuing and generous support which is given unobtrusively by the social workers.

Parents' Association

The parents of those attending the junior and adult training centres at Whitehaven and Distington respectively meet at monthly intervals in one of the centres. An interesting development arising from their discussions has been that a Sub-Committee appointed by the Parents' Association has organised social evenings for the trainees at monthly intervals from October. These have been very well attended and have provided a range of activities and interests, not only to the trainees who attend the centres, but also to their young relatives and those subnormal patients who are in employment. Members of other youth groups in the area have been invited and have participated enthusiastically. I look forward with interest to the further development of this venture as providing a medium for the easier acceptance of the adolescent and younger adult subnormal into a fuller life in the community.

Holidays

During the summer months parties of young subnormals of both sexes varying in number from 16 to 25 took part in weekend camps either by the sea or in the Lake District on four occasions and a youth hostelling weekend attracted a somewhat larger group (30 in all). The training centre staffs and the social workers joined forces to organise and supervise these expeditions which provide enjoyable leisure activity under holiday conditions in combination with social education.

AMBULANCE AND SITTING CASE CAR SERVICE

Section 27 of the National Health Service Act, 1946

"It shall be the duty of every local health authority to make provision for securing that ambulances and other means of transport are available, where necessary, for the conveyance of persons suffering from illness ..... or expectant or nursing mothers from places in their area to places in or outside their area."

EMERGENCY HELICOPTER TRANSPORT

AMBULANCE SERVICE

The highlight of the County Ambulance Service in 1965 was the introduction of the direct service at Wigton and in West Cumberland, thus implementing major parts of the plans which were first approved in 1961.

The direct service in Wigton commenced on 1st April, 1965, and replaced the contractual arrangements with C. Over and Son at Aspatria. The station was the first purpose built station in the county and provides accommodation for two ambulances and two dual purpose vehicles. There is ample room for future expansion and two staff houses are also provided. A staff of seven including the officer in charge was appointed, three of whom previously worked at the Bush Brow Station, Carlisle. There was therefore a nucleus of trained and experienced staff when the station opened and this undoubtedly accounts for the smooth manner in which it commenced functioning.

In West Cumberland the direct service commenced on 1st June, 1965, replacing the contractual arrangements with Mr. J. Adams for Whitehaven and Mr. W. Morgan for Workington. The station located at Distington controls all operations in West Cumberland with sub-stations on a modified contractual basis at Maryport and Cockermouth. It was originally intended to establish a sub-station to the south of Egremont but suitable arrangements could not be made and this area is now satisfactorily covered from the Distington Station.

At Distington, staff numbers 28 including the officer in charge. There are five ambulances and five dual purpose vehicles; while at each of the sub-stations there is one ambulance and one dual purpose vehicle. Already there is evidence that further accommodation will be needed at Distington in the not too distant future and an adjacent plot of land has been acquired for this purpose. Four staff houses are provided on the site.

At the outset there were some initial difficulties, perhaps not unexpectedly in a new service, especially as its introduction came in a period of hospital reorganisation. These were, however,

suprisingly few. The fact that the Superintendent at Distington, Mr. Taylor, was appointed six weeks before the opening of the station and was therefore able to prepare the ground and to give some training to the new recruits to the service undoubtedly contributed to the smooth transition.

Some difficulties in connection with requests for ambulance transport are still being experienced, but close liaison is being maintained with the hospital authorities in an effort to reduce these to a minimum.

The only remaining area with an unmodified agency service for the foreseeable future is Alston, plans having been agreed for the establishment of a direct service in Keswick.

Concurrent with the opening of the new service in West Cumberland and Wigton was the introduction of Radio Control in these areas and the separation of the ambulance service from the police network. This entailed the establishment of main transmitters at Penrith, Carlisle, Moota Fell, Egremont and Millom as well as the equipping of 17 vehicles not already on radio and the provision of sets at all stations and in the ambulance headquarters in Portland Square, Carlisle. Unfortunately, various factors such as delay in obtaining planning permission, which in turn delayed the placing of the order for the equipment, the inability of the G.P.O. to provide the required land lines on time and difficulty in obtaining permission from the quarry owners at Moota Fell regarding establishing a transmitter there, contributed to a general delay in the installation of the scheme so that only part of West Cumberland had radio cover when the Distington Station opened on 1st June, 1965. The rest of the scheme was completed in stages: Millom by 30th June, Carlisle by 6th August, Moota Fell by 27th August, and finally Penrith by 24th September.

Operational experience so far has shown that reception in the area between Thursby and Wigton, and in the Longtown area, is not up to expectations. This has been taken up with the company who advised that the Carlisle aerials, at present in Portland Square, are not high enough. This site was in fact third choice and was used only because the other two were not available. It seems that

the only way the reception in the areas around Carlisle can be improved is by the erection of a higher mast or the finding of a higher site. Negotiations have been opened with the East Cumberland Hospital Management Committee for permission to erect an aerial on the roof of the Cumberland Infirmary, Carlisle.

During the year three traditional ambulances, two dual purpose vehicles and a high speed ambulance were purchased. This latter is the second of these specialist vehicles to be bought and is in service in East Cumberland, the other being stationed at Distington. These are well thought of by consultant surgeons who request them for their patients and from time to time they are being used to convey City patients to centres of specialist treatment at the request of the consultants and with the concurrence of the City Medical Officer on a repayment basis.

These vehicles, good as they are, do not provide the complete answer as the roof is too low to allow transfusion apparatus to be used and accommodation generally is limited. I hope that it will be possible in the not too distant future to buy a Mercedes Benz vehicle, the only vehicle of its kind purpose built for speed and reasonable convenience.

During the year it was necessary to arrange the "aero-medico" evacuation by helicopter of two seriously ill patients from the West Cumberland Hospital, Whitehaven, to the Royal Victoria Infirmary, Newcastle. Both flights went very smoothly and earned high praise from the medical staff who accompanied each patient. I am glad to say that one of them has made a good recovery. The cost of the two journeys was £268 and were the first to be arranged since the Ministry of Health Circular 14/64 placed the cost of these on Local Health Authorities.

As I forecast in my annual report of last year the total mileage covered by all vehicles in the service has again increased; this year by nine per cent.

The statistics of the work done during the year show that the mileage has increased without a correspondingly proportionate increase in the number of patients carried. Three factors account

for this. Firsty, the location of the new District General Hospital and the consequent reorganisation of the hospital services in West Cumberland has resulted in additional mileage for vehicles from the north of the catchment area, particularly those from the Maryport district. Secondly, there has been an increase in the number of journeys to the specialist treatment centres in the Newcastle area; and the third factor is that with the introduction of the direct service it has been possible to vet more strictly the provision of ambulance transport and to limit it to those patients who could not travel by public transport. This is, of course, a continuing process.

It will be noted that the work done by the Hospital Car Service shows a tremendous increase. These drivers who give their time and services are providing a most valuable service and I am most grateful to them and to the British Red Cross Society who handle the administration. There is no doubt that their work will continue to increase and further drivers are required, particularly in West Cumberland.

Mr. Brownrigg, a Hospital Car operator from St. Bees, comments that a close liaison between the Ambulance Station and himself is always maintained and he goes on to say that any problems which may arise are always fully discussed with the officer in charge. This attitude which is very gratifying and to be commended is I feel sure, typical of the majority of the members of the service and can only lead to increased efficiency generally.

Mrs. Blurton, who operates from Brampton, comments that she finds Hospital Car Service work most enjoyable and above all rewarding; she speaks highly of the close liaison with the officer in charge at Bush Brow Control Station and also the Hospital Transport Officer at the Cumberland Infirmary.

Pending the receipt of the report of the Working Party on Training and Equipment set up by the Ministry of Health, a course in Advanced First Aid was arranged at West Cumberland Hospital, where the lectures were given by Hospital Consultants. The course was repeated so that all drivers could attend. This was followed by in-hospital training for all the staff, which again took place at

the West Cumberland Hospital. I am indebted to the consultants for all their help and to the Hospital Management Committee for so kindly putting all their training facilities at our disposal.

Now that the Working Party report has been received, it is pleasing to note that these courses, which have had such an obvious value, are closely in line with the recommendations. The main recommendations are that all members of the Service should have a common basic training, including Civil Defence, which should be a residential course of eight weeks run on national lines at either a central or regional school. During the first probationary year, new entrants should spend at least a week in the casualty department of an approved hospital and at the end of the year after passing written and practical tests, should be awarded a proficiency certificate. There should be Advanced courses for those seeking promotion and special courses for instructors and control room operators, with refresher courses of one week every three years for everybody.

A Central Ambulance Services Council with Standing Committees on Training, Equipment and perhaps Organisation is also recommended.

Throughout the year drivers have continued to take the Institute of Advanced Motorists' Driving Test and so far 90 per cent have been successful; a few drivers have still to take the test. Of those who failed, I do not think this was due to any lack of technical skill but rather that they were over-awed by the occasion. I am confident that when they re-take the test as they are being encouraged to, they will pass and this is also the view of the examiner.

During the year a Working Party was set up by the Employers' Secretary of the North Western Whitley Council for Local Authorities' Services (Manual Workers) to recommend standard ranks for officers in the ambulance service generally up to and including the rank of superintendent. I am pleased to say that the Deputy County Medical Officer and the County Ambulance Officer were invited to attend. Because Cumberland's changeover to a direct service is now almost complete and also because of the

County's peculiar geographical position, I am certain they have had a very worthwhile contribution to make.

I am certain that the Committee now have a virile service staffed by enthusiastic personnel—one of which they can be justly proud.

I am indebted to Mr. P. A. M. Weston, F.R.C.S., Consultant Surgeon, Cumberland Infirmary, for the following report:—

"I am not only pleased to comment on the different aspects of the County Ambulance Service which concerns me, but to express my appreciation for the great keenness and efficiency shown by the ambulance drivers in the service. The patient's introduction to the hospital is often through the ambulance service and the drivers do their best to make this experience a pleasant one. During the last year, the week which each of them has spent working with us in the hospital, has provided us with the opportunity for the discussion of those aspects of the service which concern us both.

"I think it is generally agreed that ambulance vehicles should only be used for urgent and non-ambulant patients and that the majority of sitting cases should be carried in cars. The provision of special 'crash vehicles' is not quite so clear. In a large industrial complex where major injuries are a frequent occurrence a 'crash vehicle' and specially trained crew who are used for this work only, could be justified. In this region, however, I think we have to compromise by adding to the normal complement of ambulance vehicles a limited number of high speed ambulances. These vehicles would be used for any emergency call and would not be specially equipped or specially staffed; one of these vehicles would, however, be always available for one of the following purposes:—

(a) Transfer of specialised injuries or diseases to units in the larger hospitals of Newcastle, Sheffield or Glasgow.

(b) To carry specialised equipment and staff in the form of a resuscitation unit from the hospital to the site of a major accident or severe injury arising on the mountains or on the roads.

" The Super-Snipe ambulance which has been available during the last year has been used on a number of occasions with great benefit to the patient; and an area of this size would I am sure warrant the purchase of a second vehicle of a type such as a Mercedes Benz which has more headroom than is available in the Humber Snipe.

" The equipment to be carried in the ambulance vehicles should I believe be limited as at present to the provision of oxygen, splints, dressings and suction apparatus worked off the manifold of the engine. I think it is very creditable that on the crews' initiative this suction apparatus has been installed and I am sure it will save lives.

" The provision of a radio-telephone set in the accident department has made our links with the County Ambulance Service even closer, and has made it feasible to provide the organisation for call-out of a resuscitation unit based on the Cumberland Infirmary. This consists of equipment for maintaining respiration and for blood transfusion, carried by one medical officer and one nurse. This unit has fortunately not yet been required. I do not think that such complicated equipment should be carried in all the ambulances because it can only be used by medically trained personnel who are familiar with these particular techniques. The radio contact and high-speed ambulances should allow the unit to be carried rapidly to an accident. I should perhaps add at this point that I do not believe that very high speeds sometimes used by ambulance drivers to bring injured patients to hospital are in the best interests of the victim. Only rarely do seconds count in the saving of a life and in this case it would be better to meet the resuscitation unit on the road side so that the trained medical team could start resuscitation in the ambulance.

"I well appreciate the difficulties facing an ambulance driver who has the very responsible job of the initial care of seriously ill or injured patients; perhaps the most difficult decision is whether any active measures are required or not. Considerable experience, training and judgement are required and I am sure that in the future we should aim at providing the ambulance drivers with more extended training particularly in the management of respiratory or circulatory difficulty or arrest. For this reason also, therefore, I have welcomed the opportunity of showing the ambulance crews some of the methods which we are able to use in the hospital so that they can have a better idea how to improvise when they are on their own in an ambulance.

"The closest co-operation is desirable between the hopsital and the ambulance crews and this has certainly been rendered considerably easier following the introduction of the unified county ambulance service instead of the old contractual system. One can only hope that the process of unification will be carried forward so that we may have one ambulance authority to deal with in this area instead of three or four. It is clear to those of us who work in the hospital that deployment of ambulances and drivers and uniformity of equipment would thus be considerably facilitated.

"Finally, it is also clear that the ambulance centre for the area should be placed either in or as near as possible to the main hospital. It is regrettable that the present ambulance access facilities to the Accident Department are not fully adequate for the increasing volume of ambulance traffic and that frequently the drive-way and the turn-round facilities are blocked by visitors' cars. Obviously there is great need for alternative parking space for visitors' cars, thus leaving the ambulance access route undisturbed. This problem would of course be greatly accentuated if we ever have to deal with large numbers of vehicles from a 'major accident'. Once again may I thank you for co-operating at all times and for this opportunity of expressing my point of view."

I am also grateful for the following comments from Mr. R. G. Miller, S.R.N., Charge Nurse, Casualty Department, West Cumberland Hospital:—

" The standard of service has improved considerably from the old routine, in particular the waiting time for patients. In some instances which are probably unavoidable, a patient may have to wait some time; in these particular cases I think it would help if the reason, especially when it can be foreseen, was explained to the patient at the time of request whenever possible. For example, one patient may delay a group who are travelling in the same vehicle, especially from the more distant ambulance stations.

" Liaison between ambulance crews and Accident Departments is now first class and the drivers and attendants are ready to assist when asked. I have impressed upon my staff the importance of a quick turn round of ambulances and this has been achieved by the extra supply of slings and blankets which replace those left by the Ambulance.

" The standard of first aid has also improved considerably, and I find that all the ambulance personnel are keen to learn anything new that we can teach them, and this I encourage my staff to do."

The following reports from two officers in charge of stations are of interest.

Mr. J. Butler, Bush Brow Ambulance Station, writes:—

" Since April, 1965, Bush Brow has been the control centre for East Cumberland, including Keswick and Alston, the result being better co-ordination and improved efficiency.

"The Hospital Car Service is doing a magnificent job, carrying approximately 80% of physiotherapy patients. I can in the future visualise a two-tier service, the Hospital Car Service carrying all physiotherapy patients, leaving ambulance personnel to the more specialised work for which they are

trained. No complaints have been received from patients regarding the Hospital Car Service which speaks highly for the people who make themselves available for this service.

" All personnel have completed one week's training at the Cumberland Infirmary; everyone found it very interesting and enlightening. Also the relationship between hospital staff and ambulance personnel has improved one hundred per cent.

" We are now on our own radio frequency which is an important step and when negotiations for the re-siting of the aerial have been completed, better reception will be had all round. Radio has recently been installed at the Casualty Department and Transport Office at the Cumberland Infirmary, the full effect of which has not yet been felt.

" All vehicles in East Cumberland are under five years old, and in my opinion are the best equipped in the country (except one 1960 Austin which is kept as spare).

" British Red Cross and Civil Defence personnel continue to train several nights a week at Bush Brow.

" We are fortunate in having an interested and enthusiastic staff who work harmoniously together at Bush Brow."

Mr. G. McGarry, Millom Ambulance Station, comments that:—

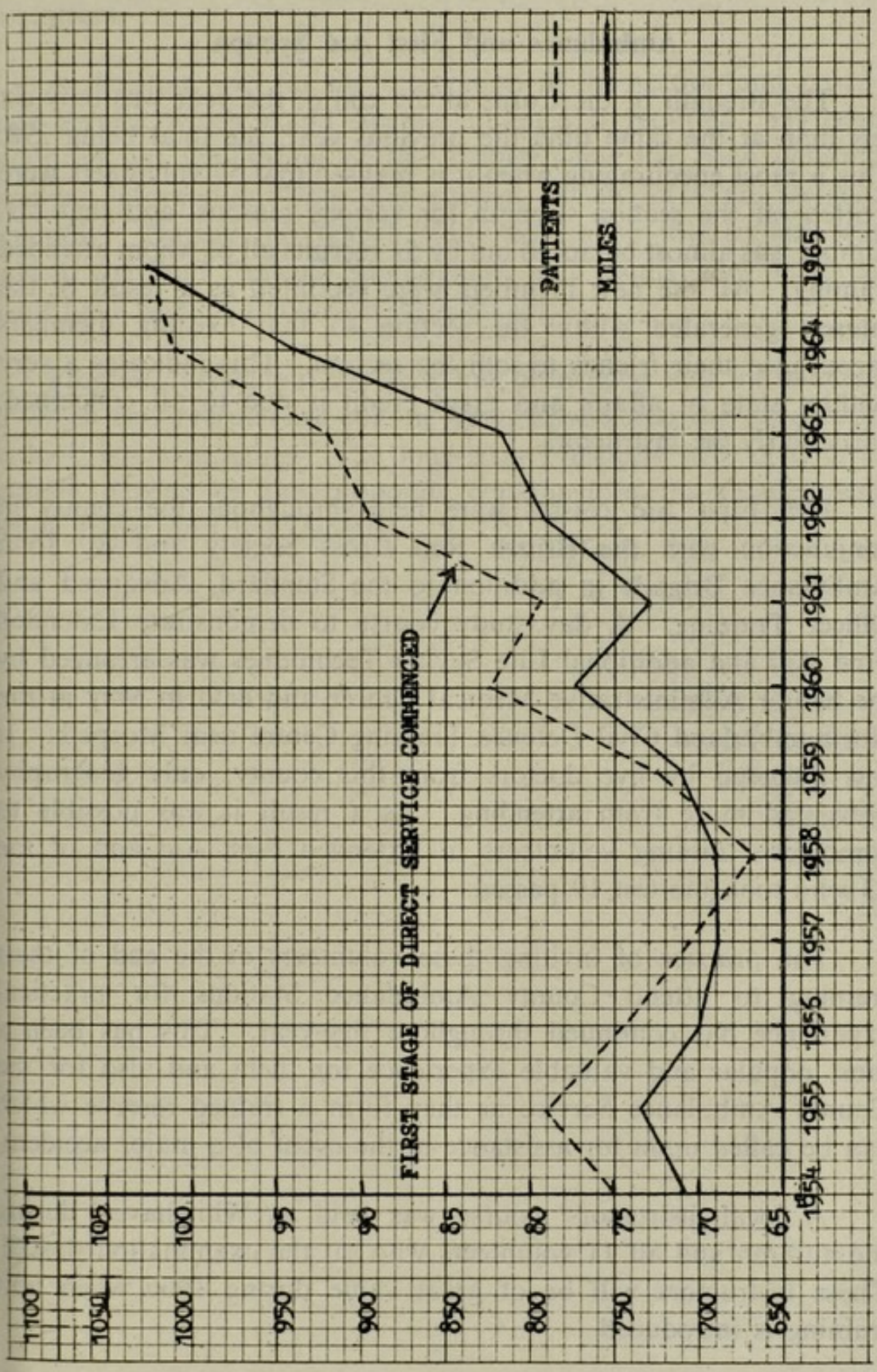
" There is no doubt that the local doctors are satisfied with the way the service can help them, both as to equipment and treatment of patients and we receive every co-operation from them.

" Hospitals too are very helpful, including North Lonsdale Hospital, Barrow-in-Furness. After discussion with the Hospital Secretary, I am now able to arrange Out Patient Appointments so that morning and afternoon appointments can be covered by two journeys with the vehicle standing an average of one hour each trip at the Hospital.

" The opening of the County Station at Distington has led to a more efficient service all round, and relations between us have been excellent from the start. The vehicle repair and overhaul service they give us is very good indeed and this has proved a great blessing, cutting down to an absolute minimum the time a vehicle is out of service. The advent of radio in June, 1965, was the greatest boon of all; in fact I do not know how we managed to work without it."

		Ambulances		*Sitting-Case Cars*		*Hospital Car Service*		*Summary of all Services*	
		Total No. of Patients carried	*Total mileage*	*Total No. of Patients carried*	*Total mileage*	*Total No. of Patients carried*	*Total mileage*	*Total No. of Patients carried*	*Total mileage*
1964	Agency Service	9494	134912	61479	464520	1105	23910	72078	623342
	Direct Service ...	19978	217949	—	—	8815	98390	28793	316339
		29472	352861	61479	464520	9920	122300	100871	939631
1965	A.	2946	33477	26081	199371	342	6613	29369	239461
	D.	47805	439706	—	—	25434	349505	73239	789211
		50751	473183	26081	199371	25776	356118	102608	1028672
Increase or decrease compared with previous year		+21279	+120322	—35398	—265149	+15856	+233818	+1737	+88991

GROWTH IN THE USE OF THE AMBULANCE SERVICE



CIVIL DEFENCE

Ambulance and First Aid Section

The strength of the Corps at the end of the year was only six less than at the same time the previous year, the total being 298. This is most encouraging when it is realised that 57 volunteers were written off the section strength for various reasons, and that this number was almost balanced out by 51 recruits all of whom attended training. All the new members were recruited as a result of the interest generated within the section so that existing members encouraged their friends to join the section. This indicates a very healthy state of affairs and great credit is due to all concerned, particularly the instructors.

Full First Aid classes were held throughout the county in conjunction with the British Red Cross Society and St. John Ambulance Brigade in addition to the Standard, Advanced and Officer Training. A day study course to demonstrate Extended First Aid and additional Life Saving Techniques was arranged by the Senior Administrative Medical Officer and held in May at the Northumberland Civil Defence Training Centre near Morpeth. It was attended by five doctors from this county; only geography prevented more from attending. As a result it was possible to commence training volunteers in Extended First Aid and of the 23 who took the test 19 passed.

The practice of inviting these volunteers at the end of their training to attend County Ambulance Stations for practical experience has continued throughout the year. This has been a most popular and valuable experience for them and also for the County Ambulance Service as they form a trained reserve which can be called upon for assistance in the event of a major accident.

A local instructors' course was held at Whitehaven during the autumn and all 11 volunteers who sat the examination passed. These instructors will be of great value during 1966 when unit training is introduced.

The section was fully represented at all the sectional and week-end exercises held in and out of the county, as well as the County

Rally at Keswick—another indication of the enthusiasm of the volunteers.

A skeleton plan for the integration of the section and peace-time service which could operate at once if required, has been produced but finalisation of the arrangements has been deferred pending information from the current review of Civil Defence generally. During the year a study course on this subject was held at the Staff College, Sunningdale, and results show that our plans have been laid down on the right lines.

Progress throughout the year has been good and the manner in which new recruits are coming along shows that the immediate outlook is encouraging. The long-term prospects will, of course, entirely depend on the proposals contained in the Government White Paper on Civil Defence.

GENERAL PUBLIC HEALTH

Infectious Diseases

Inspection and Supervision of Food

Water and Sewerage

Housing

Infectious Diseases

Examination of the table within will show that notifications in 1965 have centred again on Measles on the one hand, and on gastro-intestinal infections on the other.

With regard to measles, I would refer to my remarks in the section on Immunisation and Vaccination on the question of the possible use of the now available measles vaccines. Although in a year like 1965 with 3½ thousand notifications and no doubt more unnotified cases, the morbidity from this disease must be very considerable and not entirely short-term; the moment does not yet seem ripe for a general introduction of measles vaccination by by the Local Authority. This procedure is, of course, available for family doctors to apply in their practice as they see fit. No doubt the time will come when an antigen more conveniently combined with others already applied will commend itself for more general administration.

1965 saw two sharp outbreaks of gastro-intestinal infection in the county—the first featuring Sonne Dysentery early in the year and affecting mainly the Penrith area. This was a very disturbing outbreak the exact origin of which, as so often happens with dysentery, defied identification. Being a disease to some extent endemic most of the time, one tends to search for some particular breach of personal hygiene in a vital spot such as a catering establishment. However, this outbreak was characterised by a steady build up of cases over a number of weeks, followed by a 'plateau' for a few more weeks and then a gradual decline. Intensive measures of health education on personal hygiene were of course concentrated on schools and catering establishments, as well as a great deal of work on contact tracing and follow-up in which the health visitors participated most helpfully with the overtaxed public health inspectors in the area mainly affected. The only clear lesson emerging was the same as stands out in the control of all such infections, namely, the paramount importance of practising sound and consistent hand and kitchen hygiene.

Paratyphoid appeared at the beginning of August imported from Lancashire and Blackpool by returning holiday-makers. 31

cases in all were notified and the Wigton district was more severely affected than any other. Fortunately the infection was a mild one and few second-generation cases occurred. As always, of course, cases did occur in highly dangerous situations, associated with food production and distribution, and occasioned some anxious moments and decisions. Perhaps the greatest significance of the 'outbreak' was the indication it gave of how easily typhoid could be introduced and how readily spread. This leads me to refer to a memorandum which I submitted to the Health Committee in 1965 on the subject of sanitary facilities in certain strategic situations in the National Park within the county. It expressed my concern about the lack of sanitary facilities at many places in the Lake District and in two sites in particular. The Health Committee, and, in due course, the County Council accepted my strong plea that every effort should be made to encourage the authorities directly concerned and responsible (whether District Council, Lake District Planning Board or National Trust) to pursue the matter of adequate sanitary provision urgently.

NOTIFICATION OF CASES OF INFECTIOUS AND OTHER NOTIFIABLE DISEASES, 1965

	Scarlet Fever	Whooping Cough	Poliomyelitis	Measles	Dysentery	Meningococcal Infection	Acute Pneumonia	Acute Encephalitis Infective	Post Infectious	Enteric or Typhoid Fever	Paratyphoid Fever	Erysipelas	Food Poisoning	Tuberculosis Respiratory	Meninges and C.N.S.	Other T.B.	Puerperal Pyrexia	Ophthalmia Neonatorum
URBAN DISTRICTS—																		
Workington	2	—	—	239	4	—	—	—	—	—	—	1	—	9	2	1	1	—
Whitehaven	18	—	—	758	6	—	5	—	—	—	2	1	—	7	—	2	4	—
Cockermouth	—	—	—	65	8	—	—	—	—	—	4	—	—	—	—	—	—	—
Keswick	—	—	—	4	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Maryport	8	2	—	202	—	—	1	—	—	—	2	1	—	3	—	3	—	—
Penrith	5	—	—	99	94	—	—	—	—	—	2	—	1	6	—	—	1	—
RURAL DISTRICTS—																		
Alston	—	—	—	4	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Border	2	—	—	498	63	—	—	—	—	—	4	1	4	4	—	2	—	—
Cockermouth	12	—	—	285	15	—	1	—	—	—	6	—	—	2	—	—	—	—
Ennerdale	16	—	—	868	27	—	—	—	—	—	—	—	—	17	—	1	1	—
Millom	2	12	—	198	4	—	1	—	—	—	—	1	4	4	—	—	—	—
Penrith	4	2	—	40	27	—	—	—	—	—	—	1	—	2	—	—	—	—
Wigton	7	1	—	220	13	—	1	—	—	—	11	1	1	2	—	1	—	—
TOTAL FOR YEAR ...	76	17	—	3480	261	—	9	—	—	—	31	7	10	56	2	10	7	—
1964	119	152	—	1064	12	—	16	—	—	—	1	4	4	73	2	13	2	2
1963	23	119	1	1836	50	5	22	—	—	1	—	4	31	76	1	12	12	—
1962	35	39	2	2485	149	6	40	—	1	—	—	4	40	94	1	12	33	—
1961	57	72	4	2204	149	—	85	—	—	—	—	10	15	80	—	15	21	—
1960	114	392	—	1999	35	2	83	—	1	—	—	6	95	126	1	16	9	—

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, 1965.

	Total Samples Obtained		Genuine		Unsatisfactory	
	Milk	Other Foods	Milk	Other Foods	Milk	Other Foods
Submitted to Public Analyst	44	248	32	232	12	16
Tested by Sampling Officers	456	—	449	—	7	—
	500	248	481	232	19	16
	748		713		35	

During the year 748 samples were obtained of which 500 were of milk and 248 were of food and drugs . The number of samples submitted for analysis is of course limited on account of the cost involved but an endeavour is made to cover as wide a range of food as possible. From the many different articles of food on sale it is sometimes difficult to decide just what type of food to sample to ensure that the best possible use is being made of the service administered for the protection of the consumer. Even one particular type of food may be produced by many different manufacturers. However, when it is considered that many local authorities are carrying out this service under the Food and Drugs Act and that in many instances similar articles of food are obtainable throughout the country, it is probable that the majority of foods are periodically sampled hence giving protection to consumers irrespective of the area in which they reside.

Samples of fresh fruit and vegetables were obtained for examination for residues of pesticidal and insecticidal sprays and dressings. Samples of drugs consisted of proprietary medicines and B.P. and B.P.C. drugs available to the public.

All the samples of foods and drugs and 32 of the milk samples were submitted to the Public Analyst. In addition to the normal analysis of milk samples the Public Analyst also tests the milk for antibiotics if it is known that the milk is from one source of supply and not a mixture from different suppliers. The remainder of the milk samples (456) were tested by the Sampling Officers. The average quality of these samples, including seven slightly below standard, was 3.6% fat and 8.7% solids-not-fat compared to the presumptive standard of 3.0% and 8.5%.

The percentage of unsatisfactory samples, of the total number of samples obtained, was 4.7% compared to 7.2% and 5.5% for the previous two years. Taking the milk samples separately, 3.8% were below standard and of the remaining samples of food 6.4% were either of unsatisfactory quality or incorrectly labelled.

The unsatisfactory samples were dealt with as follows.

Milk:

Two samples of milk contained 10.8% and 12.0% of extraneous water. Following a complaint from the Milk Marketing Board samples were taken from a consignment of three churns of milk which had been placed ready for collection by the M.M.B.'s lorry. After the sampling officer had returned to his office the farmer telephoned him to state that one cow had been treated with antibiotics and some of the milk should not have been prepared for sending to the Board, consequently two churns had been removed from the collecting stand. The analyst found no trace of antibiotics in any of the three samples and one did not contain any extraneous water. The farmer was charged with having in his posession for sale for human consumption milk to which an addition had been made, in respect of the two churns containing added water, for which he was fined £25. This was the only case serious enough to warrant legal action in respect of unsatisfactory milk samples.

Four samples of milk were slightly below standard in solids-not-fat. Samples taken later from the same source were satisfactory.

Two unsatisfactory milk samples contained extraneous matter. One contained vegetable tissue and the dairyman concerned was cautioned. He was unable to state with certainty the actual source of supply so three producers, who supplied him with milk, were interviewed to make sure that adequate precautions would be taken to prevent a recurrence of the trouble. The second sample was from a supply a school milk. This sample contained 40 parts per million of extraneous matter consisting of cotton fibre and moist miscellaneous vegetable debris. The recommended limit for moist extraneous sediment is 30 parts per million. The attention of the producer was drawn to the unsatisfactory state of the milk and it was stressed that the milk be properly strained. Since then no further complaint has been received concerning this producer.

One sample was found to be deficient in fat content and two "appeal to cow" samples were slightly deficient but not to the same extent as the orignal sample. Enquiries revealed that the fat deficiency in the original sample could be attributed to the producer's method of bottling. This routine has now been changed and the whole of the milk is thoroughly mixed before bottling takes place. With regard to the fat deficiency in the "appeal to cow" samples the producer took steps to improve the quality of the milk. Samples taken later were of satisfactory quality.

One sample of milk contained an antibiotic. It was found that one of the farmer's cows had had an antibiotic injection and the milk from that cow had been excluded from the milk sold from three milkings following the injection. The farmer was informed that affected milk should be excluded until all trace of the antibiotic had disappeared and that his veterinary surgeon would be able to advise him on that point.

The milk samples tested by the sampling officers and not submitted to the analyst included seven slightly below standard. In such cases it is the practice to take further samples to see if the quality has improved. If results are still unsatisfactory, sam-

ples are submitted to the analyst to confirm the findings of the sampling officer and the matter is then taken up with the producer concerned. When initial tests indicate more than slight variations from the presumptive standards, or when doubtful results are obtained, formal samples are immediately forwarded to the analyst.

Unsatisfactory food other than milk:

The number of samples of food, other than milk, certified by the analyst to have irregularities was sixteen. Seven of these were cases of labelling infringements concerning soup mix, malt vinegar (2), pastilles, compound food, lemon and orange drinks. The attention of the manufacturers was drawn to the infringements to enable them to amend their labels to conform with the requirements of the labelling regulations.

Some beef suet was slightly deficient in fat content. Variations are possible in this article when it is divided into three different portions for sampling and in view of the small deficiency in fat no further action was taken. Samples of this article from the same manufacturer had on other occasions been satisfactory.

A caution was issued in respect of a sample of ice cream of unsatisfactory quality. It appeared that a genuine mistake had been made and a further sample taken later was of satisfactory quality.

Two samples of rum butter deficient in rum resulted in the manufacturers being cautioned.

Double cream was found to be deficient in fat content. Enquiries disclosed that the herd, from which the cream was produced, had been put "out to grass" the same week in which the sample was taken and would probably account for the fat deficiency and another sample taken later was found to be satisfactory.

A calcium drink was certified to contain sodium cyclamate which is not permitted under the Artificial Sweeteners in Food Order. No action was taken as this matter was being dealt with by another food and drugs authority and the manufacturers had agreed to replace the sodium cyclamate with saccharin.

A sample of lemon cheese was slightly deficient in soluble solids and the attention of the manufacturers was drawn to the deficiency.

Two samples of ice cream, deficient in fat to the extent of 32% and 44% resulted in the two manufacturers being prosecuted. The former was fined £15 plus an advocate's fee of £5/5/- and £3/18/- costs and the latter was fined £25 plus £3/18/- costs.

Complaints regarding unsatisactory food:

A number of complaints were received from members of the public concerning unsatisfactory articles of food and the following are those which were serious enough to warrant legal action.

A meat and potato pie which contained a piece of glass resulted in the baker being fined £10 plus £5/5/- costs.

A firm of bakers was prosecuted in connection with a fruit pie containing a hook shaped piece of metal and the firm was fined £10 plus £10/10/- costs.

A loaf of bread contained a partially smoked cigarette and the bakers were fined £20.

RURAL WATER SUPPLIES & SEWERAGE ACTS 1944-1961

Water Supplies

All the seven new schemes were submitted by the West Cumberland Water Board and consisted of small water extensions costing between £300 and £2,000.

In all seven cases, Ministry Grant was notified during the year and the County Council made matching grants. The works are proceeding.

With regard to Carlisle Corporation's major capital works scheme, the Carlisle Water Order 1965 was received during the year, authorising the construction of works in the Border Rural District and work on the first stage of the scheme, the Waygill Hill reservoir, commenced in November 1965.

The County Council reviewed the arrangements for making observations on both water and sewerage schemes submitted under the Rural Water Supplies and Sewerage Acts and decided that, in order to save time with the submission of schemes to the Ministry, the Sewerage and Water Supplies Committee be delegated power to make observations on schemes not exceeding £10,000 capital cost. By this method, a delay of some six weeks can be avoided with the smaller schemes.

Sewerage Schemes

Three new schemes were submitted for the County Council's observations under the Rural Water Supplies and Sewerage Acts and these are set out in the schedule following showing the Council's observations.

These are all schemes prepared by the appropriate District Council's consulting engineers.

With regard to Skirwith, schemes were submitted in 1950, 1960 and 1961 but did not proceed.

Two grants were notified during the year in (i) the Lazonby and Kirkoswald scheme or (ii) the Wetheral Pastures scheme and in both cases the Council decided to match the Ministry Grant. Work on the former scheme is expected to start shortly whilst the latter is nearing completion.

Water Schemes

Scheme Submitted by	*Name of Scheme*	*General Outline*	*Estimate or Final Cost*	*Grants*		*Remarks*
				Ministry	*County*	
W.C. Water Board	Supply to Scarness, Bassenthwaite	To provide a piped water supply to Scarness.	£2,050	£642	£642	Approved as sound and adequate.
W.C. Water Board	Supply to Bolton Wood Lane	To replace existing untreated spring supply.	£1,600	£488	£488	Approved as sound and adequate.
W.C. Water Board	Supply to Heathfield	To supply 10 properties at present without public water supply.	£2,750	£863	£863	Approved as sound and adequate.
W.C. Water Board	Supply to Brothy Beck	To supply two farms.	£900	£210	£210	Approved as sound and adequate.
W.C. Water Board	Supply to Lorton Low Bridge	To lay 160 yards of 3″ main to Lorton Low Bridge.	£300	£91	£91	Approved as sound and adequate.
W.C. Water Board	Main at Nealhouse	To serve existing properties and new development.	£470	£121	£121	Approved as sound and adequate.
W.C. Water Board	Extension at Bassenthwaite	To serve new development.	£510	£159	£159	Approved as sound and adequate.

Sewerage Schemes

Scheme Submitted by	*Name of Scheme*	*General Outline*	*Estimate or Final Cost*	*Grants*		*Remarks*
				Ministry	*County*	
Penrith R.D.C.	Skirwith Sewerage & Sewage Disposal Scheme	Sewerage for the Village of Skirwith.	£33,700			Approved as sound and adequate.
Border R.D.C.	Irthington and Newtown Sewerage and Sewage Disposal	Sewerage and Sewage Disposal for the villages of Irthington and Newtown.	£31,150			Approved as sound and adequate.
Border R.D.C.	Wetheral & Gt. Corby Sewerage & Sewage Disposal Scheme	Improvement of Sewage and sewerage disposal facilities for the villages of Wetheral and Great Corby.	£104,474			Approved as sound & adequate subject to discussion with Consulting Engineer on points of detail
Penrith R.D.C.	Lazonby and Kirkoswald Sewerage	To provide a combined treatment works at Kirkoswald to which sewerage from Lazonby will be pumped.	£44,000 (1962 figure)	£305 per ½ year for 30 years.	£305 per ½ year for 30 years.	Approved as sound and adequate. (To commence in 1966)
Border R.D.C.	Wetheral Pastures	To provide Sewerage and Sewage Disposal for Wetheral Pastures.	£11,950	£84 per ½ year for 30 years.	£84 per ½ year for 30 years.	Approved as sound and adequate.

HOUSING RETURNS FOR THE COUNTY OF CUMBERLAND

For year ended 31st December, 1965

(N.B.—Corresponding figures for 1964 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.	White-haven Boro'.	Working-ton Boro'.	Cocker-mouth U.D.C.	Keswick U.D.C.	Maryport U.D.C.	Penrith U.D.C.	Total for County
	Population — 1951 (Census) — 1961	2,327 2,105	29,845 29,644	20,455 20,966	29,676 30,859	13,428 15,094	11,723 11,638	23,746 21,866	24,620 27,566	28,891 29,552	5,235 5,827	4,868 4,765	12,234 12,393	10,492 10,927	217 540 223,202
A 1	Total number of occupied dwelling houses in the district	829 (819)	9,084 (8,899)	7,012 (6,965)	9,882 (9,887)	4,595 (4,552)	3,603 (3,712)	7,365 (7,247)	8,044 (12,636)	9,464 (9,006)	2,137 (2,041)	1,720 (1,685)	4,093 (4,025)	3,595 (3,601)	71,423 (75,075)
	2 Total number of occupied dwelling houses subject to Demolition Orders, Closing Orders or Undertakings:	1 (1)	— (—)	6 (10)	143 (51)	1 (1)	12 (13)	13 (31)	28 (50)	6 (4)	12 (36)	— (3)	54 (70)	26 (20)	302 (290)
	3 Estimated number of houses (exclusive of above) which are unfit for habitation and cannot be made fit at a reasonable cost: ...	13 (13)	326 (190)	154 (191)	376 (496)	264 (270)	80 (86)	273 (226)	100 (80)	N.A. (60)	127 (154)	3 (3)	85 (119)	65 (62)	1,866 (1,950)
	4 Estimated number of sub-standard houses (exclusive of above) which could be repaired and made fit:	50 (54)	520 (560)	N.A. (N.A.)	N.A. (N.A.)	198 (210)	430 (450)	1,158 (1,176)	N.A. (N.A.)	N.A. (1,000)	20 (20)	90 (90)	59 (75)	50 (51)	2,575 (3,686)
	5 Number of houses found to be overcrowded:	6 (6)	22 (19)	1 (—)	— (—)	7 (7)	16 (24)	2 (9)	— (—)	10 (20)	— (—)	— (—)	— (—)	7 (6)	71 (91)
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:	12 (25)	220 (224)	460 (450)	498 (422)	161 (217)	61* (59)	456 (472)	677 (790)	720 (750)	141 (106)	101 (230)	269 (247)	143 (205)	3,919 (4,197)
C	NEW DWELLINGS COMPLETED DURING THE YEAR														
	1 By or for the Council—														
	For aged persons	— (—)	20 (4)	— (7)	— (33)	14 (28)	6 (8)	16 (20)	— (—)	16 (24)	15 (—)	— (—)	35 (10)	— (—)	122 (134)
	For aged persons grouped with welfare facilities	12 (—)	— (20)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	21 (—)	— (—)	— (—)	21 (—)	54 (20)
	For agricultural workers	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)
	General purpose dwellings	— (—)	11 (*51)	9 (20)	15 (280)	— (—)	— (—)	93 (41)	74 (131)	86 (96)	36 (12)	24 (—)	86 (35)	— (3)	434 (669)
	2 Private building	2 (—)	83 (108)	42 (63)	70 (73)	42 (16)	22 (34)	40 (49)	84 (97)	56 (140)	24 (48)	17 (13)	23 (39)	56 (59)	561 (739)
	Total of 1 and 2 ...	14 (—)	114 (183)	51 (90)	85 (386)	56 (44)	28 (42)	149 (110)	158 (228)	158 (260)	96 (60)	41 (13)	144 (84)	77 (62)	1,171 (1,562)
D	1 Number of houses for which application was made by private persons for Grants. (Improvement and Standard Grants)	10 (11)	79 (88)	64 (83)	85 (82)	59 (58)	49 (45)	69 (53)	26 (25)	66 (87)	2 (6)	12 (10)	35 (40)	30 (24)	586 (612)
	2 Number of houses for which grants were approved:	10 (11)	78 (93)	63 (83)	51 (85)	50 (53)	45 (44)	63 (51)	25 (24)	60 (79)	2 (6)	12 (10)	34 (40)	28 (20)	521 (599)
	3 Number of houses where improvements were carried out and grants paid:	11 (5)	75 (75)	64 (73)	65 (73)	37 (57)	41 (46)	50 (61)	22 (29)	51 (77)	5 (4)	8 (12)	18 (41)	13 (20)	461 (573)
	4 Number of houses purchased or taken over by the Council with a view to improvement or conversion:	— (—)	1 (2)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	1 (31)	— (—)	2 (33)
	5 Number of houses improved by the Council—														
	(i) with grant	— (—)	1 (—)	34 (—)	— (76)	— (4)	— (—)	— (—)	— (—)	— (1)	— (—)	— (6)	— (—)	— (—)	35 (87)
	(ii) without grant	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)
E	HOUSING PROGRAMME FOR ENSUING YEAR—														
	1 Dwellings to be built by or for the Council—														
	For aged persons	— (—)	8 (20)	19 (15)	57 (12)	28 (32)	22 (24)	27 (14)	16 (—)	— (16)	6 (15)	— (20)	34 (40)	— (—)	217 (208)
	For aged persons grouped with welfare facilities	— (12)	— (—)	— (—)	22 (22)	— (—)	— (—)	10 (—)	— (—)	24 (1)	— (21)	— (—)	20 (20)	— (—)	76 (76)
	For agricultural workers	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)
	General purpose dwellings	46 (—)	33 (11)	24 (25)	226 (76)	— (—)	6 (20)	56 (103)	120 (105)	285 (88)	48 (36)	38 (22)	50 (75)	24 (28)	956 (599)
	2 Private building	4 (2)	N.A. (N.A.)	55 (80)	60 (60)	25 (20)	24 (20)	50 (55)	80 (110)	50 (100)	50 (50)	41 (20)	45 (80)	20 (60)	504 (657)
	Total of 1 and 2 ...	50 (14)	41 (31)	98 (120)	365 (170)	53 (62)	52 (64)	143 (172)	216 (215)	359 (204)	104 (122)	79 (62)	149 (215)	44 (88)	1,753 (1,540)

(*1) Old People only.

(*2) Including one Warden's Flat in connection with grouped dwelling scheme

APPENDICES

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

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

III. **Mass Radiography.**

IV. **County Council Clinics.**

APPENDIX I

Annual Report on Tuberculosis and Other Chest Diseases in West Cumberland in 1965 by Dr. R. Hambridge

The Chest Service in this area during 1965 underwent a series of changes, more sweeping in character and extent than at any time in the past thirteen years. The decline in tuberculosis mortality, coupled with the very obvious reduction in the attack-rate of disease in the population prompted the following changes:—

(a) Secondment of duties of Dr. M. Sanger Hicks to the Geriatric Service leaving him at a little more than half-time availability to the Chest Service.

(b) Withdrawal of the County Nursing Service's Health Visitors from Chest Clinic responsibilities and their attachment to general practitioners.

(c) Reduction in Chest Clinic records clerk establishment.

(d) Dissolution of the mobile Mass X-ray Service and its replacement by two static units.

The transition from long established procedures to new ones, in changed premises and circumstances, might well have been effected expeditiously had it not been accompanied by illness of key clerical staff at the moment of change, uncertainty of responsibilities by others deputising in tasks with which they were completely unfamiliar; and the, in retrospect, unwise decision to attempt assimilation of Chest Clinic records into the format of the general hospital record system.

The early part of 1965 produced administrative problems far in excess of any the Chest Service has faced since its inception and some of these find expression in the statistical data which follows in the body of this report. The most telling change of those listed above, however, has proved to be the withdrawal of Health Visitor activities from daily contact with medical and clerical personnel and the alternative channels of communication have served more of the Service. That this was likely could be, and was, forecast; to isolate the Chest Service from the County Health Service than

any other single step in the co-operative exercise established in 1952. Whilst the simple physical task of conducting an outpatient session has been rapidly and efficiently undertaken by various grades of nursing personnel at both Workington Infirmary and the West Cumberland Hospital, the understanding of clinical problems and their bearing on the tuberculous household is no longer so readily—or accurately—conveyable to the Health Visitor: and her knowledge of the family is less readily available to the clinician. The main effect has been in the conduct of contact examinations, which were always difficult to arrange and frequently misunderstood by anxious, or frightened, parents. Consideration of the figures relating to the Tuberculosis Register shows that West Cumberland still has a sizeable tuberculous community for whom prevention, care and after-care are concepts with a real and practical meaning.

New Cases

This year 54 cases of respiratory tuberculosis and 10 cases of various non-respiratory forms of the disease were notified, totalling 64 (70 in 1964; 71 in 1963). Three of these cases were notified posthumously.

There were, in addition, 127 new cases of respiratory disease not requiring treatment but deemed sufficiently severe to merit close observation.

Tuberculosis Register

The West Cumberland Tuberculosis Register at the 31st December, 1965, contained the names of 513 cases (556 in 1964; 707 in 1963; 1,604 in 1955). Ten years ago the category of "observation" cases was included in the Register total: in 1965 there were 924 such cases at the end-of-year tally (1,124 in 1964). The combined "active" and "observation" registers total 1,437 (513 + 924), indicating that a tuberculous community of much the same size still remains under clinic supervision, but with disease of a far less menacing form.

Cases deemed recovered—or arrested—during the year totalled 129, their names being removed from the Register (121 in 1964).

There were again three deaths from tuberculosis—one in the Maryport area and two in Whitehaven. All three were males aged 60 years or more (one aged 83). The mortality rate is again 0.021 per 1,000 population—unchanged from 1964 (0.12 in 1955).

(Register of Patients harbouring drug-resistant organisms

A separate register of such patients is still maintained although this aspect of disease-control is no longer a major problem. With continued care in drug treatment schedules, the problem can be contained; last year's low number of four cases of partial resistance has this year doubled and eight cases of partial resistance have been identified.)

Summary of Chest Clinic Statistics

During this year clinic sessions were held at the West Cumberland Hospital, where suitably equipped and staffed accommodation was provided in the general outpatient department of the hospital : the usual sessions continued at the Chest Clinic in the grounds of Workington Infirmary; and a reduced number of sessions continued in the County Health Department's clinic premises in Millom. With the cessation of regular visits to the Millom area of the Mass X-ray Mobile Unit this community of some 12,000 has become even more deprived of basic chest service requirements. The need for some form of chest X-ray service has been recognised, but the discharge of responsibilities to a large section of the population served by the West Cumberland Hospital Management Committee has yet to take practical form.

At the West Cumberland Hospital 137 outpatient sessions were held, at which 477 new patients were seen, the total attendances being 1,980. At Workington Chest Clinic, 154 sessions were held with 533 new patients and total attendances of 1,990. Seven sessions only were held at Millon, where 17 new patients were seen and attendances totalled 60. These figures for Millom are not realistic as a large number of Millom patients is included in the West Cumberland Hospital figures. These figures show a very marked reduction on those for 1964, reflecting the changed emphasis on tuberculosis case management and contact search to which attention has earlier been drawn.

Contacts of Cases of Tuberculosis

Familial contacts of cases on the Register seen at clinics during the year totalled 769 (1,002 in 1964; 1,222 in 1963). The ratio of new contacts seen (576) to new cases of disease (64) has fallen slightly from 10 : 1 to approximately 9 : 1. Some hundreds of adult contacts in addition have been advised to attend the Mass X-ray Units, but of these only 283 are known to have attended. From amongst the contacts seen at the clinics, five cases of active tuberculosis were identified, all in children under 15 years of age. No cases were found amongst the 283 attenders of the M.M.R. Units.

Prophylatic vaccination with B.C.G. has been offered to all susceptible contacts; to the new-born children of tuberculous parents and of parents with whom a family history of the disease exists; to the susceptible siblings of children found at routine school tuberculin-testing to have sustained primary infection; and to all previously vaccinated persons whose skin-reaction has waned or reverted to negative.

Of the contact group, 198 were skin-tested, of which 15 were found reactors; the reactor-rate of 8% is no longer comparable with figures for previous years as the impact of routine testing and vaccination at school has made a decisive mark on the proportion of young contacts of school age already given B.C.G. by the time they are recognised as contacts. However, it is interesting to recall that in 1955, this age group of contacts showed a reactor-rate of 43%.

In all, 426 persons were vaccinated, of which 61 were new-born infants (521 vaccinated—113 new-born for 1964).

Case Finding Procedures

Two Mass X-ray Units have again operated continuously in this area throughout the year : one sited in the outpatient department at the West Cumberland Hospital is extremely convenient for hospital attenders, but being remote from Whitehaven town is inconvenient for other groups of possible examinees. The other, sited in the Market Place at Workington, has proved popular with

doctors' referrals, but has handled no hospital outpatients at all, being remote from the hospital. Detailed figures of the two Units' operations and an analysis of their findings are published in the separate report for the M.M.R. Service. Suffice to say that the doctors of Workington referred approximately the same number of examinees as at the Whitehaven and attended as hospital outpatients : and from both groups much the same number of cases of active tuberculosis were found. Doctors' referrals at Whitehaven were appreciably less than at Workington, with half the yield of Workington. Nevertheless the hospital-based unit shows, after one year, an enhanced efficiency over its publicly-sited sister. Moreover, if the hospital unit had not been deliberately avoided by over 50% of new hospital outpatients, there is no doubt its efficiency would have been even more significantly demonstrated. Despite repeated efforts by the Medical Advisory Committee it appears impossible for unanimous decisions to be implemented by nursing and administrative staff and this continuing defect in routine health safeguards is receiving the attention it demands.

Routine ante-natal chest X-rays on full-sized films has continued throughout the area, but the child-bearing age groups are now so free of tuberculosis that only those expectant mothers previously known to be tuberculous have been disclosed by this source.

The continued school tuberculin-testing programme has not brought to light any new cases of active disease. Nevertheless, much preventive work arises from referrals of young reactors to the Chest Clinics, although the proportion of reactor children not already known to the clinics as contacts is steadily falling.

Treatment

The much-needed provision of a day-room at Homewood for ambulant patients has caused a reduction in available beds by six cots, leaving 35 adult beds. During the year the daily average bed occupancy was 25, discharges and deaths totalling 171. The average duration of stay has been 53.38 (51.45 for 1964). Admissions to hospital have been in the proportion of one non-tuberculous to one tuberculous.

Surgical procedures have again been conducted at Seaham Hall, where one case only of tuberculous disease required resection.

Lung Cancer

The total number of cases seen at the Chest Clinics in the year was 38 (24 in 1964; 34 in 1963). Of this number, eight proceeded to operation; the number of patients known to have died from this cause in 1965 was 18 (15 in 1964).

APPENDIX II

Annual Report on Tuberculosis and Other Chest Diseases in East Cumberland in 1965 by Dr. W. H. Morton.

Introduction

The chest centre statistics for 1965 show comparatively little alteration from those of 1964. The number of new cases of active pulmonary tuberculosis has again declined—34 compared to 42 in 1964. The active tuberculosis register for the whole of the area covered by the East Cumberland Hospital Management Committee area numbers 424, but, if one includes the number of cases of tuberculosis presumed healed but still under supervision, this figure amounts to 1,248. Of the 34 new cases of pulmonary tuberculosis the diagnosis was confirmed bacteriologically in 50%. Ten new cases of non-pulmonary tuberculosis were notified compared to 12 in 1964. There is evidence, however, that this is not a true picture as we have continued evidence of failure to notify some non-pulmonary tuberculosis disease. This is a great pity as it hampers the chest centre investigation of contacts and the possible finding of an infectious case.

The picture as far as lung cancer is concerned is also a little more hopeful. Last year only 54 new cases came to our notice compared to 80 new cases in 1964. Of these new cases, 7 were admitted to the Thoracic Unit for surgery, whilst in the remainder palliative treatment of one kind or another was used. The Cytotoxic Drug Therapy Trial in bronchial carcinoma still continues but it will be some time yet before any conclusions from this can be drawn. The death rate from bronchial carcinoma remains high. Whilst the number of new cases of bronchial carcinoma has diminished, there has been, unfortunately, an increase in the number of cases of cancer of other sites presenting with secondary manifestations in the chest, chiefly pleural effusions. The most common primary site of these latter cases has been in the breast.

Bronchitis, emphysema and asthma are the chief conditions found in patients coming to the chest centre. Many patients present no chest abnormality radiologically but are usually referred

because of a recent infective illness or because of some urgent symptoms such as haemoptysis. Haemoptysis is a frequent indicator of chest disease, and as such should be regarded seriously until clinical and X-ray examinations, and perhaps even bronchoscopic examination, have excluded the possibility of pathology. Once this has been done there is usually no need to keep such patients under continuous supervision.

Chronic bronchitis remains the chief pulmonary cause of morbidity amongst the population. "Colds" which include both bacterial and viral causes and are often interpreted as such when the chronic bronchitic has his recurrent attacks, are responsible for roughly a quarter of the total incapacity for work in this country. The infective element super-added to the hypertrophy of the mucus secreting structures of the bronchial tree with its excessive secretion soon results in a greater or lesser degree of endo-bronchial obstruction. The majority of the chronic bronchitic patients when first seen at the chest centre already show symptoms and signs of endo-bronchial obstruction, and treatment is long and arduous and not always successful.

Cigarette smoking is deeply involved not only in the aetiology of both bronchial carcinoma and chronic bronchitis but also in peptic ulcer and coronary thrombosis. The evidence for the relationship of smoking and chronic bronchitis has been well summarised in the past in reports both in this country and in America. Cigarette smokers have more frequent recurrent infections and more frequent symptoms such as cough and sputum, and altogether have diminished respiratory reserves as shown by spirometry tests. Smokers die of chronic bronchitis and emphysema six times more frequently than non-smokers. **To stop smoking cigarettes is the single most effective measure** in the prevention of chronic bronchitis and bronchial carcinoma. There are two essentials, a convinced doctor and a determined patient. Our experience suggests that one can induce one in three patients to stop smoking just by advising them to do this. For a patient merely to cut his cigarette consumption to a lower level is not at all satisfactory; as often as not, in a short time, his consumption gradually reaches its previous level. Anti-smoking clinics and

campaigns have so far shown little success. Perhaps more intensive education of school children on the relationship of cigarette smoking to lung cancer and chronic bronchitis might be more rewarding.

Sarcoidosis, other collagen diseases, and "Farmer's Lung" are responsible always for an appreciable number of patients. The aetiological problems of sarcoidosis, particularly with reference to the Mantoux test, are becoming more complicated. There appears to be some association between a positive Kveim test which has been claimed as specific of sarcoidosis and the persistent negative Mantoux test after B.C.G. vaccination. The Kveim test itself is subject to marked variations when different observers assess whether this test is positive or negative. There are a certain number of children who have attended the chest centre and who have had B.C.G. at school who have failed to convert from Mantoux negative to Mantoux positive. We have not so far, however, carried out any Kveim tests on these children.

"Farmer's Lung" has been scheduled as an industrial disease since last summer and the diagnosis of this condition can be fairly easily established on clinical and laboratory evidence. Unfortunately there does not appear to be any specific cure for this disease and prevention is not entirely easy. The condition is essentially an allergic reaction to an organism which is common in musty or dusty hay or other cereals.

Pepys, who has placed the diagnosis of the condition on a sound footing, has since shown that similar allergic reactions occur in persons who keep budgerigars and pigeons where the person becomes allergic to antigens in the excreta of the birds. This condition known as "Bird Breeder's Lung" or "Bird Fancier's Lung" can be diagnosed by precipiten tests in much the same way as "Farmer's Lung". These hypersensitive states are entirely distinct from asthma and are often difficult to recognise. "Farmer's Lung" appears to be particularly common in the Westmorland and Penrith parts of this area. In many cases the clinical history is strongly suggestive of the condition but when a patient first attends at the chest centre the X-ray may be entirely negative. Masks have

been advised for use whilst working in dusty hay but these are not entirely satisfactory as the spores of the organisms concerned are only one micron in diameter and this size makes it very difficult for an effective mask to be produced. "Farmer's Lung" and "Bird Fancier's Lung" essentially involve the peripheral regions of the bronchial tree rather than the bronchi themselves which are involved in asthma.

The total number of patients seen at the chest centre last year dropped from 12,082 to 11,036, this decrease being almost entirely accounted for by the decreased number of tuberculosis contact examinations. We now only have four sessions of physiotherapy time, and full use is made of these facilities.

The static mass radiography unit has continued to function continuously throughout the year. The number of persons passing through this unit number 6,202 compared to 4,716 in 1964. This unit was responsible for seven cases out of the 34 new cases of pulmonary tuberculosis seen during 1965, and for nine cases out of the 54 new cases of bronchial carcinoma.

Tuberculosis

Table 1 shows the number of notifications throughout England and Wales for 1965 and the preceding five years.

Table 1

Year	Pulmonary	Non-pulmonary
1960	21,129	2,861
1961	19,187	2,728
1962	17,973	2,685
1963	16,355	2,608
1964	15,026	2,581
1965	13,548	2.551

Table 2 shows the number of notifications in the area for the past ten years.

Table 2

Year	East Cumberland Pulmonary	Non-pulmonary
1956	54	10
1957	54	12
1958	47	15
1959	50	11
1960	19	6
1961	8	2
1962	23	2
1963	18	5
1964	25	6
1965	14	5

The programme of therapy in tuberculosis remains as in previous years. No new drugs have been introduced. The number of cases of tuberculosis with organisms resistent to the main drugs at the end of the year total three. There have been no new cases of tuberculosis found in immigrants in the area.

Table 3 gives the number of pulmonary and non-pulmonary cases on the clinic register at the end of 1965.

Table 3

East Cumberland	
Pulmonary	**Non-pulmonary**
177	21

Contact work has greatly diminished during the year; as the number of new cases of pulmonary tuberculosis has declined so have the number of contact examinations. In addition, older contacts and particularly those who have been vaccinated successfully with B.C.G. vaccine, are now only seen at two or four yearly intervals.

Table 5 shows the number of chest beds available with the number of discharges for 1965 and 1964.

Table 5

Hospital	Beds Available	No. discharged in 1965	No. discharged in 1964
Ward, 18 Cumberland Infirmary	14	271	281
Longtown Hospital ...	26	141	132
Blencathra Hospital ...	11	43	58

Neoplasm

Table 6 shows the number of new cases of cancer of the lung seen at the chest centre during 1965 and the previous nine years. Of the 54 cases coming to our notice during 1965 only seven were found, after investigation, to be fit for surgery, and thus only palliative treatment was possible for the other 47.

Table 6

Year	East Cumberland
1956	11
1957	11
1958	27
1959	31
1960	20
1961	30
1962	29
1963	36
1964	38
1965	26

APPENDIX III

MASS RADIOGRAPHY

REPORT ON THE WORK OF THE MASS RADIOGRAPHY UNIT DURING 1965

(NOTE: Figures given in brackets throughout the report relate to the corresponding figures for 1964).

15,296 (23,663) persons were examined by the Units during the year and of these 687 (698) were referred for clinical examination.

Table 1 shows the number of abnormalities revealed during 1965 throughout the whole of the Special Area.

TABLE 1

	No. of Cases found		Percentage of total examined	
ABNORMALITIES REVEALED.				
(1) Non-tuberculous conditions:				
(a) Bronchiectasis ...	13	(27)	.08	(.11)
(b) Pneumoconiosis ...	8	(15)	.05	(.06)
(c) Neoplasm	17	(23)	.11	(.10)
(d) Cardiovascular conditions	49	(57)	.32	(.24)
(e) Miscellaneous requiring investigation ...	7	(11)	.05	(.05)
(2) Pulmonary Tuberculosis:				
(a) Active	22	(20)	.14	(.08)
(b) Inactive requiring supervision ...	65	(43)	.42	(.18)

Table 2 gives an analysis of the work of the mobile unit divided into the East and West Cumberland areas.

TABLE 2

EAST CUMBERLAND								Source of examination	WEST CUMBERLAND							
Miniature Films.	Clinical Examinations.	Active Tuberculosis.	Inactive Tuberculosis requiring supervision.	Bronchiectasis.	Neoplasm.	Pneumoconiosis.	Cardiac conditions.		Miniature Films.	Clinical Examinations.	Active Tuberculosis.	Inactive Tuberculosis requiring supervision.	Bronchiectasis.	Neoplasm.	Pneumoconiosis.	Cardiac conditions.
								Doctors' cases	115	3	—	1	—	—	1	—
								Contact cases	138	4	—	1	—	—	—	—
								Students	85	1	—	—	—	—	—	—
345	6	—	—	—	—	—	6	General Public	856	16	—	—	—	—	1	1
802	21	3	3	1	—	—	4	Surveys	171	4	—	2	—	—	—	—
1,147	27	3	3	1	—	—	10	TOTALS	1,365	28	—	4	—	—	2	1

Table 3 gives an analysis of the work of the Static Unit in Carlisle, the Static Unit at the West Cumberland Hospital and the work of the mobile unit while operating in a static role at Workington Infirmary.

TABLE 3

STATIC UNITS	CARLISLE							WHITEHAVEN								WORKINGTON							
Source of Examination	Miniature Films	Clinical Examinations	Active Tuberculosis	Inactive Tuberculosis	Bronchiectasis	Neoplasms	Cardiac Conditions	Miniature Films	Clinical Examinations	Active Tuberculosis	Inactive Tuberculosis	Bronchiectasis	Neoplasms	Pneumoconiosis	Cardiac Conditions	Miniature Films	Clinical Examinations	Active Tuberculosis	Inactive Tuberculosis	Bronchiectasis	Neoplasms	Pneumoconiosis	Cardiac Conditions
Doctors' cases	2,651	277	6	8	9	8	19	743	53	2	11	1	1	4	2	1054	55	4	13	—	4	1	3
Contact cases	153	2	—	—	1	—	—	99	6	—	1	—	—	—	—	46	1	—	—	—	—	—	—
General Public	1,920	91	1	3	1	1	8	990	15	2	2	—	—	1	2	1418	28	—	5	—	2	—	—
Hospital Outpatients	—	—	—	—	—	—	—	990	33	3	8	—	1	—	1	—	—	—	—	—	—	—	—
Employees ...	1,414	44	—	1	—	—	3	893	17	1	6	—	—	—	—	115	1	—	—	—	—	—	—
Students ...	64	1	—	—	—	—	—	171	7	—	—	—	—	—	—	63	1	—	—	—	—	—	—
TOTALS ...	6,202	415	7	12	11	9	30	3,886	131	8	28	1	2	5	5	2696	86	4	18	—	6	1	3

Table 4 gives the relative figures as between East and West Cumberland for the past eight years.

TABLE 4

Year	EAST CUMBERLAND						WEST CUMBERLAND					
	Active Tuberculosis	Inactive Tuberculosis	Neoplasm	Cardiac Conditions	Bronchiectasis	Pneumoconiosis	Active Tuberculosis	Inactive Tuberculosis	Neoplasm	Cardiac Conditions	Bronchiectasis	Pneumoconiosis
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
1961 ..	20	11	24	144	23	4	13	20	5	24	10	42
1962 ...	24	14	25	71	22	2	12	63	9	18	19	60
1963 ...	17	4	21	67	27	6	8	58	3	23	18	37
1964 ...	13	7	16	47	22	1	7	36	7	10	5	14
1965 ...	10	15	9	40	12	—	12	50	8	9	1	8

Table 5 refers solely to the area covered by the East Cumberland Hospital Management Committee and shows the number of new cases of neoplasm discovered.

TABLE 5

	1958	1959	1960	1961	1962	1963	1964	1965
No. of cases of neoplasm seen at Chest Centre	59	59	54	64	60	74	80	54
No. discovered by M.M.R.	10	13	19	24	25	21	16	9

Comments

Statistics for 1965 do not show any material alteration from those in 1964. The number of new cases of pulmonary tuberculosis is practically static while the number of new cases of pulmonary carcinoma found by the mass radiography units has dropped. This latter finding is similar to that at the Chest Centre where the total number of new cases of bronchial carcinoma for 1965 has dropped compared to the previous two years.

It should be remembered that the commoner chest condition —chronic bronchitis—often reveals no radiological abnormality and the fact that a person with chronic bronchitis does get a normal x-ray report should not deter him or his doctor from seeking further advice on the treatment of his condition. I call attention to this as many patients with a chronic cough and sputum appear to be completely reassured on the receipt of a normal x-ray report. I would stress, however, that all patients with a chronic cough and

sputum should have a periodic x-ray examination to exclude more sinister pathology. Naturally, such patients should consult their own medical practitioners in the first place.

The mobile x-ray unit now operates at Workington Infirmary four days each week and there have been no operational changes compared to last year.

APPENDIX IV

County Council Clinics

Centre	Address	Clinic Services
Alston ...	Cottage Hospital, Alston.	Child Welfare, Dental.
Anthorn ...	Welfare Office, ... Anthorn.	Child Welfare, Vaccination and Immunisation.
Aspatria ...	St. Mungo's P., ... Aspatria	Ante-Natal, Child Welfare, Dental, Speech Therapy, Orthopaedic, Vaccination and Immunisation.
Brampton ...	Union Lane, ... Brampton.	Ante-Natal, Child Welfare, Chiropody, Dental, Orthopaedic, Vaccination and Immunisation.
Carlisle ...	14 Portland Sq., ... Carlisle.	Child Guidance, Dental, E.N.T., Ophthalmic, Orthoptic, Orthopaedic, Speech Therapy, Vaccination and Immunisation, Cervical Cytology.
Cleator Moor ...	Ennerdale Rd., ... Cleator Moor.	Ante-Natal, Child Welfare, Dental, Orthopaedic, Vaccination and Immunisation.
Cockermouth ...	Harford House, ... Cockermouth.	Ante-Natal, Child Welfare, Chiropody, Dental, Ophthalmic, Orthopaedic, Speech Therapy, Vaccination and Immunisation, Cervical Cytology.

Centre	Address	Clinic Services
Crosby (Maryport) ...	Nurse's House, 6 Parkside, Crosby, Maryport.	Child Welfare.
Dalston ...	Victory Hall, Dalston.	Child Welfare, Vaccination and Immunisation.
Dearham ...	Nurse's House, Central Road, Dearham	Child Welfare.
Egremont ...	St. Bridget's Lane, Egremont.	Ante-Natal, Child Welfare, Chiropody, Dental, Orthopaedic, Vaccination and Immunisation.
Frizington ...	Council Chambers, Frizington.	Ante-Natal, Child Welfare, Vaccination and Immunisation.
Houghton ...	The Village Hall, Houghton.	Child Welfare, Vaccination and Immunisation.
Hunsonby ...	The Village Institute, Hunsonby.	Child Welfare, Vaccination and Immunisation.
Keswick ...	13-15 Bank St., Keswick.	Ante-Natal, Child Welfare, Dental, Orthopaedic, Ophthalmic, Speech Therapy, Vaccination and Immunisation.
Longtown ...	T.A. Centre, Longtown.	Child Welfare, Dental, Orthopaedic, Vaccination and Immunisation.

Centre	Address	Clinic Services
Maryport ...	24 Selby Ter., ... Maryport.	Ante-Natal, Child Welfare, Child Guidance, Orthopaedic, Speech Therapy, Vaccination and Immunisation, Cervical Cytology.
Millom ...	18 St. George's ... Road, Millom.	Ante-Natal, Child Welfare, Child Guidance, Dental, Speech Therapy, Surgical, Chest, Gynaecological, Medical, Minor Ailments (G.P.s), Ophthalmic, Orthopaedic, Vaccination and Immunisatoin, Cervical Cytology.
Penrith ...	Brunswick Sq., ... Penrith.	Ante-Natal, Child Welfare, Dental, Family Planning, Hearing Therapy, Vaccination and Immunisation, Psychiatric, Speech Therapy, Orthopaedic, Orthoptic, Cervical Cytology.
Scotby ...	The Village ... Hall, Scotby.	Child Welfare, Vaccination and Immunisation.
Seascale ...	Gosforth Road, ... Seascale.	Ante-Natal, Child Welfare, Dental, Chiropody, Orthopaedic, Vaccination and Immunisation.
Seaton	Miners' Welfare ... Hall, Seaton.	Child Welfare, Vaccination and Immunisation.
Thornhill ...	Community ... Centre, Thornhill.	Child Welfare, Vaccination and Immunisation.
Thursby ...	The Church ... Hall, Thursby.	Child Welfare, Vaccination and Immunisation.

Centre	Address	Clinic Services
Wetheral ...	The Village Hall, Wetheral. ...	Child Welfare, Vaccination and Immunisation.
Whitehaven Flatt Walks ...	Flatt Walks, Whitehaven. ...	Ante-Natal, Child Welfare, Child Guidance, Chiropody, Dental, Family Planning, Hearing Therapy, Ophthalmic, Orthopaedic, School, Speech Theraphy, Vaccination and Immunisation, Cervical Cytology, Orthoptic.
Mirehouse ...	Dent Road, Mirehouse, Whitehaven. ...	Ante-Natal, Child Welfare, Dental, Vaccination and Immunisation.
Woodhouse ...	Woodhouse, Whitehaven. ...	Ante-Natal, Child Welfare, Vaccination and Immunisation.
Wigton ...	Birdcage Walk, Wigton. ...	Ante-Natal, Child Welfare, Chiropody, Dental, Orthopaedic, Speech Therapy, Vaccination and Immunisation, Cervical Cytology.
Workington ...	Park Lane, Workington. ...	Ante-Natal, Child Welfare, Child Guidance, Chiropody, Dental, Family Planning, Hearing Therapy, Marriage Guidance, Orthopaedic, School, Speech Therapy, Cervical Cytology. (**Note**—Spastic Therapy Clinic held about three times a year.)
Salterbeck ...	Holden Road, Salterbeck, Workington. ...	Ante-Natal, Child Welfare, Dental, Cervical Cytology, Orthoptic, Vaccination and Immunisation.